Witness Name: Alan Clamp
Statement No.: No.1
Exhibits: 12
Dated: 05/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Alan Clamp, Chief Executive, Professional Standards Authority for Health and Social Care

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I, Alan Clamp, will say as follows: -

I have been the Chief Executive of the Professional Standards Authority for Health and Social Care (PSA) since 2018.

I was previously the Chief Executive of the Security Industry Authority (SIA). The SIA is a public body established under the Private Security Act 2001 to regulate private security in the UK. Between 2011-2015, I held the post of Chief Executive at the Human Tissue Authority (HTA), an independent regulator sponsored by the Department of Health and Social Care.

In addition to my role at the PSA, I am a Non-Executive Director at the Parole Board and the Intellectual Property Regulation Board, and a Trustee of the Institute of Regulation.

PART 1 – The PSA, its functions, policy work and its work on regulatory reform and improvement

Functions of the PSA

1. The PSA promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. It is an independent body, accountable to the UK Parliament.
2. It does this through:
    - A performance review process for ten UK professional regulators, these being the nine statutory regulators of health professionals in the UK, and the regulator of social workers in England

- An accreditation process setting standards for organisations holding voluntary registers for people in unregulated health and care occupations
- Review of the outcomes of the final hearings of statutory regulators' fitness to practise process, with powers to take action where decisions fail to protect the public
- Regulatory policy work including: sharing good practice and knowledge, conducting and publishing research, introducing new ideas including our concept of Right-touch regulation, and monitoring policy developments in the UK and internationally.

3. The PSA provides advice to Governments and others on matters relating to the regulation of people working in health and care, and has also advised on policy and process in relation to the regulation of other professions. The PSA also undertakes international commissions, which extend our understanding of how regulation works in different contexts.

Performance review

4. The PSA's performance reviews look at whether the statutory regulators are meeting the Standards of Good Regulation, which cover the four key functions of guidance and standards; education and training; registration; and fitness to practise. There are also general standards covering areas such as equality, diversity and inclusion, the implications of public inquiries, and work with stakeholders to minimise risks to the public. There are 18 standards in total.
5. A report is published annually for each regulator detailing how many of the standards have been met, based on decisions reached by an assessment panel which has considered the evidence and analysis. The regulators' performance is monitored regularly and reviewed in three-year cycles, with a more in-depth analysis once every three years.

Accreditation of registers

6. The PSA also has a statutory role in strengthening quality and patient safety by setting standards and accrediting registers of people working in occupations not regulated by law. It is intended to enhance public protection and support choice by members of the public when seeking services from practitioners in occupations not regulated by law. It is a proportionate means of managing risks.

7. At the time of writing the scheme covered almost 130,000 people on registers held by 29 registering organisations. The purpose of accreditation is to improve the quality of registration carried out by the organisations holding these registers and to promote good standards of behaviour, technical competence and, where relevant, business practices by their registrants.
8. In order to be accredited, an organisation holding a register must meet standards set by the PSA in a number of areas, including protecting the public, complaints handling, governance, setting standards for registrants, education and training, and managing the register. While the standards mirror our Standards of Good Regulation, which are applied to statutory regulation, an Accredited Register differs from statutory registers because practitioners are not required to be on an Accredited Register in order to practise.

The PSA's background in regulatory policy and improvement

9. The PSA has a track record over twenty years in publishing reports and practical recommendations on different aspects of regulatory policy and practice, based on the best available evidence. These have been influential in the development of regulatory policy and the Government's reform programme for the sector. The publication *Right-touch regulation* AC/1, discussed further below, has been widely recognised and adopted as an approach to regulatory decision-making internationally, evidenced for example in the publication *Right-touch regulation in practice: international perspectives* AC/2. Here, regulators from Australia, Canada, Ireland and New Zealand reflected on how right-touch regulation had influenced their work, as did some UK regulators outside health and care. INQ0017164 INQ0017166
10. The PSA has been commissioned by Governments and others in the UK to advise on different aspects of professional regulation, including on the appropriate form of regulation – for example it was commissioned to advise on the appropriate form of regulation for sonographers by Health Education England. Its report was published in 2019 as *Right-touch assurance for sonographers based on risk of harm arising from practice. Report to Health Education England* AC/3. It was also commissioned by the Scottish Government to advise on the implications of regulation an occupation in fewer than all four UK countries – see *Regulating an occupation in fewer than all four* INQ0017988

UK countries – Implications for policy-makers, the public, and practitioners; Advice for the Scottish Government AC/4. INQ0017983

11. The PSA has commissioned numerous pieces of research into different regulatory policy questions where the evidence base for good regulation was lacking, and has supported researchers to access sources of funding and work with regulators. It hosts a busy programme of policy and research discussions with stakeholders. It has frequently been commissioned by regulators overseas to advise on performance, policy and process in their different contexts. These commissions have generated practical recommendations for improvement of those regulatory arrangements and have promoted learning about good regulation more widely.

How the PSA works with UK Governments, NHS bodies and stakeholders UK-wide to understand where the risks and issues lie and to propose solutions to protect the public

12. The PSA hosts a rolling programme of meetings, seminars, symposia and research conferences to convene stakeholders to discuss emerging issues in regulation, to understand these issues better, to identify their associated risks, and to discuss how these might be mitigated, both by regulators and others through practical, prioritised solutions. Outside this programme of meetings, the PSA engages regularly with stakeholders on matters of common concern and interest. As mentioned above, it has frequently been commissioned by the UK Governments and regulators in other countries to provide advice on specific regulatory matters.

13. Through its policy work, the PSA publishes its analysis of the evidence of what it thinks are the most effective solutions to issues to which regulation can make a contribution, with recommendations on best practice and improvement. A recent example is the 2022 publication *Safer care for all* AC/5, which discusses INQ0017989 the wider contribution of professional regulation in health and care in relation to high level issues currently affecting health and care services including inequalities, changes in the funding and delivery of care, the workforce crisis and accountability. It includes for example a recommendation that each of the countries of the UK should have a Health and Care Safety Commissioner, whose job would be to identify, monitor, report, and advise on ways of

addressing patient and service user risks, bringing together the fragmented regulatory landscape, and supporting it to work as a coherent whole.

14. The PSA engages with organisations such as the Institute of Regulation and the Council for Licensure, Enforcement and Regulation (CLEAR) that support learning across boundaries between the regulation of different professions and jurisdictions.

Key themes in PSA's regulatory improvement work

15. The PSA has published a series of policy statements and reports setting out its views on how regulation should be reformed in order to be an effective and coherent force for patient safety, and the underlying principles that should determine the direction of that reform. The key themes that run through these papers include that:
    - The arrangements for ensuring the safety of health and care in the UK are too complicated, fragmented and difficult to navigate in particular for patients and the public when they try to raise concerns
    - There are too many organisations involved, creating difficulties in determining where remits overlap, and where there are gaps, and in managing these
    - The structures and frameworks in place do not have the agility to change and develop at pace with changes in the delivery of health and care, and the demands placed on the NHS
    - Regulation should be underpinned by a shared set of values and objectives, and achievable outcomes, across professional and system regulation
    - A consistent and coherent approach to assessing the risk that arises from the practice of different professions should underpin decisions about who is regulated and how
    - Policy makers should consider the full range of options available for addressing risk of harm, and statutory regulation should only be considered where other means to mitigate risks would be demonstrably ineffective
    - The responsibility for the quality and safety of care lies primarily with those who deliver and manage it

- The focus of regulation should be more towards the prevention of harm through the effective promotion and upholding of standards, rather than post-hoc action after harm has occurred (i.e. fitness to practise, which is the most costly of the regulatory functions)
- There is scope for regulation to play an enhanced role in achieving patient safety, through engagement and collaboration with others

16. The PSA has sought to propose reform in the sector which will establish a regulatory system that is proportionate to the harm it seeks to prevent, simple to understand and operate, and efficient and cost-effective.

PART 2 – Policy background to NHS manager regulation; potential contribution and application of *Right-touch regulation*

Background to manager regulation

17. The PSA has carried out a rapid review of policy making in this area, going back to 2001, when an inquiry led by Sir Ian Kennedy recommended that:

> *'Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice.' The Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol.*

18. The Government turned down this recommendation on grounds of impracticality (*Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*). Instead, it proposed a series of measures, including the creation of a code of conduct, which became the Code of Conduct for NHS Managers, to be incorporated into NHS contracts.

19. In 2011, the Government once again tried to address the question of manager accountability, committing to '*commission independently led work to agree consistent standards of competence and behaviour for senior NHS leaders.*' The Secretary of State for Health asked the PSA[1] to develop *Standards for Members of NHS Boards and Clinical Governing Groups* AC/6 which were

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[1] Then the Council for Healthcare Regulatory Excellence.

published in 2012. These Standards were accepted by the Secretary of State, and originally intended as the foundation for a review of accountability arrangements for NHS senior leaders.

20. In 2013, the Francis Inquiry into failings at Mid Staffordshire NHS Foundation Trust recommended:

> *'A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.'* Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 3: Present and future, Annexes

21. The Inquiry stopped short of recommending statutory regulation explicitly because there was little enthusiasm for this among most stakeholders at that time. The Government of the day argued that the Standards developed by the PSA fulfilled the first part of Recommendation 215 relating to a code. For the compliance part of the recommendation, the Government proposed a new test of fitness for Board Directors, which became the Fit and Proper Person Test (FPPT). (*Hard Truths The Journey to Putting Patients First, Volume Two of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: Response to the Inquiry's Recommendations*). However, the FPPT was never formally linked to our Standards as seemed to have been originally intended. In 2019, Tom Kark KC reviewed the FPPT and recommended strengthening the requirements including setting up a barred list, but did not call for statutory regulation for NHS directors. A revised FPPT framework has been in place since September 2023. (*A review of the Fit and Proper Person Test Commissioned by the Minister of State for Health by Tom Kark QC and Jane Russell (Barrister)*).

22. It is of note that neither our Standards, nor the FPPT, whether in its original or updated incarnation, were aimed at managers below Board level – this part of the recommendation seems to have been widely overlooked. Mechanisms resulting from this recommendation have focused on Board-level directors, and always stopped short of any kind of statutory scheme – whether a public 'negative register' of individuals who have been barred, or a full regulatory

scheme like that for doctors. Our Standards were never put on any formal footing and appear to have fallen out of use.

23. For other managers, nothing formal has been put in place. I am unclear whether the NHS's own *Code of Conduct for NHS Managers* is still official policy – a small number of NHS Trusts still has the Code on their website, but we can find no current NHS England endorsement of it. NHS England has a range of resources for Board members and managers. It is also considering how to take forward some of the outstanding Kark recommendations, and those of the Messenger review of leadership in the NHS. *(Independent report Leadership for a collaborative and inclusive future, Independent report from General Sir Gordon Messenger and Dame Linda Pollard into leadership across health and social care in England*).

24. One of the difficulties with policy development in this area is that old frameworks are rarely explicitly revoked. For example, it seems that both the *Code of Conduct for NHS Managers*, and the CHRE/PSA *Standards for Members of NHS Boards and CCG Governing Bodies* have largely fallen out of use, but no formal decisions have been made or communicated about their status.

25. Any further policy development in this area should include a thorough review of existing frameworks, guidance documents, codes and so on, applying to NHS managers, to ascertain what should be retained, revived or retired, as part of developing an effective solution towards strengthening accountability and upholding standards.

Right-touch regulation and its potential application to regulating NHS managers

26. I would advocate that the principles of *Right-touch regulation* are applied to the question of how regulation might be introduced for NHS managers. A *Right-touch regulation* approach involves understanding both the nature and the scale of unmanaged risk, in order to identify the most effective regulatory measures for mitigating that risk. Applied to a healthcare profession or occupation, as per our *Right-touch Assurance* (RTA) AC/7 methodology, this requires an assessment of three types of risk:

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- ***Intervention/complexity***: potential for harm caused by features of practice such as prescribing, surgical and psychological interventions, or other kinds of physical therapies such as massage or invasive diagnostic techniques
- ***Context:*** different working environments will provide varying levels of oversight, consider for example hospitals, hospices, patients' and service users' homes, and high street premises
- ***Agency/vulnerability***: contact with patients and service users who may have less or more ability to exercise control over their care, and actively manage related risks, depending on their circumstances

27. The RTA methodology also involves two steps:
    - An assessment of the intrinsic risk of the occupation
    - A review of other (extrinsic) factors, such as existing mitigations, risk appetite, market impacts and so on.
28. A further hallmark of this approach is consideration of the full range of measures for addressing identified risks. The strongest form of professional regulation – statutory regulation along the lines of what exists for doctors or nurses – should only be used when the level and type of risk demands it. Short of this, there is a range of options for assurance, most of which do not require legislation. These include employer-led codes to underpin recruitment practices, licensing, accredited registers, and credentialling.
29. In January 2022 the DHSC published a consultation on criteria for which professional groups should be regulated. *Healthcare regulation: deciding when statutory regulation is appropriate* AC/8 referenced and drew on our work on RTA, and was rooted in the principle of regulating only where necessary to protect the public from risk of harm. INQ0017982
30. I would therefore recommend that the following be taken into account in any decision-making process regarding regulatory arrangements for NHS managers:

    Understanding the problem:

    - **Who?** Distinguish between the constituent groups that make up 'NHS managers'
    - **What's the problem?** Be clear about the problems to address

- **Is it about risk?** If so, describe and quantify the public protection risks attached to the different groups; include a comprehensive review of existing mitigations

Identifying solutions:

- Consider **strengthening or rationalising existing arrangements** where possible, rather than overlaying new ones
- If appropriate **replace existing mechanisms – and revoke them** – to create a simple, coherent transparent framework
- Consider the **full range of options for assurance** (including an accredited voluntary register, negative register, employer-led mechanisms, and so on), and use statutory regulation only if clearly indicated by the level and type of risk
- Check for **unintended consequences**

31. The NHS holds a wealth of data, which could be used to help build a case for or against more regulation of the different types of NHS manager. Other sources of evidence could be coroners' reports, for example, or data from NHS Resolution. A challenge with this assessment may be to make a firm link between the actions and decisions of people who are not directly delivering care, and the impacts on patient care and its outcomes.

PART 3 – Key considerations in addressing the question of regulation of NHS managers; PSA recommendations for way forward

Advantages, disadvantages and challenges of introducing professional regulation for managers within the NHS

32. The advantage of introducing regulation in any form for NHS managers would be the potential to prevent or reduce of harm to patients. This would be achieved through better management of the risks that arise to patients through the work of managers and its impact on the care. This better management of risk should be the focus of any measures that are introduced to strengthen accountability, enforce and/or improve standards of conduct and competence, and enhance professional development.

33. I set out below some potential disadvantages and challenges in introducing regulatory arrangements for managers that the Inquiry may wish to consider in addressing this matter.

Cost-benefit assessment

34. Introduction of any form of regulation for NHS managers would not be without substantial cost and some risks. The costs of statutory regulation and accredited registration are usually met by registrants. Unless these costs were met by the NHS or subsidised, this might constitute a deterrent to applicants for these posts, particularly from those outside the NHS from whose expertise the NHS might greatly benefit. Any decision to introduce any form of regulation for managers should be cost/benefit assessed against the opportunity costs and other ways in which investment could be made towards greater patient safety or system improvement initiatives.

Potential barriers to mobility and the import of skills

35. It is often argued that management in the NHS should learn from management in other sectors. The skills involved in NHS management, despite the specific context of the NHS, include general managerial and business skills including resource management, operations and process management and improvement, financial management, turnaround, digital and AI expertise, and so forth. People working in these fields are able to transfer their skills and thus their employment between sectors in a way which does not apply to those working in clinical roles. They come from a wide range of career and academic backgrounds, and many have managerial expertise through experience, sometimes having moved into full-time management from a clinical role.
36. It is also worth noting that statutory regulation for the healthcare professions is, with one exception, UK-wide. Regulating healthcare leaders in England only could have unintended consequences relating to mobility of staff around the UK.
37. These factors all present challenges to creating a coherent and effective regulatory system based for example on common, recognised and quality-assured qualifications.

Defining who is included

38. A further challenge to the introduction of a regulatory arrangement is simply one of definitions – who is in and who is out, and how can this be defined? First, there is the sheer range of different kinds of manager role – including general management; IT; HR; finance and so forth. These different managerial areas play different roles in the way that resources are used, impacting in different ways on the safety of care and the outcomes that are achieved for patients. In parallel, they are managing risks specific to their own areas of expertise and responsibility which may materialise into different kinds of negative outcome and harm.
39. I note that arrangements for holding board-level directors to account have been reviewed by Tom Kark KC, and strengthened requirements have been in place since September 2023. It is probably too soon to establish the effectiveness of the new arrangements, but given that they are in place, it will be important to note the differences between board members and other NHS leaders/managers in any policy development on regulation of NHS managers.

Dealing with dual registration

40. There is also the question of dual registration/regulation, if clinical managers – or, say accountants - are regulated in their capacity both as professionals, and as NHS managers. This would not be a unique situation – a small but not insignificant proportion of regulated healthcare professionals are dual-registered, e.g. someone who is both a nurse and a physiotherapist, or for some oral and maxillofacial surgeons who are both GDC- and GMC-registered. There are arrangements in place between regulators for the appropriate sharing of information, as well as for recognition of disciplinary/fitness to practise findings and decisions by other regulators. Our work on this in 2011 showed that the regulators the PSA oversees took a pragmatic approach to dual registration. For example, they may agree which of them will take the lead on an FtP case, depending on the nature of the concerns.
41. Fitness to practise with dual registration should start from the principle that each regulator should consider what action is necessary for the protection of the public in the specific circumstances of each case, and against the standards required by that regulator. That said, this arrangement does raise the question as to whether a further layer of regulation would be needed for those already

regulated by statute – this is another factor to consider when defining who should be in scope of any new regulatory arrangements.

Evaluating risks and potential harm

42. Even within these groups, there will be differences in scope of responsibility in theory (i.e. as recorded in job descriptions) and in practice. Director-level managers will be participating in a different set of decision-making processes to general managers in specific clinical areas, for example. Even within defined groups of managers, their actual influence on decisions and outcomes will differ greatly depending on a range of factors including the pressures on particular services, the effectiveness of working arrangements between managers, clinician-managers and clinicians, and the skills and competences of particular individuals. I am not aware that any such risk assessment has been carried out on the work of NHS managers.

The need for evidence of the current scope and impact of the work of managers

43. Decision on the introduction of regulatory arrangements that apply to any or all of these groups should be taken based on a thorough evidence gathering exercise of the current state of play for the range of roles that might be covered by NHS manager regulation; what their scopes of practice are on paper and in practice; what their influence in decision-making and outcomes is; and a clear understanding of where the differences lie. It may be the case that an assessment of these factors against what would be required for them to meet the Standards of accredited registration brings to light that different regulatory or assurance approaches may be appropriate for different groups within the broad definition of NHS managers.

Drawing on a wider range of views and evidence

44. Again on the point of the evidence currently in play, much of the current discussion around manager regulation (and NHS culture) is focussed on the findings of inquiries into situations where there have been significant failings. The arguments being put forth for the regulation of managers appear to be coming from other groups and do not appear to have taken account of the views

or insights from managers themselves. This is a significant gap in the range of evidence being taken into account, and any future decisions in this area should look to widen the evidence base being deployed.

45. It is also the case that much of the evidence currently in play arises from situations where care has failed catastrophically. We should also be looking to learn from positive examples, to understand more about what makes it possible for safe care to be delivered.

Distinguishing between issues of competence and accountability

46. Concerns about standards of competence have often been conflated with concerns about a lack of accountability, when the two are distinct problems with potentially distinct solutions. Regulatory measures for professional development aimed at raising standards of competence may not be the same as those that would address an accountability gap. It is important therefore to be clear about how different measures would address different kinds of problem.

47. Examples of ways to tackle a problem of inadequate standards of competence and/or performance of a group include:

- raising requirements for entry to a particular role or set of roles
- strengthening or introducing ongoing training and learning requirements
- the use of tiered qualifications to support career progression and match competence expectations to levels of seniority
- improving the quality of training provision
- improving the quality of local supervision and support
- providing employers with means of identifying and remediating poor performance
- introducing a code of conduct and/or competence

48. The limitations of any of these mechanisms should be acknowledged. Even in the best-case scenario, improvements are likely to take time to manifest, and may be thwarted by other problems (e.g. staff turnover, challenging working conditions etc).

49. Examples of ways in which a person can be excluded from a role/ activity/ practice following serious wrongdoing/ departure from standards include:

- a (positive) register from which a person can be removed
- a (negative) register onto which a person can be placed if they are barred from practice
- coordinated employment practices to prevent re-employment
- enforcing a code of conduct/competence through disciplinary and exclusion mechanisms.

50. Statutory regulation is often coveted by unregulated occupations, who see it is a means of improving or securing their status. But the introduction of barriers to entry to, and mechanisms for exclusion from a profession can have a negative impact on workforce numbers (see Chapter 5 – Unintended Consequences of our report, *Regulating an occupation in fewer than all four UK countries – Implications for policy-makers, the public, and practitioners, Advice for the Scottish Government* AC/9). INQ0017983

51. It is important to note that accountability mechanisms would apply to all, but generally only be used on a small percentage of the overall group, whereas measures to improve standards would affect everyone. This is important, because accountability or enforcement mechanisms that protect the public and maintain public confidence, can also foster bad faith within the group if they are seen to be wielded unfairly.

52. Most people in healthcare roles want to do their best and should be supported to do so. Enforcement and accountability measures, while important, can be seen as punitive. Rather than necessarily supporting well-meaning staff to perform to a sufficient standard, they can actively work against this. As so much of the literature on safety cultures makes evident, the fear of individual accountability mechanisms can drive negative behaviours, such as defensive practices, blame and cover-up culture. They can also have a deleterious effect on morale, if it is felt that people are not being given the tools to do the job properly, and then threatened with punitive measures if they fail.

53. There is a risk that in order to address the shortcomings of the few, measures are introduced that negatively affect the practice of the many. It is therefore important to consider the interplay and trade-offs between the two approaches of raising standards and strengthening accountability.

The way forward

54. I believe that steps should be taken to enhance the professional development and accountability of NHS managers. These steps should be proportionate, targeted, and based on a clear understanding of the problem.

55. I am not in a position to recommend a specific form of regulation, as the risks that arise from the practice of managers have not yet to my knowledge been sufficiently identified or quantified. However I offer some initial thoughts below on possible options.

56. I am minded at this stage to discount the option of full statutory regulation, such as is in place for doctors. I have not yet seen evidence that this is required at this stage, and further work would need to be done to establish if it is necessary. I am also reluctant to suggest a statutory regulatory solution to what appears to be primarily an employment issue.

57. My understanding is that NHS managers are employed under NHS contracts (directly or through commissioning arrangements). Consequently, I would urge the Inquiry to explore whether the NHS itself could perform the roles that statutory regulation might be expected to play – that of standards setter and gatekeeper. This would need to be underpinned by robust HR policies and processes, such as clear job descriptions setting out roles, responsibilities and reporting arrangements; joined-up recruitment processes to ensure that entry to these roles is appropriately controlled; and robust, consistent disciplinary processes.

58. A further non-statutory alternative would be to create an external registration body, to quality assure training programmes, hold a voluntary register of people with the appropriate qualifications, and take decisions about whether to remove a person from the register. Alongside this, NHS employment (or equivalent through commissioning arrangements) for particular roles could be contingent on registration status. A similar arrangement is in place for some roles within the NHS Talking Therapies Programme.

59. PSA accreditation of this registration body could provide assurance that this register was being run properly, in the public interest. Having it operationally separate from NHSE would remove it from the hierarchy and structures that

are seen by some to drive some of the fear and negative behaviours, and provide public and registrant confidence that accountability decisions were made independently. Our *Standards for Accredited Registers* would provide a framework for assessing what would need to be in place in order for such a register to operate in the public interest. This could support any evaluation of the feasibility and timeframes for creating such a register.

60. Alongside either of the above options, I would recommend the development of an NHS management career framework, based on competencies, a code and standards, to underpin either more robust employment practices, or a non-statutory register. Definitions of seniority of managers for the purposes of any accountability mechanisms could then be linked to a progression framework, qualifications and so on.

61. While the Inquiry's question focuses on accountability, I am keen to highlight the importance of these supportive frameworks. Often political attention is focused on accountability mechanisms that take effect after harm has occurred, but it is these positive steps to give everyone the tools they need to do their jobs that can make the biggest difference, by:

    - Raising standards of competence for all
    - Fostering good faith
    - Driving positive behaviour change
    - Improving retention, and
    - Helping to prevent harm.

62. If in time it were to become clear that these measures were not capable of addressing the problems, further mechanisms could be considered – including statutory regulation, for which the above could provide the some of the building blocks.

63. I note the recent changes to accountability arrangements for NHS board members. It may be beneficial to assess the impact of these changes as part of policy development on the possible regulation of NHS managers. Anything that is put in place for NHS managers below board-level should be as

congruent and compatible as possible with the arrangements for Board members.

Part 4 – PSA views on candour and workplace culture

The PSA's work on candour

64. The PSA has published a number of reports reflecting on the importance of cultures which support candour, and compliance with the professional duty of candour. For example, in 2019, the PSA reviewed the progress of professional regulators on that duty. Its report included observations on factors that encourage and discourage candour, which are summarised below, together with points arising from an earlier literature review on factors influencing candour (*Telling patients the truth when something goes wrong, Evaluating the progress of professional regulators in embedding professionals' duty to be candid to patients* AC/10). **INQ0017984**

65. The report observed that regulators had made wide-ranging efforts to embed candour, including but not limited to introduction of candour-related standards, creation of candour guidance, inclusion of candour in fitness to practise documents and embedding candour in education and training. Regulators can both promote and encourage candour, and take appropriate action where professionals have not been candid.

66. I also bring to your attention to a review of the literature on candour, openness and disclosure when care has gone wrong, carried out by the PSA in 2013, as part of a commission from the then Secretary of State for Health *(Candour, disclosure and openness, Learning from academic research to support advice to the Secretary of State* AC/11). More recently, researchers working within the **INQ0017985** European Association of Workplace and Organisational Psychology have been looking at the reasons that people in the workplace stay silent. Their work has analysed the various different reasons that people do not tell what they know, seeking to understand the psychological and social factors at play that result in inaction and developing a series of archetypal situations in which people do not speak. This work demonstrates that silence is often far from a neutral state, but rather, one which is conflictual and stressful for the individual, and that there

are many different reasons for it. The below is informed by these various sources, as well as our general observations of patient safety failings.

Workplace culture

67. The capacity of individuals to be candid is highly influenced by the environment they work in. Influencers in that environment include the wider culture of the organisation, team members and non-clinical staff.
68. Organisations that have a blame culture, or a culture of defensiveness, are not environments in which the professional duty of candour can thrive. If an organisation's culture is defensive, staff can be fearful about making admissions for fear of being criticised, and judged by, or alienated from, colleagues and employers. Professionals may fear becoming isolated if they are candid. Good leadership and management however can support staff in moving towards an open culture.

Time pressure

69. Timely action is essential when something has gone wrong, not least because a long delay can call into question the authenticity of an apology. Regulatory space for candour can be created where a regulator's legislative framework has the flexibility to allow and encourage a two-way exchange of information at an early stage. Where a professional has a heavy and stressful workload, this may have a negative impact on the time they are able to spend with patients where something has gone wrong, and by extension on candour.

Education and training

70. Education and training organisations have an important part to play in equipping professions with the skills they need to communicate confidently and well, including having candid conversations with patients when things have gone wrong. Interprofessional education helps to prepare professionals to comply with the duty of candour in a multidisciplinary context. However, education alone is not enough to support or ensure candour when trainees join the workplace.

Fear of the regulator and litigation

71. The prospect of regulatory and criminal or civil prosecution proceedings may discourage professionals from being candid. Professionals may worry that regulators will not be fair to those who have been candid, and may perceive regulatory action as punitive or looking to apportion blame, with individuals being held responsible for organisation-wide problems.

Bystander apathy, or the bystander effect

72. The bystander effect is a long-recognised phenomenon in psychology, where there is a diffusion of responsibility when things go wrong, such that individuals do not feel compelled to take action. Overload may be a factor that contributes to bystander inaction. Other psychological factors have been identified which contribute to professionals' difficulty in acknowledging error, such as 'denial' 'discounting' and 'distancing'.

Divided loyalties

73. Raising serious concerns brings with it the prospect both of the uncomfortable admission of personal liability for mistakes, and the incrimination of colleagues, which may feel like a betrayal of long-standing professional relationships. This was encapsulated by Paeth when he wrote 'the decision to engage in whistleblowing is not an act of pure unvarnished moral righteousness. Rather, it involves the evaluation of competing moral claims on one's identity and action, and a decision to act in ways that honour one set of moral obligations at the expense of another'.

Impact on career

74. Loss of reputation, position and career advancement are all potential impediments to disclosure.

The role of employers in creating an open culture

75. The literature suggests however that there is much that can be done by employers to support a culture of openness. This includes:
    - Providing support to those who might raise concerns, including helping them come to terms with their own mistake and its consequences

- Taking demonstrable action to prevent recurrence of mistakes highlights to both the individual concerned and the wider workforce, the organisation's commitment to improvement, and that there is a value in reporting
- Making the routes for raising concerns clear: what, when and how
- Emphasising the patient's right to information about their care when things have gone wrong
- Supporting and maintaining professionals' skills in disclosing difficult information sensitively and constructively, in particular in relation to communication with patients.

76. The PSA has no statutory remit to monitor the NHS, and its oversight of professional regulators does not provide the basis for an opinion on the extent to which the NHS has embraced a culture of candour. However, from the PSA's scrutiny of fitness to practise final hearing outcomes, it is our opinion that a lack of candour and an unwillingness to disclose important information by healthcare and care professionals is a recurrent theme, consistent with the findings of statutory and other inquiries into major failings in care. My colleagues who review the records of these cases often see that failure to disclose has either caused harm or unwarranted risk of harm, or has delayed proper investigation and remedial action.

77. However, there are two factors which I would bring to your attention. First, the effect of the pandemic on employees' attitude to work, and its potential effect on willingness to go 'above and beyond' and raise concerns. After the first wave of the pandemic, the PSA commissioned Professor Deborah Bowman to explore the ethical experiences of practitioners. Her report *Ethics in extraordinary times* AC/12 sets out starkly the ethically conflicted and sometimes traumatic experiences of practitioners during that period, and makes clear that for some, the outcome of their actions and decisions was moral injury. Although I am not aware that this has been directly studied, the experience of the pandemic seems likely to have changed practitioners' relationship with their employer, their loyalty to its aims, and their attitudes as to where their responsibilities lie in relation to wider safety issues. There is no doubt that this will affect their decision making on when to report concerns, when weighing up the various factors that we have set out above. INQ0017986

78. I also raise the current workforce and demand crisis in the NHS. Given the factors that I have already described that are at play when decisions are made as to whether to raise concerns, it is highly likely that the current levels of demand on the service, and the turbulence in service provision including from the junior doctors' strikes, will be making decisions about whether to report concerns even more difficult.

PSA view on culture – balancing learning and accountability

79. In our report *Safer care for all AC/5*, we discussed culture and the importance for improvement in patient safety of striking the right balance between individual accountability and recognition of organisational and systemic factors when things go wrong. INQ0017989

80. We are fully supportive of the drive to improve patient safety through safety cultures, and to create spaces in which people feel able to speak up and raise concerns. In addition to local initiatives, such as the pioneering work by NHS Mersey Care, we are aware of two national initiatives that fall under this bracket: the Health Services Safety Investigations Body (HSSIB) safe spaces approach to safety investigations, and the new Patient Safety Incident Reporting Framework (PSIRF).

81. We do however have some concerns about how these approaches are meant to intersect with arrangements for individual accountability, and particularly professional regulation, which relies on information being available and shared about the actions of individuals. Investigations into major failings in care often identify information not being shared with the right people at the right time as a contributing factor – and there is a risk that in an effort to promote learning, avoid 'blame' and to protect disclosures, barriers to the identification and free-flow of safety-critical information are being erected.

82. The PSA has recently convened a roundtable with relevant stakeholders to identify ways through these tensions, and will be looking at what more professional regulation can do to support learning cultures.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 5 April 2024