Witness Name: **Tom Kark KC**
Statement No.: **1**
Exhibits: [XXXX]
Dated: **24/07/2024**

THIRLWALL INQUIRY

WITNESS STATEMENT OF TOM KARK KC

I, Tom Kark, will say as follows: -

CAREER BACKGROUND

1. I am a barrister, called to the Bar at Inner Temple in 1982. Since pupillage (training), I have been a member, now an associate member, of QEB Hollis Whiteman Chambers in London.

2. My early years of practice from the 1980s into the 1990s focused almost entirely on criminal law. In the mid-1990s I began doing some work in medical regulation, by and large presenting cases for the General Medical Council against doctors. I expanded that practice to other medical regulators including work for the General Dental Council; advising the HFEA (Human Embryo and Fertilisation Authority); the NMC (Nurses and Midwifery Council); and the Osteopathy Council to which I was appointed as a legal assessor (legal adviser to specific disciplinary panels). In the meantime, I continued practising in criminal law and occasional Coroners inquests.

3. In 2000 I was appointed as a Recorder (part time judge of the Crown Court). I continue to sit as a Recorder when time permits. In 2010 I was appointed Queen's Counsel. I am also a Governing Bencher of Inner Temple.

4. In 2010 I was approached by Robert Francis (now Sir Robert Francis) to act as Counsel to the Inquiry under his chairmanship in the Mid Staffordshire NHS Trust Public Inquiry. That was an inquiry into very poor care delivered to patients at that hospital. I undertook that role, which was a significant piece of work, and which lasted over a year. Since then, I have undertaken other private inquiry work and continued to act in medical regulation and criminal law.

5. In 2018 I was approached by the (then) Minister for Health Steven Barclay MP, to examine the working and effectiveness of the Fit and Proper Person Test which is a statutory test under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**Regulation 5**"). In February 2019 my report entitled "*A Review of the Fit and Proper Person Test*" also known as "*The Kark Report*" was published.

6. In 2022 I was approached by the (then) Minister for Health in Northern Ireland, Robin Swann MLA, to chair a public inquiry into the abuse of vulnerable patients at Muckamore Abbey Hospital in county Antrim, Northern Ireland. I am currently chairing that inquiry and sitting with two expert panellists. The Inquiry is based in Belfast.

7. I have been asked to make a statement in relation to my work on the Fit and Proper Person Test and what follows is my best recollection of the events surrounding that report and subsequent meetings relevant to it.

8. When I undertook my work for that report I was assisted by another barrister, Jane Russell of Essex Court Chambers, who specialised in public and employment law.

THE REASON FOR AND TERMS OF REFERENCE OF THE REPORT

9. In July 2018 I was asked by the (then) Minister for Health Steven Barclay MP, to review the effectiveness of the Fit and Proper Person Test ("**FPPT**") as it applied to directors of hospitals and other health Trusts under Regulation 5. I was asked to report by the Autumn of that year. I delivered my report in November 2018, and it was published in February 2019.

10. There was a widely held perception that the test under Regulation 5 was not working effectively and an examination of the test was recommended by Dr Bill Kirkup in January 2018 in his report into problems at Liverpool Community Health Trust where there had been a significant failure of management by the board.

11. In his report into the Mid Staffordshire NHS Foundation Trust, published in 2013, Sir Robert Francis QC made a large number of recommendations to the government. Some of those recommendations were directly relevant to the role of senior management in hospital Trusts. During the Public Inquiry into Mid Staffordshire another scandal was investigated, that at the Winterbourne View Hospital.

12. One of the identified problems relating to management in relation to those two organisational failures was the ability of poorly performing managers and directors to

move from Trust to Trust, often following a settlement agreement and a pay-off. As Sir Robert Francis QC set out in his executive summary at 1.144:

> "*There has been understandable concern at the circumstances surrounding the departure from the Trust of the Chair and Chief Executive. While the business demands of the Trust may have required their swift departure and therefore a commercially understandable compromise, the public demand for accountability was left unsatisfied. Directors should be liable to disqualification from the role unless they are Fit and Proper persons for it. The test of fitness should include a requirement to comply with a prescribed code of conduct. A finding that a person is not a Fit and Proper person should disqualify a person from being a director of any healthcare organisation. Where a regulator is no longer satisfied that a director is a Fit and Proper person, there should be a power to remove or suspend that person from office after due process. Where a director's employment or appointment is terminated in circumstances where there is reasonable cause to suspect he or she is not a Fit and Proper person, the organisation should be obliged to report that information to the regulator*."

13. In response to this, the government published, in January 2014, a document called '*Hard Truths*' which claimed as follows (at paragraph 53):

> "*There will be a new stronger Fit and Proper Persons test for Board level appointments which will enable the Care Quality Commission (CQC) to bar directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. The Government believes that the barring mechanism will be a robust method of ensuring that directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact*."

14. The current scheme, brought into effect under the 2014 Regulations, did not set up a barring scheme, but was nevertheless thought to be a model for addressing the concerns raised in the Winterbourne View and Mid Staffordshire Inquiry.

15. The regulation, as it stands, primarily relies on Trusts implementing the test the effectiveness of which can be subsequently reviewed by the CQC when they undertake what they refer to as a '*Well Led*' inspection. The CQC has no direct power over individual directors of NHS Health Trusts, has never had such power, has never sought such power, and is not structured so as to be capable of undertaking the task the

government had suggested it would undertake. The CQC in general regulates organisations and not individuals. It does not directly regulate individual directors within Trusts and has no power to do so. The highpoint of its powers, where there is a failure by a Trust, is to put that Trust into special measures.

16. There is currently no power lying in any organisation to disqualify a director from being employed as a director on the board of an NHS Trust nor any wholly independent way of investigating complaints made against directors.

THE REVIEW I UNDERTOOK

17. I started my review by interviewing a large number of individuals, including leaders and managers across the spectrum of the NHS. The purpose of this was to gain an understanding of how the test was applied in practice, its efficacy and what could be improved about it. As mentioned above I undertook all interviews with information providers with Jane Russell (Barrister) and with a civil servant present to make notes. We interviewed a wide range of information providers. I also interviewed the leaders of other organisations which apply some form of the Fit and Proper Person test as well as a number of different regulators in health and in other disciplines. The notes of interview may be available from the DHSC or I may be able to collate a selection of them from various emails. I have not so far done so, and this would be a significant task.

18. To the best of my recollection the list of those we interviewed included:

Several Trust Chairs

Chief Executives and other Executives of various Trusts

Senior Nurses

A Human Resources Manager at a Trust

NHS Providers (Chris Hopson Chief Executive)

The Deputy Chief Executive of the NHS Confederation

The Patients Association

BMA (Dr Anthea Mowatt Representative Body Chair)

A number of whistle-blowers and a whistleblowing forum

Senior Management of the Care Quality Commission ("**CQC**")

The Chief Inspector of Hospitals (Professor Ted Baker)

The Chief Nurse (Jane Cummings)

National Medical Director, NHS England (Professor Steven Powis)

Representatives of Clinical Commissioning Groups

The Professional Standards Authority (Mr Harry Cayton CBE Chief Executive Officer)

Chair of Birmingham Women's and Children's Foundation Trust (Sir Bruce Keogh)

The National Guardian (Dr Henrietta Hughes)

Chair Mid Staffordshire NHS Trust Public Inquiry (Sir Robert Francis)

Chair of Report into Liverpool Community Health Trust (Dr Bill Kirkup)

NHS Improvement ("**NHSI**")– (Baroness Harding (Chair), Mr Ian Dalton (Chief Executive) Dr Kathy McLean (NHSI Medical Director and COO))

The Leadership Academy (Stephen Hart (CEO) and Peter Homa (Chair))

General Medical Council ("**GMC**") (Paul Buckley Director of Strategy)

Royal College of General Practitioners (Dr Susi Caesar Lead for Revalidation)

Amanda Oates Chief Director of Workforce Mersey Care NHS FT

Office for Standards in Education (OFSTED)

Financial Conduct Authority (FCA)

Ministry of Defence (Wing Commander Nigel Ayers)

Teaching Regulation Agency (Alan Meyrick, Chief Executive Officer)

General Dental Council (Ian Brack CEO)

Healthcare Professions Council (Marc Seale, Chief Executive Officer)

MPs Frank Field and Rosie Cooper

19. I apologise if this is not a complete list, which it may not be.

THE FIT AND PROPER PERSON TEST, A BRIEF EXPLANATION

20. The Fit and Proper Person test, applies to board directors, (both executive and non-executive) and those performing equivalent roles in NHS Trusts. Subparagraph (2) of Regulation 5 provides –

> *"(2) Unless the individual satisfies all the requirements set out in paragraph (3) a service provider must not appoint or have in place an individual --*
>
> *(a) as a director of the service provider, or*
>
> *(b) performing the functions of, or functions equivalent or similar to the functions of ... a director*."

21. The effect of this is that a Health trust may not appoint to its board as a director someone who does not pass the Fit and Proper Person test nor may they employ such a person as a Director. Subparagraph (3) sets out separate criteria some of which automatically make an individual unfit, (i.e. those listed in schedule 4) – including being an undischarged bankrupt or being barred from working with children or vulnerable adults as a result of being on the disclosure and barring service list.

22. Subparagraph 3 (b) requires that:

> *"the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed".*

23. Subparagraph 3 (d) requires that:

> *"the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity".*

24. Subparagraph (4) provides that

> *"in assessing 'good character' the provider must consider the matters set out in Part 2 of Schedule 4 which, in turn, requires the provider to consider the issue of whether a person has been convicted of any offence or has been erased from the medical register or struck off any professional health register*."

RECOMMENDATIONS

25. The recommendations I made are all set out in paragraph 1.8 on page 13 of my report. In very brief summary, there were seven recommendations. Five of those, which I set out below, were accepted by the government and some action has been taken to bring them into effect. Two of the recommendations (number 5 and 7) have not been acted upon.

26. The previous government undertook several steps to implement some of the recommendations I made. They did not implement the 5th recommendation which related to the disqualification of senior executives found guilty of serious misconduct nor the seventh. In brief summary, I made the following recommendations:

Recommendation 1 was that specific standards of competence should be defined which all directors of Trusts should be able to meet.

The purpose of this was to set some standards so as to make sub-paragraph 3(b) of Regulation 5 meaningful. This would benchmark the fit and proper person test and would provide aspiring candidates to directors' positions an identifiable framework of competencies to understand what was required of the role to which they might aspire .

This recommendation has been responded to in the new Fit and Proper Test Framework for board members ("**The Framework**") published by NHS England ("**NHSE**") on 2 August 2023 and the subsequently published standards. I will comment further on this later in this statement.

Recommendation 2 was that a central database should be created holding relevant information in relation to the qualifications and history of each director accessible by employing trusts and other relevant authorities.

The purpose of this was so that employers would not have to start afresh with every director they sought to employ in terms of accessing his or her history and qualifications. This would also help to build up a picture of each Senior Director in the NHS so that strengths and weaknesses could more easily be identified. This would bolster recommendation 1, because it would allow checks against the required competencies to be made, and further training to be offered where there were deficiencies.

This has been implemented in part. Under the Framework, personal data relating to the FPPT will be retained in local record systems (I assume this means by the

employing Trust) and in the NHS Electronic Staff Record ("**ESR**"). A record of FPPT outcomes will be held on the ESR.

Recommendation 3 was the creation of a mandatory reference requirement including information on complaints and any disciplinary process involving the director concerned.

The purpose of this was to require a full and honest reference upon the departure of a director which could not be curtailed by a settlement agreement. This would support recommendation 2 and would deny Directors who were leaving a Trust under a disciplinary investigation (or had faced other disciplinary issues in their employment) the ability to hide that fact through a settlement agreement and an agreed reference.

This has in part been implemented within the Framework. A standardised board member reference has been introduced which requires disclosure of disciplinary issues including unresolved disciplinary matters. However, my understanding is that this is a voluntary obligation. Without legislation I am uncertain at present whether this voluntary obligation will be sufficient to overcome the obstacles of a legal settlement agreement containing terms in relation to the reference to be given to the departing director.

Recommendation 4 was that the FPPT be extended to all commissioners and other ALBs (Arms Length Bodies).

The purpose of this was to stop the 'revolving door' so that disgraced or underperforming directors could not go from one Trust to another or into one of the other bodies related to the NHS, such as commissioning or improvement, which had been a frequent occurrence.

I was told this has been implemented through the Framework, but this may require the amendment of current legislation to make it fully effective.

Recommendation 6 was that the current legislation should be amended by removing the words 'privy to' from the test.

The purpose of this was to remove these words from the legislation because nobody we spoke to understood how to apply this part of the test and it was so wide as to be meaningless.

I was told this recommendation was accepted but there has not, to date, been any amendment of the legislation.

Recommendation 7 was that more work be done to examine how the test works in social care. This recommendation has not so far been taken forward.

27. **Recommendation 5** was that a new regulator should be created (potentially) called the Health Directors' Standards Council ("**HDSC**"). This organisation would have the power to investigate poor behaviour by directors covered by the FPPT and, where serious misconduct was proved, to disqualify them for a period, or for life, from acting as a senior director of a health trust. This was to be extended to all other health bodies from which NHS services are commissioned. I was given to understand that the great majority of private providers are commissioned by the NHS for certain services. The effect of this amendment would be to deny those providers NHS contracts unless their directors met the FPPT standards.

28. Chapters 9 and 13.5 (pages 98 – 111 and pages 132 – 134) of my report set out in detail how the HDSC would work. Serious misconduct should be defined specifically to include behaviour incompatible with holding a role on the board of a health trust. The HSDC was not intended as a full regulator like the GMC, which effectively requires every doctor to be on its register and applies accreditation and revalidation. The HDSC was to be a much simpler model, closer to the Teachers Regulation Agency, which only steps in to disqualify teachers for serious misconduct but leaves less serious disciplinary issues for each school or authority to resolve.

29. The importance of this recommendation was that there has been a constant churn of directors, some of whom have been accused of serious misconduct but who escape sanction because there is no sanction. This disempowers those who complain, or who feel bullied, and it empowers those who have behaved badly to continue to do so. The current answer in the NHS to poor behaviour by directors is very often a dismissal or an agreed departure with a confidential settlement agreement and the problem is passed to the next employer, either another Health Trust or one of the ALBs (arms-length bodies) or commissioning bodies. This has commonly been called the '*revolving door*' of the NHS. There is also currently a significant inequality in that doctors and nurses who are part of a board can be sanctioned for serious misconduct by the GMC and NMC, whereas other directors cannot be.

30. I also recommended that NHS contracts with senior directors are written to reflect that a finding of serious misconduct is regarded automatically as gross misconduct to

prevent an individual receiving notice period money or a '*golden goodbye*' package.

31. The HDSC:
    i) Would need to have legal authority to investigate and adjudicate upon complaints;
    ii) Need to be independent of the employing provider;
    iii) Could lie within NHS England;
    iv) Should be independent of the DHSC and independently chaired; and
    v) Should have powers to investigate, determine complaints and allegations, and sanction the individual.

32. The creation of a mini regulator such as that which I am recommending would almost certainly require legislation.

33. As I have indicated, the government did not adopt this recommendation.

FOLLOWING THE REPORT

34. Prior to publication of the report, but after I had furnished a draft copy to the DHSC, I received a letter from the Parliamentary Health Ombudsman in relation to the publication of a report by his office into failures by the CQC properly to investigate an FPPT complaint. This report was laid before parliament in December 2019 and I can furnish the inquiry with a copy of the correspondence between myself and the Ombudsman if required.

35. On Monday 11 March 2019, I attended a meeting with Stephen Hammond MP Minister of State for Health to discuss the review. I am afraid I do not have notes of this meeting.

36. On 12 March 2019, together with Jane Russell, I appeared before the Health and Social Care Select committee chaired by Dr Wollaston, and answered questions from Members of Parliament on that committee. This can be found online.

37. Following this appearance, I was put in touch with Helen Baimbridge, the Head of Parliamentary Engagement.

38. Between April 2019 and 2022, I had sporadic meetings and correspondence with various officials in the DHSC including with NHS Improvement. Despite these meetings I found it difficult to ascertain with any clarity which parts of my recommendations were being positively taken forward although I did discover in 2023

that a 'Kark Implementation Group' has been set up within the DHSC and that there was a 'Kark Implementation Programme manager' in place.

39. In 2022 at their request I attended a virtual meeting with Sir Gordon Messenger and Dame Linda Pollard in relation to their review of leadership in the NHS.

40. On 27 July 2023 Jane Russell and I met via teams with Carolyn May (Director of Talent, Workforce Training and Education Directorate NHS), Em Wilkinson-Price (National Director People NHS England), Celia Weldon (unsure of job specification), who gave us some explanation about the competency framework which was to be published the following day. I have some notes (by way of email) of that meeting should the Inquiry wish to see them.

41. In September 2023, following the convictions of Ms Letby, the Health Secretary in addressing parliament on the setting up of your inquiry, reportedly asked the DHSC to review my 5th recommendation.

42. On 7 December 2023, I attended a virtual meeting with the Secretary of State for Health, Victoria Atkins MP. There will be a note held by her team of this meeting, but I am afraid I do not have one. I do recall that she was surprised that there was still no central database of directors and she indicated the government's interest in reviewing again the 5th recommendation.

43. On 30 January 2024, I was invited to attend an expert panel of the Commons Health and Social Care committee examining, amongst other issues, the FPPT which I did. A transcript of that meeting is available and I can send a link to the inquiry if that is required.

44. Following the election, in July of this year, I was invited to submit to the new Secretary of State for Health, Wes Streeting, a note on how the 5th recommendation could be implemented swiftly. I submitted that note but have not had a response.

ACTION ON RECOMMENDATIONS AND EFFECTIVENESS

45. My understanding is that the publication of the Framework (see paragraph 26.above), on 2 August 2023, was a response to my report and recommendations. As it says in paragraph 1.2 at page 3:

> *"The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are*

not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward."

46. The Framework appears to cover all those who would be caught by the FPP test, including all executive and non-executive board members, interim directors and any other individuals called directors within Regulation 5.

47. Doctors and Nurses acting as directors who are separately regulated will still be assessed as against the Framework. The Framework is also said to cover all NHS organisations including all trusts, Integrated Care Boards, the CQC and NHS England. This appears to reflect my 4th Recommendation, to extend the test to commissioners and ALBs.

48. Paragraph 1.4 of the Framework provides that all personal data relating to the FPPT assessment will be retained on local record systems as well as on the NHS Electronic Staff Record ("**ESR**"). This appears to reflect my 2nd recommendation.

49. The Framework sets out in detail the steps which need to be taken before an appointment to a board director position can be made.

50. Paragraph 3.4 provides that:

> *"NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process. As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document."*

51. The Framework places a responsibility upon the Chair of each board to ensure that the FPPT process is effective and properly undertaken.

52. The Framework sets out how NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- *"Good character.*
- *Possessing the qualifications, competence, skills required and experience.*
- *Financial soundness.*

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and

selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc"

53. In relation to my first recommendation of setting specific standards of competency for board directors, the Framework provides (see paragraph 3.9)

> *"The Leadership Competency Framework will help inform the 'fitness' assessment in FPPT. This is in line with the Kark Review's (2019) recommendations on professional standards. The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives."*

54. In relation to my third recommendation (mandatory references), the Framework sets out (paragraph 3.9) that:

> *"A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS".*

55. The requirements of each reference are set out (paragraph 3.9.1):

> *"NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment. NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally."*

56. In relation to settlement agreements and '*agreed references'* the Framework sets out that:

"If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference. Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence."

57. Importantly, in line with my 3rd recommendation, the Framework (paragraph 3.9.1) does now require references to include information about past investigations and disciplinary issues, even where not concluded:

"The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

• Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

• Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

• Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT."

58. It is specifically asserted (paragraph 3.9.3) that if a reference reveals something which is incompatible with the requirements of Regulation 5, the individual should not be appointed to the role.

59. A reference template is provided to try to ensure consistency and full disclosure.

60. The Framework sets out, at paragraph 4, the CQC's continuing role for assurance quality checking. Again however, it is clear that the CQC are not provided with any additional powers. As was stated in my report, the CQC is process-driven and will examine the processes for trusts concluding that an individual is a fit and proper person.

THE COMPETENCY FRAMEWORK

61. On 28 February 2024, NHSI published the Leadership Competency Framework for board members (the "**Leadership Competency Framework**"). It sets out six leadership competency domains. Every board member from Chief Executive down should be assessed against these six competencies. A further document will be published later this year, '*The Board member Appraisal Framework*'.

62. This document is clearly intended to meet my first recommendation that:

> *"In order to assist the effectiveness of Boards and Board directors and to encourage people within the service to consider Board posts, we recommend that NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Medical Royal Colleges, define, design and set high level core competencies which must be met by any person holding or aspiring to a directorship post (including Interim directors and NEDs64) in a Health Trust. Whether or not a director meets the requirements of Regulation 5 (3)(b) should be assessed against the identified competencies."*

63. Before giving any opinion on whether I believe the current approach is likely to be effective in meeting the recommendation I think one would need to see the document apparently being published in the autumn of this year. One would also want to wait and see how these competencies are applied and embed themselves, if they do, in practice.

MY VIEW OF THE FRAMEWORK AS A WHOLE

64. In relation to both frameworks, they are clearly pieces of work that have taken significant time and effort and if the Framework for Board members is properly applied and adhered to, I think it will meet a number of the goals aimed at by my recommendations. Many such initiatives, such as the GMC's revalidation process, take a significant time to bed down and become workable.

65. As always there is the conundrum that well-led trusts will be well-led anyway and will find the new guidance helpful but perhaps unchallenging, because many or all of the principles set out will be already embedded in their systems. Poorly managed trusts will see it as a tick box exercise and treat it as such, in which case it will fail to make any improvement. The CQC will in my view have to be rigorous to ensure that their well-led reviews incorporate significant focus on the new framework for the FPPT.

66. I am concerned that the mandatory reference scheme, without legislative support, may not have sufficient weight to overcome a legal settlement agreement in requiring a full and honest reference to be written, however employment law is outside my specialty and there are others better equipped to answer that question.

VIEWS ON THE HEALTH DIRECTORS STANDARDS COUNCIL (HDSC) NOW

67. I am still of the view that an independent regulator with powers of disqualification when serious misconduct is proved, such as that which I recommended in recommendation 5, would be of considerable value to the NHS.

68. Although it would be a challenge both technically and financially to set up such a regulator the long-term benefits are, I believe, clear. There would be many benefits which would include:

- Stopping the revolving door whereby badly behaved or incompetent directors move from one Trust to another part of the health service without sanction;
- Empowering whistleblowers (or others who speak up) so that they feel that when a complaint is made, something can be done, and there would be an independent organisation outside of the Trust about which they are complaining which will investigate the complaint;
- Empowering members of staff who have a serious grievance against senior members of management to have a route of independent challenge; and
- To reassure the general public about the competence and good behaviour of senior directors in the NHS.

69. Although it would be tempting to take the easy route and create a voluntary register of directors who might then be removed from that register, I am unconvinced that this system would have the power to disqualify directors and it would not in my view satisfy those who, for many years, have complained about the apparently invincibility of directors subject to complaints.

70. Some principles of the inception of the HDSC might be that:

i) It would need to have legal authority to investigate and adjudicate upon complaints;

ii) It would need to be independent of the employing provider;

iii) It could lie within NHS England;

iv) It should be independent of the DHSC and independently chaired;

v) It should have powers to investigate, determine and sanction the individual; and

vi) It is unlikely to sit easily within the CQC and I suspect they would resist such a suggestion.

71. Considerably more detail is given in Chapter 9 and 13 of the report and elsewhere. However, in my view the most obvious pitfalls or difficulties in creating such a body would include:

i) Ensuring any legislation and roll-out is drafted and publicised as a positive measure to assist boards. There is already a significant challenge recruiting good people to boards and this could be a disincentive to belonging to a board unless carefully done; full and proper consultation should be undertaken with current boards and others;

ii) Ensuring there was no disparity between doctors and nurses who sit on boards and are already regulated by the GMC or NMC; Consideration may have to be given to excluding them from the authority of the HDSC otherwise they would find themselves regulated by two different bodies;

iii) Ensuring that this change will only effect those whom it is designed to affect. The test of serious misconduct should match that of other regulators and there must be a robust filtering process to remove unjustified complaints;

iv) Ensuring the HDSC is properly funded so that it has sufficient staff to deal with an early surge of complaints and does not immediately create a backlog of cases.

72. It must be recognised that it would be a challenge for any government to set up a new regulator. It takes considerable work and pre-consultation, careful thought around any legislation, legislative time and political support. I believe however that there would be cross party support for such legislation.

73. In relation to whether '*senior managers'* in the NHS should be regulated, the real issue is what is meant by *'senior managers"*? The test currently applies to Directors. On an acute ward the '*senior manager'* might be a band 7 nurse or ward sister/manager. I cannot see it as beneficial for the test to be applied to that level of management. As lawyers we need to be very cautious using words commonly defined but which in healthcare may have very different significance. In my report I recommended that each trust should provide a list to the CQC of those who are to be regarded as Directors under the Fit and Proper test.

74. The only purpose of regulating '*senior managers'* would be if there is clear benefit to services provided to patients by doing so. Trust structures can be enormously complex with several layers of management below board level. Currently the FPPT only applies in general to board level appointments. Decisions made on the wards or at Directorate level, and even as part of a disciplinary process, may never reach board level management. I do not think this is a question a lawyer can answer without considerable consultation as to what benefits and what unintended consequences might result.

75. In relation to the question of whether the existence of a regulator such as the HDSC could have affected behaviour of individuals at the Countess of Chester Hospital I am not willing (with respect) to comment upon. I do not know sufficient about the circumstances of the tragic deaths which occurred and only know what I do through newspaper and media reports. It would be unhelpful in those circumstances for me to offer any opinion.

MY EXPERIENCE IN THIS REVIEW OF MAKING RECOMMENDATIONS

76. I have found the experience of making recommendation in this and other reviews I have been involved in quite challenging. Upon publication, the author of a report in general terms has no further power. Although I did have subsequent meetings in relation to my report, I found it difficult to keep track of who was in charge of implementing it or whether it was being implemented at all.

77. I am pleased that so many of my recommendations have been taken forward, although one might think many of them were so obvious as not to require a report. More importantly many of my recommendations had, in essence, been recommended before me in various reports such as that of Lord Rose. Governments find it much easier to

order a report or a Public Inquiry than they do putting the consequent recommendations into effect.

78. It would have been helpful to me to have a key person in the DHSC to whom one could have recourse to see what action if any was being taken in response to the report once it had been published.

79. I am still hopeful that recommendation 5 will now be taken forward by the new government.

80. I will of course be willing to assist the Inquiry by answering further questions if that is thought necessary.

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: 

Dated: 24 July 2024