18 February 2025

NHSProviders

Leading the NHS: proposals to regulate NHS managers

NHS Providers response to the government consultation, by question

Q: Do you agree or disagree that NHS managers should be regulated?

- Strongly agree
- Agree
- **Neither agree nor disagree**
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

NHS Providers is the membership organisation for all NHS trusts and foundation trusts providing hospital, mental health, community and ambulance services in England.

We appreciate the thorough approach being taken in this consultation, and the focus on patient safety, alongside leadership, accountability and organisational culture.

We believe a supportive, development-focused regulatory system could provide opportunities for strengthening public accountability, and could benefit the NHS by setting clear and consistent standards and expectations for managers.

However, it is also important to reflect on the purpose, scope, and limits of regulation.

- On its own, regulation cannot guarantee patient safety or enforce a better speaking up culture. It is also unlikely to guarantee that a determined criminal would be stopped.
- It is important to remember that management is not a profession as such, as it is not defined by a specific discipline, qualification or entrance exam, unlike medicine, nursing or law. Regulatory provisions would need to account for this difference.
- It is important to draw a distinction between 'management' and 'leadership'. These tend to be used interchangeably in the consultation document. However, these terms have different meanings: chairs and non-executive directors (NEDs) are 'leaders', due to their role in shaping the strategy and vision of the organisation, and their collective responsibility for the performance of the organisation as part of the board. However, they are not employees, and have no formal management responsibilities, so cannot accurately be described as 'managers'. Conversely, junior

managers are within the scope of this consultation, but are not leaders in the same way as board executives.
- It is vital that regulation is equitable in its application and impact: there is a risk that it could entrench structural inequalities and racial discrimination. Care must be taken that it has the opposite effect.

Q: Do you agree or disagree that there should be a process to ensure that managers who have committed serious misconduct can never hold a management role in the NHS in the future?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

This proposal would be in line with Kark's review of the fit and proper person test and his recommendation on "the power to disbar directors for serious misconduct". This was intended to stop managers moving around the service even after serious misconduct has been found.

The vast majority of NHS leaders and managers join the service to provide the very best possible care for their patients, and their ultimate goal is to ensure the safety of those using their services. Under sustained, severe pressure, leaders are doing their best to fulfil their duties and to keep the service running as smoothly and as effectively as possible. In these circumstances, it is essential that any regulatory system remains focused specifically on professional misconduct, rather than wider issues such as organisational or system performance.

We recognise it is always possible that there are individuals who are not fit to practise and whose serious misconduct poses a risk to patient safety. Regulation should therefore include a mechanism by which these individuals could be removed from practice. We believe, however, that any allegations of serious misconduct should always be considered by the individual's employer in the first instance, before being escalated to an independent body for review.

Allegations of serious misconduct should be independently investigated, and this may lead to disbarment from leadership posts. This process should be aligned with the definition of senior misconduct included in the Kark review. For the most serious cases, permanent disbarment may be appropriate. However, in line with other professional regulators, for less severe cases there should be a possibility of restoration after a certain period of time, and once a restoration panel has been satisfied that the individual is safe and suitable to return to practice.

Statutory regulatory schemes for healthcare professionals such as doctors and nurses allow for:

- **conditions to be placed on their registration, and**
- **their registration to be suspended if their fitness to practise is found to be impaired.**

Q: If there was a disbarring process, do you agree or disagree that the organisation responsible should also have these sanctions available to use against managers who do not meet the required standards?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

A disbarring process should not be used in isolation because, while potentially appropriate in severe cases, this would create a regulatory system that is essentially punitive. If introduced, such a mechanism should exist in addition to a more positive regulatory provision, which has support, development and improvement at its core. On its own, a list of barred individuals may serve the purposes of transparency and public accountability, but it would not provide managers with the necessary support and improvement opportunities, neither would it improve the overall quality of management, or increase public trust.

We would therefore only favour disbarring as part of a more positive regulatory system. This would also be in line with Kark's review, which argued that "any introduction of a power to disbar would have to go hand in hand with the bolstering of training and development for directors and aspirant directors".

Before reflecting on the sanctions that a disbarring organisation could impose, all existing accountability mechanisms in place for managers and leaders in the NHS should be considered. These include:

- Board accountability – e.g. to the Care Quality Commission (CQC) and NHS England (NHSE).
- Individual performance review and appraisals.
- Controls on employees – e.g. employment law, existing professional regulation, etc.
- NHSE's work taking forward the recommendations of various management and leadership reviews.
- The fit and proper person test (FPPT) framework, introduced in 2023 to build on the recommendations of the Kark review.
- National Freedom to Speak Up guardians, introduced in 2016, following Sir Robert Francis QC's Freedom to Speak Up review.

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- The well-led framework for trusts, developed jointly by CQC and NHSE.

For example, disbarring must complement, and not overlap with or duplicate, the FPPT.

The type of organisation established to undertake this role should also be considered, to determine whether it can impose conditions and suspensions. This works well in the case of full statutory regulation, but might not be applicable in the case of a disbarring service, which simply involves a public list of barred individuals.

Q: Do you agree or disagree that there should be a professional register of NHS managers (either statutory or voluntary)?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

In line with our response to the previous question, we believe that any new system of regulation should be positive and constructive, rather than negative and punitive.

A professional register could enhance personal and professional pride for NHS managers. It could guarantee that managers have signed up to a common code of conduct, undergone the necessary training, and that they possess the required experience and/or qualifications. A professional register could also allow employers to ensure that they only employ candidates who have met specific requirements.

It is important to bear in mind, however, that any new regulatory system must not undermine or conflict with the employer/employee relationship and must be aimed at increasing consistency and raising professional standards among managers, rather than adding a bureaucratic layer to existing provisions.

Additionally, any new system must overcome, and must not reflect, structural inequalities and discrimination that already exist in society, in the NHS, and in the professional regulation of its staff. For example, there is evidence of disproportionately higher fitness to practise complaints against ethnic minority healthcare professionals, and of longstanding inequalities in the use of disciplinary procedures. These have been repeatedly highlighted in the Workforce Race and Disability Equality Standard reports, produced by NHSE. This is unjust, and has repercussions on people's health, wellbeing and morale, which ultimately will affect services and the patients who depend on them. The lessons from these trends and experiences should be taken into account when devising, implementing and evaluating a new regulatory system for managers.

Q: If you agreed, do you agree or disagree that joining a register of NHS managers should be a mandatory requirement?

This could be either a statutory requirement or made mandatory through NHS organisations choosing only to appoint individuals to management positions who are members of a voluntary register.

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

We believe that if we are to make the most of the potential benefits that regulation can offer, the best option would be full statutory regulation. However, we acknowledge that this will come with additional cost, effort and burden. Therefore, every effort should be taken to ensure that any new regulatory system does not introduce unnecessary bureaucracy, or duplicate existing measures.

Any new system of regulation for NHS managers should be aligned with the principles of 'right-touch regulation' – the conceptual framework developed by the Professional Standards Authority (PSA, 2015). The right-touch regulation principles are: proportionality, consistency, targeted nature, transparency, accountability, and agility.

We also recognise the value of a voluntary register, which could be a proportionate mechanism for increasing accountability, and could be made mandatory by way of application and enforcement by employers – for instance, if NHS organisations were only able to recruit people from an accredited register.

Q: Which, if any, of the following categories of managers within NHS organisations do you think a system of regulation should apply to? (Select all that apply)

- Chairpersons
- Non-executive directors
- **Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)**
- **All NHS staff aspiring to be board level directors**
- **Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)**

- **Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)**
- **First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)**
- **Foundation managers (approximately bands 4 to 5, for example administrator, receptionist, medical secretary, clinical support worker, clinical assistant, healthcare assistant)**
- Don't know
- Not applicable - managers should not be regulated

Please explain your answer. (Maximum 300 words)

If professional regulation is to support and improve NHS management, it should apply to all managers, starting with the most junior levels of management.

This would be a major undertaking and might risk delaying the introduction of a regulatory system. Applying the system to senior managers only, at least in the first instance, would be quicker and would reflect where the greatest responsibility, and therefore accountability, lies. However, it would mean the full potential benefits of regulation would not be available, at least initially.

Trust leaders have a range of views on whether to include chairs and NEDs. As part of the unitary trust board, chairs and NEDs share responsibility for the decisions the trust makes. Their conduct and behaviour will impact the culture and running of the organisations they serve. And, their decision-making powers carry a high level of collective and individual responsibility. Therefore, many will argue that chairs and NEDs should be held accountable in the same way as executives.

While they are leaders, chairs and NEDs are not NHS employees or managers, which might preclude regulation, and a system focused on management standards and skills might not be applicable to them. Also, introducing a requirement for NEDs to be registered NHS managers would close the door to candidates from other professional backgrounds, leading to less diverse boards in terms of background, experience and knowledge – this breadth is key to the added value that boards currently bring to the NHS. NEDs and chairs are already subject to the FPPT, which should prevent unsuitable individuals from being appointed to new roles, and they would share this form of accountability with executives.

The above arguments should be considered carefully, and the government should provide a strong justification for the inclusion or exclusion of chairs and NEDs from regulation.

Q: Which, if any, of the following categories of managers in equivalent organisations do you think a system of regulation should apply to? (Select all that apply)

- **Appropriate arm's length body board members (for example, NHS England)**
- **Board level members in all Care Quality Commission (CQC) registered settings**
- **Managers in the independent sector delivering NHS contracts**

- Managers in social care settings
- Don't know
- None of these

Please explain your answer. (Maximum 300 words)

NHSE, CQC and integrated care board (ICB) managers should be held to the same standards as NHS provider managers. It would be inconsistent for those overseeing trust leaders and holding them to account for performance and patient safety not to be subject to the same standards – particularly when ICBs, NHSE and CQC are able to influence, via funding decisions or regulatory powers, the actions trust leaders take, which affect patient safety.

In addition, as the goal of manager regulation is ultimately about preventing misconduct that poses a risk to NHS patient safety, it is also appropriate that regulation applies to managers of independent sector providers that deliver NHS contracts. This would also be in line with Kark's review and its recommendations.

We fully support the aspiration that the health and social care sectors, including their management and leadership, should become better aligned, in line with the findings of the Messenger Review. However, it is important to remember that the NHS and social care are two distinct systems, funded and commissioned separately, and subject to different lines of accountability. So, it may be appropriate to consider how social care managers are held to account, but that consideration should be outside of the scope of this exercise.

Q: If managers are brought into regulation through the introduction of a statutory barring system, which type of organisation do you think should exercise the core regulatory functions outlined above?

- Executive agency of DHSC
- Professional membership body
- Don't know
- **Other type of body**
- Not applicable - managers should not be regulated through a barring system

Please explain your answer. (Maximum 300 words)

Any new regulatory system should be fully independent, both of those it regulates, and of political influence or interference. Therefore, an executive agency of the Department of Health and Social Care (DHSC) would be an inappropriate option for this role.

A professional membership body, such as a royal college, would be a viable option in the setting up of standards and in the provision of training resources, peer support and professional development. It could also be used to host a voluntary register of NHS managers. However, that role should be kept separate from the barring provisions. A statutory barring mechanism is normally used to hold a list of those found unsuitable to practise, rather than a list of those deemed 'fit to practise'.

As explained earlier in this response, a barring system should only exist if a positive regulatory element (such as an organisation holding a register of practising managers) is introduced.

Therefore, a separate independent body is the only viable option.

Q: If managers are brought into regulation through the introduction of a professional register (either a voluntary accredited register or full statutory regulation), which type of organisation do you think should exercise the core regulatory functions outlined above?

- **Independent regulatory body**
- Executive agency of DHSC
- Professional membership body
- Don't know
- Other type of body
- Not applicable - managers should not be regulated through a professional register system

Please explain your answer. (Maximum 300 words)
The arguments listed above, regarding the need for a fully independent regulatory body, apply here too.

The answer depends on whether ministers choose voluntary or full statutory regulation.

If full statutory regulation is introduced, that should be exercised by either a newly established regulatory body, or an existing one that is suitable to regulate NHS managers.

If voluntary regulation is introduced via a register held by a professional membership body, that would need to either be a new dedicated organisation, or an existing one which is significantly changed to serve this purpose.

Q: If managers are brought into some form of regulation, do you have an organisation in mind that should operate the regulatory system? (Select all that apply)

- **An existing regulator**
- **An existing membership body**
- An existing arm's length body (for example, an executive agency)
- **Establish a new independent regulatory body**
- **Establish a new membership body**
- Establish a new arm's length body (for example, an executive agency)
- Don't know
- Other
- Not applicable - managers should not be regulated

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Please explain your answer - if you said an existing regulator, membership body or arm's length body, please specify which. (Maximum 300 words)

The answer to this question depends on whether the new system would be statutory or voluntary. In the case of full statutory regulation, we would favour the creation of a new independent regulatory body. That would need to be a dedicated organisation covering the full spectrum of responsibilities, from training accreditation and registration, through to standard setting, fitness to practise and revalidation.

A suitable existing regulatory body could also be considered for the purposes of manager regulation. Its suitability could be judged, for example, on the basis of the Professional Standards Authority (PSA)'s annual performance reviews of regulators.

In the case of voluntary accreditation, a register could be hosted by a new or an existing organisation, similar in type to the medical royal colleges, which incorporates membership, and provides opportunities for peer learning, professional training and development. A new, bespoke organisation would be the preferred option. However, it could also be a repurposed existing organisation. A voluntary register, as described above, should be accredited by the PSA, which independently assesses and accredits voluntary registers of practitioners/professionals not regulated by law.

If a disbarring system is to be introduced, we believe that should be exercised by a bespoke independent organisation. Although there is a precedent for the same organisation to hold both a register and a barred list of individuals (i.e. in the case of the Teaching Regulation Agency), we believe it would be preferable to keep this function separate from that of a statutory regulator, to give the regulator a clearer focus on the positive elements of professional regulation. This would also align with, and extend Kark's recommendation, whereby the disbarring service would be complemented by, but separate from, manager training, support and development, and would sit separately from the enforcement of the FPPT.

Q: Do you agree or disagree that there should be education or qualification standards that NHS managers are required to demonstrate and are assessed against?

- Strongly agree
- Agree
- **Neither agree nor disagree**
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

Any new regulatory system must set out clear expectations around the standards of competence and/or standards of conduct and behaviour expected of managers.

The work that NHSE is currently doing in developing a leadership and management framework, which would introduce a single code of practice, a set of core standards and a development curriculum for

managers, could be beneficial in that regard, and would support managers and leaders to undertake further training to improve their effectiveness and to progress in their careers. Manager regulation should be developed with this work in mind.

Any new standards must be achievable and outcome-focused, and there needs to be a fair and equitable process for ensuring that standards are continuously met (this could mean including an initial threshold in the form of a qualification, assessment, or similar, and a proportionate and effective process of revalidation).

In addition to being developed in consultation with all relevant groups, the new code of conduct and standards for managers would need to be nationally recognised and accepted, regularly reviewed and updated, and consistently used to hold all managers within the scope of these new provisions to account. It should be recognised that there is cost and burden associated with this.

It is important to be mindful that there is an intrinsic difference between regulated professions, which are defined by professional qualification thresholds and standards, and non-clinical managers, for whom professional qualifications do not currently exist. Given the disparate avenues via which leaders in the NHS will become managers, and the variety of their clinical and non-clinical roles, it may be most suitable to focus on high-level leadership-focused training, development and learning opportunities. These would complement the code of practice, standards and curriculum being developed by NHSE, and would need to be accredited by the new regulator.

Q: If a professional register is implemented for NHS managers, do you agree or disagree that managers should be required to periodically revalidate their professional registration?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

Revalidation is a useful mechanism for ensuring that professionals' skills, competencies and training remain up-to-date, and that they are safe and fit to continue practising in their roles. However, there is need for realism about what revalidation can and cannot achieve. For example, revalidation would not be a suitable mechanism for identifying poor performance or serious misconduct.

Revalidation would not be compatible with a regulatory mechanism focused solely on disbarring. Should a positive and developmental regulatory system be introduced, we would support embedding periodic revalidation from the start, as it would support the professionalisation of the newly regulated group.

It is vital that any revalidation system is light-touch and focused: if done badly, this could multiply the cost and bureaucratic burden associated with a new regulatory regime, distracting leaders from leading their organisations.

For a system of revalidation to be successful and proportionate, it would need to:

- account for the requirements of such a broad and disparate professional group,
- be clearly linked to existing referencing and appraisal processes,
- work as seamlessly as possible with existing revalidation processes that managers who are already members of regulated professions are subject to,
- and factor in the right training for those developing and reviewing it.

If these are in place, revalidation is more likely to be understood and accepted by those who are subject to it.

Q: If you agreed, how frequently should managers be required to revalidate their professional registration?

- Annually
- Every 2 years
- Every 3 years
- Every 5 years
- Less frequently than every 5 years
- **Don't know**

Please explain your answer. (Maximum 300 words)

It is not for us to determine the frequency of revalidation. However, as stated above, revalidation should be designed as a light-touch, easy to follow approach. Managers should be aware of the expectations and should be able to use their ongoing professional responsibilities to prove their continuing commitment to self-development.

Any new system for revalidation should be developed jointly with NHS managers and their representative organisations. It should be easy to navigate, outcomes-focused and non-burdensome, and should genuinely support professional development rather than being a purely bureaucratic exercise.

Q: What skills and competencies do you think managers would need to keep up to date in order to revalidate? (Maximum 300 words)

We are supportive of the work that NHSE is carrying out around the creation of a management and leadership framework. This work aims to define standards and competencies set at different levels of skill/competency, depending on seniority and job role. While this work is still in progress, if done well, it may provide the set of skills and competencies at the heart of the new regulatory system.

Q: Do you agree or disagree that clinical managers should be required to meet the same management and leadership standards as non-clinical managers?

- **Strongly agree**
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

There should be consistency in the management and leadership standards expected of clinical and non-clinical managers. A common code of practice would be a very useful mechanism for embedding that consistency. The new standards should cover a unique set of skills and capabilities common for clinical and non-clinical leaders and managers, and should exist in addition to any other requirements and regulatory frameworks they may be subject to.

Q: If you agreed, how should clinical managers be assessed against leadership or management standards?

- **They should hold dual registration with both their existing healthcare professional regulator and the regulator of managers**
- They should only be required to hold registration with their existing healthcare professional regulator who will hold them to account to the same leadership competencies as non-clinical managers
- They should only hold registration with an existing healthcare professional regulator that will determine any leadership and managerial competencies
- Don't know
- Other

Please explain your answer. (Maximum 300 words)

It would be a significant endeavour to try and incorporate the new sets of management standards and expectations into regulatory systems already in operation (within and outside of healthcare) that people are currently subject to. That effort would be in addition to the setting up of a new regulatory body for managers.
The most straightforward solution would be to focus on setting up a new, dedicated organisation for regulating leaders and managers, which would incorporate these new standards, and anyone who is currently regulated would have this as an additional regulatory body to respond to and comply with.

Dual regulation brings risks and disadvantages to those affected, including an extra regulatory/membership fee, additional scrutiny, fitness to practise and revalidation requirements, etc. However, this would be the only way to guarantee parity, equal access to support, and public and professional accountability for clinical and non-clinical managers.

Arrangements for dual regulation are not currently uncommon. For example: oral and maxillofacial surgeons need to be registered with both the General Medical Council and the General Dental Council; practitioners registered with the Health and Care Professions Council may also be registrants of one of the other regulators for health and care in England; and there are professionals who are simultaneously regulated by one of the healthcare regulators, as well as the Solicitors Regulation Authority.

The important consideration here is to establish strong and clear channels of communication and memoranda of understanding between any new and existing regulators, and to create a system of regulation which is workable, outcomes-focused and non-burdensome.

Q: Do you agree or disagree that a phased approach should be taken to regulate NHS managers?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

A phased approach to implementation would acknowledge the need for careful consideration of any policy, legislative and operational changes that might be required. It would also give space and time to assess the existing accountability provisions which exist in the service and build on these. An enhanced version of one of the existing arrangements – for example the FPPT – might be considered as a viable intermediate option, if not a full solution.

While it is not our preferred approach, a system of voluntary accreditation would be a plausible option to pursue for the regulation of managers. It might also work well as an intermediate step towards full statutory regulation, should that be the approach that is chosen. This would build on the recommendations of Sir Robert Francis and of Ian Dalton's 2010 review on assuring the quality of senior NHS managers.

Q: If managers are brought into a statutory system of regulation, do you agree or disagree that individuals in NHS leadership positions should have a professional duty of candour as part of the standards they are required to meet?

- Strongly agree
- **Agree**
- Neither agree nor disagree
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

It would be fair and proportionate to introduce a common standard to apply to both clinical and non-clinical managers. The duty of candour is one of the fundamental principles behind any professional code of ethics and performance in health and care, and a legal duty which applies to all health and care providers regulated by CQC.

However, the difference in terminology used in this and subsequent questions, referring explicitly to 'NHS leaders' is potentially confusing, as it appears to draw a distinction between management and leadership. The interchangeable use of 'managers' and 'leaders' in these questions implies a difference in definition and application which is not explained and potentially complicates the introduction of a regulatory system that might equally cover both groups.

Q: If you agreed, which categories of NHS managers should a professional duty of candour apply to? (Select all that apply)

- Chairpersons
- Non-executive directors
- **Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)**
- **All NHS staff aspiring to be board level directors**
- **Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)**
- **Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)**
- **First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)**
- **Foundation managers (approximately bands 4 to 5, for example administrator, receptionist, medical secretary, clinical support worker, clinical assistant, healthcare assistant)**
- Don't know

Please explain your answer. (Maximum 300 words)

As per previous responses, this should apply to all the manager groups covered by the new regulatory regime. Whether or not to include chairs and NEDs depends on the answer to the earlier question on which categories of managers a system of regulation should apply to.

Q: Do you agree or disagree that NHS leaders should have a duty to ensure that the existing statutory (organisational) duty of candour is correctly followed in their organisation and be held accountable for this?

- Strongly agree

- Agree
- Neither agree nor disagree
- **Disagree**
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

We believe that organisational and professional duties should be kept separate. Boards are already, correctly, jointly responsible for enforcing the organisational duty of candour.

Q: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to record, consider and respond to any concern raised about healthcare being provided, or the way it is being provided?

- Strongly agree
- Agree
- **Neither agree nor disagree**
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

This would be in line with the Infected Blood Inquiry's final report and recommendations for NHS leaders, so we agree in principle. However, the relevant recommendation refers to people 'in leadership positions' and to 'any person in authority', which does not necessarily apply to all managers.

Please see our earlier point on the complication introduced by the use of different terminology in the last set of questions.

Q: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to ensure that existing processes in place for recording, considering and responding to concerns about healthcare provision are being correctly followed?

- Strongly agree
- Agree
- **Neither agree nor disagree**
- Disagree
- Strongly disagree
- Don't know

Please explain your answer. (Maximum 300 words)

As above, we agree with this in principle, but this duty should be proportionate to the responsibility people hold as part of their specific role.