

Care Quality Commission consultation on the Guidance for NHS bodies on the fit and proper person requirement for directors and the duty of candour

NHS Confederation and NHS Employers joint response

About the NHS Confederation and NHS Employers

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

The NHS Employers organisation represents the whole range of views from across employing organisations in the NHS in England on workforce issues, and supports employers to put patients first. Our work spans the whole remit of workforce issues and has both an overview and responsibility for the supporting delivery of a number of workforce functions including pay, reward, employment practice, regulation, planning and supporting cultural and behaviour change. NHS Employers is part of the NHS Confederation.

1. Introduction

- 1.1 Thank you for the opportunity to comment on the draft guidance for NHS bodies on the fit and proper person requirement (FPPR) for directors and the duty of candour.
- 1.2 The timescale for this consultation has been very short, as it was for the initial consultations on these policies by the Department of Health. We are concerned this has not given our members enough of an opportunity to engage with the proposals and feedback effectively. We therefore welcome the CQC's commitment that they wish to continue to engage with the service, via the networks and forums from across the Confederation and NHS Employers as the guidance continues to be refined and implemented.
- 1.3 We retain concerns around the collective impact of a number of both recent and forthcoming legislative and regulatory changes on our members from across the system. It is essential that this impact is reviewed and all of the various requirements are effectively aligned.
- 1.4 Employers are supportive of systems that help to attract and retain high quality individuals. Board level roles in the NHS are complex and challenging. We must support leaders to build open and trusting relationships with their teams and individuals if we are to enable an open environment at a local level.
- 1.5 The approach of regulators will be crucial to the success of the additional requirements coming into effect between now and April 2015.
- 1.6 Our response has been informed by engagement with our members. NHS Employers discussed the issues with a group of HR Directors from across our HR networks and hosted an information webinar on 2 September 2014, where Carole Long of CQC provided an overview of FPPR. The NHS Confederation Hospitals Forum Steering Group had the opportunity to feed in their views on both FPPR and duty of candour directly to CQC representatives on 4 September 2014.

2. Comments on the fit and proper person requirement

- 2.1. We fully endorse the principle of holding corporate bodies to account for their role in neglect, abuse or poor care, as part of ensuring public confidence and a transparent patient-centred system. There is a general view from across our membership that recruitment practices for both executive and non-executive roles are of a high standard, with most of the FPPR requirements already covered. We reiterate the need for a proportionate and risk-based approach on that basis.
- 2.2. We have concerns about the number of unanswered questions about the requirements. These anxieties have been reinforced in subsequent conversations with leads in NHS provider organisations. **We would therefore urge the CQC to work with key stakeholders and providers on these proposals in the coming months to help address them.** Towards this end, we would be more than willing to have a discussion with the CQC about how we can support this process.
- 2.3. NHS Employers has responsibility for keeping [NHS Employment Check Standards](#) up to date. The standards are applicable across all NHS organisations and stipulate a number of pre and post-employment checks that need to be undertaken. We are therefore pleased that providers will retain the responsibility for appointments to their senior team and that the CQC's role is to be assured that registered providers have robust recruitment processes in place, in line with FPPR.
- 2.4. We are uncomfortable with the notion that individuals deemed to be 'unfit' by CQC have no right to appeal. As this would effectively act as a barring mechanism for potential directors, we would welcome a conversation about how to ensure the principles of natural justice are applied.
- 2.5. The clarity now provided within the guidance regarding the phrase 'to be of good character' is welcomed. However further information is needed about the precise circumstances upon which paragraph 3d ("the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement...") applies. We are pleased that the CQC wishes to work with providers on addressing this point and suggest our networks and forums are ideally placed to offer the necessary support.
- 2.6. The confirmation provided by the CQC that the FPPR regulation will be aligned with those within Monitor's licensing requirements is very much welcomed. We would **appreciate further detail as to how this will be achieved in practice to ensure our members only have to meet the requirements once.**
- 2.7. Clarity is still needed about whether the regulation comes into effect for a range of appointments in particular circumstances. Examples cited by our members included the renewal of a chair's term and external appointment of directors by CQC, Monitor or NHSTDA. It is crucial that provider responsibilities in meeting FPPR are unambiguous and we hope this can be examined promptly in further discussions with CQC.
- 2.8. It remains important to understand how FPPR may impact different types of providers. We believe there may be particular considerations here for primary care providers, especially single-handed GP practices.
- 2.9. We would be grateful for clarification around how the CQC will retain relevant information about individuals and how such information will be used. This is important in ensuring that confidence in FPPR can be established.

- 2.10. There is a gap between what the draft CQC guidance provides around specifying FPPR and what employers are expected to do in order to meet it. It will be **important to ensure there is a shared understanding of the requirements**. While 'fitness' is perhaps more clearly defined, we have a number of concerns about what 'unfit' means and how disagreements might be resolved.
- 2.11. As the result of continued uncertainty across a range of areas connected with implementation of FPPR, we are concerned that NHS providers may need more time to implement the requirement effectively by the current planned date in mid-November, unless the necessary clarity is swiftly delivered. **We would urge the CQC to consider delaying the implementation of FPPR for NHS bodies and align this with the planned extension to other sectors from April 2015**. We feel this would permit a more planned approach to implementation.
- 2.12. We would also be keen to continue to help facilitate engagement between the CQC and our members to ensure requirements are fully understood and applied as intended.

3. Comments on the duty of candour

- 3.1. We support the principle of having a duty of candour for organisations providing NHS care and for the threshold to be set at 'moderate harm'. However it is also worth emphasising that a culture of openness and transparency will ultimately be driven locally and should be delivered in the context of the whole system working together effectively.
- 3.2. The success of this policy will depend upon effective engagement and communication with staff. **Language is critical around a duty of candour**. Staff are familiar with raising concerns, apologising, reporting risks or near misses and their own professional responsibility for delivering safe care. We would urge the CQC to think carefully about the language it uses with staff and the public when seeking assurance.
- 3.3. We would argue the CQC should emphasise that many of the elements of the duty are already commonplace across NHS trusts and avoid any impression that the service is starting from scratch when it comes to handling cases in an open and transparent way. **The duty should therefore be seen as building upon strong foundations in many organisations**.
- 3.4. We explored the concept of 'comply or explain' with a group of employers who were keen to ensure that professional judgement can be exercised, particularly around the timing of being candid. We would be happy to discuss this in more detail with CQC following this consultation.
- 3.5. There needs to be alignment between the approaches adopted by CQC and local commissioners to ensure providers are not being asked to provide different evidence to the same questions.
- 3.6. We would still urge that more consideration is given to the application of the duty in different care settings. The current draft guidance doesn't appear to reflect, for example, the specific circumstances of mental healthcare or the potential impact of the duty on single-handed GP practices. Furthermore, as services become increasingly integrated, there is the risk that having different definitions of harm for health and social care will become more confusing. We would welcome a more detailed conversation with the CQC about how this would work in practice.

- 3.7. The Mental Health Network (MHN) remains broadly supportive of the introduction of a duty of candour. However it has a set of specific considerations, previously highlighted to the Department of Health, which have yet to be addressed. MHN is happy to work with CQC on developing guidance around the following points:
- 3.7.1. Clear drafting about the requirements and what constitutes a breach in mental health settings.
 - 3.7.2. Clarity around the moderate harm threshold in the mental health sector. Greater consideration is needed about how this would be applied and enforced.
 - 3.7.3. Acknowledgement that mental healthcare is delivered within the concept of recovery, and that the management of clinical risk is a key component of the therapeutic approach.
 - 3.7.4. Mental health organisations are required to deliver care in the context of human rights law and the legal framework balancing personal and public protection. It is important to acknowledge the inherent risk in mental healthcare.
- 3.8. Further explanation of what constitutes “reasonable effort” and “reasonable attempts” in practice would be helpful to provide more clarity about how the duty will be applied. However it also remains important that the introduction of the duty does not result in a swathe of new bureaucratic processes that risks distracting staff from patient care.

4. Follow up

- 4.1. If you have any questions about this submission please contact either Nyla Cooper (nyla.cooper@nhsemployers.org) at NHS Employers or Sam Hunt at the NHS Confederation (sam.hunt@nhsconfed.org).