DHSC consultation on leading the NHS: proposals to regulate NHS managers

18 February 2025

About us

The NHS Race and Health Observatory (NHS RHO) is an independent expert body, established by the NHS to identify and tackle the widespread, entrenched inequity experienced in health and healthcare by minoritised ethnic patients, communities, and the workforce in England. We work as a proactive investigator by mobilising robust evidence, enabling impactful policymaking, and facilitating long-term transformational change across health and care.

About the consultation and our response

In November 2024, the Department of Health and Social Care (DHSC) launched a consultation on the need for formal regulation of the NHS management function. It seeks views on wide-ranging proposals that could constitute a regulatory framework for NHS managers, including:

- The creation of a professional register to which managers might be expected to subscribe
- The ability to sanction and disbar managers who have committed serious misconduct
- The development of minimum education or professional standards for managers
- The alignment of standards for managers subject to multiple regulatory frameworks
- The duty for managers to speak up and to provide robust routes for others to do so

We welcome this opportunity to respond to the government's proposals to regulate NHS managers. To inform our response, we have scoped extensive evidence and engaged with experts on ethnic health and workforce inequalities and NHS leadership. We recognise that there are strongly held, and at times opposing, views on these proposals, and we have endeavoured to account for them in our response.

We ultimately believe that in order to increase accountability, raise professional standards, and improve patient safety and care quality, managers should be formally regulated. We reiterate that this will necessitate investment in managers' professional development, a clear framework of expectations and standards, and a commitment to tackling the systemic inequity. If developed and applied equitably and proportionately, we believe that regulation has significant potential to address the role managers play in maintaining ethnic health and workforce inequalities.

Response from the NHS Race and Health Observatory

Overall approach to the regulatory model

1. **Do you agree or disagree that NHS managers should be regulated?**
    - **Agree**

Explanation:

The NHS Race and Health Observatory (NHS RHO) agrees that NHS managers should be regulated, providing the prospective regulation is equitable and proportionate in its application. Managers' conduct has a considerable impact on workplace culture and staff practice, which in turn, influences patient safety, care quality, and outcomes for all. The current lack of regulation inhibits accountability among managers when failings do occur, in contrast with the clinical workforce.

Regulation alone is not a silver bullet. It necessitates robust, supportive interventions for managers' development, including a clear framework of expectations and standards. This done well, has significant potential to redress the current disparity of accountability and address the role managers play in maintaining ethnic health and workforce inequalities. Accounting for the following considerations will be critical to the successful development of this regulation:

1. The evidence of ethnic health inequalities indicates that avoidable harm and patient safety incidents are disproportionately experienced by minoritised ethnic patients, in which a common driving factor is providers' dismissive practice regarding their concerns (NHS RHO, 2022; 2025).

2. The racism that minoritised ethnic staff face from colleagues, including managers, has long been reported and reflected in successive NHS staff surveys. Evidence indicates the troubling extent of managers' refusal to tackle reported racism and the punitive repercussions victims can incur after speaking up (Kline and Warmington, 2024).

3. The inequitable treatment of minoritised ethnic staff can prevent them from raising patient safety concerns (Francis, 2015; Kline and Somra, 2021), this is reflected in the latest NHS staff survey, with minoritised ethnic respondents reporting feeling less safe raising clinical safety concerns. Should they do so, they face a heightened risk of detrimental treatment from managers (Archibong et al., 2019).

2. 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?

- **Neither agree nor disagree**

Explanation:
We believe that in considering sanctions, it is critical that existing routes to early informal resolution are made more effective through fair, equitable, and transparent processes. The prospective regulator should, in all cases, use the full range of sanctions available to existing healthcare professional regulators.

We are concerned that unless the government and NHS England (NHSE) make significant progress in redressing the stark ethnic disciplinary gap, the introduction of a statutory barring mechanism would replicate existing discriminatory practice with grave consequences for minoritised ethnic managers, staff, and patient safety. The most recent figures demonstrate that minoritised ethnic staff are 1.25 times more likely than White staff to be taken through a formal disciplinary process in almost 50% of NHS trusts (NHS WRES, 2024). The same figures show that minoritised ethnic representation at very senior manager level has risen by more than half, and at executive board level to more than one in ten. Without the implementation of supportive, developmental measures, there is a material risk that a statutory barring mechanism could lead to minoritised ethnic managers being disproportionately sanctioned. The landmark claim by Michelle Cox, a Black nurse manager who was victimised because of her race after raising patient safety concerns, is a salient reminder that seniority does not preclude racist treatment.

What constitutes 'serious misconduct' must be clearly defined. We believe that attempts from NHS managers to prevent minoritised ethnic staff, patients, families, and carers from raising safety and wellbeing concerns (including race discrimination), and attempts to cause detriment through vexatious, retaliatory, or punitive action, must be explicitly considered serious misconduct. The impact of these practices on minoritised ethnic patients and staff is acute, and effective mechanisms that end the recycling of senior leaders engaged in them are needed.

3. 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?

- **Neither agree nor disagree**

Explanation:
Please see our response to question 2.

A professional register

4. **Do you agree or disagree that there should be a professional register of NHS managers (either statutory or voluntary)?**
    - **Agree**

Explanation:
We agree that a professional register that transparently lists monitored NHS managers who are considered qualified and fit to practice would be a necessary component of an effective regulatory system. This would reassure the clinical workforce, patients, the public, and managers themselves that registrants are held to a comparable standard to clinicians and ultimately build trust and confidence in NHS management and leadership.

We believe that a professional register would also offer a range of proportionate sanctions to address concerns, such as temporary suspension, conditional registration, and remediation. We note that those designing the prospective regulation should seek to improve, rather than duplicate, existing accountability measures and related inequities in the NHS which will be further detailed in our response. This includes existing, well-established board governance, regulatory regimes, the fit and proper persons framework, and NHS England's leadership competency framework, among other measures.

5. **If you agreed, do you agree or disagree that joining a register of NHS managers should be a mandatory requirement?**
    - **Agree**

Explanation:
We agree that it should be a mandatory requirement for NHS managers to join a register, as it would demonstrate a level of parity and alignment between the regulation of NHS mangers and the clinical workforce. It would inspire more confidence in the regulatory system and assure the clinical workforce, patients, the public, and managers themselves, that registrants meet a consistent standard.

We acknowledge the potential benefits of a voluntary register as a part of a phased implementation of regulation further on in our response. We maintain that should a voluntary register be implemented, that NHS organisations should only be able to appoint individuals to management positions who are members of it.

We acknowledge that there is a broad spread of levels and salaries under the management umbrella, and that throughout our response, we broadly agree with the government's starting position that the most senior of leaders should be within the scope of the regulation. Should the regulation broaden its scope, there is a risk that the fees associated with professional registration could act as a deterrent to taking on management positions. This could be countered by, for example, introducing a sliding scale of fees depending on NHS pay band.

We would expect the government to outline if and how it would expand the scope of the regulation beyond its starting position, informed by further consultation and engagement.

Scope of managers to be included

6. **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)**

- **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)**

Explanation:
Our view is that the degree of a professional's influence on patient care and safety and the working environment of NHS staff should ultimately determine their inclusion within the scope of the proposed regulation. We broadly agree with the government's view that, as a starting position, the most senior of managers should be regulated. We acknowledge that mid-level and senior managers (bands 8-9) also have significant decision-making powers and responsibilities that influence patient safety, care quality, and service improvement as well as the working environment, development, and progression of the staff reporting to them. The regulation should account for the variety of roles and responsibilities that exist at board level and beyond.

We would expect the government to outline if and how it would expand the scope of the regulation beyond its starting position, informed by further consultation and engagement.

7. **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**

Explanation:
We believe that managers in equivalent organisations should be within the regulatory scope, given their influence on patient care and safety and the working environment of staff. Regulatory standards for those who regulate and collaborate across the health and care sector are essential to the delivery of the NHS' three shifts and enabling truly integrated working from neighbourhood to national levels. Inconsistent regulation could create a perverse incentive for managers to avoid employment within NHS organisations, creating a drain of talent.

In the case of arm's length bodies, we believe that given their decision-making, investigatory, and regulatory powers over healthcare providers, there is a strong case for their inclusion to ensure parity of accountability for the most senior leaders in the health and care system. We reiterate the need for supportive, developmental measures, noting the findings from a recent independent review into the Care Quality Commission's (CQC) handling of whistleblowers, in which 'clear evidence … of a widespread lack of competence and confidence within CQC in understanding, identifying, and writing about race and racism' was found (CQC, 2023).

While we acknowledge the logistical challenges in regulating managers within independent and social care providers delivering NHS and public sector contracts, the care they provide to millions of patients means not doing so could lead to significant disparities of accountability and patient safety. This is especially relevant in light of the NHSE and independent sector partnership agreement as well as the reforms and independent commission to transform social care, announced earlier this year.

As above, the regulation should account for the variety of roles and responsibilities that exist at board level and beyond. We would expect the government to outline if and how it would expand the scope of the regulation beyond its starting position, informed by further consultation and engagement.

The responsible body

8. **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?**

Given that we neither agree or disagree with the introduction of a statutory barring system, and no multiple-choice option provided reflected our position, we did not respond to this question.

9. **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**

Explanation:
Our view is that a new, independent regulatory body should be established to operate the regulatory system and hold the professional register, this would demonstrate a level of parity between the regulation of NHS mangers and healthcare professionals.

Regardless of which organisational form it might take, the prospective responsible body must acknowledge and actively work against replicating the racism and inequitable practice evident in existing regulators. These issues have been recently spotlit in an independent culture review of the Nursing and Midwifery Council (NMC, 2024). They have also been highlighted in reports and guidance on the role regulators have to play in redressing differential attainment evidenced within the minoritised ethnic healthcare workforce (GMC, 2017; PSA, 2023).

An anti-racist approach should be adopted in establishing the prospective responsible body, in which decision-makers carefully review and seek to redress the ethnic disciplinary gap, the racism and inequitable treatment faced by minoritised ethnic NHS staff and managers, and how this relates to poor outcomes for minoritised ethnic patients. A necessary, critical step to achieving this will be decisionmakers' concerted and sustained public engagement with minoritised ethnic staff, managers, and patients, as well as the organisations championing them.

10. **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)**
    - **Establish a new independent regulatory body**

Explanation:
Please see our response to question 9.

Other considerations: professional standards for managers

11. **Do you agree or disagree that there should be education or qualification standards that NHS managers are required to demonstrate and are assessed against?**
    - **Agree**

Explanation:
We reiterate that regulation is not a panacea, it can only play a part in improving the capacity, capability, and culture of NHS leadership. While disciplinary mechanisms are a core component of effective regulation, the ultimate goal of improving patient safety will be unattainable without developing and supporting managers to enable restorative, just, and learning cultures within their organisations.

We oppose implementing arbitrary, inaccessible barriers to entry, such as mandating that managers have tertiary education, or not acknowledging the skills gained through on-the-job experience that does not

result in a formal qualification. We instead advocate for a fully resourced package to develop, train, and support NHS managers to carry out their duties effectively.

We firmly believe that anti-racist leadership skills are essential to reducing ethnic health and workforce inequalities, and that they should be prioritised as a core educational standard for NHS managers. It has been evidenced that a fundamental lack of cultural competence is the driving factor behind the ethnic disciplinary gap (Archibong et al., 2019). In a survey of over 1000 minoritised ethnic NHS staff, 57% of respondents stated they would not raise a concern of race discrimination for fear of repercussions from their line manager or organisational leaders (Kline and Warmington, 2024). This inequity extends to those in leadership, with a survey of minoritised ethnic NHS leaders revealing that 69% of respondents had experienced workplace racism from other managers (NHS Confederation, 2024).

With bullying and discriminatory practice common themes in almost every independent review of systemic patient safety failings from Francis to Ockenden, ethnic workforce inequalities take on further, troubling significance to population health. Acquiring and maintaining anti-racist leadership and cultural safety skills should be a prerequisite for progressing into and staying in management positions.

12. If you agreed, which categories of NHS managers should this 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)**
- **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)**

Explanation:
Please see our responses to questions 6 and 7.

Other considerations: revalidation

13. 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?

- **Agree**

Explanation:
We agree that revalidation would be integral to an effective professional register. It would enable a regulatory system in which maintaining managerial standards is not a one-off or tick box requirement, but necessary to demonstrate continuing competence and fitness to practice.

Revalidation, linked to an effective annual appraisal system, would provide regular opportunities to identify any potential practice concerns at an early stage, allowing for the implementation of supportive interventions before escalation. It would set an expectation on managers to prioritise continual professional development, and on government, NHSE, and employers to take concrete steps to resource and facilitate this.

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

- **Every 5 years**

Explanation:

To strike a reasonable balance between ensuring ongoing competence as senior leaders, and the administrative load that a formal revalidation process would require, we believe that managers should be required to revalidate their professional registration every five years.

This would provide greater alignment with the clinical workforce, and account for the significant and complex nature of the responsibilities undertaken by the senior leaders that we think should fall within the scope of this regulation. As within the clinical workforce, the revalidation process for managers should be linked to an effective annual appraisal system.

15. What skills and competencies do you think managers would need to keep up to date in order to revalidate?

As outlined previously, we firmly believe that anti-racist leadership and organisational skills should be prioritised as a core educational standard for NHS managers. This would include managers maintaining skills and competencies in, and being able to evidence how they: enable culturally safe practice, redress ethnic health inequalities, and tackle interpersonal and institutional racism. In practice, for example, we believe this should include leaders ensuring their organisation's clinical and workforce key performance indicator data is split by ethnicity as a minimum.

Much work has been conducted at a system level to nail down the professional standards that managers should exhibit, including in NHSE's leadership competency framework, well-led framework, and the code of governance for trusts. Many organisations also have their own internally developed training programmes. Those deciding the prospective skills and competences for managers should clarify how these existing frameworks, codes, and initiatives would be developed, improved, and consolidated within the regulatory framework without duplication and confusion.

Other considerations: clinical managers and dual registration

16. 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**

Explanation:

We believe that the management and leadership standards between clinical and non-clinical managers should be aligned as much as possible, to avoid division or disparity of accountability. As previously outlined, we reiterate our view that a robust, demonstrable commitment to tackling ethnic health and workforce inequalities should be consistently prioritised as a core management and leadership standard for both clinical and non-clinical managers.

Those developing prospective regulation should explore routes to alignment between regulatory systems, for example, through establishing a memorandum of understanding between regulators to define how matters related to clinical managers are addressed.

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

- **Other**

Explanation:

Please see our response to question 16.

Other considerations: phasing of a regulatory scheme

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

- **Neither agree or disagree**

Explanation:
We understand the practical, implementation considerations that would support a phased approach, and as previously stated, we broadly agree with the government's starting position regarding scope, that the most senior of managers should be regulated.

While phasing would better enable the roll-out of regulation at pace, we believe that a considered approach should be adopted, given the significance of the regulatory changes proposed in this consultation. The government and NHSE should take the appropriate time needed to gather and scrutinise evidence, before implementing any element of a regulatory system, phased or otherwise. As previously outlined, an anti-racist approach should be adopted in developing and implementing this regulation, in which decision-makers carefully review and seek to redress the ethnic disciplinary gap, the racism and inequitable treatment faced by minoritised ethnic NHS staff and managers, and how this relates to poor outcomes for minoritised ethnic patients. A necessary, critical step to achieving this will be decisionmakers' concerted and sustained public engagement with minoritised ethnic staff, managers, and patients, as well as the organisations championing them. A considered, phased approach would enable this, allowing those designing and responsible for the regulation to act upon potential evidence of inequitable practice, intervening at an early stage to make regulatory changes.

There is, however, a risk that the introduction of what are proposed as temporary solutions, such a wholly voluntary register, last longer than intended. This could lead to a lack of clarity and piecemeal implementation, taking significant time and resource that ultimately disrupts and delays a more effective, long-term solution.

As previously stated, we would expect the government to outline if and how it would introduce changes to the regulation, informed by further consultation and engagement.

Duty of candour for NHS leaders

19. 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?

- **Agree**

Explanation:
As it stands, those in management roles have an explicit duty to create an environment where staff feel safe to raise concerns and expect to have them listened to and acted on. NHS organisations have a statutory duty of candour, enforceable by the CQC, who can pursue criminal sanctions. It is clear that this duty is not being fully upheld, and that existing routes to early informal resolution need to be made more effective and equitable. In a system where there is a professional duty of candour for healthcare professionals, there is a strong argument for the same standard to be expected of managers.

This is reinforced by the fact that among respondents to the most recent NHS staff survey, only 71% felt safe speaking up about clinical safety concerns, and only 56% believed that they would be listened to. The Hospital Consultants and Specialists' Association has felt compelled to provide advice on the tactics that managers have used to dismiss patient safety disclosures from staff, including discrediting doctors and referring them to the General Medical Council (HCSA, 2024). The impact is acute for minoritised ethnic staff, with the British Medical Association finding that minoritised ethnic doctors are nearly twice as likely not to raise patient safety concerns for fear of being blamed (BMA, 2018).

Those designing this regulation must consider and redress the factors driving managers' misconduct. As previously detailed, there is a clear need for supportive and developmental measures for NHS managers, without which attempts to mandate honesty and transparency will fail. Reports on the experiences of NHS chief executives highlight the immense, top-down pressure senior leaders are under (Timmins,

2016), and such factors should not be diminished. We reiterate that an anti-racist approach is needed to avoid replicating and exacerbating the ethnic disciplinary gap among minoritised ethnic managers.

20. 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)**
- **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)**

Explanation:
Please see our responses to the questions 6 and 7.

21. 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

- **Agree**

Explanation:
Please see our response to question 19.

22. If you agreed, which categories of NHS managers should the statutory 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)**
- **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)**

Explanation:
Please see our responses to the questions 6 and 7.

NHS leaders' duty to respond to safety incidents

23. 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?

- **Agree**

Explanation:
The NHS RHO has contributed to a growing body of evidence indicating that the dismissal of minoritised ethnic patients' concerns is actively contributing to ethnic health inequalities (NHS RHO, 2022). This troubling pattern can be observed in all areas of the healthcare system, from maternity to sickle cell care, and was recently highlighted in our work with NHSE's National Worry and Concern Improvement Collaborative in the context of the implementation of Martha's Rule (NHS RHO, 2025). This, together with

the previously detailed disproportionate challenges that minoritised ethnic healthcare professionals face when raising patient safety concerns, reiterates a clear need for accountability among NHS leadership.

A statutory duty for NHS managers to record, consider, and respond to concerns would be an effective intervention to deter the poor practices we have outlined throughout our response. An anti-racist approach is needed to avoid replicating and exacerbating the ethnic disciplinary gap among minoritised ethnic managers. Regulation should not implement rigid, onerous processes that prevent managers from accounting for the complexity or context of specific concerns. We reiterate that existing routes to early informal resolution need to be made more effective through fair, equitable, and transparent processes. There is a risk that this could otherwise lead to a hesitancy to adopt such solutions for fear of non-compliance with statutory requirements.

Done well, this could complement a statutory duty to ensure that existing processes in place to record, consider, and respond to concerns are being correctly followed. We acknowledge the argument that such duties could lead to an unmanageable caseload for managers, but we reiterate that the solution to this is improving patient safety as opposed to reducing regulation. It would also generate a wealth of evidence to inform quality improvement activity, ultimately driving up standards for patient care.

24. If you agreed, which categories of NHS managers should this 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)**
- **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)**

Explanation:
Please see our responses to the questions 6 and 7.

25. 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?

- **Agree**

Explanation:
Please see our response to question 19.

26. If you agreed, which categories of NHS managers should this 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)**
- **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)**

Explanation:
Please see our responses to the questions 6 and 7.