

# Blowing the whistle: an investigation into the Care Quality Commission's regulation of the Fit and Proper Persons Requirement



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## Executive summary

This report is about our investigation into the Care Quality Commission's (CQC) regulation of the Fit and Proper Persons Requirement (FPPR), which requires NHS providers to ensure that their directors are 'fit and proper' to carry out their duties. One of the aims of FPPR is to prevent directors who have committed misconduct from moving around the NHS. This investigation follows a complaint brought to us by a whistle-blower, which we have partly upheld as a result.

### The complaint

Ms K (the whistle-blower) complained to us that the CQC took an incomplete and unclear approach to regulating FPPR in regards to employing a Chief Executive at Trust P. Ms K had been subject to reprisals from the Chief Executive in a previous trust (Trust J) after raising a genuine concern about the Chief Executive's misconduct. Ms K said the CQC's approach to reviewing FPPR for the Chief Executive at Trust P was not fair, transparent or proportionate.

Ms K claimed the CQC failed to fully consider her Employment Tribunal judgement from 2014, which found she was unfairly penalised for whistle-blowing. She felt the CQC's application of the FPPR diminished the seriousness of the Chief Executive's conduct and gave the message that those who victimise whistle-blowers will escape accountability. She complained that if the CQC had handled the situation better, the Chief Executive would not have been able to get another job in a different NHS trust.

### Background

In January 2014 an Employment Tribunal found that the Chief Executive's previous Trust, Trust J, had subjected Ms K and her colleague to reprisals after she raised a genuine concern about serious misconduct by the

Chief Executive. The Employment Tribunal found that the Chief Executive breached the code of conduct for NHS managers and the Trust's recruitment and selection policy. It also criticised the Trust's internal investigation report into Ms K's allegations. It concluded that Trust J prevented Ms K from returning to her job – the Chief Executive wanted to withdraw an offer of employment unless Ms K stopped her Employment Tribunal proceedings.

Following the Employment Tribunal findings, the Chief Executive was suspended from Trust J in February 2014 and resigned in May 2014.

In August 2014, the Clinical Commissioning Group for Trust J made a complaint to the Professional Regulator that the Chief Executive's fitness to practice was impaired due to misconduct. The Professional Regulator's report concluded that no regulatory action was to be taken against the Chief Executive by them.

The Chief Executive was then employed by Trust P as 'interim Chief Operating Officer' in October 2015.

A third-party referred this issue to the CQC in October 2015, asking the CQC to review FPPR in relation to the Chief Executive in light of the Employment Tribunal.

In February 2016, the CQC concluded that there was no breach of FPPR as the information Trust P had provided was sufficient, and they closed the referral.

At the end of April 2016, the Chief Executive was promoted to 'interim Chief Executive' at Trust P.

Two weeks later, in May 2016, the Chief Executive was suspended from Trust P following separate allegations of financial fraud when working at Trust J. The CQC was not aware of these allegations at this time.

Ms K complained to the CQC in February 2017 to express her concern about the CQC

accepting assurances from Trust P about employing the Chief Executive.

Ms K referred her complaint to us in January 2018, which we accepted for investigation.

In January 2018, after consultation, the CQC updated its guidance on FPPR.

## Findings

Our investigation found that the CQC's handling of FPPR was not transparent, fair or proportionate and it amounted to maladministration. This is due to two reasons.

Firstly, the CQC's record-keeping was poor. To be 'open and accountable' the CQC should have created and maintained useable records as evidence of their decision and reasons for closing the FPPR matter for Trust P in 2016. The CQC's records did not explain their decision, what they thought of the evidence presented to them and how they weighted different pieces of evidence.

Secondly, the CQC did not adequately weigh up the evidence and they dismissed relevant considerations in their assessment of whether Trust P made a reasonable decision on FPPR in relation to the Chief Executive. We would expect the CQC's decision-making to take account of all relevant considerations, ignore irrelevant ones and balance the evidence appropriately. However they dismissed the criticisms of the Chief Executive in the 2014 Employment Tribunal findings while other evidence such as the Chief Executive's references, apology for their handling of Ms K's allegations in their interview with Trust P and the Professional Regulator's report, were given more importance without good reason. The grounds that CQC relied upon for accepting Trust P's view on FPPR were inadequate.

The Employment Tribunal explicitly contradicted Trust J's internal investigation and criticised the Chief Executive's actions. While the Professional Regulator's report was an

important piece of evidence, the CQC placed too much weight on it as it did not cover all the FPPR issues the CQC needed to address. It did not give a clear view about the allegation of whistle-blower suppression.

In addition, the CQC said that had the Chief Executive been applying for a permanent role at Trust P then they would have likely carried out an independent investigation. However, the 2015 guidance was clear that the FPPR applied to both permanent and interim roles. The employment status of a director is not a relevant factor in the FPPR regulation, given the aim of FPPR is to prevent unsuitable directors moving around the NHS.

We found that the CQC's consideration of the evidence presented to them contained fundamental flaws and the seriousness of the failings in this case raises the possibility that the failings go beyond this case. Their decision to close the FPPR case for Trust P was flawed. It caused Ms K significant upset and exacerbated her distress as a result of the Employment Tribunal and her previous mistreatment by Trust J.

It would be speculative to establish what would have happened had the CQC undertaken a robust consideration of Trust P's handling of the FPPR, therefore we are unable to uphold this element of Ms K's complaint.

## Recommendations

We recommend that within eight weeks of this report, the CQC should:

- send a formal apology to Ms K for the injustice and distress that their actions have caused her;
- offer £500 to Ms K in recognition of the injustice caused to her; and
- review their learning from this case and report back to us on the improvements they have made to demonstrate rigour in their FPPR considerations.

## Introduction

1. This report sets out the key pieces of evidence we considered from Ms K and the CQC through enquiries, interviews and their comments on our provisional views. The CQC's comments led us to revisit our finding about their approach and process for handling third party concerns about the Fit and Proper Persons Requirement (FPPR). Whilst we may not have referred to all the evidence we have seen, we are satisfied that relevant information has been fully considered and the key information is included in this report.
2. We have **partly upheld** the complaint as we found several instances of maladministration. Whilst we did not find maladministration in the CQC's general policy approach to FPPR, we found that the CQC's consideration of the evidence put before them in this case was incomplete – relevant considerations were discounted without good reason and irrelevant factors were given weight. For these reasons, we have found that the CQC's decision on FPPR in relation to Trust P and the Chief Executive was flawed. Whilst we cannot say if the outcome in this case would have been different in the absence of maladministration (and therefore we cannot fully uphold the complaint), we accept that the CQC's flawed handling of FPPR caused Ms K frustration and distress, as well as making her lose confidence in their ability to regulate FPPR. Further, we consider the circumstances of this case were so serious that it may have created a wider injustice around ensuring robust and transparent regulation of FPPR.

## The complaint

3. Ms K complained about the CQC's handling of FPPR matters in relation to the appointment of a Chief Executive to Trust P in 2016. Ms K said that the CQC's process was insufficiently challenging as any reasonable observer would have concluded that Trust P finding that the Chief Executive was a Fit and Proper Person was 'perverse', even without factoring in later events that resulted in a criminal finding of fraud. In particular, Ms K said that the CQC failed to fully consider the findings of her Employment Tribunal (ET) judgment from 2014 in relation to the Chief Executive's poor treatment of whistleblowers and the ET's view that the Chief Executive was an unreliable witness. Further, Ms K said that the CQC failed to consider that the Chief Executive was relying on an investigation report from Trust J that had been criticised by the ET. Even so, with the press attention the ET attracted, Ms K considered that the CQC must have been aware of the matter when considering FPPR.
4. Ms K said that she was unemployable following her whistleblowing, yet until the financial fraud became public knowledge, the Chief Executive was protected by the CQC and others, and was rewarded despite inappropriate behaviour. Ms K considered that the CQC's handling diminished the seriousness of the Chief Executive's conduct and gave a message that those who victimise whistleblowers may escape proper accountability and can quickly be re-employed. Ms K said she had to watch helplessly as the person who placed her in her current situation was given a good job, and this was accepted by the CQC, which did nothing about the Chief Executive's treatment of whistleblowers. Ms K found the CQC's handling distressing and upsetting as it appeared that the Chief

Executive's contribution was valued more than hers. Ms K would like the CQC to acknowledge their mistake in how they applied FPPR and to apologise for the distress and upset their actions caused. She also seeks compensation from the CQC for exacerbating the distress caused by the Chief Executive's actions towards her. Furthermore, Ms K would like the CQC to review their handling of referrals in other cases and implement the FPPR regulation properly.

## Legal and administrative background

5. Under section 12(3) of the *Parliamentary Commissioner Act 1967*, we can question the merits of a discretionary decision taken by an organisation *only* where there is evidence of maladministration in the way the decision was made. We cannot question a decision on the grounds that we might have reached a different decision from the one that was actually made.
6. When considering the actions of public bodies, we take account of the legislative and administrative standards in place at the time of the events. These standards provide a benchmark upon which we can take a view about whether or not the actions of the public body were administratively sound and reasonable. If maladministration has occurred, we can also use these standards to form an opinion on what would have happened but for maladministration, and what injustice this has created for the individual making the complaint. Once we understand any injustice that has occurred, we can develop an understanding of the appropriate remedy. We have set out the relevant standards for Ms K's complaint below.
7. The Ombudsman's Principles of Good Administration<sup>1</sup> are broad statements of what public organisations should do to deliver good administration and customer service, and how to respond when things go wrong. The Principles that apply in this case are:
  - **Getting it right** – acting in accordance with the law and the public organisation's policy and guidance; decision making should take account of all relevant considerations, ignore

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<sup>1</sup> <https://www.ombudsman.org.uk/sites/default/files/page/0188-Principles-of-Good-Administration-bookletweb.pdf>

irrelevant ones and balance the evidence appropriately;

- **Being open and accountable** – public administration should be transparent; being open and clear about policies and procedures and ensuring that information is clear, accurate and complete; creating and maintaining reliable and usable records as evidence of activities, stating criteria for decision making and giving reasons for decisions;
- **Acting fairly and proportionately** – public bodies should be prepared to listen to their customers, ensuring that decisions and actions are proportionate, appropriate and fair. Further, when taking decisions, and particularly when imposing penalties, public bodies should behave reasonably and ensure that measures taken are proportionate to the objectives pursued, appropriate in the circumstances and fair to the individuals concerned. In addition, people should be treated fairly and consistently, so that those in similar circumstances are dealt with in a similar way;
- **Putting things right** – acknowledging mistakes and apologising where appropriate, putting mistakes right quickly and effectively; and
- **Seeking continuous improvement** – reviewing policies and procedures to ensure they are effective; ensuring the public organisation learns lessons from complaints and uses these to improve services and performance.

8. In May 1995 the Seven Principles of Public Life were published by the Committee on Standards in Public Life. These are known as the Nolan Principles; they say that a

holder of public office should act solely in terms of the public interest. Further, their actions should reflect, among other things, their integrity, objectivity, accountability and honesty.

9. The *Public Interest Disclosure Act 1998* (PIDA) includes provisions that protect workers by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern (whistleblowing) about patient safety, malpractice and illegality.
10. In 2002 the Department of Health published a Code of Conduct for NHS Managers<sup>2</sup> (the Code), which was intended to act in parallel with the Nolan Principles. Among other things, it required NHS managers to act honestly and with integrity. The Code was to be included in the contracts for NHS chief executives and directors – alleged breaches of the Code could be investigated informally or under local disciplinary procedures.
11. Concerns about safeguarding patients and ensuring appropriate leadership in the NHS arose following inquiries into allegations of patient abuse in Winterbourne View Hospital in 2011, and in relation to substandard care provided by the Mid Staffordshire NHS Foundation Trust in 2010. The subsequent Francis Inquiry by Sir Robert Francis QC into the Mid Staffordshire NHS Foundation Trust in 2013 recommended, among other things, that there was a proper degree of accountability for senior managers and leaders.
12. After the Francis Inquiry, during 2014 the Department of Health undertook consultations about the implementation of a Fit and Proper Person Requirement (FPPR) for senior managers and directors

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2 [http://www.nhsemployers.org/-/media/Employers/Documents/Recruit/Code\\_of\\_conduct\\_for\\_NHS\\_managers\\_2002.pdf](http://www.nhsemployers.org/-/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf)

working in health and social care in England. It discussed the possibility of the CQC operating a barring scheme for directors whose conduct and competence made them unsuitable to work in the health and care system, so they were prevented from working and moving to a similar job within the sector. The CQC told us that this option was constrained however, by the practicalities of what the CQC could feasibly achieve when their role is to regulate providers. The outcome was that the CQC's role in FPPR focused on regulating how providers undertook their duties in relation to FPPR. In particular, it was decided that the CQC should not operate a barring scheme for directors.

13. When the regulation was passed, the responsibility for administering FPPR was placed with providers only. Regulation 5(3) of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (Regulation 5)<sup>3</sup>, in relation to FPPR set out requirements for providers for the appointment of senior directors, including chief executives, working in NHS trusts. The CQC was not able to prosecute providers for non-compliance with FPPR, but could issue requirement and enforcement notices and withdraw a provider's registration. Among other things, Regulation 5(3) (d) required providers to consider when appointing directors 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.'*

14. There are two routes for the CQC to consider FPPR matters, which are summarised here. The first is through their inspection of providers; inspectors will consider FPPR in the context of whether appropriate checks (Disclosure and Barring Service (DBS), bankruptcy, references, for example) have been undertaken by providers for their directors. The second route, which is the focus of this complaint, is the CQC's consideration of information of concern it receives about FPPR breaches externally from third parties, members of the public and so on.
15. *Regulation 5: Fit and proper persons: directors, NHS bodies, Information for CQC staff* from March 2015 (the 2015 guidance) was the guidance drawn on by the CQC during the period relevant to the complaint. We will use the 2015 guidance, therefore, to consider the CQC's actions on this complaint. It said that Regulation 5 applied to interim and permanent positions. It also said that the CQC would not determine what is and is not serious mismanagement and misconduct, but would make a judgment about the reasonableness of the provider's decision.
16. The CQC's 2015 guidance said that when information of concern was received, an FPPR panel would be convened, including the Chief Inspector of Hospitals and Director of Legal Services.<sup>4</sup> Further, that the FPPR panel would make no judgment about the information of concern it had received. Rather, when the FPPR panel received a response to the FPPR concerns from a provider, it would consider whether the process that the provider had followed was robust and thorough and if it had reached a reasonable conclusion. The 2015 guidance said that if the process followed

<sup>3</sup> FPPR is also referred to as Regulation 5 throughout this report.

<sup>4</sup> This refers to the Director of Governance and Legal Services.

by the provider was not robust or an unreasonable decision had been made, the FPPR panel could request further dialogue with the provider, schedule an inspection or take regulatory action (if a clear breach was established). The 2015 guidance said that staff would be supported in making the right decision through training, a compendium of case histories as they arose and a frequently answered questions (FAQs) document that would be updated regularly.

17. The FPPR FAQs document (the FAQs) from 15 May 2015 said that the CQC would look for corroborated evidence including employment tribunals and reports from Royal Colleges. It added that the CQC would apply standards where it could:

*‘However, sometimes we have to develop standards from case histories over time, which is the case here as it is a new regulation.*

*We can’t specify standardized thresholds because each individual case needs to be considered on its merits at this point.*

...

*We would not be deterred from looking further at someone simply because the GMC was not reviewing them. We would want to look at GMC’s judgment if they said action was needed.’*

18. The FAQs confirmed that the principle of whistleblower suppression was core to influencing FPPR and should be used to improve quality and safety:

*‘We would need to be clear about the level of suppression and the evidence that supports this. We are not accountable to whistle blowers however and we should follow our business as usual procedures.’*

19. The CQC’s Enforcement Policy from April 2015 explained that the CQC can issue requirement notices when there is a breach of regulation, but people using the service are not at immediate risk of harm. Warning notices are issued when NHS trusts (only) are not meeting conditions of the registered person’s registration and the CQC impose a timescale for improvement which they ask the trust to meet. Section 29A Warning Notices are issued to NHS trusts (only) if the CQC considers significant improvement is required. If providers do not comply with the CQC’s enforcement action, their registration with the CQC is at risk. It is a criminal offence for providers not to be registered by the CQC. Providers can challenge the CQC in relation to enforcement steps, such as warning notices and the imposition of conditions on registration, or the variation or cancellation of registration, which carry rights of appeal. The CQC said that it was theoretically possible that they could bring criminal enforcement action against a foundation trust for an FPPR-related breach where the FPPR breach meant service users were exposed to avoidable harm or significant risk of exposure to harm. However, the CQC said that any FPPR breach in such circumstances would very likely be incidental to other failings more clearly evidencing broader deficiencies in systems and processes.

## Background

20. In January 2014 an employment tribunal (the ET) found that the Chief Executive's previous trust, Trust J, had subjected Ms K and her colleague to detriment for making a protected disclosure (paragraph 9). This related to a whistleblowing allegation by Ms K that the Chief Executive had arranged for the appointment of a relative's partner into a post at Trust J. The ET found that the Chief Executive's evidence was inconsistent and there was a failure to disclose knowledge of the candidate during the recruitment process. The ET noted that Trust J's independent report had found that there was no case to answer for the Chief Executive in relation to there being a breach of Trust policy,<sup>5</sup> but the Trust report had noted that there might be a case to answer under the Code of Conduct for NHS Managers (paragraph 10). The ET's 'unanimous view' was that the failure to disclose knowledge of the candidate by the Chief Executive was a breach of the Code of Conduct for NHS Managers (paragraph 10), a breach of the Trust's Recruitment and Selection Policy, which required disclosure of personal interest, and a breach of implied good faith to Trust J. The ET disagreed with Trust J's previous internal investigation report into Ms K's allegations to this extent – that Trust J's HR policy had been breached. The ET also said that the Chief Executive (not Trust J) had made it clear that Ms K continuing in her role was impossible, as it was considered that Ms K and her colleague's allegations were vexatious and motivated by malice. The ET noted evidence that showed the Chief Executive did not want to continue the working relationship with Ms K and

her colleague. The ET then said it was Trust J that created the impediment for Ms K returning to her job. In particular, the ET noted that a subsequent offer of employment made to Ms K and her colleague was withdrawn because the Chief Executive considered that the offer of employment should not be made unless they withdrew ET proceedings. This led to the job offers being withdrawn. The ET included a further statement that, 'We have been asked by [Trust J] to record that the claimants gave no evidence that they believed that [the Chief Executive] was guilty of misconduct in public office.' The finding of the ET was that Trust J prevented Ms K and her colleague from returning to work on grounds of their public interest disclosures (paragraph 9) and Trust J did not want them back while they persisted with their complaint.

21. The Chief Executive was suspended from Trust J in February 2014 and resigned in May 2014. In August 2014 the clinical commissioning group for Trust J made a complaint to the Chief Executive's professional regulator (the Professional Regulator) that the Chief Executive's fitness to practice was impaired by reason of misconduct.<sup>6</sup>

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<sup>5</sup> The Trust's policy required disclosure when an interview applicant was a family member or close friend.

<sup>6</sup> This can involve issues outside professional or clinical matters, but only if they could affect the protection of patients, undermine public confidence or undermine public expectations of standards of behaviour.

## Key events

22. In October 2015 the Chief Executive began working at Trust P as an interim Chief Operating Officer.<sup>7</sup> A few days later, on 12 October 2015, the CQC received a referral from a third party asking them to review FPPR in relation to the Chief Executive. Another third party endorsed the FPPR referral to the CQC the following day and enclosed a copy of the ET judgment (paragraph 20).
23. FPPR panel meetings were held at the CQC in October and December 2015, where the concerning information about the Chief Executive was discussed. The FPPR panel considered that the allegations should be raised with Trust P and the CQC took steps to do that. The CQC did not accept Trust P's initial response to them of 13 January 2016, where Trust P said it considered FPPR had not been breached. It was agreed by the Chief Inspector of Hospitals and the Director of Governance and Legal Services at the CQC that more information should be sought as the panel did not have sufficient assurance from Trust P that FPPR had been met.
24. Trust P responded to the CQC again on 4 February 2016. Trust P listed and provided all the documentary evidence taken into account by Trust P's Chairman in reaching the decision that FPPR had not been breached. These included notes of the interview Trust P conducted with the Chief Executive at the end of October 2015 (after the Chief Executive had been appointed) where the Chief Executive explained the view that the actions taken were not dishonest, but that if they could do it again, there would be a change in the way matters were handled and they were sorry. The documentary evidence also included Monitor's<sup>8</sup> *Pool* references from four NHS trust chief executives and two other senior directors of NHS trusts, a solicitor's briefing, the ET judgment from January 2014 (paragraph 20) and Trust J's internal independent report (also paragraph 20). Trust P's own consideration noted that some of the evidence about the Chief Executive's behaviour in the course of events that led to the ET in 2014 would appear to be of concern and could come under the headings of misconduct or mismanagement (paragraph 13). However, Trust P said that the independent investigation by Trust J found that the Chief Executive had not arranged for someone they knew to obtain a post and there was '*no case to answer*'.
25. Further, Trust P said that they received excellent references for the Chief Executive which attested to their honesty and integrity. Trust P noted in particular that one of the references considered the ET was one isolated incident in 10 years. Trust P provided evidence that they had sought legal advice on the FPPR process, and they considered that an appropriate process was followed and the conclusion that the Chief Executive met FPPR was a legitimate one. Trust P concluded that the ET finding was of concern, but was not sufficiently serious to counterbalance years of excellent service in the NHS. The interview Trust P undertook with the Chief Executive showed that they expressed regret about the events that resulted in the

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7 For ease of reference, this report will continue to refer to the Chief Executive even when working as Chief Operating Officer.

8 Monitor became part of NHS Improvement in April 2016. Its role, among other things, was to regulate NHS trusts and ensure that they were well-led. It held a list of directors that NHS trusts could draw on for appointments into vacant roles.

ET and that they could have done more to get Ms K and her colleague back to work. Furthermore, Trust P referred to Monitor's consideration that the incident did not reflect on the Chief Executive's abilities and talents. Trust P concluded that lessons had been learnt from the incidents by the Chief Executive and they concluded that they met the FPPR requirements.

26. Also on 4 February 2016, the Chief Executive wrote to the CQC directly about their appointment to the role under FPPR. In doing so, the Chief Executive enclosed a statement given to the Professional Regulator in relation to the ET in 2014. The statement to the Professional Regulator included the statement that since the events at issue, the Chief Executive had ensured that they followed Trust policy on recruitment and only became involved in recruitment at an appropriate level. The Chief Executive told the CQC that the Professional Regulator also found '*no case to answer*'.
27. On 10 February 2016 the FPPR panel discussed receiving letters from the Trust and the Chief Executive. In particular, the FPPR panel wanted to check the Chief Executive's contention that the Professional Regulator found no case to answer.
28. The CQC then obtained a copy of the Professional Regulator's decision, which had been determined in December 2015 following the complaint they had received in August 2014 (paragraph 21). The Professional Regulator said it had considered the papers before it as to whether there was a case to answer for the Chief Executive. The Professional Regulator's considerations included:
  - The Professional Regulator accepted the Chief Executive's account that they had not met the candidate at Trust J before

interview and did not know about the depth of their relationship with the Chief Executive's relative. It accepted that the Chief Executive's conduct showed an error in judgment, but would not be regarded as dishonest;

- The Professional Regulator noted the ET judgment from January 2014 – that the Chief Executive would not allow Ms K to return to work following the whistleblowing and thwarted efforts for her to obtain alternative employment. However the Professional Regulator said it referred to this matter simply to put the complaint into context;
- The Professional Regulator said that there was a case to answer in respect of a second matter, unrelated to Ms K. However, the Professional Regulator noted the Chief Executive's remorse and insight about that;
- The Professional Regulator also took account of Trust P's recent consideration of FPPR, which found that the Chief Executive met the test of a Fit and Proper Person;
- The Professional Regulator noted that it was unable to conclude that these allegations represented isolated incidents, but concluded that they were out of character for the Chief Executive. Further, it noted that there was no evidence before or since that their actions required regulatory intervention;
- The Professional Regulator did not consider there was a real prospect of a current finding of impairment of fitness to practise being made by it. Therefore, the Professional Regulator concluded there was no case to answer for the Chief Executive.

29. The Chief Inspector of Hospitals exchanged emails with CQC colleagues on 12 February 2016 as they noted that there was a second issue in the Professional Regulator's determination that they had not known about. The Director of Governance and Legal Services at the CQC said they thought the CQC could accept *'this'*. The Chief Inspector of Hospitals then emailed to say that they had read the report from the Professional Regulator in full. They said that it did not change their view that the CQC could close the case on FPPR. Further, the Chief Inspector of Hospitals added:
- 'However, their judgement that there is 'no case to answer' is an interesting one given that they identified two incidents of 'suboptimal practice'. They clearly put considerable weight on the fact that [the Chief Executive] had shown 'insight, remorse and remediation', but this does not mean that [their] behaviour had been in line with what would be expected of a CEO.'*
30. An addendum was added to the FPPR panel note of 10 February 2016 (paragraph 27) to note that the Chief Inspector of Hospitals had confirmed that the information was sufficient, although not straightforward, and agreed the referral for Trust P should be *'closed'*. On 16 February 2016 the CQC wrote to Trust P and the Chief Executive to say that the FPPR panel did not consider there was a breach of FPPR and reserved the right to reopen the case later if further information came to light.
31. Following an approach from a further third party (who participated in setting up FPPR) to the Chief Inspector of Hospitals enclosing a copy of the ET judgment from 2014, the FPPR panel met again on 11 March 2016 to discuss the Chief Executive. The CQC considered that Trust P's response showed thorough FPPR checks and that the Professional Regulator's decision had been independently verified. It was agreed that the case in relation to the Chief Executive and Trust P should be closed.
32. At the end of April 2016 the Chief Executive was promoted from interim Chief Operating Officer (paragraph 22) at Trust P to interim Chief Executive. No further consideration of FPPR took place by Trust P and the CQC was not aware of the promotion. However, after being in the new post for two weeks, the Chief Executive was suspended from Trust P following separate allegations of financial fraud when working at Trust J. The CQC was not aware of the allegations of financial fraud at that time.
33. In August 2016 the CQC issued a Section 29A Warning Notice (paragraph 19) to Trust P following an inspection from June 2016. The eight grounds for the Warning Notice included that FPPR was not being managed properly. The Warning Notice was not as a result of Trust P's consideration of FPPR in relation to the Chief Executive, but rather that Trust P's personnel files showed directors were not having their qualifications, DBS clearances or references and so on appropriately managed.
34. On 1 February 2017 Ms K wrote to the CQC to express her concern that they had accepted assurances from Trust P with regard to the Chief Executive. Ms K asked the CQC what learning they would draw from this episode and how they would arrive at such learning.
35. On 6 March 2017 the CQC responded to Ms K's concerns. The CQC explained that they had received information of concern about the Chief Executive in October 2015 and based on information provided by the Trust P and the Professional Regulator they had concluded that FPPR had not been

breached. The CQC went on to explain that they received information that led them to reopen the case in April 2016. When the CQC inspected Trust P in mid-2016, they issued a warning notice to the Trust requiring improvement to their processes around FPPR. Furthermore, the CQC said that they would be monitoring Trust P closely and would be returning to check that the improvements had been made.

36. The CQC's letter to Ms K also explained that the policy intention of Regulation 5 was to ensure that unfit directors could not move with ease between organisations. It sought to achieve this without needing an individual barring scheme that would be costly to operate. In addition, the CQC said it was not their responsibility to assess directors, but to check the providers' systems and processes. As Regulation 5 only came into force in April 2015, the CQC said they had not yet assessed its effectiveness. The CQC said that in the first years, they received challenge from people who expected them to assess fitness to practice, so they had been looking at improving their internal systems for handling referrals under FPPR. The CQC said they would be openly consulting with the general public on proposed changes in 2017.
37. Following consultation in summer 2017, on 19 January 2018 the CQC updated their guidance on FPPR, *Regulation 5: Fit and proper persons: directors – Guidance for providers and CQC inspectors* (the 2018 guidance – see annex<sup>9</sup>). Whilst we have not used the 2018 Guidance in considering maladministration, because the 2015 guidance was in place at the time of the events, the CQC has referenced it in their evidence below.

## Evidence from the CQC

### Interviews

38. During our investigation, we interviewed the former Chief Inspector of Hospitals,<sup>10</sup> the Deputy Chief Inspector of Hospitals and the Director of Governance and Legal Services at the CQC, all of whom sat on the FPPR panel when Trust P's handling of FPPR was being considered. The key points they gave us about the CQC's approach to Regulation 5 and their considerations of Trust P are set out below.
39. The Chief Inspector of Hospitals said that the CQC had looked at two things:
  - i) Had the provider done a thorough job; and
  - ii) Had the provider come to a reasonable conclusion, even if it was not the same decision that the CQC would have made.
40. The Chief Inspector of Hospitals said the CQC never met individual directors about whom FPPR allegations were made, as it is the provider's responsibility to ensure compliance with Regulation 5. At the time of the Chief Executive's case, the CQC was making a decision based on their experiences of cases at that time. The Chief Inspector of Hospitals said that the FPPR panel had relied on their interpretation of Regulation 5 until case law emerged. However, that involved the professional judgment of highly experienced people including the CQC's Chief Inspector of Hospitals, Deputy Chief Inspector of Hospitals and most senior legal adviser (the Director of Governance and Legal Services).

<sup>9</sup> [https://www.cqc.org.uk/sites/default/files/20180119\\_FPPR\\_guidance.pdf](https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf)

<sup>10</sup> In post between 2015 and 2017.

The commonality of decision making was achieved because the same people at the CQC were on the FPPR panel.

41. The Chief Inspector of Hospitals did not consider that the CQC could have reached another conclusion as Trust P had done a thorough job and had come to a reasonable conclusion. The CQC was not aware of the Chief Executive's financial fraud at the time when they assessed whether Trust P had applied Regulation 5 appropriately. Following the CQC's request for further information, Trust P had provided legal advice and interview notes with the Chief Executive which, crucially to the Chief Inspector of Hospitals, stated the Chief Executive was reported to be highly remorseful. Trust P also provided a list of names of referees who had supported the Chief Executive's appointment. The remorse from the Chief Executive was in relation to their decision to be on the interview panel at Trust J. The Chief Inspector of Hospitals said that it was unwise of the Chief Executive not to declare an interest during the interview process at Trust J. However, the Chief Inspector of Hospitals was not sure that this in itself was sufficient to say that the Chief Executive could not be a director.
42. In relation to the Chief Executive's treatment of Ms K, the Chief Inspector of Hospitals noted that, although the ET stated that much of the Chief Executive's evidence was inconsistent, it had been more damning about the Chair of Trust J stating that their evidence was quite '*simply incredible and plainly wrong*'. Further the ET stated Ms K gave no evidence that she believed the Chief Executive was guilty of misconduct in public office (paragraph 20). The ET was a negative piece of evidence for the Chief Executive, but the Chief Inspector of Hospitals considered that it had to be considered alongside all the other pieces of evidence, which included positive pieces of evidence, the solicitor's advice, Trust P's interview and a myriad of references. The Chief Inspector of Hospitals noted that only one of those references referred to one error of judgment in 10 years, but all the other references were positive.
43. The CQC had also taken into account the Professional Regulator's comment on the second matter (paragraph 28, bullet point iii). The Chief Inspector of Hospitals said that the three issues (the recruitment issue that led to the whistleblowing, the ET and the second matter considered by the Professional Regulator) had to be set against the positives recorded by Trust P. Overall, the Chief Inspector of Hospitals believed that the decision taken by Trust P had been reasonable. If they had been on Trust P's interview panel, the Chief Inspector of Hospitals might have decided not to employ the Chief Executive as their view was that there were some concerns, but the CQC was looking at two factors above (paragraph 39). The Chief Inspector of Hospitals thought that Trust P had done a thorough job and made a reasonable decision, even if it was not the decision that they might have made. In the Chief Inspector of Hospital's opinion, the CQC would have made the same decision regarding the judgment made by Trust P. In relation to the email sent on 12 February 2016 (paragraph 29), the Chief Inspector of Hospitals thought the case should be closed as the Professional Regulator's report found no case to answer and FPPR should not hang on the second matter considered by the Professional Regulator.
44. The Chief Inspector of Hospitals said Regulation 5 implied that if a director were deemed 'unfit' this would mean that

they could never again hold a director-level position in the NHS in England. This is not the case for professional regulators, such as the GMC, who can, for example, suspend individuals for a period (for example, a year). The Chief Inspector of Hospitals would have preferred this to be the case for NHS managers too. The CQC had not issued a warning notice or taken enforcement action in relation to an FPPR referral from a member of the public<sup>11</sup>. The main value of FPPR had been its deterrent effect. Providers were paying more attention to their processes as the CQC's inspectors would look at their personnel files. He said that it was also a deterrent to individuals applying for director roles.

45. The Deputy Chief Inspector of Hospitals (the Deputy Chief Inspector) told us that all third-party referrals of FPPR concerns would be sent to the FPPR panel, unless the individual whom the allegations had been made against could not be traced or was unidentifiable. The Deputy Chief Inspector said the CQC relied on the actual regulation (paragraph 13) as a guide in supporting the CQC's view of FPPR. The CQC did not assess the fitness of a director and had discretion in applying all its regulations. Their decision rested on whether the provider had gone through a reasonable process. Some decisions were subjective, which was why the FPPR panel was in place to ensure consistency, and it was open to the CQC to take a different view from the provider. The CQC's decisions on FPPR were rooted in the consideration of evidence, consistency, proportionality and reasonableness. In making decisions, the FPPR panel applied experience and judgment – the provider did not have the luxury of a strict rule book and the only

judgment that the CQC could provide was whether the provider had taken reasonable steps.

46. The Deputy Chief Inspector said that a provider needed to make a decision about the length of time an individual could be deemed as not being fit and proper after being found to have acted in a manner that constitutes misconduct/mismanagement. They said that there was nothing to say that people could not be rehabilitated if in the past they had been sacked for gross misconduct.
47. The Deputy Chief Inspector said the CQC was trying to regulate FPPR, but that it did not meet the public's ambition for what FPPR should achieve. Regulation 5 had been difficult to apply. Therefore, the Deputy Chief Inspector and the Director of Governance and Legal Services had taken the FPPR issue to Counsel for legal advice. This had resulted in the consultation and revision of the CQC's FPPR guidance in January 2018 (the 2018 guidance – see annex).
48. The Deputy Chief Inspector said that the case of Trust P was a complex and high-order decision. The CQC was provided with a comprehensive list of assurances, independent references from notable NHS Chief Executives and a fellow regulator, Monitor. They also received a copy of the Professional Regulator's report, which said there was categorically no case to answer. In the CQC's view, Trust P had done all they could to assure themselves of FPPR.
49. The Deputy Chief Inspector noted that the Chief Executive was a high-profile person prior to their appointment to the Trust because they were the NHS lead on a particular NHS priority. In addition,

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<sup>11</sup> Enforcement action by the CQC has occurred in relation to FPPR following a hospital inspection. A CQC inspection would look at providers' processes in relation to checking directors' references, DBS, bankruptcy and so on.

the Chief Executive had previously been acknowledged as an individual of some credibility and the assurances from Trust P included a list of assurances and character references from individuals who could reasonably be judged to be senior and credible within the NHS. Further, the Chief Executive had not been disciplined for gross misconduct by Trust J. If Trust P had not taken such in-depth steps to consider FPPR, the Deputy Chief Inspector said that they would almost certainly have been in breach of Regulation 5. However, they thought the response from Trust P had been reasonable and in accordance with the principle of good governance, therefore it was not possible for Trust P to provide any further assurance than they had.

50. In relation to the Professional Regulator's report, the Deputy Chief Inspector said the Professional Regulator was focusing on the fitness to practice of the individual, while the CQC was looking at the process of the provider. However, the CQC had to trust their fellow regulator's (the Professional Regulator's) decision that the Professional Regulator's process was sufficient. No more weight had been placed by the CQC on the Professional Regulator's decision and all the information provided about the Chief Executive had been considered by the CQC in the round.
51. The Deputy Chief Inspector said that the inspection of Trust P in June 2016 was not linked to the Chief Executive's suspension from the Trust in May 2016. Further, the Warning Notice issued to Trust P in August 2016 was not linked to their consideration of FPPR in relation to the Chief Executive. The matters relating to FPPR at Trust P arose from the June 2016 inspection results.
52. The Director of Governance and Legal Services said their view was that Regulation 5 was a compromise as to what could

practically be delivered following the Winterbourne View Hospital case and the Francis Inquiry (paragraph 11). The reality of the FPPR process presented a communication challenge as the public were expecting a barring scheme. Further, that it was delivered in the context of other provisions brought about through Sir Robert Francis' recommendations about fundamental care standards, which the CQC was tasked with implementing. These were being implemented in stages to allow the CQC to develop relevant tools and training<sup>12</sup>. In relation to FPPR, the CQC had considered the meaning of misconduct and mismanagement and concluded that it carried its natural meaning. In particular, Regulation 5(3)(d), as it relates to serious misconduct, requires the employing trust to ensure that it does not appoint a person who has been responsible for conduct that effectively equates to gross misconduct.

53. The Director of Governance and Legal Services told us that the CQC looks at whether a trust made a decision that any reasonable trust could have made. Whether or not the decision is one that the CQC would have made is not the question asked; rather, there will be a spectrum of what may be reasonable, and the assessment is whether or not the decision falls within that. The CQC looked at the totality of the information considered by a trust.
54. The Director of Governance and Legal Services said that the threshold for serious misconduct was high as it had the effect of saying that someone could not be employed as a director in the NHS and had a high impact on the individual. The language of misconduct and mismanagement was considered to have its

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<sup>12</sup> Regulation 5 was passed in November 2014, but did not come into effect until April 2015.

natural meaning; an action that was grounds for dismissal and in line with standard statutory interpretation.

55. The Director of Governance and Legal Services said that the CQC would look for indications that the provider made an appropriate determination of FPPR through HR processes or other ways. The CQC would look at the decision by a trust more closely if it looked odd or out of keeping, as the duty on the provider was to have a fit person in role. Specifically, if the CQC saw an issue arising from an anomaly in the FPPR process, the CQC would look at it more closely. Therefore, the CQC was looking at Regulation 5(3) in the context of an employment setting and how to ensure good employment.
56. The Director of Governance and Legal Services confirmed that they had provided legal advice to the FPPR panel on the Chief Executive and Trust P's case through their attendance. The Director of Governance and Legal Services acknowledged that the note taking and recording of the FPPR panels was not as thorough as it could have been. The Director of Governance and Legal Services said the ET from 2014 (paragraph 20) was relevant to Trust P's consideration of the Chief Executive, however, the CQC was mindful that the ET was making a finding about Trust J and not the Chief Executive and unfair dismissal. Therefore, the Director of Governance and Legal Services considered that the ET was relevant, but was not in itself a determining factor in relation to FPPR. If Trust J had conducted an investigation about the Chief Executive under their human resources processes that had led to a finding of serious (or gross) misconduct, then this would have been a clear outcome, which the CQC could have accepted as such. However, it would still have been for Trust P to make their own determination of the relevance of that finding to their duty under FPPR, but no doubt the outcome would have been very different.
57. The Director of Governance and Legal Services said the CQC was concerned to check that Trust P had taken all the relevant information into account and had come to a reasonable decision in relation to Regulation 5. They considered that the ET did not automatically result in a finding about a director's own gross misconduct and that the CQC would need to have seen evidence of the employer trust taking further action in relation to an ET in order for there to have been grounds to go behind the decision to appoint taken by Trust P. When asked about directors such as the Chief Executive who resigned before disciplinary action could be properly considered by providers, the Director of Governance and Legal Services said that these types of behaviours are not something that Regulation 5 can prevent, but they certainly made FPPR more difficult to apply.
58. In relation to Trust P's evidence given to the CQC in February 2016, the Director of Governance and Legal Services said that the CQC was considering whether Trust P was in breach of Regulation 5. And to do so would have required 5(3)(d) (paragraph 13) to have been met, and thus the decision that Trust P made to have been unreasonable. It seemed to the CQC that Trust P had taken account of the relevant information and it appeared that the enquiries were thorough, including having taken account of the ET. Further, Trust P had reviewed references from chief executives and Monitor (paragraph 25), who play a role in the appointment of NHS directors. These all indicated that the actions of Trust P were reasonable.

59. The CQC could have suggested that Trust P commission an independent investigation, however, at the time the Chief Executive was applying for an interim post as Chief Operating Officer at Trust P (paragraph 22), not as interim Chief Executive. The CQC had not known that the Chief Executive had moved into an interim Chief Executive role until their suspension in May 2016, and they had never considered FPPR in relation to that role. Commissioning an independent investigation could certainly be appropriate in some circumstances and gives a degree of independent assurance to a trust where for example, public confidence might have been an issue. Had the CQC been considering the Chief Executive's appointment to a different (and permanent) role, it would have been more likely that the CQC would have pointed Trust P towards this as an option, although the CQC could not instruct a trust to take a particular course of action. The Director of Governance and Legal Services said that it might not have been proportionate to do so in relation to what was an interim appointment, where recruitment to the permanent role would have given the CQC a further opportunity to scrutinise the Trust's processes, and given the length of time, cost and impact that an independent investigation carries with it.

60. The CQC had gained experience over time of what worked when applying FPPR and what did not work. It was difficult to know if the decision would have changed in retrospect. The Director of Governance and Legal Services did not think it would have because the Chief Executive was in an interim role. The Director of Governance and Legal Services noted that the Regulation 5 criteria included a criminal conviction, which the Chief Executive now had, so the Regulation had worked in that

the Chief Executive was now excluded from working in the NHS – it had just taken a long time.

## CQC's further comments and evidence about FPPR

61. The CQC told us that since Regulation 5 was passed in November 2014, they have received 79 third-party referrals about FPPR in relation to NHS trusts and independent healthcare providers. The CQC's involvement in these has led to two incidents of providers taking disciplinary action and dismissing two directors, although the CQC told us that external allegations can lead to further inspections of care services.

62. In response to our provisional view, the CQC told us that their FPPR guidance is designed to assist providers to understand the nature of obligations under Regulation 5. They said their guidance was not for their staff or to explain how the CQC approaches any alleged breach by a provider of an FPPR obligation. They said that the CQC's guidance does not set a standardised threshold for FPPR and nor should it because the threshold for FPPR is set in legislation (Regulation 5 – paragraph 13) and applied to providers on a case-by-case basis. They added that:

*'it is not part of the regulatory role of CQC to set a high benchmark. On the contrary, it is for each registered provider to decide whether any proven facts in any individual case amount to "serious" misconduct or mismanagement.'*

63. The CQC said that it was a feature of Regulation 5 that it does not permit a provider to make a discretionary decision that an individual's past serious misconduct or serious mismanagement should be outweighed by other factors such as

the period of time since the misconduct or mismanagement occurred. The CQC said that compliance with an individual director's rights under the European Convention of Human Rights (ECHR) and other factors meant that a high threshold of the seriousness of misconduct and mismanagement must be established before an individual should be prevented from being able to act as a director for a provider.

64. The CQC told us that the Director of Governance and Legal Services had correctly identified the statutory tests (paragraph 54). They added that:

*'However, compliance with these tests was a matter where the Employing Trust was the decision-maker. Those individuals were assessing whether the Employing Trust had properly investigated the matter and had reasonably come to the conclusion that the individual had not been guilty of serious mismanagement or misconduct. ...Once it is appreciated that the CQC panel was assessing the conduct of the Employing Trust and not assessing the conduct of the relevant individual, the claimed [issue of] inconsistency of approach no longer arises.'*

65. The CQC reiterated that it was for each provider to decide whether any proven facts in any individual case amounted to serious misconduct or mismanagement. They said that the 2018 guidance (see annex) for providers and CQC inspectors set out a series of examples of behaviour which a provider could reasonably conclude met the required threshold of seriousness – it included fraud, theft, sexual harassment, bullying and victimisation of staff who raise legitimate concerns.

66. The CQC highlighted that the FPPR panel considered the ET was a piece of negative evidence in relation to the Chief Executive; however Trust P had also highlighted some countervailing positive pieces of evidence. The CQC said:

*'that is plainly the correct approach because the primary fact finder here is the Employing Trust and not CQC.'*

...

*it was not for the CQC to "place weight" and make findings. The role of CQC was to express a view on the findings made by [Trust P]... CQC was fully entitled to take account of all the factors properly considered by [Trust P].*

...

*[[There was a] need for CQC to look at the evidence in the round in its review of the decision-making of [Trust P] – as well as the ET decision and the finding of the Professional Regulator, this evidence included: a summary of the internal investigation report [by Trust J], references from Monitor's Interim Turnaround Pool, a reference from Monitor, references from ...NHS Recruitment, the individual's interview with [Trust P] and a report from [Trust P's] solicitors. Taken together, these demonstrated to CQC that [Trust P] had taken relevant considerations into account in its decision-making.'*

67. The CQC told us that they accepted criticism about their record keeping in 2016 and that since then they had taken action to improve their record keeping processes in light of that.

## Evidence from Ms K

68. During our investigation Ms K told us:

*'There already exists a Code of Conduct for NHS Managers [paragraph 10] and of course, the Nolan Principles [paragraph 8]. FPPR requires NHS providers to ensure that their directors and boards are fit and proper to carry out their duties as providers of NHS care and services – to their patients, service users, customers and staff. The Care Quality Commission has the regulatory responsibility to ensure that providers fulfil their FPPR duties effectively [but] I believe, that this is where Robert Francis' intentions [paragraph 11] have been watered down and are now being treated by the CQC in its loosest possible interpretation. NHS trusts are expected to determine if their directors are fit and proper to hold their directorship role. Regardless of any information in the public domain or otherwise, highlighting that a director's behaviour has been short of the standards required, CQC will not intervene. In [the Chief Executive's] case they only acted after [they were] sacked from [Trust P], once the fraudulent behaviour was identified. The fact that [the Chief Executive] had previously caused whistleblower reprisal [at Trust J] was, it appears, deemed to be acceptable and fit and proper!*

*'In its current implementation, CQC is not actually taking any action regarding the fit and proper standing of any directors. To the best of my belief, I don't believe that any director has been removed from a board position or denied a board position under FPPR since its inception. It is quite clear that FPPR doesn't protect NHS organisations, their staff or their patients and that ostensibly, there is no regulation in practice, or any kind of sureties in place to identify, dig out or prevent those who have evidenced poor practice, from holding the most senior and responsible positions in our NHS organisations. Sadly, ... the idea and the initial intention of FPPR was very positive and could have been effective in providing protection for our prized asset, the NHS. Unfortunately, the loopholes and the lack of responsible, regulatory application, has rendered it unfit for purpose.'*

69. In particular, Ms K said that the CQC had access to the ET that had criticised the Chief Executive and they should not have placed weight on Trust J's investigation report, which was completed prior to the ET and had been criticised by the ET (paragraph 20).

70. Ms K said that she was extremely unwell during the ET, which was also compounded by a personal bereavement. She said that she felt alienated from her colleagues and was having little contact with anyone outside her family and lawyers. She said that, *'Since then, my ... health has been improving although I still have not been able to secure employment back in the NHS'*. Ms K told us that the actions of Trust J and the Chief Executive (not the CQC) were *'personally devastating and life changing for me... Not only had I lost my job, career, financial security and well-being, I was then to witness the*

*recycling of [the Chief Executive by an NHS regulator]* to another post. Ms K said that *'this was especially galling as I, who had done nothing wrong, was now finding it hard to secure further employment in the NHS due to probable black-listing'*.

Ms K felt that the CQC placed more value on the Chief Executive than on her. In light of ongoing media interest in the case, Ms K said that issues with the Chief Executive didn't go away and it was upsetting for her.

71. Ms K said that her priority was to hold the CQC to account for their actions so that this situation did not happen to others. She wanted the regulation of FPPR to be effective. The way that the CQC had refused to act upon even solid evidence of whistleblower reprisal, such as Employment Tribunal judgments, had made whistleblower reprisal acceptable. Ms K considered that the CQC's 2018 guidance (see annex) merely repeated the same things and that it placed too much emphasis on the providers. She did not consider that the CQC was regulating anything.

## Findings – maladministration

72. Ms K's complaint is that the CQC's process for FPPR was insufficiently challenging in relation to Trust P as it was evident in her mind that the Chief Executive was not fit and proper. In order to answer this key issue we will focus on three elements – the CQC's interpretation of Regulation 5/FPPR, the process that the CQC used to consider FPPR and how the CQC applied their FPPR process in this case.

### CQC's interpretation and process for Regulation 5/FPPR

73. Ms K told us that she considered the CQC took an unfair interpretation of FPPR (paragraph 68). Ms K also said in their current implementation, the CQC was not taking action against providers in relation to FPPR. We will, therefore, consider what the CQC's interpretation and approach is to considering providers' actions regarding FPPR. Regulation 5 (paragraph 13) sets out requirements for providers to consider when appointing directors, which the CQC is responsible for regulating. It is not our role, or within our power, to impose our interpretation of regulations on organisations in our jurisdiction, but we can comment on whether the CQC's approach to, and process for, Regulation 5/FPPR takes account of our Principles (paragraph 7) – *'getting it right'* (acting in accordance with the law), *'being open and accountable'* (being open and clear about procedures and policies) and *'acting fairly and proportionately'* (treating people fairly and consistently).
74. The CQC's 2015 guidance said they did not determine FPPR matters – they expected the provider to make its own decision by

following a thorough process and reaching a reasonable decision (paragraph 15). The FAQs also said that the CQC could not give ‘*standardised thresholds*’ because each case needed to be considered on its merits (paragraph 17) and these would depend on emerging case law. CQC staff also told us they considered whether the provider had done a thorough job and reached a reasonable conclusion (paragraph 39); that some decisions were subjective and consideration of FPPR was rooted in consideration of evidence, consistency, proportionality and reasonableness (paragraph 45); and that the CQC would look at a decision more closely if it looked odd or out of keeping with the duty of a provider to have a fit person in role (paragraph 55). The CQC told us that it was not for them to set a threshold for serious mismanagement and misconduct, although they considered the threshold needed to be high and should equate to gross misconduct (paragraph 52). Rather the CQC considered that it was for the providers to reach a view depending on the facts of a case (paragraph 62). From this we can conclude that the CQC expect providers to establish that there is evidence of serious misconduct in a jurisdictional context or in employer or regulator findings. This is not set out in the 2015 guidance.

75. The approach and process of the 2015 guidance for FPPR appears to have enabled the CQC flexibility in considering the actions of providers on their individual merits and allowed the CQC to take account of the evidence before them in the round. We consider that this was fair and proportionate. In addition, we accept the CQC’s view – that intrinsic in their consideration of this was that whatever threshold is set by the provider it should be a high one (paragraph 52) – is appropriate in light of the impact it might have on an

individual director and the importance of taking account of relevant employment legislation (paragraph 63).

### CQC’s records of their consideration of Trust P in relation to the Chief Executive

76. Ms K considered that the CQC’s decision to close the FPPR case for Trust P in relation to the Chief Executive was ‘*perverse*’ because she considered there was evidence available to show that FPPR had not been met. To be ‘*open and accountable*’ the CQC should have created and maintained useable records as evidence of their decision and reasons for closing the FPPR matter for Trust P in 2016 (paragraphs 30 and 31). However, the CQC’s records did not explain their decision. In particular, the records do not reflect what the CQC thought of the evidence presented to them by Trust P, how they weighted different pieces of evidence and why they considered that this meant the FPPR matter for Trust P should be closed. The CQC has acknowledged that their record keeping of FPPR panel matters was not as clear as it could have been (paragraph 56) and that action has been taken about record keeping for FPPR panels since these events (paragraph 67). However, their actions on this case were not open and accountable and this amounts to maladministration.

### CQC’s consideration of Trust P in relation to the Chief Executive

77. As a result of the lack of detailed records, we have largely relied on the evidence that the CQC received from Trust P and what CQC staff told us about their considerations in order to piece together how the CQC reached their view on FPPR in this case. Therefore, we will consider their actions on this case by looking at

what they said they did. In relation to our Principles (paragraph 7), *'getting it right'*, we would expect the CQC's decision making to take account of all relevant considerations, ignore irrelevant ones and balance the evidence appropriately. In relation to *'acting fairly and proportionately'* we would expect the CQC to behave reasonably and ensure that measures taken are proportionate to the objectives pursued, appropriate in the circumstances and fair to the individuals concerned. We will consider whether what the CQC said they did in this case took account of the 2015 guidance and approaches they said they applied.

78. We have considered also the reasonableness of the CQC's decision making in relation to the pieces of evidence presented to them in this case – whether they balanced the evidence appropriately. The CQC focused first on the ET from 2014 (paragraph 20) because this is what gave rise to their concern about serious misconduct and resulted in them asking Trust P to provide assurance on FPPR. It is also the piece of evidence that Ms K considers shows the Chief Executive's failure to meet expectations under FPPR. The CQC told us that they took into account that the ET judgment was much more critical of the Chair at Trust J than the Chief Executive (paragraph 42). They also said they considered the ET together with all the evidence in the round weighing up the positive and negative pieces of evidence – the ET was a negative piece of evidence, but the solicitor's advice, Trust P's interview with the Chief Executive and the myriad of references showing this was one mistake in 10 years were positive evidence (paragraphs 42 and 48). The CQC also took into account the investigation by Trust J (paragraph 49). In our view, these considerations by the CQC meant that key observations and

findings from the ET were missed and other evidence was given more importance without good reason, leading the CQC to place less weight on the ET as a piece of evidence.

79. The CQC did not recognise that while Trust P's view was that they were content that Trust J had investigated the Chief Executive's actions in relation to serious misconduct, the ET explicitly contradicted Trust J's investigation (paragraph 20) to the extent that the ET considered the Chief Executive had breached HR policies and the NHS Code of Conduct for Managers. Furthermore, Trust P's provision of references for the Chief Executive showed the references did not dispute the events of the ET, rather the references pointed to individual experiences of the Chief Executive's honesty and integrity and/or that the ET was an isolated incident. The Chief Executive's interview with Trust P also noted the Chief Executive's regret and remorse about not doing things differently with regard to Ms K (paragraph 25). Lastly, Monitor did not consider the ET did not reflect the Chief Executive's abilities and talents. In other words, these pieces of evidence from Trust P (which the CQC regarded as positive in relation to FPPR) did not directly speak to the main issue – whether or not the alleged serious misconduct had occurred and if Regulation 5 had been breached. Therefore, we do not consider the CQC's view – that these were positive pieces of evidence to offset the ET judgment – fully and fairly reflected the evidence they were presented with from Trust P. For these reasons, we do not consider that the grounds the CQC relied on, above, for accepting Trust P's view on FPPR were reasonable in this regard.

80. The CQC also told us that the ET did not directly relate to the conduct of the Chief Executive, but instead to Trust J, because the proceedings were issued against them and not personally against the Chief Executive (paragraph 56). This failed to take into account that the Chief Executive's evidence was assessed by the ET and the Chief Executive was specifically referred to as having been found, by 'unanimous' decision, to have breached the Code of Conduct for NHS Managers and recruitment and selection policies and their implied duty of good faith to their employer (paragraph 20). In addition, whilst the CQC said the ET finding was about Trust J and not the Chief Executive, the ET made findings about Trust J that were closely linked to decisions that the ET had noted were made by the Chief Executive. For example, the ET said that the Chief Executive made it clear to Ms K that returning to her job was impossible, leading to the ET's conclusion that Trust J created an impediment to Ms K returning to her job (paragraph 20). For these reasons, we believe the CQC should have questioned why Trust P had not placed more weight on the ET's formal and indirect findings about the Chief Executive in relation to considerations of serious misconduct, rather than treating the ET as something that was solely about Trust J and too far removed from the direct actions of the Chief Executive.
81. The above shows that while the CQC looked at Trust P's handling of FPPR, they did not follow their guidance in relation to considering the reasonableness of Trust P's decision. Nor did the CQC balance the evidence appropriately in relation to the ET, either because the CQC was unclear about what they were looking for or they simply missed it. For these reasons, the CQC did not get it right.
82. We now move on to the second key piece of evidence relied on by the CQC – the Professional Regulator's report. It was this report, unseen by Trust P during their consideration of FPPR, which led the CQC to consider there was sufficient evidence for them to close the FPPR matter relating to serious misconduct for Trust P (paragraphs 29 and 30). We accept why the CQC might have considered the regulatory report by the Professional Regulator (paragraph 28) into the Chief Executive to be an important piece of evidence in relation to Trust P in light of the Professional Regulator's own consideration of misconduct under its own criteria. We recognise that the Professional Regulator's report, in isolation, provided evidence that they did not take regulatory action against the Chief Executive.
83. However, even if we consider the CQC's handling of the Professional Regulator's report in relation to the considerations they said they made in relation to the 2015 guidance, we believe that the CQC placed too much weight on it when it did not cover all the FPPR issues the CQC needed to address. We believe the CQC failed to balance the evidence in the Professional Regulator's report appropriately. The CQC did not note that the Professional Regulator's report had not addressed all the FPPR issues raised in relation to Trust P and the Chief Executive – the Professional Regulator (paragraph 28) did not give a clear view about the allegation of whistleblower suppression (paragraph 18) against the Chief Executive because it merely noted the ET finding in relation to Ms K for context only. Furthermore, the CQC did not weigh up the opposing views of the Professional Regulator's report and the ET on the recruitment issue at Trust J (the Professional Regulator did not consider the Chief Executive acted dishonestly while the ET

found that the NHS Code of Conduct had been breached). The CQC may have given more weight to the Professional Regulator's report because they considered (wrongly in our view – paragraph 82) that the ET made this finding about the Trust instead of the Chief Executive. Without Trust P reconciling the discrepancies between the Professional Regulator's report and the ET, we cannot see that it was possible for the CQC to establish whether Trust P's handling of FPPR was reasonable.

84. The FPPR panel members' understanding of the Professional Regulator's evidence was flawed in other ways. The Deputy Chief Inspector said that the Professional Regulator found there was '*categorically no case to answer*' (paragraph 48) when the Professional Regulator's report (paragraph 28) said that some of the Chief Executive's actions were concerning (in relation to the second matter considered by the Professional Regulator) and that it could not be sure the incidents were isolated ones, but it did not think it would be able to progress those concerns further. In addition, the Deputy Chief Inspector said that the CQC had to trust the judgment of the Professional Regulator (paragraph 50) when the CQC's FAQs (paragraph 17) said that a professional regulator's opinion would not preclude the CQC proceeding with FPPR concerns. For the reasons above, the CQC failed to follow their guidance in relation to the reasonableness of Trust P's decision on FPPR – the CQC did not balance the evidence appropriately when considering the Professional Regulator's report as they misconstrued its conclusions and did not identify that it did not address some matters. Therefore, the CQC did not get it right.

85. Problems with the CQC's application of its approach to FPPR, and its weighing up of the evidence, are also reflected in the FPPR panel members views on proportionality. The Deputy Chief Inspector said that it was not possible for Trust P to provide more assurance on FPPR than they had (paragraph 49). In comparison, the Director of Governance and Legal Services said that had the CQC been considering the Chief Executive's appointment to a different (and permanent) role, it would have been more likely that the CQC would have suggested that Trust P commission an independent investigation into the facts, but the Director of Governance and Legal Services did not consider that this would have been proportionate as at the time the Chief Executive was in an interim post and was not appointed into a Chief Executive role either (paragraph 59). However, the 2015 guidance was clear that Regulation 5 applied to both permanent and interim roles (paragraph 15) – neither the Regulation nor the CQC's guidance make such a distinction between permanent and interim roles. Nor is there evidence that the employment status of a director (whether the appointment was for a chief executive role) would affect the CQC's regulation of FPPR, particularly when the aim of FPPR was to prevent unfit directors working and moving around the NHS (paragraph 11). Therefore, irrelevant considerations appear to have been taken into account in relation to Trust P, and the CQC did not get it right.

86. For these reasons, we consider that the CQC's decision to close the FPPR case for Trust P was flawed. The FPPR panel members cannot demonstrate consistency in the considerations they made of the case. Further, the CQC's decision was made on the basis of incomplete consideration (they did not properly consider the evidence before them), relevant

considerations were discounted without good reason (the ET and the possibility of asking Trust P to do further work) and irrelevant factors were given too much weight. Therefore, the CQC did not get it right – it was maladministration.

## Findings – injustice

87. Our view is that the CQC's decision to close the FPPR matter in relation to Trust P and the Chief Executive was flawed for the reasons set out above. This does not automatically mean that the CQC's decision was wrong as it is possible that they might have reached the same decision on this case if their actions had been administratively sound. Therefore, to take a view on whether the CQC's actions created an injustice, we have considered what would have happened, but for maladministration.
88. We have found that the CQC's decision to close the FPPR matter in relation to Trust P was made on the basis of incomplete consideration of the evidence. We consider that, in the absence of maladministration, the CQC would have needed to consider whether Trust P should be asked for further evidence to provide assurance of FPPR in relation to the Chief Executive, or whether the available evidence was sufficient to demonstrate that Trust P was in breach of FPPR so regulatory action was required (paragraph 19). We recognise that such a decision would be finely balanced so we cannot say what the CQC would have decided – whether a breach of FPPR by Trust P would have been determined or whether further work by Trust P on FPPR would have been required by the CQC. The outcome of possible further work by Trust P cannot be known. That is because some of the issues covered in the ET judgment and the consideration by the Professional Regulator may have been explored in more detail and that further work may have led to Trust P taking action on FPPR. Further, we are mindful that the events unfolded quickly – within two to three months of the CQC's February 2016 decision for Trust P on FPPR, Trust P had

suspended the Chief Executive. It seems unlikely that further work by Trust P would have been complete by then. These factors demonstrate that it would be speculative to attempt to establish what would have happened but for maladministration, and are why we cannot say what the outcome would have been.

89. The CQC suggests that the conviction for fraud now precludes the Chief Executive from working in the NHS under FPPR (paragraph 60), so the regulation is having its intended effect. We note, however, that the Chief Executive's exclusion from working in the NHS resulted from a criminal conviction not regulation of FPPR. We found that the CQC's considerations of the evidence presented to them contained fundamental flaws. The seriousness of the failings on this case raise the possibility that the failings go wider than this case. We cannot say with confidence that the changes to guidance (see annex) or improvements in record keeping (paragraph 67) will in themselves rectify this. This causes a risk of a systemic injustice as it questions the ability of the CQC to provide robust and appropriate regulation of FPPR.

90. We recognise that there is a personal injustice to Ms K. However, we can only comment on the actions of the CQC and any injustice they caused directly in this case. We see that much of Ms K's distress flows from her dealings with Trust J and not the CQC (paragraph 70) and the injustice from this was dealt with by the ET – and she told us that her health had improved since the ET (paragraph 70). Nevertheless, we accept that Ms K will have the retrospective knowledge that the CQC did not handle these FPPR matters properly which she found '*galling*'. In particular, she told us that it was upsetting to see the

Chief Executive welcomed back into the NHS, following incomplete consideration of FPPR, while she felt '*blacklisted*' by the NHS. Therefore, whilst we cannot say that the outcome would have been different, we accept that Ms K felt that the Chief Executive should not have met FPPR criteria and the knowledge that the CQC has not handled these matters properly will confirm that for her. For these reasons we accept that the CQC's actions caused Ms K distress, frustration and upset – the CQC's actions would have exacerbated the distress she felt about her own situation and given rise to a loss of opportunity for a robust outcome. Further, Ms K lost confidence in the CQC's ability to properly regulate FPPR. These are injustices to her.

## Recommendations

91. In considering recommendations, we have referred to our Principles for Remedy. These state that where maladministration or poor service has led to injustice or hardship, the public body responsible should take steps to provide an appropriate and proportionate remedy. They also say that public organisations should seek continuous improvement, and should use the lessons learnt from complaints to ensure that maladministration or poor service is not repeated. Finally, our Principles also state that public organisations should ‘put things right’ and, if possible, return the person affected to the position they would have been in if the poor service had not occurred. If that is not possible, they should compensate them appropriately. In reaching a view on compensation, we refer to our Scale of Severity of Injustice<sup>13</sup> process and we consider cases where we have made recommendations about similar injustices.
92. In order to remedy the injustice we have identified that resulted from the CQC’s maladministration, we recommend that within eight weeks of this report, the CQC should:
- a. apologise to Ms K for the injustice (loss of opportunity, frustration and distress) their actions have caused her; and
  - b. offer Ms K £500 in recognition of the injustice caused to her;
  - c. review their learning from this case and report back about improvements they have made to demonstrate rigour in their FPPR considerations in future.

**Rob Behrens CBE, Parliamentary and Health Service Ombudsman**  
**December 2018**

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<sup>13</sup> <https://www.ombudsman.org.uk/sites/default/files/Our-guidance-on-financial-remedy-1.pdf>

## Annex

On 19 January 2018 the CQC updated their guidance on FPPR<sup>14</sup>. It included:

- *‘Ultimately, a provider should determine which individuals fall within the scope of the regulation, and CQC will take a view on whether they have done this effectively.’*
- There may be occasions where there is a dispute about the relevant facts, and the provider’s investigation should seek to ascertain the facts of the case including taking account of people who have spoken up. This may involve seeking external and independent help by the trust. Hearsay evidence could be relevant, but providers should be cautious before making decision solely based on hearsay evidence and should carefully balance evidence where there is a conflict of evidence.
- The CQC said that misconduct means *‘conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.’*
- The CQC said that mismanagement was, among other things, *‘Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct. ...Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual over the interests of people who use a service, staff or the public.’*
- The CQC said that providers should reach their own decisions as to whether an alleged breach met the threshold of serious misconduct or serious mismanagement. The CQC said that serious misconduct differed from mismanagement as one single incident of misconduct could amount to serious misconduct. The CQC emphasised that a breach of FPPR would require any misconduct to be serious. The CQC gave examples of this which included fraud or theft, criminal offence, bullying, victimisation of staff, deliberately transmitting information known to be false and disregard for appropriate standards of governance including undermining due process.
- If actions reach the threshold of serious mismanagement or misconduct, the CQC said that providers should consider whether the individual director played a central or peripheral role, and whether there were any mitigating factors.

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<sup>14</sup> [https://www.cqc.org.uk/sites/default/files/20180119\\_FPPR\\_guidance.pdf](https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf)



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