Faculty of
Medical Leadership
and **Management**

Faculty of Medical Leadership and Management response to the Department of Health and Social Care's consultation 'Leading the NHS: proposals to regulate NHS managers'

February 2025

Q1. Do you agree or disagree that NHS managers should be regulated?

- Agree

The regulation of leaders and managers should mirror how clinical practitioners are regulated, reflecting their significance in the health and care sector.

Given that even defining who is operating in a leadership/management role is challenging, implementing regulation will be a difficult task, but one that should be regarded as of vital importance to improve healthcare delivery and the public's confidence in its quality, efficacy and safety.

Regulation provides assurance, accountability, consistency and transparency. It will lead to an improved culture of learning, increased safety, higher quality of care, and crucially, better patient confidence in our health service.

However, regulation without education would be a half measure, that would not remedy the ills it aims to cure. While a regulatory framework and clear standards are needed, equally – if not more – important is having an organisation that delivers the training, education, support and development that managers and leaders need to improve their skills and abilities, to meet any new agreed standards. On its own, a regulator would simply help maintain a base level of competency rather than improve

standards; it must go hand in hand with the creation of a professional educational body for clinical leaders and managers.

A new regulator should be created, but the Faculty of Medical Leadership & Management (FMLM) is best placed to take on the mantle of educator and has wide stakeholder support to do so. FMLM already has a solid, growing membership base of senior clinical leaders; an evidence-base for how good leadership improves outcomes; leadership & management standards for healthcare teams; a development curriculum for under/postgraduate students in all clinical specialities (providing through-career support from day one); mature partnerships with academic and clinical thought leaders across all four NHS administrations and internationally; and a growing portfolio of leadership development offers.

Q2. Do you agree or disagree that there should be a process to ensure that managers who have committed serious misconduct can never hold a management role in the NHS in the future?

- **Strongly agree**

FMLM strongly agrees that any member of staff who is found to have committed serious misconduct should not hold professional management/leadership roles in healthcare.

Recent events at organisations like the Countess of Chester Hospital, and the events that led to Martha's rule, make clear the need for greater accountability – something that has also been recognised by successive reports into the NHS.

Currently, there is no overarching process that can bar managers, and they do not face uniform consequences across the NHS, with disciplinary measures at the discretion of their employer.

But actions – or lack of – have consequences and FMLM backs a statutory barring mechanism, alongside the professional registration of managers and leaders, particularly those operating in a clinical setting.

A troubling potential factor preventing this from happening presently, is the deficiency of a clear pipeline of high-quality, uniformly qualified managers and leaders, meaning that a small number of less able managers may remain in the system due to the relative paucity of supply. While there is no suggestion that managers who have

committed serious misconduct are being or should be re-employed, it is apparent that poorer performers are sometimes moving around the system, without much in the way of support to help them improve or develop.

While also rightly acknowledging the pockets of excellent managers and leaders already within the NHS, the need to increase the number and uniform quality of managers was recognised by Lord Darzi in his Independent Investigation of the National Health Service in England. FMLM believes that regulation must be brought in gradually, and be matched by concerted efforts to increase the number of managers and leaders available to the NHS, as well as the quality.

Q3. 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?

- Agree

While sanctions undoubtedly have a place, FMLM believes the emphasis should be on education and support for poorer performers, rather than immediate and reactive punitive measures.

As is the case now, Performance Improvement Plans for underperforming staff should be used in the first instance, with a progressive framework developed that sees support move towards sanctions, including conditions placed on their registration and disbarring.

In the private sector, the intention behind PIPs often seems to be to move staff on, but FMLM firmly believes in providing the opportunity to those who are struggling to learn and improve. A College of Clinical and Executive Leadership might assist organisations when such improvement processes become necessary with staff.

Capability or performance management processes should be the first port of call in all but the most serious cases, and in these cases, organisations should be empowered by the regulator to deploy proportionate, agreed sanctions.

Care must also be taken to ensure checks and balances are put in place to prevent sanctions from potentially being overtly or inadvertently used to reinforce structural inequalities and discrimination.

Q4a. Do you agree or disagree that there should be a professional register of NHS managers (either statutory or voluntary)?

- **Strongly agree**

FMLM believes that a full statutory register for clinical managers would be an evolutionary step-change for the delivery of care.

A statutory professional register of NHS managers could enhance accountability, standards, and transparency, ensuring managers meet ethical and professional requirements.

It would boost public confidence, provide reassurance and improve leadership and governance. Crucially, regulatory oversight would offer better protection against mismanagement and enforce more consistent decision-making

A register, clear standards and a training body would also help provide clearer career pathways with structured development for managers and leaders; potentially enhancing their professionalism and effectiveness across the system.

It could also help with workforce planning, addressing shortages and improving service delivery. Contrary to popular narratives, it is believed that the NHS is undermanaged in comparison to other UK sectors and other international health systems. However, a key challenge for the NHS is that it doesn't have a full picture of how many managers and leaders there are across the system. NHS Digital statistics suggest that in October 2024, there were 40,096 managers in the NHS, representing just 2.9% of the overall workforce. These managers are classified as operating in 'NHS infrastructure support' yet leadership and management roles exist at many levels and in various forms across the NHS; they are not just operational roles. This figure excludes those in clinical and care leadership/management positions held by doctors, nurses, and other clinicians.

So, not only would a register improve accountability and quality, but it would facilitate a better view of any areas that are undermanaged and require support. For transparency purposes, the register should make clear the specialty background of each registrant.

Q4b. If you agreed, do you agree or disagree that joining a register of NHS managers should be a mandatory requirement?

- **Strongly agree**

A register must be mandatory if it is to truly fulfil its purpose, and therefore we might expect that is laid in primary legislation. A voluntary one would undercut other measures around regulation and education, and be a self-defeating half-measure.

An independent body would be required to hold the register and be mandated to enforce standards. Progressive disciplinary processes would need to be clearly defined, fair, and transparent to avoid unnecessary litigation or scapegoating.

There may be resistance to the introduction of mandatory registration, with some leaders and managers seeing it as an unnecessary constraint or challenge to their authority. This should be overcome via the creation of a separate body – a College of Executive and Clinical Leadership – which would help set the standards and provide the training support that would enable and empower leaders to meet them.

Without such a body, there is a risk that a statutory professional register simply becomes a deterrent to professionals looking to take on leadership and management roles, which could prove fatal for an already undermanaged health service.

Q5. Which, if any, of the following categories of managers within NHS organisations do you think a system of regulation should apply to?

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

matron, up to head of service, for example head of nursing, head of performance and delivery)
- First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)

Leadership failures in the NHS are often systemic and multi-factorial, rather than down to individual incompetence, so regulation must apply to a wider scope of staff rather than just those at the very top. It would help build a culture of excellence and collective responsibility throughout organisations while creating logical development pathways for staff at all levels.

Q6. Which, if any, of the following categories of managers in equivalent organisations do you think a system of regulation should apply to?

- 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

Managerial regulation should apply across all organisations delivering care.

This would create professional consistency. It could also foster greater connectivity, understanding and innovation across health and care management; consistency of standards across the sectors could mean that staff better understand why others work the way they do, allowing for increased empathy and consideration – creating a more collegiate operating environment. It could also potentially lower barriers across sectors, encouraging greater collaboration and the sharing of best practices.

It should be mandated that the staff of providers in the "independent sector", particularly those providers in receipt of government and NHS contracts, be held account to the same set of standards. We envisage that the regulator would oversee processes in the same types of organisations that the Care Quality Commission (CQC)

currently inspects. Lessons could be learned about the acceptability of the CQC's past processes.

Q7. 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?

- **Other type of body**

An independent body should be created to act as a regulator to administer these core functions, alongside a complimentary organisation that provides the knowledge and education that meet these standards. While the two organisations would work together to create the standards, develop curricula etc, the regulatory body would be entirely independent from the professional body, and all other NHS-related agencies. This is to ensure independent governance, control and decision-making.

Q8. 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**

There is a strong risk of conflict of interest with any option other than an independent regulator, and education must be separated from regulation to prevent the 'marking of one's own homework'.

If the regulatory body is not truly independent from NHS management structures, it could fail to hold senior leaders accountable effectively.

A professional membership body should be established with strong links to an independent regulatory body, but it must be separate. This would allow a carrot-and-stick approach, with a professional membership body (via the education, support and development of managers/leaders) effectively providing the incentive for good work,

and the regulatory body providing sanctions for those who are failing, to push people towards the right leadership behaviours and goals.

Q9. If managers are brought into some form of regulation, do you have an organisation in mind that should operate the regulatory system?

- **Establish a new independent regulatory body**

A new independent regulatory body must be formed, as per the reasons outlined previously. Existing organisations are not best placed to administer the work of such a body, and by adding this onto their remit, it runs the risk of devaluing the initiative, creating the perception that the health service and government are not serious about proper oversight of leaders and managers.

A separate, new independent multi-disciplinary body (a different construct from existing Medical Royal Colleges) is also needed to act as the educational arm and provide networking and support for managers and leaders. As a well-established organisation already offering this function, FMLM is best placed to provide the foundations on which a regulator-complimentary body is built.

Q10a. Do you agree or disagree that there should be education or qualification standards that NHS managers are required to demonstrate and are assessed against?

- **Strongly agree**

Evidence clearly demonstrates a positive link between clinical leadership, better patient outcomes and organisational performance. With this in mind, the Faculty of Medical Leadership and Management developed its Leadership and Management Standards for Medical Professionals, aiming to provide a framework for staff to develop the skills needed to become excellent, effective leaders and deliver exceptional patient care.

It is FMLM's view that education qualification standards are crucial for staff to demonstrate their competence and deliver high-quality care. Any regulatory framework must be built around patient-focused standards, and it is our view that the

evidence-based standards we have developed with clinicians and experts over many years should form the bedrock of any new benchmarks.

But setting standards without providing the education needed to help achieve them is senseless, which is why the creation of dual bodies – one regulatory, one educational – rather than a regulator alone, is so vital. Alongside any regulator, a College of Executive and Clinical Leadership should be created to deliver education programmes that improve existing leaders and help train aspiring ones to meet new standards.

FMLM is currently working with a consortium to further develop professional standards for managers for NHS England, and we believe that these should form the basis of any regulatory standards.

However, so that these do not simply lead to the longer-term creation of a tick-box culture where managers focus on meeting bureaucratic requirements instead of driving innovation and improving services, we would envisage the College of Executive and Clinical Leadership working in partnership with the regulator, and wider stakeholders, to regularly review the efficacy and appropriateness of the standards, ensuring that safe, high-quality patient care remains their driving purpose.

Q10b. If you agreed, which categories of NHS managers should this apply to?

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

- **First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)**

FMLM's leadership and management standards are designed to develop leaders throughout their careers and are applicable from student through to Chief Executive. Everyone in a position of leadership should be expected to meet certain standards, embody certain values, and adopt certain behaviours. FMLM's standards provide a structured framework for assessing, developing, and regulating leadership competencies, that would help support the development of an NHS managerial register.

As such, mirroring the earlier question about which roles should be subject to regulation, these standards should apply to anyone operating in a role that requires elements of clinical leadership.

FMLM's standards are structured to encompass four domains – self, team, organisation and system – which align to different levels of management within healthcare. This includes aspiring leaders, established leaders, strategic leaders and system/national leaders.

This means the standards are relevant to early-career professionals up to medical Royal College Presidents, or board members/Chief Executives. All grades above foundation managers should seek to meet them.

Most of the competencies and behaviours outlined in the standards are also applicable to non-clinical managers, and we would encourage their wider adoption by executive, operational, and administrative leaders.

Q11a. If a professional register is implemented for NHS managers, do you agree or disagree that managers should be required to periodically revalidate their professional registration?

- **Strongly agree**

Clinicians must revalidate to ensure they are up to date with best practice, and that they themselves remain fit to practise. The purpose of the process is to ensure patient safety and improve the quality of patient care. With the field of leadership having its

own distinct set of skills and standards, FMLM sees no reason why clinical leaders and managers should not be required to revalidate as the same principles apply.

Given how important good clinical leadership is, it is vital that practitioners stay up to date, keep abreast of new professional developments and commit to continual professional development. As such, clinical leaders and managers should have periodic reviews to ensure they are continuing to meet agreed standards.

In line with FMLM's current status as a designated body, a College of Executive and Clinical Leadership could also provide revalidation services, alongside other existing designated bodies, with the regulator overseeing the overall process. The new College would be able to review supporting information from those seeking revalidation and make recommendations, with the regulator approving, inspecting or rejecting as appropriate.

Q11b. If you agreed, how frequently should managers be required to revalidate their professional registration?

- Every 5 years

The revalidation for clinical leaders should align with the medical revalidation cycle; every five years. This will be less onerous for managers and there may be cross-over with the appraisal evidence used in both revalidation processes, meaning the process can be kept as light touch as possible.

As with clinical revalidation, the process for managers and leaders would be informed by their annual appraisals, with the revalidation date moved forward or delayed, based on how they are performing according to their reviews.

This timeframe also allows for new developments in the field to have emerged and for managers to have either learned, adapted and adopted new practices, or failed to do so. A smaller window would add too much pressure and potentially force the adoption of emerging techniques that have not been fully evaluated, creating a potential risk to patients.

Q11c. What skills and competencies do you think managers would need to keep up to date in order to revalidate?

In line with FMLM's professional standards, clinicians should (depending on their level), be able to demonstrate their skills in and continuing commitment to:

- Self-awareness and personal development.
- Leading with integrity and accountability.
- Managing people and resources.
- Effective teamwork and collaboration.
- Improving organisational culture and innovation.
- Quality improvement.
- Effective communication and influence.
- Delivering patient-centred care.
- Research, education, and evidence-based practice.
- Strategic and systems thinking.

It is particularly important that they demonstrate their CPD activities, quality improvement activities (e.g. audits), and positive feedback from colleagues and patients.

This detail would be part of their annual appraisal process, which would inform their revalidation. Each appraisal would cover:

- A description of their scope of work.
- Professional Development Plan, and reflections thereon.
- Reflection on challenges, achievements and aspirations.
- Reflection on personal and professional wellbeing, including work-life balance.
- Supporting information (CPD, QIPs, feedback etc).
- A record and reflection upon significant events and any complaints.
- Any specific items the Manager has been asked to bring to their appraisal.
- Derivation of 3-6 Personal Development Plan themes per year.
- Signed health declaration.
- Signed probity declaration.

Q12a. 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

There is a significant overlap in the values, behaviours, competencies and skills required to be a good clinical leader/manager, with those required to be a good non-clinical leader/manager. Most of the competencies and behaviours outlined in FMLM's standards are also applicable to non-clinical managers, and we would encourage their wider adoption by executive, operational, administrative leaders.

Q12b. If you agreed, how should clinical managers be assessed against leadership or management standards?

- **They should only be required to hold registration with their existing healthcare professional regulator who will hold them to account to the same leadership competencies as non-clinical managers**

Dual registration could cause statutory difficulty; it would be unclear which of the two bodies has legal primacy and risks being administratively challenging. It may also require the repeal of existing primary legislation if the clinical manager is a doctor (GMC), dentist (GDC) or nurse (NMC). At present, the regulatory body for each profession covers that colleague's whole 'scope of work' and dual registration would partition this responsibility.

Q13. Do you agree or disagree that a phased approach should be taken to regulate NHS managers?

- **Agree**

A phased approach is sensible and preferred. An immediate programme of change risks unintended consequences and overwhelming organisations and staff. Not only will a phased approach help build buy-in and reduce resistance, but it will allow for unforeseen issues to emerge, provide time to unravel potential problems, and help refine plans and frameworks. Lessons from early phases can be used to adjust processes before full implementation.

Introducing regulation too quickly might deter potential leaders; a gradual implementation provides time for current and aspiring managers to understand expectations and adjust accordingly.

It will also ensure that the necessary infrastructure and resources are in place, and allow for testing and pilot programmes – which FMLM strongly encourages – that can

be evaluated and improved before wider, thoroughly planned roll-out. A pilot programme would also allow for the learnings and benefits to potentially be expanded to devolved nations and private providers.

However, clear time scales, actions and milestones for the introduction of regulations should be produced early in the development process and communicated widely, to allow consultation with appropriate stakeholders.

Q14a. If managers are brought into a statutory system of regulation, do you agree or disagree that individuals in NHS leadership positions should have a professional duty of candour as part of the standards they are required to meet?

- **Strongly agree**

FMLM strongly agrees with the principle of a professional duty of candour, with it woven through its own professional standards and embedded from the outset of a leader's development. To meet FMLM's standards, leaders must "speak up and speak out when standards, quality or safety are threatened and challenges discriminatory behaviours and attitudes".

It is already required of some – usually more senior – healthcare professionals by regulators, such as the General Medical Council and the Nursing and Midwifery Council and should continue.

The professional duty of candour should be expanded to include the staff categories selected in the next question.

Individual bodies could continue to have oversight at a professional level, but at a statutory level responsibility should lie with a new regulator.

Q14b. If you agreed, which categories of NHS managers should a professional duty of candour apply to?

- **Chairpersons**
- **Non-executive directors**

- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- All NHS staff aspiring to be board level directors
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)
- First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)

Most of these categories of staff already have similar agreements or arrangements in place (for instance, it is commonplace for nurses), but embedding this principle at an early stage for leaders will foster a greater commitment to its practice throughout their careers. It will help promote a culture of openness and transparency throughout entire organisations, rather than leaving it those 'at the top', and create a more collaborative, patient-focused environment. Giving the responsibility to those at the start of their careers will also help 'police' those above, helping hold them to account.

Q15a. Do you agree or disagree that NHS leaders should have a duty to ensure that the existing statutory (organisational) duty of candour is correctly followed in their organisation and be held accountable for this?

- Strongly agree

Ensuring adherence to a statutory duty of candour would give patients and their families greater confidence that organisations and staff are being honest, safe in the knowledge that there are serious repercussions were staff not to be. An independent regulatory body should have overall responsibility for this, with staff at a range of levels accountable for compliance – ensuring it is a team/cross-organisational effort. However, the punitive measures available to a professional regulator would need to be

on a scale that takes into account seniority and/or responsibility, rather than a 'one size fits all' approach.

In the 2023/24 financial year, the NHS paid out over £2.8 billion in compensation and associated costs for clinical negligence claims. Better communication at all levels may help reduce this litigation bill; should patients and families receive honest, timely explanations about errors, along with sincere apologies and clear steps for resolution, they may be less likely to pursue legal action.

The fostering of a more open and learning-based culture, rather than one that sees a defensive approach to errors, could lead to fewer repeated mistakes, therefore resulting better outcomes for patients, as well as fewer lawsuits.

Q15b. If you agreed, which categories of NHS managers should the statutory duty of candour apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- All NHS staff aspiring to be board level directors
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)
- First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)

Please see the reasons outlined at a professional level.

Q16a. Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to record, consider and respond to any concern raised about healthcare being provided, or the way it is being provided?

- Strongly agree

Leaders already – rightly – have a duty to record and action concerns via various regulatory frameworks including Regulation 20 (Duty of Candour) in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the NHS Whistleblowing Policy.

Less senior management staff have obligations, but these should be put on a statutory footing while recognising their level of seniority, power and responsibility.

Again, this is to create an improved culture of collective responsibility. It must be enabled by clearer reporting mechanisms and escalation procedures, and put into practice in a way that does not significantly add to administrative duties, with different members of staff creating multiple points of entry to the same concern or complaint.

Q16b. If you agreed, which categories of NHS managers should this apply to?

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

- First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)

Again, introducing statutory responsibilities at an earlier career stage creates an instinctive behaviour and automatic practice for junior managers and leaders. This early learning means they expect and welcome the accordingly increased expectations and responsibilities around reporting as they progress in their career, thus producing better leaders and delivering better patient care.

Again, statutory expectations and sanctions must be commensurate with the level at which staff are operating.

Widening responsibility also encourages greater reflection, accountability, learning and collective responsibility for safety.

Q17. Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to ensure that existing processes in place for recording, considering and responding to concerns about healthcare provision are being correctly followed?

- Strongly agree

Anyone and everyone in a position of management should have a level of responsibility to ensure that appropriate mechanisms and clear reporting procedures are in place, easy to use, fully socialised and well understood. Every level has a role to play in this, with each feeding into the other.

Q17b. 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)

- All NHS staff aspiring to be board level directors
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)
- First-time line managers (approximately bands 6 to 7, for example project manager, staff nurse, occupational therapist, team supervisor, team manager)

Any manager with a level of clinical involvement should ensure that processes are appropriate, sufficient and robust but place quality and safety at their heart. They should ensure that these processes are understood and utilised by the levels below them, with managers above them ensuring alignment with their own reporting needs.