Written evidence submitted by the Medical Protection Society (MPS) (PSN0013)

Introduction

Medical Protection Society (MPS) is the world's leading member-owned, not-for-profit protection organisation for doctors, dentists and healthcare professionals. Our in-house experts assist members with the wide range of legal and ethical problems that can arise from their professional practice.

We welcome the opportunity to provide comments to the Expert Panel in relation to the patient safety recommendations where we have most to add.

Maternity care and leadership

Recommendation 1: *"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths but is in our view no less applicable to maternal and perinatal deaths and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full and recommend that steps are taken to do so without delay." (From the inquiry into Morecambe Bay Investigation, 2015)*

MPS shares the view that better systems should be in place surrounding the reporting of perinatal and maternal deaths. However, with indemnity in relation to the vast majority of pregnancy and births in the UK provided by one of the state-backed schemes, MPS has limited direct experience to contribute to the expert panel in relation to this area of healthcare.

Other relevant professional bodies and patient charities with work focusing on this area will likely have more detailed feedback and evidence of the current state of play that they can provide. For example, we understand that charities such as Sands and Tommy's, and their Policy Unit, are completing extensive work to consolidate information from the variety of perinatal and maternal reports that currently exists.

Recommendation 2: *"A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013.)*

MPS believes there is a strong case for a common code of ethics, standards and conduct for senior board-level healthcare leaders and managers in the NHS.

Such a decision should be made based on clear principles for what regulation aims to achieve in healthcare. A good starting point that the Expert Panel may wish to consider are the proposals set out in the 2022, consultation by the Department of Health and Social Care's on *'Healthcare regulation: deciding when statutory regulation is appropriate*'.

The findings from this consultation set out the criteria for deciding whether to regulate a profession, and that this includes the level and quantification of harm that the profession may have on patients and other individuals, the proportionality and targeting of potential regulation and whether other comprehensive forms of management or regulation would be more suitable.

While the criteria were established to inform decisions about which healthcare professions should or not should not be regulated, we believe that this also sets out a perspective that should be applied to healthcare leaders and managers.

Senior board-level healthcare leaders and managers have a huge impact on the organisations that they lead. They are at the helm of not only the Trusts that they manage, but the community that stems from these Trusts as well; the culture, environment and behaviour of other staff and colleagues are influenced by their conduct and actions. When problems occur, the lack of regulation and standardisation makes it difficult to hold senior level managers accountable. The 'revolving door' of senior NHS management also makes this problematic.

Healthcare workers are, by law, expected to hold high standards of honesty, integrity and openness. If they do not, they may be investigated by their regulator and risk losing their job and profession. There is not a standard code of conduct, ethics or legislation that exists for managers which holds them to the same standard. In our view, this is unacceptable.

There are of course many high-quality healthcare leaders across the UK. Independents reviews and investigations into poor care, such as the Ockenden Report, East Kent Maternity Investigation, the Morecambe Bay Investigation, and the Cwm Taf Review, do however often cite poor managerial support, procedures, and accountability as contributing factors to why issues had not been addressed earlier. Bill Kirkup in the East Kent Review went as far as to make one of the report recommendations that, 'NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership'[1].

MPS believes that there is a strong case for the regulation of NHS managers. The current culture of removing senior leadership from a trust when something goes wrong and seemingly parachuting in new managers to address the issue does not adequately provide opportunities for accountability. Regulation would go some way in addressing this, as well as changes in culture and process.

Culture of safety and whistleblowing

Recommendation 4: *"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.*

Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis. Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led." (From the Freedom to Speak Up Review, 2015)

We support creating an environment where clinicians feel empowered and confident to admit errors, and learn from mistakes, without fear of incrimination. There must be explicit support from leaders who need to be equally committed to the principles of open disclosure, for clinicians not to fear being blamed when admitting a mistake.

[1] Reading the Signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation, October 2022: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

The fear of being subject to an investigation is one of the areas which is causing healthcare professionals unnecessary stress and anxiety. Covid-19 and the growing pressures on the NHS only made this anxiety worse as healthcare professionals did not only have to be fearful of the possible complaints and claims arising from their practice, but also to the ones which may have arisen as a result of delayed referral or the backlog of cases.

A survey of our members carried out in January 2021 found that nearly 4 in 5 GPs in the UK (77%) said they were concerned about facing investigation if patients came to harm as a result of delayed referrals or non Covid-19 services being unavailable or limited[2].

Our concerns it that a blame culture places too much emphasis on punishment and even criminalisation, while neglecting to nurture a system where mistakes can be learned from and avoided in the future.

Positive reforms to create a more learning culture

In our experience, more often than not, apologising, admitting a mistake and communicating effectively will help to mitigate litigation. However, this is only plausible if there is a change in the current mentality which allows for healthcare professionals to be open about mistakes without the fear of being blamed and subsequently faced with regulatory, civil or criminal proceedings.

Defence organisations have an important role to play in the creation of an open and learning environment. At MPS, we draw on our experience and expertise to raise awareness of the causes of claims, the conditions behind these, and how errors can be prevented. We also aim to reduce the prospect of claims, by offering education programs and advice to our members.

Reforms to address the blame culture in the NHS

Alongside the above-mentioned proposals that would proactively promote a learning culture, we strongly support reforms aimed at addressing the way in which individual healthcare professionals are held to account for adverse incidents in patient care.

We strong support reforms aimed at ensuring a more proportionate approach to professional regulation.

There are few developments that worry a healthcare professional more than receiving a letter from their professional regulator. This is why it is vital that their investigations are carried out efficiently, fairly, sensitively and proportionately.

The vast majority of GMC investigations are closed without action, the result being that far too many doctors and dental professionals go through a stressful process each year, while many complainants also endure a lengthy process with a disappointing outcome.

We have long argued for reforms to the Medical Act to enable the GMC to streamline their processes, improve efficiency, reduce the number of investigations into less serious allegations, and conclude investigations in a more timely manner, giving them discretion to not take forward investigations where allegations clearly do not require action. The status quo serves neither doctors nor patients and could be a factor impacting the recruitment and retention of workers within the health and social care sector.

We also believe that the current legal bar for convicting healthcare professionals of manslaughter in England is too low. A striking feature of the current legal position on gross negligence manslaughter in England and Wales – unlike Scotland – is that neither 'disregard' nor 'recklessness' are required for a

[2] The survey of 688 UK GPs carried out in January 2021, follows a report from Macmillan which estimates that there are around 50,000 'missing' cancer diagnoses across the UK.

conviction. Over the past two decades, there have been cases of medical professionals and patient mortalities involving momentary – yet significant – errors, with no evidence of either recklessness or disregard on the part of the doctor, but still resulting in conviction.

By way of contrast, in Scotland, the nearest comparable offence is that of culpable homicide. Under Scottish law, culpable homicide is the killing of a person in circumstances which are neither accidental nor justified, but where the wicked intent to kill or wicked recklessness (required for murder) is absent. The tests for distinguishing both murder and culpable homicide are objective.

Everyone loses in such cases. A family has lost a loved one; a doctor risks losing their career and liberty; our NHS, already under considerable pressure, potentially loses a valuable doctor as well as suffering the untold damage to an open, learning culture.

While the number of GNM cases in the UK are low, we have seen in recent years the impact that these cases have on the wider profession and the fear that they can create. Therefore, while we fully appreciate that the Committee will be considering a wide range of proposals for improving workforce retention that will have a more significant causal impact, we recommend that the Committee also considers the positive impact that progress in this area could have.

About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals with more than 300,000 members around the world.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

MPS is not an insurance company. We are a mutual non-for-profit organisation and the benefits of membership of MPS are discretionary as set out in the Memorandum of Articles of Association.

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact us.

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