Written evidence submitted by The Professional Standards Authority submission (NLR0047)

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care is the oversight body for the ten health and care professional regulators including the General Medical Council, the Nursing and Midwifery Council, the Health and Care Professions Council and Social Work England. The Authority currently has four key functions:

- driving improvements in the ten statutory regulators in health and social care by undertaking annual reviews of effectiveness
- providing a safety net for any fitness to practise decisions that are insufficient to protect the public
- raising standards in health and social care professionals in non-statutory roles through our Accredited Registers programme
- using research and policy development to improve regulation and registration to better protect patients, service users and the public.

1.2 We welcome the Committee's consideration of the question of litigation, and in particular, the focus on learning environments and blame cultures. Our response focuses on the following areas of interest for the Committee:

1. To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?

2. How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?

3. What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?[1]

1.3 As the oversight body for ten statutory professional regulators in the UK with an interest in the duty of candour,[2] we would like to draw the Committee's attention to a number of important considerations.

1.4 It is generally accepted within the NHS that organisations should aspire to a learning culture, and move away from one of blame. This is well documented and understood, and has been highlighted in response to previous high-profile failings in the NHS.[3] A trickier question is how to balance learning with transparency, accountability and redress – all essential parts of a functioning patient safety framework.

1.5 This framework, of which professional regulation is one part, litigation another, needs to find a way to allow organisations and individuals to learn from mistakes without sacrificing the ability for them to be held to account, and for patients and families to be kept informed and compensated, where appropriate.

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[1] Our numbering.
[2] https://www.professionalstandards.org.uk/what-we-do/improving-regulation/find-research/duty-of-candour
[3] National Advisory Group on the Safety of Patients in England 2013, *A promise to learn – a commitment to act, Improving the Safety of Patients in England*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

2. Blame cultures and litigation

1. **To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?**
2. **How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?**
3. **What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?[4]**

2.1 There is evidence that moving to a non-adversarial clinical negligence system can encourage a more open, constructive approach to clinical incidents – and conversely that adversarial negligence schemes can contribute to a "blame culture".[5] This is consistent with what we found in our literature review on the barriers faced by professionals to candour and openness, carried out in 2013 but still substantially relevant.[6] We identified the fear of litigation as a key source of reticence among healthcare professionals in coming forward when avoidable harm had occurred. We hear through our engagement on the duty of candour that this continues to be the case for some, despite clear messaging from NHS litigation bodies in the UK that being candid and offering apologies do not constitute admissions of liability.[7]

2.2 There is also a growing body of evidence that no-fault compensation schemes lead to fewer claims.[8] This is because a defensive organisational response to avoidable harm tends to encourage rather than discourage patients and families from taking action. The University of Michigan pioneered a framework that encourages full and early disclosure where things have gone wrong in healthcare. It reports the following:

> *'After more than 15 years of using the approach that forms the basis of CANDOR, the University of Michigan Health System has seen dramatic drops in the number of new lawsuits, the number of malpractice cases that make it to court and the amount paid to compensate patients.*
> *At the same time, clinicians across U-M's hospitals and clinics have felt more free to report situations that caused harm, near-misses or that could pose a hazard.*
> *This has allowed faster response to investigate each situation and reduced the chance of harm in the future by changing procedures, equipment and clinical practice. It's also made it possible to offer immediate apologies and compensation to patients when needed.'*[9]

2.3 This quote highlights the interdependencies between the approach to negligence claims and general attitudes to openness and learning. This is unsurprising given that staff take the lead from their employers: managers in the US who took part in a widescale survey in 2002 were twice as likely not to disclose preventable harm if their employer had concerns about the malpractice implications of disclosure.[10]

2.4 Overall, we believe that there is evidence to suggest a move to a less-adversarial model for clinical negligence claims could be beneficial to patient care and safety, by addressing one of the documented barriers to openness and learning.

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[4] Our numbering.
[5] See the Committee's own inquiry findings on The Safety of Maternity Services: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1906.htm#_idTextAnchor035
[6] https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/candour-research-paper-2013.pdf?sfvrsn=5b957120_8
[7] https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry.pdf
[8] Richard C. Boothman, Sarah J. Imhoff, Darrell A. Campbell Jr. Winter 2012. Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: lessons learned and future directions. Frontiers of Health Services Management. 28:3
[9] https://labblog.uofmhealth.org/industry-dx/hospitals-can-break-through-wall-of-silence-new-toolkit
[10] Rae M. Lamb, David M. Studdert, Richard M.J. Bohmer, Donald M. Berwick, Troyen A. Brennan. 2003. Hospital Disclosure Practices: Results of a National Study. Health Affairs. 2003; 22 (2).

3. Other barriers to learning and openness

3.1 It is important also for the Committee to recognise that a move to a less adversarial model for compensating harmed patients and families is unlikely on its own to deliver the cultural change that appears to be needed. Our literature review identified a range of other social, cultural, and psychological barriers to candour and openness which necessarily inhibit learning:

- It is not my responsibility – someone else will report it
- A workplace culture where standards start to slip
- Not wanting to own up to mistakes because others may think I am incompetent
- A toxic workplace where a culture of blame thrives
- Concerns about how speaking up might affect me and my career (including referral to my professional regulator if relevant).

3.2 There is no single means of tackling these issues, however our work in this area suggests that education and training in patient safety generally, and candour specifically, can help individuals to respond more constructively and openly to adverse events.[11]

3.3 There is also a particular role for professional regulators to provide clarity where possible about the situations in which clinical error is likely to affect a professional's overall fitness to practise,[12] and how responding in the right and wrong ways can affect outcomes favourably or unfavourably.[13] The case of Dr. Bawa-Garba highlighted the damage that can be caused to professional morale and confidence in the regulator, where there is fear that individuals may end up taking the blame for organisational failings beyond their control.[14] On the other hand, it is important that regulatory systems enable individuals to be held to account, and shortcomings to be addressed if appropriate, where they are responsible for serious failings in care.

3.4 This requires not only clarity on the roles of the different national patient safety bodies and the criminal justice system, but also transparency and cooperation between them, so that individual and corporate responsibility can be established by the bodies best placed to do so.

4. Concerns about the Safe Spaces legislation

4.1 Related to the above, we welcome the introduction of exemptions to allow the Healthcare Safety Investigation Branch (HSIB) to share information if it believes it is necessary to address a 'serious and continuing risk to the safety of any patient or to the public'.[15] However, we still believe there is a risk that professional regulators' ability to protect the public could be reduced, because as we understand it,

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[11] The development of the Patient Safety Syllabus by Health Education England (https://www.hee.nhs.uk/our-work/patient-safety) to be rolled out across the NHS, looks like a positive development, though much will depend on the extent of its reach. We found in our candour work that pre-qualifying education also had a role in teaching softer skills to allow professionals to come to terms with their own errors, and talk about them sensitively and constructively with colleagues and patients.

[12] For example, in the wake of the Bawa-Garba case, the GMC set outs a new approach to dealing with single clinical incidents in Fitness to Practise: https://www.gmc-uk.org/news/news-archive/fewer-full-gmc-investigations-after-pilot-scheme-success

[13] For example, we have recommended that regulators make a positive case for candour by highlighting how a candid response to a clinical incident can be considered as mitigation by fitness to practise panels. See *Telling patients the truth when things go wrong*, available at *https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6*

[14] See for example: https://www.nuffieldtrust.org.uk/news-item/the-unwritten-contract-the-moral-and-ethical-obligations-of-doctors#a-dangerous-divide

[15] Health and Care Bill 2021 (as introduced), Schedule 14, Clause 4(a). Available at: https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf

even with this exemption, safe spaces would put in place a barrier to the fluid sharing of intelligence in two ways:

- by limiting the circumstances in which HSIB can share information using closely circumscribed criteria, noting that they differ from the tests used by professional regulators, and
- by putting HSIB in control of determining what information should be released to other organisations.

4.2 For example, information held by HSIB might not on its own point to a 'serious and continuing' risk, but might do so if linked to information held by other bodies. This is precisely the sort of scenario that often comes to light where there are serious failings such as Paterson and Mid-Staffs – different bodies each holding pieces of the puzzle and not bringing them together to see the full picture. [16]

4.3 In addition, to return to the question of cultures, we know that there are persistent cultural barriers to openness in parts of the NHS, and we would be concerned if the safe spaces model inadvertently reinforced these barriers.

4.4 While it undoubtedly has merit, the safe spaces approach risks upsetting the balance that we referred to in the opening sections, between learning, accountability, transparency and redress. We therefore recommend that the role of HSIB is kept under close review as and when the safe spaces approach is introduced, to check for these potentially serious unintended consequences.

5. Further information

5.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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[16] We note that the PHSO has concerns about the possible loss of access to information they need for their investigations as a result of the safe spaces legislation. https://www.ombudsman.org.uk/news-and-blog/news/ombudsman-welcomes-venice-commissions-opinion-health-and-care-bill