NHS leadership, performance and patient safety inquiry
Submission from HCSA – the hospital doctors' union

Health and Social Care Committee
8th March 2024

HCSA – the hospital doctors' union is a nationally recognised professional association and trade union which represents and advises all grades of hospital doctor in the UK, both in the NHS and private sectors. HCSA frequently supports members who have had unsatisfactory, and often distressing, experiences of speaking up. Our impression is that the cases we know of indicate a far greater systemic problem perpetuated by NHS leadership and a 'cover-up' culture. To evidence this, we conducted a survey of 526 hospital doctors from across the UK between 20th October 2023 to 2nd November 2023 which we will refer to in this submission. HCSA advocates strongly for substantial and far-reaching reforms to address a culture that is failing staff and patients. We will go onto detail our proposals in this submission.

1. How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?

HCSA – the hospital doctors union is firmly of the view that the current system for speaking up, overseen by NHS leadership, is entirely ineffective in instilling confidence in staff to raise patient safety concerns. Instead, when hospital doctors speak up, their concerns are disregarded and worse, our members find themselves silenced and victimised to protect the reputation of the hospital. Too many NHS staff do not take this first crucial step in speaking up, for fear of recrimination or out of exasperation at a system that does not function. This leads to systemic failures in patient safety and undermines the resilience of the workforce.

HCSA launched a survey of 526 hospital doctors across the UK in October 2023 to understand experiences of speaking up. The response showed clear failings across the NHS and indicated that processes for the handling of staff concerns are frequently ineffective and unfair. Over 70% of respondents told us that it is not possible to raise patient safety concerns to their employer without career detriment, with two-thirds of those who had spoken up reporting impacts to their personal lives, and a further two-thirds experiencing detriment in the workplace. Commonly cited impacts and detriment were related to mental health, removal of promotional opportunities, employment and fitness to practice processes being used to 'punish' the individual and issues with relationships in the workplace or at home. Many were pressurised to withdraw their allegations and threatened with formal proceedings against them were they to continue.

93% of those who had spoken up were not satisfied with the response from management, with anecdotal responses describing inadequate or slow processes, or worse, complete inaction. On the Freedom to Speak Up (FTSU) Guardian initiative in England, designed to enable speaking up, 4 out of 5 hospital doctor respondents reported this has failed to give them confidence to speak up in

their Trust. Many hospital doctors felt that the FTSU Guardian did not have sufficient power or seniority to challenge the structures and stakeholders within the Trust, with one member commenting “The guardians are as effectively bullied as anyone else.” Others described the initiative being used simply as a “tick box exercise” by employers. Some respondents reported not being familiar with the initiative.

It is clear to HCSA that NHS leadership has failed to create a culture of safe speaking up, instead often protecting its own interests by targeting those make disclosures. This must change or patient safety will continue to suffer.

HCSA therefore recommends the following outcomes to address the systemic issues within the NHS and across leadership:

1. An immediate review by all Trusts of their internal ‘speaking up’ processes to ensure that they are fit for purpose, transparent and that cases are being handled robustly without interference by managers.

2. The establishment of an independent statutory national whistleblowing body outside of the NHS. This body would register potential or actual whistleblowers at the point of disclosure, to protect against recriminations, monitor the investigation into the original allegations and the actions of the regulatory bodies, as well as investigations into those who might have acted unlawfully against individuals who expose safety concerns. We are monitoring the implementation of the NHS-specific Independent National Whistleblowing Officer (INWO) introduced in Scotland, which is not an exact match for our proposal, however gives a blueprint for establishing such a body elsewhere.

3. The creation of a new criminal offence of causing detriment to people who have made protected disclosures.

4. Reform of the Maintaining High Professional Standards (MHPS) process to prevent its abuse or use to make vexatious complaints. This is the process by which doctors are investigated formally within NHS employers, which we see misused to victimise individuals who speak up.

5. A regulator for non-medical managers. Managers could then be referred to the regulator for behaviours which contribute to a culture of silence. There is currently no accountability for non-medical managers’ professional conduct. The regulator could also take a firm position against abuse by managers of disciplinary procedures.

6. An extension to the government’s ‘prescribed persons and bodies list’ - those able to receive a formal whistleblowing disclosure – to include trade unions.

7. Stronger governance within the NHS, with all Executive Directors including Non-Executive Directors held firmly to account for compliance with The Seven

Principles of Public Life ("The Nolan Principles")[1]. Every NHS Trust should have a Board Member with responsibility for whistleblowing. All protected disclosures made under the Public Interest Disclosure Act 1998 (PIDA) should be reported to the board. The board should have a duty to monitor the processing of all protected disclosures and a duty to make regular reports to and answer enquiries from NHS England, the Care Quality Commission and the independent statutory national whistleblowing body recommended in point 2 above.

8. NHS England and the Care Quality Commission should each be given a responsibility auditing and acting (according to their respective regulatory responsibilities for the management and operational safety of Trusts) upon unsatisfactory performance by Trusts in the management of whistleblowing cases.

2. <u>What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?</u>

HCSA welcomes the publication of the Fit and Proper Person Test Framework, which aims to standardise competencies, reference requirements and learning resources for board members. It is HCSA's view that appointing board members with appropriate knowledge and experience is a crucial component of a well-led Trust. Unfortunately, we believe many board members at present do not have suitable experience which contributes to dysfunctional governance and a defensive 'cover-up' culture within the Trust.

HCSA notes with dismay that the framework, a direct response to the Kark Review 2019, was only recently published in September 2023, suggesting this important work has not been prioritised. Clearly, at the time of writing it is too early to measure the success of the framework. However, we note with caution that its use is recommended rather than mandatory (subject to review in 2025). This undermines the importance of the framework and is likely to lead to opt-outs or delays in Trust implementation.

HCSA would like to see more transparency in the public domain on directors' appointments and responsibilities. We would also like to see non-executive directors empowered to take a leading role on governance within Trusts. As separate from the staff team, non-executive directors are appropriately placed to be utilised as a crucial check and balance on Trust structures and particularly on the actions of senior leadership. All board members should be held to account throughout their time in office and their behaviour measured against The Seven Principles of Public Life. We therefore support the Kark Review's call for a body with the power to suspend and disbar directors for serious misconduct and note there has not been sufficient progress towards this.

[1] The Seven Principles of Public Life, Committee on Standards in Public Life, Gov.uk

3. What progress has been made to date on recommendations from the 2022 Messenger Review?

HCSA supports the recommendations of the Messenger Review which include enhanced staff training, inclusive leadership practices, management standards, a simplified appraisal system and a focus on recruitment and training of non-executive directors. We note that many of our members have been brought into managerial roles without adequate support and hope we can see progress in this area as an outcome from Messenger.

However, we are unable to comment on any specific progress that has been made since 2022. We would support publicly available monitoring on implementation of the recommendations from such reviews so that membership bodies like HCSA can assist in scrutinising progress. The issues we have identified further up in this submission continue to be dominant forces and our members have not reported to us any significant shift in leadership culture as a result of the Messenger Review.

4. How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?

It is deeply disheartening for the medical profession to observe a stream of statutory and non-statutory public inquiries, investigations and reviews over patient safety issues year on year yet see very little progress made. To date, there is an abject failure to address root causes of recurring patterns across NHS Trusts. The anecdotal information provided anonymously by hospital doctors in our survey on whistleblowing suggests that the cases in the public domain are only the tip of the iceberg of patient safety issues that have not been adequately addressed by leadership.

5. How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?

HCSA has already highlighted in this submission our call for a regulator for non-medical managers, to set professional standards which managers must comply with. Managers could then be referred to the regulator for non-compliance, including for exhibiting behaviours which contribute to a culture of silence. The regulator could also take a firm position against abuse by managers of disciplinary procedures.

We also believe stronger governance would hold leadership to account. We see the strengthening of the role of Non-Executive Directors, along with setting standards for their work, crucial in scrutinising the work of very senior managers.

6. How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?

HCSA has outlined earlier in this submission our view that whistleblowers and patients are being failed by unfair and ineffective processes for handling disclosures, that often result in patient safety issues and victimisation of those who speak up.

This 'blame culture' begins before any formal process is underway. In our call to review whistleblowing processes, we also urge for investigations to consider what was happening before the member of staff reached the point of speaking up. This can be enlightening and crucial to addressing root causes.

7. How could investigations into whistleblowing complaints be improved?

Our members tell us that investigations arising from whistleblowing complaints are too often used as tools to silence those who speak out, rather than fair and transparent processes. Others report that investigations are 'tick box' exercises with foregone conclusions. Often, those carrying out the investigation are not able to act with full independence due to conflicts of interest related to their own position or that of whom they report to. It is not always the case that such investigations are reported to the board for high-level scrutiny. HCSA is also concerned by the use of malicious or vexatious allegations to coerce whistleblowers. These allegations should be identified and removed, with perpetrators investigated and if necessary, referred to their regulatory body.

Ultimately, HCSA is firmly of the view that an independent statutory national whistleblowing organisation, that sits outside of the NHS, is essential to instilling fairness and transparency into the whistleblowing process. This is key for patient safety.

8. How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha's Rule?

Regrettably, patient safety concerns raised are usually not investigated and in turn, the complaints system does not prevent such incidents from escalating. It is therefore crucial that all such concerns are investigated. Records of concerns raised and actions taken must be kept and monitored externally. Where concerns are raised by a staff member, the staff member in question should be consulted to agree that action has been taken before the case is closed.

On Martha's Rule, it is evident that there are occasions whereby a second opinion would be useful and may not necessarily have been sought by the treating team. Enabling parents, relatives and carers to access a critical care outreach service will be potentially lifesaving in some cases. We note the risk that the service may become overwhelmed with requests for review but this can be reflected on after the rule has been embedded in the system.

9. What can the NHS learn from the leadership culture in other safety-critical sectors e.g. aviation, nuclear?

As the professional association and trade union for hospital doctors, we cannot comment usefully on experience of other sectors. However, it is encouraging that the Committee is looking at best practice elsewhere. We would however advise that care is taken in considering adaptation of outsider models, given that the health sector is uniquely placed in having complex national and local structures, and the extensive exposure staff face every day to patient safety risks.