Accountability, fear, and public safety

> ‘Fear is toxic to both safety and improvement.’

Don Berwick, A promise to learn – a commitment to act[260]

In this chapter we examine the apparent tension between professionals learning from their mistakes and taking responsibility for their actions. We explore what this means for regulation, and for its role in protecting the public.

It is widely accepted that health and care professionals practising in fear – of their regulator,[261] their colleagues, or their employer[262] – is a bad thing.[263] But when things go wrong, we also need people to take responsibility for their actions.[264] The extreme working conditions NHS and social care staff endured during the pandemic have brought this challenge for professional regulation into the spotlight.[265] Even before this, the case of Dr Bawa-Garba drew widespread criticism from doctors fearing that a single mistake could end their career. Fear is not just bad for professional wellbeing, with all the unsettling effects that has on recruitment and retention, it can also lead to defensive practice, or worse, cover-ups.

Alongside this, repeated, high-profile failings like those at Shrewsbury and Telford NHS Trust remind us how important accountability is when care goes wrong.

Having ways of holding individuals to account is clearly in the public interest. These include, where possible enabling a practitioner to address concerns about their competence or conduct, or removing the very small number of reckless, dangerous, dishonest practitioners from the workforce to prevent further harm.

By doing this, professional regulation shows the public that they can have confidence in the profession, while sending a message to other professionals about what is acceptable.

Are our accountability mechanisms working? How can regulation protect the public without undermining efforts to address toxic, fear-based cultures in health and social care? Conversely, how can we deliver cultural change in frontline care without undermining individual accountability?

Repeated, high-profile failings remind us how important accountability is when care goes wrong

A deeper understanding of the causes of safety incidents in health and care

> ‘We cannot change the human condition, but we can change the conditions under which humans work.’

James Reason, Human error: models and management[266]

Over the last two decades or so, national and local approaches to patient and service user safety have started to recognise how toxic fear can be in safety-critical work environments. These new approaches are based primarily on a more sophisticated understanding of how individuals function within systems, although implementation remains patchy.

In his work on organisational safety, James Reason developed the concept of the ‘just culture’ – often contrasted with the ‘blame culture’. In a ‘just culture’, it is understood that mistakes primarily result from organisational factors, and the priority is to identify what went wrong rather than who was responsible.[267] This approach has been embraced in the world of aviation to the extent that it is now enshrined in European law, and has been adopted in healthcare less formally.[268,269] For example, Suzette Woodward’s thinking, building on Sidney Dekker and Eric Hollnagel’s pioneering work on safety cultures, has explicitly influenced the patient safety strategy for the NHS in England.[270] The strategy document explains that:

‘Blame is a natural and easy response to error. It allows the cause of mistakes to be boiled down to individual incompetence, carelessness or recklessness and asserts that the problem is the individual. Blame relies on two myths. First, the perfection myth: that if we try hard, we will not make any errors. Second, the punishment myth: if we punish people when they make errors, they will not make them again.’

In the wake of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Don Berwick advocated for the closely related concept of ‘learning’ cultures, inherent in systems and organisations that want to learn from their mistakes in order to improve. He wrote: ‘when people find themselves working in a culture that avoids a predisposition to blame, eschews naïve or mechanistic targets, and appreciates the pressures that can accumulate under resource constraints, they can avoid the fear, opacity, and denial that will almost inevitably lead to harm.’[271] One sign of progress is the move to incorporate ‘human factors’ into patient safety approaches – ‘enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities’.[272] The push towards ‘psychological safety’, – ‘a shared belief held by members of a team that the team is safe for interpersonal risk taking’ – is another.[273]

Unsurprisingly, social work is on a similar path. In 2011, the Munro Review of child protection in England identified that an overly bureaucratic, rules-based approach that aimed to remove all risk was disempowering social workers, and encouraging a blame culture. To counter this, the rules needed to be pared back to allow room for professional judgement, system learning, and an acceptance that people make mistakes: ‘sometimes mistakes happen because people mess up. In child protection, it is very usual and easy to blame individuals when things go wrong. But blaming individuals each time something goes wrong can get in the way of seeing that the system was (also) at fault.’[274]

A more recent review of child protection in England, chaired by Josh McAlister, reported that little progress had been made, and that there is still ‘a high level of anxiety when making decisions and social workers and organisations

continue to feel vulnerable to public, regulatory and Government scrutiny if things do go wrong.'[275]

Alongside this, healthcare policy makers have been looking at the impacts of approaches to clinical negligence. Unlike some other countries, such as New Zealand and Sweden, the UK does not have 'no fault' compensation for clinical error. In our tort-based system, someone must be found to be liable in order for compensation to be awarded. This means that even though NHS workers are covered financially by NHS compensation schemes, which differ across the UK, the schemes tend to pay out on the basis of a healthcare professional having been found to be negligent.[276] Some see this as a barrier to more open, learning-based approaches to clinical error, because it encourages harmful, defensive practice,[277] and pits claimants, who have to make the case for negligence to a greater or lesser extent, against professionals and employers. The English system is currently being reviewed by the UK Government, as well as coming under scrutiny from the Health and Social Care Committee in Westminster.[278, 279]

Why individual accountability matters

> 'Justice is coming for every baby'
>
> **Julie Rowlings, mother who lost a baby due to poor care at Shrewsbury and Telford Hospitals NHS Trust**[280]

When care has gone wrong and people have died, or been left with life-changing injuries, victims and families typically want the truth about what happened. They want an apology, financial compensation, and to prevent the same thing from happening to others.[281, 282]

There are multiple systems involved in the aftermath of a serious care incident including:

- local statutory investigations
- local complaints frameworks
- system and professional regulators
- ombudsmen
- public redress agencies
- private insurers.

Even without public inquiries or criminal investigations, it is a complex, even baffling mix of investigations and responsibilities.[283] Much of it is aimed at identifying what went wrong, and learning from it to prevent future harm, although learning can be limited if professionals are not fully candid because they fear personal repercussions.[284]

We saw in the previous section how important it is to understand the role that systemic issues have played in failures of care. While this is undoubtedly true, establishing the part played by individuals is as important; they may be the primary cause of harm, through the original incident, or the cause of 'second harm' through a poor institutional response.

There is a long line of inquiries and reviews, most recently the Ockenden Review, that have documented not only failings in care, but also concerted efforts by institutions, and the individuals within them, to conceal the truth from patients, service users and families.[285] Attempts to improve safety that focus on systemic and institutional failings alone can obscure the responsibility of individuals (both regulated and unregulated) within that system, leaving them unaddressed. They also assume that none of the behaviour was in fact 'blameworthy'. While this is probably the case most of the time, the pattern of almost systematic lack of candour uncovered by public inquiries shows that these assumptions can be misplaced. It is also worth noting that a reduction in individual

accountability can have other unintended effects, such as impeding collaborative learning,[286] increasing risk-appetites,[287] and even lowering standards of behaviour.[288]

The Ockenden Review makes very little of the role of professional regulators – in line with the terms of reference.[289] This differs to the approach taken in, say, the Mid-Staffordshire Foundation Trust Inquiry,[290] or the Shipman Inquiry, which considered, the latter in forensic detail, how cases were handled by regulators, and made recommendations for change. There is little explanation of what action was, and was not, taken by professional regulators in relation to Shrewsbury and Telford, in respect of the professionals involved. It is not necessarily the case that any regulator was at fault in this instance, but it is more that the Review does not help us understand if they were or not – or if there are flaws in the regulatory model itself.

We recognise that terms of reference may need to vary between inquiries or reviews. However, when major variations aren't explained, big pieces of the puzzle may be missing, and weaknesses in the systems that exist to keep people safe can go undetected and unchallenged. We are also aware of differences in how reviews and inquiries are set up and run. For example, the legal status of statutory inquiries means they have legal powers to compel witnesses to give evidence, provide legal safeguards, and can set limits on the government's discretionary control of an inquiry. As the House of Commons Library Briefing points out, the threshold for establishing a public inquiry, 'matters of public concern' is open to wide interpretation.[291] From the healthcare perspective, it is unclear why Paterson, Cumberlege, and Ockenden were not set up as, or converted to, statutory inquiries, particularly given the scale of harm identified.

We do not make these points to lay blame about what has gone before; but to highlight a structural gap that appears to be hindering a more joined up, coherent approach to inquiries and reviews.

An independent, centralised mechanism for coordination, determining criteria and providing oversight of public inquiries should be introduced. [This would form part of the role of the recommended Health and Social Care Safety Commissioner.]

This would help to bring greater consistency and coherence of approach to the scope and rigour of inquiries. Picking up on points made in our inequalities chapter, such a framework would also give us a way of analysing the findings and recommendations to identify trends, for example the demographics of those affected, and ensure coordinated follow-up on recommendations.

To return to the key question posed in this section, why is individual accountability important?

It matters because, if it didn't exist, the resulting changes in behaviour could ultimately undermine safety and care. It also matters, fundamentally, because people can cause harm; and when that happens, it needs to be confirmed and addressed.

People who use services need to be confident that accountability mechanisms exist; public inquiries and reviews are one such mechanism, and professional regulation – our core focus – is another.

We need greater consistency and coherence of approach in the scope and rigour of inquiries

Professional regulation – individual accountability when care goes wrong

> ‘Justice must not only be done, but must also be seen to be done.’

R. v Sussex Justices, Ex parte McCarthy [1924] 1 KB 256, [1923] All ER Rep 23

Professional regulation is part of the harm prevention framework. The over-arching objective of the regulators we oversee as well as our own,*[292] is the protection of the public. According to the law, this involves:

- protecting, promoting and maintaining the health, safety and wellbeing of the public
- promoting and maintaining public confidence in the professions regulated by the regulatory bodies
- promoting and maintaining proper professional standards and conduct for members of those professions.

While the first of these three objectives may seem to be the only one that relates to public safety, the second and third are indirect means of preventing wider harms. Losing confidence in a profession can affect people’s willingness to seek treatment, leading them to take risks with their care.

Declaring and upholding professional standards shows professionals and the public what is deemed unacceptable, which in turn can have a positive impact on other professionals’ behaviour, as well as on people’s willingness to seek care.

Case law in this field has established that decisions about individuals should be forward-looking, and not punitive. In essence:

- Does the way that you have behaved in the past, combined with what you may have done to address any past failings and any insight you have shown, lead us to believe that you will harm patients or service users again in the future?
- If not, did your past actions and behaviour fall so far short of what is expected of a professional that action needs to be taken to maintain public confidence or professional standards?

The second question can appear punitive because it acknowledges that it is not about the threat posed by the individual,[293] however it is an important and well-established part of the role of professional regulation that aims to prevent wider harms. In fact, the three objectives have parallels with the principle of justice needing to be both done and seen to be done, and apply in similar form to other parts of the patient and service user safety frameworks.

When a safety incident has occurred, regulators may have to investigate and take action relating to the individuals involved. The decisions that they have to make are complex and mainly case-specific, though there are a number of factors the regulators look at when weighing up whether a registrant’s fitness to practise is called into question. The sorts of considerations that inform their assessment of future risk of harm, impact on public confidence, and the need to declare and uphold professional standards include:

- Is the incident a one-off or repeated?
- How serious are the failings (as measured against established approaches), and how great a risk was the patient/service user exposed to as a result?
- Is this conduct that puts patient and service user safety at risk?
- Is there evidence that the professional has insight and has attempted to remedy their failings?

* With the exception of the PSNI.

- Does the case raise any concerns about the professional's attitude (for example: were the actions deliberate? Was the professional negligent, or reckless? Was there dishonesty and/or a failure to be candid, such as an attempt to cover up or minimise the harm or their part in it? Did the professional ignore the concerns of colleagues or otherwise show a lack of aptitude for teamwork?)
- Were there mitigating factors such as challenging working conditions?

Some cases, where a patient or service user has been harmed, fall less obviously under the remit of professional regulators than others. Low-level failings that can be addressed by the registrant (known as remediation), and those where there is no evidence of serious attitudinal issues, are more clearly the responsibility of employers. This assumes of course that the registrant is employed, and that the employer has the mechanisms and resources to pick up on competence issues and address them.

The most serious concerns for regulators are often when a professional has also demonstrated deep-seated attitudinal issues, because these may be very difficult to remediate. This means they are likely to put patients at risk again in the future – as well as affecting public confidence.[294]

It can be harder to articulate the role of the regulator in cases where the failings are serious, but there are no outstanding competence concerns, and no evidence of attitudinal issues or of ongoing risk to patients. Mitigating factors relating to the difficult conditions the professional was working in can add further complexity – something that came to the fore at the height of the pandemic[295] – and the fact that his or her record was otherwise unblemished.[296]

However, we also need to recognise the value of the processes themselves. Where professional failings are sufficiently serious, knowing that the regulator will investigate and may refer to a hearing helps maintain public confidence, as well as being essential to establishing if action needs to be taken. In addition, while fitness to practise is a forward-looking exercise for most regulators, part of the analysis must include what has happened in the past, and that may be enough by itself to require an impairment finding and sanction.

We mentioned in our introduction, the case of Dr Bawa-Garba, a doctor who failed to spot the signs of sepsis in a child who died as a result. In summary:

- the doctor was found guilty of gross negligence manslaughter by the Courts
- the Medical Practitioners Tribunal Service (MPTS) decided that she should be suspended for 12 months
- the GMC appealed this, arguing that she should have been struck off
- the High Court agreed with the GMC
- on appeal by the registrant, the MPTS's original decision was reinstated by the Court of Appeal.

The Court of Appeal noted that the doctor's conduct had been found to be criminally negligent and had had a tragic outcome, but that it had been a single incident, and the environment on that day had been dysfunctional. It also took into account the fact that the doctor had subsequently remediated the concerns and practised safely for four years.*(1)

Clearly, the case was serious and the public interest compelled the regulator to take action, to maintain public confidence and professional standards. However, the way the GMC handled the case in appealing to have the doctor struck off, even after a panel had imposed a 12-month suspension – caused consternation among professionals, politicians and the wider public. It prompted two reviews of how gross negligence manslaughter/culpable homicide are handled in healthcare.[297, 298]

* (1) The full timeline is more complex. See: BMJ, The Bawa-Garba case. Available at: https://www.bmj.com/bawa-garba

We should acknowledge that some of this concern may have been the result of misunderstandings. This was a complex case spanning several different legal processes – the regulator's fitness to practise decisions, as well as the criminal proceedings, and two appeals to the Courts.

Action against Medical Accidents (AvMA) argued that 'a lot of fear has been stirred up unnecessarily. A prosecution for gross negligence manslaughter, as happened to Dr Bawa-Garba, is incredibly rare. It was irresponsible of some to have suggested it can happen to any doctor who makes a simple honest mistake.'[299] This was perhaps symptomatic of a wider problem, that regulatory roles and processes are often not well understood by the general public, nor by the regulated professions themselves.[300, 301] For example, cases concerning clinical competence alone made up only 1.7% of GMC suspensions and erasures between 2012 and 2020.[302]

Ultimately, the legal challenges in Bawa-Garba, along with others where professionals appear to have been sanctioned for one-off failings,[303] help to explain the broader purpose of professional regulation. Health professionals and social workers are not robots, and by virtue of the high-risk work they do, can make mistakes that lead to permanent injury and even death. These mistakes are more likely to happen when professionals are under pressure, and working in challenging conditions.

It is the role of professional regulation neither to punish for past wrongdoing,*(2) nor to divorce professional failings from the context in which they occurred.[304] That said, there are discrepancies in the current system, as the GCC and GOsC both have outdated legislation requiring them to take action based on past misconduct, rather than current impairment – we hope that the current round of reforms will address this.

Maintaining public confidence and upholding professional standards can require regulators to take action where the professional no longer presents a risk to public safety. Action must be balanced and proportionate, and take the registrant's rights, mitigations, and any public interest in keeping competent professionals in the workforce into account.[305] These concepts are complex and may not even have an agreed meaning.*(3) They are further complicated by the fact that the circumstances of each case are different and must all be weighed to reach an appropriate decision; and, as the Bawa-Garba case showed, there is often scope for legitimate disagreement as to the appropriate sanction.

There is also the question of consistency of approach across the regulators. As the Williams Review identified, there are perceived inconsistencies in the way that regulators deal with apparently similar cases, leading to perceptions of unfairness.[306] This was compounded by the lack of understanding about the basis on which outcomes were determined on public confidence grounds.

Regulators should do more, both individually and collectively, to clarify and explain their approach to cases where a professional has been involved in a patient or service user safety incident, with reference to their thresholds for referral into and through the fitness to practise process.

(2) Sir Anthony Clarke, Master of the Rolls, in Meadow v. General Medical Council [2007] 462 at [32] said: "In short, the purpose of FITNESS TO PRACTISE proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

(3) We reported in our advice on public confidence that: 'There is a limited consensus on the types and seriousness of behaviours which are likely to damage public confidence and the public have different views in relation to different professions.' See: Professional Standards Authority, 2019, *How is public confidence maintained when fitness to practise decisions are made? Advice to the Secretary of State*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/how-is-public-confidence-maintained-when-fitness-to-practise-decisions-are-made.pdf?sfvrsn=c8c47420_0

This would help to dispel myths and reduce unnecessary stress on professionals, it would reduce fear, and promote positive working environments, as well as increasing confidence in the process and its outcomes. For this to be effective, regulators need to communicate information clearly and through the right channels, for example working with employers and other partners to limit unwarranted referrals and disseminate clear information about decisions that have been made against registrants, and how they fit with their policies on thresholds for referral.

As part of this, regulators still need to work on understanding and describing public confidence, and its importance in regulation, more clearly. It is a key element of decisions where a professional has seriously failed, but no longer poses a risk to the public.

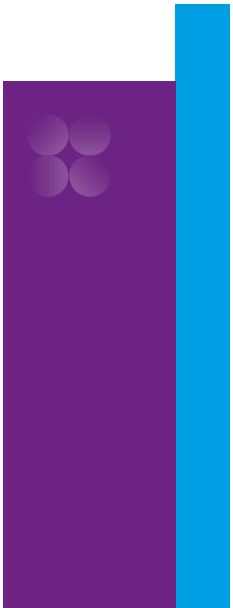
A review we conducted in 2019 told us that public confidence was not well understood and was applied differently in fitness to practise across the regulators.

We will consider how we use our policy and research function in this area, as part of our commitment to supporting the actions outlined in this report.

In addition, while fitness to practise is the regulatory function causing much of the fear, it is necessarily reactive, and slow. Cases in fitness to practise can be concluded years after the event. Regulators have more proactive tools at their disposal to support registrants practising in challenging circumstances.[307] They can work with other bodies to raise concerns about difficult working conditions that are compromising registrants' ability to provide safe care. Regulators also have what is sometimes referred to as preventative, or upstream powers such as setting standards, providing guidance, setting revalidation/CPD requirements, and influencing training curricula. These can all be used to equip registrants with a better understanding of how to navigate difficult working conditions using sound judgement.[308]

Employers can also do much more to reduce the need for referrals to the regulator, both by providing a more supportive, learning environment, and by resolving performance, quality and safety issues locally, where appropriate. This could involve building in more time for self-reflection for individuals and teams, and there are many models of good practice in this area. But as we highlighted in the chapter on inequalities, this kind of support may not be accessible to everyone equally, and employers should ensure that everyone can benefit from them.

Regulators have proactive tools at their disposal to support registrants practising in challenging circumstances



Building trust while maintaining independence

> 'We need to look beyond the actions of an individual and understand the role of other people, the culture and environment they were working in when something went wrong. Only then can we identify what needs to happen to keep people safe in the future – even if we're not the ones who can take that action.'

NMC guidance, Taking account of context [309]

The regulators we oversee are broadly aware of the counter-productive effects of fear on their registrants, and are making efforts to keep pace with moves in the sector away from 'blame cultures'. Overall, we support these approaches where they are about understanding and communicating their role more clearly, increasing compliance and promoting learning when harm has occurred:

- The GOsC was one of the first regulators in our sector to identify the counterproductive nature of a relationship between regulator and regulated based on fear.[310]
- The GMC's response to the Bawa-Garba case includes incorporating a 'Supporting a profession under pressure' strand in its corporate strategy, 'to address the issues that have been raised with us about the environments in which doctors work, and the impact of systems pressures on medical practice'.[311]
- As well as focusing on support for its registrants in its strategy, the NMC has developed a framework for taking context into account in fitness to practise decisions, supporting learning rather than assigning blame; echoing thinking on just and learning cultures.[312]
- A major collaborative report on the concept of seriousness in fitness to practise published this year compares approaches across the regulators.[313] It should help regulators better understand and communicate the factors affecting decisions about the seriousness of professional misconduct, and bring greater consistency across bodies.
- Several regulators have now developed employer liaison functions to support employers (who refer a large proportion of cases to regulators), to identify the right sorts of cases for referral. This could also help address over- or under-referral of groups with particular protected characteristics.

We should sound a note of caution, however. There is a fine line between cultivating trust, and getting too close to the profession; the latter comes with the risk of becoming a less effective regulator, insufficiently focused on all three limbs of public protection. The Authority and the regulators we oversee will need to stay vigilant to ensure that the cumulative effect of these initiatives does not compromise our ability to protect the public effectively.

In addition to the regulators' work, the Governments' proposals to extend the use of consensual approaches to fitness to practise without a tribunal (accepted outcomes) could also help to alleviate the fear of action by the regulator.[314] While these measures are not designed to change the sorts of situations in which regulators can take action, the final decision-making process should be less daunting, and take less of a toll on professionals.

These benefits will only be realised if regulators are transparent about the basis for their decisions, in support both of just cultures, and of maintaining public confidence.

Accepted outcomes, where decisions are taken in private, are, by their nature, less transparent than any decisions made by a tribunal. It will therefore be all the more important that regulators publish good, clear explanations for the public and the profession about accepted outcomes processes and decisions.

As we can see, tackling the problems presented by fear of regulatory consequences is well underway. We welcome this shift in approach, which can and should be compatible with the three aims of professional regulation set out in the previous section, provided it focuses on clarifying and communicating the role of the regulator, and increasing compliance.

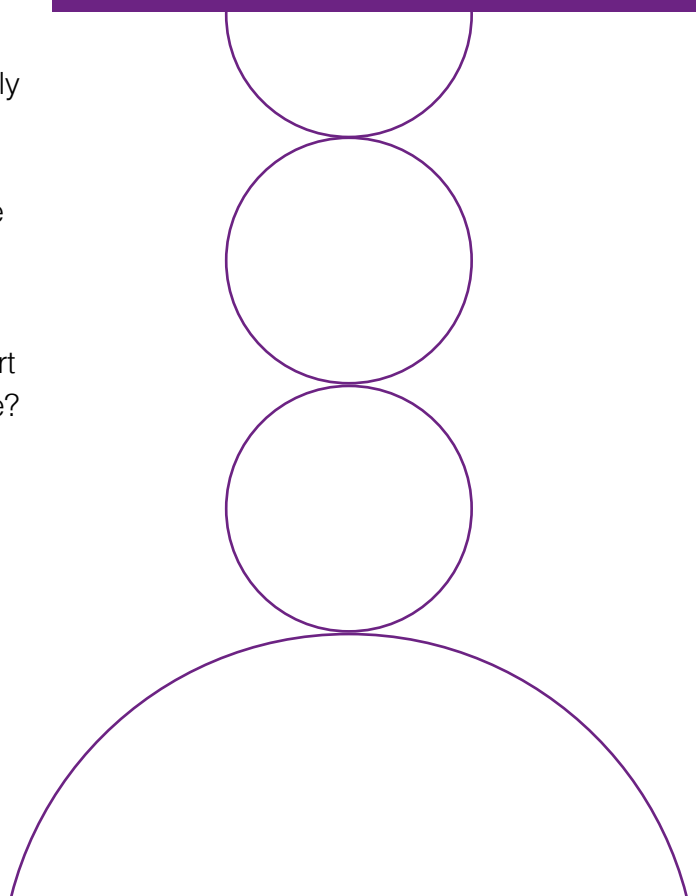
Will it lead to improvements? In our view there are three priority areas to review:

1. Fitness to practise policy: do the regulators' policies and guidance support fair decision-making that takes context into account while maintaining the three limbs of public protection?
2. Fitness to practise communication: are regulators sufficiently clear in their communications about the factors that are likely to lead to action on registrants when there has been a safety incident? Are they working with professionals, employers, patients and service users to ensure their role is understood?
3. Standards, guidance, and training for registrants: do regulators do enough to support registrants to do the right thing under pressure?

Taking these steps forward piecemeal will limit their value. That is why it is essential that regulators work together to develop a coherent approach to dealing with harmful mistakes in health and social care.

We must be realistic about what can be achieved in this way. Professional regulation involves apportioning responsibility for errors to individuals, and holding them to account for their actions. It is almost inevitable that it should be feared to an extent. What it can aim for – and what we want to help it achieve – is a more trusting relationship with the people it regulates, and policies and partnerships that support, rather than obstruct the development of just and learning cultures in the workplace. But as we will see in the next section, it is also important that these developing approaches to patient and service user safety support fair and just individual accountability.

Regulators need to be transparent about the basis for their fitness to practise decisions



Healthy work cultures that support professional accountability

> 'When things do go wrong and cause harm, it is very rare that this is because individuals deliberately depart from good practice or act maliciously. However, if that were the case, the individuals would need to be held to account.'

AvMA, A vision of what a 'just culture' should look like for patients and healthcare staff [315]

While it is certainly not the intention, could there be unintended consequences for patient and service user safety, and for the wider public interest, of a move to a 'no blame' approach at local or national level?

The Just Culture Guide provided by NHS England, but used in other parts of the UK too,[316] describes just culture as a way of evaluating the actions of staff involved in a patient safety incident. Unsurprisingly, given that it has the support of regulators and patient safety bodies, it is not about shielding individuals from personal responsibility. It stresses that the priority of a patient safety investigation is 'to identify underlying causes that need to be acted on to reduce the risk of future incident.' It also makes clear that it is essential to establish the roles played by individuals in any incident. However, this must be done fairly and transparently, in a way that is readily understood by those involved – for example, asking questions about the particular context for the professional's actions and whether another professional would have acted in the same way in those circumstances. Interesting approaches have also developed locally, like the Restorative Just and Learning Culture espoused by Mersey Care NHS Foundation Trust,[317] which has gone on to be adopted by other providers.[318]

These encouraging policies show that just cultures do not only coexist with individual accountability frameworks – but also that a fair and transparent approach to individual accountability is an integral part of a just culture.

But local patient safety investigations sit alongside multiple national mechanisms, each of which fulfils a different societal benefit – providing financial redress, assessing criminal liability, and protecting patients from future harm.

We mentioned above some of the thinking on no-blame approaches to redress and compensation. There is some criticism though that they can, in fact, reduce levels of accountability and in doing so actually have a negative impact on patient safety. A 2015 study comparing approaches to indemnity in medicine found that 'Despite the seductive nature of the no-fault system – the absence of the spectrum of guilt and accusation, the decrease of confrontation, the possibility to compensate more patients – it must be acknowledged that it also presents serious flaws, including the almost complete absence of accountability, […] and the potential degradation of the standard of conduct of health professionals.'[319] This paper concludes that no-fault approaches are more flawed than tort-based systems, and that efforts should be focused on improving the latter rather than trying to move to the former. We are not in a position to assess the merits of this particular finding; but it is certainly interesting that the benefits to patient safety of a no-fault approach may not be as clear-cut as some have suggested; precisely because it could cut across the mechanisms that identify fault at individual level.

The Safe Spaces policy embraced by the English Healthcare Safety Investigation Branch (HSIB) for its national investigations and recently placed on a statutory footing by the Health and Care Act epitomises our concern about national approaches.[320] It is undoubtedly true that people can be put off speaking up if they are

concerned about what this might mean for them or their career,[321] (illustrated by the Ockenden and Mid Staffordshire NHS Foundation Trust inquiries), and that creating 'safe spaces' where people can raise concerns without fear of the consequences can help.

We welcome the fact that the safe spaces policy would not apply to local investigations as was originally planned,[322] and has never been extended to the statutory maternity investigations that will continue to be conducted by HSIB until the creation of a dedicated Special Health Authority.[323] We nonetheless question whether the benefits of the safe spaces approach, even when limited to national investigations, will outweigh the drawbacks. This may depend to some extent on how it is implemented.

Our main point is that evidence of concerns about the conduct or competence of an individual or organisation, may not be shared with the appropriate parties, stopping those best placed to assess if there are fitness to practise concerns from taking action.

It is hard to say how often this kind of situation might arise, but the problem is that the policy itself appears flawed – it creates an information silo by design, when there is ample evidence that the free flow of information is essential to safety.[324] Exemptions to the safe spaces policy, as drafted in the current Health and Care Bill, do little to address this issue because they place responsibility for deciding whether the threshold for sharing is met with the body holding the information.

The concern is threefold: that the regulator should be able to make its own judgement as to whether information raises concerns that may be of relevance to its role; that the generic threshold set in the HSIB legislation is unlikely to match that of the regulators; and that in any case, the evidence held by HSIB may not on its own suggest a serious concern (and therefore meet the threshold for sharing), but may do so when combined with pieces of evidence held elsewhere. This is particularly relevant at a time when other regulatory bodies are recognising the importance of effective information-sharing to identify risk to the public, for example via the CQC's Emerging Concerns protocol.[325]

It is worth noting that HSIB safe spaces are primarily necessary where local workplace cultures are causing people to fear repercussions – but they work around the symptom without attempting to address the cause. This approach should not be a distraction from the more fundamental task of tackling toxic cultures.

As long as local ways of working allow for full and candid accounts to be shared with patients, service users and families, and for appropriate action to be taken, they are to be welcomed. The problem with the HSIB approach is that, almost by design, it imposes a model that seems to cut across both these things.

There is another issue too, of a slightly different order, which is that this information silo could undermine the professional duty of candour. This is a duty that requires professionals to be open and honest with patients, service users and families when care has gone wrong, and sits alongside the statutory organisational duty, where it is in place.[326] It seems hard to reconcile this duty with a framework that prevents information about patient safety incidents from being shared by law – and yet we see that catastrophic failings in care are often accompanied by a lack of candour.

The fact that the HSIB is a body for England only adds more complexity. The above issues would apply to patient safety incidents in England, but not Wales, Northern Ireland or Scotland. On the other hand, the health professional regulators that cover England also cover other parts of the UK, creating a complex patchwork of different approaches to patient safety incidents.

The HSIB was created in response to the very real concerns about the effect of blame on the willingness of professionals to speak up, and the ability of the system to learn from mistakes.

It is still possible that the lessons learnt from this approach may result in greater public protection benefits overall. But the UK Government should proceed with caution with the 'safe spaces' approach for England, building in a review to ensure that it is addressing more risks than it is creating. The review should also check that it is not cutting across the duties of candour, or otherwise having a negative impact on transparency. It should consider the possibility that the safe spaces policy may be so fundamentally flawed that it should be set aside in favour of more transparent mechanisms.

Additionally, if the Government has to make trade-offs, patients and the public should be told, openly.

The UK Government should ensure that the 'safe spaces' investigation approach being implemented in England does not cut across the duty of candour or otherwise negatively impact on transparency or accountability.

These new powers for HSIB highlight the absence of a coherent review stage for new policy initiatives to consider how they fit within the existing legislative framework and ensure they do not undermine established safeguards for patients and service users to the ultimate detriment of public safety.

Policy checks should be introduced to ensure that any new national approaches linked to patient and service user safety are coherent with, and do not undermine, existing mechanisms. This would form part of the role of the recommended Health and Social Care Safety Commissioner.

While we have made recommendations throughout this chapter that may go some way to alleviating some of the tension between accountability and just, learning cultures, we recognise the limits of the work we have been able to do on this. To do justice to the complexity – and urgency – of this issue, we need an open, sector-wide conversation, with input from patients and service users, professionals, employers, and many others.

The Authority will bring stakeholders together to find ways for the 'safe spaces' approach of the Healthcare Safety Investigations Branch (HSIB) England, and other local and national initiatives for improving safety culture, to support candour and accountability.

New national approaches to patient and service user safety shouldn't undermine existing mechanisms

Accountability, fear, and public safety: our conclusions

The theme of this section is, fundamentally, about how to make individual accountability work in a system that learns from mistakes and is safe for patients and service users, and fair to professionals.

We conclude that:

- Individual accountability plays a key part in keeping people safe in health and care, and professional regulation is integral to this framework. Inquiries and reviews investigating major failings should understand this.
- Professionals' fear of being unfairly blamed is, to an extent, inevitable, but we believe that it is sometimes driven by misunderstandings about the role of the regulator.
- Actions by regulators need to be fair and transparent, with clear explanations of how and why decisions are taken, with reference to the three limbs of public protection.
- Employers have a key role in communicating and acting on regulators' expectations, referring members of staff to the regulator only where concerns are sufficiently serious, in line with the regulator's own guidance.
- The safe spaces approach taken by HSIB for England appears to cut across the professional duty of candour and individual accountability mechanisms.
- Professional regulation is neither the cause of, nor the solution to, toxic workplace cultures – this is the preserve of the employer. But it does need to do more to become part of a just culture without compromising safety.

Recommendations

We recommend that:

- Regulators should do more, both individually and collectively, to clarify and explain their approach to cases where a professional has been involved in a patient or service user safety incident.
- The UK Government should ensure that the 'safe spaces' investigation approach being implemented in England does not cut across the duty of candour or otherwise negatively impact on transparency or accountability.

Recommendations that could form part of the Health and Social Care Safety Commissioner's role:

There should be an independent mechanism for centralised coordination and oversight of public inquiries.

- Policy checks should be introduced to ensure that any new national approaches linked to patient and service user safety are coherent with, and do not undermine, existing mechanisms.

The Authority will:

- Bring people together to find ways for the HSIB England's 'safe spaces' approach, and other initiatives for improving safety culture, to support candour and accountability. This will include patients, service users and families, professionals, regulators, and many others.