

# Priorities for the new government

2019

**I**n the election, we rightly saw a huge amount of attention paid to health policy and the future of our NHS. At a time of change, challenge and opportunity for healthcare in the UK, we can never lose sight of the fact that healthcare is first and foremost about one thing - people.

It's about patients - who have a right to safe, quality care. For that, it's about the doctors, dentists and other healthcare professionals who go in to work every day, with the express aim of improving people's lives.

*We consider there to be three pillars of professionalism. The first, is to do no harm to patients. The second, is to ensure that a professional is practising ethically and in line with the highest clinical and behavioural standards. The third, is that healthcare professionals constantly strive to improve quality and deliver even better patient outcomes.*

Medicine and dentistry are brilliant careers. However, the increasing level of burnout amongst doctors and dentists is extremely troubling.

It is perhaps one of the great paradoxes of our age, that modern healthcare allows practitioners to do more for their patients than ever before, yet mounting evidence shows that doctors and dentists feel stressed and burnout in ever greater numbers.<sup>1</sup> Indeed, in a June 2019 survey of MPS members, almost one in two doctors responded to say that they have considered leaving the profession for reasons of personal wellbeing.

From a litigious environment in clinical negligence; to lengthy judicial investigations when things go wrong in treatment; to a regulatory regime that is no longer fit for purpose – healthcare professionals increasingly feel that the deck is stacked against them.

In this new parliament, the Medical Protection Society (MPS) is calling on the Government to prioritise legislation that addresses these concerns.

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members in the UK and 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. Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place.

In this document, the Medical Protection Society (MPS) sets out our *priorities for the new Government*.

Some, we acknowledge, are long term ambitions; others are areas where the Government – working with devolved governments across the UK – can set to work immediately.

1. Medical Protection 2019 – Breaking the burnout cycle: keeping doctors and patients safe

## What we're calling for

- ✓ The delivery of long-awaited regulatory reform, through the introduction of legislation to reform healthcare professional regulation – particularly in respect of the GMC and GDC.
- ✓ A dedicated review, tasked with examining how the law on Gross Negligence manslaughter in England and Wales can be reformed, so good healthcare professionals are not unnecessarily charged for momentary errors.
- ✓ The creation of a National Coroner Service; so there is consistency in how investigations are carried out across the country.
- ✓ The re-introduction of the Health Service Safety Investigations Bill, in order to drive up patient safety.
- ✓ Wide ranging tort law reform, to help address the rising cost of clinical negligence.

# 1. Getting healthcare professional regulation right: reforming the General Medical Council (GMC) and the General Dental Council (GDC)

Few areas of regulation in the UK are more overdue reform than healthcare professional regulation.

In supporting our members, we have considerable experience of the regulatory functions performed by the General Medical Council (GMC) and the General Dental Council (GDC). In recent years, both have made changes to their Fitness to Practise (FtP) processes. Some of these have been positive and have yielded success; others less so.

The common theme amongst all recent regulatory reforms at the GMC and GDC, is that both have been heavily restricted in the changes they can make under the legislative framework underpinning healthcare professional regulation. Both work within the confines of legislation that is over 35 years old and which have not kept up with changes in medicine and dentistry.

Fitness to Practise is an area ripe for reform. Thousands of healthcare professionals go through needless, stressful and slow processes each year at both the GMC and GDC, while many patients making a complaint also end up disappointed with the outcome. We believe the regulators should be given greater discretion – albeit with inbuilt safeguards - to not take forward investigations in case where the allegations clearly do not require action. Current legislation is overly prescriptive and prolongs the process. This serves no one.

It is now imperative that the new government brings forward legislation to reform healthcare regulation in the UK. In 2019, the previous government published its response to a consultation on wide ranging reform. We were deeply concerned that this long-awaited response did not set out clear details on what the next steps would be, and when.

**We urge the new government to publish a strategy, outlining its vision for healthcare professional regulatory reform. This strategy should include a commitment to introduce a draft reform Bill by the half way point of its term.**

A priority and immediate reform that the new government should instigate, is the removal of the GMC's right of appeal over decisions made by the Medical Practitioners Tribunal Service (MPTS). This power is unnecessary and merely duplicates the role of the PSA in such situations. This was a central recommendation of the Williams Review<sup>2</sup> – and the last government agreed that the GMC should lose this power. It is vital this now happens without further delay, as it is an important step in rebuilding trust between doctors and their regulator.

**We are calling on the new government to immediately bring forward the necessary statutory instrument, to remove the GMC's power to appeal MPTS decisions.**

## 2. The increasing criminalisation of the healthcare profession

In recent years, there has been a growing fear amongst healthcare professionals, about the increasing presence of criminalisation in healthcare. No case has brought this concern into sharper focus, than the case of Dr Hadiza Bawa-Garba. The events that followed her appearance before the Medical Practitioners Tribunal Service (MPTS) led to the former Secretary of State for Health and Social Care – The Rt Hon Jeremy Hunt MP – establishing a rapid review of the application of Gross Negligence manslaughter law in healthcare. That review, led by Sir Norman Williams, reported in June 2018 and the government accepted its recommendations in full.

MPS has an unparalleled wealth of experience in supporting doctors faced with Gross Negligence manslaughter (GNM) charges. These cases are always a tragedy, as at the centre of each is a family mourning the loss of a loved one. However, the effect such investigations and charges have on the healthcare professionals involved cannot be over emphasised, and nor can the wider ramifications for the health service.

We believe that the current legal bar for convicting healthcare professionals of manslaughter is too low. This is resulting in good doctors being charged and criminalised for momentary errors. 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.

There is considerable public interest in the maintenance of a safety culture in medicine. We believe it is not in the public interest to discourage doctors from discharging the myriad of duties they have in respect of patient care, in the fear of prosecution. The entire workforce involved in patient care must not be afraid of being candid about errors. This is vital for patient safety.

In Scotland, charges are only brought against doctors if an act is proved to be intentional, reckless or grossly careless. We consider both the law and its application in Scotland, to be more robust and better suited to determining the culpability of doctors in the event of patient death, than the law and its application in England.

Legal counsel in Scotland informs us that the Crown have actively considered culpable homicide cases involving doctors and patient mortalities, however they have only proceeded to prosecute one single case – and this resulted in acquittal. This is striking when compared to the experience in England.

The public, and the profession itself, would always expect that the most reckless and severe cases be prosecuted, and we of course fully endorse this position. We are calling on the Government to explore bold options for law reform in respect of GNM in a healthcare setting.

Recent opportunities to reform the law surrounding ‘medical manslaughter’ in England have not been seized. The Coroners and Justice Act 2009 - the most recent review of the law – left the law on GNM unchanged.<sup>3</sup> In 2006, the Law Commission of England and Wales reported on their review programme of the law on homicide.<sup>4</sup> This followed a public consultation a year earlier on updating the Homicide Act 1957.<sup>5</sup> This review recommended no changes to the law on GNM.

**We strongly advocate that the English law on Gross Negligence manslaughter should be reformed, and moved towards the Scottish position and the legal test for culpable homicide. The UK Government should establish a judge led inquiry, co-chaired by a senior member of the English & Welsh judiciary and the Scottish judiciary; the inquiry should be tasked with assessing how a comparable offence of culpable homicide could replace GNM in England & Wales.**

3. Coroners and Justice Act 2009

4. The Law Commission (LAW COM No 304). Murder, Manslaughter and Infanticide. *Project 6 of the Ninth Programme of Law Reform: Homicide.* (Order by the House of Commons to be printed – 26th November 2006)

5. The Law Commission of England & Wales. *A New Homicide Act for England and Wales? Consultation Paper No 177.* (2005)

### 3. Creating a National Coroner Service

As a medical defence organisation, we are regularly called upon to support members involved in coronial investigations.

Given the local nature of the coroner services in England and Wales – practice, policy and resource provision – can all vary considerably from one locality to another.

Regardless of whether it occurs in Swansea or Sunderland, the investigation of a patient's death by the coroner must be carried out in a consistent way. Too often, we see prolonged investigations in some parts of the country, where a comparable incident elsewhere would see the same case swiftly closed.

A postcode lottery in the coroner service serves no one. It is not fair on a deceased patient's family, who can be held in the coronial system during an unnecessary or unnecessarily long investigation, when the case should be dealt with at hospital level - so they get the answers they deserve promptly. Neither is it fair on healthcare professionals, who may be unnecessarily subjected to the stress of a coroner's investigation, when a colleague with a comparable case in another area would face no investigation by their local coroner. Finally, it is not fair on the taxpayer, who too often must fund delays and unnecessary processes in these investigations.

The coronial system must be consistent and robust. The Chief Coroner and his predecessor have both taken welcome steps in a bid to achieve greater consistency, but much more needs to be done. Indeed, in the Chief Coroner's Annual Report, he lent his support to the creation of a national coroner service.<sup>6</sup> We strongly commend this policy. We have seen first-hand the contrast between the way the system operates in Scotland in comparison to England and Wales – where the Crown Office and Procurator Fiscal Service decide when an inquiry is in the public interest. In our experience, this approach yields greater consistency across Scotland, which serves everyone well.

**We believe the creation of a national coroner service in England and Wales would lead to the better use of resources and ensure consistent practice across the country. This is in everyone's interests: bereaved families, healthcare professionals and the taxpayer. We would encourage the Government to consult on the creation of this service.**

## 4. Driving up patient safety: a Health Service Safety Investigations Body

In the last parliament, the Government brought forward the Health Service Safety Investigations Bill. As an organisation that exists to support doctors and dentists when things go wrong in the delivery of healthcare – and as an organisation whose ethos is to avoid adverse events occurring – this Bill was an important piece of legislation for MPS.

We have long been a supporter of the work of the Healthcare Safety Investigation Branch (HSIB). The HSIB has been calling for it to receive statutory status for many years – so the prospect of an evolution to the Health Service Safety Investigations Body (HSSIB) is very welcome.

**While the legislation will require considerable scrutiny to ensure it is fit for purpose, we urge the Government to re-introduce the Bill at the earliest parliamentary opportunity.**

Many factors weigh upon doctors when engaging with these processes. As well as the personal and professional desire to identify learnings, there are regulatory, legal, contractual, professional and ethical considerations – many of which interconnect, but many of which have a tension between them and the human instincts of self-preservation. For instance, dentists must consider the statutory Duty of Candour, and also their obligation with the General Dental Council.

There is an understandable sense of fear on the part of many in the healthcare profession, that by fulfilling their obligations and professional desire to be reflective following adverse events, they can incriminate themselves to such a degree as to leave themselves open to potential suspension or erasure from their professional register. If we are to make the shift to an open and learning culture in healthcare, where mistakes can be discussed and learnt from, we need appropriate ‘safe spaces’ for healthcare professionals. This Bill represents a very welcome step in this direction. We have long called for the Government to give the Healthcare Safety Investigation Branch a statutory underpinning, so it can give legal protection to individuals, and their comments, when engaging with an investigation. We hope to see this Bill return to Parliament in the near future.

## 5. Tort reform: tackling the rising cost of clinical negligence

On the recommendation of the National Audit Office and the Public Accounts Committee, a joint commitment was made by the Department for Health and Social care and the Ministry of Justice to publish a cross departmental strategy by September 2018, aimed at tackling the rising cost of clinical negligence.<sup>7</sup> This strategy is still eagerly awaited.

Latest figures from NHS Resolution show that the NHS paid out £2.4bn on clinical negligence in 2018/19.<sup>8</sup> The annual cost of clinical negligence in NHS England has risen by more than 200% over the past ten years, and we urge both the DHSC and MoJ to publish a joint strategy on how this rising cost can be tackled, as soon as possible.

Legal reform is urgently needed to strike a balance between compensation that is reasonable but also affordable. At a time when the NHS is being given welcome additional financial resource by this Government, the billions paid out in clinical negligence cannot be overlooked. The amount paid-out last year would equate to the cost of training over 10,000 new doctors.

The rising cost of clinical negligence also impacts on healthcare professionals who are not covered by a state-backed indemnity scheme and who bear the cost of protecting themselves from clinical negligence claims. As a responsible not-for-profit mutual organisation, we have an obligation to ensure that we collect sufficient subscription income to meet expected future costs so we can be in a position to defend member's interests long into the future.

**Wide ranging and ambitious reform is needed. Four such reforms that we commend to the new government are:**

- **A fixed recoverable costs scheme for clinical negligence claims up to a value of £250,000 – to stop lawyers charging disproportionate legal fees.**
- **The introduction of an ultimate 10 year limit between the date of an adverse incident and when a claim can be made (with judicial discretion in certain cases) – to reduce the number of claims that are delayed and inflate due to loss of records, medical staff retiring/dying or having little recollection of the facts.**
- **The use of national average weekly earnings to calculate damages awarded, instead of a patient's weekly earnings – to avoid higher earners receiving more from the NHS in compensation than lower earners, for a similar claim.**
- **An increase in the small claims track threshold for clinical negligence claims up to £5,000 – so more low level, straightforward claims are routinely managed within the small claims track and the cost of these claims are reduced.**

While legal reform is vital, it must be done so alongside a constant drive to improve patient safety and the quality, and reliability, of care delivery. Medicine and dentistry are not exact sciences, and sometimes adverse events can happen. It is how those events are learned from that is key. This is why an open, learning culture is so important. At MPS our ethos is about seeking to prevent problems from occurring in the first place and supporting our members with risk management.

7. National Audit Office – Managing the costs of clinical negligence in trusts (7 September 2017); House of Commons Committee of Public Accounts – Managing the costs of clinical negligence in hospital trusts (Fifth Report of Session 2017-19)

8. NHS Annual Report and Account 2018/2019. Pg.9

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