Witness Name: Professor Philip Banfield
Statement No.: 1
Exhibits: 54
Dated: 21 February 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF PROFESSOR PHILIP BANFEILD ON BEHALF OF THE BRITISH MEDICAL ASSOCIATION

I, Professor Philip Banfield, of the British Medical Association (the "**BMA**"), will say as follows:

1. Since July 2022, I have served as chair of the BMA's UK council, chair of the BMA's board of directors and a member of the chief officer team of the BMA. I am a Consultant Obstetrician and Gynaecologist based in North Wales and am honorary professor in the Cardiff University School of Medicine. Before being appointed as chair of council, I spent several years as a representative of BMA Cymru Wales, as chair of both Welsh council and the Welsh consultants committee. I have sat on the UK council since 2012.

2. When chair of Welsh council, I initiated work within Wales on raising concerns in the workplace in 2014 in the wake of the Francis report into Mid Staffordshire Hospitals and the Andrews report in Wales, which exposed fundamental breaches of care at two of Wales' largest hospitals and recognised the need to adopt a fresh approach to complaints based on openness, early dispute resolution and mediation.

3. In my capacity as chair of UK Council, I regularly meet with doctors who have raised safety concerns only to suffer remarkably adverse consequences to their professional and personal lives.

4. On 30 November 2023, the BMA received a Rule 9 request made under the Inquiry Rules 2006 by the Thirlwall Inquiry (the "Inquiry"). I provide this statement in response to the Inquiry's request. Given the breadth of topics and questions posed by the Inquiry, I have sought input and assistance from colleagues within the BMA, namely from key individuals within the policy, communications, governance, member relations and operational teams.

5. The headings used in this statement broadly reflect the topics and questions set out in Annex A of the Inquiry's Rule 9 request.

6. In support of this statement, the BMA has provided documents specifically requested by the Inquiry as well as documents that support and/or are referred to in this statement. Where a document is referred to within this statement, it will be referred to with the following reference [**PB/X - XXXX**].

7. The information contained within this statement is true to the best of my knowledge and belief.

Background: The British Medical Association

The BMA's role, function and membership

8. The BMA is a professional association and trade union for doctors and medical students in the UK. It represents, supports and negotiates on behalf of all doctors and medical students in the UK across all branches of medical practice and specialties. As of the date of this statement, it has a membership of approximately 191,000, over half of registered, practicing doctors in the UK[1].

9. For the avoidance of any doubt, the BMA is not the regulatory body for the medical profession. Accordingly, the BMA does not provide regulatory guidance to the profession, nor does it set the standards to which medical professions are expected to adhere to. This responsibility lies with the General Medical Council ("the GMC").

The BMA's governance and management structure

10. The BMA's senior elected leadership is comprised of four chief officers. These are:

[1] Each member is part of a local BMA structure called a Division, and falls with a specific area (branch) of practice such as consultant, general practitioner, academic etc.

10.1 The **chair of council**, who chairs the UK council and the BMA's board providing strategic leadership in developing and implementing BMA policies and represents the views of all BMA members externally.

10.2 The **deputy chair of council** deputises for the chair of council both internally and externally. The deputy chair leads on issues and strategic projects as delegated by the chair of council and sits on the BMA board.

10.3 The **chair of the representative body** chairs the Annual Representative Meeting ("ARM") and ensures that the policy set by the ARM is acted on by the Association. The chair of the representative body sits on the BMA board and BMA council, and leads the Association's policy work in particular areas, including workforce, equality and diversity and climate change.

10.4 The **treasurer** is responsible for the good stewardship of the Association's financial and property assets, and chairs key governance committees including the finance committee. The treasurer is a member of the BMA council and is deputy chair of the BMA board.

11. In addition, the BMA appoints a **President** to serve a one-year term of office, commencing at the completion of the ARM held annually, usually in June or July. The President's role is largely ceremonial, and they do not play a role in the day-to-day running of the Association, although they are invited to sit, ex officio, as a non-voting member on most committees, including the UK council.

12. The BMA's senior staff leadership team works closely with the Association's chief officers and elected members. The co-chief executives lead the senior leadership team and BMA staff in the day-to-day running of the BMA. This involves the provision of services to members, such as employment advice, alongside delivering on the policies and priorities of BMA members, committees and their elected members in the BMA's role as a professional association and a trade union. The senior leadership team structure is set out in the organisation chart below (Figure 1):

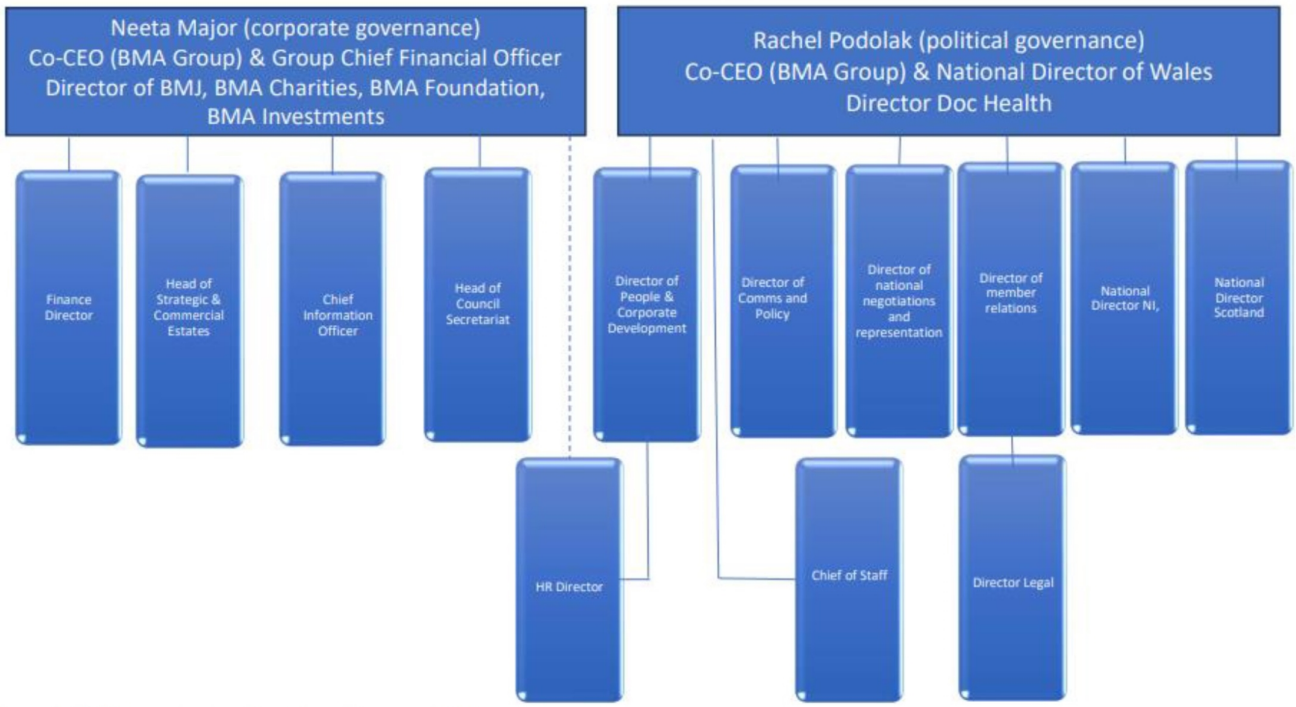

Figure 1: BMA Organisation Chart (as of January 2024)

13. The BMA's elected representational structure involves several local, regional and national forums. The relationship between the different governance bodies of the BMA is illustrated in the chart below (Figure 2):

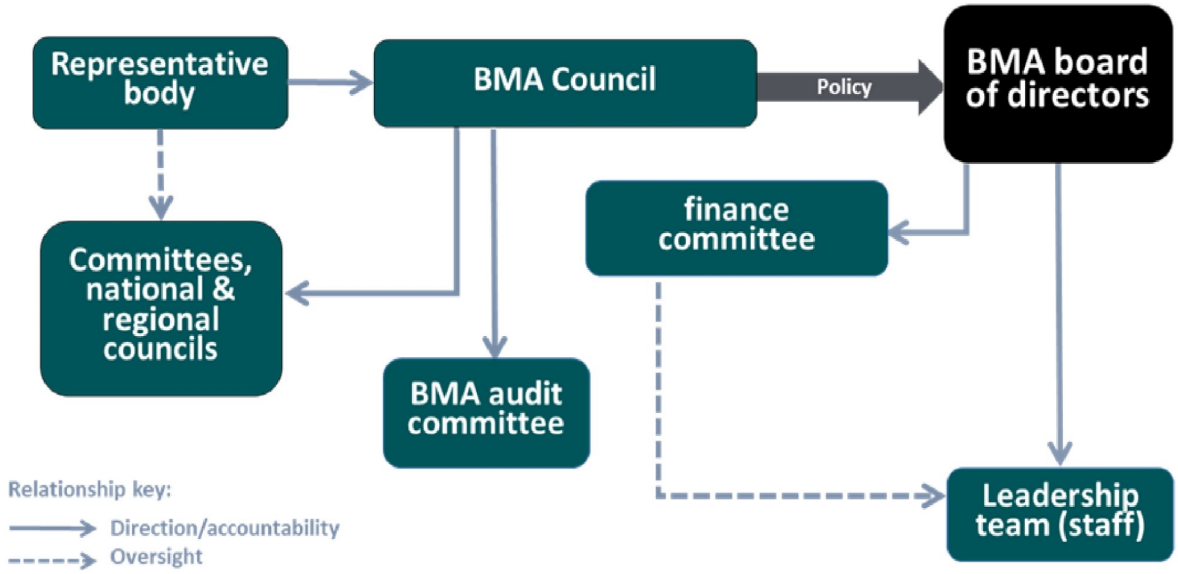

Figure 2: BMA elected representation structure (as of January 2024)

14. The following bodies operate at a UK-wide level:

14.1 **The representative body**: the main policy-making function for the BMA, meeting once a year at the ARM. Members of the representative body are elected by their peers, doctors and medical students from constituent bodies including divisions and branches of practice.

14.2 **BMA UK council**: As the Association's principal executive committee, the UK council is responsible for the lawful conduct of the Association as a recognised trade union and as a professional association. UK council sets the strategic direction of the Association (with the board) and co-ordinates the implementation of policy decided by the representative body at the ARM. It has the power to formulate and implement policies in between meetings of the representative body.

14.3 **Board of directors**: The board is responsible for the management of the finances, operational administration, and strategic direction (with the UK council) of the BMA, in addition to oversight of the British Medical Journal (the "BMJ") (which is wholly owned by the BMA). The composition of the board of directors is outlined in the Articles of Association and Bye-laws of the BMA and includes:

14.3.1 the council chair (chair of the board);

14.3.2 the representative body chair;

14.3.3 the treasurer (deputy chair of the board);

14.3.4 the deputy chair of council;

14.3.5 three medical persons as may be elected and/or replaced by council from time to time;

14.3.6 the chief executive officer(s);

14.3.7 the group chief finance officer;

14.3.8 one lay (non-medical) person experienced in business and commerce to be elected and/or replaced by council from time to time;

14.3.9 the BMJ chair.

Currently, the council has also appointed an additional lay (non-medical) person to the Board.

14.4 **Branch of practice committees**: Reporting to UK council, there are 10 UK branch of practice committees that represent doctors in different areas of medical practice, for example, GPs, consultants, junior doctors and public health.[2] Branch of practice committees have delegated authority to negotiate terms and conditions of service. Each devolved nation also has functioning committees addressing issues relevant to each nation.

14.5 **Professional activities and special interest committees**: Reporting to the UK council, the professional activities and special interest committees represent the interests of doctors and patients across a range of professional activities and special interests. There are currently 9 UK professional activity and special interest committees.[3]

14.6 For clarity, the BMA does not have committees which represent individual specialties.[4] While some of our committees overlap with some specialties (for example, occupational medicine or general practitioners) this is largely due to the structure of their contracts and who they are contracted with. Generally, the royal colleges and faculties provide for the development of and training in medical specialties. As a professional association, we provide ethics, equalities and professional regulatory guidance which can often be applied across specialties.

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[2] Branch of practice committees at the BMA consist of the Armed forces committee, the Consultants committee, the Junior doctors committee, the General Practitioners committee, the Medical academic staff committee, the Medical students committee, the Occupational medicine committee, the Public health medicine committee, the Retired members committee, and the Staff, associate specialist and specialty doctors committee.

[3] The professional activity and special interest committees at the BMA consist of the Board of science, the international committee, the Junior members forum, the Medical ethics committee, the Medico-legal committee, the Patient liaison group, the Pensions committee, the Private practice committee and the Professional fees committee.

[4] Previously, the consultants committee had specialty subcommittees. However, it still has specialty leads within the committee.

15. At the devolved level, the following bodies operate:

15.1 **Northern Ireland council, Scottish council and Welsh council**: reporting to the UK council, the national councils have devolved power to consider all matters of specific relevance to the medical profession and healthcare in their nations. They determine policy and action where the application is exclusive to their nation. The BMA's national offices have their own elected branch of practice structure and executive-led teams to enact policies set at the ARM that are relevant to their respective countries. Branch of practice committees have delegated authority from their national councils to negotiate terms and conditions of service.

15.2 **English Regional councils**: are forums to discuss matters of regional interest, and report into the UK council. Regional councils do not have devolved authority.

16. The following structures also operate at a local level throughout the UK:

16.1 **BMA divisions**: Every UK BMA member belongs to one of 169 divisions, which bring together members in all disciplines and branches of practice in their local area.

16.2 **Local negotiating committees ("LNCs") and forums**: Each trust and health board has a local negotiating committee that has the authority to make collective agreements with local management on behalf of medical and dental staff of all grades.

Notable changes to the BMA's governance and management structure since June 2015

17. The BMA has not undergone any significant changes to its governance structure between June 2015 and the date of this statement.

18. With respect to changes to its management structure, various changes have been applied to the Senior Leadership Team and internal directorate structures. Of note, in November 2020 the policy directorate merged with the engagement & communications directorate to form a new 'communications and policy' directorate because the areas being addressed by each individually overlapped so much in practice. Further, having existed as a function at the BMA, the 'national negotiations representations' ("NNR") team became a formal department. The primary purpose of the NNR department is to

provide policy and political advice to UK Council and committees across the UK and to negotiate national terms and conditions for doctors.

19. Since July 2022, the BMA has sought to improve the way our member relations directorate functions with respect to increasing our capacity as a trade union. This has resulted in the BMA bringing our (individual) casework and (collective) bargaining staff functions closer together and simplifying our management structure. This created seven regional teams in England, which began operating in November 2023. We believe that this will help us better support members, by improving frontline triage and support for members with workplace issues and better connecting patterns we note through casework with our local and national campaigns and organising activity.

The BMA's relationship with other health bodies in relation to Freedom to Speak Up: June 2015 - Present

20. In specific circumstances, the BMA has collaborated and worked with other health organisations such as the GMC, the Medical Schools Council and NHS England. We are in regular contract with such organisations to discuss issues within the health sector and have worked with other health bodies to address issues where there is a common objective.

21. The BMA is also a member of the Social Partnership Forum ("SPF") which brings together various trade unions, NHS Employers, NHS England and the Department of Health and Social Care to contribute to the development and implementation of policy impacting the health care workforce. The SPF Strategic Group (which sits within and reports to the wider SPF Group) is normally attended by the BMA's Head of Public Health and Healthcare. The SPF Workforce Issues Group ("WIG") undertakes more detailed work on workforce issues and reports into the SPF Strategic Group. WIG meets on a monthly basis and has been attended by the BMA's Head of Healthcare Delivery and over the past year, a Senior Policy Advisor in the BMA's population health team. Speaking up in the NHS is a policy area that sits within the remit of the WIG. The group will, from time to time, take updates from and feed into discussions led by the NHS England lead for speaking up.

22. Examples of projects where the BMA has collaborated and worked with other organisation are the *Building positive workplace cultures in the NHS* toolkit which is accessible through SPF's webpage, the Charter for staff and associate specialist and

specialty doctors which was published by the BMA in collaboration with NHS Employers, Health Education England and the Academy of Medical Royal Colleges and the joint pledge to end sexism in medicine which has garnered over 60 signatories.

23. It is likely that the BMA had been privy to meetings with other organisations where the Freedom to Speak up Guardian system has featured in discussions. However, we are unable to identify an instance where we formally collaborated with another health organisation with respect to the Freedom to Speak up Guardian, specifically.

Raising Concerns – BMA Guidance and Support

Guidance

24. The BMA produce and publish a variety of guidance, the vast majority of which are made publicly available on the BMA website. Guidance is often signposted through communications sent from the BMA to its membership and is reviewed and updated when/if required, often in response to policy and/or legal changes[5]. Of the guidance currently published on the BMA website, the following guidance has particular relevance to the issues being investigated by the Inquiry:

- *Raising a concern: guide for doctors* [**PB/001**] INQ0011924
- *Responding to concerns: a guide for doctors who manage staff* [**PB/002**] INQ0011925
- *Raising concerns as a consultant under pressure* [**PB/003**] INQ0011926
- *Dealing with complaints made against you personally* [**PB/004**] INQ0011927

25. At present, the BMA does not collate data on the impact/effect of the guidance we publish, nor has it done so in the past. From our perspective, it is difficult to measure the impact of specific BMA guidance on doctors (and the wider medical profession) as it is not always possible to have full visibility on who has read the advice, the extent to which they have read it and whether actions they have taken (or abstained from taking) are attributable to having read BMA guidance. Further, members will also have access to a

[5] For example, the BMA updated its guidance in the aftermath of the Court of Appeal case, *Bawa-Garba v General Medical Council* [2018] EWCA CIV 1879 a case in which the BMA also participated in as an intervener.

range of advice and guidance from sources other than the BMA such as the GMC, Freedom to Speak up Guardians and their defence bodies.

26. While we do not collate data on the perceived impact of our guidance, the BMA does gather information in relation to the frequency pages of its website are accessed. This includes the webpages where the guidance listed at paragraph 24 above are hosted [**PB/005**][6]. The key category of data that indicates the number of times each webpage is accessed is titled 'page views' which refers to the number of times a page has been viewed on a website within the chosen period of time. All page views are counted, no matter how many times a user has visited the website in the chosen period of time. The data indicates that, of the guidance mentioned at paragraph 24, *Raising a concern: a guidance for doctors* was the most accessed guidance having been accessed and viewed over 17,500 times between March 2020 and January 2024.

27. The BMA does not currently (or in the past) produce guidance at a specialty level. Accordingly, the BMA has not produced guidance on safeguarding and the protection of babies in hospitals nor does the BMA produce clinical guidance. The reason for this is that the BMA has a primary role in employment matters whereas specialty Royal Colleges and the GMC have responsibility for setting standards of care. With reference to the issues being investigated by the Inquiry, specialty specific guidance is most likely produced by the Royal College of Paediatrics and Child Health ("RCPCH") and/or the Nation Institute for Health and Care Excellence ("NICE") who the BMA notes have also been issued with Rule 9 requests from the Inquiry.

Support – Member relations

28. The BMA's member relations directorate is the primary limb of the Association providing direct support to membership. Support and advice provided range from contract checking, representation during grievances, advice on TUPE transfers, disciplinaries and whistleblowing cases (among the many other matters associated with a member's employment).

29. Generally, all member queries will come in directly to the BMA's First Point of Contact ("FPC") function where information is gathered about the member's issue(s) and

[6] While the data range provided in this document starts in 2019, records do not begin until March 2020. This is because prior to March 2020 the BMA website was hosted on a different platform which has since been decommissioned. Therefore, the BMA does not have access to data prior to March 2020. **PB/005 INQ0011928**

attempts are made to address these if it falls within the FPC staff's expertise. Where issues cannot be resolved at the FPC level (or are more appropriately dealt with by more experienced member relations staff), they are escalated and assigned to an employment advisor ("EA") who will be better placed to provide more detailed, expert advice and representation as needed, especially if an issue is approaching (or is already at) a formal proceeding stage or require direct contact with an employer. Cases involving complex issues around bullying and harassment, discrimination and whistleblowing (among other things) are assigned to senior employment advisors ("SEAs").

30. With respect to raising concerns and whistleblowing, member relations advisors have access to a 'best practice guide' produced by the BMA [**PB/006**] which provides practical advice and guidance for member relations staff in assisting members raise concerns with their employers. This was first produced in 2017 and regularly reviewed (last reviewed in June 2023). INQ0011929

31. In some instances, as a member case progresses, it may become clear that legal advice/representation is required to raise issues before an employment tribunal. The BMA has appointed a panel of 3 external law firms to provide advice and representation in instances where a case has escalated. Such representation is subject to compliance with the 'myBMA' terms and conditions [**PB/007**]. Importantly, to secure support, a member's case will be referred to a panel law firm for a merits assessment. If, in the panel law firm's view, the member's claim has a greater than 50% chance of success and that the estimated financial expenditure on the case is proportionate to any award of compensation potentially recoverable, the BMA may indemnify the member for the legal costs incurred in pursuing the claim. The reason for this threshold is that the Association has a duty to exercise sound stewardship of the BMA's assets to ensure that resources are used appropriately and proportionately. Supporting whistleblowing claims is important to the BMA. Accordingly, since January 2022, if a panel law firm did not believe a case met our merits threshold required for the BMA to provide support, this opinion could be passed to an independent barrister for a second opinion, so as to satisfy the BMA that, in the opinion of two intendent legal experts, a prospective case did/did not meet the merits threshold. INQ0011930

32. Another way in which members are afforded support by the BMA is through the deployment of Industrial Relations Officers ("IROs")[7]. IROs work at a local Trust level

[7] Referred to as assistant secretaries in Wales, Scotland and Northern Ireland.

and provide direction, representation and support for local members and conduct local negotiations on a collective basis. They lead on LNC's established within NHS Trusts where issues arising within a Trust can be raised and decisions can be made as to how to address these. IROs are assigned to distinct geographical regions and work within the Trusts located in those regions. For example, there are approximately 4 IRO's employed in the 'North-West' of England and who, between them, are responsible for supporting the Trusts within that region.

33. In the devolved nations, the employment support and IRO functions have been combined for many years. This makes it more possible to link individual employment issues with wider concerns within the employing organisation. In 2015, for example, contemporaneous with the events at the Countess of Chester Hospital, BMA Cymru Wales raised formal concerns about a decision taken by the health board to close consultant provided maternity services at the hospital I work at and supported a local GP and patient in a judicial review, which resulted in the health board having to agree to its decision being quashed by the High Court.

34. As part of their new strategy, the member relations directorate plan to request more qualitative data from employers on various issues, one of which will be asking trusts about resolution of raising concerns issues at a local level. We intend for this to become a standing item on LNC agendas so that we can ascertain the status of the concerns raised.

35. The member relations directorate collates data on the 'category' of employment related queries received from members. These queries are organised into broad categories such as 'remuneration', 'leave' and 'raising concerns and whistleblowing'. The table below (Figure 3) depicts the total amount of queries received by the member relations directorate each year (commencing 2016) and the portion of these queries that relate to 'raising concerns and whistleblowing'.[8] Currently the 'raising concerns and whistleblowing' category has no subcategories as such we are unable to provide more granular data on what percentage of 'raising concerns and whistleblowing' related inquiries have, for example, a patient safety or discrimination component. Further, the BMA migrated its CRM system in March 2015 and therefore only holds data on categories of member queries from this date onwards.

[8] This represents the number of pure 'raising concerns and whistleblowing' claims. Such claims which are intertwined with other types of claims (e.g. discrimination) are not represented in these figure.

Year	Total Employee Queries	Total Raising Concerns and Whistleblowing
2016	40594	93
2017	42794	105
2018	40822	195
2019	42644	241
2020	47558	243
2021	42873	230
2022	44224	203
2023	56018	274

Figure 3: BMA member queries (from 2016)

36. Notable recent cases where the BMA have supported whistleblowing members include:

(a) Dr Rosalind Ranson – the former chief medical officer at Manx Care on the Isle of Man who was subjected to significant detriments on account of raising safety concerns about Manx Government's handling of the Covid outbreak [**PB/008**]. This represented one of the BMA's biggest wins which resulted in a £3.2 million settlement for Dr Ranson[9].

(b) Dr Shyam Kumar – a consultant orthopaedic surgeon whose employment was terminated following whistleblowing disclosures pertaining to patient safety concerns. [**PB/009**][10].

(c) Dr Martyn Pitman – a consultant obstetrician and gynaecologist who alleged he was victimised by his employer after he had made a number of whistleblowing disclosures [**PB/010**][11].

37. The BMA has also supported numerous whistleblowing members whose cases did not proceed to hearing but instead were settled on a confidential basis. Equally, there are a number of ongoing cases where the BMA is providing support which cannot be commented on at this time.

[9] *Dr Rosalind Ranson v Department of Health and Social Care* ET 21-20 INQ0011931
[10] *Dr S Kumar v The Care Quality Commission*: 2410174/2019 INQ0011932
[11] *Mr M Pitman v Hampshire Hospitals NHS Foundation Trust and L Alloway*: 1404274/2021 INQ0011933

The Countess of Chester Hospital

38. The Inquiry has asked whether the BMA was approached by any doctors working at the Countess of Chester Hospital (the "Trust") with concerns regarding the neonatal unit and/or concerns about the wider culture on the unit. With particular reference to paragraph 29-31 above, which outlines the broad framework as to how issues are raised by members and supported by the BMA, one such case has been identified in which a member approached the BMA communicating concerns at the Trust and in particular the neonatal unit. The case involved Dr Ravi Jayaram who, at the time he approached the BMA for support, was a consultant paediatrician in the neonatal unit at the Trust. Dr Jayaram's case file, as recorded on his BMA case file, is summarised below.

BMA Support of Dr Ravi Jayaram

38.1 On 24 October 2016, the BMA (through FPC) was contacted through the BMA website's 'chat' function by Dr Ravi Jayaram [**PB/011**]. Dr Jayaram explained he had received a letter from the Trust's HR department inviting him to attend a meeting with respect to an investigation into a grievance being pursued against the Trust by Lucy Letby. Dr Jayaram provided that the broader context of the grievance was that 7 consultants in the neonatal team, including himself, had expressed concerns about Lucy Letby with the Trust's executive team in that they had noted a significant increase in unexplained neonatal deaths and near misses over the previous 2 years. In response to this, the executive management at the Trust had commissioned an external review. This was the earliest the BMA had been made aware of issues associated with unexplained deaths at the neonatal ward at the Trust. INQ0011740

38.2 Shortly after contacting the BMA with his concerns, a BMA employment advisor, Tom Carver[12] (the "BMA EA") was appointed to support Dr Jayaram in the Trust's HR departments investigation into Lucy Letby's grievance.

38.3 The BMA EA accompanied Dr Jayaram to a grievance meeting on 11 November 2016. It was reiterated that Dr Jayaram was attending as a witness

[12] Tom Carver left the BMA in October 2023. As such, we have not been able to discuss this matter with him and/or illicit any further information other than what was saved on the member relations case file on CRM.

and was not being accused of wrongdoing. The meeting was recorded, and notes taken by Trust staff [**PB/012**]. INQ0011838

38.4 On 8 February 2017, Dr Jayaram contacted the BMA EA explaining that the consultant team attended a meeting with the Trust executive team and were informed that following an investigation, no further action was to be taken against Lucy Letby and that she would be returning to her role. The consultant group remained uncomfortable with the situation, wanting to push their concerns further saying that they intended to write to the Trust expressing this [**PB/013**]. INQ0011771

38.5 On 13 February 2017, Dr Jayaram provided the BMA EA with the draft letter the consultants intended to send to the Trust [**PB/014**] [**PB/015**]. The consultant group later received a response to their letter from Tony Chambers, the then CEO of the Trust [**PB/016**] [**PB/017**]. INQ0011820 INQ0011934 INQ0011825 INQ0011935

38.6 By way of phone call on 28 February 2017, Dr Jayaram updated the BMA EA communicating that the Trust agreed to refer the matter to the coroner, as requested by the consultant group [**PB/018**]. Dr Jayaram and one other consultant were asked to attend a mediation with Lucy Letby but noted that they were the only two asked to attend (out of the 7 consultants who signed the letter). It also transpired that the consultants had agreed to issue an apology to Lucy Letby to which Dr Jayaram said he would forward a draft to the BMA EA [**PB/019**] [**PB/020**]. INQ0011936 INQ0011830 INQ0011937

38.7 Dr Jayaram sought advice with respect to the suggested mediation. It was agreed that Dr Jayaram would participate in a preliminary meeting on 7 March 2017, a meeting he later reported to being frustrated by the process of [**PB/021**] [**PB/022**]. INQ0011877 INQ0011938

38.8 By way of phone call on 28 March 2017, Dr Jayaram stated that he intended to take a step back from the issues as the Trust CEO had verbally agreed to contact the police about the deaths on the neonatal unit. Dr Jayaram was to continue with the mediation process but there was growing discontent and eroding trust within the consultant group with respect to the Trust. Dr Jayaram wrote to the Trust HR director outlining his concerns with the mediation process and the way his actions had been characterised by Lucy Letby [**PB/023**]. INQ0011939

38.9 By way of phone call on 11 April 2017, Dr Jayaram communicated that the Trust was continuing to consider whether to refer the matter to the police. The Trust executive team asked that Dr Jayaram meet with a barrister engaged by the Trust to gain a greater understanding of the situation [**PB/024**]. INQ0011940

38.10 By way of phone call on 12 May 2017, Dr Jayaram communicated that he had since met with the Trust appointed barrister. Dr Jayaram reported that he continued to experience difficulties with the Trust. He had not managed to obtain information in relation to the grievance initiated by the Lucy Letby from the Trust HR department but confirmed he did not wish to raise a grievance of his own against the Trust. However, he was willing to use the SAR process to obtain sight of the documentation where he suspected inaccurate information was communicated about him [**PB/025**]. INQ0011941

38.11 On 16 June 2017, Dr Jayaram advised the BMA EA that a police investigation had been underway, and he had been interviewed as a witness by two detectives and intended to send the BMA EA a draft copy of his statement once drafted by the police. Dr Jayaram continued to press to obtain information by way of subject access request ("SAR"). The BMA EA obliged to review the witness statement with the caveat that they could only do so from an employment law perspective [**PB/026**] [**PB/027**]. INQ0011901 INQ0011942

38.12 On 25 July 2017, it appears that the BMA EA accompanied Dr Jayaram to a meeting with the Trust's HR department to discuss the SAR where he was (belatedly) provided with the documents he had requested [**PB/028**]. It is recorded that Dr Jayaram was upset by the contents of the documents as he felt they questioned his integrity. The BMA EA reviewed the draft letter Dr Jayaram sought to send in response to the contents of the received documents [**PB/029**] [**PB/030**]. INQ0011943 INQ0011944 INQ0011946

38.13 On 3 October 2017, by way of phone call, Dr Jayaram updated the BMA EA providing that they were awaiting the outcome of the police investigation, and he continued to consider contacting the Information Commissioners Office ("ICO"). Given some of the issues being raised fell outside of employment law (such as data protection and defamation) the BMA EA suggested that BMA

Law[13] may be in a better position to provide/procure specialist advice if Dr Jayaram desired to pursue these [**PB/031**]. INQ0011947

38.14 I&S INQ0011921

38.15 The next substantive entry on the case file appears on 16 August 2023 when the BMA EA reached out to Dr Jayaram while the trial of Lucy Letby was ongoing and offered to put him in touch with the BMA media team in case he sought support following the court's decision. A meeting was subsequently held with the Dr Jayaram on 21 August 2023 over MS Teams to prepare Dr Jayaram in the event he was approached to be interviewed by the media [**PB/034**]. INQ0011790

38.16 At the meeting (which I attended), Dr Jayaram communicated that he had upcoming interviews with ITV and News at 10 and had been receiving support from Doctors in Distress. He provided that he was aware of available BMA support but considered that he did not need it at that time [**PB/035**]. It also appeared that there had been suggestions on social media that the BMA had advised the consultant group to issue an apology to Lucy Letby. This was incorrect, and the media team were briefed to issue a statement addressing this misunderstanding, if required. INQ0011792

38.17 The last activity on the case file occurs on 22 August 2023 where the BMA EA has forwarded my number to Dr Jayaram which I wanted to provide in case Dr Jayaram ever wanted to discuss any further matters with me [**PB/036**]. INQ0011793

I&S

39. In reviewing Dr Jayaram's case file, it became evident that another member approached the BMA in relation to concerns they had with the neonatal unit at the Trust.

[13] BMA Law Limited is an independent law firm regulated by the Solicitor's Regulation Authority and overseen by the BMA and marketed to BMA members who are afforded a discounted rate as a member benefit.

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I&S

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40. Other than the case of Dr Jayaram and I&S outlined above, no other concerns were raised with the BMA by doctors working at the Trust in relation to potential criminal behaviour and/or concerns about Lucy Letby. Similarly, no issues were raised by members with respect to any concerns, including unexpected deaths, incidents in the neo-natal unit or concerns about culture on the neo-natal unit.

41. In identifying the above cases, the BMA member relations department reviewed approximately 80 member cases that were raised around the same period and did not identify any other cases that are associated with the issues contained in the Inquiry's Rule 9 request. In addition, the local BMA IRO at the time has confirmed that they had not been made aware of any issues being raised at the LNC about the medical director or issues within the neonatal unit.

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I&S

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47. I&S

BMA press statement's following the conviction of Lucy Letby

48. On 19 August 2023, following the conviction of Lucy Letby, the BMA issued a press statement commenting on the verdicts in the trial [**PB/040**]. In summary, I expressed shock at the gravity of the crimes and highlighted the challenges faced by doctors in raising concerns about patient safety. I also reiterated that the BMA had long called for non-clinical managers in the NHS (and other health service providers) to be regulated in keeping with the way clinical staff are regulated by professional bodies. INQ0011949

49. Having been approached by media to elaborate on my past comments calling for non-clinical managers to be regulated, I was quoted in the Telegraph on 21 August 2023 INQ0011950 [**PB/041**] stating that:

> *"The BMA has long called for non-clinical managers to be regulated in the same way that doctors are – something since supported by Sir Robert Francis, who led the inquiry into the Mid Staffs scandal.*
>
> *"For any regulator to be effective it needs to be supportive but also have a range of powers and sanctions available. If there is no ability to remove or disbar someone after persistent or serious failings, then that makes the regulator toothless and regulation futile. In regulating non-medical management this would have to remain an option available to ensure that those who truly fell below required standards were not able to repeat the mistakes again in a new role."*

50. Most recently, in my New Years message to the Association, I reiterated the BMA's commitment to supporting whistleblowers and advocating/lobbying for whistleblowing legislation that is fit-for-purpose [**PB/042**]. INQ0011951

The BMA's reflections on Section C of the Inquiry's Terms of Reference

51. The Inquiry has asked that the BMA reflect on Section C of the Inquiry's Terms of Reference which outlines that the Inquiry is to investigate:

> *The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.*

52. The Inquiry has identified an article I opined which was published on the BMA website on 25 August 2023 [**PB/043**]. In that article, I expressed dismay at the events that took place at the Trust relating to Lucy Letby. In particular, I wanted to highlight the broader context of the events which placed a spotlight on the poor cultures surrounding speaking up as well as the need for independent regulation of non-clinical managers within the NHS. INQ0011952

53. The broader issues being looked at by the Inquiry are no stranger to investigation and scrutiny. In particular, this Inquiry will be aware of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC (as he was known then) which examined, among other things, the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 (the "Mid Staffordshire Inquiry"). The resulting report from the Mid Staffordshire Inquiry was published on 6 February 2013 (the "Francis Report"). Notably, Robert Francis KC said that "NHS staff are not to blame. That in the vast majority of cases it's systems, environment, and the constraints they face that lead to patient safety problems" and that "operational targets and financial management have taken precedence over delivering high quality care." Whistleblowers told the inquiry of the pressure to mislead regulators. To hide the truth about what was really going on. The Mid Staffordshire Inquiry shed much needed light on institutions avoiding openness and transparency and the NHS hiding errors and cloaking the truth. The Francis Report was subsequently followed by a review conducted by Donald Berwick on patient safety in England, later published as '*A promise to learn – a commitment to act: Improving the safety of Patients in England*' in August 2013 (the "Berwick Report").

54. As part of the response to the issues identified in the Francis and Berwick reports and the recommendations made, the government established the National Guardian's Office in 2016 which is tasked to lead, train and support a network of Freedom to Speak Up Guardians in England.

55. Further, in response to the Francis Report, Monitor, the Trust Development Authority and NHS England introduced a national whistleblowing policy, a draft version of which was issued on 16 November 2015. The BMA made a submission [**PB/044**] to the consultation on the proposed policy which ran from 16 November 2015 to 8 January 2016. INQ0011953

56. A major piece of work the BMA has conducted with respect to highlighting the challenges faced by doctors in the NHS was the *Caring, supportive, collaborative* Project (the "CSC Project") in 2018 which culminated in the publication of the *Caring, supportive, collaborative* Report (the "CSC Report") [**PB/045**].[14] The CSC Report, which conveyed doctor's views on working within the NHS, was informed by a substantial survey of doctors conducted by the BMA between May-June 2018 (the "CSC Survey"). A total of 7,887 doctors took part in the survey across the UK which ran from 3 May 2018 to 5 June 2018. A summary was also published which consolidated the CSC Report's findings [**PB/046**]. These findings are referenced in more depth below. INQ0011955

57. The CSC Project sought to understand and suggest solutions to the challenges being reported by doctors. The CSC Report focused on three broad categories, 'culture', 'workforce' and 'structures' which were explored through various questions. Central to the CSC Project was addressing the question 'what needs to change to improve care for patients and the working lives of doctors in the NHS?'.

Reporting concerns: structures, management and governance of NHS hospital organisations

58. The BMA's research points to various reasons why clinicians remain inhibited from reporting concerns. These include:

58.1 **Lack of support from management** - Generally, doctors do not feel that they have sufficient support and protection from hospital management, regulators or government. With reference to the CSC Report, of the doctors who said they would not always be confident in raising concerns about patient care, 50% said they were afraid they would be unfairly blamed or suffer adverse consequences (the second most common reason for a lack of confidence, after the 59% who said their workload makes it difficult to find the time to raise concerns). The majority of the doctors surveyed agreed with the statement '*I believe there is insufficient protection and support for those reporting errors*'.

58.2 **Competing priorities** - According to the doctors surveyed for the CSC Project, 77% said that they believe the pursuit of national targets/directives are prioritised

[14] Similar reports were published in Scotland (BMA Scotland 2018 member survey) and Northern Ireland (Better culture, better care). INQ0011954

over the quality of patient care, with 74% stating that financial targets are prioritised in the same way.

58.3 **Insufficient support to learn and reflect** - three-quarters of doctors stated that they are cautious about recording reflections for fear it could be used against them. Just one quarter (26%) said they feel comfortable about reflective practice. An example of this was the case of Dr Bawa-Gaba, where her use of reflective practice in her education portfolio was used against her by the GMC. The GMC then sought to remove her from the medical register after she was found guilty of gross negligence manslaughter. The Medical Practitioners Tribunal Service ("MPTS") rejected this action, accepting Dr Bawa-Garba's explanation that the hospital unit was overly pressured, understaffed and under severe pressure and that she had failed to receive senior support. There was particular concern that the manslaughter conviction had been based partly on evidence from her own self-appraisal, including - controversially - reflective notes containing details of the incident that she filled in 7 days afterwards.

58.4 **Added stress from CQC inspections and regulations** - 79% of doctors provided that inspections divert time and resources away from patient care, and 71% said they add to fear and worrying amongst staff in the workplace, while just 12% of doctors say the CQC rating system provides a fair assessment of an organisation's performance. The CSC Report sets out that regulation needs to encourage improvement and support a learning culture. The current approach to regulation in the NHS – both of individual doctors and the organisations they work in – contributes to the culture of blame that many doctors have said negatively affects patient care and in particular the CQC system in England. The regulation of employer organisations needs to change. They must reduce the time doctors and other staff have to spend away from patient care and place more emphasis on staff wellbeing as a vital ingredient in providing good care. Current approaches focus too narrowly on the performance of individual organisations, without sufficiently accounting for the impact of problems in the wider health system. In England, we have called for Government and the CQC to fully reform the CQC's approach to regulation and inspection (removing aggregate ratings) and overhaul the bureaucratic nature of the CQC's registration system, which unnecessarily duplicates much of the work GP practices are required to report to NHS England.

Culture and patient safety

59. Culture was a central theme specifically investigated in the CSC Project. The environment and culture in which a doctor is educated, trains and eventually works in can have a significant impact on their wellbeing and the wellbeing of their patients. A poor workplace culture causes fear and apprehension in the people that work in them often leading a feeling of being unable to speak up when things go wrong and can lead to unlawful discrimination, healthcare inequalities and threats to patient safety. Following the Francis Inquiry and, in particular, the publication of the Berwick Report on the patient safety lessons, there was an increased recognition within the NHS of the importance of creating and fostering a culture in which staff and patients feel able to raise concerns without fear or retribution.

60. Doctors responding to the CSC Survey expressed feeling they were increasingly expected to provide patient care in an unsafe, unsupportive environment, where a persistent culture of blame stifles learning and discouraged innovation. In particular, the BMA sought to understand doctors' views on how the environment of the NHS affected their well-being at that time, whether they felt they worked in a supporting culture in which they felt enabled to fulfil their professional duty and whether they felt able to raise concerns to improve quality of care and safety. With respect to responses associated with culture and patient safety, the CSC Survey identified that:

- A majority (78%) of doctors say that NHS resources are inadequate and that this significantly affects the quality and safety of patient services.

- Around three-quarters of doctors say that national targets and directives are prioritised over the quality of care.

- Nearly half of doctors (45%) are often fearful of making a medical error in their daily workplace and over half (55%) say they are more fearful than they were five years ago.

- 89% of doctors say one of the main reasons for making errors is pressure or lack of capacity in the workplace.

- Over half of doctors (55%) worry they will be unfairly blamed for errors that are due to system failings and pressures; as a result, approximately half of doctors practise defensively (49%).

- 93% of doctors say that system pressures have a negative impact on their ability to deliver safe patient care.

- Three-quarters of doctors are cautious about recording reflections for fear it could be used against them; with junior doctors expressing particular concern.

- Two-fifths of doctors said that bullying, harassment and undermining is often or sometimes a problem in their main place of work.

- In England, just 9% of doctors say CQC inspections take into account system pressures, with 71% saying that these inspections add to fear and worry amongst staff.

61. The results of the CSC Survey painted a damning picture of the culture within the NHS which broadly consisted of a culture of fear and blame. This was particularly disappointing given that the views received from respondents came five years after the Francis and Berwick Reports placed a spotlight on these issues. Responses to surveys also provided evidence suggesting a strong link between staff wellbeing and the quality of patient care. It is a difficult to accept that, by observing and dutifully fulfilling professional obligations set out by the GMC to take prompt action if patient safety is being compromised, the result can often be that the individual raising concerns suffers, a potential, irreversible transformation – from doctor to whistleblower.

62. 'Culture' within the NHS is not limited to the ability of employees to speak up and raise concerns. It also includes the tolerance threshold and appetite to address instances of bullying and harassment. Once a doctor becomes a whistleblower they can become a target for bullying, harassment and intimidation. The BMA's '*Bullying and harassment: how to address it and create a supportive and inclusive culture*' report [**PB/047**] provides that there needs to be a comprehensive and strategic approach to eradicate bullying and harassment, and that action needs to be targeted at all levels. INQ0011956

63. The BMA's vision for change is to recognise that raising concerns and learning from them is essential to improve quality and safety. The NHS must work towards an environment in which all staff feel able and supported to raise concerns about patient safety and the blame culture that is reported by doctors must be addressed to improve the quality of care and safety in the NHS. Raising concerns should be welcomed and

the investigation of them should be part of the everyday vernacular of NHS patient safety.

64. Employers and NHS Management must be accountable for deterring poor behaviour and protecting staff. Not only is this the right thing to do, but patient outcomes depend on it. The BMA has consistently called for a professional code of conduct to be developed for managers as well as accountability of NHS managers for patient safety and a learning culture in their organisations.

Black and ethnic minority perspectives

65. Since its inception, the NHS has been heavily reliant on staff from ethnic minority backgrounds. This includes International Medical Graduates ("IMGs") who are disproportionately more likely to be from an ethnic minority background. Further, many doctors in the NHS were not trained in UK. A report into the ethnic diversity of NHS doctors was published by the Institute for Fiscal Studies in January 2024 which indicated that 31% of junior doctors from the study's February to April 2021 sample were recorded as having trained abroad, while 38% of consultant and 68% of non-consultant specialist doctors trained abroad [**PB/048**]. INQ0011957

66. Unfortunately, as we have learnt, the experience of ethnic minorities differs from that of their white colleagues. This difference in experience spans across a variety of situations including circumstances where a doctor may be inclined to voice a complaint or concern and instances of bullying and harassment. The CSC Survey found that confidence in raising concerns differs by ethnicity. Ethnic minority doctors were almost twice as likely as white doctors to say that they would not feel confident in raising concerns about patient care (14% compared to 8%). Ethnic minority doctors were also more likely than white doctors to say that they might not be confident in raising a concern because they feared being blamed or suffer adverse consequences (57% vs 48% of white doctors) or they worried how the reports would be used (48% vs 38% of white doctors).

67. With respect to bullying and harassment, ethnic minority doctors were more than twice as likely to say that there is a problem with bullying, undermining or harassment in their main place of work (18% vs 7%). Further, 49% of ethnic minority doctor said they would feel confident reporting incidents of bullying, undermining or harassment to their employer compared to 61% of white doctors.

68. Ethnic minority doctors are also consistently disproportionately regulated. For example, a GMC report in 2019 found they were twice as likely to be referred for fitness-to-practice processes by their employer. In addition, ethnic minority doctors are nearly twice as likely not to raise patient safety concerns because of fear of being blamed.

69. Towards the end of 2021, the BMA undertook research into discrimination in the medical workplace. This culminated in the BMA's *Racism in medicine* survey report [**PB/049**] INQ0011958 which was published in 2021. The *Racism in medicine* survey report indicated that experiences of racism are significantly under-reported in that 71% of respondents who personally experienced racism chose not to report this to anyone. The most common reasons given by respondents for not reporting experienced incidents were: (a) not having confidence that the incident would be addressed (56%) and (b) being worried about being perceived as a troublemaker (33%). For those who did report, the most common outcome reported was that no action was taken (41%).

70. Such inequality was exacerbated during the Covid-19 pandemic where the complexity of race affected how doctors may voice complaints to managers and senior managers. 85% of doctors who died from COVID-19 in the UK were from ethnic minority backgrounds. Like many issues in the COVID-19 pandemic, PPE and its lack of availability did not impact the medical profession equally. Doctors from ethnic minority backgrounds more commonly experienced shortages and pressure to work in environments without sufficient PPE and ethnic minority doctors and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE.

71. The fact that twice as many ethnic minority doctors as white doctors reported feeling pressured to work in high-risk settings without adequate PPE (another finding of our 2021 call for evidence) and a greater fear of raising concerns (and impacting careers or being judged negatively by colleagues), demonstrates that it is likely that the NHS still has a significant degree of institutional racism.

72. Overall, the research conducted by the BMA depicts an environment where the experience of ethnic minority doctors notably differs from their white colleagues. There are many factors that may contribute to this for example, ethnic minority doctors are more likely to be reliant on their employment with respect to their immigration status/right to work in the UK which may add to the already existing apprehensions about raising concerns in fear of the repercussions. This is but one factor that may add to the

complexity of the experience of ethnic minority doctors and their inclinations on whether to raise a concern or not.

The role of managers and steps for meaningful change

73. The BMA has taken an active role in calling for change to NHS culture to promote learning rather than blame and encourage the development of systems to improve safety and quality of care.

74. Learning from errors and improving quality can't happen unless staff feel safe to report errors and raise concerns. There have been steps to encourage greater openness and transparency in the NHS, such as the introduction of an organisational duty of candour, reporting systems for patient safety and organisational roles to support staff in speaking up (for example, the freedom to speak up guardians in England and whistleblowing champions in Scotland), but it remains evident that much more needs to be done. Specifically, the BMA has previously called on employers to:

- acknowledge the role of system and human factors and consider these as part of any investigation.
- recognise the impact of a patient safety incident on staff and provide them with support.
- give sufficient protected time for learning and development, including in the GP contract, so doctors can develop professionally and support quality and safety improvements throughout their careers.
- adopt the NHS Resolution 'Just and Learning Culture Charter' (England).
- prioritise developing better metrics on quality of care, staff engagement and culture and encourage more of a focus on them.
- abandon crude targets and replace them with quality assessments that recognise the context in which local providers are working.

Furthermore, leaders in NHS organisations across the UK must demonstrate openness by sharing learning from past incidents and where possible involve patients and carers

to share positive patient feedback to reinforce learning from positive behaviours and outcomes.

75. The experience of our members is that, when concerns are raised, they are often not welcomed by managers or trust boards, with inconsistencies in, and bias in, who and what is investigated or dismissed. This leads to doctors with a professional obligation to raise concerns under the GMC 'Good Medical Practice' coming into a conflict with colleagues, employers and the organisations in which they work. It is not always obvious at what point the concern legally constitutes a protected disclosure, nor when the person raising the concern has become a whistleblower. A wider culture at NHS Trusts persists whereby when issues and concerns are raised, the organisation tries to protect itself rather than patients or consider that there may be wider failings beyond specific incidents that the organisation should take ownership of. The cases of Dr Peter Duffy at Morecambe Bay, Dr Rosalind Ranson in the Isle of Man; Dr Martyn Pitman at the Hampshire Hospitals NHS Trust; Betsy Bassis at NHS Blood Transfusion; and Tristan Reuser at University Hospitals Birmingham demonstrate that there is a tension between medical staff and their senior managers.

76. In summary, there appears to be a pervasive cultural problem within a number of NHS Trusts. Not only are such Trusts reluctant to listen to those with concerns about bullying, medical incompetence, or other serious matters, people who raise concerns have often found themselves as victims having attempted, in good faith, to raise these concerns and have these openly addressed.

Accountability of senior managers in a health setting – the BMA's view

77. The BMA acknowledge the inherent difficulty in leading and managing a team in often high-stress, high-stakes environments. The BMA has long held the view that the accountability of senior managers needs to be strengthened. Those who run NHS organisations must, like doctors, be accountable for their actions and for the decisions that they have made. In some cases, it has been alleged that poor performing NHS executives are conferred a degree of protection by NHS England or other healthcare providers and shuffled out of prominent roles and into other senior positions within the NHS. As long as a culture of protectionism rather than accountability holds sway, those raising difficult issues will continue to face organisational resistance.

78. Calls within the BMA for such strengthening dates back to 2010 where, at the Association's ARM, the BMA formally adopted policy providing:

> ...
>
> *1816. That in respect of the management of the NHS, this meeting:*
>
> *i. believes that there must be a system of public accountability for senior executives in the NHS;*
>
> *ii. believes that the number and cost of NHS management staff should be kept under continual review;*
>
> *iii. believes that commissioning organisations should have effective clinical advice;*
>
> *iv. calls on all doctors to invite local NHS management staff to gain exposure to clinical practice.*

79. Similarly, at the 2016 ARM, the Association also voted in favour of the following motion:

> ...
>
> *1448. That this meeting insists that all managers must be accountable to a professional body, such as health professional registration.*

80. The above motions are BMA policy. When citing reasons on why they may not feel confident to raise concerns about patient care within their place of work, 20% of respondents considered that they felt discouraged from doing so by their manager/leaders. In addition, in 2018, 91% of the of the senior managers who participated in a survey conducted by Managers in Partnership union said they agreed, in principle, of professional regulation of NHS managers.

81. While it is BMA policy to call for a system of public accountability for senior managers/executives in the NHS, we do not have a formal position statement outlining exactly how we'd like to see this achieved. We have members who contribute constructively on these issues who sit on the Kark Review Steering Committee. Discussion is often brought back to the BMA's consultants committee and considered. For example, following the conviction of Lucy Letby, a briefing on the regulation of non-clinical medical managers was provided to the BMA consultants committee [**PB/050**] INQ0011959

and discussed at the consultants committee meeting held on 27 September 2023 INQ0011960 [**PB/051**]. It was agreed that the consultants committee needed to provide their feedback as the implications would stretch beyond those directly affected (non-medical managers themselves).

82. Most recently, as mentioned at paragraph 48 - 50 above, I have made statements to the media reiterating our call for the regulation of non-clinical NHS staff, particularly those who hold senior management positions.

Effectiveness of the Freedom to Speak Up Guardian and whistleblowing policies

83. When introduced, the BMA supported the creation of the Freedom to Speak Up Guardian, which came as a direct response to the recommendations made in the Francis Report.

84. As seen in the BMA's consultation submission to the national whistleblowing policy for the NHS, when asked whether the Association considered the national policy will make it easier for all staff to raise concerns, including those who may be more vulnerable, the BMA submitted that the success of the policy would need to be seen through its application (as opposed to its form). While the policy framework needed to set the foundation for substantive cultural change, success ultimately depends on the cultural lead given by the NHS in ensuring that the raising of concerns is normalised in healthcare services.

85. Notably, Freedom to Speak Up Guardians are only in post in England. On 5 May 2021, during my tenure as the Chair of the BMA Welsh consultants committee, I opined an article which highlighted the fact that NHS staff often still feared that speaking out or raising concerns may either compromise their career prospects or expose them to aggressive behaviours from more senior staff. I cited that the lack of Freedom to Speak Up Guardian in Wales (or equivalent) was glaring and the implementation of Freedom to Speak Up Guardians in Wales could assist in addressing this culture and instilling accountability [**PB/052**].[15]

86. However, the success of Freedom to Speak Up Guardians in supporting healthcare workers attempting to raise concerns to prevent patient harm appears to have been

[15] There are similar positions installed in some Health Boards in Wales. INQ0011961

limited. The National Guardians Office itself conducted a survey of Freedom to Speak Up Guardians in 2023 [**PB/053**]. The survey illustrated two-thirds (66%) of respondents said their organisation had a positive culture of speaking up, which has not risen since 2020 (67%). In addition, the number of Freedom to Speak Up Guardians reporting improvements in culture has dropped. In 2023, 59% of respondents said the speaking up culture in their organisation had improved over the last 12 months, falling from 74% in 2021. Respondents perceived that fear of detriment as a result of speaking up and concerns that nothing will be done were key barriers to speaking up in the organisation(s) they supported. Almost two-thirds of respondents (66%) identified the concern that nothing will be done was a barrier to workers in their organisation speaking up. This is an eight-percentage point increase compared to responses to the 2021 survey (58%) and puts feelings of pointlessness as equivalent to the fear of detriment as the main barrier to speaking up. INQ0011962

87. This decline was consistent with the findings of the 2022 NHS Staff Survey. When asked the question 'I feel safe to speak up about anything that concerns me in this organisation' had the percentage of respondents who answered 'agree' and 'strongly agree' had fallen to 61.5% (from 65.7% in 2020).

88. Regrettably, implementation of Freedom to Speak Up Guardians has not had the impact the BMA would have liked. Whilst this has been a step in the right direction, in that it sought to support those who felt it necessary to raise a concern, it is evident that many medical professionals do not feel empowered to raise concerns nor do Freedom to Speak Up Guardians feel empowered to escalate concerns to resolution as concerns can still be dismissed at executive or board level, leaving the Guardians to become whistle-blowers themselves to follow through on concerns they are then made aware of.

89. The BMA retains concerns that the Freedom to Speak Up Guardians have limited power to raise and escalate concerns because they are part of the organisational structure that may need independent or external scrutiny, or support. The BMA is undergoing major reforms and restructuring to enhance local support for members in the workplace who find themselves in trouble for trying to raise concerns through their defined governance structure, which we expect will assist the Freedom to Speak Up Guardians to be more effective.

90. The BMA remains open to working with related organisation to develop and implement changes to improve the effectiveness of Freedom to Speak Up Guardians.

Moving forward – Legislative Reforms

91. The BMA's medico-legal committee considers and reports on medico-legal issues of concern to the profession. In July 2023, the medico-legal committee produced a position paper [**PB/054**] which made 6 recommendations with respect to legislative reforms and whistleblowing. Specifically, MLC recommended: INQ0011963

    (a) *that we [the BMA] call for the scope of statutory whistleblowing protection to be extended, for example to medical students and explore the possibility of establishing a network of freedom to speak up guardians for medical schools.*

    (b) *that the BMA supports the extension to 12 months in all tribunal claims, from 3 months, as seen in Protect's bill*[16]*.*

    (c) *the BMA lobbies for the introduction of a benchmarking tool in healthcare sectors (private and NHS) as exemplified by the tool developed by Protect to help assist Organisations measure the effectiveness of their whistleblowing policies.*

    (d) *that more emphasis is put on how concerns need to be raised; if protected disclosures and complaints were raised correctly using the proper platform(s), a detriment would not often follow. This type of preventative work would be beneficial.*

    (e) *there could be a requirement, similar to the requirement for meaningful consultation on redundancies, that the employer should meaningfully consider the disclosure.*

    (f) *that the BMA publicises the NHSE's Whistleblowers' Support Scheme to members.*

92. Recommendations from committees do not become formal BMA policy until they are tabled and approved by UK Council. The position/recommendations proposed by the MLC in July 2023 are yet to be put to UK Council and continue to be considered and refined. The MLC and the BMA continue to actively consider and advocate for issues posed to doctors with respect to whistleblowing and the wider culture within the NHS to

[16] As found on the Protect webpage, last updated May 2022. We note that Protect in fact suggests an increase to 6 months (from 3 months). The MLC have confirmed that they are in favour of an extension to 12 months.

facilitate safe reporting. It is our view that these improvements will also have the downstream effect of improving patient safety and outcomes.

Concluding comments

93. It is clear that not enough substantive change for clinicians raising concerns in the NHS has occurred since the Francis and Berwick Reports, and the awful events at the Countess of Chester Hospital perpetrated by Lucy Letby. That is not to say that commendable efforts have not been made by those within the health community to effect change, rather it reflects in a culture that is engrained and persisted despite efforts being made to address these.

94. There is a long way to go to foster a culture of accountability and empowerment for doctors to speak up and raise concerns. Addressing these cultural issues will ultimately be a key method in improving patient safety. As long as doctors and other healthcare professionals feel overburdened, working in a health service where they feel unable to provide the best care possible due to system pressures, in what seems like a perpetual and never-ending crisis, an open and transparent culture will be difficult to achieve, and we can expect those raising patient safety concerns will continue to do so in a hostile environment.

95. The BMA remains committed to representing and advocating for our members in all respects of their working life, including when they seek to raise concerns, individually or collectively, or conversely are victimised for having done so.

96. Respectfully, it is my view that this inquiry should consider whether what I have outlined in this statement represents a system that is able and willing to listen to and learn from healthcare professionals, and others, raising concerns. Or whether aspects of it are broken and require urgent attention. I would suggest, given the many inquiries and reviews to date, and the appalling tragedy at the Countess of Chester that led to the deaths of so many newborn babies, that it is imperative that the Inquiry considers not only the treatment of those who attempted to raise concerns within the Trust but the treatment of those who make attempts to raise concerns within the health sector generally.

97. If there is any other way in which the BMA can assist or if the Inquiry has any follow up questions, it should not hesitate to get in touch.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 21st February 2024