Royal College of Anaesthetists

07 June 2018

Written submission from the Royal College of Anaesthetists to the Joint Committee on the Draft Health Service Safety Investigations Bill

Introduction and summary of main points

The Royal College of Anaesthetists (RCoA), representing the largest single hospital specialty in the NHS, welcomes the progress of the Draft Health Service Investigations Bill and the establishment of the joint committee.

We have consistently called for a 'no-blame' learning environment where staff and organisations can learn from mistakes when they do happen. The establishment of an independent Health Service Safety Investigations Body (HSSIB), backed by effective legislation, is a considerable step forward in enabling honest and open conversations to take place.

This submission echoes our response to the call for evidence from the Department of Health and Social Care on the draft Bill last autumn, in which we raised a number of issues, including:

- The lack of statutory provision in the Bill to include clinicians and medical experts on investigation panels
- A lack of clarity over the definition of 'serious patient safety issue' and implications on patient safety
- Potential conflicts of interest with arrangements which would allow stage 2 accredited Trusts to investigate themselves
- The potential human rights breaches arising from some provisions in the Bill

We hope the committee will look at these issues more closely.

The committee will also be aware of the recent Government commissioned Williams Review and the General Medical Council's corresponding Review into gross negligence manslaughter in healthcare.

The multi-faceted apparatus that facilitates the transparency, accountability and learning in the health service is fundamental to safe and effective patient care. The recent case of Hadiza Bawa-Garba has placed these values under scrutiny and revealed what Sir Robert Francis QC has described as a 'climate of fear' in the NHS. It is against this backdrop that this Bill has been identified as a route to offer legal protection for doctors' reflections, and this is something we would encourage the committee to consider.

In our response to the Williams Review[1] we have suggested that the HSSIB could play a role in these rare cases, when they do arise, either by carrying out investigations directly or by setting standards and providing training for others to carry out such investigations.

We look forward to engaging with the committee providing insight from a specialty group that cares for two in three hospital patients in the UK.

If you have any questions regarding our submission please contact Elena Fabbrani, Policy and Patient Information Coordinator, at efabbrani@rcoa.ac.uk or on 020 7092 1694.

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About the Royal College of Anaesthetists

- 16% of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[2 3 4]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[5] and 99 per cent of patients would recommend their hospital's anaesthesia service to family and friends[6]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

General comments on the draft Bill

Coordination and delivery of ongoing initiatives

a) In February 2014 the Report of the NHS England Never Events Taskforce, Commissioning the conditions for safer surgery[7], recommended [recommendation 6] that an independent Surgical Incident Investigation Panel be established to undertake a number of functions related to the investigation of serious incidents.

b) Recommendation 27 of the same report noted that, 'Colleges and specialty associations [should] investigate the possibility of retrospective audit (under amnesty) of never events, to identify cases and their causes'[8]. As we have previously noted in evidence provided to the Commons' Public Administration Committee to inform its comprehensive report, Investigating clinical incidents in the NHS[9], unlike other sectors such as aviation '…the healthcare sector remains afflicted by a deep-seated 'blame' culture, making staff wary of reporting incidents for fear of repercussions'.[10]

c) The provisions for the creation of a 'safe space' within the Bill appear to facilitate the same objective as recommendation 27 of the February 2014 report and address concerns raised in our evidence to the Public Administration Committee, which is a welcome step.

d) The draft Bill is a progressive step and we are broadly supportive of its provisions. However, there appears to be a lack of coordination between the delivery of recommendations in previous national reports - such as NHS England's Never Events Taskforce - and the development of regulation which aims to broadly achieve the same policy objectives.

e) The need to improve the representation of clinicians and medical experts in the HSSIB investigations process is noted in our issues for further consideration, below, and is symptomatic of the wider issue of clinical expertise being side-lined from decision-making.

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Issues for further consideration

1. Lack of statutory provision in the Bill to include clinicians and medical experts on panels

1.1 Back in 2015 the RCoA responded to the call for evidence by the Independent Patient Safety Investigation Service Expert Advisory Group (subsequently renamed the Health Safety Investigation Body).

1.2 In our response, we expressed concern that the investigation teams would not have adequate representation from clinicians and medical experts. This is an issue that has often been associated with the arms-length bodies (ALBs) who have performed a regulatory function: in July 2014 a report from the Commons' Public Accounts Committee into the functioning of Monitor (now part of NHS Improvement) noted that 'Monitor's effectiveness is hampered by a lack of clinical expertise and frontline NHS experience' with just 7 of 337 members of staff having a clinical background[11].

1.3 We strongly believe that specialist clinical knowledge needs to be married with that of other non-medical experts in order to effectively analyse and interpret findings and fulfil HSSIB's duty to carry out fair and impartial investigations.

1.4 On reading accompanying fact sheets 6 and 8 for example, we were disappointed to see that clinicians and medical experts are not mentioned specifically in the composition of investigation teams and that, as written, they may not be an integral part of investigation panels. The fact sheets state that 'other subject matter experts may be called upon to join the team, as required', which disregards the unique culture of the healthcare sector with respect to incident management.[12]

1.5 As highlighted in our response to the Williams Review[13], we believe that a credible expert witness is someone who has the required clinical expertise and training, which must be current and up to date, but also has direct experience and understanding of applying clinical judgement in pressurised and challenging healthcare environments. We recommend that the HSSIB employs a similar approach when selecting medical experts for its investigations. Such experts would offer a balanced view of both clinical expertise and the human factors at play in challenging healthcare scenarios.

1.6 We recommend amendments to the draft Bill to incorporate a specific clause for the mandatory inclusion on panels of experts with relevant clinical expertise, knowledge of human factors and understanding of the pressures of working in challenging healthcare environments, as appropriate to each case investigated.

2. Lack of clarity over the definition of 'serious patient safety issue' and role of the HSSIB in setting standards for investigations

2.1 According to the proposals the HSSIB will investigate 'up to 30 serious patient safety issues a year', which meet its criteria for investigation, implying that not all incidents will be investigated – even where there might be justification to do so. While this is understandable, we believe that the HSSIB has a wider role to play – with adequate additional resources - in

cascading training in trusts for the delivery of high quality and consistent local investigations, thus enabling healthcare providers to apply the HSSIB's principles of focussing on system failures and fostering a culture of learning from mistakes in their own investigative processes.

2.2 The draft Bill does not offer a clear definition of what would constitute a qualifying incident for investigation and how the determination of a 'qualifying incident' will be shaped by exiting protocol such as the (Revised) Never Events Policy and Framework.[14]

2.3 We are concerned that, while the HSSIB will be considering which cases it should investigate (which we anticipate could take many months), there will be hesitation by trusts as to whether they should initiate their own internal investigations, resulting in delays and missed opportunities to learn from mistakes and to improve patient safety.

2.4 Whist we appreciate that, as stated in fact sheet 6, the HSSIB will not replace existing frameworks for investigating serious incidents, we feel that more clarity is required in the legislation on:

a. what will constitute a 'qualifying incident' for the HSSIB to investigate with its limited resources
b. whether trusts will be allowed to initiate their own investigations without delay and follow their own internal procedures for learning from mistakes, while the HSSIB considers whether it will undertake its own investigation
c. whether trusts will still be allowed to carry out their own investigations in cases where the HSSIB will also investigate the incident

2.5 We also note that, under stage 2 accreditation proposals, trusts would be able to investigate themselves, albeit only those trusts which have satisfied the highest accreditation standards set by the HSSIB.

2.6 Again, the definition of a qualifying incident and the speed with which HSSIB can make a decision about if it will undertake an investigation will be crucial, in order for an accredited Trust to be certain as to which 'investigative process' it should follow.

2.7 As part of its inquiry into the costs of clinical negligence, the Commons' Public Accounts Committee has recently received evidence from a number of law firms. The Committee noted that time delays in the investigation process – due in large part to a delay in reporting an incident - had a direct impact on the inflation of claims financial value and that failure by trusts to conduct an early investigation is the main cause for claimant lawyers to initiate their own investigation.[15]

2.8 Prolonged and multiple investigations also have a detrimental effect not only on staff directly involved in serious incidents, but also on their colleagues and on patients and their relatives.

3. Potential conflicts of interest for stage 2 accredited Trusts

3.1 We see potential conflicts of interest with arrangements which would allow stage 2 accredited trusts to investigate themselves, especially if a report by the investigation team is later used to inform financial redress to patients and/or relatives who have suffered injury from the incident.

3.2 With this in mind we suggest that a clear separation between HSSIB and the body responsible for dispute resolution, NHS Resolution, should be put in statute to ensure that – for example – legal expertise involved in an HSSIB investigations team could not later be involved in the resolution process with a patient/relative which could involve financial compensation.

4. Potential human rights breaches in some of the provisions in the Bill

4.1 The provisions under section 5, *Entry to premises and inspections,* and specifically 5(3)(c), which give inspectors powers to 'seize and remove from the premises any documents, equipment or item' seem excessive.

4.2 Always under 5 (3) 'If the investigator considers it necessary or expedient for the purposes of carrying out the investigation and it is authorised, the investigator may'-
(d) 'interview any of the persons falling within subsection (6) **in private'**.

4.3 As currently written, this could be interpreted and enforced in a way which prevents an individual - being interviewed by the HSSIB - from being accompanied by a colleague who they may wish to be present in order to offer support. In some instances a member of staff may wish to be accompanied by a representative of their respective union or professional association and we would not support a provision which blocked this.

4.4 The principle of the development of a 'safe space' risks being undermined by a provision worded in a way which enables opacity in the investigation process. This would be particularly worrying in cases where trusts investigate themselves under stage 2 accreditation: paragraph 7 of the accompanying fact sheet 7 notes that the 'safe space' structure will not be extended to local investigations conducted by trusts accredited by the HSSIB until after they have been 'fully tested' at an undetermined date.

4.5 A clear definition of what is meant by **'in private'** in this provision is required to ensure that individuals interviewed by the HSSIB have adequate access to support and fair right to representation during these interviews.

5. Accreditation process

5.1 Section 23 sub-section (1), *Functions relating to investigation,* states that 'A trust may do anything that is necessary for the carrying out of an external investigation or internal investigation (as the case may be).' We recognise that, despite the broad language of this provision, its operability is regulated by the preceding provisions under section 22 sub-section(s) (2) through (7). However, it seems an oversight to allow an accredited trust to revise its principles and procedures under section 23 sub-section (5) but not require a re-determination of the trust's accreditation.

6. Duty of Candour

6.1 The implementation of the Bill will change the statutory and operational landscape considerably – but the extent and direction of this possible change will not be clear until the joint committee reports in July 2018.[16] The Bill may introduce a 'safe space' in which investigations undertaken by the HSSIB operate, and there has been suggestion that some of the provisions of the Bill could contravene the ethos of the duty of candour, where an investigation creates a barrier between professional and patient. Specifically, the Commons' Public Administration Committee (PAC) considered the implications of investigation 'safe spaces' during its follow-up to the Parliamentary and Health Services Ombudsmen (PHSO) report 'Learning from Mistakes'.[17]

6.2 We believe that the extension of a 'safe space' is welcome and agree with the government response to the PAC report[18], which stated that NHS Trusts and Foundation Trusts will need to be accredited in order to carry out patient safety investigation with the benefit of a 'safe space'.

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