Comments from the Royal College of Anaesthetists to the call for evidence: NHS complaints and clinical failure

Please note that this response includes the views of both lay and clinical members of the RCoA

Anaesthesia is the largest single hospital specialty in the NHS. The Royal College of Anaesthetists is the professional body responsible for the specialty throughout the UK, and it ensures the quality of patient care through the maintenance of standards in anaesthesia, critical care and pain medicine.

1. The effectiveness of the NHS’s current approach to investigating and addressing untoward clinical incidents.

Our clinical respondents have commented that, despite some changes in recent years, there is still a lot of improvement to be made in how clinical incidents are reported, investigated and addressed. They also noted that there is considerable variation between hospitals and even between departments in hospitals, but generally it was felt that hospitals/departments who handle clinical incidents well are thought to be examples of good practice.

In general there is agreement with the Public Administration Select Committee that, unlike other industries such as airline/engineering, where a culture of learning is at the forefront of driving improvement, the healthcare sector remains afflicted by a deep-seated ‘blame’ culture, making staff wary of reporting incidents for fear of repercussions. Our respondents also agree that clinical failures are not handled effectively by the NHS and its watchdogs, and do not lead to learning and positive outcomes.

Some issues in particular have been raised, as to why the current approach does not work:

• The reduction in Mortality and Morbidity (M&M) meetings and the reluctance by some staff members to attend them; this, coupled with in some cases an unsupportive attitude by senior management members, makes learning, internal reflection and consequently improvement very difficult to achieve.
• In the experience of many respondents small incidents often go unreported, and some have reported how even major incidents involving the death of patients, have not led, despite investigations, to any clear lessons being cascaded down to staff.
• Too many systems for reporting incidents are used by different Trusts (NRLS, Datix, MHRA Yellow Card, Individual Trusts’ reporting systems) and none of them managed centrally in an effective manner. A universal, easy to use reporting system via a single portal of entry, needs to be rolled out so that clusters of incidents and recurring trends can be quickly identified and appropriate action taken to prevent recurrence of incidents, via a dedicated organisation similar to, as PASC has already proposed, the independent investigators used in other industries. We are aware that NHS England is currently in the process of commissioning a new patient safety incident management system to replace the current National Reporting and Learning System (NRLS) and other parallel functions to create a single national patient safety incident reporting and learning function. Particular dissatisfaction was expressed by our respondents about the design of the Datix form which is used by many Trusts to report patient incidents. The main limitation is that it uses very limited drop down menus and has minimal space for free text. The drop down menus are mandatory and many do not offer appropriate clinical choices. Consequently reporting using the Datix system is very poor, with users forced to use inappropriate choices, leading to
inaccurate descriptions of incidents. It was also reported that it is very difficult to search Datix for clinically related incidents, without specific training on how to use the system, making all the information recorded in the database largely inaccessible.

Our lay respondents have commented that incident reporting and handling of complaints should be separate issues. Whilst patients and family members would benefit from knowing that lessons have been learnt from an incident, guidance has already been issued by regulators on how to handle patient complaints and on encouraging a duty of candour in healthcare, therefore healthcare providers should adhere to existing guidance on complaints.

2. How lessons about best practice, procedures and human factors should be learned and disseminated.

Dissemination of lessons from critical incident reporting already takes place locally within Trusts and clinical specialties (anaesthesia as a profession promoted the collection of incident data and created M&M meetings several decades ago). What is needed is a universal system for reporting in the healthcare sector with all the data analysed centrally and quickly by an independent body.

Some respondents have suggested that ‘Human Factors’ modules should be introduced as part of the training of healthcare professionals with regular tutorials involving role play to raise awareness of the concept and how it affects patient care.

PASC may already be aware of the concordat ‘Human Factors in Healthcare’ which could help in providing a roadmap to improved failure and complaints management

The primary aim of patient safety investigation is to learn from incidents and determine what can be done to significantly reduce the likelihood of recurrence. Root cause analysis (RCA) is a method of incident investigation that allows a systems approach to investigation and was selected as the method of choice by the National Patient Safety Agency. RCA is a diagnostic tool rather than a safety solution in itself. A good quality RCA investigation is characterised by a systems approach (i.e. looking at the role of systems in the incident rather than solely looking at the role of individuals). As such it is based on a systematic methodology and recommending systemic improvements.

While some incident reviews are handled poorly, Anaesthesia arguably has a good record in identifying, discussing and acting on errors/complications and disseminating learning. The National Audit Projects (NAPs http://www.nationalauditprojects.org.uk/) are a strong example of where a specialty has learned from local incidents and created a specialty focus - working together to examine complications of practice in a voluntary and transparent manner, subsequently to learn from these cases and act on the lessons learnt. NAP3 (complications of spinals and epidurals), NAP4 (complications of airway management) and NAP5 (accidental awareness during general anaesthesia) each examined recognised complications of anaesthesia that are of importance to patients and that rank high in their concerns, complaints and litigation. They have together involved data taken from almost every anaesthetist in the UK (and certainly every hospital). NAP3 led to improvement in practice in >50% of hospitals and by 50% of individuals after one year. NAP4 led to improvements in practice in >95% of hospitals in two years. These projects are already recognised at international level as providing a useful model for other specialties and healthcare providers to adopt.
3. The value that a new, single, clinical accident investigation branch of the Department of Health would bring to the healthcare sector and how this could improve the complaints process.

Overall our respondents have indicated that such an investigation agency would be helpful especially when accompanied by a single-portal clinical incident reporting system. In the experience of our respondents a large number of complaints, leading either to litigation or referral to the GMC, start off as clinical incidents which could have been defused by a proper response to patients or colleagues in a more timely manner and then used for learning and future service improvement. A more coordinated and committed system for handling them would increase patient confidence, decrease patient anger and frustration, enhance learning and reduce litigation (NHSLA paid out over £1bn in 2013, and is estimating £26bn for future claims and some respondents feel that this level of expenditure is not sustainable and a drain on NHS resources).

In terms of the practicalities faced by those tasked with setting up such an organisation, our clinical respondents have raised some issues below, which will need to be addressed if the new system is to take place successfully.

- Investigations must take place quickly after events have taken place, if the investigating organisation is to get a clear picture of what has gone wrong. The organisation will need to be adequately staffed and resourced to be able to start investigations quickly and at short notice once incidents are reported.
- Staff may be reluctant to offer statements to an external organisation.
- Unlike the airline and other industries, medicine has many different disciplines and specialties. It may be worth considering appropriate expertise for the different specialised clinical branches with the relevant knowledge and competence required to investigate and analyse events and reports from the various clinical fields.
- Doctors have recently experienced ‘regulation’ fatigue, with the requirements of revalidation and engagement in new CQC inspections and also the most recent legislation on duty of candour and wilful neglect. It is imperative that this organisation is set up and presented as an opportunity for learning and not punishment.
- Whilst the funding for this organisation will inevitably have to come from the DH, respondents would prefer if it operated independently of and be adequately removed from the DH and CQC.
- On the issue of funding for such an organisation, the question comes to mind on how all of this will be funded in the current climate of cuts and reduced funding for the NHS. Will the already cash strapped NHS see more of its allowance eroded to fund the new, but justified, organisation? It will be difficult to quantify initially, but the output of such an organisation will inevitably reduce claims, improve clinical services and engender better NHS working practices so although it will be at some cost – it will generate even greater value.
- We recognise from our work with NHS England, and prior to this the NPSA, that they already have considerable expertise in the establishment of clinical incident investigations systems which may be useful.

4. The current capacity of the PHSO to manage and investigate complaints relating to clinical incidents, and their ability to analyse and assess medical evidence.
Our lay respondents have commented that research done by The Patients Association has shown that the PHSO is not fit for purpose, being either understaffed and/or overwhelmed with complaints. They would therefore support earlier investigation at local level, more communication with the patient and sharing of best practice. Our lay respondents also believe that many complaints would be avoided if doctors took the time to honestly discuss with patients what has gone wrong with their care.

5. The impact that Department of Transport accident investigation branches have had in the transport sector and the lessons that have been learnt from the establishment and use of such bodies, in the UK and in healthcare systems in other countries.  
N/A

6. How any such body within the healthcare sector would support the work of PHSO.  
N/A

7. The legal drivers behind increased challenges associated with the issue of medical liability, and the failure to address clinical incidents and complaints.  
N/A