The Royal College of Pathologists
Pathology: the science behind the cure

Response from the Royal College of Pathologists to the Joint Committee on the Draft Health Service Safety Investigations Bill: Call for written evidence

The Royal College of Pathologists' written submission

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1.0 About the Royal College of Pathologists

The Royal College of Pathologists (RCPath) is a professional membership organisation with charitable status. It is committed to setting and maintaining professional standards and to promoting excellence in the teaching and practice of pathology. Pathology is the science at the heart of modern medicine and is involved in 70 per cent of all diagnoses made within the National Health Service. The College aims to advance the science and practice of pathology, to provide public education, to promote research in pathology and to disseminate the results. We have over 10,000 members across 20 specialties working in hospital laboratories, universities and industry worldwide to diagnose, treat and prevent illness.

RCPath's response reflects comments made by Fellows and members.

About this response

This response from the College provides background information on the medical examiners (MEs) initiative and looks at the interaction between MEs and the **Health Service Safety Investigations Body** (HSSIB). Some sections of this response reflect comments made by Fellows and members.

2.0 General issues

- Will the HSSIB command the confidence of patients and their families and healthcare professionals?
- Should the HSSIB's remit extend to private healthcare?
- Can patients and the public be confident that 'safe space' investigations will remedy the deficiencies of existing NHS complaints mechanisms?
- Are there any deficiencies in the drafting of the Bill that would prevent it from achieving the government's objectives?

College response

2.1 The College thinks that the remit of the HSSIB should extend to private healthcare to ensure that the learning can be shared across healthcare sectors and the expectations for safe, high-quality services delivered to given standards is a requirement of all.

2.2 Patients and the public's confidence would be increased if they had patient and public representation on the HSSIB. Having an independent body investigating would also assure the public and patients that there is no bias in the investigation.

2.3 How will the 'safe space' provided by the HSSIB operate?

2.4 The role of NHS Improvement and patient safety would need to be clearly defined such that the HSSIB could work independently of it.

Comments from College Fellows

2.5 A College Fellow commented that, as the NHS becomes increasingly 'privatised' and the division between NHS and private care becomes more blurred, it is essential that the HSSIB covers all healthcare – and this should include healthcare provided by organisations based outside the UK who operate in the UK through subsidiaries (or in the case of pathology, for example, deal with referrals in laboratories in countries outside the UK).

2.6 A College Fellow added that they would support any initiative that seeks to rectify the gap in whistleblowing protection that has become recently evident. They expressed concern that it may still lead doctors in training to feel vulnerable unless all people involved in the HSSIB are distinct from all organisations involved in doctor employment and training.

2.7 The College Fellow was confident with the open policy in the hospital trust they work in and believes patients can have faith in 'safe spaces' with clear lines about how to manage this.

A safe space does not mean that all errors are without consequence. The College Fellow added that patients should be aware of how these lines protect them from poor standards of care while protecting staff from unfair treatment in cases of human error.

2.8 A College Fellow commented that the HSSIB will only command the confidence of patients and their families and healthcare professionals when it has proved to be effective and shown to encourage a culture of learning to mitigate future occurrence. The representatives on the HSSIB would be key – they would need to be made up of a diverse mix of both health professionals and public/patient representation.

2.9 A College Fellow could not see any obvious deficiencies in the drafting of the Bill that would prevent it from achieving the government's objectives.

3.0 Establishment and powers

- Will the establishment of the HSSIB add to confusion about the responsibilities of the various bodies currently dealing with complaints and safety concerns in healthcare?
- Would the draft Bill equip the HSSIB with adequate powers to achieve the government's objective of improving patient safety, or the ability of the Secretary of State to secure the improvement of the safety of the NHS? Does it go too far in any respect?
- Would it be appropriate to model the powers and status of the HSSIB more closely on similar bodies which investigate safety incidents in the aviation, rail or maritime industries?
- Does the draft Bill ensure that the HSSIB is sufficiently independent of both the NHS and the government?

College response: Medical examiners

Background

3.1 RCPath is the lead medical royal college for MEs. MEs will be part of a national network of specifically trained independent senior doctors (from any specialty). Overseen by a National ME, they will scrutinise all deaths across a local area that do not fall under the coroner's jurisdiction. We were delighted with the announcement by the Parliamentary Under Secretary of State in October 2017 that a national system of independent MEs will be introduced from April 2019. The College has long campaigned for the implementation of this vital patient safety initiative, which was recommended by the Shipman, Mid Staffs and Morecambe Bay inquiries.

3.2 Pilot studies have demonstrated that MEs ensure that death certificates are accurate, cases are referred appropriately to the coroner and, most importantly, that bereaved relatives have the opportunity to ask questions and raise any concerns they may have. MEs are also ideally placed to identify trends relating to deaths and highlight areas for further investigation, giving relatives the answers they deserve and improving care for future patients. MEs work closely with families and health professionals to answer questions, address concerns and identify problems with care at an early stage so action can be taken to safeguard patients in the future.

3.3 Importantly, MEs will seek and record the opinions of relatives of the deceased and will document and pass on relevant concerns. The College's view is that no other patient safety initiative can provide these benefits in such a truly independent and universal way.

Areas for discussion

3.4 Medical examiners will play a vital role in improving patient safety. Whilst we do not think a memorandum of understanding between MEs and the HSSIB is necessary, the circumstances when and how (if at all) an individual ME (or probably a region/National ME) raises a concern should be clarified.

3.5 The College is keen to ensure that the MEs initiative is integrated with the HSSIB. Clarification is needed on when and how MEs' evidence fits in with the HSSIB although the HSSIB investigation may happen at a later stage.

Comments from College Fellows

3.6 A College Fellow raised concerns that a further body is likely to cause more confusion – could this be included in the remit of the Care Quality Commission (or UKAS for the labs)?

3.7 A College Fellow commented that staff are already encouraged to speak freely when investigating incidents and there are services such as Patient Advice and Liaison Service (PALS) for patients to voice their concerns.

3.8 A College Fellow expressed that 'time will tell' if the draft Bill will equip the HSSIB with adequate powers to achieve the government's objective of improving patient safety or enable the Secretary of State to secure the improvement of the safety of the NHS. The Fellow wanted to understand the governance framework of the HSSIB and its members' accountability, if the HSSIB is to be independent of any NHS body.

3.9 A College Fellow commented that if models of powers and status exist for similar bodies which investigate safety incidents in the aviation, rail or maritime industries, if these have been shown to work effectively and meet the objectives of improving patient safety and reducing incidence, then the model of powers and status of the HSSIB should more closely reflect those models.

3.10 A College Fellow raised concerns about whether the draft Bill ensures that the HSSIB is sufficiently independent of both the NHS and the government as there will need to be representation of clinical experts on the HSSIB who will be dependents of the NHS.

4.0 Safe space

- Is a legally protected 'safe space' necessary to successfully undertake NHS investigations?
- Will creating a 'safe space' for safety investigations 'encourage patients, families, NHS staff and other participants in an HSSIB investigation to speak freely for the purposes of promoting learning and improving safety'?
- Would the draft Bill adequately protect from disclosure information given to the HSSIB?

College response

4.1 MEs will provide the opportunity for families to speak freely following the death of a relative. We anticipate MEs will filter cases for Learning from Deaths reviewers who will use structured judgement review of cases; it is likely this will lead to improved interaction with the bereaved.

4.2 The College organised a joint conference, Introducing medical examiners, with the Department of Health and Social Care on 22 March 2018. There were more than 100 attendees, representing more than 60 acute trusts. One of the common themes that emerged from the conference was the high levels of satisfaction with the system from bereaved families and the need to engage with key stakeholders, particularly coroners at every stage.

4.3 Further evidence from the pilot schemes includes the following.

4.3.1 Common areas of concern highlighted by MEs include end of life care, Do Not Attempt Resuscitation consent, failure to escalate when a patient deteriorates, falls and medication errors or side effects. MEs have spotted trends and reduced future harm; for exampl improving International Normalised Ratio control, and feeding in the stroke unit.

4.3.2 The pilot schemes provide weekday-only support. Experience is that families want the Medical Certificate Cause of Death to be accurate rather produced urgently.

4.3.3 If a complaint is reported to the ME, the family are signposted to the complaints department. MEs can facilitate discussions between family and clinical teams to resolve concerns.

4.3.4 MEs must make a judgement about the most appropriate time to contact bereaved relatives. In Sheffield this is usually towards the end of the first 24 hours after death. In Brighton, the ME talks to the person who phones the Bereavement Office.

4.3.5 Feedback from relatives has been very positive. No one has found the contact intrusive.

4.3.6 It was stressed that the intention is for MEs to eventually cover all non-coronial deaths

Comments from College Fellows

4.4 A College Fellow was unclear on how a legally protected 'safe space' is necessary to successfully undertake NHS investigations as successful investigations would be more reliant on the appropriately competent individuals on the HSSIB. The College Fellow questioned whether safe spaces exist for other such models such as aviation, rail and maritime, whether they encourage the public, customers, staff and other participants in an investigation to speak freely for the purposes of promoting learning and improving safety?

4.5 A College Fellow suggested that there may need to be the addition of the signing of legally binding confidentiality clauses for each investigation by the members of the HSSIB, which would make each member legally accountable if they disclose information.

5.0 Accreditation

- Will the public have confidence in trusts carrying out their own 'safe space' investigations, and will this build public confidence in the NHS safety investigations system more generally?
- Are the accreditation provisions in the draft Bill satisfactory?
- Will the HSSIB be able to maintain standards of investigation?

College response

5.1 Independence is important, including for MEs. If MEs are hosted within the NHS, the independence of the HSSIB is an important safeguard to enable whistle blowing to be taken seriously when MEs pass on concerns.

6.0 Reporting

- Will the HSSIB be able to effect change and ensure its recommendations are acted upon?
- Would there be adequate safeguards for people referred to in HSSIB reports?

College response

6.1 Feedback between the HSSIB and MEs will be important if MEs report cases.

6.2 MEs have a number of options when passing a case or cases for further review. These include, coroner, local responsible authority (e.g. trust, local authority, clinical commissioning group), National ME, Care Quality Commission, and now possibly the HSSIB. We will provide guidance for MEs on when and how to do this, but the mechanism for HSSIB referrals requires clarification to avoid confusion.

6.3 Communication of investigation findings to MEs is of great importance – they can then be vigilant to detect ongoing issues.

Comments from College Fellows

6.4 A College Fellow commented that the HSSIB's ability to effect change and ensure its recommendations are acted upon would depend on the governance and lines of accountability of the HSSIB, and the ability to impose consequences on those organisations that persistently require this level of investigation; or hold organisations to account to show lessons learnt, implementation of remedial and corrective action and improvement.

6.5 For adequate safeguards for people referred to in HSSIB reports, legally binding confidentiality clauses or agreements would need to be signed up to by all members of the HSSIB.

7.0 Further thoughts

7.1 A mature and functioning ME system should detect patterns and themes that warrant further review that extend across the health and social care system, including private care.

7.2 MEs specifically detect and pass on the Learning from Death criterion when significant concerns are raised by the bereaved.

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