Royal College of Nursing (RCN) Submission: Draft Health Services Safety Investigation Bill, June 2018.

Key priorities

We welcome this Bill's proposal to create an independent body which will investigate serious patient safety incidents in England. The Health Services Safety Investigations Body's (HSSIB) core aim of sharing learning and encouraging reflective practice may benefit patient outcomes and help increase public confidence in the health and care system. The nursing workforce is the largest proportion of the health care workforce and one of its primary concerns is the safety of patients. However, the health system is not currently understood, at a system level, as a safety critical industry.

This Bill presents a ground breaking opportunity to redefine common understanding and ensure that health and care services are regarded as a safety critical industry, as it is indeed a "system comprising individuals, technology and organisations in which safety is of paramount importance and where the consequences of failure or malfunction may be loss of life or serious injury, serious environmental damage, or harm to plant or property."[1]

In order to do this, we strongly urge the Joint Committee on the Draft Health Service Safety Investigations Bill to revisit the purpose and intent of the Bill, and to ensure that it is underpinned by principles and detail which reflect our following concerns:

The framing and approach within this Bill

The stated intention of this legislation is "to bring about whole-system change to how the NHS investigates and learns from healthcare error".[2] However, in current proposed drafting, the legislation fails to provide this, as it is disproportionately focused on the individual person, or people, involved in a safety incident.

The primary focus of the legislation and powers granted to the HSSIB when conducting investigations, must be identifying and understanding the system context, and the causal factors which lead to and/or contribute to a safety incident. However, in its current form, the Bill currently starts from a position that it is the actions of one individual or a group of individuals providing frontline services who fail to care safely and effectively, which results in an "unavoidable" death.

In any incident, a system must credibly and adequately analyse the range of factors and circumstances which led to a mistake or failure, and identify learning to apply for the prevention of future problems. This must take into account both local (micro) and national (macro) systems, including policy making and wider governance of the health and care system, so that learning can be applied at all levels of accountability.

At the highest level of accountability for patient care, policy-makers are responsible for decisions about what health and care can be delivered for the population through NHS-funded and local-authority funded care, irrespective of provider, as well as funding levels to meet these needs. There is currently a lack of political will to have this conversation transparently with the public - which means that there is increasing variation in access to services and patient outcomes. System leaders and frontline professionals are both operating within financial constraint and are

[1] Baron, M.M. & Pate-Cornell, M.E. (1999) *Designing risk-management strategies for critical engineering systems IEEE Transactions on Engineering Management*, 46(1) 87-100. Available here: http://fionasaunders.co.uk/safety-critical-industries-definitions-tensions-and-tradeoffs/

[2] Department of Health and Social Care, *The Draft Health Service Safety Investigations Bill – the investigation process,* 2017. Accessed May 2018. Available here: https://www.gov.uk/government/publications/health-service-safety-investigations-bill

focused on requirements to demonstrate efficiency and productivity. We know that the NHS is not funded to effectively meet need of patients, with total health care spending in England per person falling in 2016/2017.[3] These systemic pressures present conflict between the ambition of the health care system's to consistently deliver high quality care, paired with the lack of resources, including an adequate workforce supply, to do so. In England, approximately 40 000 nursing posts are unfilled, and more than half of nurses report their last shift being understaffed, and patient care compromised. Nursing staff report that they are having to manage a disproportionate amount of risk to deliver safe and effective patient care, and that they are afraid that poor working conditions created by understaffing, may lead to mistakes. [4]

There is currently an implicit assumption at local and national levels that it is acceptable for the margin of risk associated with variations quality and outcomes of clinical care to be absorbed by frontline staff. These professionals are juggling delivering health care without adequate supply of resources and workforce required to meet the needs of patients. Health and care staff are too often individually held to account for all care that is delivered, irrespective of the resources and funding context. In fact, the provider should hold ultimate accountability at local level for decisions about what service can be provided safely and effectively with resources and workforce available.

Accountability for access, quality, experiences and outcomes of health care should exist at all levels within a system determined by local and national decision making. These should therefore be explored consistently as part of any HSSIB investigation process. The systemic context in which health and care staff operate should be examined by the HSSIB first, to understand the causal factors that contributed to a patient safety incident. Although frontline individuals are accountable for their actions, there is a much greater understanding that work is contextual, and it is the responsibility of senior leadership to ensure care can be delivered effectively and safely. Among other benefits, this would also limit subconscious prejudice of the investigations panel when discussing and reflecting on the incident with individuals.

The creation of the HSSIB is a positive opportunity to fully understand accountability for safe and effective care within a complex system, and to recognise health care as a safety critical industry. It is possible to identify and follow a 'golden thread' of accountability for care, including accountability for an incident. This begins with reviewing the wide range of system context, factors and conditions in which an incident occurred, before any discussions with individuals take place. This is the methodology used by the Air Accidents Investigation Branch (AAIB), and we recommend that this principle be adopted by this Bill. This would rebalance the current disproportionate, primary focus on an individual. [5] This Bill could therefore facilitate a significant shift in the framework for quality and accountability, including the development of an effective, enabling regulatory framework, and the affirmation of accountability for overall safety by organisational and agency leadership.

Detailed recommendations for the draft Bill and areas for clarification

1. Patient safety is paramount in all health and care settings

1.1 The introduction of the Health Services Investigation Branch in 2017, was a welcome move to address some of the different forms of investigation which exist and are carried out by different agencies. The purpose of this Bill to further develop the HSSIB as a fully independent body is a positive step forward in dealing with inconsistencies when investigating safety issues. However, patients who use both NHS-commissioned health care services, and those who opt to have healthcare provided by private services, should receive the same rights to protections and safety from harm. Therefore, extending the remit of the HSSIB to investigate patient safety incidents within private healthcare sector providers should be considered. Learning and best practice should be shared with all

[3] Health Foundation, *False economy: an analysis of NHS funding pressures, 2018.* Accessed May 2018, Available here https://www.health.org.uk/publication/false-economy

[4] RCN, *Nursing on the brink*, 2018. Accessed May 2018, Available here: https://www.rcn.org.uk/professional-development/publications/pdf-007025

[5] Air Accidents Investigation Branch, *Report on the accident to Airbus A319-131, G-EUOE, London Heathrow Airport,* Accessed May 2018, Available here: https://assets.digital.cabinet-office.gov.uk/media/55a4bdb940f0b61562000001/AAR_1-2015_G-EUOE.pdf

health care professionals and providers if patient safety is to be given the prominence it deserves.

1.2 The mechanisms and relationships that the HSSIB will share with the current functions, and the different health agencies remains unclear. Clarity is required on the ways in which HSSIB will cooperate with other national health bodies who hold powers and responsibilities for reporting on patient safety incidents, and the causal factors which impact patient care, for example the Care Quality Commission. For the HSSIB to effectively achieve its aims, the multiplicity of its functions in relation to other bodies must be made clear. We would welcome any guidance which resolves this.

2. The powers granted to the HSSIB to investigate patient safety incidents

Developing and co-producing investigation criteria

2.1 For the HSSIB to be successful in achieving its aims, it will be important for the Committee to seek clarity on the criteria that the HSSIB will use to determine which patient safety incidences they opt to investigate. We would like clarity on the language of 'qualifying incidents', and rationale for why the number of investigations the HSSIB can conduct per year is 30.[6] Investigations must be conducted in response to demand and the ability to investigate incidents must not be hindered by resources or funding. The HSSIB will be mandated to determine and publish the criteria they will use to assess whether they will investigate an incident. This criteria should be co-produced with health service leaders, both clinical and non-clinical, as these stakeholders will be best placed to offer advice and guidance on which incidents require, and will benefit from independent review within a safe space. We recommend that the HSSIB publishes annual data on the number of investigations which have been referred to them, against the number which they have undertaken.

2.2 We recommend reviewing section 3(6) to broaden consultation to include health care professionals, patients and families. Currently, the Bill calls on the HSSIB to consult with the Secretary of State, and other relevant people identified by the HSSIB on devising the processes for conducting investigations. These processes, both on how they will decide to investigate, and how to involve relevant organisations or individuals, should specifically include consultation on the proposals with health care staff and patients, and their families. These groups will be able to share their expertise and ensure that any investigation remains patient focused, with learning as the goal. We have concerns related to the extent to which the HSSIB has to consult on its processes with the Secretary of State. This intervention may hinder the ability for the body to act independently to set their agenda for investigating patient safety incidences.

Nurse staffing levels for safe and effective patient care

2.3 The UK nursing workforce is in crisis, with not enough staff being trained, recruited or retained in our health and care services. Patient care is being left undone, or is consistently compromised, because of a shortfall in registered nurse numbers. Our data based on a survey conducted in 2017 with over 30,000 total responses, revealed that in England, 71% of respondents had eight or more patients to each nurse on their last shift on an adult acute care ward. This would have been coded as a red flag for patient care being unsafe in accordance with NICE guidelines produced in 2014.[7] 1,200 respondents in England specifically reported nurse staffing levels of 14 or more patients to one registered nurse in an acute adult ward. And, 44% of respondents working in accident

[6] Department of Health and Social Care, *Fact Sheet 6, The Draft Health Service Safety Investigations Bill – the investigation process,* 2017. Accessed May 2018. Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/644185/HSSIB_investigation_process_fact__sheet.pdf

[7] NICE, *Safe staffing for nursing in adult inpatient wards in acute hospitals,* 2014. Accessed May 2018, Available here: https://www.nice.org.uk/guidance/sg1/chapter/1-recommendations

and emergency reported having no choice but to leave some necessary care undone.[8] Safe staffing levels are a persistent issue across health and care, and too often financial pressures takes precedence over workforce planning that is based on long term service need. One nurse responding to our survey said:

'I now find myself regularly feeling that I've not been able to provide safe – let alone quality – care to my patients. This is completely inappropriate and unacceptable, and to be put in a position where I feel as although I am harming patients due to a systematic lack of concern for safe staffing levels'. [9]

2.4 Research revealed that risk-adjusted hospital mortality rates for common surgeries differed across hospitals, and each increase of one patient in the patient-to-nurse ratio correlated with a 7% increase in mortality.[10] Failure to tackle the significant issue of shortages of registered nurses for care to be safe will no doubt contribute to the numbers of safety incidents. The recruitment, retention and professional development of nurses must be prioritised by Government. In England, the Health Education England (HEE) budget for 'workforce development', which is largely used for CPD for nurses, has been cut by 60% over the past two years, from £205m in 2015/16 to £83.49m in 2017/18. In contrast, the 'future workforce' postgraduate medical and dental budget was increased by 2.7% in 2017/18.[11]

2.5 Currently, short staffing as a system-wide issue is not adequately scrutinised in a safe space regime, and labelled as such, as it would be in other industries (such as aviation). To rectify this, the HSSIB must review both planned and actual nurse staffing levels within the health care setting in question at the time when an incident takes place, and do so in every investigation which they undertake. Staffing should be prioritised as a course of action in any recommendations made. Data collection and reporting on staffing levels by the HSSIB will begin to shed light on the systematic issues that impact on patient safety and support learning to prevent future incidents.

2.6 We believe that nurse staffing levels for providing safe and effective patient care should be enshrined in law in England and Northern Ireland. Wales have recently implemented legislation, and similarly in Scotland, a safe staffing Bill has been published by the Scottish Government. Across the UK, we are calling for Governmental, national and local system accountability for staffing to be specified in law, including the requirement for health and social care systems to have credible and robust workforce strategy, and data-driven workforce planning.[12]

3. Delivering patient care: workforce planning and skill mix of health care staff

3.1 Systematic failings which may have led or contributed to mistakes, should be reported on by the HSSIB. The HSSIB, as part of their investigations should be mandated to collect data on workforce levels (both planned and actual), and the skill mix of nursing staff who were on duty in the setting where the incident took place. Evidence is clear that sufficient numbers of registered nurses lead to improved patient outcomes, reduced mortality rates and increased productivity.

Accountability for workforce planning and appropriate skill mix of health and care staff

3.2 The Bill does not go far enough to place accountability on the Secretary of State for their role in workforce planning, and patient safety. Interim or full reports published by the HSSIB following an investigation should have recommendations that are structurally,

[8] RCN, *Safe and effective staffing: Nursing against the odds,* 2017. Accessed May 2018, Available here: https://www.rcn.org.uk/professional-development/publications/pdf-007025
[9] Ibid.
[10] L. Aiken et al, *The Effects of Nurse Staffing and Nurse Education on Patient Deaths in Hospitals With Different Nurse Work Environments,* 2012. Accessed May 2018, Available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217062/
[11] Health Education England, *Proposed Budgets for 2017/18,* Accessed October 2017, Available here: https://hee.nhs.uk/sites/default/ files/documents/7%20-%20Proposed%20 budgets%20for%202017-18.pdf
[12] RCN, *Nursing on the brink*, 2018. Accessed May 2018, Available here: https://www.rcn.org.uk/professional-development/publications/pdf-007025

organisationally and individually focused. We recommend amending sections 31(3) and 32(3) to mandate that the HSSIB must provide recommendations to the Secretary of State as well as the individuals immediately involved in an incident.

Suggested addition to: Section 31(3) *The report must – c) make such recommendations as to the action to be taken by the Secretary of State.*

The responsibility for change and improvements should not only be prescribed to individual members of staff. Responsibility for the structural conditions where mistakes have happened, sit with the Secretary of State, including recommendations that are the responsibility of the Secretary of State to carry out, will ensure the true independence of the HSSIB, and that patient safety improvements can be made across the whole health and care sector.

3.3 NHS Improvement publishes organisation specific patient safety incident reports which set out the number of patient safety incidents reported by each NHS trust.[13] This data could be a helpful tool for the HSSIB to use when assessing patterns of harm. By investigating common themes that cause, or are suspected of leading to patient safety incidents, the HSSIB - when producing and disseminating learning from their investigations - can ensure that their investigations benefits patient outcomes on a bigger scale and therefore increasing trust among the public.

4. Creating a culture of learning and reflective practice

Duty of Candour

4.1 We strongly support informing patients when things have gone wrong as an essential part of an open clinical culture that respects the autonomy of the patient. Nursing staff who adhere to the Duty of Candour at the time of a mistake, but then in due course, reflect further on the incident with the HSSIB, could leave themselves open to allegation that they have withheld information at the time an incident occurred. We require clarity that nurses and health care staff who share information as requested of them by the Duty of Candour process, and then subsequently within the 'safe space' during an HSSIB investigation, are not treated unfairly for disclosing or reflecting on practice in hindsight after the initial event took place. Any conflict of interest, or worry about sanctions among staff will be counterproductive to the welcome ambition to share learning from mistakes. Nurses and healthcare teams should be fully supported to disclose their concerns and reflect openly on the events that led to the incident, rather than fear immediate referral to the Nursing and Midwifery Council (NMC) or other regulators.

[13] NHS Improvement, *National Quarterly data on patient safety incident reports,* Accessed May 2018. Available here: https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports/

Conducting investigations within a safe space

4.2 We agree in principle with the adoption of a safe space in health care safety investigations. This should provide an additional space for rigor, objectivity and reflection which ultimately lead to improvements in patient safety. A workforce has to feel confident in raising concerns without fear of retribution, and this could be achieved by creating the NHS as a safety critical industry. Although front line individuals are accountable for their actions, there is a much greater understanding that work is contextual and it is the responsibility of the senior leadership to ensure work can be carried out effectively and safely. Safety critical industries, such as aviation, have a greater safety infrastructure such as safety management systems, richer understanding of the social-cultural factors of work and they integrate safety with workforce.

4.3 Currently, healthcare professionals have little trust that action will be taken when concerns are raised with employers. In line with the NMC code, there is an obligation on nursing staff to raise concerns when staffing levels are low, which 72% of respondents to our 2017 staffing for safe and effective care survey felt comfortable to do. However, worryingly, 44% of respondents believed that no action was taken to remedy the unsafe situation identified.[14] It is essential that the HSSIB investigations are objective, credible, and capable of enacting meaningful change.

4.4 The HSSIB must not undermine the processes already in place which allow staff to raise their concerns in a confidential and anonymous forum, or be relied upon as the only mechanism available to staff who wish to speak out. We would support any measures to share best practice and proposals for both formal and informal knowledge-sharing networks as a means of promoting quality improvement. The HSSIB should build on existing models of shared learning, and continue efforts to move away from a blame culture. We would like absolute clarity about how the different roles, such as speak out guardians, will work alongside the HSSIB.

Statutory exemptions for disclosing information

4.5 The statutory exemptions for the disclosure of information held by the HSSIB during an investigation must only be shared if there evidence of serious professional misconduct.[15] Confidential disclosure of information is absolutely critical to investigations revealing how incidents occurred, and for learning to recognise what needs to change. The guidance required to be published by the HSSIB which sets out their exemptions for sharing information must be developed with stakeholders. Statutory exemptions used by the HSSIB to determine which information declared in the safe space is passed to regulatory bodies, and others, must be carefully defined, easily understood by practitioners and not open to interpretation.

4.6 Safeguards should be put in place to ensure that individuals who give evidence in the safe space are not inadvertently put at risk by information shared with regulatory bodies. We welcome the commitment in section 33, to prevent learning shared within an HSSIB investigation being admissible for use in other proceedings without a Court order. Information gathered by the HSSIB should not be admissible to patients and families, as this may undermine the safe space principle. We ask for section 33 to be strengthened to ensure that the release of any report for use in other proceedings would only be requested in exceptional circumstances.

4.7 The Bill refers only to professional misconduct which is considered serious by the investigations team at the HSSIB. The definition of serious professional misconduct is missing. We would suggest that a definition of serious professional misconduct is behaviour that presents a clear, continuing and significant risk. It is crucial to us that there is greater clarity and a shared understanding about what constitutes professional misconduct by all involved in investigations. Without that, health care staff may act defensively, and the benefits of safe space lost. Health

[14] RCN, *Safe and effective staffing: Nursing against the odds,* 2017. Accessed May 2018, Available here: https://www.rcn.org.uk/professional-development/publications/pdf-007025

[15] Department of Health and Social Care, *Fact Sheet 5, The Draft Health Services Safety Investigations Bill - duty of cooperation,* 2017. Accessed May 2018, Available here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/644182/HSSIB_duty_of_cooperation_fact__sheet.pdf

care staff must be explicitly informed before their involvement with the HSSIB, of the possibility that information they supply could lead to a referral to their regulator. Any referral to a regulatory body should be signed off by a senior official within the HSSIB, and if a referral should occur, the individuals involved must receive a copy of any information shared. The safe space will only work effectively if frontline staff feel that they can reflect on practice in the confidence that only activity relating to the most serious professional misconduct will be disclosed.

5 Accrediting NHS Trusts to conduct investigations

5.1 We have serious reservations about NHS Trusts or any independent or private health care providers being granted powers to conduct their own internal investigations, and how this would occur. Under section 23(a), the Bill also states that an NHS Trust who has achieved accreditation to conduct external or internal investigations, 'may do anything that is necessary' to conduct the investigation. If health care settings were able to investigate neighbouring settings, this may lead to a breakdown of positive working relationships and disrupt the vision to achieve integrated health care. For this reason, accreditation should be taken out of the remit of this Bill, and put forward as a separate matter for parliamentary scrutiny.

About the Royal College of Nursing
The Royal College of Nursing is a professional body and trade union representing over 430,000 registered nurses, midwives, nursing students, health care assistants and nurse cadets. Our members work in a variety of hospital and community settings in the NHS and independent sector.

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