Written evidence submitted by the Healthcare Safety Investigation Branch (NLR0037)

About HSIB

We conduct independent investigations of patient safety concerns in NHS funded care across England. Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or the potential for harm to patients. The safety recommendations we make aim to improve healthcare systems and processes, to reduce risk and improve safety. We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never seek to attribute blame or liability.

Introduction

The Healthcare Safety Investigation Branch (HSIB) became operational in April 2017 to undertake independent, professional patient safety investigations to aid system learning and reduce systemic risks, to develop standards and improve the quality of local patient safety investigations, and to improve the involvement of families and patients throughout investigations. In April 2018, we also become responsible for undertaking all local trust maternity investigations that met the Royal College of Obstetrics and Gynaecologists' Each Baby Counts criteria as well as all maternal deaths. The core purpose of the maternity investigations programme is to:

- undertake a consistent standard of high quality, independent patient safety investigations that offer meaningful involvement of patients and families,
- provide clear and full accounts of what happened and answer to the best of our ability, families' questions, and
- provide insight into the local and systemic risk factors that contribute to harm in the provision of maternity care in the NHS to support trusts and staff to reduce the likelihood of recurrence.

Since April 2018 HSIB has completed over 50 national investigation reports and themed learning reports on wide ranging patient safety topics, and more than 1800 maternity investigation reports provided to the family and the local trust. Collective themes are fed back to the trusts, regionally and nationally.

Our responses to the Committee's call for evidence is informed by learning from both the national and maternity investigations programmes.

Inquiry questions

1. *What are the key changes the Government should consider as part of its review of clinical negligence litigation? In particular: What role could an expanded Early Notification Scheme play in improving transparency and efficiency system-wide?*

Harmed patients and families may seek to pursue the medico-legal route for several reasons, including to:

- obtain a meaningful apology

- have access to all the information about the incident to find out the truth of what occurred
- ensure there was learning so that the same incident do not happen to others
- gain resolution in the form of closure and recognition that harm had occurred
- see individuals 'held accountable' for the event
- obtain financial recompense for loss or costs resulting from an incident.

For harmed babies in maternity cases, if a family does not get answers to their questions through the investigation process, they may look to the legal system to get those answers. HSIB has undertaken a significant amount of work with NHS Resolution to reduce the burden of reporting for trusts and ensures a safety investigation has been completed prior to NHSR taking forward further consideration of financial renumeration. The changes to HSIB criteria for maternity investigations and NHSR reviewing cases in relation to outcome has supported families with the greatest need to be prioritised for investigations to ensure that they have clarity about the reasons why things went wrong, and to reduce the need for clinical negligence litigation to be pursued by harmed families.

HSIB and NHSR are jointly responsible for Safety Action 10 of the Maternity Incentive Scheme for trusts, which requires trusts to report 100% of qualifying cases to the Early Notification Scheme. As part of this work and the safety surveillance work, HSIB works with and shares information appropriately, within the context of our operational our independence, with NHSR, CQC and NHSEI and other national organisations that are working to improve maternity safety.

By sharing intelligence appropriately, national agencies can provide appropriate support targeted at the trusts where risks are emerging or elevated. Most importantly it enables identification of themes that require system level change and are outside of the ability of individual trusts to influence.

The Early Notification Scheme should be the means by which the length of time and legal expense required to reach settlement and compensation is reduced. Since it can take some years for the full extent of birth injury, and the financial and practical implications of this to the family, to be fully understood – any ENS must ensure that patients and families are not inadvertently penalised or disadvantaged financially for the true costs of care, by expedited settlement processes. Expanded ENS approaches also have the potential to produce information that can support system-wide intelligence about patient safety. This should not add to reporting burden for trusts.

2. *To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?*

In the current clinical negligence system claimants, particularly in birth injury cases, seek to prove negligence of clinical practice of an individual person but this does not take into account the multiple systemic factors which increase the risk of errors in the delivery of care. This can dissuade healthcare professionals from speaking openly, because they can be blamed for consequences that have resulted from systemic pressures.

HSIB investigators generally experience NHS staff as open, honest and willing to share as much as they can about the circumstances of a patient safety incident. However, we have found, on occasions, that clinicians have been unwilling to speak candidly because they have been afraid of the implications of doing so, or because they themselves have been too distressed and traumatised as a result of the incident (which is a well-recognised phenomenon). These clinicians often report fearing blame by their trust, their professional regulator or even legal authorities. Also HSIB understands

from medical indemnity providers that medical professionals often experience a coroner's inquest as feeling like a fault-finding process.

3. *How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?*
4. *What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?*

Safety science has established that actions to prevent harm are far more effective if they are oriented towards systems, processes and the wider environment in which clinicians work rather than at individuals. As long as a criminal negligence process focuses on the actions of individual clinicians, even the learning and commitment to change as a result of action will likely be focused erroneously on individuals rather than the systemic factors.

To ensure that system learning can take place, cases would need to involve trained safety investigators to understand the impact that systemic factors had upon the decision making and actions of healthcare professionals at the time. Where it can be established that systemic risks and organisational factors contributed to the patient safety incident then organisational and system level responsibilities to address the risks could be considered, alongside any needed financial compensation to support the harmed patient and family.

5. *How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?*

Amongst the reasons that claimants give for pursuing litigation are difficulty accessing details of what has happened, a lack of confidence in the independence and accuracy of local investigations and a feeling of exclusion from the investigation process. HSIB's investigation process seeks to include patients and families from the outset, which happens in over 90% of cases. Feedback from patients and families particularly values this involvement and that HSIB's investigations are independent and carried out by trained, professional investigators.

HSIB's maternity investigations have the greatest potential to reduce litigation costs and support trusts to be open and transparent with families. Feedback from families who have decided not to pursue litigation has been that this is because they have been satisfied with the information, findings and recommendations of their HSIB maternity investigation. HSIB does not have any enforcement role, and no remit to ensure actions are delivered by trusts. However, HSIB investigators can feed back to trusts their observations of whether recommended safety actions have been effectively implemented or need to be adapted. HSIB's quarterly review meetings with trusts help to ensure that senior leaders including the trust board, maternity safety champion, CCGs and regional chief midwives are aware of HSIB's findings and recommendations.

HSIB undertakes other investigations where the scope to influence and improve local investigations is more indirect. This is achieved through the learning that is shared during an investigation with the local organisation that may support rapid actions to reduce a safety risk. HSIB national investigations reports will often include safety observations about actions that local providers can

take to help mitigate a safety risk. HSIB's national themed learning reports have provided detailed guidance about how to undertake effective patient and family engagement during an investigation, and how to effectively and appropriately support staff who are involved in patient safety incidents.

Education of local providers to recognise systemic factors which contribute to harm, along with systems of effectively working with families to communicate learning and responses, will negate some of the early catalysts in pursuing clinical negligence claims. HSIB's award framework in Safety Investigation will offer training and mentoring for local investigators in conducting independent patient safety investigations, along with clear standards to support training for improved local safety investigations. Educating local providers to recognise systemic factors which contribute to harm, and how to communicate effectively with families about investigations and how and why harm occurs, will help to negate some of the early catalysts that contribute to a patient or family's decision to pursue a clinical negligence claim.

6. What legislative changes would be required to support these changes?

It is important that the powers for the HSSIB which are set in the Health and Care Bill are implemented, including the power to provide protection for witness statements given to HSIB investigators (so called "safe space"). Additional powers within the Bill to allowing access to clinical records and requiring trusts and other bodies to collaborate with HSSIB investigations will help gain the confidence of patients, families and staff that HSSIB will conduct professional investigations focussed on learning and improving.

The establishment of HSSIB as an independent, professional investigation body will allow for changes to legislation to provide appropriate financial compensation for patients and families without the requirement to prove clinical negligence.

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