Independent Patient Safety Investigation Service Expert Advisory Group – Call for Evidence

Overview

In July 2015 the Rt. Hon Jeremy Hunt MP, Secretary of State for Health, announced the Government's intention to create a new independent patient safety investigation service (IPSIS). Operating from April 2016, IPSIS will offer support and guidance to health and care provider organisations on investigations into serious patient safety incidents, and carry out certain investigations itself.

An Expert Advisory Group (EAG) has been set up to make recommendations on how the new investigation service should work.

The EAG will make recommendations on the scope, governance and operating model for IPSIS. It will draw on the expertise of its members in patient safety, healthcare and investigation and seek the views of and evidence from a broad range of stakeholders, including service users, those who have experience of investigations and staff.

The EAG comprises a core group of individuals and will meet fortnightly. It will be examining evidence and taking views from those with an interest on five inter-related themes. These are detailed in full in its terms of reference and the questionnaire. In summary, they are:

- Independence, governance and accountability
- Engagement and transparency
- What IPSIS should investigate
- Supporting improvement and learning
- People, skills, operation

The Expert Advisory Group seeks views and evidence from service users, families, clinical staff and anyone else working in related fields with an interest in patient safety and investigation. This will assist its consideration on all of the above areas, and any other issues relevant to the design and operation of IPSIS.

The views shared as part of this Call for Evidence will feed into the work of the Expert Advisory Group. It is not a formal consultation. Further engagement, including face-to-face events and opportunities, will also be used to get views and evidence.

Introduction

1. What is your name?

Name: Health and Care Professions Council (HCPC)

2. What is your email address?

Email: policy@hcpc-uk.org

3. Would you categorise your response as from

Individual

Public sector organisation – the Health and Care Professions Council

Charitable/voluntary sector

Private sector - Healthcare

Private sector - other

What the Expert Advisory Group would like your views on

The Expert Advisory Group is looking at a number of questions across five inter-related themes. These are:

- Independence, governance and accountability
- Engagement and transparency
- What IPSIS should investigate
- Supporting improvement and learning
- People, skills, operations

There is no need to answer all questions against all themes, unless you wish to do so. For those which you do answer it would be helpful if you could provide any additional information or evidence to support your answers wherever possible. If you wish to send us supporting documentation please email as an attachment to IPSIS.SEC@dh.gsi.gov.uk

Only information that is relevant will be accepted. The review team will consider views and evidence in addition to responses to the questions below that are deemed to be relevant. The review team is unable to respond to individual cases or consider complaints.

Independence, governance and accountability

4. What should independence in relation to this investigation function mean?

We welcome the introduction of a service to offer support and guidance to health and care provider organisations on investigations into serious patient safety incidents and to carry out certain investigations itself. However, it is difficult to comment fully on these proposals in the absence of further information or more detailed proposals covering the proposed scope, remit, operations and role of the Independent Patient Safety Investigation Service (IPSIS) including whether it will operate on an England only or UK-wide basis.

We would welcome clarity on what the IPSIS would classify as 'serious patient safety incidents' and the circumstances whereby the IPSIS would launch an investigation itself. This is particularly pertinent in order to avoid a potential duplication of work between different organisations including regulatory bodies who operate in a health and social care setting. This issue is explored in more detail below.

There is a wider question of how the IPSIS should be funded including if it was self-financing would this aid its independence and impartiality in carrying out its work. The IPSIS would also need to have in place effective governance structures to ensure that the organisation is robust and able to carry out its functions effectively.

5. What are the conditions necessary for this service to secure and maintain its independence and impartiality? How can these conditions be achieved?

Among other things, we think that in order to ensure that the IPSIS secures and maintains its independence and impartiality it will need to build trust with relevant stakeholders. This has many facets: the IPSIS will need to build trust with service users, carers and families to ensure that concerns and incidents are effectively investigated; and trust with the health and care provider organisations that the IPSIS will carry out its duties effectively and impartially. The IPSIS should strive to ensure that it has the full facts available to it when carrying out its work and that it acts impartially at all times. There is also a question of whether IPSIS should be empowered to compel evidence from individuals or organisations, in order to carry out its work effectively similar to the statutory powers which currently exist for many regulatory bodies when handling and investigating complaints.

6. What are the necessary accountability arrangements to ensure this investigation service maintains its independence and impartiality?

We have no specific comment to make on this issue.

7. What are the necessary internal and external governance arrangements to ensure this investigation service maintains its independence and impartiality?

We have no specific comment to make on this issue.

8. What are legal and other implications for aligning with and supporting existing and developing statutory bodies such as coroners, regulators or medical examiners?

It is paramount that a good working relationship and information exchange (such as through a memorandum of understanding, where appropriate) takes place between the IPSIS and other statutory bodies such as regulators. However as referred to above, it is particularly important that the establishment of the IPSIS does not create unnecessary duplication of work being carried out by regulatory bodies and/or IPSIS. Key questions need to be considered including a clear delineation between the remit of the IPSIS and the health and care professional regulators when handling and investigating different complaints and concerns. Professional regulators already investigate fitness to practise (FTP) complaints received against individual health and care professionals. Similarly the interaction between the IPSIS' operations, role and remit; and the service regulators such as the Care Quality Commission (CQC) needs to be considered. For example, if a complaint was being investigated about multiple individuals in the same Trust how would IPSIS handle this? Would they investigate the concern themselves; pass it on to the service regulators or the relevant professional regulators (or a combination of all three)? What if the different bodies reported very different outcomes to this issue? There is also the need to consider the impact of a number of different investigations running parallel including the impact on patients and on the health and care professionals and / or services being investigated.

Engagement and transparency

9. How can the function make sure patients, their families, carers and healthcare staff feel supported when things go wrong, and have the confidence to act appropriately? Are there any other elements that could be introduced to ensure the function is valued and credible?

It is important that the IPSIS works effectively with its stakeholders (including service users, their families, carers and healthcare staff) to support them in raising and reporting relevant concerns. The IPSIS should strive to work effectively with its stakeholders to explain what types of incidents or concerns it can investigate; its investigation process; and the resulting actions or recommendations it can make (including monitoring procedures). The IPSIS should also provide adequate information to its stakeholders via brochures, website content and in correspondence to them. It is also important that the IPSIS should seek feedback from its stakeholders which could be used to identify areas for further improvement.

10. What information should IPSIS be sharing and putting into the public domain?

IPSIS should publish as much of its conclusions and findings in the public domain as possible. Where appropriate certain information such as sensitive personal information should be anonymised. Other statutory bodies such as regulators regularly publish the outcome of their fitness to practise (FTP) processes including final hearings on their websites and / or issue press releases, as it is in the interest of members of the public to have this information. It is also in the public interest that if a body such as a hospital Trust has recorded a number of serious patient safety incidents that this information should be made available to the public. Similarly it would be useful to know whether a

Trust (or similar organisation) had accepted the outcome and findings of an IPSIS investigation and had acted on this.

What should IPSIS investigate?

11. The service may respond to requests from providers or others to conduct investigations, and proactively identify incidents or concerns to investigate, what are the advantages and disadvantages of doing both or one or the other?

We do not have strong views about whether IPSIS should respond to requests to conduct investigations or proactively identify incidents to investigate, and it is difficult to comment without seeing more detailed proposals. However, as referred to above since there are a number of statutory bodies (including regulators) already operating in this area; IPSIS would need to communicate effectively with regulatory counterparts and others to ensure that there was no duplication of work in this area.

12. Given the scale of patient safety incidents in the NHS, the function could not hope to investigate all reported incidents. How should the new service prioritise the incidents or concerns required for investigation? What type of criteria could it apply?

The use of 'big data' (similar to the intelligence monitoring process undertaken by the CQC or information provided by the Health and Social Care Information Centre) may aid the IPSIS to identify trends and prioritise the most serious or wide-ranging patient safety incidents. Given the scale of patient safety incidents in the NHS there is a need for the IPSIS to consider developing an appropriate threshold for carrying out its investigations. For example, IPSIS could record the number of complaints received about a particular Trust which would require the recording of key data including geographical location. If there was a high number of concerns received in a particular geographical setting or by a particular provider (or organisation) this could possibly trigger an IPSIS investigation. In England this could involve liaising with the CQC or other regulators. Similarly where information came to light which would signal a concern which should be investigated by another appropriate body such as individual regulators this information should be passed on.

13. Should there be legal powers or legislation for the immunity of those giving evidence?

It is difficult to comment fully on this issue in the absence of further information or more detailed proposals. It should be noted that professional regulatory bodies do not have this power in their legislation. Also further clarification is required with regard to the scope of this immunity including ensuring that it would not adversely impact on the FTP processes and proceedings launched by a professional regulatory body either pre or post any IPSIS investigation and / or resultant criminal proceedings.

Supporting improvement and learning

14. Should the function develop and/or recommend solutions or be limited to undertaking and reporting the findings from investigations?

Arguably the IPSIS would function more effectively if it made recommendations for solutions to any problems identified and if these were binding on the organisations in question in order to embed good practice and try and avoid a reoccurrence of a particular patient safety issue. If the IPSIS' functions are limited to undertaking and reporting the findings from investigations there is more risk that the in the absence of changes within the organisation, the patient safety issue could reoccur.

15. What can be done to ensure this support results in longer-term, sustained improvement in the quality of investigations and reduces or prevents incidents happening again? Should this this be monitored and, if so, how?

We understand that the reference to 'sustained improvement in the quality of investigations' in the above question relates to those carried out internally by health and care provider organisations. As referred to above, consideration should be given to ensuring that the findings of a particular investigation carried out by the IPSIS are binding on an organisation. The IPSIS should also consider what follow up or monitoring procedures would be appropriate for an organisation which underwent an investigation to ensure that there is sustained improvement over the longer term. The true test of whether this action has been effective will be evident if IPSIS receives similar complaints in the future and if the same issues arise within that organisation.

16. Should the implementation of recommendations made by the national function, either as a result of individual investigation findings or wider insights be monitored and, if yes, how could this be achieved?

Ideally the results of individual investigation findings or wider insights should be monitored. This may be a resource intensive exercise but would be worthwhile to ensure compliance by the organisations in question in relation to the IPSIS recommendations and / or findings. Further consideration should also possibly be given to the role of service regulators such as the CQC (and its equivalent in other parts of the UK) in monitoring an organisation after an IPSIS investigation has taken place and relevant recommendations and / or findings have been made.

People, skills, operations

17. What are the skills and capabilities required for those undertaking investigations and working in the function more widely?

We have no specific comment to make on this issue.

18. **How can the function and its staff complement and support the wider patient safety learning and leadership functions?**

    This could be achieved by working effectively with other relevant stakeholders to raise awareness of key findings and identify best practice. These include professional regulators, service regulators, education and training providers, and service user representative organisations such as Healthwatch England.

19. **Is there any risk of duplication with the processes for handling complaints and whistleblowing both nationally and at the local level? If so, how might these be overcome?**

    Yes. Please see our response to questions 8 and 12. We think this could be overcome by clarifying the scope, purpose, remit and role of the IPSIS. This is very important in a time where resources are scarce. Appropriate information sharing between IPSIS and other stakeholders such as professional and service regulatory bodies would also be an important consideration in order to prevent a risk of duplication including in complaints handling.

20. **What other systems, processes or organisations exist that may play a similar role to IPSIS? Are there any risks of duplication and if so how may these be overcome**?

    As referred to above professional and service regulatory bodies also have a role to play here. The answer to the second question is yes. Please see our response to questions 8, 12 and 13. This issue could be overcome by clarifying the scope, purpose, remit and role of the IPSIS and / or putting in place appropriate information sharing agreements and procedures with relevant stakeholders.

Any other comments?

21. **If you have any other comments on the scope, organisation or function of IPSIS that you would like to submit as part of this Call for Evidence for the Expert Advisory Group to consider, please do so here (stating what aspects it relates to).**

    We have no specific further comment to make on the call for evidence. However, we would welcome further discussions and consultation between the Expert Advisory Group and professional regulatory bodies prior to establishing IPSIS to ensure that the issues referred to above are addressed satisfactorily.

Further information

As this consultation and listening process progresses the names of individuals or organisations providing responses will be listed on the following website to acknowledge their contribution to this important piece of work

https://www.gov.uk/government/groups/independent-patient-safety-investigation-service-ipsis-expert-advisory-group. [DF1]

You are about to submit your response. By clicking 'Submit Response' you give us permission to analyse and include your response in our results. After you click Submit, you will no longer be able to go back and change any of your answers. Thank you for your views.