Jog Hundle and **Stuart Craig**, partners at national law firm Mills & Reeve, ask whether HR processes enabled Ian Paterson's unusual surgical character to 'hide in plain sight'?

The Paterson Inquiry report

HR processes and patient safety

There is an ongoing focus on ways to improve safety culture in healthcare and the role of HR processes - an issue covered in detail in the recent independent inquiry report on Ian Paterson, a former consultant breast surgeon at the Heart of England NHS Foundation Trust chaired by the Rt Revd Graham James. Paterson was convicted in 2017 of 13 counts of wounding with intent and three counts of unlawful wounding. He was jailed for 20 years.

For the purposes of this article, we explore some of the HR issues raised by the findings of the Paterson report from Freedom to Speak Up concerns to disciplinary matters.

The inquiry revealed that concerns regarding Ian Paterson were dealt with 'under HR processes and not as a patient safety issue' and did not receive 'significant attention' from the hospital board.

The inquiry was surprised at this 'lack of curiosity' on the part of the board, given that Paterson was the subject of many reviews. This lack of curiosity was to have far-reaching and devastating consequences.

It is clear that getting the right levers at a national and local level to help support a safe healthcare system is still work in progress - and one aspect of that is the Freedom to Speak Up agenda.

The report describes this as 'getting the basics right' and implementing existing systems across both the independent healthcare sector and the NHS. It is worth noting that current guidelines for training on Freedom to Speak Up is limited to NHS boards and does not include the independent sector.

According to the inquiry HR processes, employee confidentiality 'stood in the way of patient safety' allowing the disgraced surgeon to continue to operate despite clinical colleagues raising concerns about his professional competence and conduct.

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The inquiry said colleagues were 'genuinely fearful' about voicing concerns with many reporting bullying and repercussions after raising concerns.

Of the 13 recommendations made by the inquiry, a number focus on improving how hospitals should respond to adverse incidents, from openness when things go wrong to escalating complaints to an independent body for the investigation of healthcare professionals' practice.

The inquiry is unequivocal in its recommendation that when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, 'any perceived risk to patient safety' should result in the suspension of that healthcare professional.

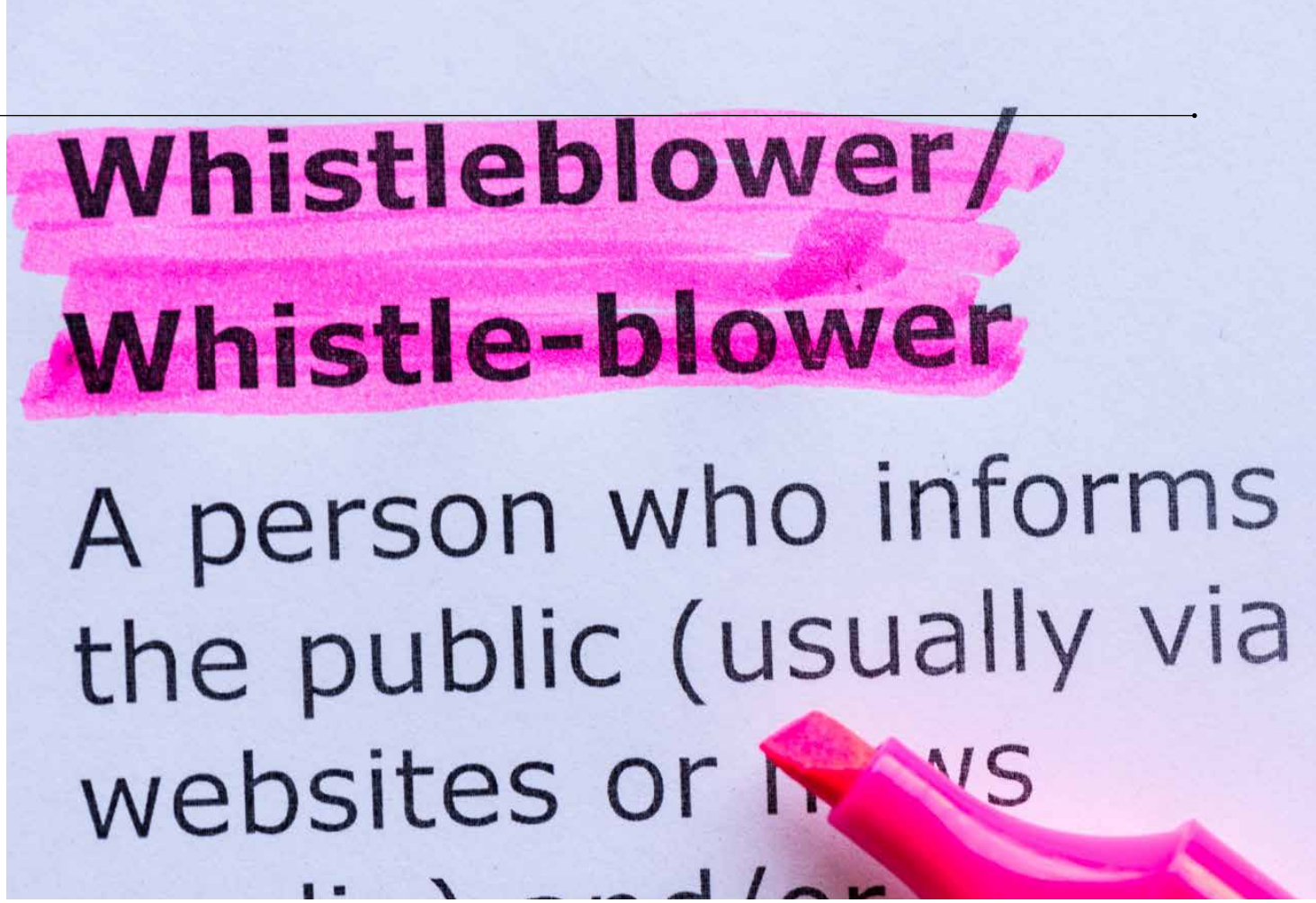
However, it is well established that good employment practice, as well as the majority of disciplinary policies, provide that suspension should be a matter of last resort.

This does highlight that restricted practice should, therefore, be more actively explored than it is currently. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.

HR processes supporting disciplinary and or capability investigations, need to focus on clear terms of reference for the investigation and the prompt completion of the investigation within an appropriate timetable.

Investigators should ensure that they have the time and skills to devote to the investigation, and ought to be released from some of their day-to-day duties to give the investigation proper focus to ensure timely completion of the investigation report.

The current pandemic has reinforced the value and ease of holding virtual meetings with the aid of technology, which should assist with ensuring



investigative processes are not long-drawn-out affairs and that meetings can still take place even if the practitioner concerned cannot be in the same room as the investigator or their representative.

Many independent sector providers have been working to improve practices in anticipation of this report – and in October last year, the Independent Healthcare Providers Network published the *Medical Practitioners Assurance Framework*, which has sought to address a number of the inquiry's recommendations. But whether the new framework focusses on the 'battle', as the King's Fund put it, against serious quality failures in healthcare to provide sufficient reassurance to the government remains to be seen.

The framework focuses on:

- Being clear about the individual respective responsibilities of medical practitioners
- The boards and senior leaders of providers reinforcing that it is the patients who are the priority for care delivered in the independent sector

It also covers the respective governance responsibilities of commissioners and NHS organisations whose employed medical practitioners also provide treatment in the independent sector.

The foreword emphasises that oversight of medical practitioners is an area where the independent sector and the NHS should work together to improve clinical governance through transparent, evidential assurance on the quality of an individual medical practitioner's practice.

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The inquiry makes a specific recommendation on enhanced information: a single repository of consultant data across England, setting out consultant practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently.

This data should be accessible to the public and mandated for use by managers and healthcare professionals in both the NHS and independent sector.

This report is yet another clarion call for the need to build on the safeguards now in place since Ian Paterson's actions first came to light – and to challenge difficult workplace cultures, encourage transparency and collaborative working to protect patients.

It is clear that health and safety cultures will only improve if, in addition to establishing strong Freedom to Speak Up environments, HR processes are seeing as fully facilitating, supporting and strengthening such cultures, rather than acting as barriers. We would encourage you to examine your disciplinary and capability processes and practices to ensure that they achieve this goal.