**APIL briefing: Part four of the Health and Care Bill – The Health Services Safety Investigations Body – House of Commons Second Reading – July 2021**

## The need for a patient safety body

In 2019/20, there were 637,077 reported patient safety incidents resulting in harm throughout the NHS in England – an average of 1,745 every day. Of these incidents, 5,919 resulted in severe harm (an average of 16 every day) and a further 4,241 resulted in death (an average of 12 every day)[1]. Every one of these incidents represents a patient or family who have suffered because something went wrong when it should not have done.

It is vital that those who have suffered are given a full explanation of what happened, why it happened, and an apology. It is equally important for health services to learn from what went wrong, and ensure it never happens to another patient.

While the aim of the Health Services Safety Investigations Body (HSSIB) is laudable, a culture of secrecy is inevitable if proposals to allow the HSSIB to withhold information are implemented. Patients and families may not receive the answers they need to be able to move on after a needless incident, and health services may never learn from their mistakes.

## Lack of openness and transparency

The HSSIB has been championed by the Government as something which will "promote transparency and openness…"[2], yet the Bill allows HSSIB to withhold information from patients and their families.

[1] NRLS national patient safety incident reports: commentary, page 12 https://www.england.nhs.uk/wp-content/uploads/2020/03/NAPSIR-commentary-Sept-2020-FINAL.pdf

[2] Draft Health Service Safety Investigations Bill, page 4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645961/Draft_bill_health_service_safety_investigations_bill.pdf

Clause 106 of the Health and Care Bill says “the HSSIB, or an individual connected with the HSSIB, must not disclose protected material to any person”. Subsection 2 defines “protected material” as any information, document or equipment or other item which is held by the HSSIB, or an individual connected with the HSSIB, for the purposes of the HSSIB’s investigation function, and which relates to a qualifying incident (whether or not investigated by the HSSIB) and has not already been lawfully made available to the public.

Allowing the HSSIB to withhold information from those who have been harmed undermines the Government’s previously stated commitment to openness and transparency. We know from the experience of our members that sometimes the only thing people want after an incident is a full explanation of what went wrong. An injured patient or a bereaved family may never be able to put their lives back together if all the information about what went wrong is not shared openly.

When someone is injured, healthcare professionals must abide by the duty of candour, which was introduced by the Government. As part of this, they must:

- Tell the patient (or, where appropriate, the patients’ advocate, carer or family) when something has gone wrong
- Apologise to the patient (or, where appropriate, the patient’s advocate, carer or family)
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain fully to the patient (or where appropriate, the patient’s advocate, carer or family) the short- and long-term effects of what has happened[3].

A prohibition on disclosure of information is in direct contradiction to this duty of candour, which was introduced to create a more open and transparent NHS.

### More cost and delay

There will be occasions when patients or their families decide to take legal action against an NHS Trust after an incident. A prohibition on the disclosure of information will, however, create additional barriers to litigation, cause delays and increase costs.

[3] https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand____pdf-61540594.pdf

For a solicitor to know if a legal claim has merit, he must conduct initial inquiries, which includes reviewing a serious incident report. This will provide a contemporaneous note of the recollections of staff after an incident which may not be available from other sources, such as the patient's medical notes. This report, which will provide a full account of the incident, allows a decision to be made as to whether a claim can or should be pursued.

At present, a serious incident report is disclosed before a legal claim has been issued. If the prohibition on disclosure of information is introduced, and the necessary information is not obtained before a claim is issued, potentially negligent failings may not come to light. A case that should be pursued may not be, which will deny an injured person justice and an opportunity to receive much-needed compensation.

Schedule 14 of the Bill does allow a solicitor to apply to the High Court for an order for any protected material to be disclosed. The problem is that the requirement to apply for a High Court order will cause a delay in a legal claim, and increase the costs involved with the case. This undermines the ongoing work by the Department of Health and Social Care to reduce the cost of legal claims against the NHS.

## About APIL

The Association of Personal Injury Lawyers (APIL) is a not-for-profit campaign group which has been committed to injured people for more than 30 years. Our vision is of a society without needless injury but, when people are injured, they receive the justice they need to rebuild their lives. We have more than 2,800 members who are committed to supporting the association's aims, and all are signed up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives, paralegals and some academics.

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