Department of Health

Providing a “safe space” in healthcare safety investigations

A response by the Association of Personal Injury Lawyers

December 2016

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 20-year history of working to help injured people gain access to justice they need and deserve. We have around 3,500 members committed to supporting the association's aims and all of which sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction
APIL will always welcome steps to improve learning and prevent repeat incidents within the healthcare system. We fail to see, however, how the "safe space" as proposed in the Department of Health's consultation would assist with improving the learning culture, or how it sits with other measures already introduced to create a more open and transparent NHS, i.e. the duty of candour. Far from encouraging staff to be open and honest to patients and their families about what has gone wrong, the proposed "safe space" provisions will be a retrograde step, encouraging secrecy and a closed culture within NHS Trusts.

We do not agree that "safe space" should apply to any investigation where there has been harm, including those investigations carried out by HSIB.

Q1) Do you consider that the proposed prohibition on disclosure of investigatory material should apply both to investigations carried out by HSIB, and to investigations conducted by or on behalf of NHS Trusts, NHS Foundation Trusts and other providers of NHS funded health care?
HSIB investigations
We accept that HSIB investigations can be seen as analogous to those carried out by the Air Accident Investigation Branch (AAIB), i.e. limited in number and resulting from systemic failures that have affected or have the potential to affect a large number of people.

However, one of the principles of HSIB is transparency, with a requirement that the board acts as "an exemplary model of openness and transparency, including genuine engagement with patients and their families throughout the investigation process, from start to completion". How can this requirement can be complied with if a "safe space" is implemented which allows information to be hidden away from patients and their families? A systemic issue that causes harm to a wide number of people would be exactly the scenario where there should be open disclosure. The only suitable investigations for a "safe space" to be implemented are those HSIB investigations which involve a near miss, but no actual harm. In this instance, a safe space may help to encourage learning, to ensure that the near miss does not result in harm in the future.

All NHS investigations
The logic of extending "safe space" from Air Accident Investigations to *all* NHS investigations is particularly flawed. There were 194 correspondence investigations and 32 field investigations carried out by the AAIB in 2015. Each of these affected or had the potential to affect a large number of people – there is always the possibility of a manufacturing or design fault that, once identified, will have consequences for other aircraft. Applying the same "safe space" provisions to all NHS investigations, would require 30,000 safe spaces to be created each year[1], and each one is likely to involve an incident affecting one person. These investigations are not analogous to those carried out by the AAIB.

Effects of being unable to obtain serious incident report pre-issue
An NHS wide roll out of "safe spaces" will also create barriers to obtaining all necessary evidence to proceed with a claim where negligence has occurred. Serious incident reports are a vital part of claimant solicitors' initial inquiries, providing a contemporaneous note of the recollections of staff after an incident which cannot be extracted from notes, and providing a full account of the incident and allowing a decision to be made as to whether a claim can or should be pursued. At present, the serious incident report is disclosed on a pre-issue basis - in 2015, the Pre-Action Protocol for the Resolution of Clinical Disputes was amended to set out that a claimant's request for health records could include documents created in relation to any adverse incident, notifiable safety incident or complaint. If "safe spaces" are introduced NHS-wide, and the necessary information is not obtained pre-issue, potentially negligent failings may not come to light and a case that should be pursued may not be, leading to a denial of access to justice and a failure to bring those

[1] The consultation states that there are 30,000 serious incidents reported annually.

responsible for the negligence to account. Early disclosure of serious incident reports can also avoid very expensive and lengthy liability investigations in cases where there has been clear negligence. It also provides an opportunity for early collaboration and intervention by way of rehabilitation.

There would also likely be a rise in unmeritorious claims. Without the opportunity to view the serious incident report pre-proceedings, the claimant will be unable to properly assess the merits of the case and may decide to pursue a claim regardless. If the claimant had been able to obtain the serious incident report early on, this may have contained information that would make it clear that no negligence has occurred and they would have then decided not to bring a claim.

Increased costs due to requirement to apply for court order
The requirement to apply for a court order for the disclosure of "safe space" investigation reports will also add an extra layer to the process, increasing costs. This is counter to the current moves to reduce costs in the clinical negligence claims process. Requiring a court order in every potential case so as to obtain vital information that is currently disclosable on request will lead to substantial delay and costs and impose a further strain on the court service.

Duty of candour cannot be complied with
The consultation acknowledges throughout that there is an issue with a lack of openness and a "closed culture" within the NHS. We fail to see how the "safe space" provisions as currently proposed will allow for the statutory duty of candour - which was introduced following recommendations from the Francis Report to improve openness and transparency within the NHS- to be complied with. Roughly 10 per cent of incidents per year[2] reach the threshold for the statutory duty of candour to kick in. The statutory duty of candour requires registered persons to act in an open and transparent way with patients and their families when there is an incident that results in moderate to severe harm, prolonged psychological harm or death[3]. Being open and transparent requires the registered provider to give a notification of the incident in person, provide an account of the facts, advise the relevant person what further inquiries are appropriate, and to apologise. Creating an environment where information from an investigation is not automatically shared with the patient and their family cannot be in line with this duty, and will be contrary to the open and transparent environment that the duty is intended to create.

We suggest that instead of rolling out the safe space provisions to all NHS trusts, the focus on an open and transparent culture should continue with further guidance on the duty of candour and a focus on ensuring that all trusts comply with this duty. Some members have reported a positive change in culture since the introduction of the duty of candour, including greater openness and a willingness to admit when things have gone wrong. This positive impact appears to vary from Trust to Trust however, so there is clearly more work to do to ensure that the culture change is applied throughout the whole of the NHS.

The safe space proposals seem to be an attempt at a short cut to the cultural change that has been identified as being required. There is no "quick fix" and focusing on educating people on the duty of candour, instead of introducing a provision to allow Trusts to hide information, will be far more effective in bringing about the change from a culture of blame to a culture of learning.

Q2) For those investigations undertaken by or on behalf of providers and commissioners of NHS-funded care, should the proposed prohibition on disclosure apply only in relation to

[2] There were 825,416 patient safety incidents between October 2014 and March 2015, and 5.3 per cent of these caused moderate harm, severe harm or death[2]

[3] The duty of candour applies where there has been a "notifiable safety incident" Regulation 20(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. A notifiable safety incident is "any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that…could result in, or appears to have resulted in the death of a service user…severe harm, moderate harm or prolonged psychological harm to the service user." – Regulation 20(8) of the 2014 Regulations.

investigations into maternity services in the first instance or should it apply to all investigations undertaken by or on behalf of such bodies?
We state above why safe space provisions should not apply to any investigation where there has been harm, and fail to see why maternity services should be singled out. Issues with delay, added expense and contradictions to the duty of candour would apply in maternity cases just as in all other investigations.

Q3) Do you have any comments about the type of information that it is proposed will be protected from disclosure during healthcare investigations?
Safe space investigations should not apply to any investigation where there has been harm, for the reasons set out in answer to question one. We have no further comments on this question.

Q4) Do you agree that the statutory requirement to preserve the confidentially of investigatory material should be subject to such disclosure as may be required by High Court order?
For the reasons set out in answer to question one, we do not agree with the "safe space" provisions as proposed. However, if "safe space" does apply, we agree that the statutory requirement to preserve the confidentiality of investigatory material should be subject to disclosure as may be required by a High Court order.

Q5) Do you agree with the proposed elements of the test to be applied by the High Court in considering application for disclosure?
We believe that the safe space provisions should not apply to any investigation where there has been harm. If and where safe space does apply, the test to be applied by the High Court set out in the consultation document is vague. The test should be no more stringent than that for disclosure of material held by the AAIB.

Q6) Do you have any views on the proposed exceptions that would apply to the prohibition on disclosure of material obtained during investigations by the HSIB and by or on behalf of providers and commissioners of NHS service?
It is vital that the patient and their family are kept fully informed and that findings from all investigations, including HSIB investigations, are not withheld from them. The tone of paragraph 5.31 of the consultation appears to contradict what Jeremy Hunt told *Health Service Journal* on this issue in October this year. When questioned about the risk of safe space cutting across the duty of candour and leaving families excluded, Mr Hunt said "the first thing I have been absolutely clear about is that the safe space must involve families, so this is not about concealing the information from families". Paragraph 5.31of the consultation instead states that "there has been some suggestion that there should also be an additional exception [to safe space investigations] in relation to sharing information with patients and members of his or her family."

As stated above, the safe space provision as currently set out is contrary to the duty of candour. It is key that patients and their families are not kept in the dark about what has happened and the steps being taken to rectify the mistake and ensure that it does not happen again. For this reason, we do not agree that the safe space provisions should apply to any investigation where there has been harm, including HSIB investigations. If the safe space provisions are implemented, it is extremely important that cases where the duty of candour threshold is met are included as an explicit exception to the prohibition on disclosure. Otherwise, we fail to see how the duty of candour can continue to be complied with.

Q7) Do you have any views on where the bar should be set on passing on concerns to other organisations whose functions involve or have a direct impact on patient safety?
Q8) Do you consider that the exceptions proposed could undermine the principle of "safe space" from the point of view of those giving evidence to investigations?

Questions 7 and 8 provide an example of the tensions that will arise should a safe space be implemented. Doctors have an ethical duty to report concerns to the GMC. It is simply impossible for there to be a guaranteed safe space. As above, the culture of learning rather than blame should be created through an environment of openness and transparency, not secrecy.

It appears that the real driver behind the "safe space" proposals is the concern about whistle blowing and consequent disciplinary action. This is clearly an issue - highlighted by the consultation paper at 3.11, where it is stated that a 2015 NHS staff survey revealed that only 43 per cent of respondents agreed or strongly agreed that their organisation "treats staff who are involved in an error, near miss or incident fairly". If the focus is intended to be on employees and workers feeling less inhibited about raising concerns, those who should be kept out of the safe space are the employers, not the patient and their families. It is unclear how the proposals as currently drafted would actually protect employees of the NHS from disciplinary action should they speak out following an incident.

Q10) If you consider that the prohibition on disclosure should be subject to an exception allowing for the disclosure of certain information to patients and their families, what kind of information do you consider should be able to be disclosed in that context. And when would be a sensible, workable point for patients and families to have access to information – e.g. should they see a pre-publication draft report for comment?
The duty of candour should be fully complied with. Patients and their families (where a patient lacks capacity or has died) should be fully involved in the process throughout, with nothing withheld from them. Patients and their families should also be able to see and have input into pre-publication reports.

Q11) Do you see any problems in the requirement that investigatory bodies must apply to the High Court if they wish to gain access to information obtained during investigations by the HSIB or by or on behalf of providers or commissioners of NHS funded care?
Reforms to the coronial process within the Coroners and Justice Act 2009 mean that an inquest must now be completed within a six month time frame. This can already be tight, and will be even more difficult to comply with if there is now going to be an additional requirement that the coroner must apply for a High Court order to obtain information that is necessary to their investigation. This may mean that, in order to comply with the six month timeframe, the coroner's investigation is potentially rushed due to delayed disclosure; or that the time frame is not complied with and the bereaved family has to wait longer for answers.

Q12) Do you have any concerns about the use of the phrase "safe space" in relation to this policy; and, if so, do you have an alternative preference?
From the point of view of an injured patient, who wants nothing more than to find out what happened and to be reassured that lessons have been learnt, "safe space" may be inflammatory language, particularly as in some cases those protected by this space will have been negligent or guilty. "Safe space" may portray an image of immunity for those who should be brought to account.

Q13) Do you see any problems in exempting information obtained during healthcare investigations from access under the Freedom of Information and Data Protection regimes?
Not only should the information obtained during healthcare investigations not be exempted from the Freedom of Information and Data Protection regimes, healthcare investigations should specifically be **subject to** these regimes. Organisations such as Virgin and Care, who are commissioned to provide healthcare services by Trusts, are private corporations, and are therefore not subject to the Freedom of Information Act at present. All healthcare investigations should be accessible through the Freedom of Information Act, regardless of whether they are carried out by the NHS or a private contractor.

Q14) Do you agree that guidance, or an alternative source of support, should be developed?

As above, we do not think that safe space provisions should be extended to any investigation resulting from harm. We agree that guidance should be developed for staff, but that this should focus on other ways of ensuring that the culture of learning and openness is consistent throughout the NHS. At present, there are inconsistencies from trust to trust as to whether the duty of candour is complied with.

There should also be guidance to staff to demonstrate that where an investigation has taken place, this will be a learning exercise rather than carrying any employment ramifications. Fears of whistle blowing appear to be the main driver of the proposal to introduce “safe space”. These fears could be more effectively addressed by guidance and the publication of examples of positive outcomes following an investigation where everyone has been open and honest, and lessons have been learnt.

Q16) Do you have any concerns about the impact of any of the proposals on people sharing protected characteristics as listed in the Equality Act 2010?
Families should have all of the information in their relative's medical treatment and well-being.