Browne Jacobson

‘Safe spaces’ and improving quality - one step closer to a new investigative body in the public health sector

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Background

In December 2018, the Government published its response to the Report of the Joint Committee on the Draft Health Service Safety Investigations Bill, a bill which aims to establish an independent body to investigate patient safety incidents. This will have the overall aim to support system wide safety improvement and learning.

The Healthcare Safety Investigations Branch (HSIB) was set up in April 2016 to investigate serious patient safety incidents in England. Following this, the draft bill was published in September 2017, proposing to establish the Health Service Safety Investigations Body (HSSIB), as independent body to investigate patient safety in England. The Bill outlines the legislative powers that the HSSIB would have, in order to conduct effective investigations as an independent investigator in its own right.

The focus of the HSSIB would be to investigate incidents that have the potential to maximise learning throughout the healthcare system.

The Joint Committee was appointed to scrutinise the draft Bill in Spring 2018 and reported on the Bill in August 2018. The Government’s response was published in December 2018 and a link to the report can be found here.

Government’s response

The Government confirmed that they accept many of the Committee’s recommendations in full, although a small number of recommendations were not accepted.

Safe space

The provision of a ‘safe space’ is likely to be the most controversial recommendation in the Bill but this was supported by the committee. A ‘safe space’ in investigations would ensure that information provided to the new body (HSSIB) in connection with an investigation could only be disclosed in limited circumstances or by order of the court. This would allow NHS staff and others to contribute fully to investigations.

The policy to establish the ‘safe space’ is comparable to similar legal provisions for bodies that investigate air, rail and marine accidents. These investigation branches have had great success in using the safe space principles in achieving significant safety gains, which is hoped could be replicated in the health service.

The Committee advised that the HSSIB would need to engage with patients, families and their advocates in order to ensure that the safe space principles were widely understood by them. If was felt that the prohibition on disclosure should be clarified in public statements and

in the Bill itself. The Government has taken this on board.

The Committee felt quite strongly that the safe space principles should not apply to Trusts at a local level and should merely be used for HSSIB investigations. The Government agreed and confirmed that it will remove the provision of accreditation of NHS Trusts to carry out ‘safe space’ investigations from Bill. Instead one focus of the HSSIB’s role will be to improve local safely investigations and spread a learning of culture in the NHS.

The Committee also recommended that the safe space principle should be extended to allow prohibition of disclosure of documents provided for the purpose of promoting patient safety, which was accepted by the Government but that HSSIB could disclose some documents to the police, regulators and/ or Trusts in certain circumstances.

This clearly has implications for disclosure and inspection, should the incident lead to a clinical negligence claim/ inquest at a later date.

Coroners and safe space

The Committee recommended that it be made clear in the Bill that the safe space cannot be compromised, save in the most exceptional circumstances and that applies equally to Coroners. This recommendation takes a very firm line, even expressly stating that the inquest process should not become the 'back door' to obtaining safe space information. Whilst Coroner’s will still have access to all the information they are currently entitled to, this obviously represents an interesting change of direction in light of decisions like Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013] - link to the Chief Coroner’s guidance note is here.

Maternity investigations

A recommendation which was not accepted was that the maternity investigations should be recognised as the responsibility of NHS Improvement and not HSSIB. The Government will not be incorporating this change into the Bill. The Government wishes to ensure learning and improvements to maternity safety and therefore believes that the HSSIB should be allowed to undertake maternity investigations.

Private healthcare

The Bill may not just extend to the NHS following the Committee review. The Committee suggested that the HSSIB’s remit extend beyond NHS funded services to the whole healthcare system, although the funding of this should not come from the NHS. The Government is going to consult with stakeholders in the private sector on this aspect of the recommendations. Social care will however be exempt from investigation under HSSIB, as their investigation and regulation is covered by the Care Quality Commission (CQC).

Investigative powers

The indications from the Bill and the Committee response are that the HSSIB will have wide ranging powers. The Committee recommended that the body have the power to summons witnesses, there will be sanctions for non-compliance and have powers to enter residential premises, provided they have a warrant to do so.

The Government is going to review this recommendations but it is clear that the HSSIB will be a body to be taken seriously by all involved in public healthcare.

The future

It is not clear when the amended Bill will be back with Parliament but it is clear that the Government considers that establishing the HSSIB is the best way to bring about meaningful improvements to healthcare safety and investigations in England.

They state that the goal is to have a culture of learning embedded in the way the NHS respond to incidents. The HSSIB should bring about significant safety gains and spearhead and exemplify good practice and high quality, which should be replicated in the investigations at local level.

The HSSIB will have a central role in bringing about a culture change in healthcare and should nurture and promote high quality, professional safety investigations.

It is clear that in both litigation and advisory, the new body will have consequences, particularly given the proposals for privilege over documentation. It will be interesting to see the final format of the Bill when it is passed.

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