Department of Health

Providing a 'safe space' in healthcare safety investigations

Consultation response

The Royal College of Physicians of Edinburgh ("the College") was founded in 1681. We support and educate doctors in the hospital sector throughout the UK and the world with over 12,000 Fellows and Members in 91 countries, covering 30 medical specialties. 50% of our UK Fellows and Members working in the NHS in England, and we welcome the opportunity to respond to this Department of Health consultation.

Question 1 - 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?

If the proposals are pursued the openness with which lessons learned are disseminated must be paramount, and there should be consistency across providers.

Within investigations safe space needs to be available for staff to feel able to comment on the actions of others without fear of reprisal from senior colleagues. This is currently not always the case, and there can be tension between staff and management. The latter may not always appreciate the difference between genuine error for which the solution may be systemic or training; and recklessness or misconduct for which a disciplinary approach may be warranted. Legislation alone cannot change to this internal culture, which is alluded to in the consultation document.

If safe space is employed it still may be that the lessons learned identify an individual. For example, if the lesson learned was that a particular technique needs to be undertaken under more supervised circumstances then it will not be a large step to realise that it was the individual undertaking that procedure who was found to be wanting in the investigation. Safe space or not, they may be identifiable.

Question 2 - 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 investigations into maternity services in the first instance or should it apply to all investigations undertaken by or on behalf of such bodies?

It would be sensible to undertake a pilot to raise any potential challenges or teething problems, although we have some concerns that maternity and child health is an emotive area and that it might be more sensible to begin in another service.

There should be consistency across all providers.

Question 3 - Do you have any comments about the type of information that it is proposed will be protected from disclosure during healthcare investigations?

It appears to be a fine line between ensuring that workers are protected but preventing patients and their families (and the wider public) from having a clear picture of what has happened. There could be a perception that the balance is being tipped too far in favour of health workers, if the guidance is not transparent.

The document does not mention complaints investigations or claims and should include information that can be obtained by legal counsel.

Question 4 - Do you agree that the statutory requirement to preserve the confidentiality of investigatory material should be subject to such disclosure as may be required by High Court order?

Yes, but there should be further clarification of the sorts of situations when a High Court order might be made.

Question 5 - Do you agree with the proposed elements of the test to be applied by the High Court in considering an application for disclosure?

Yes.

Question 6 - 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?

There needs to be transparency as to who would decide whether there is a continuing risk to patient safety and what the criteria would be. Unless this is very clear there could be a danger that different investigations might apply different criteria to the decision about what could be disclosed, and that different patients would find out more or less that others in different locations.

If all data is anonymised then all material should be able to be shared unless there is criminal intent. The disclosure should stress learning rather than blame.

Question 7 - 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?

Anonymisation is important unless there is evidence of criminal intent. Evidence of systemic failure in the institution revealed in investigation needs to be shared.

Question 8 - 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?

From both a staff and patient/ families point of view there needs to be a clear understanding of what the exceptions are otherwise it may reduce confidence in the ‘safe space’ process.

NHS staff understand that safety is paramount and that they are responsible to the professional standards upheld by varying agencies.

Question 9 - Do you support the principle of a 'Just Culture' (that would make a distinction between human error and more serious failures) in order that healthcare professionals might come forward more readily to report and learn from their mistakes without fear of punitive action in circumstances that fall short of gross negligence or recklessness?

A just culture is as important as a 'safe space' but this is a difficult area. For example, current pressures in the NHS means that staff may have to create workarounds to get the job done, due to a lack of support or resources. These may judged by some to be reckless.

Question 10 - 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/families to have access to information - eg, should they see a pre-publication draft report for comment?

There is a lack of clarity about how the proposals would be implemented and whether it would be possible to achieve a consistent process across the whole of the NHS which safeguards both health workers and patients/families. Individual families are more likely to feel that their own concerns have been dealt with effectively if the process is as open as possible. It would be unreasonable (especially for grieving families) for them to have to apply to the High Court for information which is highly relevant to what has happened to them or their loved one.

The important issue is how the draft report is delivered and its outcomes explained to the family. This must be done both sympathetically and sincerely.

Data should be anonymised and information should stress the learning rather than blame. This may be difficult with complaints which may be made against an individual.

Question 11 - Do you see any problems in a requirement that investigatory bodies (such as professional regulators, coroners and the police) 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?

This could delay regulatory and other proceedings, for example, it could undermine the prospect of any investigation and (appropriate) action being taken by a regulatory panel if there was a significant delay in obtaining the information or if the application was denied. It may also engender a suspicion that there is information to hide unless the culture/spirit of the law is understood and accepted.

Question 12 - 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?

It may not necessarily convey what the purpose is – 'safe space' has connotations of providing protection for a marginalised group. It might be better to use a term which conveys that anyone using the space is not part of a marginalised group, rather that they are clearly an important part of the organisation– perhaps the term used by Sir Robert Francis would be better ie a Freedom to Speak Up Zone or similar.

Question 13 - Do you see any problems in exempting information obtained during healthcare investigations from access under the Freedom of Information and Data Protection regimes?

No

Question 14 - Do you agree that guidance, or an alternative source of support, should be developed?

The whole concept would need to be very clearly articulated and robust training provided – mere guidance seems likely to be insufficient to ensure that there is consistency across the whole NHS and with other providers of NHS services.

Question 15 - Do you think it would be helpful for NHS staff to be supported by a set of agreed national principles around how they would be treated if involved in a local safety incident investigation; and, if so, do you have any suggestions for the areas that such a set of principles should cover?

It is imperative that there is clear guidance and national principles which sets out the different types of risk, personal accountability, difference between genuine error and malicious intent, and the role of systemic influences. It should also explain how staff can be supported and by whom.

Individual patients/families need to be provided with information which makes them feel that their experiences are not simply used for learning but that they receive appropriate detail about why things went wrong and whether it could have been prevented.

Question 16 - 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?

No

Question 17 - Do you have any concerns about the impact of any of the proposals on families? If you envisage negative impacts, please explain.

The proposals to encourage staff to speak out are important; however there is the possibility that patients and their families could see this as staff protecting their own interests. We have some concerns that families are not at the heart of the proposals, and it is unclear as to whether the proposals will make a real difference to promoting a learning culture.

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