Department of Health

FACT SHEET 1

The Draft Health Service Safety Investigations Bill – why we need a Bill

"I have concluded there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them."

Freedom to Speak Up, Sir Robert Francis, February 2015.

This fact sheet explains why we need to legislate to establish an independent safety investigation body for the NHS in England.

What will the Bill do?

1. The Draft Health Service Safety Investigations Bill proposes three main things, to:
   (i) establish a new independent investigation body (the Health Service Safety Investigations Body (HSSIB)) aimed at improving patient safety;
   (ii) create a 'safe space' by prohibiting the disclosure of certain information held by the HSSIB in connection with an investigation; and
   (iii) make provision for the HSSIB to accredit NHS trusts and foundation trusts to carry out investigations into patient safety with the benefit of 'safe space'.

2. The Health Service Safety Investigations Body (HSSIB) will conduct investigations into incidents which appear to evidence serious patient safety risks in NHS-commissioned services in England.

3. The HSSIB will also develop standards on best practice in carrying out investigations and will be able to give advice or assistance to other bodies.

4. The aim of the legislation is to give the public confidence in the independence of HSSIB and that it will conduct fair and unbiased investigations which provide potential for system-wide learning across the NHS.

5. It is expected that NHS organisations will cooperate fully with the HSSIB investigations and benefit from the shared system learning that results.

6. However, the draft Bill provides powers for the HSSIB, where necessary, to access premises and material relevant to an investigation unless these premises are a private home, and to sanction organisations that do not comply with the HSSIB's requests for information.

7. The HSSIB will conduct investigations using 'safe space' which prohibits the disclosure of certain information held in connection with an investigation, apart from in certain limited circumstances.

8. These powers are comparable to similar legal provisions for bodies that conduct investigations into air, marine and other safety critical industries.

9. ‘Safe space’ is designed to encourage patients, families, NHS staff and other participants in an HSSIB investigation to speak freely for the purposes of promoting learning and improving safety.

10. Information gained during a ‘safe space’ investigation, such as statements, sensitive or personal information and records, which may identify participants or others, will be protected. (*See Fact Sheet 3 for more details on ‘safe space’*).

11. NHS trusts accredited by the HSSIB must publish a report on the outcome of the investigation. The report must focus on ascertaining the risks to patient safety rather than apportioning individual blame. Recommendations must focus on addressing those risks.

12. The overarching aim of accrediting NHS trusts and foundation trusts to conduct ‘safe space’ investigations is to improve local safety investigations and spread a ‘just culture’ of learning across the NHS.

Why do we need legislation?

13. There are around 24,000 serious incidents a year in the NHS but there is little capacity to investigate safety concerns effectively or address system-wide causes of healthcare harm.

14. Major serious incidents in the NHS cause untold distress to patients, their families, and staff and are often lengthy and costly. Estimated costs to the NHS of unsafe care itself total as much as £2.5 billion each year.

15. Sir Robert Francis’ inquiry into Mid Staffordshire NHS Foundation Trust found that there was a culture, within many parts of the NHS, which deterred staff from raising patient safety concerns.

16. In 2015, the Public Administration Select Committee called for an independent body to be established to conduct patient safety investigations in the NHS.

17. Legislation is required to establish an independent body to investigate patient safety in NHS-commissioned services and to provide that body with the necessary powers for its role.

18. Accreditation requires primary legislation, as does the setting up of a legal ‘safe space’, sanctions and powers of entry and inspection. (*See Fact Sheet 2 for more on legal powers.*)

FURTHER INFORMATION

- *The Mid Staffordshire NHS Foundation Trust Public Inquiry Report,* chaired by Robert Francis QC, February 2013, http://www.midstaffspublicinquiry.com/report
- *Freedom to Speak Up report, Sir* Robert Francis, February 2015. http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/
- *Learning Not Blaming: the government response to the Freedom to Speak Up consultation*, the Public Administration Select Committee report, *Investigating Clinical Incidents in the NHS*, and the Morecambe Bay Investigation. https://www.gov.uk/government/publications/learning-not-blaming-response-to-3-reports-on-patient-safety