



The Draft Health Service Safety Investigations Bill – how new legal powers will improve patient safety investigations

“Our main recommendation is that the Secretary of State for Health should bring forward proposals, and eventually legislation, to establish a national independent patient safety investigation body.”

Investigating Clinical Incidents in the NHS, Public Administration Select Committee,
24 March 2015

This fact sheet explains how the statutory powers in the draft Bill will help the new Health Service Safety Investigations Body (HSSIB) carry out ‘safe space’ investigations and build a new culture of safety improvement in the NHS.

Background

1. Major investigations such as the Public Inquiry into Mid Staffordshire NHS Foundation Trust and the Morecambe Bay Investigation have shown there is a need for a systemic approach to investigations and learning in the NHS when things go wrong.
2. The Draft Health Service Safety Investigations Bill aims to improve investigative capability in the NHS and to remove inefficient and ineffective practice. The aim is to help embed a culture of learning and safety improvement throughout the NHS so that, when things go wrong, lessons are shared throughout the system.
3. The draft Bill proposes a new independent body, the HSSIB, to conduct major safety investigations using ‘safe space’, which will allow

patients, families, NHS staff and other participants to be candid and open in the information they provide for the purposes of learning.

What will the new safety investigation body do?

4. The draft Bill set outs various powers to enable the HSSIB to investigate patient safety incidents that have (or may have) implications for the safety of patients receiving NHS-commissioned services in England.
5. The HSSIB will carry out investigations with the benefit of a ‘safe space’ with the aim of exemplifying good practice in patient safety investigations and fostering a learning culture across the entire NHS to improve patient safety.
6. The HSSIB will also develop a system of accreditation for NHS trusts and foundation trusts so that in the future they can seek approval to conduct safety investigations using ‘safe space’.

7. The HSSIB will also have a duty to provide assistance to NHS trusts and foundation trusts to improve their investigative practice and to set standards and guidance for the NHS.

What legal powers will HSSIB have and why?

8. Although it is expected that in most cases organisations providing NHS services will co-operate with an investigation, the HSSIB will be able to require any organisation which provides NHS-commissioned care in England to provide information, documents, equipment or other items relevant to an investigation.
9. Investigators will have powers of entry and inspection in order to access premises and material relevant to an investigation, unless these premises are a private home.
10. These powers are similar to investigatory bodies in other safety-critical industries, such as the Air Accident Investigations Branch (AAIB).
11. Under the provisions of 'safe space', information such as statements, sensitive or personal information and records will, however, be protected.
12. The HSSIB will be prevented from disclosing any information held in connection with an investigation, except if it uncovers evidence of a serious ongoing risk to patient safety, serious misconduct, or criminal activity, or if the High Court orders it should be disclosed in certain limited circumstances. (See *Fact Sheet 3 for further details on 'safe space'*).

How will these legal powers be enforced?

13. NHS organisations and national system partners will have a duty to cooperate with the HSSIB on a safety investigation. They will also be expected to provide information if requested.
14. If NHS organisations and national system partners do not provide this information, the HSSIB will be able to issue a formal request using its powers in the Bill.
15. Depending on the type of organisation, if they do not comply with the request, the HSSIB will be able to issue a civil penalty or report non-compliance to the Secretary of State.

FURTHER INFORMATION

- *The Mid Staffordshire NHS Foundation Trust Public Inquiry Report, chaired by Robert Francis QC, February 2013, <http://www.midstaffspublicinquiry.com/report>*
- *The Report of the Morecambe Bay Investigation, Dr Bill Kirkup, March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf*
- *Investigating Clinical Incidents in the NHS, Public Administration Select Committee, 24 March 2015, <https://www.publications.parliament.uk/pa/cm201415/cmselect/cmpublicad/886/886.pdf>*