Department of Health

FACTSHEET 3

# The Draft Health Service Safety Investigations Bill
# 'Safe space': what is it, why we need it and how it will work

*"Academic evidence shows there is a strong connection between 'psychological safety' and a culture of learning within an organisation."*

*Providing a safe space in healthcare safety investigations: consultation*. October 2016

*This fact sheet explains why legislation is needed to create a 'safe space' for investigations into serious health safety incidents in the NHS in England.*

## What is 'safe space'?

1. The Bill creates a 'safe space' for investigations conducted by the Health Service Safety Investigations Body (HSSIB) and accredited trusts. This prohibits the disclosure of any information, document, equipment or other item held by the HSSIB or an accredited trust in connection with an investigation, apart from in certain limited circumstances.

2. This is comparable to similar legal provisions for bodies that investigate air and marine accidents.

## Why do we need 'safe space'?

3. Recent inquiries have revealed that staff need to feel more confident that the information they give to safety investigations will not be used unfairly.

4. 'Safe space' is designed to encourage NHS staff and other medical professionals to speak freely during the course of an investigation in the knowledge that information they provide will not be passed on unless one of the exceptions set out in the legislation applies.

5. The focus of the HSSIB's investigations will be on learning from serious safety incidents in order to improve patient safety in the NHS, rather than assessing or determining blame.

## What are the benefits of 'safe space'?

6. In order to understand how to improve patient safety, we first need to understand what went wrong. The creation of a 'safe space' for investigations carried out by the HSSIB and accredited trusts will encourage patients, families, NHS staff and other participants to be as candid and open as possible in the information they provide.

7. This will enable lessons to be shared throughout the entire NHS, when things go wrong, in order to improve patient safety for the future.

## How will ‘safe space’ work in practice?

8. Prohibition on disclosure prevents the HSSIB and accredited trusts from sharing any information held by them in connection with an investigation unless one of the exceptions applies or the High Court makes an order for disclosure. This could include notes of an interview, patient correspondence, or medical records, but does not include any information, document, equipment or other item which is in the public domain.

9. There are a number of exceptions to the prohibition on disclosure, which are designed to allow the HSSIB or an accredited trust to share information with other bodies in the following limited circumstances:
    - The HSSIB or an accredited trust will be able to notify the police where any information, document, equipment or item may provide evidence of the commission of an offence.
    - The HSSIB or an accredited trust will be able to notify the relevant NHS trust or foundation trust, NHS England or relevant clinical commissioning group, NHS Improvement (which comprises the NHS Trust Development Authority and Monitor), the Care Quality Commission, the Health and Safety Executive or the Secretary of State if any information, document, equipment or item may provide evidence of a continuing and serious risk to the safety of any patient.
    - The HSSIB or an accredited trust will be able to notify the relevant regulatory body (for example, the General Medical Council, General Dental Council etc.) where any information, document, equipment or item may provide evidence of serious misconduct by any individual providing NHS services or managing the provision of those services.
    - The HSSIB or an accredited trust may notify the relevant NHS trust, foundation trust, NHS England or clinical commissioning group where there is evidence of the commission of an offence, a continuing and serious risk to the safety of a patient or evidence of professional misconduct that raises safeguarding issues.
    - An accredited trust must disclose to the HSSIB any information, document or item held by it in connection with an investigation if the HSSIB requests it to.

10. The High Court may also order the HSSIB or an accredited trust to disclose information to a person if it determines that the interests of justice served by disclosing the information, document, equipment or item in question outweighs any adverse impact on future investigations by the HSSIB or accredited trusts by deterring persons from participating in them or the ability of the Secretary of State to secure the improvement of the safety of the NHS.

## ‘Safe space’ and Duty of Candour

11. The creation of a ‘safe space’ for investigations by the HSSIB and accredited trusts is intended to build on the statutory duty of candour.

12. Medical professionals will continue to be required to comply with the general duty to act in an open and transparent way. *(See Fact Sheet 4 for further details on the duty of candour)*.

## How does ‘safe space’ affect the rights of patients and their families?

13. The NHS treats more than one million people every 36 hours. Most patients and families receive good care from NHS services but sometimes things go wrong.

14. Families and patients will continue to have access to information and redress, as they currently do, from the NHS organisation that provided the care and as part of any local safety investigation that follows a serious safety incident.

15. Patients and families will continue to be able to raise concerns with their NHS provider, or clinical commissioning group, as set out in the NHS complaints procedure. Also, they will still have access to the Parliamentary and Health Service Ombudsman if they are unhappy with how their complaint was handled.

16. The aim of an HSSIB safety investigation is to address risks to patient safety by improving systems and practice in NHS services.

17. The HSSIB is under a statutory obligation to develop processes that involve patients and their families in safety investigations as far as are reasonable and practical.

**FURTHER INFORMATION**

- *The Mid Staffordshire NHS Foundation Trust Public Inquiry Report*, chaired by Robert Francis QC, February 2013, http://www.midstaffspublicinquiry.com/report
- *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