Department of Health

FACT SHEET 4

# The Draft Health Service Safety Investigations Bill – duty of candour and 'safe space'

*"A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity."*

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

*This fact sheet describes how the creation of a 'safe space' in investigations carried out by the Health Service Safety Investigations Body and accredited trusts relates to the duty of candour for NHS staff and professional bodies.*

## Background

1. The Health Service Safety Investigations Body (HSSIB) is being established to investigate serious patient safety risks in the NHS in England.

2. HSSIB investigations will focus on what went wrong and the system-wide learning from serious safety incidents.

## Duty of Candour

3. Since 2014, all NHS organisations have been subject to a statutory duty of candour, which includes a general duty to act in an open and transparent way with patients and their families. Other specific obligations include:
   a. informing the patient if a notifiable safety incident has occurred,
   b. providing an account of all the facts known at the date of the notification,
   c. advising the patient what further enquiries will be carried out, and
   d. providing an apology.

4. In April 2015, this duty was extended to all other health and social care providers registered with the Care Quality Commission (CQC).

5. Separately, in November 2014 the General Medical Council and Nursing and Midwifery Council refreshed their codes of conduct and guidance on professional duties of candour. This requires health professionals to apologise, tell the patient or their family and offer a remedy, if something has gone wrong with their treatment or care.

## 'Safe space'

6. The creation of a 'safe space' for investigations by the HSSIB and accredited trusts will build on the duty placed on NHS service providers to act in an open and transparent way.

7. The HSSIB and accredited trusts will be prevented from disclosing information held by the HSSIB or an accredited trust in connection with an investigation, except in certain limited circumstances or where the High Court makes an order for disclosure. *(Further details on 'safe space' can be found in Fact Sheet 3).*

8. 'Safe space' will encourage patients,

families, NHS staff and other participants in an investigation carried out by the HSSIB or an accredited trust to be as candid and open as possible in the information they provide.

9. The HSSIB's focus will not be on apportioning blame or holding individuals to account and information gathered by the HSSIB during an investigation will be for the purpose of learning and improving patient safety.

## Will 'safe space' replace a duty of candour in an investigation?

10. 'Safe space' will not replace any existing duties of candour that apply to an incident that is later investigated by the HSSIB or an accredited trust. NHS staff and providers must continue to adhere to these professional and legal duties.

## Will patients and families still be able to raise concerns locally?

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

12. The NHS complaints procedure will continue to be the main route for concerns to be addressed and there will continue to be other local investigations into safety incidents and concerns.

13. Patients and families will continue to be able to raise concerns related to historical issues with their NHS provider, commissioner or clinical commissioning group, as set out in the NHS complaints procedure.

14. Also, patients and families will still have access to the Parliamentary and Health Service Ombudsman if they are unhappy with how their complaint was handled.

15. The HSSIB will be required to develop processes that involve patients and their families in HSSIB safety investigations, as far as is reasonable and practical.

**FURTHER INFORMATION**

- *Investigating Clinical Incidents in the NHS*, Public Administration Select Committee, 24 March 2015 https://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf
- *Complaints and Raising Concerns,* Health Committee, 13 January 2015 https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/350.pdf
- *Openness and honesty when things go wrong: the professional duty of candour,* Nursing and Midwifery Council & General Medical Council, http://www.gmc-uk.org/DoC_guidance_englsih.pdf_61618688.pdf
- *Duty of candour: Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare,* Care Quality Commission (2015), http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
- *Duty of Candour, Regulation 20, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.* http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf