

Our advice to parliament: Health Service Safety Investigations Bill

Lords Second Reading, 29 October 2019

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Introduction

The Equality and Human Rights Commission has been given powers by Parliament to advise Government on the equality and human rights implications of laws and proposed laws, and to publish information or provide advice, including to Parliament, on any matter related to equality, diversity and human rights. The Commission has a strategic priority to improve treatment in institutions, including ensuring that people sharing protected characteristics or those at particular risk of vulnerability are not subject to unlawful treatment in healthcare settings, and can access mechanisms to challenge unlawful treatment where it occurs.

This briefing provides our advice on the Health Service Safety Investigations Bill. The Bill establishes the Health Service Safety Investigations Branch as an independent public body with responsibility for investigating patient safety incidents in NHS services in England.

Issue

- NHS services in England reported almost 10,000 incidents in 2018/19 resulting in severe harm or a patient's death.¹ The UK Government is required by domestic and international human rights law to ensure there are effective investigations into all incidents of ill-treatment and deaths for which the state may be responsible. Several reviews and major reports have highlighted the often poor quality of NHS investigations.² Many patients and families share these concerns.³
- There is some evidence to suggest people with protected characteristics may be disproportionately affected by issues relating to patient safety.⁴ Further, people who are detained in state care may be particularly vulnerable to harm,

¹ NHS (2019), [NRLS national patient safety incident reports: commentary](#), table 5. The definition of severe harm is "any unexpected or unintended incident that caused permanent or long-term harm to one or more persons". Note that some reporters provide an incident's potential rather than actual degree of harm. Reporting is largely voluntary.

² See Joint Committee on the Draft Health Service Safety Investigations Bill (2018), [Draft Health Service Safety Investigations Bill: a new capability for investigating patient safety incidents](#), para 3.

³ Care Quality Commission (2016), [Learning, candour and accountability, a review of the way NHS trusts review and investigate the deaths of patients in England](#).

⁴ See EHRC (2019), [Response to the NHS Improvement consultation on developing a patient safety strategy](#).

with evidence of routine use of restraint on detained adults and children with mental health conditions, learning disabilities and autism.⁵ There were 48 reported deaths from unnatural causes in mental health units in 2017/18.⁶

Recommendations

We welcome the introduction of the Health Service Safety Investigations Bill and recognise that independent, learning-focussed investigations have the potential to improve patient safety, prevent future harm and improve public confidence in the system. However, we are concerned that the provisions may not go far enough to meet the Government's equalities and human rights obligations, and recommend that the Bill is amended to:

1. **Strengthen compliance with the requirements of the Human Rights Act 1998** by clarifying the importance of investigations into systemic failings in order to drive widespread improvements and minimise the risk of similar incidents happening again.
2. **Extend the remit of the new body to include private hospitals** to ensure a whole system approach to improving patient safety.
3. **Ensure the new body's investigation powers are sufficient to generate real improvements in patient safety**, by ensuring patients, carers and families are appropriately involved, and that NHS services are held to account for taking action to address its recommendations.
4. **Secure the Health Service Safety Body's independence** by ensuring its non-executive members and investigators are in practice independent from the services they are investigating, including allowing for appropriate parliamentary scrutiny.
5. **Make the Health Service Safety Body subject to the Public Sector Equality Duty specific duties** to ensure it considers equality in planning its work, sets

⁵ See Independent Review of the Mental Health Act (2018), [Modernising the Mental Health Act](#), and EHRC (2019), [Parliamentary briefing: reforming the Mental Health Act](#).

⁶ Care Quality Commission (2019), [Monitoring the Mental Health Act in 2017/18](#), fig. 12.

equality objectives and monitors whether its recommendations lead to improved outcomes for all protected groups.

Legal framework

- Article 2 of the European Convention on Human Rights (ECHR), enshrined in UK law by the Human Rights Act 1998, requires the Government to **protect the right to life**. The Government must take positive steps to prevent accidental death and ensure there are effective investigations into all deaths for which the state may be responsible. Investigations must be independent, prompt and open to public scrutiny, and must involve the person's next of kin.
- Under Article 3 ECHR the Government must take positive steps to **prevent torture and inhuman or degrading treatment**, including ensuring there are effective investigations where there are clear indications that serious ill-treatment may have occurred. Case law has established that there must be a practical independence between the investigator and the subject of the investigation.⁷
- The UK Government is required under the **UN Convention Against Torture**, which is legally binding in international law, to ensure there are prompt and impartial investigations wherever there are reasonable grounds to believe an act of torture has been committed (Article 12). This extends to other forms of cruel, inhuman or degrading treatment that fall short of torture, and to private settings where the state knows or has reasonable grounds to believe ill-treatment is being committed.⁸ The Government must also ensure that anyone who alleges they have been subject to cruel, inhuman or degrading treatment has the right to complain to and have their case promptly and impartially examined by its competent authorities (Article 13), and be fairly compensated, including the means for as full rehabilitation as possible (Article 14). In its examination of the UK's compliance with the Convention the UN Committee Against Torture has expressed concern about ill-treatment in healthcare

⁷ Al Skeini v UK (2011) 53.

⁸ Committee Against Torture (2008), [General Comment No. 2](#).

services, the inadequacy of investigations into serious incidents, and the number of deaths in mental health detention.⁹

- Under the **public sector equality duty (PSED)**, the Government and public bodies must have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations. The general duty is supported by specific duties, which require certain listed public bodies to set equality objectives and publish data demonstrating compliance with the PSED.¹⁰

Background

Remit of the new body

The Health Service Safety Investigations Body (HSSIB) is expected to carry out 30 investigations annually.¹¹ There are many more incidents resulting in serious harm or patient deaths in NHS services each year, with almost 10,000 reported in 2018/19.¹² Several reviews and major reports have highlighted the often poor quality of NHS investigations.¹³ NHS Improvement has identified that they may be carried out to satisfy a process rather than improve patient care, and that time is spent investigating very similar incidents which fail to generate new learning.¹⁴ Many patients and their families do not experience the NHS as open and transparent, and feel there are missed opportunities to learn from deaths that may have been prevented.¹⁵ While we welcome the HSSIB's focus on "promoting better standards for local investigations and improving their quality and effectiveness",¹⁶ we recommend the Government provide further reassurance on how it will meet its obligations under human rights law to ensure there are independent investigations into all deaths and ill-treatment for which the state may be responsible. We would also emphasise the importance of investigations into systemic failings, so that the

⁹ See EHRC (2019), [Torture in the UK, update report](#).

¹⁰ Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

¹¹ See [Explanatory notes on the Health Service Safety Investigations Bill](#), para 138.

¹² NHS (2019), [NRLS national patient safety incident reports: commentary](#), table 5 [see footnote 1].

¹³ See Joint Committee on the Draft Health Service Safety Investigations Bill (2018), [Draft Health Service Safety Investigations Bill: a new capability for investigating patient safety incidents](#), para 3.

¹⁴ NHS Improvement (2018), [The future of NHS patient safety investigations](#).

¹⁵ Care Quality Commission (2016), [Learning, candour and accountability, a review of the way NHS trusts review and investigate the deaths of patients in England](#).

¹⁶ [Health Service Safety Investigations Bill, explanatory notes](#), p4.

work of the HSSIB can drive widespread improvements and minimise the risk of repeat incidents.

Privately-funded care

The HSSIB's investigations are limited to NHS services and do not extend to privately-funded care (Clause 2). A recent Care Quality Commission report on 206 independent hospitals rated 41 per cent as 'requires improvement' in safety and 1 per cent as inadequate.¹⁷ The Joint Committee on the draft Health Service Safety Investigations Bill highlighted that restricting the HSSIB to NHS-funded care will mean that private organisations providing NHS-funded care will fall under the HSSIB's remit, but privately-funded care delivered by the same provider at different premises will not.¹⁸ The Public Administration Select Committee reported that the "[exclusion] of the independent sector from the jurisdiction of the new body would not be consistent with a whole system approach, which many witnesses regard as essential."¹⁹ We recommend the Government look further at extending the HSSIB's remit to privately-funded care, as it committed to do in response to the Joint Committee's pre-legislative scrutiny.²⁰

Criteria for investigations

The Bill provides that the HSSIB is responsible for developing its own criteria for the incidents it will investigate (Clause 3). We recommend that specific consideration is given to ill-treatment and deaths among people who are detained in hospitals and care homes, who may be particularly vulnerable to harm. We have ongoing concerns about the treatment of people in these settings, including the use of restraint – for example, in a single month this year there were more than 2,600 restrictive interventions recorded in inpatient settings for people with learning disabilities and autism, of which 875 were used against children.²¹ Since our 2015 inquiry into deaths in detention we have called on the Government to

¹⁷ Care Quality Commission (2018), [The state of care in independent acute hospitals](#).

¹⁸ Joint Committee on the Draft Health Service Safety Investigations Bill (2018), [A new capability for investigating patient safety incidents](#).

¹⁹ Public Administration Select Committee (2015), [Investigating clinical incidents in the NHS](#).

²⁰ Department for Health and Social Care (2018), [The Government response to the report of the Joint Committee on the Draft Health Service Safety Investigations Bill](#).

²¹ See EHRC (2019), [Parliamentary briefing: reforming the Mental Health Act](#).

establish an independent body to investigate non-natural deaths in psychiatric hospitals, mirroring the arrangements in criminal justice settings.²²

Disclosure

The Bill sets out a number of provisions around disclosure of information with the aim of creating a 'safe space' environment to help ensure openness and candour in its investigations. We agree this is an important factor in making sure investigations are independent and effective in line with the requirements of Articles 2 and 3 ECHR. We would also emphasise that the 'safe space' provisions must be balanced with the rights of patients and their families to be involved in the investigation process, and the requirement for investigations and their results to be open to public scrutiny.

Reporting

The Bill requires the HSSIB to publish a report on investigations including recommendations for action (Clause 22). The addressee of the report must provide a written response by the HSSIB's deadline, setting out the action it will take to address its recommendations (Clause 26). We recommend that the addressee is also required to make follow-up reports on its actions and their outcome, to ensure meaningful and lasting improvements to patient safety.

Membership and independence

Schedule 1 of the Bill provides that the Chair and at least four non-executive members of the HSSIB are appointed by the Secretary of the State. To secure the HSSIB's independence we recommend that all non-executive members are appointed by the Chair, and that the appointment of the Chair and non-executive members are subject to parliamentary scrutiny. The Joint Committee on the draft bill recommended that both the Chair and the Chief Investigator are subject to pre-appointment scrutiny by the Commons Health and Social Care Committee.²³ In

²² EHRC (2015), [Preventing deaths in detention of adults with mental health conditions](#).

²³ Joint Committee on the Draft Health Service Safety Investigations Bill (2018), [A new capability for investigating patient safety incidents](#).

response to the Committee the Government agreed to consider the best way to achieve this.²⁴

Equality duties

The Bill makes the HSSIB subject to the general public sector equality duty under the Equality Act 2010. We recommend that the HSSIB is also subject to the specific equality duties, so that it is required to publish information on its compliance with the general duty and set specific and measurable equality objectives. We believe this would help inform the HSSIB's evidence-gathering and allow it to track whether its recommendations address any evidence that patients with particular protected characteristics are disproportionately likely to suffer severe harm or avoidable death.

Further information

The Equality and Human Rights Commission is a statutory body established under the Equality Act 2006. Find out more about the Commission's work at [our website](#).

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²⁴ Department for Health and Social Care (2018), [The Government response to the report of the Joint Committee on the Draft Health Service Safety Investigations Bill](#).