NATIONAL QUALITY BOARD

For meeting on: 22 November 2017

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Paper for:

Decision	Discussion	Information
	X	X

HEALTHCARE SAFETY INVESTIGATION BRANCH AND HEALTH SERVICE SAFETY INVESTIGATIONS BILL: UPDATE

SUMMARY

Following lessons learnt from major investigations and inquiries such as the Public Inquiry into Mid Staffordshire NHS Foundation Trust and the Morecambe Bay Investigation, as well as longstanding calls from Parliament and the public for a more systematic approach to investigation and learning in the NHS, the Healthcare Safety Investigation Branch (HSIB) was established in 2016 under Directions given to the NHS Trust Development Authority (TDA). The HSIB commenced its operations on 1 April 2017, and has since launched six investigations into safety incidents.

The Department of Health also committed to establishing an independent investigation body in the longer term and published the Draft Health Service Safety Investigations Bill in draft on 14 September 2017 for parliamentary scrutiny.

PURPOSE

The NQB is asked to:

- **Note** the role of HSIB;

- **Consider** how it could work closely with HSIB as it begins to make recommendations to the system; and

- **Comment** on the draft Health Service Safety Investigations Bill.

ALB Involvement in development and sign-off of paper:

NHS England	Care Quality Commission	NHS Improvement	NHS Health Education England

Public Health England	NICE National Institute for Health and Care Excellence	NHS Digital	Department of Health
			X

HEALTHCARE SAFETY INVESTIGATION BRANCH AND HEALTH SERVICE SAFETY INVESTIGATIONS BILL: UPDATE

1. ESTABLISHMENT OF THE HEALTHCARE SAFETY INVESTIGATION BRANCH

1.1 Major investigations and inquiries such as the Public Inquiry into Mid Staffordshire NHS Foundation Trust and the Morecambe Bay Investigation demonstrated the need for a systematic approach to investigation and learning.

1.2 As a result, Parliament (including the Public Administration and Constitutional Affairs Committee), patient and family advocates, and academics have called for the healthcare system in England to have a more robust, reliable and effective way of understanding the causes of, and learning from safety incidents.

1.3 The policy to established a new investigation branch for the health service was set out in *"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 (July 2015)".*

1.4 The Healthcare Safety Investigation Branch (HSIB) was established in 2016 under Directions given to the NHS Trust Development Authority (TDA). The HSIB commenced its operations on 1 April 2017.

1.5 The HSIB has the overarching aim to investigate incidents that evidence risk to patient safety, with a focus on learning and not attributing blame or liability. Following each investigation, the HSIB will provide recommendations to ALBs through its reports to ensure system wide change.

1.6 Since launching in April 2017, the HSIB has announced six investigations into the following:

a) Cardiac and vascular patient pathways (July 2017);

b) Wrong site interventions (September 2017);

c) Provision of mental health services in emergency departments (September 2017);

d) Recognising and responding to critically unwell patients (October 2017);

e) Transition from child and adolescent mental health services to adult mental health services (October 2017); and

f) Wrong route administration of an oral drug into a vein (November 2017).

2. HEALTH SERVICE SAFETY INVESTIGATIONS BILL

2.1 Whilst welcoming the establishment of the HSIB, the Public Administration and Constitutional Affairs Committee (PACAC), as well as health experts and patients and family advocates, argued that for the HSIB to be truly effective it needs to be completely independent of the NHS and to have powers analogous to investigation bodies in other safety critical industries such as the Air Accident Investigation Branch (AAIB).

2.2 In its 2017 General Election manifesto, the Government committed to 'legislating for an independent healthcare safety investigation body in the NHS'.

2.3 The Department of Health published the Health Service Safety Investigations Bill in draft on 14 September 2017. The draft Bill will undergo a process of pre-legislative scrutiny, either by a parliamentary committee or by public consultation.

2.4 The draft Bill makes provision in relation to three main subject matters:

a) First, the establishment of the Health Service Safety Investigations Body (HSSIB) as an **independent statutory body**, with powers to

conduct investigations into incidents or accidents within the NHS which appear to evidence risks affecting patient safety.

b) Second, the Bill creates a **'safe space'** within which participants can provide information for the purposes of an investigation by imposing a prohibition on the disclosure of information held by the HSSIB in connection with an investigation. Information will only be able to be disclosed by order of the high court or in certain, limited circumstances.

c) Third, the Bill makes provision for **the accreditation of NHS trusts and foundation trusts** to carry out investigations into patient safety with the benefit of 'safe space'.