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Integration and innovation - improving standards for investigations into safety incidents

This article looks at the proposal to establish a new independent body, the Health Service Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for patient safety.

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As part of a range of measures designed to contribute to improving quality and safety in the NHS, the 'Integration and innovation: working together to improve health and social care for all' White Paper proposes the establishment of a new independent body, the Health Service Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for patient safety.

The proposals build on plans initially set out in the Health Service Safety Investigation Bill (HSSI), which was introduced in October 2019, to put the Healthcare Safety Investigation Branch (HSIB), on a statutory footing.

Since it was established in April 2017, HSIB has been part of NHS Improvement but the White paper sets out proposals to establish HSSIB as an Executive Non-Departmental Public Body on the basis that its independence is seen as crucial to ensure that patients, families and staff have trust in its processes and judgements.

The White Paper also includes proposals for:

- A plan to extend HSSIB's remit to cover healthcare provided in and by the independent sector.
- A 'safe space'
  - A prohibition on disclosure of information held by the HSSIB in connection with its investigatory function 'save in limited circumstances set out in the bill'.
  - A regulation-making power allowing Secretary of State to set out additional circumstances when the prohibition on disclosure (safe space) does not apply.

  The concept of a 'safe space' whereby participants to an investigation can provide information to HSSIB in confidence and therefore feel able to speak openly and candidly is controversial. Whilst it is seen by many as fundamental to the effectiveness of HSSIB, concerns have previously been raised about the potential adverse effect on transparency and trust if information obtained during investigations is not shared openly.
- HSSIB to be tasked with providing advice, guidance and training to organisations to encourage the spread of a culture of learning within the NHS, promoting better standards for local investigations and improving their quality and effectiveness.
- A power to enable the Secretary of State for Health and Social Care to require the HSSIB to investigate particular qualifying incidents or groups of qualifying incidents – although it is not yet clear what these 'qualifying incidents' will be.

Comment

These proposals are an important strand of various wider initiatives which seek to improve the quality of incident investigation and learning in the NHS. In this respect, the National Patient Safety Strategy (2019) highlighted the 'significant insight into the system-level causes of harm' which HSIB currently provides.

The White Paper makes it clear that this expertise is a critical element to facilitate effective learning and improvements in patient safety. However, we will need to await publication of the bill for more details of the proposals and those relating to the creation of a 'safe space' for HSSIB investigations are likely to attract considerable scrutiny and debate.

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