Patient safety drive - Are you up-to-speed?

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Summary

The national drive to improve patient safety continues to gather momentum. The latest developments include:

- Learning from Deaths Framework - to help NHS Trusts with the looming deadline for having a policy in place which meets the requirements of this new framework, NHS Improvement has published a template Learning from Deaths policy.
- A new, statutory Health Service Safety Investigations Body (HSSIB) is in the pipeline, with details of how that would work having now been set out by the government in a draft bill, including robust 'safe space' provisions modelled on air accident investigations.

In this briefing, we take a closer look at these developments and their impact.

Learning from Deaths Framework - Are you ready?

As set out in our previous alert on the Learning from Deaths Framework, one of the central planks of this is the introduction of 'case record reviews' (essentially, desk-top reviews of deaths falling within specified criteria using a set methodology) to decide if there were problems with the care and, if there were, whether a death is more likely than not to have been due to problems in the care.

The key timescales are:

- September 2017 – Trusts are expected to have in place by the end of this month a new/updated Learning from Deaths policy setting out how the Trust will comply with the Framework, including how case record reviews will be done.
- December 2017 – Trusts will be expected to start publishing (via a paper to the public board meeting) quarterly data about deaths, including numbers of case record reviews and an estimate of how many deaths were more likely than not to be due to problems with care, plus how findings from reviews/investigations are being used to improve quality.

To help Trusts meet these requirements, NHS Improvement has recently published a template Learning from Deaths policy for Trusts to work from. This includes detailed guidance on what the policy will need to cover, including:

- Roles and responsibilities - e.g. who will take lead responsibility at board level for the learning from deaths agenda;
- How the Trust will select deaths for case record reviews;
- What methodology the Trust will use (examples of potential methodologies for different patient groups are given in the template policy);
- How the Trust will support and involve bereaved families/carers;
- How the Trust will use reviews/investigations to improve quality/patient safety.

If Trusts have any queries about what the Learning from Deaths Framework requires and/or about what their policy should contain, see 'How we can help' below.

How will the proposed new statutory investigations body work?

With the relatively new Healthcare Safety Investigation Branch (HSIB) having started work from 1 April this year, the government has just published a draft bill setting out plans to build on this by creating a more powerful, statutory investigations body - the Health Service Safety Investigations Body (HSSIB) - which would be modelled on the 'learning not blame' principles applied for air accident investigations.

How would HSSIB work?

The proposed HSSIB would be a creature of statute, with its functions and powers enshrined in legislation.

HSSIB's core function would be to investigate incidents which have (or may have) implications for the safety of patients and which meet criteria to be set down by HSSIB. Its investigations would have to focus on learning, rather than attributing

blame.

It would also have functions around 'giving assistance' to NHS Trusts by disseminating information about best practice/standards for carrying out investigations, plus it would be able to grant accreditation to Trusts to carry out 'safe space' investigations themselves (see further below).

How much power would it have?

HSSIB would be able to investigate any incidents occurring during the provision of NHS care or on premises where NHS care is provided. Importantly for independent sector providers, this would include incidents occurring during provision of NHS services in private hospitals or privately owned care homes.

Its powers would be quite considerable - including a power to enter and inspect premises and to obtain documents/equipment. It would also be able to impose financial penalties (subject to a right of appeal) of up to £20,000 for failure to comply with requests for information.

How would accreditation for NHS Trusts work?

The draft bill proposes the introduction of an accreditation scheme, which would allow NHS Trusts to apply to HSSIB to be accredited to carry out 'safe space' investigations at other Trusts ('external investigations') and - if they can show they have carried out a sufficient number of external investigations effectively - within their own Trust.

It would be for HSSIB to decide on the accreditation criteria, although the draft bill says these should include Trusts being able to show that they can produce reports that focus on safety issues and learning, not on individuals' actions and blame.

Such accreditation is likely to be a 'feather in the cap' for Trusts and would, for example, help evidence a strong culture of learning for the purposes of CQC 'well-led' assessments.

What does the 'safe space' aspect involve?

HSSIB investigations (and investigations by accredited Trusts) would be governed by 'safe space' principles similar to those which already apply to air accident investigations.

This means that the proposed legislation would prohibit the disclosure of any information, document, equipment or other item held by HSSIB (or an accredited Trust) in connection with an investigation unless one of the statutory exceptions apply (relating to commission of an offence, continuing and serious risks to patient safety or serious misconduct) or the High Court orders disclosure (if the Court decides that the interests of justice served by disclosure would outweigh any adverse impact on future investigations - e.g. by deterring people from participating).

In terms of the 'output' from investigations, HSSIB (or the accredited Trust) would have to publish a report including findings of fact/analysis of those facts plus recommended actions. Before publication, a draft of the report would have to be circulated to all organisations/individuals who participated in the investigation asking them to comment by a set deadline.

In line with the 'no blame' ethos of these provisions, HSSIB/accredited Trust investigation reports (whether draft, interim or final) could not be used as evidence in proceedings to determine civil or criminal liability, employment tribunals or in professional regulatory cases.

Timescale

The proposed new HSSIB is only at the very start of its journey through the legislative process, with the next step being for the draft bill to undergo pre-legislative scrutiny. It is therefore likely to be some considerable time before these plans see the light of day, but it is likely that, in time, this will form a key pillar of the NHS patient safety agenda.

How we can help

Our national team of healthcare regulatory lawyers has extensive experience of supporting and advising health and social care providers on a wide range of matters relating to patient safety including:

- Advice and support in complying with the requirements of the Learning from Deaths Framework, including what needs to be covered in new/updated Trust policies;
- Clinical governance scrutiny to assess the effectiveness of incident investigations, organisational learning and board leadership/culture on learning;
- Duty of Candour requirements;
- Terms of Reference for investigations into serious incidents/patient deaths;

- Reviewing draft serious incident investigation reports/actions plans;
- Liaison with external bodies - e.g. CQC, commissioners, coroners;
- Training for serious incident investigators and Duty of Candour workshops;
- Inquest advice and representation;
- Representation and support in relation to further investigations which may be linked to incidents/patient deaths, including HSE or police investigations.

If you need advice in relation to the Learning from Deaths Framework or the wider patient safety agenda, please contact Corinne Slingo on: +44(0)117 918 2152 or cslingo@dacbeachcroft.com.

Authors

Corinne Slingo
Bristol
cslingo@dacbeachcroft.com

Peter Merchant
Leeds
pmerchant@dacbeachcroft.com

Belinda Dix
Winchester
bdix@dacbeachcroft.com

DAC BEACHCROFT