



HEALTHCARE SAFETY  
INVESTIGATION BRANCH

**Helen Jones - National Safety Investigator**

# HSIB – who we are, what we do...



- HSIB undertakes independent safety investigations of patient safety incidents in NHS-funded care, in England
- Our experts in safety investigation have backgrounds in the NHS, aviation and military investigations, human factors and other safety critical industries
- Aim to model the values and behaviours that support transparency and blame-free learning
- We collaborate with organisations, healthcare staff, patients and families during our investigations

# Patient Safety Incident Response Framework



- Part of the National Patient Safety Strategy led by NHSE and I
- Intended to address shortcomings of the Serious Incident Framework
- High quality incident investigation requires the right skills, systems, processes & behaviours
- PSIRF proposals explore:
  - a broader scope
  - transparency & support;
  - a risk-based approach
  - reinforcing the purpose;
  - investigator time & expertise
  - cross-setting investigations
- Proposals closely reflect the HSIB objectives and principles



## National Investigations

- HSIB's purpose is to identify the safety risks, follow the evidence and develop effective safety recommendations
- Our investigations are risk based learning reviews, rather than outcome based investigations
- HSIB decide what to investigate based on:
  - **the scale of risk and harm**
  - **the impact on individuals involved and on public confidence in the healthcare system**
  - **the potential for learning to prevent future harm**
- National investigations do not replace local investigations or legal processes

## Independent Investigations

- Diverse experience of HSIB investigators and analysts results in MDT with multiple perspectives: clinical and non-clinical
- Investigation teams are routinely made up of a principal national investigator, two national investigators and an intelligence analyst
- Professional background and prior learning determine membership of each investigation team
- We work with subject matter experts / advisors
- Investigators receive training in human factors and safety science in investigations at Cranfield University – world renowned in accident investigation



## Independent Investigations

- HSIB investigations draw on a range of methodologies to collect and analyse evidence
- Investigation process: importance placed on site visits and observations in local area in addition to interviews with staff, reviews, simulation, cognitive work etc.
- Consider 'sequential' methods of analysis but also adopt 'systemic' methods used in more complex systems
- HSIB focus on the quality of the learning review, rather than stringent deadlines for completion
- Whilst we have a timeframe, we create shorter milestones

# Reporting

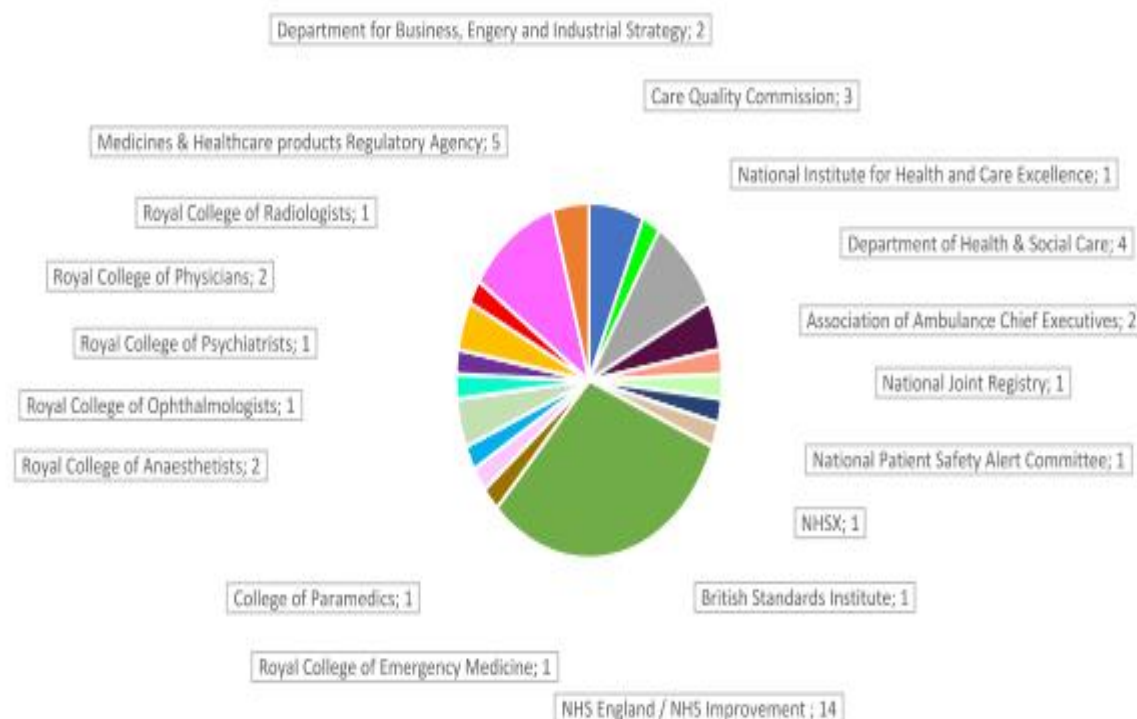


- HSIB publishes investigation reports identifying its findings and making safety recommendations and safety observations to national bodies
- To date this has included published reports into a range of care settings:



# NATIONAL SAFETY RECOMMENDATIONS

(at 30 September 2019)



## Safety Recommendations (14 published reports)



## Additional actions noted (no response required)





# Professionalising Safety Investigations



- Safety investigation is undertaken by HSIB as a specialist professional activity
- Our ethos is one of collaboration and learning – this will inform our approach to supporting improved local investigations
- Keen to ensure that we have sufficiently developed and tested our methodologies and processes before we start presenting them as exemplars for trusts
- We are currently establishing an in-house learning and development function to systematise this process
- Have you any views about what support you would find helpful with your local investigation processes, or aspects you find particularly challenging?

## Engaging with Staff



- Engaging with staff within organisations is an important part of our process
- Aim to speak to a range of staff, whether directly involved in a specific event, or have expertise on a particular subject matter
- We may ask staff to attend interviews with us, or hold conversations with staff in the process of carrying out observations in clinical environments
- Staff provide a vital insight into 'work-as-done' and local rationality
- It helps us to understand what happened, how it can happen again and identify wider issues relating to patient safety



## Support and Involvement of Staff

- Full account from staff in safe environment can be cathartic
- Direct staff to support services if required and let them know the stages in the investigation process
- Share draft reports with staff involved for chance to review and comment
- We do not name staff or the organisations where we've investigated
- We do all we legally can to ensure that sensitive information shared with us by staff is not disclosed outside of HSIB



# Family Engagement



The **prompt, effective** liaison  
between a **family** and an investigation  
to ensure the family is **integral** to the  
investigation and is treated professionally,  
respectfully and according to their **individual**  
**needs.**

# Working with Families



- Family involvement is fundamental from the start, identifying a dedicated liaison person
- Listening to patients/families account of events
- Ensuring they understand the scope of the investigation – setting realistic expectations
- Agree communications – no surprises or uncertainty
- Sharing our draft reports
- Disengaging

# Family feedback



HEALTHCARE SAFETY  
INVESTIGATION BRANCH

Please tick the box with a tick or cross according to your view	Strongly agree	Agree	Undecided	Disagree	Strongly disagree	Not relevant to my situation
1. I was initially informed about the involvement of HSIB and given a choice as to how to communicate with investigators						
Comments						
2. HSIB investigators contact with me enabled me to take part in the investigation						
Comments						
3. I was given details of a specific individual and how and when I could contact them						
Comments						
4. The investigators showed flexibility in their approach towards me						
Comments						
5. The investigators kept me informed throughout the investigation as much as I wished to be						
Comments						
6. I was given the opportunity to make comments on the draft report						
Comments						
7. The investigators gave me a realistic assessment of how long the investigation may take						
Comments						
8. I received a copy of the final report and was given the opportunity to make comments on it						
Comments						



# Family Engagement

## NATIONAL FAMILY FEEDBACK

(at 30 September 2019)

### EPMA INVESTIGATION

"I was not only grieving for the death of my mum but the fact she had been wronged in her final days. To have Helen and Saskia sit patiently and listen to everything we had to say felt like being unburdened. Just to know we were being listened to, taking us seriously and doing something about it, gave me great peace of mind. Just knowing my Mums death may not be in vain and may prevent similar incidents happening to other families. That is the best legacy I can think of in memory of my wonderful Mum and it is what she would've wanted. THANK YOU."

### REPORT TRANSLATION FROM ENGLISH TO TELUGU

"I have gone through the telugu version and all looks good. Translation is so accurate."

# Q&A/Discussion

[Helen.jones@hsib.org.uk](mailto:Helen.jones@hsib.org.uk)

If you would to know more about HSIB

**WWW.HSIB.ORG.UK**

 **@hsib\_org**