Our plans for NHS patient safety investigation

What do you think?

collaboration  trust  respect  innovation  courage  compassion
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Introduction

This report is about how we look into things that have gone wrong when we treat patients.

This report explains:

- How we look into things that go wrong
- Some of the problems with the way we look into things that go wrong
- Things we could change to make it better
We want to know what you think about our ideas for change.

Please read through the report and tell us what you think by answering the separate questionnaire.

Please send your answers back by Tuesday 12 June 2018.
Keeping people safe

Things can go wrong when we are treating people.

Even the best people will make mistakes some of the time.

Safe systems

The best way to keep people safe is to make sure that the whole system is safe.

The system is:

- The way people work
- The way people work together in teams
- The equipment we use
- The hospitals, buildings and grounds
Staff are trained to follow particular instructions for all the different things they do.

Patient safety investigations will focus on the system.

If something goes wrong, there will probably need to be changes to the system.
Investigating what went wrong
The Healthcare Safety Investigation Branch (HSIB) are independent.

They look into things that have gone wrong.

They may suggest that the NHS makes some changes to the system.

They cannot investigate everything.

NHS managers have to be able to do good investigations too.
Serious incidents

The NHS has written guidelines about how to deal with serious incidents.

This involves:

- Making sure that staff report serious incidents
- Setting up the investigation team
- Involving patients, families, carers and staff
- The way that investigations should be carried out
- How to write a report and close the investigation
Investigations must:

- Be open, so that anyone affected can be involved and supported
- Look at how to make sure the serious incident never happens again
- Focus on the facts and not be influenced by personal feelings
- Be done in good time
- Look at all aspects of the problem
- Work well with other organisations
Problems with the way we do investigations

Involving patients, families and carers

Patients, families and carers often think that NHS organisations do not share information with them when something goes wrong.

Patients, families and carers often think that NHS managers are trying to blame someone else instead of trying to find out what happened.

Patients, families and carers often feel they do not get enough support from the NHS when something goes wrong.
Too many investigations
Managers in health organisations are asking for a lot of investigations.

This is a problem because:

- Good investigations are expensive. They take time to do properly

- There are not enough staff to do all the investigations that are being requested

- Often concerns or questions about what happened can be answered by the manager without having a full investigation

Doing investigations for the wrong reasons
Doing investigations for the wrong reasons can stop people learning from mistakes properly.
It can stop people being open and honest during an investigation.

For example:

1. Some managers use safety investigations to decide how good staff are at their job in a way that is not good.

2. Sometimes when someone dies an investigation is used to work out why someone died and not what went wrong and why it did.

3. Sometimes those affected may want someone to take personal responsibility for the situation.

   This must be looked at separately by managers doing investigations for other purposes.
Sometimes a lot of investigations are done on similar incidents. These might not be done very well because there are not enough investigators with enough time to do them all well.

It might improve care and save costs if better investigations were done on a smaller number of incidents.

**The way reports are used**

Senior managers in the NHS are responsible for making sure that health staff have the right training and work in the right systems to keep people safe.

Sometimes managers are looking at the wrong information.

They need to focus on what needs to change in the system rather than how many reports are done and how many are done on time.

They are in danger of making changes to staff instructions based on the wrong information.
Lack of time and skills
Investigations are very complicated.

They need to be carried out by people who:

- Have enough time to do a good job

- Have the right skills to do the job

Sometimes there are not enough people with the right skills available to investigate a situation.

Investigators are supposed to finish an investigation in 60 days. Sometimes investigators have to work a lot of extra hours for no extra pay to complete them on time.
Not using the right method to carry out investigations
Some investigations do not follow good ways of working.

They spend too much time collecting information and not enough time thinking about:

- What the information means
- Testing and setting up ways to stop incidents from happening

Investigators may need more training in good ways of carrying out the investigations.
Next steps

We want to know what you think.

Please give us your views by answering the questions in the questionnaire.

We need to have your answers back by Tuesday 12 June 2018.

We will take your views into account when we decide how and when the NHS does safety investigations in future.

For more information

If you need more information please contact us at:

Email: patientsafety.enquiries@nhs.net

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