

# A new national safety investigator for healthcare: the road ahead

*Short title: A new national safety investigator*

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Competing interests:

CM declares consultancy in patient safety for NHS and other healthcare organisations. CM acted as an advisor to the Public Administration Select Committee inquiry into the 2015 investigation of clinical incidents in the NHS, was a member of the Healthcare Safety Investigation Branch Expert Advisory Group and is currently advising the Healthcare Safety Investigation Branch establishment team.

CV declares consultancy in patient safety for NHS and other healthcare organisations and acted as an advisor to the Public Administration and Constitutional Affairs Committee in relation to the Government's 'safe space' consultation.

The most fundamental principle of patient safety is that we must learn from the past to improve the future. From April 2017, the English National Health Service (NHS) becomes the first healthcare system in the world to have a specialist agency dedicated to investigating and learning across the entire healthcare system. This represents a watershed moment. The use of system-wide, expert-led, learning-focused safety investigation is an essential feature of other safety-critical sectors such as aviation, but has long been missing in healthcare.

In this journal in 2014 we set out the case for establishing a national patient safety investigator along with practical proposals for how it might function.<sup>(1)</sup> That paper triggered a Parliamentary select committee inquiry in 2015<sup>(2,3)</sup> and, after extensive consultation, legal directions and expert guidance for establishing HSIB were published in 2016<sup>(4,5)</sup>. The Healthcare Safety Investigation Branch (HSIB) will systematically and routinely investigate the most serious risks to patient safety across the healthcare system, publicly report on its findings and issue recommendations for improvement. These safety investigations are solely for the purpose of learning and will explicitly avoid allocating liability or blame. The independence of HSIB, still to be fully achieved, will allow it to investigate and make recommendations to any relevant party; these include organisations such as healthcare regulators, equipment manufacturers and education providers who cannot easily be influenced by other agencies

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Now the real work begins. Building a trusted, respected and effective national safety investigator will take time and the challenges are considerable. Some challenges are technical, such as developing appropriate analytical and investigative methods. But in our view, the greatest challenges facing HSIB are primarily social and cultural in nature. These are threefold. First, establishing the legitimacy, authority and independence of national investigative activities. Second, earning the trust and confidence of healthcare professionals, patients and the public. And third, creating systems that constructively support practical improvement across the healthcare system.

### **Independence: establishing legitimacy and an authoritative view**

It is hard to overstate the critical importance of independence for a national safety investigator(6). Safety issues span the entire healthcare system, so HSIB must be able to impartially investigate all organisations entirely free from conflict to build an authoritative system-wide view. Everyone must be confident that the sole purpose of investigation is learning and improvement so HSIB must be entirely separate from any regulatory or oversight bodies. And a national investigator must not be put

in a position of investigating issues that it may itself have contributed to, so HSIB must never be involved in the design or implementation of improvements.

HSIB has initially been formed as a functionally independent body under the auspices of a regulator, NHS Improvement.<sup>(4)</sup> As an interim measure this is understandable. But it is imperative that primary legislation is brought forward to establish HSIB on an independent institutional footing. Without this, HSIB will have to work unnecessarily hard to combat the perception that it remains part of the regulatory establishment, meaning it may struggle to gain the professional trust, public confidence and authoritative view that its work depends upon.

### **Trust: accessing, protecting and disclosing safety information**

The core purpose of a national safety investigator is to maximise system-wide learning from past events. This requires a deep understanding of the causes of safety issues, which in turn requires accessing detailed information about events. In practice, the most valuable information is often contained in personal memories of past events. The success of HSIB will therefore depend on trust: people's willingness to openly and fully engage with safety investigations. To encourage the open flow of safety information, healthcare professionals and organisations must be assured that any information generated solely for the purposes of safety investigation—such as witness statements or investigators' notes—will only

be used for the purposes of learning and will not be routinely passed to regulators or courts. The Government has committed to establish 'safe space' protections to do just this.<sup>(7)</sup> However, as in other safety-critical industries and in line with the principles of a just culture,<sup>(8)</sup> any protection of safety information must be aligned with other responsibilities. Patients and families must be assured they will receive all relevant information in line with the duty of candour, and detailed investigation reports must be published publicly.

HSIB will rely primarily on trust and cooperation to ensure complete and insightful investigation. However, where individuals or organisations seek to conceal information, HSIB will need strong formal powers to access all relevant safety information from any relevant party. Critically, it should be an offence to hide or tamper with evidence or otherwise interfere with an HSIB investigation. Safety investigations should not generate any fear of being blamed, punished or victimised—but everyone should take seriously their responsibility to participate fully and openly in investigations intended to save lives.

### **Improvement: acting as a catalyst of learning and change**

The ultimate objective of HSIB is to bring about practical change and improvement across the healthcare system. As a small organisation with a budget of less than £4m a year this will be challenging, but there are unique opportunities. An immediate challenge is determining where to focus

investigative resources given the enormous quantity of safety incidents reported each year. HSIB must be robust and systematic in prioritising its investigations, principally by evaluating the underlying systemic risk to patients and appraising the 'safety value' of investigation.(9) HSIB has many opportunities to improve learning across the NHS. Two stand out. First, it is ideally situated to coordinate a national network of local investigators and safety specialists. This would allow HSIB to disseminate exemplary methods and expert guidance, draw on local expertise in the investigation of system-wide risks, and establish systems for cross-boundary sharing of safety information, peer support and local lessons. Second, HSIB is well placed to lead the development of innovative approaches to widely circulating safety lessons by using the power of patient stories to engage with professionals, patients and the public, particularly through media such as powerful and engaging films.(10,11) Ultimately, it will be essential that the work of HSIB is rigorously evaluated, both to monitor learning from recommendations and to improve the effectiveness of HSIB itself.

### **A beacon for learning and improvement**

Remarkable progress has been made in the short time since this journal published our proposal for a new national safety investigation body for healthcare(1). Many challenges lie ahead, and the most complex concern social issues of legitimacy, authority, trust, influence and learning. But,

with careful thought and committed action, the Healthcare Safety Investigation Branch has the potential to lead the way in institutionalising one of the most fundamental tenets of patient safety improvement: a future in which the past is treated with the rigour, respect and sensitivity it deserves.

## References

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