Health Services Safety Investigation Body (HSSIB)

HSSIB is fully independent arm's length body of the Department of Health and Social Care. It is independent of the NHS, it is hosted under the Care Quality Commission (CQC).

Their role is to carry out independent patient safety investigations that do not find blame or civil or criminal liability with individuals or organisations.

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The **charity** for **patient safety** and **justice**

AvMA is the charity for patient safety and justice. We provide specialist advice and support to people when things go wrong in healthcare and campaign to improve patient safety and justice.

For advice and information visit
www.avma.org.uk

Or call our helpline
10am-3.30pm Monday-Friday
(03 calls cost no more than calls to geographic numbers (01 or 02) and must be included in inclusive minutes or there can be a cost per minute)
0345 123 2352

82 Tanner Street
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Registered charity in England & Wales (299123) and Scotland (SCO39683)

What is HSSIB and what it their role?

HSSIB is fully independent arm's length body of the Department of Health and Social Care. It is independent of the NHS, it is hosted under the Care Quality Commission (CQC)

Their role is to carry out independent **patient safety investigations** that do not find blame or civil or criminal liability with individuals or organisations. HSSIB investigations do not decide whether any action needs to be taken against an individual by a regulatory body. They do not name individuals concerned.

HSSIB investigations are carried out using the principle of a "Safe Space". This means that information staff provide as part of a health service investigation will be kept confidential except where there is an immediate risk to patient safety or where the High Court orders disclosure of the information provided.

HSSIB investigations do not replace any existing investigations or other processes that individual patients or families may use to help them address a patient safety concern such as NHS complaints or Patient Safety Incident Response Frameworks (PSIRF), formerly Serious Incident Reporting. Where the patient safety incident meets the definition of a notifiable patient safety incident, notification and investigation of the incident under the statutory duty of candour must still be carried out regardless of whether HSSIB investigates. HSSIB investigations cannot investigate individual incidents, resolve complaints, or act on behalf of patients or families. Please click on the links for more information on PSIRF and the **Duty of Candour**.

What can HSSIB investigate?

They can investigate patient safety concerns that:

• occur in England during the provision of healthcare services, and

• have or may have implications for the safety of patients.

Health Services Safety Investigations Body (HSSIB) investigations can consider healthcare provided in the NHS and the independent sector where safety learning could also help to improve NHS care. There are four key principles that determine whether they investigate:

i. How widespread and how common the patient safety issue is in healthcare.

ii. The extent to which the issue may impact on the safety of patients, including consideration of any groups of people who may be disproportionally affected.

iii. Consideration of any current or future investigations or improvement work carried out to mitigate the issue.

iv. The potential for an HSSIB investigation to drive positive change and improve patient safety.

How do patient safety concerns come to their attention?

There are a number of ways the HSSIB becomes aware of cases:

- Direct contact with patients and families.
- Direct contact with NHS and healthcare staff.
- Access to patient safety incident reporting systems.
- Regular contact with national organisations.
- Regular contact with organisations that represent patients including AvMA.

How do they investigate and how might my family or myself be involved?

If HSSIB decide to investigate they will gather a range of evidence which can include:

• Speaking with patient and families.

• Reviewing relevant medical records, local policies and incident reports.

HSSIB aims to:

• Listen to concerns shared by patients when they select areas for investigation, to help them focus on the most serious issues.

• Work with patients and families, or representative groups, during investigations to understand your experiences of care.

For additional information for patients and families please see:

hssib.org.uk/investigation-process/information-for-patients-and-families/

For detailed information on the evidence they gather and how they investigate such as the methods used , resources referred to and expert advice please see:

www.hssib.org.uk/investigation-process/evidence-collection-and-analysis/

• HSSIB have extended powers to enter premises, investigate and seize items from premise such as documents and equipment.

• Compel people to speak with them.

Will I be sent a copy of the report?

Once an investigation has been completed HSSIB will share investigation reports for comment and feedback before they publish a final report, to help them check and challenge their findings, safety recommendations and other safety learning.

Their investigation reports produce findings that identify where action can be taken to improve patient safety. These are shared in full in HSSIB reports, which are published in the **patient safety investigations** section.

Findings include:

• safety recommendations

• safety observations

• safety actions

• local learning

For further information please see:

hssib.org.uk/investigation-process/findings-and-safety-recommendations/

Please note that because HSSIB investigations are carried out under the safe space principle (see above information on safe space) that means any information provided to HSSIB during their investigations is protected, you will not be entitled to hear or see any statements, evidence, or other information which might have been provided to the investigating team even if you bring legal proceedings. The only way you can see this information is if a High Court Judge orders this which they are extremely unlikely to do.

How do I let HSSIB know of a concern?

You can tell HSSIB your concerns about a healthcare experience you as a patient or a family member may have experienced in three ways:

• Complete online form.

• Email **insights@hssib.org.uk**.

• Leave a message on answerphone service on **01252 222200**.

If you would like to tell HSSIB about a concern using a different language or format, you can email **insights@hssib.org.uk** or leave a message on answerphone on **01252 222200**.

They will send you an acknowledgement and may seek to get additional information from you. All information shared is treated in the strictest confidence.

How can AvMA help me?

AvMA has a team of highly qualified caseworkers who are all either medically and/or legally trained and can provide advice and assistance on a wide range of issues relating to concerns you may have about your medical care.

Typically, we can:

• Help to resolve any questions you may have about the criteria for HSSIB national investigations

• Advise you on the NHS complaints process

• Help you understand the HSSIB investigation report

• Advise you on other routes for investigation such as the NHS complaint process, and health professional fitness to practice procedures if you feel that a health professional is unfit to practice

• Put you in touch with a specialist AvMA accredited solicitor who has the experience and expertise to assist you in this highly complex area of medicine and law

www.avma.org.uk/donate

Be part of the movement for better patient safety and justice

Support AvMA's work today

You can help make healthcare safer and fairer for all

Our vision is a simple: **People who suffer avoidable medical harm get the support and the outcomes they need.** This vision is underpinned by four objectives, we believe, will transform trust in the NHS and healthcare generally and significantly cut the cost – financial and human – which is incurred annually in settling legal claims as well as dealing with the human costs associated with traumatic medical injuries and death. Our four key objectives are:

- To expand the range of communities we serve and so enabling more people experiencing avoidable harm to access services from us that meet their needs
- To empower more people to secure the outcomes they need following an incident of medical harm, whilst providing caring and compassionate support
- To eliminate compounded harm following avoidable medical harm
- To have the necessary diversity of sustainable resources and capacities to deliver

Ongoing donation from as little as £5 a month could go a long way:

£5/month could provide vital advice to patients and families via our helpline

£10/month could help train a volunteer helpline advisor

£50/month could help support a family through an inquest hearing

Your help could make a real difference to patient safety in the UK

Please donate today at www.avma.org.uk/donate

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