Case study

NHS England | Department of Health

Designing the new Healthcare Safety Investigation Branch for England

There will be a new Independent Patient Safety Investigation Service, which will be a central hub of expertise to advise Trusts when they need to investigate something quickly and with a wholly independent team.

Jeremy Hunt
Secretary of State for Health
Summer 2015

The ambition

Following landmark enquiries, such as Mid Staffordshire and Morecambe Bay among others, the ambition was to establish a body to help the healthcare system in England respond more effectively when things go wrong.

What we did

SK designed the lines of enquiry and engagement strategy, and led the engagement with key stakeholders including staff, leaders and patient groups. We ensured the engagement captured valuable learning and ideas that would inform the Expert Advisory Group (EAG) and directly influence their recommendations. Our approach included open and face-to-face dialogue between Government and stakeholders.

Thoughtfully

Creatively

With care and sensitivity

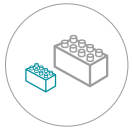
The subject of what could be done better when things go wrong is both complex and sensitive. We had to listen hard, draw out stakeholder learning and ideas with care and creativity.

We understood who needed to be part of the conversation, establishing the governance so that we could work with differences in perspectives and opinions in ways that turned them into assets, not challenges. Clear lines of enquiry ensured we explored the key issues highlighted by the EAG and stakeholders. They were factored into all forms of engagement.

We used research, questionnaires and depth and filmed interviews together with:

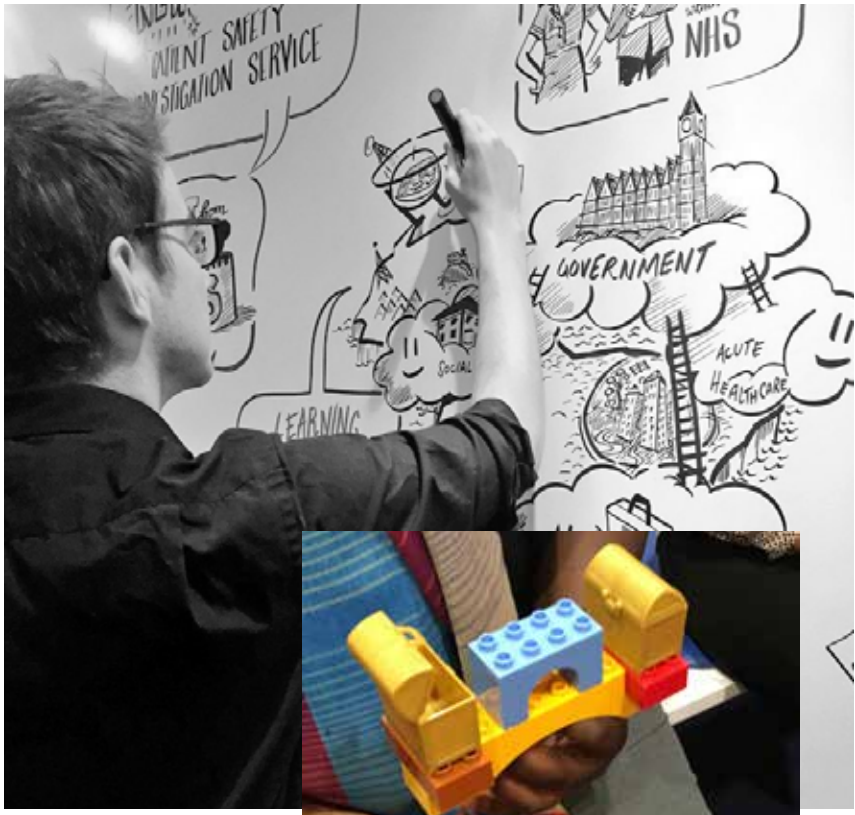
Visual storytelling

We captured ideas and recommendations with powerful visual artistry. **Why?** Because an image can show a complete set of thoughts and bring it to life more powerfully and holistically than words on a page.



Play with purpose

We used purposeful play to draw out recommendations for the design of the future body and to engage important stakeholders in considering the more complex issues that needed to change.



FACT

You use **70%** more of your brain when you build and create at the same time

With people

Open and live debate

We brought the team and members of the EAG to the stage for a live debate and voting on what the priorities for the future should be. The session proved so popular that it was streamed to extra theatres.

We engaged clinicians, patients, leaders and quality experts in open and rolling debates with policymakers and members of the EAG.

They welcomed this refreshingly transparent and collaborative approach

The outcome

Our final report mapped the findings against recommendations to determine the level of support or otherwise from stakeholders. This important feedback and evidence directly influenced the final recommendations from the EAG to the Secretary of State for Health.

A key recommendation included a change of emphasis from 'the role of investigator' to representative and supporter of 'best practice'.

The Social Kinetic team worked in partnership with us, to develop and deliver in-depth engagement to support the establishment of a new Healthcare Safety Investigation Branch. This was an important exercise to get right. It was vital that we engaged meaningfully and sought the opinions of a range of groups including patients, families and frontline healthcare staff with first-hand experience of investigations.

The Social Kinetic worked closely with us and developed and delivered a plan that reached and engaged our stakeholders meaningfully, including a variety of creative tools and techniques. The content and evidence the engagement generated was used to inform the Expert Advisory Group and its recommendations to Government around the Investigation Branch's scope and how it should operate. We are now confident that an Investigation Branch will soon be launched that is fit for purpose, supports and serves the needs of patients, families and NHS staff, and ensures learning sits at the heart of all investigations to help the NHS to continually improve as it learns from its mistakes.

Dr Mike Durkin
NHS National Director of Patient Safety