

Annual Conference – 25 May 2017
From assurance to inquiry: conversations about safety

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INVESTIGATION BRANCH

HSIB Vision

23 March 2017

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Purpose

Objectives

Method

Values



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Improve Patient Safety through ***Effective*** and
Independent Investigations that do not ***Apportion Blame***
or ***Liability***



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Determine the ***causes*** of clinical incidents

Encourage ***safety action*** and make ***safety recommendations*** to prevent recurrence

- Conduct thorough, independent, impartial and **timely** investigations into clinical incidents
- Engage NHS staff, other medical organisations and patients and/or relatives in the investigation process **incl local patient safety team**

Protect **sensitive** safety information including **witness statements**

- Treat the patients and relatives of incidents sympathetically and help them understand 'what happened' and what is being done to prevent similar events in the future
- Produce clearly written, thorough and concise reports with well-founded analysis and conclusions that explain the circumstances and causes of clinical incidents without attributing blame



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- Make ***safety recommendations*** to improve patient safety where appropriate and report on any ***safety action*** planned or already taken
- Improve patient safety by promulgating the lessons learned from investigations as widely as possible
- Encourage the development of skills used to investigate local safety incidents in the NHS
- Act as global ambassadors for safety investigations
- Maintain and develop excellence in its people and provide a fulfilling and safe environment in which to work



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- Criteria
- Trigger Event
- Preliminary Examination
- Full Investigation
- Draft Report
- Comments
- Final Report
- Safety Action and Safety Recommendations
- Responses





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