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

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## 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



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



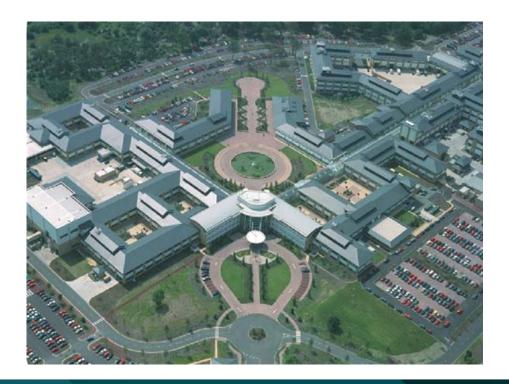
- Make safety recommendations to improve patient safety where appropriate and report on any safety action planned or already taken
- Improve patient safety by promulgating the lessons learned from investigations as widely as possible
- Encourage the development of skills used to investigate local safety 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



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









HEALTHCARE SAFETY INVESTIGATION BRANCH

