Introduction to the Healthcare Safety Investigation Branch
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
Practicalities

- The primary trigger event must have occurred after April 1\textsuperscript{st} 2017
- Up to 30 investigations per year
- Spanning all healthcare settings (primary, community, acute, MH, maternity etc) – England Only
- NHS-funded care
- Team members from a variety of backgrounds inc:
  - Human Factors
  - Clinical
  - Transport / engineering
  - Commissioning
  - Academics
Practicalities

- Independence – Legislation
- First in existence (globally)
- Applied learning from Air Accident, Rail Accident and Marine Accident Investigation Branches.
- We are learning ~ every investigation is reviewed internally for how we could have done things differently.
Safety Investigations

- Triggered by;
  - A particularly serious patient safety incident
  - A pattern of related incidents
  - Referrals from patients, families, clinicians or organisations
 Criteria

The “safety value” of an investigation is determined according to its:

1. Outcome impact
   • actual or potential impact on patients

2. Systemic risk
   • the degree to which the safety issue is system-wide across sectors or settings

3. Learning (and improvement) potential
   • the degree to which an investigation is likely to lead to improved safety
Intelligence gathering mechanisms

- Submission mechanisms
  - Direct reports from individuals, NHS organisations, regulatory and oversight bodies
- Analytic mechanisms
  - Analysis of databases (NRLS & StEIS), reports, reviews, research literature, other media. Previous reports and investigations from our database.
- Social mechanisms
  - Professional networks, consultations, forums
Recommendations

• To any appropriate body or individual that has system wide influence to improve safety, including:
  – National regulators
  – Commissioners
  – Policymakers
  – …as well as local NHS organisations
• All our reports are published on our website
• Recommendations will be shared prior to publication and require acknowledgment by owner – this doesn’t mean that they will implement it
• All recommendations and the owners response will be published on our website.
To notify us of a safety event our website

www.hsib.org.uk
Questions