



Healthcare Conference 2022

17 - 18 March 2022 | QEII Centre, London

Safety spotlight

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HEALTHCARE SAFETY
INVESTIGATION BRANCH

GS1 UK

Keith Conradi

Chief Investigator

18 March 2022

1. Current status
2. Future plans
3. Expanding role
4. Reflections

National investigations

61 * 
reports published/completed

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177 safety recommendations to 44 different organisations

137 safety observations

50 safety actions 

***As of 31 December 2021** 

Publications:



Maternity investigations



Publications:



Future Plans



From April 23...

1. Health Services Safety Investigations Body
2. SpHA (secondary legislation)



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Health and Care Bill

[AS AMENDED IN COMMITTEE]

CONTENTS

HEALTH SERVICE IN ENGLAND: INTEGRATION, COLLABORATION AND OTHER CHANGES

PART 1

NHS England

1. NHS Commissioning Board retained NHS England
2. Power to require commissioning of specialised services
3. NHS England mandate: general
4. NHS England mandate: general
5. NHS England: wider effect of cancer outcome targets
6. Public involvement: cancer outcome targets
7. Support and assistance: cancer outcome targets
8. Exercise of functions: cancer outcome targets
9. Preparation of accounts relating to provision of services
10. Funding for service integration
11. Payments in respect of quality
12. Secondments to NHS England

Integrated care boards

13. Role of integrated care boards
14. Establishment of integrated care boards
15. People for whom integrated care boards have responsibility

Integrated care boards: functions

16. Commissioning hospital and other health services
17. Commissioning primary care services etc.
18. Transfer schemes in connection with transfer of primary care functions
19. Commissioning arrangements: removal of discretions
20. General functions

Integrated care partnerships

21. Integrated care partnerships and strategies

HL Bill 114

Education



1. Current courses
2. Health and Care Bill
3. Global opportunity

Reflections

1. Staff and family engagement – **best evidence**
2. Professional approach – **SEIPS**
3. Independence of operation – **not a regulator**
4. Impartiality – **different backgrounds, no opinion**
5. Systemic learning – **few and far between**
6. Cultural change – **escalation where necessary, parallel**
7. Safety Recommendations and Safety action – **hierarchy**

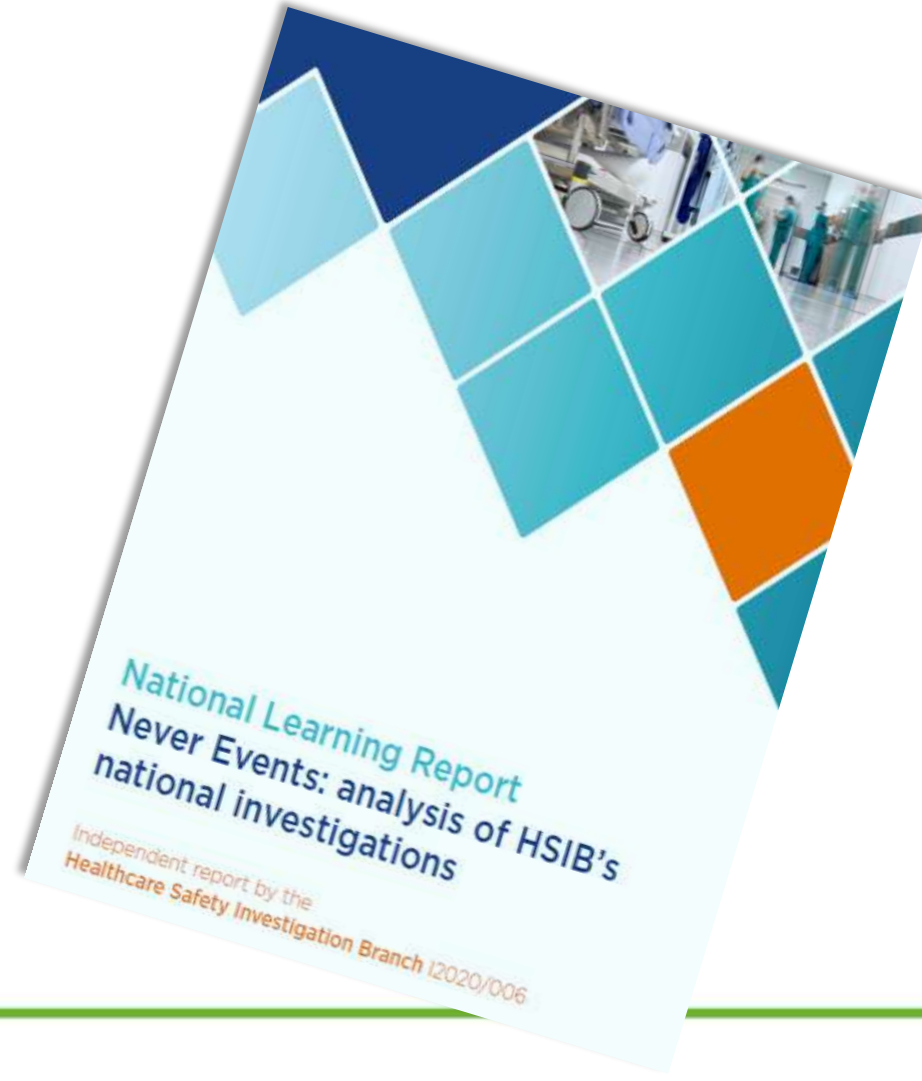
Reflections



1. 'Never events' – example of learning reports



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National Learning Report
Never Events: analysis of HSIB's
national investigations

Independent report by the
Healthcare Safety Investigation Branch 12020/006

Reflections

1. 'Never events' – how to decide what to investigate
2. Safety Recommendations – escalation
3. Impact on regulatory landscape – too many?
4. Safety leadership – too little?
5. Benefit for local Trusts – not enough

Finally...

