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#### Rozija Benīvorta,

Veselības aprūpes drošības daļas galvenā pētniece, Apvienotā Karaliste











# Improving Patient Safety in England through Investigation

Dr Rosie Benneyworth, Chief Executive Officer Healthcare Services Safety Investigation Branch











#### To err is human'

The problem is not bad people in health care — it is that good people are working in bad systems that need to be made safer









# Patient Safety in the NHS

- 5945 patients in England reported to have serious, life changing harm in the year to March 2021
- £2.26 billion the direct cost to the NHS of clinical negligence in 2020/21
- 237 million medication errors in England annually consuming 181626 bed days

https://www.nhsconfed.org/publications/patient-safety-healthcare-products-and-services











What is the impact on health and care professionals?





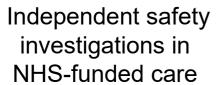






#### **About** us







Do not apportion blame or liability



Focus on systemlevel (policy and regulatory) change



Professionalise the patient safety investigator role











### Our approach









Wide ranging expertise from safety-critical industries

Multidisciplinary and inclusive teams; patient and family involvement Focus on learning not blame to reduce further risk of harm

Transparent and collaborative to support learning











# HSIB's investigation programmes

National investigations programme	Maternity investigations programme
2016 Directions – core purpose of HSIB	2018 Directions – additional specific programme
Diverse range of healthcare services and safety risks	Explicit focus on NHS maternity services in England
<ul> <li>Criteria: we decide</li> <li>scale of risk and harm</li> <li>potential for learning to prevent future harm</li> <li>impact on individuals and public confidence in the healthcare system</li> </ul>	<ul> <li>Criteria: set for us</li> <li>RCOG Each Baby Counts programme</li> <li>Direct maternal deaths</li> <li>Indirect maternal deaths while pregnant or within 42 days of giving birth</li> </ul>
Up to 30 investigations a year	Circa 1000 investigations a year
Do not replace local investigations	Replaces the local investigation
Recommendations made to healthcare and beyond	Recommendations made only to the trust
Reports published on HSIB website	Reports belong to the family and the trust

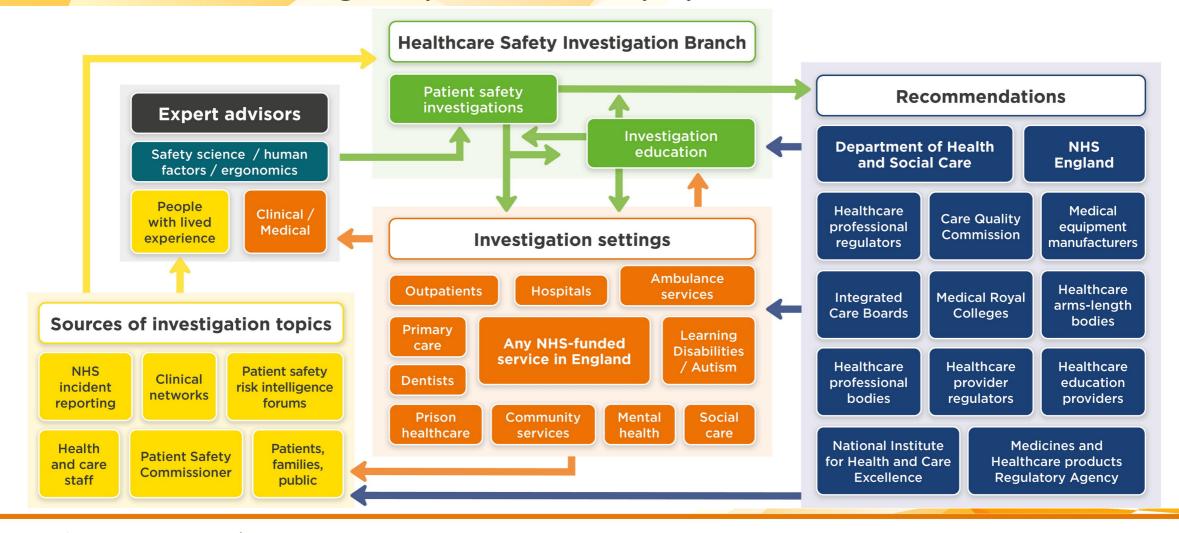








#### Our role in the English patient safety system





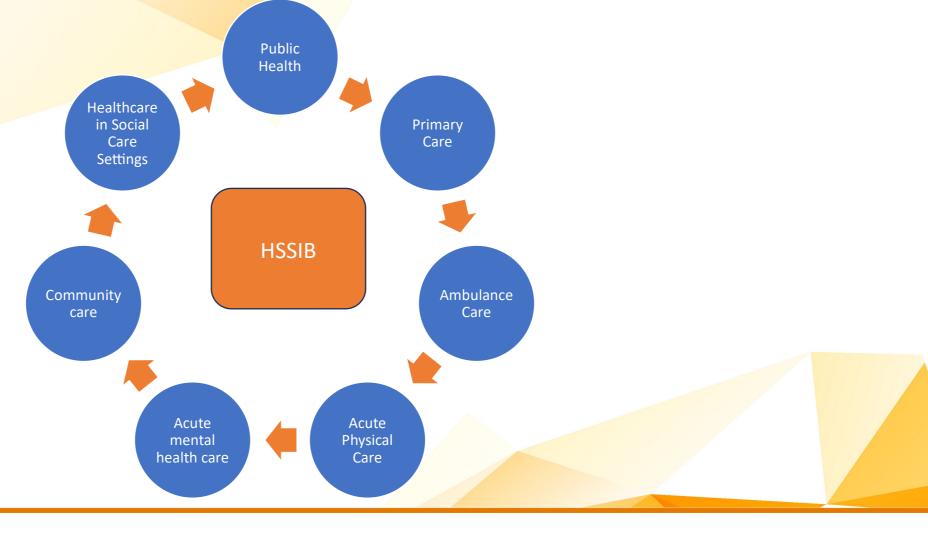








#### HSSIB can investigate at the interfaces between care sectors













# Some positive impacts from our investigation reports and recommendations

New professional guidance to improve the diagnosis of aortic dissection

Authorised engineers for hospital oxygen systems must now maintain an approved professional registration

Improvements to providers' management of outpatients to reduce missed appointments

Safer use of fetal heart rate monitoring equipment in hospital maternity units

Measures to ensure the safe and effective delivery of telephone triage for future healthcare emergencies

Providers are using HSIB investigation techniques for their own investigations Increased standardisation of common safety critical steps in the National Safety Standards for Invasive Procedures

Work is underway to improve medications safety in paediatrics care











# Health Service Safety Investigations Body

Learning from failure: the need for independent safety investigation in healthcare

Carl Macrae<sup>1</sup> and Charles Vincent<sup>2</sup>

Public Administration - Sixth Report Investigating clinical incidents in the NHS



#### Learning not blaming

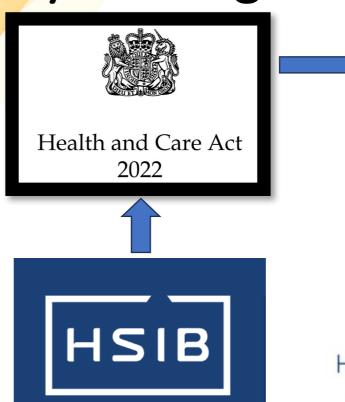
The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation



The National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016



Carl Macrae and Charles Vincent





Investigations Body











## Why safety management systems?

- The continuous improvement of patient safety is a priority for all modern healthcare systems.
- Despite improvements, there are reoccurring patient safety problems, suggesting that learning isn't being sufficiently embedded and sustained.

• Aerospace, aviation, rail, shipping, nuclear, defence, oil and gas industries have one thing in common: they use safety management systems to manage safety well.









# Our investigation

















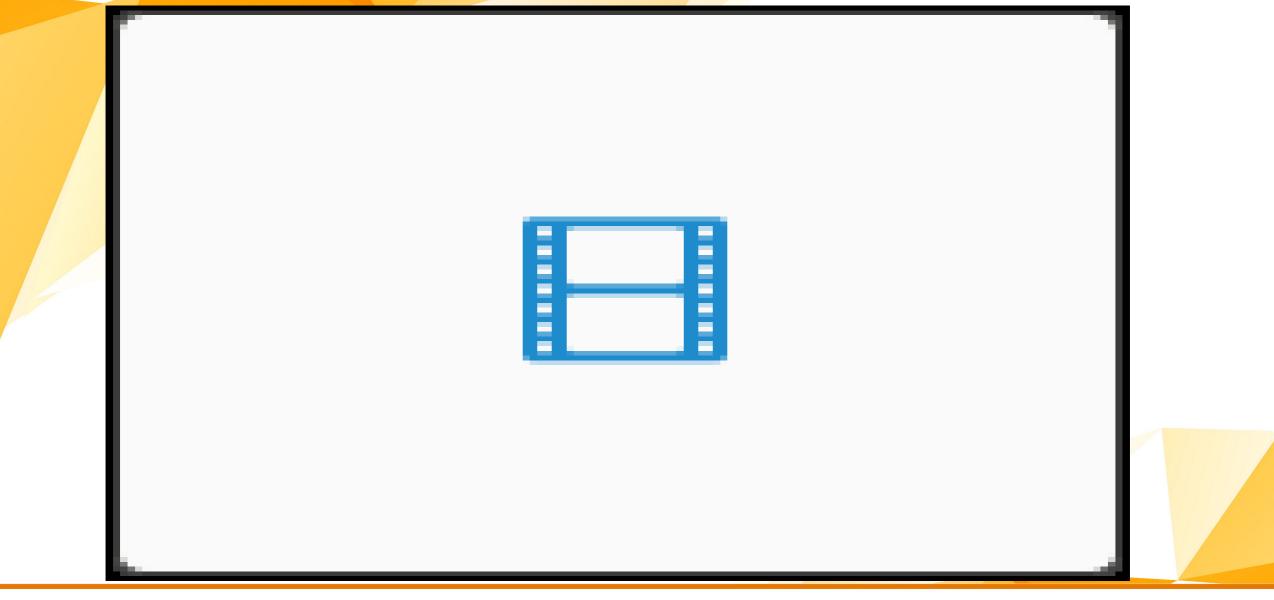






















# Questions?













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# CILVĒKS - LATVIJAS VESELĪBAS NOZARES VĒRTĪBA

2023. gada 28. septembrī







