HEALTHCARE SAFETY INVESTIGATION BRANCH
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Sent by email

07 July 2022

Dear Secretary of State

Today is my last day in office as the Chief Investigator at the Healthcare Safety Investigation Branch (HSIB). It is nearly six years since the HSIB was established with a mandate to introduce a culture of safety investigation into the NHS similar to that successfully deployed in the transport sector. My previous experience as a professional pilot and Chief Inspector of the Air Accidents Investigation Branch together with my time in the HSIB, has given me a unique insight into the approach to safety by these very different sectors. I consider this perspective adds value and I offer the following two points for your consideration.

Leadership

One of the reasons aviation safety has been so successful is because of the attention it receives from the most senior officials at government and regulatory levels. Although this is evident in some NHS organisations, I have not seen this attention replicated at the highest levels within the recent leadership of the Department of Health and Social Care and NHS England.

Successive leaders of NHS England have shown little interest in the activity and potential of HSIB and that lack of emphasis has been adopted by the underlying layers of management. I presented the work of HSIB to the leaders of nearly all the national bodies in healthcare and have been a guest at many of their Board meetings; the exception to this has been NHS England where no invitation has ever been received. A lack of NHS England participation delayed several HSIB Covid related investigations and reduced the safety impact of their output. This is unacceptable from any organisation but in particular from one that has the privilege of hosting HSIB.

I also believe the attention of the Secretary of State to safety is crucial to its success. Since the days of Jeremy Hunt, this has been far less evident and transmits a message that safety can be delegated. It cannot. For safety to be taken seriously by an organisation it has to be a priority, and signaled as such, from the very top of the organisation.

I urge you to show strong safety leadership and encourage those across the sector to do the same.

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Structure

All airlines in the UK and throughout most of the world are required by law to operate a safety management system. This is a familiar concept to safety critical industries where safety is considered in a systematic and proactive way with goal setting, planning, assurance and measurement of performance. This requires accountability from the top of an organisation and allows safety to be actively managed in the same way, *and with the same priority,* as performance and funding. In practice this means that Boards consider safety in all their decision-making tasks.

Where safety is conducted well in the NHS, it is because of the drive and enthusiasm of individuals rather than through a state organised structured approach. The Patient Safety Strategy introduced a few years ago makes a positive start to reorganising the safety system and could be even more ambitious by introducing a regulated safety management system.

I urge you to consider this approach for healthcare at national, regional and local levels. Mandating such a system would encourage the development of a safety culture amongst all staff and drive a non-punitive approach to reporting and learning from safety incidents.

Thank you for your attention,

Yours sincerely

Keith Conradi

Chief Investigator