HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

Healthcare Safety Investigation Branch

Annual Review 2017/18

WWW.HSIB.ORG.UK

Welcome

Changing the safety landscape

Keith Conradi - Chief Investigator

We are proud that HSIB is the first organisation of its kind in the world to conduct healthcare safety investigations that do not apportion blame or liability and concentrate on identifying systemic weakness. Our investigations will identify common themes, involve staff and family at their core and make safety recommendations to the healthcare system.

During 2017/18 we have developed and expanded our structure to ensure we are well placed to deliver up to 30 national investigations in 2018/19 as well as the recently launched national maternity investigation programme. We have deliberately located the HSIB head office in the Cody Technology Park in Farnborough, a hub of innovation and close to the centres of rail and aviation accident investigation from where many of HSIB's fundamental principles are derived.

We are a new organisation but we have grown to a team of over 40 people and will continue to grow as the maternity investigation programme is rolled out across the country. We are rapidly evolving through open dialogue with families, NHS staff, Trusts and national bodies. The core plan is, and will remain, the delivery of high quality investigation reports with recommendations that over time will change the safety landscape of healthcare.

We will publish our first investigation reports from June 2018. These will not specify deadlines for safety improvements but in future reports we will aim to include dates outlining when safety recommendations should be completed.

This review provides you with an overview of our work to date and our aims for the future.

Shaping a safer healthcare system

Dr Kevin Stewart- Medical Director

Healthcare is very different from aviation. It is more complex and more diverse, and breakdowns in patient safety can be much more insidious than safety failures in aviation. However, this shouldn't stop us looking to aviation and other industries for approaches to improve safety that could be adapted for use in healthcare.

One of the reasons that aviation has become so safe has been the model of safety investigation. The aviation safety investigation body is independent of the system in which it operates and investigators are independent of the organisations that they are investigating; they are full time, professional investigators. The investigation model is based on a deep knowledge of human factors, a recognition of the circumstances under which individual human fallibility leads to risk and a focus on finding system-wide solutions to safety failures.

HSIB is adapting the safety investigation techniques which have been so successful in other sectors for healthcare. We select investigations following notification of a safety event and prioritise these depending on our assessment of the safety value of a national HSIB investigation. Safety value depends on the actual or potential harm to patients that the risk represents, the degree to which it is systemic rather than local and the potential for an HSIB investigation to lead to meaningful systemic learning.

We will investigate events where little or no harm has occurred if the underlying risk holds a high potential for harm; it is common practice in other industries to investigate such near misses or low harm incidents so safety risk can be addressed before a catastrophic failure occurs. We will also investigate some events which continue to happen despite extensive focus in the past if we feel that an HSIB investigation is likely to bring a different opportunity to learn. Some recurrent Never Events have been addressed with repeated recommendations to front line staff; in other industries such recommendations are recognised as weak defences against failure unless accompanied by more systemic changes to the system.

To succeed HSIB will need the support of the patients and families that we serve, clinical professionals, other frontline staff, policymakers and system leaders. We have been very encouraged by our early work because our experience is that we have widespread support for this unique opportunity to improve the safety of healthcare.

> “Anyone can raise a safety concern with HSIB. Contact us if you would like to alert us to an event which occurred after 1 April 2017 and which could be an example of a wider safety issue in the NHS. You may contact us at hsib.org.uk and we take anonymous referrals.
>
> **Dr Kevin Stewart - Medical Director**

About HSIB

The formation of HSIB is a world-first and represents a landmark moment for the NHS in England. Our mission is simple: to help improve safety in our healthcare system by developing recommendations and sharing lessons from our investigations. This is underpinned by a philosophy focused on safety and improvement that avoids blame or liability.

Our purpose

To improve patient safety through effective and independent investigations that do not apportion blame or liability.

We will deliver this purpose through:

- **Learning for improvement** – by using findings to deliver practical solutions, address causes and contributory factors and provide support to increase the capability within local NHS systems
- **Diffusing our learning** – through effective communications and engagement with the wider health and social care system

Our values

Independence

- We are independent and work with integrity acting without obligation or direction from external organisations
- Our investigations are carried out in a professional manner with integrity, confidentiality and compassion

Collaboration

- We treat each other with respect and collaborate openly to make a greater impact
- We work in a way that supports our values and takes advantage of different perspectives
- We seek to understand and reflect the views of everyone we engage with

Trust

- We are truthful and are informed by evidence and experience
- We have courage to say and do the right thing
- We are people focussed and will create a trusting professional relationship with everyone we meet

Respect

- We seek out alternative perspectives and put our shared interests ahead of any individual or team
- We embrace, and seek to increase, the diversity of our organisation
- We are respectful of the importance of honest feedback to the people involved and the wider community on investigations

Compassion

- We treat everyone as we would expect to be treated ourselves
- We are accountable for failure as well as success and will not allocate blame
- We will show kindness and humility in our actions and behaviours

Accountability/Leadership

- We have a workplace "just" culture that values people and relationships ensuring all HSIB staff have the ability to speak openly and honestly but retain accountability
- We are accountable for our conduct and our decisions

Independence

- HSIB's independence is reinforced by impartiality. Investigations are determined by strict criteria. HSIB accepts referrals from anyone but does not investigate on behalf of specific individuals, groups or organisations.
- HSIB's investigations are conducted by a team of professional investigators from a range of safety-critical backgrounds. This includes the NHS, transport and the military. HSIB also draws on additional expertise when required, including human behaviour specialists.
- HSIB is independent of the NHS and other organisations such as the Care Quality Commission (CQC) and other NHS organisations. We are funded by the Department of Health and hosted by NHS Improvement.
- The HSIB Advisory Panel has been established to uphold the organisation's independence. The panel meets quarterly to discuss strategy and corporate objectives.

> "This represents a watershed moment. The use of system-wide, expert-led, learning-focused safety investigation is an essential feature of other safety-critical sectors such as aviation, but has long been missing in healthcare.
>
> **Carl Macrae and Charles Vincent, Department of Experimental Psychology, University of Oxford**

Key principles

We are adopting the following principles in our investigations.

Involving patients and families
We are developing our approach to ensure patients and families are involved in the investigations in a meaningful and respectful way. We are very aware that patients and families have a vital role to play in healthcare investigations and that, in the past, patients have at times felt excluded from investigations or questioned whether their contributions have been valued. We are working with researchers to ensure we are able to analyse and use what patients and families tell us as evidence, alongside staff interviews and other information to build a complete and accurate account of events.

Use of experts
To date investigations in the NHS have generally been carried out by clinicians and others who have had limited training in this field. We are applying the experience from other safety sectors using professional independent investigators who have extensive training in safety, psychology and how errors happen.

System approach
We will also shift the focus of healthcare investigations from the individual to the system. So rather than ask "who did something wrong?", we will adopt the learning from other sectors and ask "what were the circumstances under which this happened?" and "what is the safety issue here?" Our investigations will try to change the circumstances by addressing the system issues. People will make mistakes.

Transparency
As with other sectors, when front-line staff make statements to investigators, they have a degree of legal and regulatory protection. This enables staff to speak up and encourages greater transparency and an atmosphere of learning and improving, rather than blame.

Using evidence
Safety investigations in other sectors rely on technical data such as flight recorders, cameras and electronic tracking systems. Over time we will see how we can make more use of technical evidence to help triangulate what we collect from interviews and personal recollections.

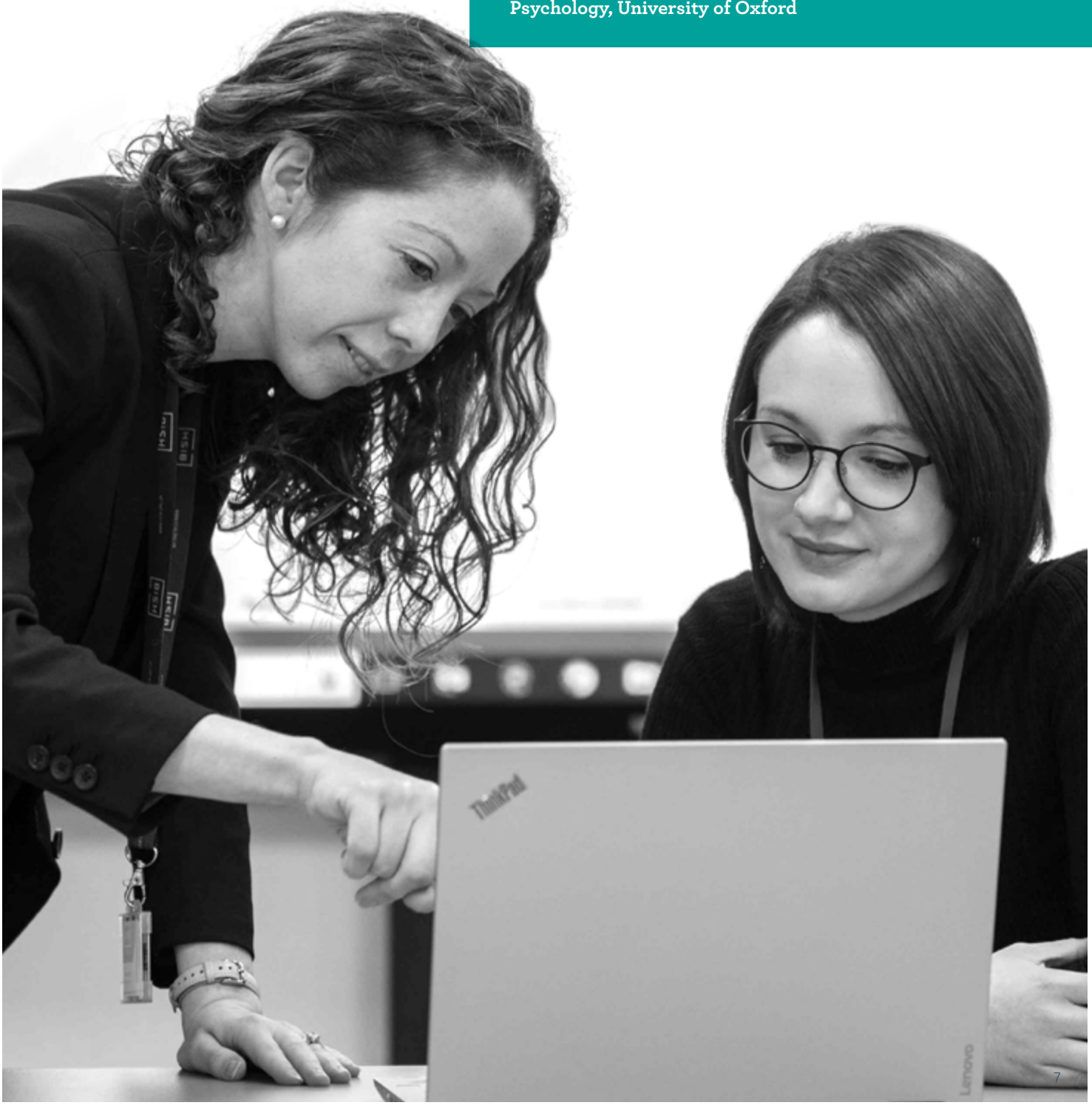
Learning from near misses
Near misses are routinely investigated in other sectors. We will adopt a similar approach in healthcare so that opportunities to prevent harm are not lost.

Our approach also includes monitoring and collecting intelligence for potential investigations from national incident reports, research literature, patient groups, mainstream media and other publications. We also carry out background research on emerging safety issues to help us make decisions about reported events.

> "Your approach was so reassuring. I could say exactly what happened without fear of being blamed.

Medical professional – comment during an HSIB investigation

> The most fundamental principle of patient safety is that we must learn from the past to improve the future. From April 2017, the English National Health Service becomes the first healthcare system in the world to have a specialist agency dedicated to investigating and learning across the entire healthcare system: the Healthcare Safety Investigation Branch.
>
> **Carl Macrae and Charles Vincent Department of Experimental Psychology, University of Oxford**



Five-year strategic goals

We have established five-year strategic goals. These are underpinned by specific and measurable objectives.

01

Undertake independent safety investigations with objectivity, underpinned by competence, credibility and integrity

Corporate objectives

- Involve patients and families in investigations, as far as practicable and appropriate
- Influence improvements in quality, safety and patient experience through professional investigations that identify systemic learning, rather than apportion blame or liability
- Operate as an exemplar within safety investigation
- Develop and define investigation methodologies that are exemplar
- Carry out up to 30 national investigations per annum
- Carry out approximately 1,000 maternity investigations per annum

02

Value and prioritise professional development for staff that includes internationally renowned safety investigation techniques and cutting-edge technology

Corporate objectives

- Develop and implement a workforce strategy and bespoke organisational development programme
- Develop and procure a bespoke safety investigation training programme with a recognised academic partner
- Develop and procure an expert IT partner to create a strategic transformation programme that exploits technological solutions and supports an agile workforce

03

Provide learning to the wider healthcare community and promote professional safety investigation

Corporate objectives

- Develop strategic alliances with academic, health and social care partners to diffuse our learning
- Develop and implement a communications and engagement strategy

04

Improve investigation skills and techniques throughout the NHS by developing scientifically robust method based principles learned from other industries and international research

Corporate objectives

- Employ and train specialist investigators each year with a professional and world renowned accredited safety training provider. The majority of these investigators will be employed on a twelve month temporary contract from the NHS and social care to work on maternity investigations

05

Be financially sustainable, well governed and legally constituted to support our independence

Corporate objectives

- Achieve non-departmental arms-length public body status by establishing the infrastructure to become a high performing organisation
- Develop robust governance, risk and assurance systems
- Establish a national HSIB citizens panel

06

To support and uphold equality across all our work areas, ensuring equitable and fair treatment, access and opportunity

Corporate objectives

- Develop and publish an HSIB equality strategy and action plan
- Invest in an Equality, Diversity and Inclusion Officer
- Work with the Equality Human Rights Commission to deliver mandatory public sector equality duty training to all staff
- Review recruitment processes to ensure processes support equality of opportunity for all
- Review our information and communication materials to ensure they are accessible and that they meet plain English standards

Getting started

As a new organisation our priority has been to build and develop an organisation that has the expertise, capability and capacity to deliver. This has involved:

- Building the right team – recruiting an experienced team from a variety of relevant backgrounds, including clinicians, human behaviour experts and investigators from a range of sectors and supporting our people with world class training
- Developing workspace – setting up offices in Farnborough and Derby to support our staff and complement the nature of our work
- Investing in IT – ensuring the team is supported by state-of-the-art IT software and equipment

Family Engagement Protocol

Genuine and effective family engagement underpins every HSIB investigation. Our family engagement protocol identifies the competencies, experience and expectations of staff to work with families during the investigation process in a sensitive and meaningful way. We have developed this protocol to ensure the information that patients and families send us forms a critical part of the evidence analysed during the investigation.

This work will continue to be expanded in 2018/19 by developing a robust family engagement model that will be led by a Head of Family Engagement for all HSIB investigations.

Training and development

We have commissioned Cranfield University, in conjunction with Great Ormond Street Hospital for Children NHS Foundation Trust, to deliver professional investigation training to support the establishment of the national team. The Cranfield University Safety and Accident Investigation Centre is part of the School of Aerospace, Transport and Manufacturing. For 40 years they have run world-renowned air accident investigation courses for professional investigation agencies across government and industry, and for marine and rail since 2004. All state-level professional accident investigation branches in the UK and many others across the world use Cranfield University to train their investigators. In 2011 Cranfield University was awarded the Queen's Anniversary Prize for its contribution to aviation safety.

The training focuses on the importance of a human-based approach to investigation, considering all contextual, human and systemic issues relating to safety investigation. The training – delivered by experts from health, transport investigation and high-fidelity simulation – includes theoretical and academic study to best equip HSIB's investigators.

Genuine and effective family engagement underpins every HSIB investigation.

The new approach to family engagement

> **The vast majority of parents want desperately to know what happened even when the truth is difficult. After all we've already experienced the worst. But too many of us are left with poor explanations and unanswered questions.**

Extract by Laura Price and Janet Scott from Sands and Michelle Hemmington and Nicky Lyon from Campaign for Safer Births highlighted in the Royal College of Obstetricians & Gynaecologists' Each Baby Counts 2015 report.

We recognise that compassionate and effective family engagement is vital to support families that have experienced loss or harm. We are committed to ensuring the new model of family engagement is timely, responsive to the needs of the family and enables effective liaison between a family and the investigators. The family will be integral to the investigation and will be treated professionally, respectfully and according to individual family needs.

We aim to create a new model of family engagement that underpins every investigation and provides a level of support that meets the needs of each family on a case by case basis. A Head of Family Engagement has been recruited to support the development of the new model and this will be continually informed by the families who interact with HSIB.

The aims of HSIB's new family engagement model include:

- working with the family to sensitively gather all relevant information in the context of the defined investigation
- analysing the needs, expectations and concerns of the family to ensure appropriate information and advice is provided, and relevant referrals to other agencies are made.

The objectives of family engagement are to:

- secure the confidence and trust of the family to ensure they are treated as integral to any investigation
- gather information from the family in a manner which contributes to the investigation
- provide information to and facilitate the required care for the family in a sensitive and compassionate manner
- inform families of the reasons for the conclusion of the family engagement role and to ensure any signposting to other agencies.

Families will include partners, parents, siblings, children, guardians and others who had a direct and close relationship with the patient.

Our first year – highlights

47
Safety Awareness Notifications submitted

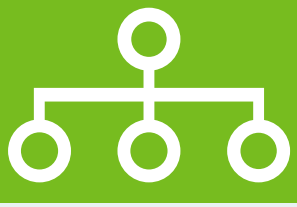
23
Safety Awareness Notifications submitted by patients and the public

26
investigators trained at Cranfield University

12
national investigations launched*

*More information on the HSIB investigations can be found on page 16

Organisational development and set-up



Two offices opened – one in Farnborough and one in Derby

40
staff recruited, including experienced investigators and support staff

HSIB Scrutiny Committee formed and investigation protocols developed

The professional safety investigator

Our team of investigators combines an in-depth understanding of healthcare in England with a track record of investigative experience in other sectors.

This experience and exposure provides us with an insight into the relationships between individual clinical incidents, national issues and underlying influences, enabling investigators to recognise common themes in the thousands of incidents reported every year.

Our approach

HSIB's approach focuses on identifying the causes of incidents and sharing learning with the healthcare sector to help prevent similar issues from happening again. These are prepared in a final report, which includes safety recommendations for the healthcare sector.

Standard for local investigations in the future

The transport model includes features which may be of benefit to healthcare once appropriately adapted. The transport investigation body is able to make recommendations to system leaders and regulators without fear of censure. Investigators are trained, full-time and independent of the organisations they are investigating, not busy people doing investigations alongside their full-time jobs.

Transport investigation methods are devised to seek system level solutions. The methods are based on established safety science principles and an understanding of the risks of human error. For instance they understand that humans will make mistakes – no matter how well-trained, hardworking or diligent they are – and therefore analysis and recommendations are focused on redesigning the systems in which people work rather than blaming the individuals. Investigators offer protection against legal or regulatory sanction for the people they interview, something that is needed in healthcare.

We are developing an investigative approach and methodology in line with the relevant principles that have supported the success of the transport model. This is an evolving process that involves careful testing and ongoing evaluation. There is an active methodology development process that draws on a range of expertise and explores, adapts and optimises key methods to apply to healthcare investigation. We are seeking to draw on cutting edge safety science and practices from a range of industries. A variety of systems-investigation methods and tools are being trialled and adapted for healthcare.

Many of these are new and innovative techniques in healthcare. It has taken new investigation bodies in other industries five or more years to develop an established investigation methodology and approach. Healthcare is much more complex.

The core principles of our investigation approach focus on a commitment to analysing the systems, processes and practices that deliver safe healthcare in a sensitive and integrated way, working closely with everyone involved in a particular area of healthcare to understand why things work, what can be improved and how things can go wrong. We collect evidence by meeting with and interviewing patients and families, interviewing and observing the work of healthcare staff, reviewing policies, protocols and other documentation; examining the design and layout of equipment and work settings; and reviewing organisational processes and regulatory arrangements. A core part of this work involves carefully examining and drawing on existing scientific evidence and relevant research for particular safety risks, to ensure that our findings and recommendations take account of ongoing advancements and improvements.

Identifying safety issues

There are three main channels that helps HSIB identify potential safety issues:

Direct submissions
Anyone can submit a patient safety issue to HSIB via the safety awareness notification form on the HSIB website. Each submission is considered against key criteria to determine whether a national investigation should be launched.

Forty-seven Safety Awareness Notifications were submitted to HSIB in 2017/18. Most were made by patients and families or frontline clinical staff alongside a number from clinical leaders, heads of patient safety, other NHS managers, coroners and whistleblowers.

Proactive analysis
We proactively identify safety issues by analysing a range of intelligence sources. This includes ongoing monitoring of NHS Improvement's Strategic Executive Information System and National Reporting and Learning System, alongside regular contact with the NHS Improvement patient safety team.

We also review coroners' reports, other relevant patient safety databases, safety alerts from Royal Colleges and professional associations, international research literature, patient safety literature and lay press to identify safety issues which might not have emerged through national reporting mechanisms.

Feedback through engagement
Several referrals have been made to HSIB because of our extensive engagement programme. Our engagement includes securing feedback and intelligence from meetings with patient safety groups, academics, Royal Colleges, patient safety collaboratives, Academic Health and Science Networks and other healthcare partners. We are grateful to our partners for also providing us with Subject Matter Experts and for their advice on investigations.

47
Safety Awareness Notifications submitted

Where our referrals come from

- Public - personal
- NHS
- Strategic Executive Information System*
- Coroner
- Other

*The Strategic Executive Information System is the reporting system for Serious Incidents in the NHS.

Our focus is to investigate serious systemic safety issues

The core focus of HSIB is investigating serious systemic safety issues that pose considerable risk to the safety of patients across the healthcare system. Prior to launching an HSIB investigation, it is important to establish that there is sound evidence and robust indications that a serious systemic safety issue exists and warrants HSIB investigation. The information that is drawn on in this process is assessed and analysed through a set of intelligence gathering mechanisms led by HSIB's Intelligence Unit.

1. **Social mechanisms.** These include bespoke forums, professional networks and stakeholder consultations.
2. **Analytic mechanisms.** These include analyses of databases, reports and reviews, research literature and other media.
3. **Submission mechanisms.** These include direct reporting from individuals, notifications from organisations and proposals from oversight bodies.

The intelligence process is a continual process of gathering and reviewing a range of safety information and then using this information to identify a set of systemic safety risks, each associated with one or more reference events.

For those risks researched that are not currently under investigation, the HSIB Intelligence Unit uses the intelligence gathered to build a library of systemic safety risks that have been reviewed and evaluated. This will help to facilitate more rapid assessment in future, if and when, reference events are identified.

Assessing referrals

We assess referrals and other sources of information against agreed criteria to determine the safety value of an investigation. The criteria have been developed by Dr Carl Macrae based on international patient safety research and approaches to systemic investigations in other industries.

Initial notifications are assessed against the criteria to determine if an investigation should be instigated; they are re-assessed at regular intervals throughout the investigation process to ensure that the criteria are still being met.

These criteria are based on:

Outcome impact
Assessing the scale and severity of the actual or potential impact that an issue represents helps to identify the most serious issues. This includes potential harm so that "near miss" and "low harm" individual events can be included, which is common practice in other industries (as they are recognised as a rich source of learning) but has been less common in healthcare. We consider the physical and emotional effects on patients and families as well as the impact on services, such as public confidence in the healthcare system and whether the safety issues have reduced the ability to deliver safe and reliable care.

Systemic risk
We review the system-wide risk associated with safety issues, including the extent to which an issue is common, widespread, persistent or system-wide. Some of the events that have occurred within very different healthcare settings have shared underlying safety issues – HSIB's approach ensures these are taken into consideration.

Learning potential
We carefully consider whether an HSIB investigation and its recommendations are likely to lead to meaningful safety improvements. HSIB is unlikely to initiate a national investigation if it cannot anticipate recommendations that could be implemented. An example of where this might happen includes issues that have already been extensively investigated and robust recommendations for improvement already exist.

On the other hand, HSIB has initiated national investigations on a number of safety issues where there has already been a lot of attention (like some recurring Never Events) but where existing interventions are clearly not robust enough or correctly directed to prevent recurrence.

We carefully consider whether an HSIB investigation and its recommendations are likely to lead to meaningful safety improvements.

Investigations in 2017/18

In the first year we received 47 Safety Awareness Notifications from a range of sources. Each Safety Awareness Notification is assessed against the key criteria before investigations are launched. Between April 2017 and March 2018 twelve national investigations have been launched.

National investigations (launched in 2017/18)	Source/Referrer
Design and safe use of portable oxygen systems	NHS Trust
Implantation of the wrong prosthesis	NHS Trust
Insertion of an incorrect intraocular lens	NHS clinician
Wrong route administration of an oral drug into a vein	Strategic Executive Information System
Transition from Child and Adolescent Mental Health Services to Adult Mental Health Services	NHS Trust
Recognising and responding to critically unwell patients	Whistleblower
Provision of mental health care to adults in the emergency department	Strategic Executive Information System
Wrong site interventions	NHS Trust
Cardiac and Vascular Patient Pathways	NHS Trust
Complex ambulance extraction	NHS Trust
Hypoxic brain injury	Strategic Executive Information System
Delay in diagnosis and end of life care	Member of the public

The HSIB Scrutiny Committee monitors and analyses investigations in line with the key criteria that initiate an investigation. Following this process, three investigations have not continued as full national investigations:

- Complex ambulance extraction
- Hypoxic brain injury
- Delay in diagnosis and end of life care

The HSIB Scrutiny Committee found that these investigations did not meet one (or more) of the assessment criteria. This means that nine full investigations have been taken forward in 2017/18 and reports with safety recommendations are being prepared for publication from June 2018 onwards.

Maternity programme

In November 2017, the Secretary of State for Health and Social Care published a refreshed National Maternity Safety Strategy Safer Maternity Care. The strategy included plans for HSIB to undertake approximately 1,000 independent maternity safety investigations.

The HSIB criteria for maternity investigations is aligned with the Royal College of Obstetricians and Gynaecologists' Each Baby Counts full 2015 report. Some cases of direct or indirect maternal deaths in the perinatal period will also be eligible for investigation. The HSIB investigations replace the local investigations conducted by NHS Trusts. The maternity investigations will continue to reflect the principles and values of HSIB – they will focus on learning, avoiding blame and involving families throughout.

A staged rollout of the programme commenced in April 2018 in the south region of England and is expected to achieve national coverage by April 2019. HSIB is expecting to complete up to 300 investigations between 1 May 2018 and 30 April 2019. During the following years approximately 1,000 investigations will be completed and the aggregated learning shared across the system.

HSIB has conducted a comprehensive national recruitment campaign to attract 120 maternity investigators of the highest calibre. An extensive and pioneering training course – run by Cranfield University in conjunction with North Bristol NHS Trust – will be completed by each investigator in preparation for their role. The 12-month secondment or contract roles will support the development of investigation skill and capacity in the wider maternity landscape.

More information on our work in this area is available on the HSIB website:
https://www.hsib.org.uk/maternity-information.

The maternity investigations will continue to reflect the principles and values of HSIB – they will focus on learning, avoiding blame and involving families throughout.

Engagement with stakeholders

We recognise we are one part of a significant safety landscape that supports the NHS and social care. As we expand our teams and build our workforce we are beginning to work more widely across the system and with other key organisations that aim to improve patient safety. We want to help build a learning culture in the NHS and social care and believe this will be achieved by joining strategic conversations with others to support the creation of a non-blame culture that focuses on learning and continuous improvement.

Our engagement programme includes working with many other including statutory and non-statutory bodies, professional regulators and Royal Colleges. We attend conferences and present to many different groups to ensure we are engaging at important events to highlight our new organisation's strategic aims and to raise awareness of HSIB.

HSIB has established a varied programme of future engagement activities with key stakeholders across the UK and internationally. The aim is to continually raise the profile of HSIB and the awareness of the expanded investigation programmes for national and maternity.

We took part in an international learning symposium in March with senior academics and safety leaders to share how we are establishing our methodologies, work programmes and plans for regular publication of safety reports and recommendations. As a world leader we are keen to engage with other countries who are exploring how to establish safety investigation branches to share ideas and best practice.

We are establishing memorandum of understanding agreements with the Royal Colleges, professional regulators, the Department of Health and Social Care, NHS Improvement and others such as the Equality and Human Rights Commission. These important documents will be published on our website and reviewed annually as part of our annual governance work plan.

Plans to evaluate HSIB activities and work

Family and staff engagement will be a top priority for HSIB and a system for capturing this important feedback is in place for both national and maternity investigations. This will enable regular reporting on the engagement and experiences of families and staff who interact with the investigation teams. We are already capturing comments from staff such as *"After talking to HSIB investigators, it's the first time I have slept in months. It is a huge relief that you are not looking to blame individuals but to understand system learning."*

HSIB will establish a system of 'tracking' safety recommendation letters, safety recommendations and safety observations for all national reports. This will include monitoring a 90 day deadline for responses from organisations who receive letters with HSIB formal recommendations and publishing those responses on HSIB website.

The implementation and impact of the national safety recommendations will need to be carefully monitored by the various national bodies who provide NHS service improvement support and oversight. It is envisaged that NHS Improvement will support local providers to implement safety recommendations and the Care Quality Commission will consider relevant HSIB recommendations for local Trusts during their inspections. More complex and detailed evaluation will require careful consideration before development to enable effective reporting on outcomes and improvements that occur from HSIB safety recommendations. This work will span a five year programme of work to enable accurate and effective reporting.

A comprehensive research and evaluation project will be commissioned in 2018/19 to support the detailed analysis of evolving HSIB national investigation methodologies and their effectiveness in creating systemic and local safety recommendations that reduce harm and mortality for both maternity and national investigations.

An annual thematic maternity learning and safety report will be published on the HSIB website each year. Individual case reports and safety recommendations will be shared with families, local providers and relevant others. They will not be published individually on the HSIB website as the maternity learning and safety annual report will be the mechanism for systemic and thematic learning to be shared.

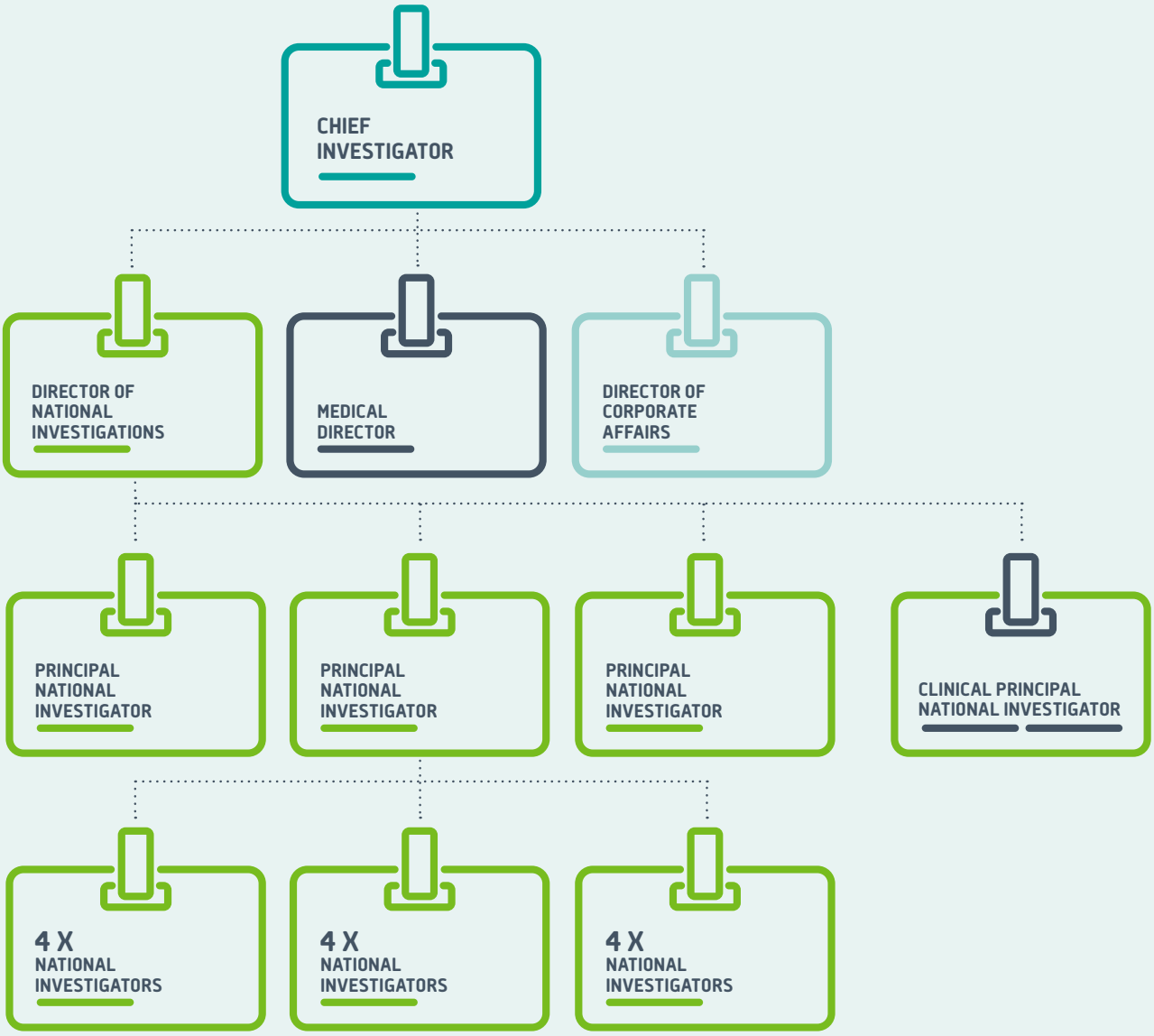
Developing capability at a local level and setting national standards to support education and training

We have been established to conduct safety investigations in the NHS and be an exemplar for local investigations. We continually assessg our methodology as we carry out investigations, including how this approach can be applied locally – the maternity programme will play an important role in determining this. The expectation is that eventually HSIB will play an important role to support investigation training potentially through bespoke accredited training for investigators, face-to-face visits or development of national standards.

> "After talking to HSIB investigators, it's the first time I have slept in months. It is a huge relief that you are not looking to blame individuals but to understand system learning.

Governance

HSIB Executive and National Investigation Teams



HSIB has a team of executives and senior officers who are leading a transformational programme to enable the organisation to become an independent public body.

Their role is to create an expanded infrastructure and a fit-for-purpose operating model. This model will ensure that the organisation is set up for success and scalable to meet its significant transformation plan requirements and increased workload.

A corporate governance roadmap and framework is being developed in 2018/19. This will be underpinned by the combined code of governance requirements for a public body and will enable the organisation to become well governed and legally constituted.

Finance

HSIB's core budget is £3.8m and will expand to more than £20m in future years to enable its rapid expansion programme. HSIB is currently hosted by the NHS Trust Development Authority which is part of NHS Improvement. HSIB financial accounts for 2017/18 will be prepared and reported within the NHS Trust Development Authority annual accounts and annual report in line with its statutory duties. Further details are available at **https://improvement.nhs.uk**

Advisory Panel

A key requirement of HSIB has been to establish a group of independent advisors as stated in the NHS Trust Development Authority (HSIB) Directions 2016: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/514217/HSIB_directions.pdf**

HSIB's Advisory Panel is governed by the following terms of reference

Independent scrutiny. Providing external challenge, critique and comment on the status, operation and outputs of HSIB as an independent body

Stakeholder input. Providing a forum to gather and consider the views, questions and interests of key HSIB stakeholders

Expert advice. Providing expert knowledge and input to the Chief Investigator and HSIB on key issues as required from professional, public and patient perspectives

Network scanning. Providing input and information to the Chief Investigator and HSIB from the collective stakeholder networks represented by Advisory Group members

Investigation prioritisation. Providing input, review and assurance on the short- and long-term prioritisation process of selecting investigations

Learning and improvement. Providing external review and evaluation on the learning impacts and improvement outcomes of HSIB reports and recommendations

HSIB selected eight members who bring a broad range of experience, skills and expertise to the Panel. The key role of the Advisory Panel has been to provide external challenge, critique and comment on HSIB's work and processes. They have several functions, including expert advice and feedback from their own networks.

The Advisory Panel meets quarterly with senior executives of HSIB. The eight independent members of the Advisory Panel are

- Murray Anderson-Wallace
- Steve Clinch
- Dr Mike Durkin
- Farrah Pradhan
- Dr Joe Rafferty
- Suzanne Shale
- Richard von Abendorff
- Jennie Stanley

HSIB

HEALTHCARE SAFETY
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WWW.HSIB.ORG.UK

Further information

More information about HSIB – including its team, investigations and history – is available at **www.hsib.org.uk**.

If you would like to request an investigation then please read our **guidance** before submitting a safety awareness form.

@hsib_org is our Twitter handle. We use this feed to raise awareness of our work and to direct followers to our publications, news and events.

Contact us

If you would like a response to a query or concern please contact us via email using **enquiries@hsib.org.uk**. We monitor this inbox during normal office hours - Monday to Fridays (not bank holidays) from 0900hrs to 1700hrs. We aim to respond to enquiries within five working days.

To access this document in a different format – including braille, large-print or easy-read – please contact **enquiries@hsib.org.uk**.

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