Healthcare Safety Investigation Branch

13th October 2017
Advisory Panel Meeting
HSIB, Farnborough

Present	Keith Conradi, Chief Investigator HSIB Lucas Hawkes-Frost, Director of Investigation, HSIB Kevin Stewart, Medical Director, HSIB Jane Rintoul, Director of Corporate Affairs, HSIB Richard Von Abendorff, Advisory Panel Mike Durkin, Advisory Panel Suzanne Shale, Advisory Panel Steve Clinch, Advisory Panel Farrah Pradham, Advisory Panel Jennie Stanley, Advisory Panel Murray Anderson-Wallace, Advisory Panel Jackie Cook, EA, HSIB
Apologies	Joe Rafferty, Advisory Panel

Welcome

Keith Conradi welcomed those present to the first Advisory Panel meeting and thanked them for their interest in HSIB. Keith Conradi confirmed to the panel that the scope of discussion would cover all matters both pre-and post-investigation but would not cover any live investigations.

Keith Conradi gave a presentation to the panel about HSIB. Points covered:

- Professionalising Safety Investigations.
- High Quality Investigations where there has been serious harm or has been the potential for serious harm, there are systemic safety issues or there is greater learning potential.
- Investigation process including reporting process recommendations.
- Variation of specialties covered by investigating teams including clinical, military, human factors.
- Location of HSIB on a non-NHS site and plans for new premises in Derby on a non-NHS site.

Panel Introductions

The panel members introduced themselves briefly and shared what they hope to add to the HSIB advisory Panel.

Suzanne Shale

Suzanne Shale is an independent consultant in healthcare ethics, medical education, and patient safety. Suzanne chairs the UK's leading patient safety charity, Action Against Medical Accidents (AvMA) and much of her current portfolio of work focuses on improving investigations into healthcare

harm and enhancing the support available to patients and professionals following adverse events.

Steve Clinch

Steve Clinch has a background as a mariner and first joined the UK's Marine Accident Investigation Branch (MAIB) in 2004, becoming the Chief Inspector of Marine Accidents in August 2010. Steve specialises in professional no blame safety investigations.

Murray Anderson-Wallace

Murray Anderson-Wallace is an independent healthcare advisor and journalist with an interest in healthcare harm. Murray is an academic professor at the London South Bank University, was a participant in the Never Events Taskforce and continues to work in mental health clinical practice. Murray was part of the group that campaigned for the establishment of HSIB.

Dr Mike Durkin

Dr Mike Durkin holds Visiting Professor appointments in Patient Safety at Imperial College London and the University of the West of England. He is also an Associate Non-Executive Director at NHS Resolution. He was National Director of Patient Safety at NHS England and NHS Improvement and led the National Patient Safety Programme for England. Mike was part of the EAG that consulted on the formation of HSIB and has a keen desire to bring 'Faith and Trust' to healthcare safety investigations and utilise appropriate contextualised data sources when investigating.

Farrah Pradhan

Farrah Pradhan has spent the past 15 years as a family and, particularly, parent advocate. Farrah has also spent time as a Children and Young Persons advocate and currently works as the Invited Reviews Manager for the Royal College of Obstetricians and Gynaecologists supporting a team of lay assessors along with clinicians. Farrah is committed to working with stakeholders to influence the work of healthcare organisations to improve and maintain standards for members of the public.

Richard von Abendorff

Richard von Abendorff, previously spent 17 years working in services for frail older people and dementia care in health, social services and home settings. Richard has been on a personal journey over the past 6 years campaigning through many channels in a voluntary capacity for learning and action in end of life care. Richard's campaigning follows many serious avoidable failings in his mother's palliative care in hospital. Richard wants to ensure incident reporting leads to robust evidenced action and an end to what, too often, becomes an attack on the messengers of harmful incidents. Richard wishes to be the patient advocate on the Advisory Panel.

Jennie Stanley

Jennie Stanley qualified as a registered Nurse in 1988 and went on to specialise in Emergency Nursing. Jennie became a whistleblower following patient safety concerns in her organisation. Jennie endured a 4 year legal battle to vindicate her name engaging during the process with the High Court. Jennie has gone on to be Lead Nurse at Patients First supporting whistleblowers and runs her own training company which is regularly utilised by Trusts. Jennie wants to bring a whistleblower's perspective to the panel and believes very strongly in making the patient the first concern.

Keith Conradi thanked the group and noted the broad depth of experience, passion and professional experience that the members would bring to the Advisory Panel.

Operations Update

Lucas Hawkes-Frost presented an Operations and Investigations update. Points covered:

Confidence and Capability including education both initial and ongoing, creation of teams and 2nd site training.

Investigation Initiation including methodology development, approaches to pre-investigation, engagement, investigation, systems. Challenges around Information Governance and access to information sources.

Investigators including the rhythm, pace and complexity of exposing teams to investigations and organisations. Analysing information being fed back and drawing conclusions. Finalising recommendations and publications.

External Engagement with regulators, colleges and professional bodies. Instigation of MOUs between bodies. The intelligence Unit currently developing links with SMEs both nationally and internationally.

Next Steps to develop style of investigations and reports ensuring that all stakeholders are involved in the development.

Draft Bill

Jane Rintoul gave a brief explanation of the Draft Bill process and its likely path to legislation. It was made clear that the DH were sponsors of this Bill and **NOT** HSIB.

There was a discussion regarding the draft bill. The Advisory Panel noted on the following:

1 Concerns that patients and families were generally underrepresented.

2 Concerns that the draft bill could give the perception that the Secretary of State has too much influence over the work of HSIB.

3 Some clarification needed of key terms such as 'interviews in private' and 'anything which might incriminate the person.'

4 Clarification of how this bill would interact with the Data Protection Act.

5 Significant concern that 'accreditation' was a regulatory function and potentially incompatible with a safety investigation organisation.

6 Concern that devolving 'safe space' powers to Trusts could be a serious risk to the reputation of HSIB and to public confidence in it. It was noted that this would move away from the model used in transport investigations where statutory powers are used only by the State Safety Investigation Authority.

7 Concerns that, as written, the Draft Bill seemed to allow several statutory authorities, not just HSIB, to prevent disclosure of sensitive information to patients and families.

Draft Bill general

Jane Rintoul advised that any specific comments regarding the Draft Bill be emailed to her at the following address jane.rintoul@hsib.org.uk

AOB

1 The date for the next Advisory Panel meeting was agreed as Friday 19th January. It was agreed that HSIB would circulate dates for the Advisory Panel Meetings for the rest of 2018.

2 Panel membership and associates – it was agreed this had been covered when Advisory panel members introduced themselves.

3 Panel Resources – the Panel agreed access to HSJ for those who do not have this available to them already. Requested by and agreed for Farrah Pradham and Richard Von Abendorff.

Keith Conradi thanked all attendees for their participation and advice. Meeting closed.