HSIB

HEALTHCARE SAFETY
INVESTIGATION BRANCH

22/23

Healthcare Safety Investigation Branch

Annual Review 2022/23

Dr Rosie Benneyworth
Chief Investigator

Foreword from the Chief Investigator

I am delighted to commend this Annual Review to you. This publication will be the Healthcare Safety Investigation Branch's (HSIB's) final review before we divide in late 2023. Our national investigation programme will form the Health Services Safety Investigations Body, a fully independent arm's length body, and our maternity investigation programme will be hosted by the Care Quality Commission and will be known as the Maternity and Newborn Safety Investigations programme.

As we continue to experience the impacts of the COVID-19 pandemic and the significant pressures on the health and care system, a focus on how we can make patient care safer for all has never been as important as it is now. The team at HSIB is dedicated to producing high-quality investigations with safety recommendations that have the maximum impact to enable sustainable change in healthcare delivery. We are also playing a key role in educating people in healthcare in how to undertake high-quality investigations and this review highlights the significant progress we have made in this area.

The last 12 months have been ones of exciting change, consolidation and progression. We have worked hard to ensure our transformation journey has been smooth. We have welcomed new leadership. And, importantly, we have listened to staff as well as the organisations we work with, to embed their feedback into

the way we operate so we can be world leading in everything we do.

In this Annual Review you will read about some of the impacts our safety recommendations have had. Indeed, our published reports make important reading for healthcare staff and gain significant interest from national, regional, local and trade press, bringing healthcare safety investigation issues to a nationwide audience. Some notable highlights include our reports on the NHS 111 response to COVID-19, the harm caused by delays in patient handover to emergency care, and care delivery within community mental health teams. These reports, and many others, are highlighted in the following pages. You will also read about the growing HSIB education function that is going from strength to strength in supporting the healthcare system to improve the quality of investigations undertaken.

Another area of our work which deserves consideration is our maternity investigation programme. Launched in 2018 the programme has gone from strength to strength, delivering just shy of 3,000 reports by 31 March 2023 and making a significant impact on improving maternity safety, as evidenced in this review.

HSIB maternity investigators conduct investigations and deliver reports which are supportive for parents and able to deliver safety recommendations which are meaningful to trusts to enable improvements and change. At a system

level our maternity teams are instrumental in raising concerns and providing a detailed understanding of trusts which are not providing safe maternity care. The hard work, commitment to improvement and the detailed investigations undertaken by our maternity teams help demonstrate the growing benefit that our maternity investigation programme provides. In particular, this is evidenced where improvement actions taken by organisations in response to our safety recommendations are shared with other trusts across England for the benefit of all.

Looking ahead, both our national and maternity investigation programmes have exciting futures, and with that comes the responsibility of helping to reduce harm and improve patient care. We cannot do it alone, but together with our partners across the healthcare system we will make a difference.

Dr Rosie Benneyworth
Chief Investigator

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Advisory Panel

The aim to create a state-level independent investigator for healthcare that used safety science to identify and investigate the most significant systemic risks without apportioning blame or liability was a laudable ambition – indeed, it was a global first.

When the Advisory Panel was formed in 2017, the legislation to establish an independent statutory body with its own system of independent non-executive governance was firmly on the horizon. In the interim the Advisory Panel, which is a group of independent people with a blend of expertise in harmed patient advocacy, citizen leadership, clinical practice, education, policy and professional investigation, was established. Our primary role has been to provide external scrutiny of the operational independence of HSIB's national investigations, while it exists as a division of NHS England. We also provide strategic advice on other matters at the request of the Chief Investigator.

While the journey toward achieving statutory powers and independence has taken much longer than anyone expected, the need for safer healthcare systems is as strong as ever. A great deal has been achieved over these years, but as Keith Conradi, the founding Chief Investigator of HSIB commented in his final Annual Review in 2022, the 'hard yards of initial development' have included significant successes as well as considerable challenge. This is to be expected in such an ambitious venture, which for the first time blended the world of professional investigation from other industries with healthcare.

In autumn 2023, the new statutory organisation – the Health Services Safety Investigations Body (HSSIB) – will be established. This will be a realisation of the vision of the many patients, families, clinicians and policy makers who campaigned hard over many years for its existence. We owe it to them to ensure that the learning and insights from the first 6 years is used to inform its future strategy.

During the early part of 2022/23, a number of senior executives moved on from HSIB. This placed significant demands on members of the senior leadership team at short notice. The Advisory Panel believes that their efforts to ensure continuity of purpose and direction should be recognised. HSIB welcomed Dr Rosie Benneyworth as Chief Investigator and her work to ready the organisation for transition began in earnest. I thank her for her openness and desire to collaborate positively with us during this time. Dr Ted Baker was also appointed as Chair designate of HSSIB, and we welcomed

the opportunities for us to comment on the emerging HSSIB strategy. We said goodbye to Patrick Vernon from the Advisory Panel and as Chair of the Citizens' Partnership. Once again his work and that of the Citizens' Partnership should be acknowledged.

Throughout the year, the Advisory Panel continued to work with the Minister and Department of Health and Social Care (DHSC) officials to tackle a range of legacy issues relating to HSIB independence that I reported in last year's Annual Review. These were important conversations and as a result, in October, I joined the DHSC Transition Board as a participant observer. This created an opportunity for the Advisory Panel to gain a degree of insight as the work to establish the independent statutory body progressed.

Among all the uncertainty of the year, the staff of HSIB continued to deliver high-quality national investigations, to innovate in the field of safety science education and to influence the national discourse for safety investigation. They have done this with remarkable focus, determination and commitment and we applaud every one of them.

As HSSIB begins its life formally in the autumn of 2023 the Advisory Panel will complete its work, as an appropriate system of non-executive governance and support is established. And, as colleagues from the other high-risk industries consistently remind me, the next phase of the journey will likely require persistence, stamina and a good deal of courage. On behalf of the Advisory Panel, we wish all the staff and incoming Board of HSSIB great success for the future. It has been a privilege to be part of this first part of their journey.

Professor Murray Anderson-Wallace, Chair

Advisory Panel members

Professor Murray Anderson-Wallace JP, Chair

Steve Clinch MNM

Dr Mike Durkin OBE

Farrah Pradhan

Professor Joe Rafferty CBE

Jennie Stanley RN

Professor Patrick Vernon OBE

Richard von Abendorff

Visit our website for more information about the **Advisory Panel**.

Our vision

To be a global leader and educator in healthcare safety investigations

Our mission

To improve patient safety through professional safety investigations that do not apportion blame or liability

About HSIB

Our organisation

We are dedicated to improving patient safety, and we conduct effective and independent investigations into patient safety concerns in NHS-funded care across England. Formed in April 2017, we are funded by the Department of Health and Social Care and hosted by NHS England, but we operate independently.

Our transformation journey

In October 2023 HSIB is due to separate into **two different organisations**. Our national investigation programme will become a Non-Departmental Public Body established under the Health and Care Act 2022 and will be called the Health Services Safety Investigations Body (HSSIB). HSIB's maternity investigation programme will be hosted by the Care Quality Commission (CQC) and will be called the Maternity and Newborn Safety Investigations Special Health Authority (MNSI). The new arrangement with the CQC, which was announced on 30 March 2023 via a **Written Ministerial Statement**, will ensure the continuation of the maternity programme and maintain the independence of maternity investigations within the NHS.

Our work

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. Our investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients.

Through safety recommendations to specific organisations we aim to improve healthcare systems and processes, to reduce risk and improve patient safety. We share our findings through effective communications and engagement across the wider health and social care system, as well as internationally. We work closely with patients, families and healthcare staff affected by patient safety incidents, and we never attribute blame or liability.

Our investigation approach

Our investigators and analysts have diverse experience of healthcare and other safety-critical industries and are trained in human factors and safety science. Human factors looks at the interactions between people, the tools and equipment they use in the workplace, and the environment in which they operate. Safety science is the study of how to increase safety in different types of systems.

We consult widely to ensure that our work is informed by appropriate clinical and other relevant expertise.

Our investigations – national and maternity

We have two programmes of work – national and maternity investigations. They are different in terms of how referrals are made and how we report on our findings. For both types of investigation:

- we do not apportion blame or liability – we carry out investigations to learn and improve patient safety
- we aim to involve patients and families throughout the investigation process
- we gather information about themes that arise across different investigations to identify areas of risk; these may inform future investigations.

Our investigation criteria – national investigation programme

We select our investigations by reviewing referrals and gathering and analysing data from a wide range of sources.

The information is then assessed against agreed criteria to determine the value of undertaking an investigation. The criteria are based on international patient safety research and approaches to system-level investigations in other industries. There is more information about our **national healthcare investigation criteria** on our website; however, in summary:

- We assess the scale and severity of the actual or potential harm that an issue represents.
- We review the system-wide risk associated with safety issues including how widespread they are across the healthcare system.
- We consider whether the investigation and its safety recommendations are likely to lead to meaningful safety improvements.

HSIB criteria for national investigations

Outcome impact

People: physical, psychological, loss of trust
Service: quality and reliability, capacity and capability
Public: confidence, political attention, media profile

Systemic risk

Systemic safety deficiency: range of care settings; geographic/specialist spread; scale through system structures; complexity of interactions
Dormancy period: time taken to identify risk; route of discovery
Persistence and expansion: permanence; potential for escalation and spread

Learning potential

Potential for increased knowledge: new knowledge; gap in current knowledge
Potential for systemic improvement: opportunity to positively influence system, practices, safety culture
Practicality of action: feasibility of conducting effective investigation; practicality of issuing influential safety recommendations
Value of intervention: adequacy and scope of safety actions by others; potential to develop local investigative capacity; potential to develop HSIB capacity and capability

Our investigation criteria – maternity investigation programme

We have set criteria which make incidents eligible for maternity healthcare safety investigations. These criteria include:

- Intrapartum stillbirth – where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death – where the baby died within the first week of life (0 to 6 days) of any cause.
- Severe brain injury – where the baby was diagnosed with severe brain injury in the first 7 days of life.

More detailed information about our **maternity investigation criteria** is available on our website.

We also investigate maternal deaths, where women/people have died while pregnant or within 42 days of the end of pregnancy. This can be from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes. We do not investigate cases involving suicide.

For more detail about the differences in our approach to national and maternity investigations **see appendix 1**.

Our education programme

We develop and provide education programmes to the NHS. These are delivered by professional healthcare safety investigation experts. Our courses aim to improve local patient investigations in NHS trusts, and to give strategic decision makers and senior leaders an overview of the principles which sit behind modern healthcare safety investigations.

Our education programme has been developed using expertise drawn from our own experience as well as specialists from around the country, all of whom are professionals in areas such as human factors, psychology, education and investigations. The curriculum is based on the training we provide to our national investigation and maternity investigation teams and combines safety science, investigation skills and the investigation process. You can read more about our education programme on **page 46**.

Our strategic goals

We have five strategic goals which frame our business and which are supported by our values.

Strategic goal 1
Undertake independent safety investigations with objectivity, underpinned by competence, credibility and integrity.

Strategic goal 2
Value and prioritise professional development for staff that includes internationally renowned safety investigation techniques and cutting-edge technology.

Strategic goal 3
Provide learning to the wider healthcare community, and promote professional safety investigations by improving investigation skills and techniques throughout the NHS.

Strategic goal 4
Be financially sustainable, well governed and legally constituted to support our independence.

Strategic goal 5
To support and uphold equality across all our work areas, ensuring equitable and fair treatment, access and opportunity.

Our values

Our values are important to us. In March 2022 we reviewed our values with staff and developed a series of supportive behaviour statements. Throughout the year we have been embedding our five values across our organisation. This has included reminders in meetings and a values-based internal communications campaign to heighten awareness among our colleagues to ensure we all live by our **HSIB values**.

Behaviour statements

Compassion

We act with care and kindness. We show concern for others and the work they do. We do our best to be warm and considerate in our behaviours.

We actively listen to those we interact with, make them feel comfortable and give them time to speak openly and honestly. We acknowledge each other's ideas and seek to understand differing perspectives, and use this knowledge to challenge our own thinking, values and assumptions.

We act with empathy, seeking to understand the thoughts and feelings of others and show concern for what matters to them. We seek to support and signpost the best we can.

Respect

We celebrate and respect our diversity and differences to ensure everyone is included.

We challenge behaviour that does not reflect our values.

We listen closely and show appreciation of others' opinions and views.

Collaboration

We engage with parents, patients, families and healthcare staff in a compassionate way which makes them feel safe, respected and listened to.

We help each other to continually learn and develop, and we support one another if we are finding things difficult.

We actively seek and encourage each other's views and contributions to enable everyone to feel equally safe and confident to contribute.

Trust

My colleagues demonstrate honesty, integrity and openness because developing trust is about being made to feel safe and creating a work environment of psychological safety.

We assure all those we work with that we are not there to judge or blame, but to fact find and improve.

We continually learn, improve and support so we can build positive relationships between each other, while recognising that some relationships may well require more work than others.

Leadership and accountability

We are each responsible for our words, our actions and our decisions.

We are each responsible for treating everyone with kindness and respect.

We have the courage to have challenging conversations with kindness and respect.

Highlights and achievements

This has been an exciting year for us as we have been going through significant change. 2022/23 is our final full year as HSIB before our national and maternity programmes diverge, separating into HSSIB and MNSI.

Therefore, in the following highlights and achievement section we wanted to celebrate our successes since we launched in 2017.

84
national reports completed

236
national safety recommendations issued to **57** organisations

6,354
enrolments on HSIB safety investigation education programmes since January 2022

3,181
people attended our three HSIB safety investigations conferences

2,949
reports produced by the Maternity Investigation Team

6,998
maternity safety recommendations made

National investigations

Over the last year our team of national investigators has published 16 investigation reports and issued 36 safety recommendations. We have also explored how we can issue interim reports where safety risks emerge as part of our investigation and there is a need to communicate these more rapidly to the healthcare system. We have published four interim reports to help us highlight where an emergent risk requires an urgent response from the system.

We have made sure that any ongoing impact of the COVID-19 pandemic on our investigations has been minimised, and where interviews could not be held in person they were conducted via video call. We have also undertaken significant work as our organisation prepares for its transition into HSSIB. This has included planning for new ways of working in line with the powers conferred to us in the Health and Care Act (2022), learning from what we have done well in the past, and considering how we can further improve our impact on safety in the healthcare system.

We continue to identify healthcare safety risks by evaluating the notifications we receive from professionals, patients, families and the general public, and by looking at information from organisations (such as coroners' prevention of future death reports).

We also identify risks through:

- horizon scanning – looking at potential safety risks by analysing serious incidents
- thematic reviews – which involve working through information and literature to identify themes from our investigations.

How we listen to patient safety concerns

We listen to patient safety concerns through our direct referrals and other sources of safety intelligence. Our direct referrals come from a variety of sources, such as patients or their families, members of the public, professional and regulatory bodies, and healthcare organisations.

Each referral is taken through the same process to ensure equity and gets reviewed by our referral team to decide if it should continue to the next stage for further intelligence gathering.

Many of the people we hear from have struggled to navigate the healthcare system or say they have not been heard by other organisations and do not know where to turn. In these cases, and where possible, we facilitate a 'warm handover' by contacting the relevant people or organisation ourselves and including the referrer so that they are not 'cold calling'.

Family engagement in national investigations

Most existing national investigations use a real incident, known as a reference event, to explore a patient safety issue. Where this is the case, we engage with the person who was involved in the reference event and obtain their consent for an initial scoping investigation. Their perspective on what happened to them is important evidence to HSIB. We will often seek the views of their family who offer insight into the care they were receiving. In the case of reference events where a patient has died, we will seek the family's consent to investigate the person's care for an initial scoping investigation. We will also seek to understand the family's views on the issues raised by the investigation.

We continue to explore innovative ways to improve our investigations and now regularly seek additional patient insight via focus groups and experts by lived experience. We have also modelled different forms of investigation that do not require a reference event, but still allow us the opportunity to explore complex areas of safety in healthcare without losing the patient voice.

Safety learning from completed investigations

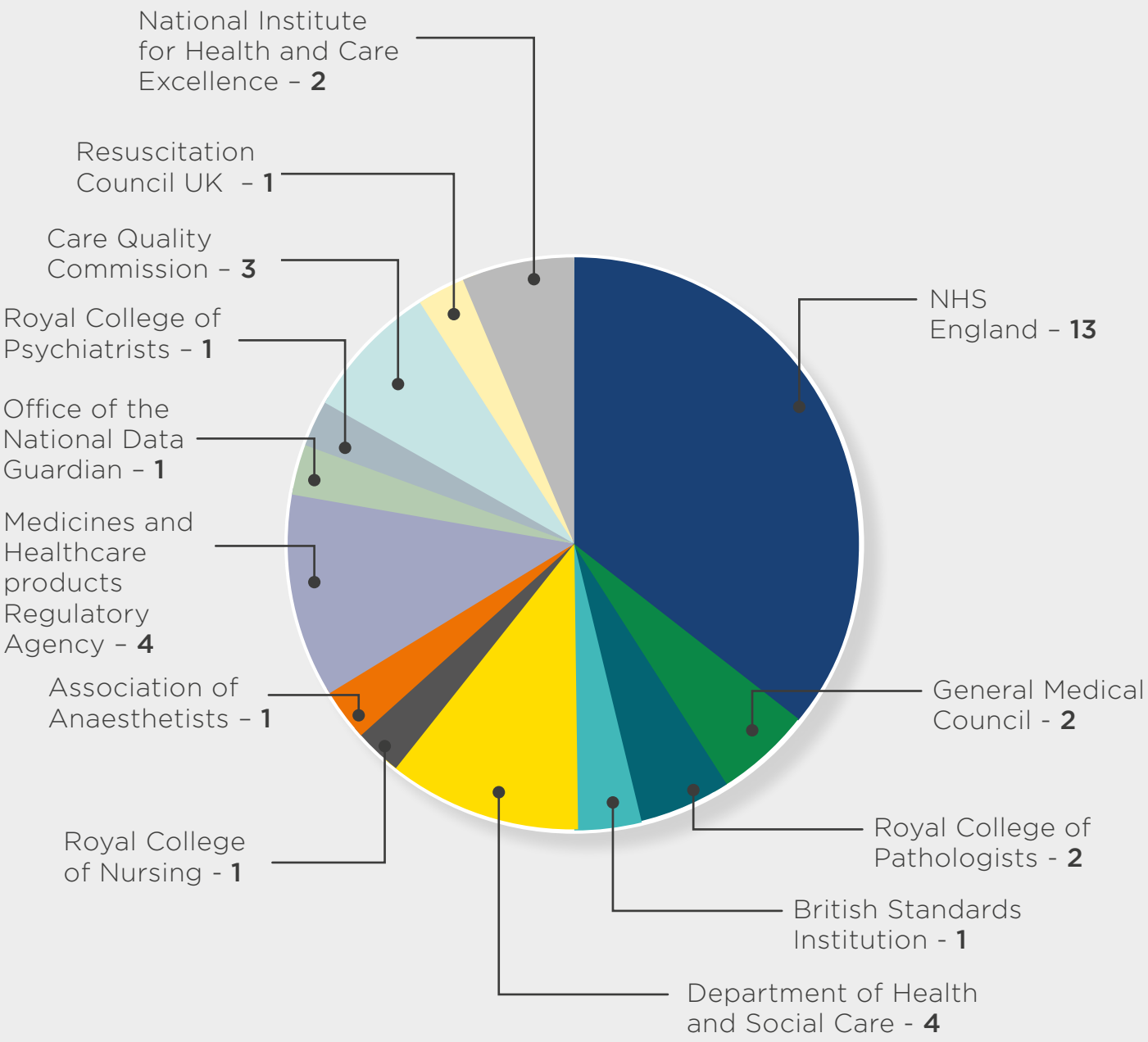
Investigation	Safety recommendations	Safety observations	Safety actions
Provision of care for children and young people when accessing specialist gender dysphoria services	NHS England and NHS Improvement (1)	4	
Unintentional overdose of morphine sulfate oral solution		2	
Decontamination of surgical instruments	NHS England and NHS Improvement (2) Care Quality Commission (1) Department of Health and Social Care (1)	5	

Harm caused by delays in transferring patients to the right place of care – interim bulletin 1	Department of Health and Social Care (2)		
Medicine omissions in learning disability secure units	NHS England and NHS Improvement (2)	3	
Administering high strength insulin from a pen device in hospital		4	1
HSIB maternity programme year in review 2021/22			
The use of an appropriate flush fluid with arterial lines	Medicines and Healthcare products Regulatory Agency (3) Department of Health and Social Care (1) Association of Anaesthetists (1) Care Quality Commission (1)	8	1
Management of preterm labour and birth of twins		3	1
NHS 111's response to callers with COVID-19-related symptoms during the pandemic	NHS England (2)	3	3
HSIB's local investigation pilot – shared learning for local healthcare systems		4	
Harm caused by delays in transferring patients to the right place of care – interim bulletin 2		1	
Clinical investigation booking systems failures – interim bulletin		1	
The assessment of venous thromboembolism risks associated with pregnancy and the postnatal period		3. Also included 5 points for local learning for maternity healthcare providers and local maternity systems.	

Detection of jaundice in newborn babies	Royal College of Pathologists (2) National Institute for Health and Care Excellence (1)	2	
Access to critical patient information at the bedside	Office of the National Data Guardian (1) NHS England (4) Resuscitation Council UK (1) Royal College of Nursing (1) British Standards Institution (1)	3	
Harm caused by delays in transferring patients to the right place of care – interim bulletin 3	NHS England (1)	1	
Assessment of risk during the maternity pathway		Included 13 prompts for NHS trusts to consider how risks may be mitigated	
Care delivery within community mental health teams	NHS England (1) Care Quality Commission (1) National Institute for Health and Care Excellence (1) Royal College of Psychiatrists (1)	4	1
Safety risk of air embolus associated with central venous catheters used for haemodialysis treatment	General Medical Council (2) Medicines and Healthcare products Regulatory Agency (1)	4	2

Total number of national report safety recommendations made to each organisation in 2022/23

We made 36 safety recommendations to the 13 organisations shown below. A full list of these safety recommendations can be found in **appendix 2**, and more information about each investigation is available in the **investigation and reports section of our website**.



We do not apportion blame or liability; we carry out investigations to learn and to improve safety.

HSIB

Ongoing national investigations commenced but not completed during 2022/23

Investigation title
Non-accidental injuries in infants attending the emergency department
Clinical investigation booking systems failures: written communications in community languages
Interim report - Keeping children and young people with mental health needs safe: the design of the paediatric ward
Invasive procedures for people with sickle cell disease
Management of sickle cell crisis
Variations in the delivery of palliative care services to adults
The selection and insertion of vascular grafts in haemodialysis patients
Risks with medication delivery using ambulatory syringe pumps: design and usability in inpatient settings
Interim report - Retained surgical swabs
Harm caused by delays in transferring patients to the right place of care
Safety management systems
Caring for adults with a learning disability in acute hospitals
Continuity of care: delayed diagnosis in GP practices
Positive patient identification
Factors affecting the delivery of safe care in midwifery units
Intubation of patients with difficult airways
Keeping children and young people with mental health needs safe: the design of the paediatric ward
Nutritional assessment and support in the acute medical unit
The clinical observation of patients detained under the Mental Health Act at risk of self-harm in acute hospitals
Perimortem caesarean section during the management of cardiac arrest
Retained surgical swabs
Workforce and patient safety: the digital environment
Workforce and patient safety: prioritising patient care
Workforce and patient safety: skill mix and staff integration
Workforce and patient safety: temporary staff

Our impact

Since HSIB was formed in April 2017 we have produced a total of 84 national investigation reports, and made 236 safety recommendations, 210 safety observations and 59 safety actions to 57 organisations in the healthcare system and beyond.

Many of the organisations which were the focus of our national safety recommendations during 2022/23 are still working on enacting them. Any safety recommendations we make support the healthcare system to revise and address system-wide issues, and may include changes to existing procedures and practices. It is currently not within our Directions (the legislation under which we operate) to monitor the implementation of safety recommendations.

There are ongoing discussions about where this function should sit following the establishment of HSSIB.

We have started to catalogue the impacts that our reports and safety recommendations have delivered. For example:

- As a result of our safety recommendations from our investigation report '**Failures in communication or follow-up of unexpected significant radiological findings**', the Academy of Medical Royal Colleges published guidance on alerts and notification of imaging reports in October 2022. The main objective of this guidance is to ensure prompt and effective imaging result notification and its subsequent action to protect patient safety.

During 2022/23, as a result of our national investigations, seven safety actions were taken by organisations. Some of the safety actions include:

- The National Institute for Health and Care Excellence (NICE) amended its recommendation on clamping to support waiting at least 60 seconds before clamping the cord of preterm babies unless there are specific maternal or fetal conditions that need earlier clamping.

- The UK Health Security Agency has taken steps to assure itself of the safe and effective delivery of telephone triage for future healthcare emergencies. These have been tested through the delivery of services for monkeypox and avian flu.

- The British National Formulary has been updated to provide information to healthcare practitioners on Humulin R U-500 insulin.

Had these actions not been taken by organisations during the investigation, they would have generated safety recommendations in the investigation reports. We feel this demonstrates how organisations are responsive to emergent findings during the course of our investigations.

During 2022/23 members of the National Investigation Team have presented at a range of conferences and forums to help increase awareness of our work and share learning from our national investigation reports. These included:

- National Safety Standards for Invasive Procedures

- National Association of Medical Device Educators and Trainers

- Clinical Human Factors Group

- Parliamentary and Health Service Ombudsman

- British Association for Parenteral and Enteral Nutrition (BAPEN)
- Association of Renal Technologists.

We have also begun to catalogue where our work has wider impacts on improving safety in the healthcare system. For example:

- A trust provided positive feedback to us about how we conducted interviews which led them to review how they undertake internal investigations. They are now adopting our approach for future internal investigations.
- The British Association for Parenteral and Enteral Nutrition (BAPEN) and the National Nutrition Nurses Group held an interactive session centred around our report '**Placement of nasogastric tubes**' with a "what next?" discussion. The session was extremely well received and sparked a lot of debate and discussion.
- In November 2022, members of the National Investigation Team attended the NHS England Winter Improvement Collaborative accelerated design event. They provided feedback and information to the system on the emerging findings from our investigation '**Harm caused by delays in transferring patients to the right place of care**'.

Synopses of national investigations

For more information about the **investigations we carried out during 2022/23**, please visit **our website**.

Looking ahead

Over the next year the focus of the National Investigation Team remains the publication of high-quality, systemic safety investigations. Our multidisciplinary team of national investigators continues to apply and adapt cutting-edge safety investigation techniques developed in academia and other safety-critical industries to fully analyse the factors that contribute to harm across healthcare and conduct no-blame and no-liability investigations.

We will carry on reviewing our operating model to ensure we continually improve how we listen to patients, and investigate the patient safety issues that will have the greatest benefit to patients and healthcare professionals.

As we become HSSIB we will look to provide a more diverse range of investigation types. This will allow us to focus on specific safety risks and areas of healthcare to help further drive improvements in patient safety at the national and regional level.

HSIB and HSSIB have no power to compel organisations to complete work outlined in our safety recommendations. We will therefore continue to explore our potential role relating to how any concerns about organisations' responses to our safety recommendations can be considered.

The national investigation programme is conducting work to ascertain the feasibility of HSSIB having a monitoring role in relation to safety recommendation implementation in the future. We are also exploring whether internal grading of safety recommendation responses should be shared via our website to identify where responses to recommendations may not be satisfactory.

We have also commissioned a project to explore how the impact of the work of HSIB and HSSIB can be considered within the healthcare system. The aim is to help us further understand where our work has been valuable, and where it can have greater impact in improving patient safety.

Maternity investigations

The HSIB maternity investigation programme, which is part of the national initiative to improve safety in maternity care, has been in operation since April 2018. We are now fully implemented in all 122 trusts providing maternity care in England. During 2022/23, the programme received 1,070 referrals (399 of which were not progressed to investigation as they did not meet HSIB's referral criteria or the family did not agree to an investigation), and completed 702 reports, taking into account the changes made to investigation criteria due to the COVID-19 pandemic.

Highlights

Over the last year, our core work in completing investigations and reports has continued. We have also continued our analysis of the data and theme discovery. Our development programmes include continuous improvement methodology and further progress in family engagement.

- During the year, the maternity investigation programme completed 702 reports. This was a similar figure to previous years. At any one time there were approximately 355 active investigations.
- The investigation referrals relating to brain injury indicate a sustained decrease in babies with abnormal MRI results or neurological damage.
- In the last year, the programme made more than 1,380 safety recommendations to trusts and other healthcare organisations.
- Families remain central to the work we undertake. All families who consented were contacted; of these, 86% agreed to participate and 14% declined further participation in the investigation.
- As part of our initial engagement and ongoing communication with families we have provided interpretation/translation services on 670 occasions.
- We have translated information into 36 languages to help families make informed choices about participating in investigations and to provide better support for their ongoing involvement.

- Both in our reports and from others such as MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries), racial differences in outcome are seen. We have formed a race equality group to develop a programme to analyse demographic data and understand the impact of racial diversity on experiences, access to care, and outcomes.

- By working closely with trusts, we have helped increase the involvement of staff in patient safety in maternity care.

- The maternity programme has deepened the understanding of the role of emerging themes and how they help to identify systemic issues contributing to harm to pregnant women/people and babies.

- Our programme improved data collection and analysis, providing a clearer picture of incidents in maternity care and informing the development of evidence-based strategies to reduce harm.

- The programme fostered collaboration between healthcare providers, patients, and regulatory bodies, promoting a culture of safety and sharing of best practices.

- A national newsletter is now published up to four times a year to support trusts in sharing improvements made in response to safety recommendations, and to provide learning opportunities across England and beyond.

- We received feedback from trusts about the investigation process and our Maternity Quality Improvement Team continues to improve investigations and support processes.

- During investigations, 'soft intelligence' related to the investigation was captured in a maternity observational diary, which shared concerns as well as good practices with trusts and information about ongoing challenges.

- The maternity team presented at regional and national meetings to share their work and findings from reports.

Reports

The maternity team has worked in collaboration with the national team to produce the following national learning reports:

- **'The assessment of venous thromboembolism risks associated with pregnancy and the postnatal period'** - published December 2022
- **'Assessment of risk during the maternity pathway'** – published March 2023
- **'Factors affecting the delivery of safe care in midwifery units'** - due to be published in 2023/24
- **'Perimortem caesarean section during the management of cardiac arrest'** - due be published in 2023/24.

Maternity investigation impacts

Our investigations have identified the following themes from the safety recommendations made to trusts during 2022/23:

Top 12 safety recommendation themes in order of frequency
Clinical assessment
Guidance
Fetal monitoring
Clinical oversight
Risk assessment
Escalation
Communication
Investigations
Clinical observations
Induction of labour
Information
Triage

Over the last year we have been carrying out work to help identify the interaction between these themes and how they impact on each other. Doing a deeper dive into this work will help in designing systemic improvements to improve patient safety.

These themes occur throughout the maternity system and manifest themselves in incidents in specific areas. One example is escalation in midwife-led units, which requires a combination of themes to interact to achieve a safe environment. The example overleaf demonstrates how staffing problems and workload led to difficulties in clinical assessment, fetal monitoring, risk assessment and escalation.

Improvements to risk assessment and escalation in midwife-led care at Royal Wolverhampton Trust

This solution involves guidance, clinical oversight, clinical assessment, communication and escalation. There are potential additional problems relating to fetal monitoring.

Guidance for staff on escalation in the Midwife Led Unit (MLU)

An HSIB investigation learned that two clinicians were sharing the care of the mother during the latent phase of labour due to the workload on the midwifery led unit (MLU). Both were unable to spend any length of time with the mother to assess whether she was transitioning to the active first stage of labour.

So that we could make improvements, we reviewed the different categories of clinical care being provided on the MLU to ensure the staffing requirements were suitable to cover all aspects of the care being provided.

After our review we designed a flow chart to be used when the MLU is busy to escalate safety concerns and ensure that senior managers are aware that, due to activity, safety may be comprised.

We launched the flow chart in September 2022 and all staff are now aware of who to contact at times when the MLU is busy, and care cannot be safely provided. We raised, via safety briefing for all MLU staff, the benefit of using concise and clear language when escalating concerns either with a patient or overall activity. We did not need to use the flow chart in the few weeks after it was launched but we have noticed (for example in a case discussion which involved a transfer from the MLU to Delivery Suite) the use of words/ language to make it very clear that a woman required transfer.

The Royal Wolverhampton NHS Trust

Escalation Process MLU at times of high activity

The staffing model for MLU is 2 x midwives and 1 x maternity support worker – this is as agreed and recommended by Birthrate+

At times when the activity is high and potentially unsafe you must escalate

When a woman in labour cannot have the required support and monitoring it is vital the Band 7 is aware.

Inform the Band 7 Co-ordinator in first instance

↓

Contact MLU staff via social media and groups and ask if anyone can support the unit

↓

Seek support from other areas; FAU, Maternity ward, request any support from including Specialist Midwives

↓

Add additional entry on Birthrate+ acuity tool which reflects activity and any red flags

Complete a Datix

Document in maternity care records and apologise to the families on MLU

↓

Consider if Postnatal women could transfer to D10

Would any women not in established labour like to return home

Consider if any women in labour should transfer to DS

↓

Discuss with Band 7

- Community midwives being requested
- Informing matron (in hours)
- Inform manager on call (out of hours)

The Royal Wolverhampton NHS Trust

This intervention was developed to allow concerns felt by midwifery staff to be escalated and support to be given.

These and other concerns found during our investigations have led to the development of a thematic report we are preparing for 2023/24 called **'Factors affecting the delivery of safe care in midwifery units'**.

Further examples of the impact of our maternity programme can be found in the **'HSIB maternity programme year in review 2022/23'**.

Newsletter

Our **national maternity newsletter** collates the learning and improvements which have been sent to us by trusts across the country. The majority of the provided examples are based on improvement responses to our investigation reports. The newsletter is produced up to four times a year and we have received good feedback from trusts and external stakeholders.

The newsletter is positively received by trusts as they have an opportunity to learn from each other's experiences in implementing change and because it provides examples of action plans from other organisations.

Quarterly review meeting

As part of our regular feedback to trusts, we hold quarterly review meetings to inform trusts of our findings, themes and trends, locally, within their region and nationally. We also update the trust on ongoing investigations and any immediate concerns we have discovered. Over the last year these meetings have progressed well with more trusts now fully engaged in the process and welcoming the discussion with our team.

We ask that a wide range of people attend these meetings and, in many trusts, not only do the safety management team attend but also the senior management, consultants and midwives from the unit. Colleagues from integrated care systems and the regional lead midwife and obstetrician are also welcome. A wide representation increases trust ownership and acceptance of safety recommendations and ideas for improvement.

Maternity Quality Improvement Team

We have an active Maternity Quality Improvement Team (MQIT), which was been set up to support quality improvement (QI) projects across the maternity investigation programme.

QI champions have been established in each of the maternity teams. In 2022/23 the MQIT completed six QI projects.

The MQIT will closely support further QI projects and explore any new improvement ideas that are put forward.

Definitions

As part of our investigation development we have produced a standard document of definitions which we use in our investigations. These definitions are constantly reviewed by the relevant experts to make sure that they are up to date and relevant.

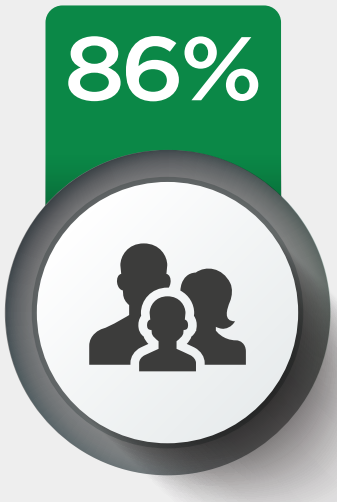
In the Ockenden report (which reviewed services at Shrewsbury and Telford Hospital NHS Trust) it was suggested that trusts completing their own reports use HSIB definitions. This year we placed the **definitions document** on our website for all to use and free of charge.

Escalating significant safety concerns arising from investigations

As the investigation programme has become more established we realised there was a need for a standardised escalation process when investigation teams have concerns about clinical care or a trust's responsiveness to safety concerns. A process of escalation has been developed to allow a stepped response to concerns raised.

During the year we issued 32 escalation letters of concern to trusts.

Family engagement in maternity investigations



% of families engaging with our maternity investigations during 2022/23

Meaningful engagement with, and involvement of families and patients remains at a good level with 86% of families engaging with our investigations during the year. This engagement starts with our teams making initial contact and then, with the family's agreement, requesting more detailed involvement throughout the time period of an investigation. Our understanding of the reasons why some families do not wish to be contacted, or choose not to be involved in an investigation, has developed over the last year. This has helped us to look at our approach, our resources and our training to try and ensure equity of access.

Families' reasons for not wishing to be involved are now captured where known and are used to explore areas of engagement locally and within the programme.

The reasons families have given for not wanting to take part have included:

- wishing to 'move on', or seeing no value in an investigation
- stating they were happy with care received or have a positive prognosis
- stating they prefer a trust/coroner's investigation
- not feeling able to discuss the events as they are too distressed
- not wishing for an independent organisation to access medical records
- no reason given/known, or requests not responded to.

Following a pilot we undertook last year, we have adopted a new approach to ensure accessibility and inclusivity for families. This family inclusivity toolkit (FIT) involves an initial conversation with a family to identify any particular needs they have in the areas of:

- communication
- health and wellbeing
- social and community.

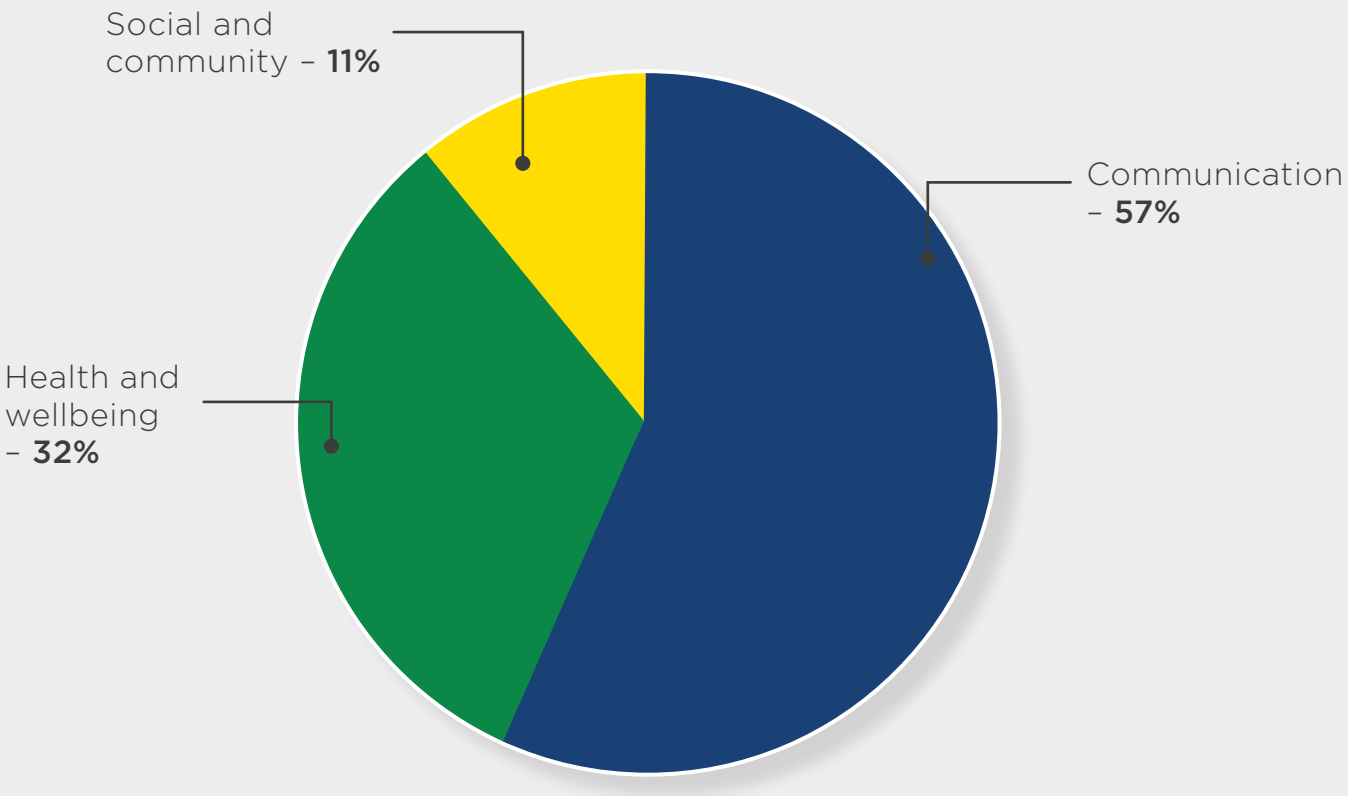
A family needs assessment is recorded and enables us to change our approach to these families and not expect them to adapt to our process. The needs assessment is revisited at different points in the investigation as needs can alter over time.

Once a need is discussed with a family and recorded, support for investigators is provided by way of information about how adaptions or adjustments could be made to the investigation process.

Data collected shows the relevance of this work with just under a third (30%) of all investigations identifying a family need:

- 57% of the needs identified involved communication considerations; the two most frequently identified were the need for interpreter/translation services, and limited or no access to technology.
- 32% of the needs identified involved health and wellbeing considerations; the two most frequently identified were mental health concerns and the effect of trauma.
- 11% of the needs identified involved social and community considerations; the two most frequently identified were concerns for the protection of a child or young person and housing matters.

Needs identified by our family needs assessment



During 2022 we proactively contacted families who have been involved in maternity investigations, to ask if they would help us by answering specific questions about their experiences of being involved with us. This has helped us to gain a greater understanding of what families expect from investigations and this information is being used to assist our ongoing development work. As we move towards establishment of a separate maternity body we intend to identify a family forum to develop this area of work and provide more opportunities for co-design.

We have reviewed our information and resources to better inform the tripartite meetings that are held following a maternity investigation. These meetings where HSIB, the family and the trust meet to discuss the next steps after one of our investigations. The meetings are now assisted by a family resource, a trust resource, and a standard operating procedure (SOP) detailing what action the trust and HSIB take in this meeting.

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) was launched by NHS England in 2022. It details the new approach to responding to patient safety incidents. One of the four key aims of this framework is compassionate engagement and involvement of those affected by patient safety incidents. In partnership with NHS England and Learn Together we have produced a **'Guide to engaging and involving patients, families and staff following a patient safety incident'**. This document will be evaluated over the coming year by an independent national survey and the findings will be combined with the Learn Together programme's broader evaluation. This will inform the next iteration of the guidance which is expected to be published in 2024.

We have developed a 6-hour training programme to support this framework and guidance, and this has been delivered during 2022/23 through six online courses and two in-person courses (**see page 46 - investigation education**).

Feedback from families during 2022/23

"We were a bit sceptical about this process, but it was actually a really helpful thing to go through and got us some very important answers on what happened."

"Thank you so much for your support and publication of the subsequent report. It was emotive and personalised and helped us feel, even in death, there would be learning from our experience."

"[The investigator] was supportive, approachable and a great communicator. She was an excellent listener and made us feel acknowledged. Even though there are still some unknowns, the process helped us to come to terms with what happened. Thank you."

Feedback from families during 2022/23

“This investigation made it clearer for me on what actually happened during my daughter’s birth and events beforehand too. Reading it on paper allowed me to come to terms with everything. I really appreciate the time taken out for this investigation and hope it helps other future mothers.”

“The main purpose of the investigation was system change, not blame, which was important to us, and also our input as service users to help implement change was equally as important, so the interaction with the team was the most helpful.”

“Feeling as though someone was listening to our experience and doing something constructive with the information … when I asked the investigator for help, she always got back to me immediately and put me in touch with hospital contacts that I couldn’t otherwise get hold of. It made me feel like I had a voice that I wouldn’t have had without her help.”

Feedback from families during 2022/23

“It was interesting to hear the findings of the report and I take comfort that by our case being investigated could prevent someone else going through a similar situation with their baby.”

“I was given information regarding the aim, scope, process and possible outcomes of the investigation. Realistic outcomes were outlined. All was done with significant empathy and personal consideration of my circumstances.”

“Thank you from [us] for agreeing to this investigation. I believe it’s important that we are allowed to look at concerns like these without placing blame on certain individuals, while at the same time admitting that system change is needed.”

Looking ahead

In March 2023 the government announced that the maternity investigation programme would be hosted by the Care Quality Commission. At the time of writing further details are still being worked out, but it is expected the hosting arrangement for the maternity programme will begin in autumn 2023.

The continuation of the maternity investigation programme will ensure maximum learning is achieved and will provide NHS trusts with the necessary expertise, resources, and capacity to investigate maternity safety incidents in the future. Initially the criteria used will remain the same as we used during 2022.

The focus in 2023/24 will be on establishing our new function and building on the knowledge and experience gained over the past 4 years.

Family engagement remains a top priority and efforts will be made to make it more accessible and reflective of our diverse population. We also plan to explore new areas of investigation and consider opportunities for collaboration and joint learning with our stakeholders to reduce the burden on frontline teams providing care.

Investigation education

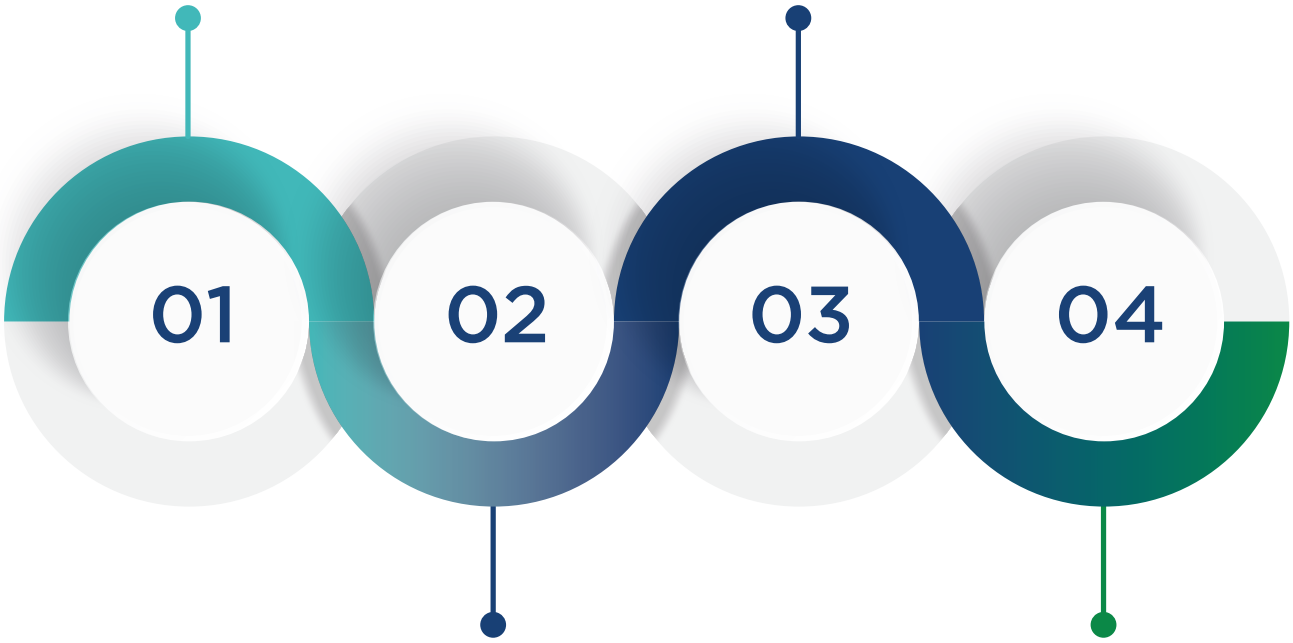
Our Investigation Education Team is drawn from multiple disciplines including human factors, systems thinking, family engagement and occupational psychology.

We have a wide variety of backgrounds from other safety critical industries as well as healthcare, education and other public services. We have established a team to provide world-leading education to meet our aims. Find out more about the **Investigation Education Team** on our website.

Our aims are to:

Support a professional approach to healthcare safety investigations

Encourage the adoption of a 'just culture' approach



Improve local patient safety investigations

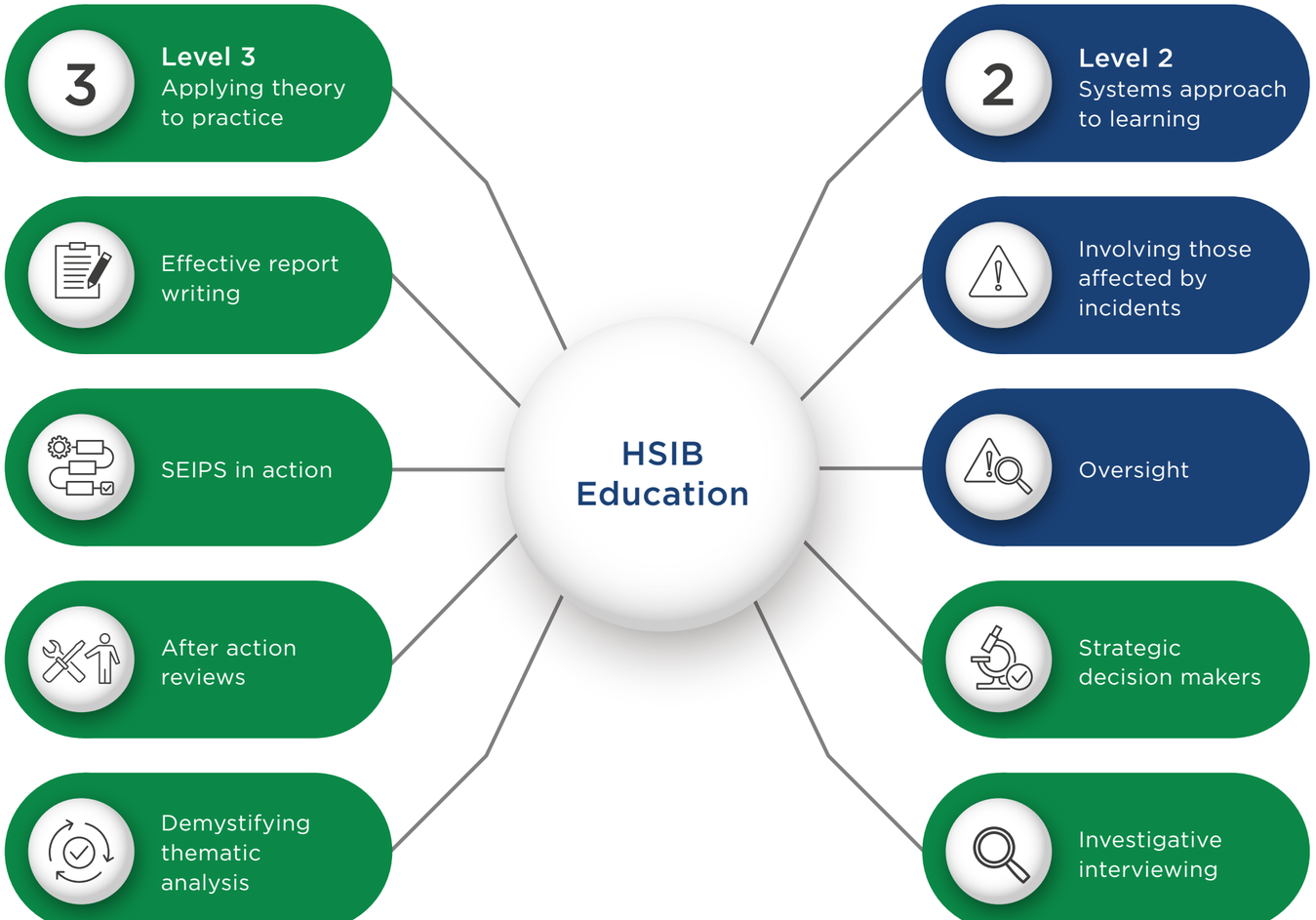
Enable learning from patient safety incidents

This year has been incredibly busy and successful and we have built on the excellent work which came to fruition with the launch of our first cohort of students in January 2022. These 1,000-plus pioneers on our innovative and unique programmes gave us invaluable feedback regarding our educational content, delivery methods and learning systems. This enabled us to build upon and further enhance our offer to the NHS. Once this initial cohort was complete, we began to create the agile programme that is available today.

The Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) was launched in August 2022 (**see page 41**).

Building on feedback and PSIRF implementation, we have created a wide-ranging programme of education as illustrated below. This programme is not purely PSIRF focused but for clarity and ease of navigation, we have labelled them as 'PSIRF Requirements' and 'PSIRF Enablers'. Our enabler programmes are shorter programmes and not interdependent to allow our learners to choose when and how they engage.



PSIRF Requirements

PSIRF Enablers

We launched our new programmes in September 2022 and were overwhelmed by the response. We continue to adapt and develop our offer, informed by our learners and what they require.

Our aim is to provide a solid academic and theoretical introduction to human factors and systems approaches to healthcare safety investigations, while recognising a pressured system and providing practical applications of the learning to inform and assist. The majority of our courses are self-enrolled. Visit the website for more information about **our courses**.

Level 2 – A systems approach to learning from patient safety incidents

Launched in September 2022, this is our core programme of education and covers:

- Philosophy and science of investigation
- Organisational factors
- Physical environment, tools and technology
- Design and systems framework (SEIPS)
- The professional healthcare safety investigator
- Involving those affected and investigative interviewing
- Writing inclusive and structured reports
- Making effective recommendations

The programme contains over 15 hours of recorded presentations and is self-directed for completion over a period of 6 months so represents very flexible learning, divided into bitesize modules of a maximum length of 20 minutes.

There were more than 3,200 learners in this initial cohort which came to an end in March 2023. This demonstrates there is a clear appetite in the healthcare system for training. A new cohort opened for enrolment in April 2023, with this programme meeting PSIRF training requirements.

Other **education and training programmes** on offer include:

Involving those affected by patient safety incidents in the learning process

This is a 1-day (6 hours) programme delivered live online by a team of family engagement experts and meets PSIRF training requirements. Since its launch, this programme has had 211 enrolled students.

Oversight

This is a 1-day (6 hours) programme delivered live online over two interactive sessions and meets PSIRF requirements. Since its launch in February 2023, this programme has had 77 enrolled students.

Investigative interviewing

We have built on the success of this programme by recording examples of the key principles of the PEACE model employed in investigative interviewing. The PEACE model is a five-stage framework to enable meaningful conversations to take place with those affected by patient safety incidents:

P – Planning and preparation
E – Engaging and explaining
A – Account (conversation)
C – Closure
E – Evaluation.

To date nearly 1,000 students have enrolled on this course.

Strategic decision makers

A bespoke 2-hour course for small groups of senior NHS leaders. It is designed to give them an overview of the philosophical and methodological principles which sit behind modern healthcare safety investigations. We have over 300 executive and non-executive directors who have undertaken this module.

Demystifying thematic analysis

This new course introduces the concept and approach to thematic analysis and is designed to complement the PSIRF requirements. This programme has over 300 enrolled learners.

Programmes in development

- Writing reports following investigations and other learning responses
- SEIPS in action
- After action reviews
- Level 3 – Applying theory to practice.

Our impact

Since September 2022 more than 5,200 people have enrolled in our programmes and we will continue to build an alumni community to provide support and guidance.

We evaluate all of our programmes before and after each course to ensure that there is a demonstrable increase in confidence levels. It is vital for us that we monitor this journey.

Comments from our course participants

“Overall, the facilitators made a topic that has the potential to be quite dry, into something really interesting. There was just the right level of encouragement for people to actively participate.”

“They were really friendly and encouraging which made me feel more confident in speaking up.”

“I feel positively challenged to be able to review investigations submitted to the ICB [integrated care board] in a more constructive way, ensuring that they are focused on systems, and not blaming an individual (even implicitly).”

“Brilliant team of facilitators - right pace and very interactive.”

Some learners experienced technology issues accessing our courses. We are exploring different systems to ensure equity of access for all. We have also established a network of 'critical friends' to help us with the continued improvement of our programmes. This includes nascent work with mental health patient safety leads.

Looking ahead

Our programmes have been developed with learning outcomes in readiness for accreditation. We are seeking Continuing Professional Development (CPD) accreditation with the Chartered Institute of Human Factors to further emphasise the value of undertaking training with us.

The team is continuing valuable work on the development of professional standards and competencies for investigators. We hope that this work will further support the professionalisation of healthcare safety investigators and investigations.

As HSIB transitions into new entities, we will continue to explore how we can add capacity to our small group teaching in order to meet the demand and will remain agile and responsive to the training needs of our learners.

We are starting to pilot face-to-face delivery of some of our key programmes to individual organisations and at integrated care system/integrated care board level to ascertain whether learning impact can be further enhanced.

Our unique offer is also garnering international attention and we are building relationships at a global level to share our learning and enhance our knowledge from other systems.

Engagement

Stakeholder engagement

Preparing stakeholders for our transition

During the year we continued to build strong partnership working and information sharing relationships with our stakeholders across healthcare in England and abroad, as we prepare for our transition to HSSIB and MNSI.

A key focus for discussions with our stakeholders has been the implications of the provisions for prohibition on disclosure, commonly known as 'safe space', of our investigation evidence and materials. We have held workshops with many organisations to explain the concept and to reassure them of its impact. These organisations included: healthcare staff and providers; patient and family interest groups; medical specialities; royal colleges; sector and professional regulators; patient safety and safety science experts; and international healthcare safety investigators.

These workshops have helped our HSSIB stakeholders understand our powers, and helped us to understand how we will operate as a fully independent public body with shared interests in patient safety.

Developing our organisational strategy

Our new Chief Investigator, Dr Rosie Benneyworth, joined us in August 2022 and we began a campaign of extensive outreach to our stakeholders, building on our existing relationships and growing new connections across the healthcare sector. These meetings have been building a growing dialogue between ourselves and our stakeholders around emerging patient safety risks, potential themes for future investigations, the development of effective safety recommendations, and sharing learning and insight from our current investigations.

These discussions have also helped to inform the development of our organisational strategy. We have partnered with NHS Horizons, a specialist accelerated change team within the Transformation Directorate of NHS England, to support the internal and external consultation processes and analysis for this work, which began in early 2023 and will continue in the lead-up to our transition later in 2023.

Responding to stakeholder views about our work

In late 2021 we asked an independent company to conduct a benchmarking stakeholder survey to review how we can improve our work. It established that:

- We have good relationships with our major stakeholders – they consider us to be open and transparent, to have high integrity, be producing useful and high-quality outputs to improve patient safety, and they would speak highly of us and our investigations and reports.

- To improve our impact, visibility and perceived value to the healthcare system, we should engage more closely at earlier stages in our investigations to ensure our safety recommendations are more effective, and to communicate more widely and in more targeted ways about our reports and safety recommendations.

In response, during 2022/23, we implemented a programme of work to address the key themes that emerged from the feedback, which are summarised below.

Theme	HSIB activities to address the theme
1 **Raising HSIB's profile and communicating its achievements and successes more effectively and more widely**	• Commenced a **monthly external newsletter called 'Spotlight on safety'** for stakeholders. It covers our investigations and investigation education outputs, and profiles HSIB's work and safety science expertise from across our team. • Held our **third annual patient safety investigations conference**. • Our Chief Investigator gave a presentation on HSIB at the World Health Organization (WHO) 2023 **Global Patient Safety Summit** in Montreux, Switzerland.

2 Improving HSIB's collaboration and communication with stakeholders across the health and care system	• Established regular external engagement with our national stakeholders throughout the year to build collaboration on patient safety issues of mutual interest. • Holding workshops with stakeholders to inform HSSIB and maternity programme strategy and implementation of HSSIB's powers. • Building stakeholder engagement into key stages of the operating framework for national investigations.
3 Focusing HSIB investigations on the most serious risks to patient safety	• A new end-to-end investigation pathway that will support HSIB to work more collaboratively with national stakeholders, drawing on intelligence generated in other parts of the healthcare system that provides insight into recurrent risks and patient safety incidents. • Establish equalities impact assessments that will ensure that the differential experiences of healthcare access, quality and outcomes will be factored effectively into HSSIB's decisions about what to investigate.

4 Ensuring HSIB recommendations are effective and actionable by stakeholders	• Earlier stakeholder identification and sense-checking engagement throughout investigations. • Training for investigators on writing recommendations. • Internal quality assurance processes and supporting stakeholders to develop effective responses to HSIB safety recommendations. • A grading system which helps us to identify opportunities for improvement in our safety recommendations development and providing a framework for engagement with national bodies about their safety recommendations. • Explore how to take forward findings from an NHS England pilot review of early HSIB safety recommendations, to see how we can build a continuous improvement and learning process around safety recommendations. • Develop academic partnerships and research activity to support the assessment and evaluation of our impact with safety recommendations.

5 Transferring HSIB learning and skills to ensure the effectiveness of local NHS organisation investigation	• Courses that directly align with and support NHS staff to implement the new NHS Patient Safety Incident Response Framework (PSIRF). • Self-directed online training widely available to staff within any provider of NHS healthcare. • Standalone modules encompassing a broad range of topics deliver more in-depth exploration of key issues underpinning a system-focused approach to safety investigations. • Develop alumni networks to provide trained individuals with direct ongoing support from HSIB staff and peer support from other trained patient safety investigators. • A network of 'critical friends' is used for pilots before general release of new courses.

Contributing our knowledge and learning to inform patient safety policy-making

To maximise our value it is important that we share learning and expertise from our investigations to support the NHS and wider healthcare system with policy-making that can deliver patient safety improvement. Policy consultations we contributed evidence to during 2022/23 include:

Organisation	Consultation
National Institute for Health and Care Excellence	NICE guideline on diabetes in pregnancy (update) (April 2022)
British Association of Perinatal Medicine	Early postnatal care of the moderate-late preterm infant (May 2022)
Department of Health and Social Care	Acquired brain injury call for evidence (June 2022)
Centre for Perioperative Care	NATSSIP guidelines for perioperative care (July 2022)
Department of Health and Social Care	Mental health 10 year plan (July 2022)
Royal College of Obstetricians and Gynaecologists	Investigation and care of a small-for-gestational-age fetus and a growth restricted fetus (Green-top Guideline no.31) (July 2022)
Health and Social Care Select Committee	Integrated care systems (August 2022)
National Institute for Health and Care Excellence	Intrapartum care for healthy women and babies (August 2022)
Medicines and Healthcare products Regulatory Agency	Equity in medical devices: independent review call for evidence (October 2022)
Medicines and Healthcare products Regulatory Agency	Improving safety communications with health professionals delivering care (January 2023)
Department of Health and Social Care	Hewitt rapid review of integrated care systems (January 2023)

Citizens' Partnership

The **Citizens' Partnership (CP)** ran between 2021 and 2023. Its purpose was to ensure the public perspective was integral to our strategy, patient safety investigations and plans.

In its 18-month existence, it undertook a range of activities and also presented individually on areas of specific interest for the benefit of the organisation. These areas include ethics, unheard voices in health and social care - an overview of disability and race; and, culture in the work place.

The CP also contributed to a number of investigations during the year, including:

- leading on the concerns of the public about the NHS 111 service during the pandemic for **'NHS 111's response to callers with Covid-19-related symptoms during the pandemic'**
- participating in work around maternity care and race equality
- contributing to **'Access to critical patient information at the bedside'**
- contributing to **'Variations in the delivery of palliative care services to adults'**.

The partnership's members have also been active in other areas across the organisation. These include:

- promotion of equality and diversity (ED) through participation in ED workstreams alongside EDI (Equality, Diversity and Inclusion) Champions, and raising the importance of using Equality Impact Assessments for investigations to support and evidence decision-making
- disability awareness
- progressing conversations around race forums led by the Chair of the CP
- raising awareness of Black History Month and Black Lives Matter by sharing their lived experience.

HSIB Safety Investigations Conference 2022

During the year we continued to engage the healthcare system in our work with considerable success, using social media, news alerts, videos, press stories in national, regional and trade media, and through webinars and blogs.

On 21 September 2022 we marked World Patient Safety Day by hosting an international conference on healthcare safety investigations. More than 1,300 people took part, joining us from as far away as Japan, Kenya, Australia and South Africa.

Programme highlights included how we can drive system level change; a practical session on our education programme; and maternity safety insights themed around inclusivity of care. You can **watch the conference in full on our YouTube channel**.

The impact of staff fatigue on patient safety: how do we manage the risk?

On the 17 March 2023, World Sleep Day, we hosted a hybrid conference on fatigue. The event brought together clinical, NHS patient safety representatives and professionals from other safety-critical industries. The aim of the conference was to share insights around the risk of fatigue, how to consider fatigue in the context of investigations and provide some pragmatic resources and plans for the NHS to introduce the concept and tools for fatigue management.

More than 1,000 people registered for the event which **you can view on our website**.

Memoranda of understanding to support collaboration

We hold memoranda of understanding (MoUs) with our key stakeholders, which frame commitments and set the terms of engagement between our organisations, our respective roles and responsibilities for patient safety, and how we will work together. This may include sharing of relevant data and information, with appropriate safeguards, on patient safety risks. Current MoUs include:

- Cardiff Health Board
- Care Quality Commission

- College of Paramedics
- Defence Accident Investigation Branch
- Department of Health and Social Care
- General Dental Council
- General Medical Council
- Health Education England
- Human Fertilisation and Embryology Authority
- Medicines and Healthcare products Regulatory Agency
- National Institute for Health and Care Excellence
- NHS England (HSIB access to National Reporting and Learning System (NRLS)/Learning from Patient Safety Events System (LFPSE))
- NHS England (HSIB access to Strategic Executive Information System (StEIS))
- NHSX
- Nursing and Midwifery Council
- Parliamentary and Health Service Ombudsman
- Powys Health Board
- Royal College of Obstetricians and Gynaecologists
- Royal College of Radiologists
- Williams Review into Gross Negligence Manslaughter in Healthcare.

During 2023/24, as HSSIB and MNSI are established, we will update these MoUs, and continue to expand our formalised partnership working with more of our key stakeholders.

Staff engagement

Over the last year we continued to invest in our colleagues and to work on promoting our inclusive and welcoming culture. We held staff conferences, training sessions and held workshops on EDI, race awareness and cultural inclusivity. Some of our work is highlighted below.

Compassion Conference

We held a Compassion Conference in July 2022, which gave all of our staff the opportunity to be inspired by a programme of expert speakers who shared their insights about how to make HSIB a better place for all. We joined facilitated group sessions and helped co-create a programme of work to make HSIB a fantastic place to be. Since the conference we have taken action in the following areas:

- enabled more focus on psychological and physiological wellbeing
- increased the frequency of face-to-face meetings
- initiated shorter meetings to allow debriefs afterwards
- prioritised wellbeing, for example prioritisation of workloads.

Civility and respect workshops

To support Anti-Bullying Week we promoted and encouraged attendance at the NHS England Civility and Respect workshops. These focused on supporting colleagues who had been affected by bullying and harassment. The events promoted a more inclusive culture of safety that values staff input to ensure colleagues feel heard.

Seasonal flu vaccines and COVID-19 boosters

We promoted the importance of vaccinations and the importance of protecting staff's health and wellbeing.

Health and wellbeing

Health and wellbeing has been a regular standing item during our HR updates The sessions have signposted staff to our dedicated health and wellbeing pages and reminded staff of our wellbeing offer which includes:

- access to occupational health
- Active Care referral (for stress)
- employee assistance programme.

Freedom to Speak Up

Freedom to Speak Up (FTSU) is an initiative run by the National Guardian's Office to support staff to speak up about anything that doesn't feel right in the workplace. Our two FTSU Guardians undertook further training by NHS England FTSU and the FTSU National Guardian's Office. They are part of a network of around 60 Guardians within NHS England.

Over the last year our Guardians have continued to work hard to raise the profile of speaking up by introducing FTSU to all staff and providing speaking up training.

So far this year, the Guardians have dealt with 17 cases in total across a wide range of subject matters. The Guardians are currently working on the transfer of data to the two new organisations when HSIB's functions separate in 2023.

Equality, diversity and inclusion

All public authorities in England, Scotland and Wales and bodies that carry out public functions must comply with obligations under the Human Rights Act 1998 and the Equality Act 2010.

In 2022/23, we ensured the actions we committed to in our '**Equality, diversity and inclusion strategy and action plan 2021-2023**' were being implemented. Actions which have not yet been completed are mainly due to capacity issues because of the added burden of our transformation programme. A revised equality, diversity and inclusion (EDI) strategy is being developed during 2023.

Our '**Equality in our workforce report 2021-22**' was approved for publication in November 2022. It provides a complete breakdown of data on protected characteristics (for example, age, disability or religion) for our intake of staff that year and for the whole organisation. Data was also presented to the senior leadership on the potential future ethnicity profile for each new organisation.

Our EDI Champions have supported seven recruitments over the year from shortlisting to appointments, and ensured equality in all areas. Due to workload regarding our transition to HSSIB, they supported a lower number than last year.

Raising awareness of protected characteristics

It is important for staff to benefit from regular opportunities for education and awareness raising around protected characteristics. Our EDI Champions have taken a lead in designing and building our intranet learning hub which incorporates resources such as reports, recordings, booklists for the nine protected characteristics in addition to cultural intelligence.

Throughout the year we have identified different ways of raising awareness with staff about different protected characteristics using key events and set days. For example, we celebrated:

- **Black History Month** with three presentations for staff. Patrick Vernon, Chair of the CP, gave feedback from a US study tour on racial inequality which included the events and milestones of the journey of black people in America. Jennifer Izekor, a cultural intelligence (CI) expert, gave personal insights and reflections related to CI. A member of our staff presented a talk on his own heritage.

- **Progressing Conversations on Race**. The Chair of the CP followed up on the previous year's series of race conversations by having a separate session on conversations for black and minority ethnic staff in May 2022. He also gave feedback on the race conversations as part of the HSIB Compassion Conference delivered to all staff.

- **Race Equality Week**. During this week we heard from Roger and Naledi Kline, race equality experts, on racism in the NHS, pace of change and impact. In our women's network, we also heard lived experience about intersectionality of being black, disabled and female.

- **Pride Month**. A member of staff wrote about personal lived experiences to celebrate the month.

- **International Men's Day**. A member of staff gave his personal reflections on promoting positive conversations and bringing up boys.

- **Disability History Month**. A member of our CP wrote with lived experience on disability and what it means.

- **Disability**. A member of staff partnered with a colleague from the CP and **developed a video** about how their disabilities had impacted their careers, and how the HSIB had provided a supportive and inclusive environment for them.

- **Women's Network**. Our women's network has benefited from presentations on areas such as micro-aggressions and hearing from external speakers such as the interim CEO of NHS Providers.

By highlighting these initiatives we want to show applicants who are interested in a role at HSIB that we are open to all diversity including disability and will make reasonable adjustments for that eventuality. We recognise that any one of us may become disabled at any point in our working lives and that it is important to be aware of hidden disabilities. This opportunity will be important in the redesign of the website when we become HSSIB.

External partnerships

We regularly network with EDI forums in a variety of organisations and formal groups (NHS and private) to make sure best practice and ideas can be captured to share across the organisation. This is a continuous dialogue of sharing and support for EDI staff who are often working solo on this agenda to instil a culture of it being everybody's business.

EDI in investigations

Involving experts by lived experience in investigations remains a key aim wherever possible and HSIB has signed up to arrangements to access a roster of patients or carers on patient pathways to facilitate this. Several investigations required additional expertise and lived experience around particular protected characteristics:

- Jaundice: **'Detection of jaundice in newborn babies'** particularly where the baby had brown or black skin. An executive level black midwife was consulted as a subject matter advisor.

- Booking systems: **'Clinical investigation booking systems failures: written communications in community languages'**. Appointment letters not available in non-English languages. Engagement was undertaken with the NHS Race and Health Observatory and NHS England. The Equality and Human Rights Commission was also consulted. An observation was made about the lack of ownership/accountability for this EDI risk in the system;

- Sickle cell disease: Our investigation **'Management of sickle cell crisis'** benefited from input from lived experience via the Sickle Cell Pain group, liaison with NHS Race and Health Observatory, Equality and Human Rights Commission, and EDI Champions in NHS England.

Equality impact assessment

In 2022/23 we developed an equality impact assessment (EIA) policy (guidance and template) for our investigations, strategies and policies.

The HSSIB overarching strategy which is being developed will also include an EIA. The EIA will be trialled as part of an investigation in year to understand if there are any refinements required and at which points in the investigation it should be reviewed and revisited to sense-check the guidance.

Race equality group task and finish group

This group continued part way through 2023 and its work will help inform the EDI vision and strategy for the maternity programme.

Family needs assessment

A family needs assessment was implemented in February 2022. We assess a family's needs at initial engagement and at touch points during the investigations. (**See page 38**.)

Language services

In line with the Public Sector Equality Duty, and because we believe it is the right thing to do, we continue to support families and those affected in investigations with their needs for different language services and other formats for communications. In the last year, we commissioned the translation of 64 documents into 36 different languages.

Accessibility

The public may submit a referral about a patient concern online via our website but this is not suitable for everyone. To increase accessibility a telephone line referral service answerphone for the public was launched in January 2022.

Accessibility for external products

In May 2022 the HSIB website was reviewed by the Plain English Campaign and an accessibility audit was carried out by a leading digital accessibility agency. The Plain English Campaign reported that HSIB has "a well laid out site with clear options". The accessibility audit stated: "... we found many positive elements on HSIB's website as well as some areas that need attention. Overall, it is good to note that some accessibility considerations had been taken into account." An action plan is being drawn up to tackle outstanding issues over the course of 2023/24.

Work is also underway to consider a translation function into multiple languages for the whole website and this would include other options such as Easy Read.

Governance

Responsibilities, accountability, and independence

We are accountable to the Secretary of State for Health and Social Care. Through this Annual Review we report on our performance every year to the Secretary of State for Health and Social Care. We also publish it on our website.

Our functions and responsibilities were established in two sets of secondary legislation from the Secretary of State for Health and Social Care:

- The NHS England (Healthcare Safety Investigation Branch) Directions 2022. These set out our responsibility for national investigations.

- The NHS England (Healthcare Safety Investigation Branch) Additional Investigatory Functions in respect of Maternity Cases Directions 2022. These Directions set out our responsibility for maternity investigations.

In July 2021 the government introduced the Health and Care Bill, which included legislation to create the Health Services Safety Investigations Body (HSSIB) as a fully independent non-departmental public body with enhanced investigatory powers.

The Bill became the Health and Care Act in April 2022. A transition board led by the Department of Health and Social Care has been overseeing the establishment of HSSIB and a new function for the maternity investigation programme, both of which are due to become operational in autumn 2023.

Information governance

The Data Security and Protection Toolkit (DSP)

The DSP is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. HSIB provided its toolkit submission in March 2023.

The impact of this toolkit submission being successfully approved means that HSIB, and later HSSIB and MNSI, will continue to be able to process, analyse and manage critical personal data.

Information requests

During the period April 2022 to March 2023:

- 33 subject access requests were received by the Information Governance Team. All requests were responded to within the timeframe set by the General Data Protection Regulation 2018.

- 46 Freedom of Information requests were received by the Information Governance Team. All 46 responses were prepared and sent to the Freedom of Information team at NHS England (as legal host of HSIB) within the timeframe set by the Freedom of Information Act 2000.

- 132 requests for copies of interviews conducted during HSIB investigations were received and processed.

- 93 requests for information from coroners were received and processed.

Looking ahead

During 2023/24 the Information Governance Team will be working on a large-scale project which involves redesigning and updating all policies and procedures with regards to information governance and records management. These updated policies and procedures will be required for our two new organisations when they are launched later in the year.

The transformation programme will provide HSSIB with new powers which will require the development of new policies and procedures.

Risk management

Our self-service risk management system continues to monitor and map risks effectively.

Financial performance

During the year we kept within our funding allocation. Our net expenditure for the year was £19,996,000.

	2022/23	2021/22
Target: Funding allocation	£20,913,000	£20,011,000
Performance: Net expenditure	£19,996,000	£18,678,000
Performance: Capital expenditure	£101,000	£178,000

Main categories of revenue expenditure

	2022/23	2021/22
Revenue	£(47,000)	-
Staff	£17,195,000	£16,387,000
Purchase of goods and services	£2,190,000	£2,142,000
Other operating income	£183,000	£149,000
Transition expenditure	£475,000	-
Total	£19,996,000	£18,678,000

(As at time of publication the above amounts are unaudited.)

In addition to the expenditure above, £101,000 of information technology hardware and websites were capitalised in the year (2021/22: £178,000).

The largest area of spend is workforce costs, representing 86% of net expenditure in 2022/23 (2021/22: 88%).

Purchase of goods and services relates to training, business travel, IT, communications and professional fees (including the fees of experts on specialist matters) and premises. Other operating expenditure is the cost to HSIB for the provision of back-office functions by NHS England. Transition expenditure are the costs incurred for the establishment of HSSIB.

Appendices

Appendix 1 Differences in our approach to national and maternity investigations

	National investigations	Maternity investigations
Start date	Programme began in April 2017.	Programme began in April 2018.
Number of investigators	15	127
Number of investigations	We were set the task of carrying out up to 30 investigations per year.	We were set the task of completing around 1,000 investigations per year that meet the criteria.
Training for investigators	National investigators receive an induction programme when joining HSIB which includes training in investigative skills and practices. This is delivered through face-to-face training sessions and mentorship by experienced investigators. There is also an annual education programme that seeks to update and enhance skills including use of accident/incident analysis models, improving the accessibility of our reports and improving wider healthcare understanding.	All investigators attend a bespoke induction and training programme which includes the theory of patient safety and the practical application of these skills. Additional training and updates are provided throughout the year.
Referrals	Any person, group or organisation can refer a patient safety concern to us through our website. We also identify issues for investigation through research.	Individual NHS trusts refer incidents to us that meet the criteria.

	National investigations	Maternity investigations
Criteria for investigations	We evaluate patient safety issues against our own criteria and decide whether to go ahead with an investigation.	We investigate maternity healthcare safety incidents that meet a set HSIB criteria. In April 2020 (with DHSC's agreement) we made amendments to the programme criteria which remain in place as of 31 March 2022. Trusts continue to refer all cases in line with the existing criteria, and we have temporarily ceased investigations of cases relating to hypoxic ischemic encephalopathy where a baby had received cooling therapy and there was no apparent brain injury. The exception to this is if the family or trust request we progress an investigation, in which case we will continue to do so.
Investigation status	Our investigation does not replace the local trust's investigation into the patient safety incident.	Our investigation replaces the trust's investigation into the maternity incident for those investigations that meet the criteria.
Reporting	We publish national investigation reports on our website.	Maternity investigation reports are shared with the family and trust. They are not published.

	National investigations	Maternity investigations
Safety recommendations	We make safety recommendations to relevant named organisations. Organisations are requested to respond to the recommendations within 90 days and we publish the responses on our website. We may also make safety observations (where we consider our findings warrant attention but there is not enough information on which to make a recommendation) and identify safety actions that have been taken during an investigation to immediately improve patient safety.	We make safety recommendations for learning to the trust. The trust is responsible for putting them into action. We gather information about themes arising from our investigations to share learning across the health sector. In addition, themes can be developed into national learning reports in collaboration with the national team to support safety recommendations to national bodies.

Appendix 2 Safety recommendations issued during 2022/23

Please visit our website for the latest information on our **investigations, reports, safety recommendations and safety recommendation responses**.

Provision of care for children and young people when accessing specialist gender dysphoria services

(April 2022)

R/2022/191 – HSIB recommends that **NHS England and NHS Improvement** incorporates the findings of this investigation into plans to further review and develop the service specifications for specialised gender dysphoria services. This should include further work with relevant stakeholders to:

A

- Identify the role of relevant voluntary and charitable sector organisations in supporting patients with gender identity concerns and facilitate information sharing between these organisations and regional professional support services.

B

- Identify work to improve the transfer of care, management, and proactive risk assessment of patients who are moving from the Gender Identity Development Service waiting list to a gender dysphoria clinic waiting list.

Decontamination of surgical instruments (May 2022)

R/2022/192 - HSIB recommends that the **Care Quality Commission** reviews and ensures that the approach used by healthcare providers to assure themselves that in-house or externally contracted sterile services for decontamination are safe and can identify and respond to patient safety concerns.

R/2022/193 - HSIB recommends that the **Department of Health and Social Care** assesses the benefits of a single regulatory and assurance framework for sterile services departments and implements the findings as required.

R/2022/194 - HSIB recommends that **NHS England and NHS Improvement** amends Health Technical Memorandum 01-01 to define 'top management' and its commitment to quality, and that external independent audits are reported directly to the responsible executive director in a trust who is accountable for the service, not just the certified department.

R/2022/195 - HSIB recommends that **NHS England and NHS Improvement** develops a competency framework, stating skills, qualifications and professional registration as required, for all sterile services staff and includes it in Health Technical Memorandum 01-01.

Harm caused by delays in transferring patients to the right place of care - Interim bulletin 1 (June 2022)

R/2022/196 - HSIB recommends that the **Department of Health and Social Care** leads, an immediate integrated national response across health and social care to reduce the daily harm occurring in the community and healthcare systems relating to flow through and out of hospitals to the right place of care.

R/2022/197 - HSIB recommends that the **Department of Health and Social Care** conduct a 'whole system' review to identify constraints, demand, capacity and flow for patients spanning the health, social and community care systems to reduce patient harm throughout those systems and implement any changes as necessary.

Medicine omissions in learning disability secure units (June 2022)

R/2022/198 - HSIB recommends that **NHS England and NHS Improvement** reviews and updates all health building guidance relating to learning disability secure units to reflect current clinical guidance on ensuring the design and layout provides a suitable environment for patients and staff.

R/2022/199 - HSIB recommends that **NHS England and NHS Improvement** develops the ongoing work to improve the retention of learning disability nurses, in line with the intent of the All-England plan for learning disability nursing.

The use of an appropriate flush fluid with arterial lines
(August 2022)

R/2022/200 - HSIB recommends that the **Medicines and Healthcare products Regulatory Agency** engages with other national regulators and relevant stakeholders to develop design guidance on labelling and packaging specific to fluids to reduce selection errors.

R/2022/201 - HSIB recommends that the **Medicines and Healthcare products Regulatory Agency** reviews and acts on the available evidence to regulate for the use of pressure infusion bags that allow fluid labels to be read when inflated.

R/2022/202 - HSIB recommends that the **Medicines and Healthcare products Regulatory Agency** communicates to all relevant stakeholders and acts on the available evidence concerning the management of the risks associated with arterial transducer line sets.

R/2022/203 - HSIB recommends that the **Department of Health and Social Care**, once post market surveillance data is available, involves relevant stakeholders including the Association of Anaesthetists' review and determine appropriate actions that could be taken to further mitigate the risk of blood sample contamination by the flush fluid when using arterial transducer line systems.

R/2022/204 - HSIB recommends that the **Association of Anaesthetists** works with relevant professional organisations to revise existing national guidance to manage the risks of contamination by the flush fluid when using an arterial line to take a blood sample.

R/2022/205 - HSIB recommends that the **Care Quality Commission** reviews the recommendations from the Association of Anaesthetists on how to manage the risks of contamination by the flush fluid when using an arterial transducer line and determines any appropriate actions for the oversight of governance and assurance arrangements within NHS providers following.

NHS 111's response to callers with COVID-19-related symptoms during the pandemic
(September 2022)

R/2022/206 - HSIB recommends that **NHS England** ensures any Single Service contract or additional services contracts reflects the minimum requirements of the core NHS 111 service for audio-recording calls.

R/2022/207 - HSIB recommends that **NHS England** reviews the risks associated with increased use of telephone triage in response to national healthcare emergencies. Consideration should be given to applying any recommendations of this review across telephone triage services within the wider healthcare setting.

Detection of jaundice in newborn babies
(January 2023)

R/2022/208 - HSIB recommends that the **National Institute for Health and Care Excellence** reviews the available evidence and updates its guidance if appropriate, regarding:

- the reliability of visual signs to detect jaundice in newborn babies, particularly in babies with black and brown skin
- risk factors for jaundice identified by this investigation, including prematurity.

R/2023/209 - HSIB recommends that the **Royal College of Pathologists** works with stakeholders to understand current practice and make any appropriate recommendations to promote the adoption of an icteric threshold at which a bilirubin test may be cascaded or reported.

R/2023/210 - HSIB recommends that the **Royal College of Pathologists** works with stakeholders to understand current practice and make any appropriate recommendations on neonatal specific reference ranges for total bilirubin and thresholds for direct communication of these results to clinicians.

Access to critical patient information at the bedside (February 2023)

R/2023/211 - HSIB recommends that the **Office of the National Data Guardian** supports local interpretation of the Caldicott Principles to give organisations and staff the confidence to display full patient names at the bedside to support correct patient identification for safer care.

R/2023/212 - HSIB recommends that **NHS England** develops guidance to providers via any digital maturity assessments that are developed, to help ensure critical patient information (such as patient identifiers and cardiopulmonary resuscitation status) must be available to clinical staff when accessing electronic patient record systems.

R/2023/213 - HSIB recommends that **NHS England** provides guidance to healthcare organisations to support local design and configuration of electronic patient records to enable end users to access critical patient information (such as patient identifiers and cardiopulmonary resuscitation status).

R/2023/214 - HSIB recommends that **NHS England**, during review of relevant Health Building Notes and Technical Memoranda, includes, as a consideration, that bedside patient information should be consistently visible.

R/2023/215 - HSIB recommends that **NHS England** assesses the priority, feasibility, and impact of future research into what and how critical information pertaining to the emergency care of patients in the acute hospital setting can be readily and reliably accessed at a patient's bedside.

R/2023/216 - HSIB recommends that the **Resuscitation Council UK** clarifies and promotes expectations around the sharing, presentation, and language of cardiopulmonary resuscitation recommendations in hospital ward environments in line with the findings of this investigation.

R/2023/217 - HSIB recommends that the **British Standards Institution**, with support from relevant stakeholders, provides symbology to standardise how information relating to a patient's resuscitation status can be displayed in electronic healthcare records and systems.

R/2023/218 - HSIB recommends that the **Royal College of Nursing** develops guidance for ward-based nursing handovers with consideration of the following: how handovers are organised, their content, the environment in which they take place and the technology needed to support them.

Harm caused by delays in transferring patients to the right place of care - Interim bulletin 3
(February 2023)

R/2022/219 - HSIB recommends that **NHS England** includes staff health and wellbeing as a critical component of patient safety in the NHS Patient Safety Strategy.

Care delivery within community mental health teams (March 2023)

R/2022/220 - HSIB recommends that **NHS England** works with appropriate stakeholders, including experts with appropriate experience, to create guidance on culture change. A quality improvement programme should also be developed to support practitioners in undertaking psychosocial assessments that are in line with guidance from the National Institute for Health and Care Excellence. Person-centred safety planning should be embedded within the process.

R/2023/221 - HSIB recommends that the **Care Quality Commission** evaluates the way in which it reviews how community mental health services assess risk of harm, to ensure its inspections are in line with the latest national guidance.

R/2023/222 - HSIB recommends that the **National Institute for Health and Care Excellence** evaluates the available research relating to the risks associated with menopause on mental health and if appropriate, updates existing guidance.

R/2023/223 - HSIB recommends that the **Royal College of Psychiatrists** forms a working group with relevant stakeholders to identify ways in which menopause can be considered during mental health assessments.

Safety risk of air embolus associated with central venous catheters used for haemodialysis treatment (March 2023)

R/2022/224 - HSIB recommends that the **General Medical Council** engages with relevant stakeholders to amend the procedure for taking blood cultures in its 'Practical skills and procedures' guidance, making clear that the procedure relates to taking blood from a peripheral site, so mitigating the risks to patient safety associated with central lines.

R/2023/225 - HSIB recommends that the **General Medical Council**, supported by the Medical Schools Council, revises 'Achieving good medical practice' to include guidance for medical students on how to handle uncertainty in clinical settings, including challenging a culture, or an expectation, that a learner undertake unfamiliar tasks to gain competencies without appropriate supervision or support.

R/2023/226 - HSIB recommends that the **Medicines and Healthcare products Regulatory Agency** amends its 2022 'Dialysis guidance' to include the safety risk of air emboli associated with unclamped haemodialysis catheters.

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HSIB
HEALTHCARE SAFETY INVESTIGATION BRANCH

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 contacting us.

@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 Friday from 09:00 hours to 17:00 hours. We aim to respond to enquiries within 5 working days.

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