Health Services Safety Investigations Body

HSSIB Public Board Meeting Agenda
Thursday 2nd May 2024, 13:00hrs-15:00hrs
Warrenfield Room, The Rufus Centre, Steppingley Road, Flitwick, Bedfordshire, MK45 1AH

Item	Time	Item	Purpose	Presenter	Delivery
1.	13:00	Welcome 1.1 Introductions 1.2 Apologies for Absence 1.3 Declaration of Quorum 1.4 Declaration of Interests 1.5 Minutes from previous meeting 1.6 Actions from previous meetings	 Information Information Assurance Assurance Approval Assurance	Ted Baker	 Verbal Verbal Verbal Verbal Paper Paper
2.	13:10	Retained Swabs Investigation Update	Information	Philippa Styles Saskia Fursland	Presentation
3.	13:30	Chair Update	Information	Ted Baker	Verbal
4.	13:35	CEO Report	Information	Rosie Benneyworth	Paper
5.	13:55	Year End Performance Report	Assurance	Executive Team	Paper
6.	14:40	Policy Review 6.1 Disclosure of Protected Materials Policy	 Approval	 Philippa Styles	 Paper
7.	14:55	Any Other Business	Declaration	Ted Baker	Verbal
8.	15:00	Close		Ted Baker	Verbal
9.		Questions from Public Attendees		Rosie Benneyworth	Verbal
For Information					
10.		10.1 Forward Planner	Information	Maggie McKay	Paper
Next meeting: 27 June 2024 10:00-12:00 - NHS Somerset, Lufton, Yeovil, Somerset, BA22 8HY					

Health Services Safety Investigations Body

Minutes of the
Healthcare Services Safety Investigations Body (HSSIB) Public Board Meeting
Tuesday 9 April 2024 09:30hrs-12:00hrs
Virtual Meeting via Microsoft Teams

Present	
Ted Baker (TB)	Chair
Rosie Benneyworth (RB)	Chief Executive
Marc Esmiley (ME)	Non-Executive Director Board Member
Marisa Logan-Ward (MLW)	Non-Executive Director Board Member
Mary Cunneen (MC)	Non-Executive Director Board Member
Mike Durkin (MD)	Non-Executive Director Board Member
Peter Schild (PSch)	Non-Executive Director Board Member
Maggie McKay (MM)	Finance and Performance Director
Philippa Styles (PSty)	Director of Investigations
Andrew Murphy-Pittock (AMP)	Education Director

In attendance	
Minal Patel (MP)	Head of Strategy, Policy and Engagement
Julia Blomquist (JB)	Business Manager to CEO and Chair
Sarah Graham (SG)	Board, Governance and Records Manager
Adam McMordie (AM)	Director of NHS Quality, Safety and Investigations, DHSC
Hannah McEwen (HM)	Board Administrator (minutes)

WELCOME / ITEM 1.1 INTRODUCTIONS

The Chair opened the meeting and welcomed Board members and other attendees. Adam McMordie joined the meeting as an observer.

ITEM 1.2 APOLOGIES FOR ABSENCE

There were no apologies for absence.

ITEM 1.3 DECLARATION OF QUORUM

The meeting was quorate with all Board members present.

ITEM 1.4 DECLARATION OF INTERESTS

There were no relevant declarations of interest.

ITEM 1.5 MINUTES OF THE PREVIOUS BOARD MEETING

The 8 February 2024 minutes were approved as a true and accurate record.

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ITEM 1.6 ACTIONS FROM PREVIOUS MEETINGS

Action 13 – agreed to close.

Action 14 – taken forward by SLT and agreed to close.

Action 15 – taken forward by SLT and agreed to close.

Action 32 – RB updated that the paper was discussed at SLT. As a small organisation the options about specific software solutions were discussed for people to raise concerns and look at external support (if any concerns were raised through that solution). Kay Robertson, HR Business Partner, is looking at the HR processes and it has been discussed whether to have an internal function as well as an external support. We recognise the importance of Freedom To Speak Up (FTSU) and that the systems and processes need to be right. A lot of exploratory work with the National Guardian's Office and other small ALBs has been done to look at the different options, this will be brought back to the Board by 8 August 2024.

MLW felt this is a good plan and questioned as a Board would we be subject to national scrutiny and if this is something that needs exploring. RB does not think we have had any formal correspondence for this as a new ALB but are following best practice and looking at tools available as other organisations do. This is certainly something to explore and come back with an answer. This is a requirement from NHS England and will need assurance for FTSU. There are no concerns where we are at the moment and PSch kindly continues to take the non-executive lead. TB will continue with focus groups for staff to hear their views and welcomed any Non-Executive Directors (NEDs) to join if they are interested to do so.

Action: RB to explore whether we need to follow any national guidance regarding FTSU and provide an update at the next meeting.

Action 35 – to be ratified at today's meeting and if approved, action can be closed.

Action 36 – to be ratified at today's meeting and if approved, action can be closed.

Action 37 – will be taken to May's Board meeting for ratification.

ITEM 2 INVESTIGATIONS UPDATE

PSty shared the investigations update, giving an overview of the work being done which was directed by the Secretary of State in 2023. A process was undertaken to define the terms of reference for investigations which was signed off in early 2024.

Following the Secretary of State direction, four investigations have officially been launched by HSSIB. A lot of exploratory work has been undertaken which included national stakeholder engagement, PSty commended the team for their engagement

PSty proceeded through the four investigations, highlighted in the presentation, advising of the summary focus, investigation update and planned publication. The theme running through all investigations is looking at NHS and independent advisors. The experiences of patients were also shared.

The final slide deck showed the early insights, the team are working incredibly hard against all of these investigations and are taking up a significant number of resources. The insights are being built up day by day so this can be brought back as another update to the Board in the future.

Questions raised by the Board:

MD raised the engagement/involvement of the secure estate issues and prisons particularly with children and young people and queried whether we are getting the active engagement with regard to secure estate aspects of mental health. PSty answered that we have had very positive engagement with national organisations in relation to the secure estate and great cross pollination across our investigation teams to consider findings in our prison investigation. The secure estates are adult patients only. There has been a focus group in a secure setting with appropriate support and risk assessments in place for our teams. The team are doing a very well considering the difficult circumstances.

MD queried the physical health of these groups, as often young people and elderly with co-morbidities, physical help are not addressed as much as they should be. This is being picked up in creating the conditions to deliver safe and therapeutic care, and also making sure care plans and provisions are in place. By looking at the holistic care of a patient and understanding the causes that may not relate to their mental health, could identify how the care pathway may have been impacted.

MC felt we need to look at how we implement recommendations at the end of our reports, PSty responded that we collaborate with key stakeholders throughout the investigation until the point of publication, ensuring what is asked is achievable. A pilot is also being launched to look at the impact of recommendations and updates will be provided in the CEO monthly reports.

MC asked how we are supporting staff and patients and managing their expectations, PSty advised we are very mindful of the impact on the wellbeing of our staff. The mental health team have been trained on trauma informed engagement and take a proactive and supportive approach and supporting our team to build toolkits, skills and resilience to be able to manage these difficult conversations. The training has been really well received and will be rolled out to all of the investigation and insights team.

In relation to patients, we have been working with MIND who have expertise and have helped facilitate groups to make sure they are supported. With regards to managing expectations, we do our upmost to be open and transparent, taking a no blame approach, organisation names are not mentioned in reports and patients are signposted where needed. Furthermore, the team have also undertaken safeguarding training.

TB questioned whether we are getting enough diversity from mental health expertise, PSty answered we are actively seeking diversity by speaking to staff across different providers to help move this conversation forward. This has been a challenge and there is more work to do. Previous mental health safety reports identified that the problems were often very early in the pathway of mental health care, and they manifest as acute crises later on which is very difficult to manage.

TB queried whether we are we looking at the whole pathway effectively in this. PSty advised we are trying to look at the learning from inpatient deaths and near misses, not just looking at the period of stay but the whole patient pathway. Out of area placements can cover 2 miles to 500 miles, so is important to take into account how far away some of these patients are from home and whether this is effective for them.

MD raised in regard to engagement it is difficult talking to parents who have lost children, particularly with justification, and whether we have an opportunity to talk to them and listen to their experiences. PSty advised the team are actively attempting to engage with these people. Our work has been fairly well publicised, and this was also the reason for reaching out to parliament for their constituents. There is still time for more proactive engagement for specific cases that are well known. RB stated we are also engaging with lots of different networks, both facilitated by NHS Providers and NHS Confederation, to reach people through every route we can.

The Board requested further updates on the progress and agreed for PSty to provide feedback to the Board when appropriate.

ITEM 3 CHAIR UPDATE

The President's Award at the Chartered Institute of Ergonomics and Human Factors has highly commended HSSIB for their work on human factors. This is great reflection of the work that is being undertaken, particularly AMP and the education team. Being champions of human factors is a very important aspect of HSSIB's work.

Since the last Board meeting RB and TB have met with Amanda Pritchard and Richard Meddings from NHS England (NHSE) and are trying to develop a positive relationship with them. As NHSE is the chief recipients of our recommendations, it is important that we form close collaboration with them to make sure they are effective.

Nick Woodier, Senior Safety Investigator was congratulated for his excellent interview on Panorama, expressing real patient safety concerns regarding transferring patients between independent providers and the NHS.

A seminar was held with HSSIB members of staff called Truth for Gaia, who was a young woman who died after misdiagnosis for neurological issues. Her mother Dorit Young is leading a campaign to improve the assessment of acute neurological problems and gave an inspirational presentation. Going forward it would be interesting to think how HSSIB can contribute to cases like this.

TB also attended The National Freedom to Speak Up Guardians Conference in Birmingham and met with some inspirational colleagues leading on this which HSSIB are fully supporting.

ITEM 4 CHIEF EXECUTIVE OFFICER UPDATE

RB was pleased to be involved in giving evidence to the Health and Care Committees looking at patient safety recommendations and will be meeting with the panel chair to discuss the report further. This work also links in with the arm's length body group.

There have been several speaking engagements within the last month. This month RB is attending the Global Ministerial Patient Safety Summit held in Chile, alongside Dr Aidan Fowler, Dr Henrietta Hughes and Mike Durkin.

HSSIB have also been invited to join the Patient Safety Research Collaborative (PSRC) 'Safety Net' Advisory Group chaired by Mike Durkin. The first meeting was held a few weeks ago which was a good opportunity to talk about how we can engage with them.

MD advised the National Institute for Health care Research (NIHR) is organised through multiple elements of DHSC and the UK Government and have provided funding for centres. This has now been made more widespread and the number of centres has increased to six. This is a great opportunity to work across other academic centres across the world, bringing in leading systems in the UK. This is a global effort to look at investigations and patient safety, understanding the impact and implications into changing the behaviour and systems.

RB is also working on recommendations across the system which is progressing very well. An academic panel has now been set up which is chaired by Carl Macrae. RB has engagement meetings arranged within the next month with Professor Stephen Powis (NHSE National Medical Director), Matthew Styles (Director General at DHSC), Julian Hartley (CEO of NHS Providers), Matthew Taylor (CEO of NHS Confederation), Julian Kelly (NHSE Chief Finance Officer) and the Academy of Medical Royal Colleges.

Lastly RB was sorry to announce that after five years at HSIB and HSSIB Maggie McKay, Finance and Performance Director has resigned and will leave the organisation on 30 June 2024. MM has played a key role in the transition to HSSIB and will be very much missed by the team. The NEDs will meet with RB for a meeting following the Board to discuss the process and assurance regarding the Finance and Performance Director role.

Action: RB, PSty, AMP to bring a proposal to the Remuneration Committee and the Board post June regarding the Finance and Performance Director role.

The Board wished MM the very best for the future and PSch offered to join the recruitment panel.

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Strategy
MP highlighted the following update:

Following feedback from the Board at the March development day, the strategy is now being prepared to go out for consultation and a 30-day consultation will be run to engage with the public and stakeholders. We will consult on the criteria at the same time, to avoid consulting twice with the same audience.

We will be working with umbrella groups, such as Healthwatch to help reach public and patients, through a range of engagement methods. As part of the consultation process, we are conducting Equality Impact Assessments to assess for any impact on protected groups.

The strategy is due to come back to the Board in June.

Communications
MP highlighted the following updates:

- A blog was published on the HSSIB website regarding the challenges facing the NHS in tackling the elective care backlog and how learning from our investigation reports may be able to help the NHS rise to this challenge.

- For Rare Disease Day, a blog was published in collaboration with the MPS Society focused on our advanced airway management report.

- The workforce investigation report, focused on involving temporary staff in patient safety investigations, gained media coverage, nationally and regionally. There was also public support for the report messaging from NHS Providers.

Education
AMP highlighted the following updates:

- On 6th March, a few of the team delivered a training day to senior regional midwives around PSIRF (Patient Safety Incident Response Framework) implementation. The pilot was delivered face to face where elements of our strategic decision-making programme and oversights programme were shared.

- Loughborough Programme (National Patient Safety Syllabus Level 3) commissioned HSSIB to deliver two of the five models of that programme to patient safety specialists (822) across the NHS in England. The online modules are now complete and in March the pilot was delivered in person. The patient safety specialists must attend five days in person as well, which is across the country. The next module will start in June. It was powerful to meet these people in person. There has been a good decrease in our no-show rates, this was tackled by increasing the number of people that could register to the programme in anticipation of some no-shows, the attendance rate is now at approximately 80%.

- Charities such as hospices and community interest companies who deliver NHS services do not fully quality for free access to our training programme. AMP will be bringing a new paper through SLT and Board in the future to propose how we tackle this. Some pilots are underway with these companies.

- Commercial work has started from the 01 October, with no marketing in order to mitigate any risk. This is working well with an estimated income so far of around £100,000, which is expected to increase.

- First small international contract in Canada. Gaining increasing international interests in our educational programmes. AMP is exploring an international contract with the United State, Penobscot Community Healthcare Organisations, AMP met with the CEO last week who is keen on purchasing places.

- HSSIB are also looking at joining the NHS Consortium for Global Health and we are also still an active member of a group exploring medical tourism and patient safety linked to Turkey and outbound medical tourism. Including exploring roadshows with the CQC, GMC regarding unregistered medical practitioners who are performing these roadshows.

- HSSIB have been asked to join a reform board for statutory and mandatory training across the NHS. AMP is the representative of HSSIB on that board.

<u>Investigations and Insight</u>
PSty gave the following updates:

- SLT have approved a pilot to look at the recommendations made by HSIB and those now being made by HSSIB in regards to the impact of the actions taken. Thank you to Matthew Wain and Matthew Mansbridge who are leading on that work and linking it with the national work that RB is leading on relation to recommendations.

- The recruitment for safety investigators is underway, the advert is now closed. There have been 482 applications which will now be shortlisted

AM questioned in regard to mental health whether interim health reports would be useful, PSty advised the investigation review milestones start in May, at which point interim reports will be considered.

AM reminded colleagues that the pre-election period for the local election period starts on 11 April, anything that had local impact will not be able to go out from that date.

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Business Services

MM gave the following updates:

- Three internal audits have now been concluded, all of which received a moderate rating (second highest), which we are very pleased with. The team are now preparing the management responses. The learning and recommendations are being fed into our work already and SLT will be kept up to date with the progress.

- We have now received the finance and budget for 24/25 - it is in line with what was expected which is 5.6 million. The additional funding is for the additional employer's contribution. There is still limited funding for the education programme, which has been raised with DHSC at the last quarterly accountability meeting.

- To cover the costs of the transition from HSIB/NHSE to HSSIB a 2023/24 budget transfer was transferred from HSSIB to NHS England via DHSC for £293,083. This was necessary because the budget for the transition was only funded to HSSIB by DHSC however some costs were incurred prior to the transition.

- HSSIB and DHSC Remuneration Committee have approved the extension of the Interim Chief Executive Officer, for three months until the 30th of June, whilst DHSC seek the necessary approvals for the permanent CEO appointment.

PSch asked under procurement the two contracts which are set to expire; Investigation Management System and Learning Management System, will these contracts rollover or will new ones need setting up with a new supplier. MM responded the contracts cannot be renewed or extended. We need to go out and reprocure whether this is using a different supplier this remains to be seen. This has been raised as a risk with the DHSC finance team and will be added to our risk register.

Action: MM to ask SG to add procurement of the Investigation Management System and Learning Management System contracts to the risk register.

ITEM 5 PERFORMANCE REPORT

Investigations

PSty provided oversight of the data and welcomed any feedback on how it is presented.

Our team have started to review and code the Prevention of Future Deaths reports, which is adding additional intelligence into our initial intelligence review meeting and is of great value to us.

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Following the review of intelligence, three topics came into the investigation proposal these were: paramedical pre-hospital interpretation of ECG, medication safety and patient harm associated with hysteroscopy.

Investigations formally proposed and launched on our website are: mental health inpatient management settings, safety management systems and healthcare provisions in prison.

The nutritional assessment and the retained swabs final report are due to go out in the next couple of weeks.

TB queried about the section on jaundice in newborn babies as the Royal College of Pathologists are not responding to our recommendations. PSty explained they are not being resistant to the recommendations. Following an escalation letter sent in January, they have now responded and met with the team. We are hoping to work in a collaborative approach and have an update for the next Board meeting.

A workshop is being planned to talk through the reporting processes at a future Board development day.

Education

The report has highlighted the top three organisations who are engaging with our education programs, the highest one has over 120 enrolments. In total we have just gone over 25,000 enrolments on our programs since the education program started in September 2022 and carried over from HSIB into HSSIB.

AMP welcomed feedback on how the data is presented and if any other specific data is required.

Communications and Engagement

MP updated that an article has been published in the journal Patient Safety and Risk Management (MP shared the link) and a paper has also been published in Safety Science by Mark Sujan, one of our senior investigators.

Finance

The financial position as of 29 February 2024, is forecasting an underspend of £157k, we are on track to have a similar underspend following the completion of the March accounts. This is due to the uncertainty of being an ALB and cost of transition. Some additional funding was given for cyber security, but we have not been able to use all of this due to only been given the confirmation for the funding in December/January. We have managed to access free training i.e. the Board training on the away day.

Regarding the workforce summary, we do not have an establishment for 2023/24 financial year, business services will depend on the business plan that is currently being prepared. Our headcount and full-time equivalent have remained the same. There have however been some new starters within the Business Services team and leavers within the Investigations team.

Mandatory training has increased up to up 83% and the sickness rate has reduced, a further update will be provided at the May board meeting. In terms of the Information Commissioner's Office there have been no cases to report on since working as HSSIB.

ITEM 6 SUBCOMMITTEE UPDATES

ITEM 6.1 AUDIT AND RISK ASSURANCE COMMITTEE (ARAC)

PSch updated that the Committee have met twice since the last Board meeting. ARAC met on the 28 February with the primary purpose to discuss the Annual Report and Accounts, that the plans were aligned, our risk mitigations and that our high-level timeline was satisfactory.

The draft Annual Report and Accounts will be shared with the Board, DHSC and NAO on the 30 April, with comments to be made by the 15 May. On the 15 May comments will be compiled and incorporated for sharing with the Board at the Board Development Day on 23 May. The ARAC meeting to recommend the approval of the Annual Report and Accounts to the Board will take place on the 14 June and we are hoping to lay the accounts by the 18 July. HS Global have been appointed to undertake the graphic design.

The 13 March was the standard ARAC meeting where key items were discussed including the declaration of interests process which is now completed. Risk management is now established thanks to SG and PSty. There are 23 risks on the risk register which will be split into three categories. PSch is meeting with PSty to discuss the audit report on risk and how we take this forward. GIAA gave a quick update on their audit plans for next year and NAO gave an update on the two areas they are going to be focusing on; presumed risk of management override controls and the transfer of opening assets and liabilities from NHS England to HSSIB on the 01 October 2023.

PSch exclaimed he is very happy at this moment in time, there are no concerns and commended MM and the team for getting a moderate rating in all three audits.

MC asked if the Board has sufficient oversight of risk and whether the Board need to go over its risk appetite approach. PSch advised the risk appetite is still in progress but will be brought to the Board once foundations are laid and all members of the Board are invited to attend ARAC.

PSty briefly stated as the audit reports are being finalised by GIAA, these will be brought to the Board along with the management action plans. RB advised all management responses completed to the GIAA, will be brought back to the Board. The risk register will also be in the performance report, with actions and risk appetite. The Board agreed to discuss this further at a development day before it is formally submitted to the Board.

Action: PSty to organise an overview of risk management/ risk appetite/ GIAA reports and management actions plans for a future Board development day.

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ITEM 6.2 REMUNERATION COMMITTEE

There were no further updates since MC reported at the last Board meeting.

ITEM 7 POLICY REVIEW

ITEM 7.1 DISCLOSURE OF PROTECTED MATERIALS POLICY

PSty presented the policy which has been developed by Sarah Graham and Deinniol Owens. The policy is based on the content of our new legislation and has gone through a lengthy development process including engagement with HSSIB lawyers, followed by internal review, engagement with our team and approval by SLT on 22 February. The recommendation from the lawyers is to go ahead and publish the policy and training sessions will follow thereafter.

PSty confirmed the Board will be notified of any disclosure and will have the opportunity to comment and make decision following the event. The frequency on reporting will be picked up from the governance structure. Any information/discussions will be captured to ensure consistency.

TB presumed whether any draft report being sent out is a protected material, PSty advised technically it would be protected as it is not in the public domain or for onward sharing, but this will be discussed at SLT. RB suggested it is also important how we manage the comments back in terms of factual accuracy because that could potentially be protected as well. TB suggested protected material should be labelled as protected material both internally and externally in the organisation. PSty confirmed it should be appropriately marked and labelled and the common view is that any report not in the public domain is protected.

MC had several comments to raise which included whether the policy is sufficiently clear for people to really understand, what training guidance are we having that is user friendly and if the lawyers have seen the final draft. RB suggested for MC to meet with PSty and the team to go through the comments outside of the meeting. Following this, the policy will be submitted to the next Board meeting to formally sign off.

Given the importance of the policy, it was agreed the policy should be reviewed annually.

Action: JB to arrange a meeting with PSty, MC, RB, DO and SG to review the Disclosure of Protected Materials Policy and bring back to the May Board.

ITEM 7.2 SOCIAL MEDIA POLICY

Thanks were given to Holly Mitchell for producing the policy. The purpose of the paper is to seek assurance from the Board to publish the HSSIB Social Media Policy. This policy is for employees that work for HSSIB to understand what is expected when using social media. Training is being provided for all staff at the next away day. The team will be providing support and guidance on a regular basis. The policy will be reviewed in May 2025 to keep up with social media changes/ trends.

RB thanked MP and the team and advised this is important for everyone to be aware of and encouraged the Board to consider this policy. A lot of people have experienced harm through social media. If anyone experiences anything on social media as a result of their role here, please do not hesitate to contact the team for advice.

The Social Media Policy was approved.

ITEM 7.3 BOARD CODE OF CONDUCT

The policy was presented to the February Board meeting where some amendments were requested regarding concerns around the terminology of the personal liability of the Board members. There were also two sections removed as it was felt the wording was inappropriate.

The Board Code of Conduct was approved.

ITEM 7.4 DOCUMENT AND RECORDS MANAGEMENT POLICY

The policy was presented to the February Board meeting where some amendments were requested, and the following changes were made;

- Expand and clarify who has the authority to release records and with the authorisation of the CEO and the Cardiac Guardians.
- Allowed for the fact that some Board members will use personal computers, any risks will be mitigated against.
- Labelling of official sensitive personal documents should be noted to be protected materials.

The Document and Records Management Policy was approved.

ITEM 8 BOARD TERMS OF REFERENCE

The terms of reference have been prepared to reflect the DHSC/HSSIB framework agreement and was a recommendation from the internal governance audit. This will be reviewed on an annual basis.

PSch suggested under item 7.1 Board membership - every Board should have a CEO and a Finance Director as permanent Board members, however it does not mention that. RB asked to discuss this further with PSch outside of the meeting, as this is not the advice received from treasury.

MD queried if we require a Senior Independent Director, although we do have a Deputy Chair. MC confirmed this was discussed previously and it was agreed we did not require a Senior Independent Director due to costs and being a small organisation, but we will keep this under review.

Action: MM to check whether there is a requirement for a Senior Independent Director in the framework agreement.

MC queried if we have a safeguarding policy, PSty confirmed the policy has just been signed off by SLT. MC is assured there is one in place and did not feel it needs to be seen by the Board.

ITEM 9 ANY OTHER BUSINESS

There were no items to discuss.

ITEM 10 CLOSE

TB thanked everyone for all their work that has gone into preparing the papers and thanked the members and guests for attending. The next meeting will be held on 2 May 2024 in Flitwick at the NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board.

The meeting closed at 11:48hrs.

ITEM 11 QUESTIONS FROM PUBLIC ATTENDEES

There were no questions submitted from the public.

HSSIB Board Meeting Action Log
Last Updated: 25/04/2024

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ID	Date Raised	Owner	Title	Detail	Update	Outcome	Target Date	Status
32	07/12/2023	Rosie Benneyworth	Freedom to Speak Up	RB to share in correspondence the Freedom to Speak Up SLT paper and submit to the February Board meeting.	08/02/24 - FTSU paper being presented at 22 February SLT meeting. This will then be shared to the Board meeting to discuss. 08/03/24 - SG submitting FSTU paper to April Board meeting. 26/03/24 - Sought legal advice, however this has caused some delay. Further discussions taking place and we are revisiting this action to form an overarching speaking up approach for HSSIB, including WB and FTSU. Update paper to be submitted to SLT in April, and presented to Board meeting in August. This will ensure actions continue whilst the final policy is drafted; including identifying alternative support for FTSU including external agencies and internal champions/advocates being trained. **09/04/24 - In progress. Paper being submitted to August Board meeting.**	Still in progress.	14/08/2024	Not Due
38	09/04/2024	Rosie Benneyworth	Freedom to Speak Up	RB to explore whether we need to follow any national guidance regarding FTSU and provide an update at the next meeting.	**24/04/24 - RB has contacted Jayne Chidgey-Clarke (National Guardian) update to follow.**		02/05/2024	In Progress
39	09/04/2024	Rosie Benneyworth	Finance and Performance Role Proposal	RB to bring a proposal to the May Remuneration Committee and then to the June Board meeting.	**24/04/24 - A proposal will be circulated in correspondence to the NEDs week commencing 29 April.**		02/05/2024	In Progress
40	09/04/2024	Maggie Mckay	Risk Register	MM to ask SG to add procurement of the Investigation Management System and Learning Management System contracts to the risk register.	**24/04/24 - SG has added to the risk register.**	Item completed and propose to close.	14/08/2024	Completed
41	09/04/2024	Philippa Styles	Risk Management	PSty to organise an overview of risk management/ risk appetite/ GIAA reports and management actions plans for a future Board development day.	**25/04/24 - In progress.**		25/07/2024	Not Due
42	09/04/2024	Julia Blomquist	Disclosure of Protected Materials Policy	JB to arrange a meeting with PSty, MC, RB, DO and SG to review the Disclosure of Protected Materials Policy and bring back to the May Board.	**23/04/24 - meeting took place on 22 April. The policy is being resubmitted to the May Baord meeting and is an agenda item.**	Item completed and propose to close.	02/05/2024	Completed
43	09/04/2024	Maggie Mckay	Board Terms of Reference	MM to check whether there is a requirement for a Senior Independent Director in the framework agreement.	**24/04/24 - MM confirmed the framework agreement does not include a requirement for a Senior Independent Director.**	Item completed and propose to close.	02/05/2024	Completed

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Chief Executive Officer Report

May 2024

CHILE

This month I represented HSSIB at the 6th Annual Global Ministerial Patient Safety Summit in Chile. **"Bringing and maintaining changes in patient safety policies and practices"**. The Global Ministerial Summits were established by the UK and they have significantly contributed to raising awareness and driving the global patient safety movement. In particular, they led to the development of the Global Patient Safety Action Plan 2021-2023 to support patient safety worldwide. Dr Neelam Dhingra, the Unit Head of the Patient Safety Flagship at the WHO gave an overview of the progress against the action plan, with an impressive 85% of the world's population covered by survey responses to the action plan. They have also seen an increase in the number of countries with targets to improve their clinical processes and reduce medication harm and Healthcare Acquired infections. A reflection from Neelam about the current view of patient safety globally was 'safety is non-negotiable and should be core, but is still seen as a competing priority'.

Dr Tedros Adhanom Ghebreyesos, Director General at the World Health Organisation outlined the sobering statistic that globally 3 million people each year die due to unsafe care, and it is estimated that half of these deaths are preventable. Sir Liam Donalson highlighted the importance of us continuing to look at learning from other industries. In particular he mentioned the aviation industry, and the change in risk with flying that has occurred in the last 50 years. In 1968-77 the risk of death from flying was 1 in 350,000 boardings. The latest figures in 2022 show a dramatic reduction to 1 in 11 million boardings. Clearly the landscape in health and aviation are very different, with health having complex causation, prevention and improvement of incidents but there is still a lot we can learn from the science and approach that underpins safety in other industries. Sir Liam also talked about the lack of industry wide standards in healthcare and the importance of bringing together of patient safety experts and experts in design when considering innovation particularly in service models.

'Embrace the wisdom of your patient community' was the message from Sue Sheridan, an incredible patient activist from the USA. Sue shared her story of her son and her husband, both of whom had experienced significant harm from delayed diagnoses of their conditions. Sue is passionate about involvement of patients in all aspects of patient safety work and empowering patients in all of their care.

One of the most interesting talks was by Francesca Colombo, Head of OECD Health Division who talked about the economics of patient safety. Approximately 15%

expenditure and activity in OECD countries can be attributed to treating safety failures. The direct cost of unsafe care in health systems is estimated at 12.6% of health expenditure and these costs are largely preventable. There is evidence that interventions to improve patient safety are effective at improving economic gains and productivity. Her clear message was that patient safety should not be seen as a 'luxury' but affordable for all.

I was delighted to be able to talk about the work HSSIB is doing in England and the impact we are starting to see as a result. There was a significant amount of interest from delegates about our work and a lot of contacts and networks made that will support our development as we go forward as we continue our quest to improve patient care here. One highlight of the summit for me was when a speaker from Florida International University highlighted the work we had done regarding Safety Management Systems in his presentation. His view was that there is little merit in concentrating on safety culture if the fundamental building blocks of safety management systems are not in place. His presentation highlighted the international reach we are having with the work we are doing.

Henrietta Hughes (Patient Safety Commissioner for England) and Aidan Fowler (NHS England Patient Safety Director) were also present at the Summit, and we were fortunate to meet the Chilean Health Minister and senior WHO teams to demonstrate the ongoing commitment we all have to patient safety.

Every year WHO have a theme for patient safety, and this year it will be on diagnostic safety. This is a theme that regularly comes up in our investigations and I am planning for us to ensure all of our learning is shared to celebrate World Patient Safety Day on 17th September.

Importantly WHO launched a patient safety rights charter at the Summit. It is the first charter to outline patient's rights in the context of safety, and will support stakeholders in formulating the legislation, policies and guidelines needed to ensure patient safety. Patient safety rights charter (who.int)

Health Services Safety Investigations Body

INVESTIGATIONS AND INSIGHTS

On 10 April, members of our Executive team visited Barnsley Hospital NHS Foundation Trust where we were invited to join the second half of their Executive Team Meeting, followed by a session with colleagues from across their organisation to talk about patient safety. This was an extremely valuable visit and provided an opportunity to increase awareness of HSSIB, our new strategy and our organisational purpose. We also heard from their teams about PSIRF implementation, the use of technology in patient care and their experience of learning from our investigations. These discussions highlighted learning for our pilot to review the impact of actions taken in response to recommendations, as well as opportunities to improve the sharing and dissemination of our reports.

Other key stakeholder engagement this month has included our regular engagement with the DHSC Joint Cyber Unit where we heard of the impact of a cyber attack on a community health equipment provider and the effect this had on hospital discharges. We also met with the NHSE Director for Sexual Safety and discussed opportunities to explore sexual safety for staff and patients through our investigations. Stakeholder engagement such as those highlighted here are recorded as patient safety insights for consideration though our intelligence review process for future investigations.

I'm pleased to confirm, following the previous CEO report, that our Head of Insights Sian Blanchard has secured a place on the Impact Leaders Programme, working alongside an academic from The University of Nottingham focused on the development of an accountability framework to proactively manage safety through a systemic approach to safety management.

Our Safety Investigator recruitment campaign closed on 8 April with 482 applicants. We have shortlisted and will facilitate 2 days of assessments at the end of April to appoint up to three Safety Investigators to our team.

EDUCATION

General enrolments have now surpassed 25,000 (an increase of a further 1,000 since the last board meeting in April 2024. Online materials we have been developing for the national patient syllabus have now been delivered to Loughborough University and are live for learners to access. We have now delivered 4 in-person sessions for Course ‘C’ and will be starting the delivery of course D in June 2024.

We are getting continued interest in our private programmes, including from overseas (see below). Our first small international contract has been completed (Canada) and active discussions now with an organisation in Maine and also the republic of Ireland. The next meeting of the International Patient Safety Organisations Network (IPSON) will take place on 13/04/24 1200 – 1330, BST. Please let us know if you would like to attend as a guest.

Health Services Safety Investigations Body

The education team are also involved in some research and publication work:

- E-delphi for investigator competencies will be starting shortly.
- Content validity testing study for the Learning report review tool (developed with NES and NHSE).
- Exploration of joint work with Macquarie University in Australia with research into improving the efficiency and effectiveness of healthcare investigations.
- We have been invited to contribute a chapter to an upcoming book on healthcare safety.
- Work is being finalised on a WHO bulletin paper "to describe and reflect on the HSSIB approach and experiences of underpinning the change in patient safety mindset through a national programme of education."

STRATEGY

- The strategy and criteria are now out for consultation, we will run a 30-day (16 April to 16 May) consultation to engage with the public and stakeholders and any other interested parties. We will be working with VSCE umbrella groups, such as Healthwatch and National Voices to help reach public and patients. There is also an electronic survey to capture views.

- Once the consultation closes on the 16 May 2024, we will review the feedback, produce a consultation outcome report, and publish the final strategy and criteria on our website. The strategy is due to go to the board at the end of June for sign off.

COMMUNICATIONS

- On 8 April, an interview with Nick Woodier, Senior Safety Investigator was featured in a Panorama episode focused on independent healthcare and patient safety. Nick's interview came across well, with a professional and balanced view and promoting our role as independent safety experts. The BBC produced a news article on the day of broadcast, and it is still available to watch on iPlayer. Spire Healthcare: Death of NHS-funded private patient raises safety concerns - BBC News

- On 16 April the retained swabs report, focused on involving temporary staff in patient safety investigations, gained media coverage nationally and regionally via the Press Association.

- Rosie, with editorial support from the Investigation and Insights Team and Comms, has authored a guest blog for the Patient Safety Commissioner's website. It explores why insight from patients and families is crucial to every safety investigation and is a good example of collaborative working.

Health Services Safety Investigations Body

BUSINESS SERVICES

The Business Services team continue to work on the establishment of the policies and procedures; the collection of evidence for the Data Security and Protection Toolkit; the development of the risk register and mitigations; the recommendations from the internal audit and supporting the organisation.

The production of the draft Annual Report and Accounts is nearly complete, with the draft to be shared with the Board, DHSC and National Audit Office on 1 May.

Dr Rosie Benneyworth, Interim CEO

Health Services Safety Investigations Body

Performance Report

October 2023 – March 2024

Health Services Safety Investigations Body

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Investigations & Insights

How we identify new areas for investigation

1 October 2023 – 31 March 2024

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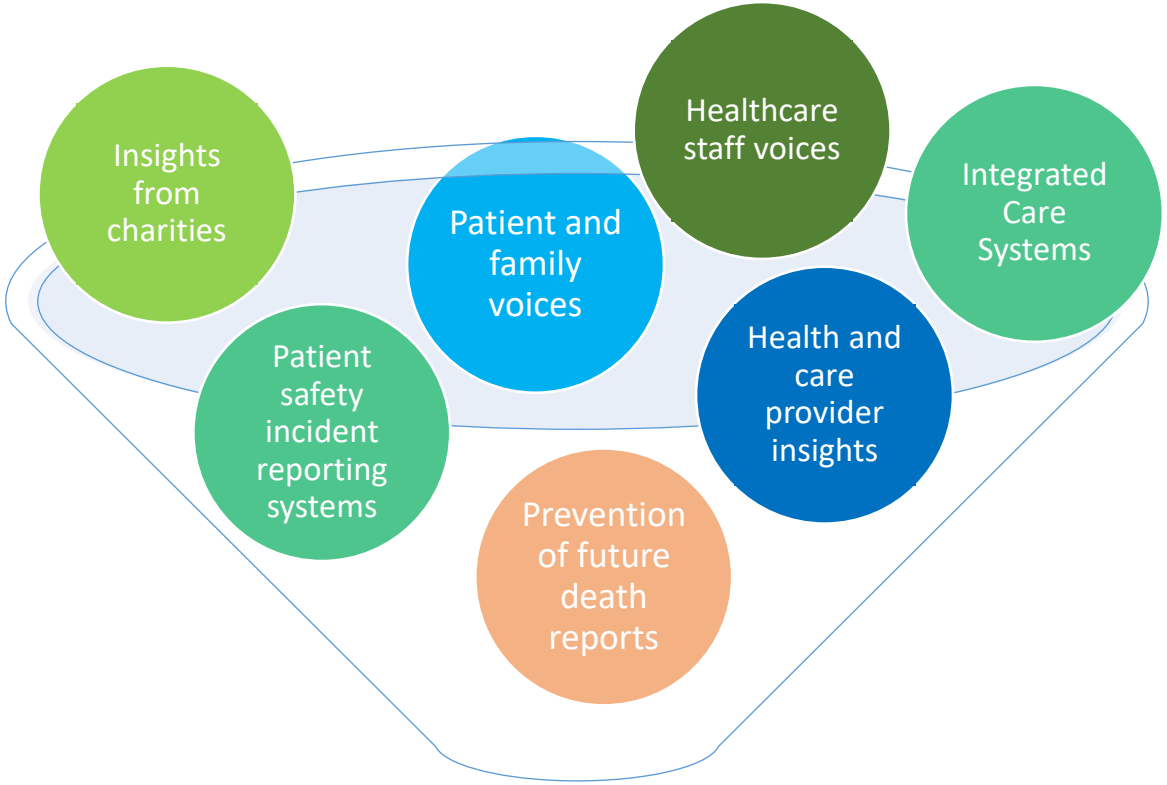


Identify patient safety topics for potential investigation

Apply HSSIB interim investigation criteria (Health and Care Act 2022)

HSSIB Investigation Lifecycle

Health Services Safety Investigations Body

Investigation proposal
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Title	Summary	Outcome	Reason for non-progression
Medication safety	Analysis of previous HSIB reports, incident data, and PFDs highlighted concerns in two general areas; the use of electronic prescribing and medicines administration systems (EPMA) and instances where medications were prescribed but not given to patients.	Progressed	N/A
Pre-hospital interpretation of electrocardiograms (ECG) in ambulance services	The investigation will explore how ECGs are conducted via two reports; the first considering how ST Elevated Myocardial Infarction (StEMI: a form of heart attack) is identified and the second focusing on paramedic education, training, competence.	Progressed	N/A
Patient harm associated with hysteroscopy	Safety risk identified through direct patient safety concerns and incident data. Risk relates to informed consent and some patients suffering severe pain that may lead to psychological harm. RCOG progressing national improvement work.	No further work to be completed at this time	Did not fully meet all HSSIB interim investigation criteria. There is national improvement work underway by RCOG in relation to hysteroscopy which limits the impact HSSIB may be able to have at this time.

Investigation proposal
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Title	Summary	Outcome	Reason for non-progression
Inclusion health groups and healthcare inequalities	Inclusion health is an umbrella term used to describe people who are socially excluded and experience multiple risk factors for poor health. Incident data and patient safety insights identified poor health outcomes, negative experiences of health services. HSSIB will address health disparities in all investigations.	No further work to be completed at this time	Did not fully meet all HSSIB interim investigation criteria. Health disparities will be addressed in all HSSIB investigations as opposed to a dedicated investigation.
Delays to diagnosis and subsequent treatment of cancer	Recurrent patient safety concerns associated with delays in the diagnosis and treatment of cancer, and 'hidden waits' with secondary care referrals.	No further work to be completed at this time	Did not fully meet all HSSIB interim investigation criteria. There are national improvement programmes underway to reform cancer care standards which limits the impact HSSIB may be able to have at this time.
Access to community public access defibrillators (CPADs)	Safety risk relates to issues accessing CPADs. National improvement programmes underway including The Circuit National Defibrillator Network.	No further work to be completed at this time	Did not fully meet all HSSIB interim investigation criteria. There is a national programme 'The Circuit National Defibrillator Network' to improve access to CPADS which limits the impact HSSIB may be able to have at this time.

New investigations launched

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Mental health inpatient settings: Four investigation reports	Safety management systems: Two investigation reports	Healthcare provision in prisons: Three investigation reports	Fatigue risk in healthcare and its impact on patient safety	Pre-hospital interpretation of ECG in ambulance services: Two investigation reports
• Learning from inpatient MH deaths, and near misses. • The provision of safe care during transition from children and young person (CYP) to adult, inpatient MH services. • Impact of out of area placements on the safety of patients with MH needs. • Creating the conditions for staff to deliver safe and therapeutic care.	• The investigation will examine how patient safety risks are managed in health and social care across two reports. • The first report will consider how safety risks and managed across organisational boundaries. • The second report will consider how patients and healthcare staff could be involved in safety management.	• This investigation will explore prison healthcare commissioned by the NHS and delivered by a combination of NHS and private healthcare providers • The first report will consider emergency care. • The second report will consider continuity of care. • The third report will consider data sharing and IT systems.	• The investigation will explore healthcare staff fatigue in patient safety incidents. It will consider how healthcare staff fatigue can be a contributory factor in patient safety incidents and the factors that influence fatigue being identified within patient safety incident investigations.	• The investigation will explore the systemic risks around misinterpretation of pre-hospital electrocardiograms (ECGs) in ambulance services. T • he first report will consider interpretation of ECGs in cases of ST-Elevated Myocardial infarction. • The second report will focus on paramedic education, training and competence.

Investigation reports pipeline
at 31 March 2024

Health Services Safety Investigations Body

Investigations	Estimated publication date
Nutritional assessment and support in the acute medical unit	April 2024
Retained swabs following invasive procedure	April 2024
The clinical observation of patients detained under the Mental Health Act at risk of self-harm in acute hospitals	May 2024
Keeping children and young people with mental health needs safe: the design of the paediatric ward	May 2024
Workforce and patient safety: the digital environment	June 2024
Workforce and patient safety: skill mix and staff integration	July 2024
Healthcare provision in prisons: emergency care	July 2024
Workforce and patient safety: Workforce and patient safety: temporary staff	August 2024
Workforce and patient safety: the digital environment	Autumn 2024
Healthcare provision in prisons: continuity of care	October 2024
Mental Health Inpatient: Creating the conditions for staff to deliver safe and therapeutic care – workforce, relationships and environments	October 2024
Safety Management Systems: Accountabilities across organisational boundaries	October 2024

Investigation reports pipeline
at 31 March 2024

Health Services Safety Investigations Body

Investigations	Estimated publication date
Mental health inpatient: Impact of out of area placements on the safety of mental health patients	November 2024
Mental health inpatient: The provision of safe care during transition from children and young person to adult, inpatient mental health services	December 2024
Healthcare provision in prisons: data sharing and IT systems	January 2025
Mental health inpatient: How providers learn from deaths in their care and use that learning to improve their services, including post-discharge	January 2025
Identifying fatigue in patient safety incidents	TBC January 2025
Mental health inpatient: thematic report	TBC March 2025
Pre-hospital interpretation of electrocardiograms (ECG) in ambulance services: Diagnosis of suspected ST Elevated Myocardial Infarction (STEMI)	TBC March 2025
Healthcare provision in prisons: thematic report	April 2025
Safety management systems: Involving staff and patients	April 2025
Pre-hospital interpretation of electrocardiograms (ECG) in ambulance services: Paramedic education, training and competence	TBC September 2025
Workforce and patient safety: prioritising patient care	TBC for closure

Investigations published summary

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Safety management systems: an introduction for healthcare Click on the report link to see further information in relation to safety recommendations	
Published:	18 October 2023
Safety recs due by:	16 January 2024
Safety recs made to:	1 x NHS England 1 x Care Quality Commission
Summary of safety recs made:	• NHS England to explore the development and implementation of safety management systems through an SMS co-ordination group. This should be in collaboration with regulators, relevant arm's length bodies and national organisations, academics, patient representatives and safety leaders from other safety-critical industries. • The Care Quality Commission should be responsible for ensuring that its regulatory assessment approach effectively assesses safety management activities.
Summary of potential impact to patient safety by implementing recs:	Patient safety risks will be better managed through consideration of a systematic and proactive approach to safety management. This will enable the health and care sector to better manage risk through safety policy, risk management, safety assurance and safety promotion.
Safety observations:	1

Caring for adults with a learning disability in acute hospitals Click on the report link to see further information in relation to safety recommendations	
Published:	2 November 2023
Safety recs due by:	31 January 2024
Safety recs made to:	4 x NHS England
Summary of safety recs made:	There was no national guidance on workforce, standardised content of a care passport, practically assessing mental capacity and a decision had yet to be made on whether the annual standards audit would continue.
Summary of potential impact to patient safety by implementing recs:	Patient care and experience is improved as staff to support their specialist needs are in post, national standard are met, staff are confident with assessing mental capacity and have access to information required to meet the patient's needs when and where it is needed.
Safety observations:	3
Integrated care boards:	3

Investigations published summary

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Risks to medication delivery using ambulatory infusion pumps – design and usability in inpatient settings Click on the report link to see further information in relation to safety recommendations	
Published:	15 November 2023
Safety recs due by:	13 February 2024
Safety recs made to:	2 x British Standards Institution (BSI) 1 x NHS England (NHSE) 1 x Medicines and Healthcare products Regulatory Agency (MHRA)
Summary of safety recs made:	BSI - Current international standards for medical devices do not fully consider Human Factors implications regarding use in varying environments and how alarms reliably notify clinical staff of a hazardous situation. NHSE + MHRA – The MHRA, outside of Yellow Card reporting, can only access medical device related incident data that is shared by NHS England.
Summary of potential impact to patient safety by implementing recs:	BSI – The BSI would develop national human factors guidance relating to medical devices and their use in varying environments, whilst also influencing international standards. Manufacturers would need to fully consider this during development of future products for implications to patient safety. NHSE + MHRA - The MHRA will have access to, and be able to fully interrogate, the NHS patient safety reporting systems for medical device related incident data. This would enable greater oversight for medical device issues by the regulator.
Safety obs:	3

Continuity of care: delayed diagnosis in GP practices Click on the report link to see further information in relation to safety recommendations	
Published:	30 November 2023
Safety recs due by:	28 February 2024
Safety recs made to:	1 x NHS England (NHSE) 1 x Department of Health and Social Care (DHSC)
Summary of safety recs made:	1) Continuity of care is widely accepted to be an important part of delivering safe and efficient care, particularly in primary care. The investigation found that despite this, the adoption of systems of continuity of care was voluntary and made a recommendation that the GP contract was amended to include the need for continuity of care for all GP practices. 2) Patients' electronic notes in primary care can be extensive and searching through them to gather a patient's medical history quickly and safely can be challenging. The GP IT standards relating to how information is displayed to GPs was last updated in 2011. HSSIB made a recommendation to NHS England that the GP IT standards are updated to ensure that patient continuity of care is maintained, and that information is displayed to GPs in a way which makes it easy to determine a ongoing medical concern.
Summary of potential impact to patient safety by implementing recs:	1) Aim of this recommendation is to improve patient safety by building clinician–patient relationships as well as ensuring information is shared in a way that clinicians can easily see a patients medical history. 2) Aim of this recommendation is to help GPs identify when a patient returns with unresolving symptoms and may need a different management plan put in place, such as onward referral to another service.
Safety obs:	1

Investigations published summary

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Interim report – Retained surgical swabs: themes identified from a review of NHS serious incident reports Click on the report link to see further information in relation to safety recommendations	
Published:	7 December 2023
Safety recs due by:	6 March 2024
Safety recs made to:	1 x NHS England (NHSE)
Summary of safety recs made:	The safety recommendation we made in the interim report was to consider removing retained surgical swabs from the Never Events list as there are no strong systemic barriers to prevent it. It should be noted that the interim report is the first step, and the main report will go a step further by bringing in risk management principles and use of technology.
Summary of potential impact to patient safety by implementing recs:	The potential impact of the safety recommendation being implemented is: - Change in perception and safety culture that this type of event should 'never' occur. - Embrace just culture and reduce blame culture surrounding this type of Never Event.
Safety observations:	1
Local-level learning:	1

Advanced airway management in patients with a known complex disease Click on the report link to see further information in relation to safety recommendations	
Published:	25 January 2024
Safety recs due by:	24 April 2024
Safety recs made to:	1 x NHS England 3 x Royal College of Anaesthetists
Summary of safety recs made:	NHS England to implement a system for sharing clinical information about people with known difficult airways. The three recommendations to the Royal College of Anaesthetists focus on aligning and agreeing clinical guidance issued by various clinical organisations and enhancing the training which clinical staff receive
Summary of potential impact to patient safety by implementing recs:	The recommendations should see an improvement in sharing of clinical knowledge which should provide an improved awareness of a pre-existing condition that a patient has. The additional training should equip clinicians to deal with the unexpected unknown clinical condition that a patient may have (e.g. Hunters syndrome) and provide them with knowledge and tools to provide care
Safety observations:	3

Investigations published summary
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Positive patient identification
Click on the report link to see further information in relation to safety recommendations

Published:	08 February 2024
Safety recs due by:	13 May 2024
Safety recs made to:	2 x NHS England 1 x Care Quality Commission
Summary of safety recs made:	NHS England to assesses future research into the risk of patient misidentification, which would inform initiatives. Also, NHS England to develop system-wide requirements for scanning technology to support positive patient identification. CQC develops its methodology for assessment to include arrangements for the positive identification of patients at transfer between healthcare organisations
Summary of potential impact to patient safety by implementing recs:	The recommendations should inform and reduce variability across all providers and support future prioritisation of work programmes to improve safety. The diversity in digital technology induces risk, by creating common requirements this should reduce siloed systems approach and improve system interoperability. Enhancing the assurance across the entire pathway should underpin improvements in care delivery
Safety observations:	6

Workforce and patient safety: temporary staff – involvement in patient safety investigations
Click on the report link to see further information in relation to safety recommendations

Published:	14 March 2024
Safety recs due by:	12 May 2024
Safety recs made to:	2 x NHS England
Summary of safety recs made:	NHS England to updates its guidance on ‘Engaging and involving patients, families and staff following a patient safety incident’. This is to include guidance on engaging temporary staff in investigations.
Summary of potential impact to patient safety by implementing recs:	The recommendations should help to ensure that temporary staff are involved and supported to engage in patient safety learning responses to ensure more thorough investigation, and subsequent improvement action, from patient safety events. This will also help to support temporary staff wellbeing to ensure they are able to work and support efforts to provide safe patient care following patient safety events occuring.
Safety observations:	1

Safety recommendations graded/published

01 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Investigation title	Safety recommendation grading	Publication of response
The selection and insertion of vascular grafts in haemodialysis patients (x4)	Accepted/Exactly as written	13/11/2023
Medicine omissions in learning disability secure units	Accepted/Exactly as written	22/11/2023
Care delivery within community mental health teams	Accepted/Exactly as written	24/11/2023
Invasive procedures for people with sickle cell disease (x2)	Accepted/Exactly as written	30/11/2023
Management of sickle cell crisis	Accepted/Exactly as written	31/01/2024
Safety management systems: an introduction for healthcare (NLR) (x2)	Accepted/Exactly as written	02/02/2024
Caring for adults with a learning disability in acute hospitals (x4)	Accepted/Exactly as written	02/02/2024
Harm caused by delays in transferring patients to the right place of care	Awaiting updated response	TBC
Risks to medication delivery using ambulatory infusion pumps – design and usability in inpatient settings (x2)	Accepted/Exactly as written	TBC
Continuity of care: delayed diagnosis in GP practices	Accepted/Exactly as written	TBC
Interim report – Retained surgical swabs: themes identified from a review of NHS serious incident reports	Waiting to be graded	TBC
Positive patient identification	Waiting to be graded	TBC

Safety recommendations overdue/escalated

at 31 March 2024

Health Services Safety Investigations Body

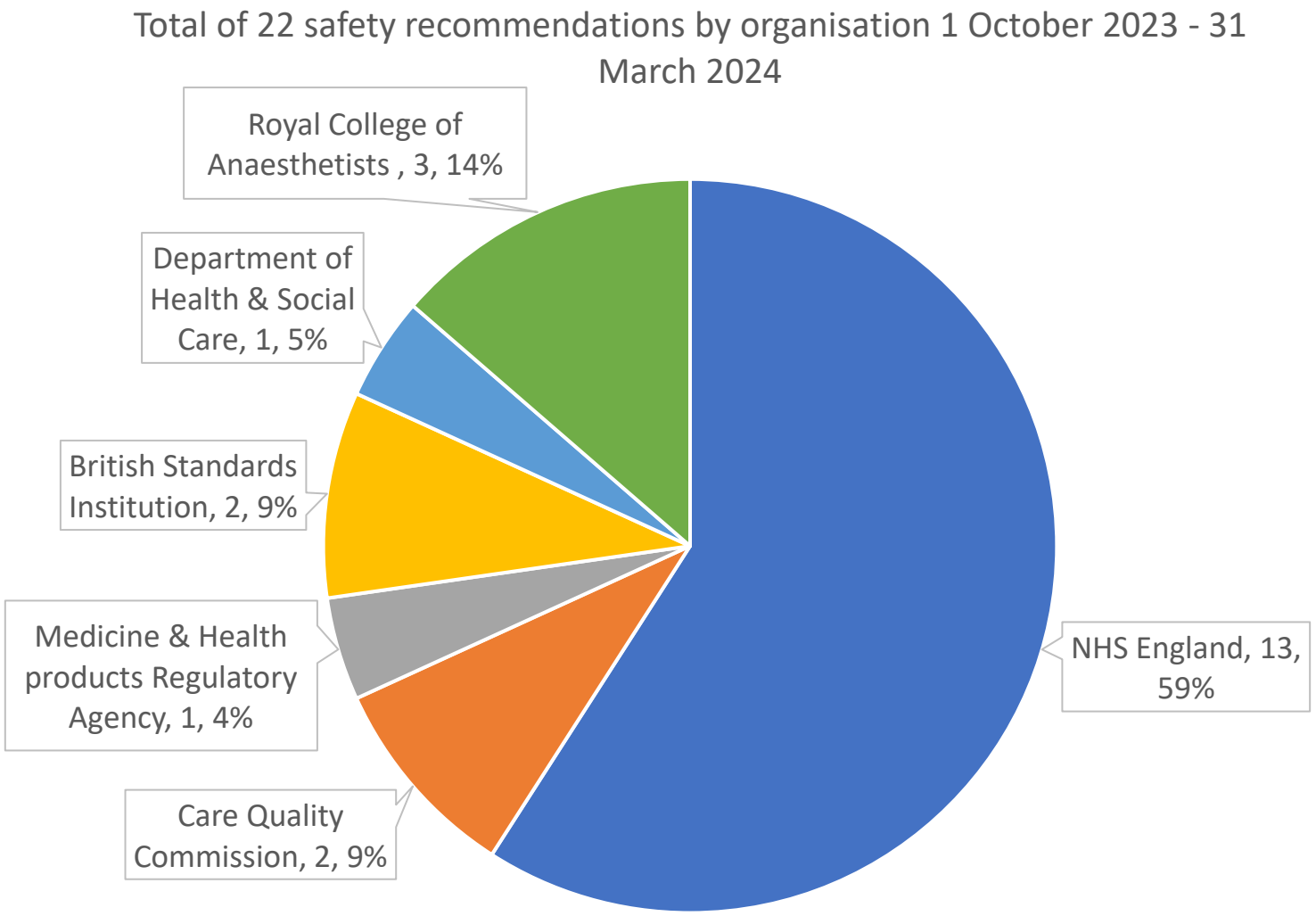
Graded and not accepted in full/follow-up underway	Organisation	Action planned
Variations in the delivery of palliative care	3 x NHSE	Follow-up underway

Overdue and/or not accepted response escalated	Organisation	Due Date	Stage
Non-accidental injuries in infants attending the emergency department	1 x NHSE	10/07/2023	Advised actions on-going and sign-off delayed
Detection of jaundice in newborn babies	2 x RCPath	24/04/2023	Escalation letter sent 08/11/23. 2nd letter sent on 22/01/24

Safety recommendations by organisation

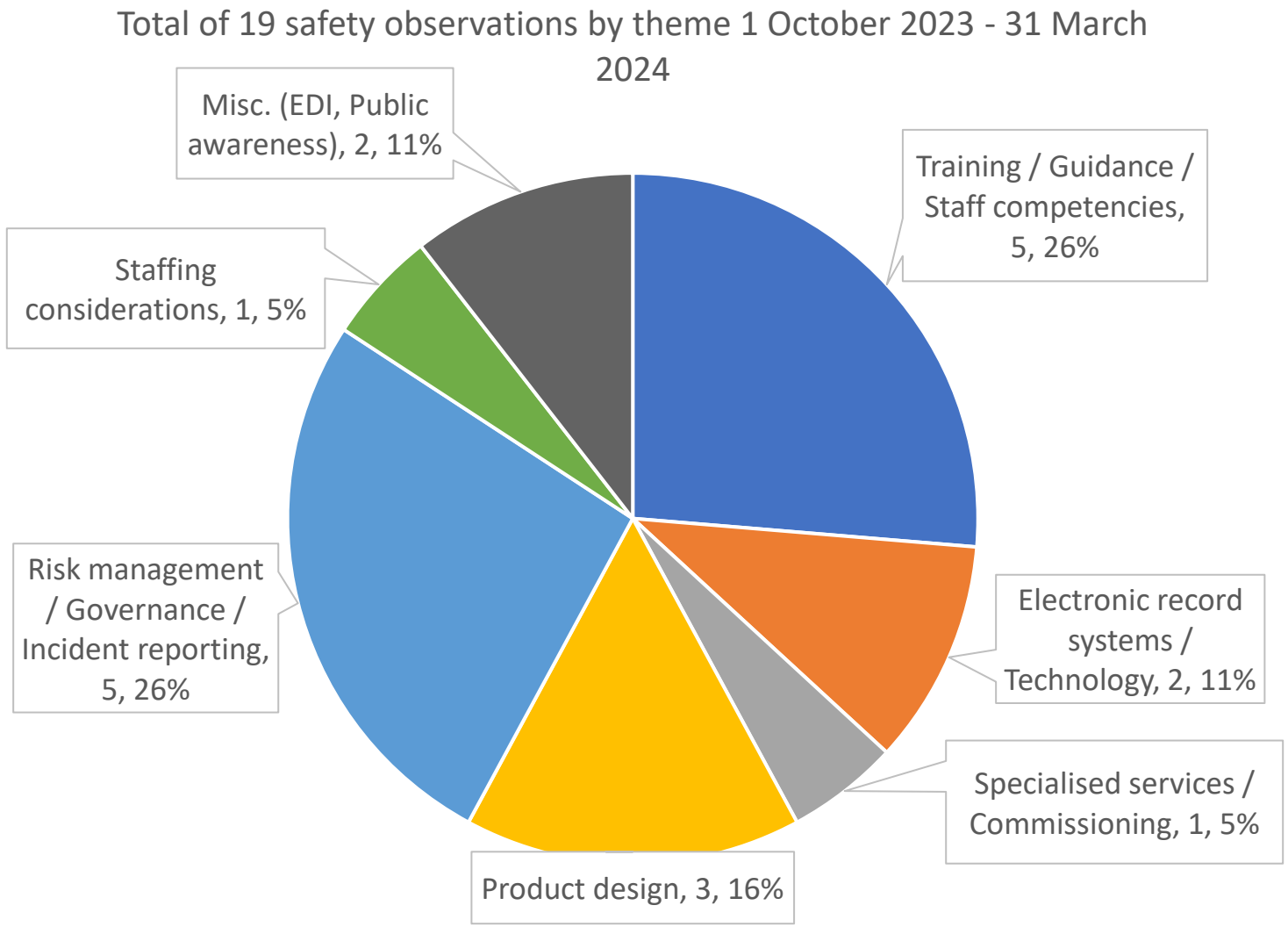
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body



Safety observations by theme
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body



Suggested safety actions to Integrated Care Boards & Local-level learning by theme

1 October 2023 – 31 March 2024

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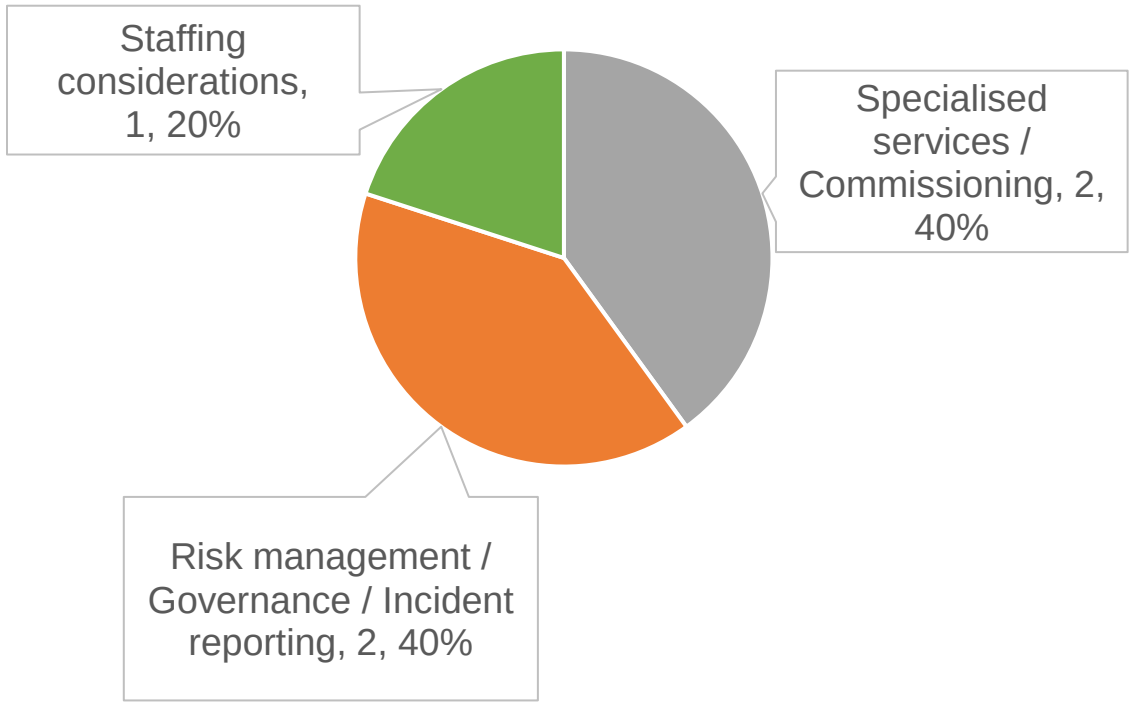
Total of 5 Integrated Care Board actions by theme
1 October 2023 – 31 March 2024



Total of 1 Local-level learning by theme
1 October 2023 – 31 March 2024

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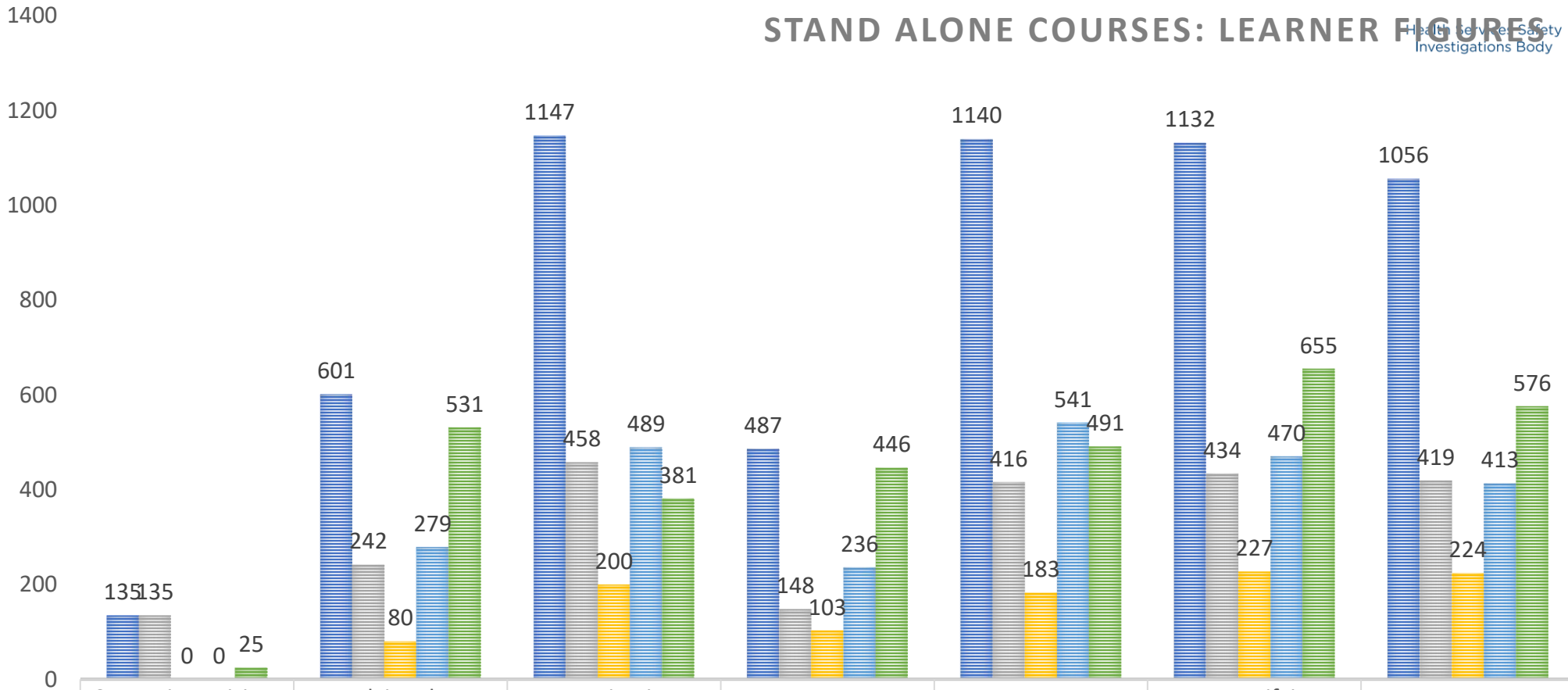
Education

HSSIB Education

HSSIB Education

Year End: 1 October 2023 – 31 March 2024

STAND ALONE COURSES: LEARNER FIGURES



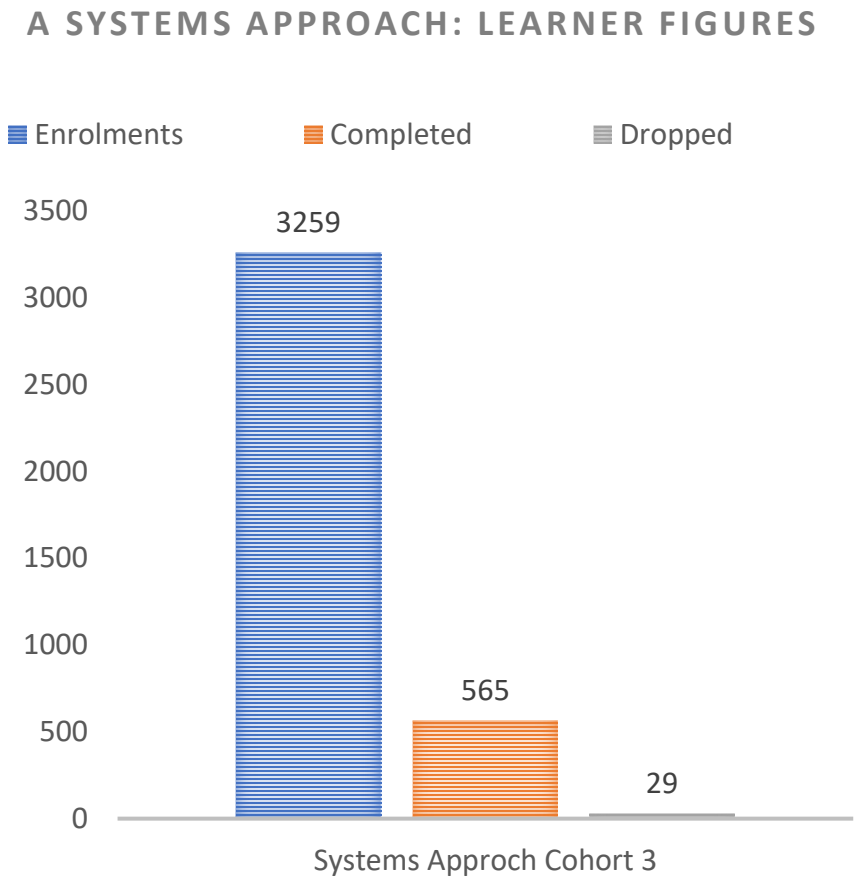
	Strategic Decision Makers	Involving those affected	Investigative Interviewing	Oversight to PSIRF	Writing Reports	Demystifying Thematic Analysis	After Action Review
Enrolled: course taken place	135	601	1147	487	1140	1132	1056
Completed & gained certificate	135	242	458	148	416	434	419
Completed but not gained certificate	0	80	200	103	183	227	224
Dropped / No show	0	279	489	236	541	470	413
Enrolled: awaiting course	25	531	381	446	491	655	576

HSSIB Education
1 October 2023 – 31 March 2024

Total registered students: 13,398
New students registered in period: 5,232
Enrolment count in period: 9,971
Total places provided: 25,181

Health Services Safety Investigations Body

A systems approach shows data from our third cohort which began on 27 November 2023 and will end on 24 May 2024.



Health Services Safety Investigations Body

Communications and Engagement

HSSIB website overview

1 October 2023 – 31 March 2024

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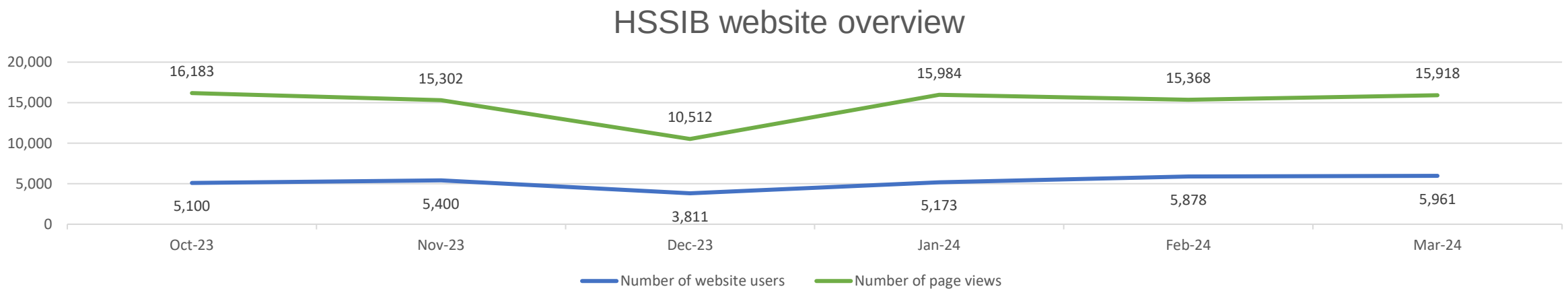
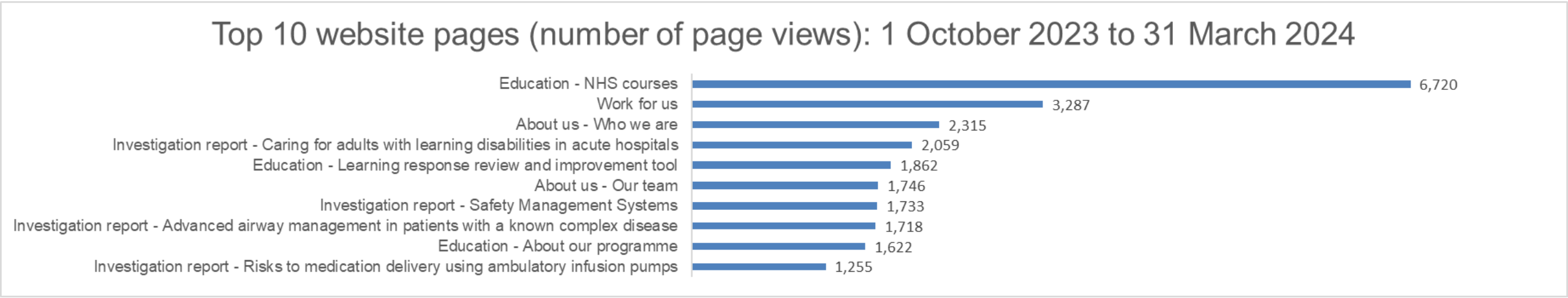


HSSIB website: top 10 pages

1 October 2023 – 31 March 2024

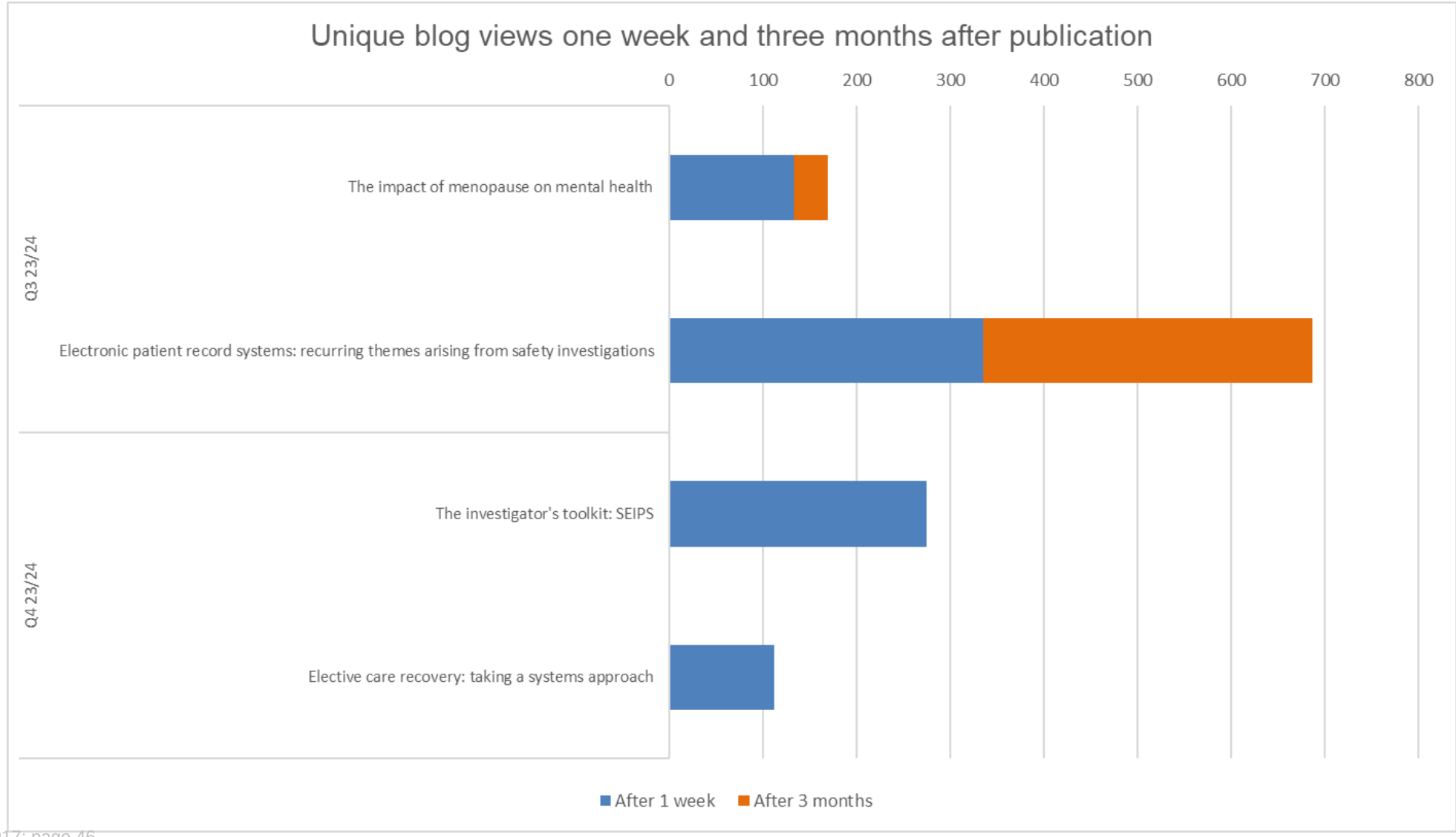
Excluding homepage and landing pages.



HSSIB website: quarterly blog performance

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body



HSSIB website: investigation performance

1 October 2023 – 31 March 2024

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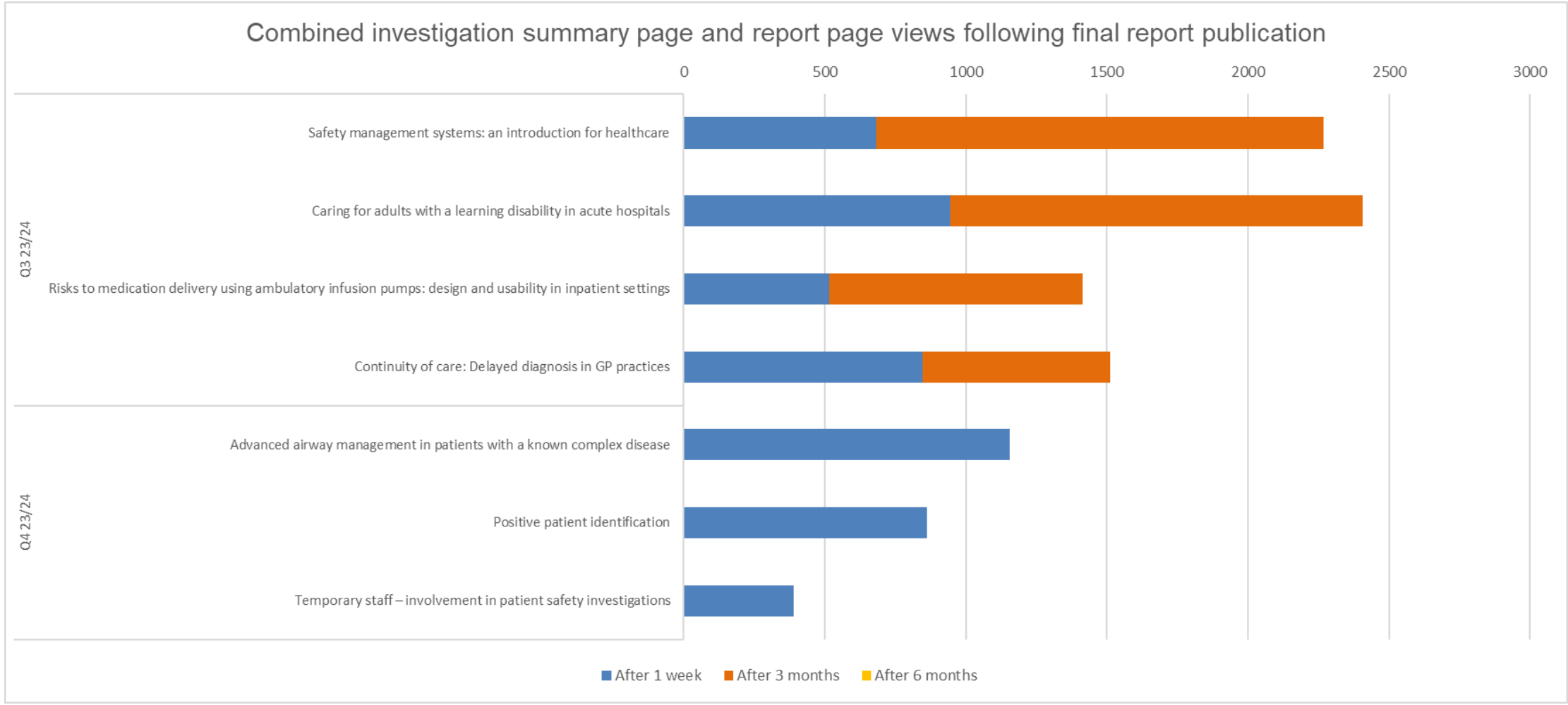


HSSIB social media: overview

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

X (formerly Twitter)

9,248 followers

345 new between 01/10/23 and 31/03/24.

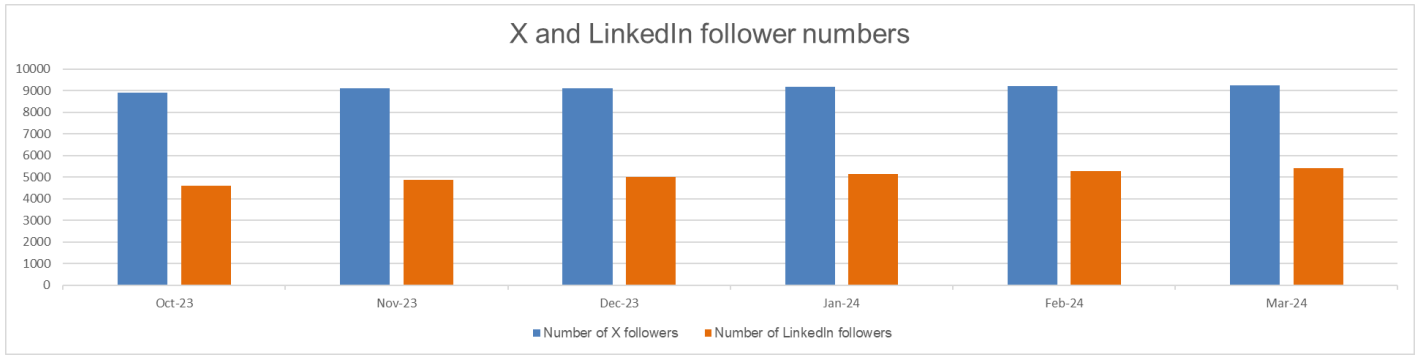
LinkedIn

5,431 followers

825 new between 01/10/23 and 31/03/24.

X	Oct 23 to Mar 24
Number of posts	61
Post impressions	129,158
Link clicks	2,015
Reposts without comments	525
Likes	667

LinkedIn	Oct 23 to Mar 24
Number of posts	48
Post impressions	97,707
Link clicks	4,527
Reposts	82
Reactions	1,727



HSSIB social media: top X and LinkedIn posts

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Top X post: Safety management systems report

- **14,398 impressions** (times a user is served a Tweet in timeline or search results).
- **525 engagements** (clicks, likes, detail expands, retweets, hashtag clicks, profile clicks, replies).

Top LinkedIn post: Director of Investigations appointment

- **11,982 impressions** (views when the post is at least 50% on screen, or when it is clicked, whichever comes first.)
- **656 clicks** and **207 reactions.**

Investigations/HSSIB Media coverage

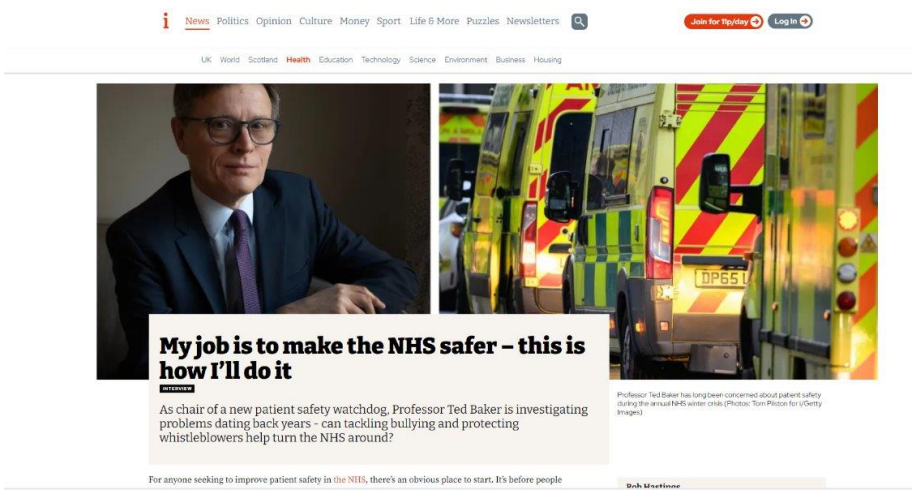
1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

Number of articles with HSSIB mention or focus (covers print, broadcast, online and national and regional media): **271**

Highlights: every report published since HSSIB establishment has gained some media coverage. We have also had general articles of interest on HSSIB including a comprehensive interview with Ted Baker, a broadcast interview with Rosie Benneyworth on IT and safety in NHS and articles/op eds on our launch on 18 October.

Media featured in include: The Sunday Times, Times, BBC, Independent, HSJ, Daily Express, The Independent, The i paper, BBC, LBC, Radio 4, Sky Radio, BMJ, Clinical Services Journal, Nursing Times, Pulse, Medscape, Hospital Healthcare Europe,



'Safe space' unit to protect NHS staff reporting medical errors

A new body backed by the High Court will allow whistleblowers to report issues of patient safety without fear of reprisal

Shaun Lintern Health Editor

NHS staff will be able to speak out about mistakes without fear of reprisal for the first time, thanks to a new investigation unit with "safe space" powers.

The Health Services Safety Investigations Body (HSSIB), which was launched last week, has been granted a remit that in effect means any testimony or evidence given to it by doctors, nurses and other medical staff will not be handed over to another agency – such as the nurse Lucy Letby at the Countess of Chester hospital. "We know that results get lost frequently across the NHS, and at the Countess of Chester we understand there may have been some lost insulin results. That's a prime example of a theme we could look at."

As well as hospitals, the HSSIB will investigate incidents in GP surgeries, dentists and private healthcare.

The body will have the power to enter and inspect hospitals and seize docu-

real catalyst for breaking the hold of the traditional blame culture in healthcare. People make mistakes that are part of a failing safety system, but rarely because of deliberate negligence or carelessness.

"Too many clinicians and staff fear being open and candid about mistakes because they then get the blame, and the HSSIB can protect them from that."

The chairman of the body, Dr Ted Baker, said: "Sometimes we blame individuals because that means we can feel

Investigations/HSSIB Media coverage

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

INDEPENDENT

NEWS SPORT VOICES CULTURE LIFESTYLE TRAVEL PREMIUM MORE

News > UK

Needs of patients with learning disabilities not being met in hospitals – report

An investigation by the Health Services Safety Investigations Body found the current system is not always designed to provide effective care.

Storm Newton • Thursday 02 November 2023 09:02 GMT

Medscape UK

NEWS

Safety Concerns Raised Over Portable Infusion Pumps

Priscilla Lynch | 16 November 2023

Portable medication device alarms may fail to effectively alert healthcare staff that medication isn't being delivered as it should, putting patients at risk of avoidable harm, an independent health care investigation watchdog has warned.

A report from the Health Services Safety Investigations Body (HSSIB) focused on the delivery and monitoring of medication via ambulatory infusion pumps, which allow continuous delivery of

New report charts safety risks associated with managing patients with known 'difficult airways'

JAN 26, 2024

EXPRESS

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Patient misidentification interventions outlined in new HSSIB report

Helena Beer 16 February 2024

Current controls are unable to prevent all patient misidentification and a proactive approach should be adopted to support staff in safety management, according to a new report by the Health Services Safety Investigations Body (HSSIB).

Patients should always be able to see the same GP

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Health Services Safety Investigations Body

Business Services

Financial Position (Draft and subject to audit)

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

£k	Actual (Oct - Mar 24)	HSSIB budget*	Variance on Budget under/(over) spend	Forecast Outturn at Feb 24	Variance on Forecast Outturn under/(over) spend	Narrative
Income	101			86	15	Additional sales from Education
Pay	2,248	3,437		2,235	(13)	Increase in pay due to movement in holiday pay accrual at year end
Non-pay	795			775	(20)	Various increases due to additional activity and personal expenses.
NHSE / HSIB **		(293)			63	In February we forecast a budget transfer of £356k to NHSE however this reduced to £293k with the final settlement between NHSE and CQC
Net Expenditure (RDEL)	**2,942**	**3,144**	**202**	**2,924**	**45**	The underspend of £166k is due the uncertainty surrounding the transition costs and the ALB costs
Amortisation and depreciation (RF RDEL)	39	N/a	N/a	40	**1**	
Net expenditure	2,981	3,144	**163**	2,964	**17**	
Capital ***	73	59	(14)	73	**(0)**	Actual expenditure is for IT equipment (laptops) to enable NHSE to provide IT support. We have been unable to make the cyber security investment that was funded due to the time required to determine the specific requirement.

* The functions of HSSIB were allocated a revenue expenditure (RDEL) budget by DHSC of £1.9m for Apr to Sep 23 when hosted by NHS England (NHSE), and £3.4m for Oct to Mar 24. £37k was awarded in Jan 24 for cyber security expenditure.
In March 24, as HSSIB was forecasting an overspend, and to ease DHSC pressures, HSSIB will self fund the additional employers pension contributions (originally NHSE would transfer £82k to fund these contributions).

** To accommodate the timing of business as usual and transition expenditure it was agreed that any budget adjustment would transfer between NHSE and HSSIB via DHSC in February.

*** HSSIB has been awarded a £59k capital budget for investment in cyber security, however HSSIB requires budget for Information Technology additions. DHSC have been informed of the capital pressure and will arrange funding.

Financial Position (Draft and subject to audit)

1 October 2023 – 31 March 2024

Net expenditure for the six months ended March 2024	
£k	HSSIB
Income	**101**
Pay	**2,248**
Non-pay	
Audit	119
Chair and Non Executive Directors	58
Charges from Service Level Agreements	
Recruitment service	13
Payroll service	11
Finance system	30
IT service	31
External contractors	13
HR related costs	19
IT licences and software	276
IT Hardware	7
Insurance	2
Legal	18
Meeting rooms	39
Training	13
Travel	97
Other establishment costs	49
Non-pay	**795**
Net Expenditure (RDEL)	**2,942**
Amortisation and depreciation	39
Net expenditure	**2,981**

Statement of Financial Position as at 31 March 2024	31-Mar-24	
	£000	Narrative
Non current assets		
Property, plant & equipment	79	Laptops & iPhones purchased in Mar-24
Intangible assets	27	Investigation and Learning Management Systems, plus Website
Total non-current assets	**106**	
Current assets		
Receivables	97	97% not due, 3% 31-60 days
Prepayments and accrued revenue	212	Various - large items are HIMS licence, lease cars, Microsoft.
Cash and cash equivalents	216	
Total current assets	**525**	
Total assets	**631**	
Current liabilities		
Payables	62	Business as usual
Accruals and deferred revenue	534	Includes transactions with NHSE incl. capital additions, IT cloud services, other SLA suppliers.
Social security and pension payables	3	Majority of liabilities paid prior to year end
Provisions	-	
Total current liabilities	**599**	
Net current (liabilities)/assets	**(74)**	
Total net (liabilities)/assets	**32**	
Financed by taxpayers' equity		
Comprehensive net expenditure for the year	(2,981)	
Grant in aid funding	2,900	Cash received from DHSC
Transfer by absoption	113	Transfer of assets, prepayments and annual leave accrual from NHS England
Total taxpayers' equity	**32**	

Workforce Summary
at 31 March 2024

Health Services Safety Investigations Body

50	Headcount
44.3	FTE
2	Vacancies
2	Active Recruitments

82.99%	Mandatory training compliance rate
3.74%	Sickness absence Rate Oct. ‘23 – Mar. ‘24

*All figures exclude the Chairs and NEDs (5) and those on external secondment (1).

Strategic Risk Register
as at 31 March 2024

Health Services Safety Investigations Body

Risk ID	Risk Area	Risk Description	Risk Controls	Inherent Risk RAG Status	Residual Risk RAG Status
SR001	Strategic delivery	There is a risk we cannot demonstrate we are delivering on our organisational mission and have a positive impact on patient safety.	Business planning process underway to deliver against our strategic ambitions. Recs pilot launched to understand, measure and demonstrate impact of our investigations.	16	12
SR002	Organisational culture and people	There is a risk that we cannot maintain and embed a positive, compassionate, values based culture. There is a risk that we fail to address the health, safety and well-being needs of our staff.	Development of OD plan including development of organisational values and plan to embed in all work. Effective HR and OD policies. EDI action plan and NED sponsor agreed by Board in Feb 2024. Occupational health, EAP and trauma support in place. FTSU arrangements being developed.	12	9
SR003	Organisational infrastucture and resources	There is a risk that HSSIB has insufficient resources to deliver our strategy.	Effective business planning to support prioritisation. Developing relationships with other small ALBs and DHSC specialist areas for specialist support and advice. Recruitment campaign for safety investigators to increase skill mix and resilience	16	9
SR004	Commercial Growth and Development	There is a risk that HSSIB takes on non-NHS funded work that negatively impacts our core business.	Monitoring within the Education Team re requests coming in for support. No initial direct marketing and no legal requirement to undertake commercial work.	6	3
SR005	Use of legal powers and legislation	There is a risk that HSSIB fail to legally and effectively use powers of investigation granted by the Health and Care Act 2022. There is a risk that we do not protect or securely manage our information in accordance with regulatory requirements, standards and legislation.	Legal advice to inform policies regarding use of legislation. Training and education for board and team. Regular review at SLT regarding use of legislation.	16	12
SR006	Business Continuity, IT and cyber security	There is a risk to business continuity due to an inherent lack of resilience in our operating systems. There is risk that HSSIB is subject to a cyber-attack, resulting in data or sensitive information being compromised, or IT services being unavailiable.	1. To be aware of our exposure to cyber risk - *training has been provided to the Board;* 2. To have the right capability and resource to handle our cyber risk 3. To undertake independent review and testing - *penetration testing proposal submitted to SLT for 22/4/24* 4. To be effectively prepared for a cyber security incident 5. To learn from others - *consulting with Government Security Centre for Cyber, member of DHSC Joint Cyber Unit ALB Forum*	16	12

Information Commissioner Cases / Data Breaches

1 October 2023 – 31 March 2024

Health Services Safety Investigations Body

- There have been no cases reported to the Information Commissioner's Office between 1st October 2023 and 31st March 2024.
- There have been no data breaches originated by HSSIB between 1st October 2023 and 31st March 2024.

HSSIB Board Cover Sheet

Health Services Safety Investigations Body

Title of paper	**Disclosure of Prohibited Materials Policy**				
Agenda Item	6		**Date of meeting**	2 May 2024	
Executive Lead	Philippa Styles				
Action Required	To Approve	☒	**Purpose**	Strategy	☐
	To Ratify	☐		Assurance	☐
	To Discuss	☐		Policy	☒
	To Note	☐		Performance	☐
Link to Strategic Goal	TBC – Strategic Goals being discussed at present time.				

Executive Summary	
The purpose of the paper is to seek assurance from the Board to publish the HSSIB Disclosure of Prohibited Materials Policy. This policy is for all staff at HSSIB as it is important that all staff members understand their information sharing obligations under the Health and Care Act 2022. This Policy initially came to Board on the 9th April. The changes that have been made since the 9th April are as follows: • Section 1.3 amended to show exact wording from Health and Care Act 2022 • Section 1.7 'contracted staff' added • Section 4.1 amended to note that it is in relation to sharing with external bodies • Section 7.1 line removed, and remaining sections removed • Section 10.4 amended to make it clear that DPA considered after lawful disclosure under HCA 2022 • Appendix 2 amended with extra explanatory strapline • Appendix 3 amended to change staff name to Chief Investigator.	
Action required/ request/ recommendations	To approve the publishing of the HSSIB Disclosure of Prohibited Materials Policy for HSSIB staff.
This Policy has been discussed at / date: • Discussed and approved at HSSIB SLT on 22nd February 2024. • Discussed at HSSIB Board on 9th April 2024. • Discussed on 22nd April – those present: Chief Executive, Director of Investigations, Chair of RemCom, Deputy Director of Investigations and the Board, Governance and Records Manager.	**This report has the following impact:** ☐Quality and Safety ☐Financial ☒Legal ☐Human Resources ☐Equality and Diversity ☐Communications and Engagement ☒Operational ☒Performance
Responsible Manager Sarah Graham, Board, Governance and Records Manager	**Accountable Director** Philippa Styles, Director of Investigations

Health Services Safety Investigations Body

Purpose of this Paper

The purpose of this paper is to seek assurance from the Board to publish the HSSIB Disclosure of Prohibited Materials Policy. This policy is for all staff at HSSIB as it is important that all staff members understand their information sharing obligations under the Health and Care Act 2022 (HCA 2022).

This policy aims to provide guidelines for HSSIB employees with regards to the sharing of information, specifically the prohibited materials identified by the HCA 2022.

Points for consideration

The Policy was brought before Board on the 9th April and it was decided that further work / discussions were required before it could be approved.

On the 22nd April, key members of HSSIB staff met with the Chair of RemCom to discuss the Policy. The changes made were as follows:

- Section 1.3 amended to show exact wording from Health and Care Act 2022
- Section 1.7 'contracted staff' added
- Section 4.1 amended to note that it is in relation to sharing with external bodies
- Section 7.1 line removed in relation to final reports to Secretary of State, and remaining sections removed
- Section 10.4 amended to make it clear that DPA considered after lawful disclosure under HCA 2022
- Appendix 2 amended with extra explanatory strapline
- Appendix 3 amended to change staff name to Chief Investigator.

Recommendations

Approve the publishing of the Disclosure of Prohibited Materials Policy for staff, through our internal communications channels.

Disclosure of Prohibited Materials Policy

Version number: v0.4

First published: Yet to be published.

Date updated: April 2024

Next review date: April 2025

Policy prepared by: Board, Governance and Records Manager

Policy Owner: Business Services Team

Brief summary of changes since previous version: Section 1.3 amended to show exact wording from Health and Care Act 2022; Section 1.7 'contracted staff added; Section 4.1 amended to note that it is in relation to sharing with external bodies; Section 7.1 line removed and remaining sections removed; Section 10.4 amended to make it clear that DPA considered after lawful disclosure under HCA 2022; Appendix 2 amended with extra explanatory strapline; Appendix 3 amended to change staff name to Chief Investigator.

Classification: OFFICIAL

Policy Number: HSSIB080

If you would like this policy in another format that would better suit your needs, or in another language, please contact us on enquiries@hssib.org.uk

Document Owner: Business Services Team	Prepared by: Board, Governance and Records Manager	First Published: TBC
Document number: HSSIB080	Issue/approval date: TBC	Version number: 0.4
Status: DRAFT	Next review date: April 2025	

Contents

1. Introduction

1.1. The Health Services Safety Investigations Body (HSSIB) has a principal function, which is to investigate Qualifying Incidents which have implications for patient safety.

1.2. The HSSIB is required to establish “safe space” protections, encouraging those engaging with its investigations to be completely candid with the information they share. This will enable more thorough investigation into what has gone wrong and the lessons that can be learned. The safe space protections must be effective if these aims are to be met.

1.3. The Health and Care Act 2022 (HCA 2022) therefore imposes disclosure obligations on the HSSIB and those working with it in relation to protected material, which means any information, document, equipment or other item which:
(a)is held by the HSSIB, or an individual connected with the HSSIB, for the purposes of the HSSIB’s investigation function,
(b)relates to a qualifying incident (whether or not investigated by the HSSIB), and
(c)has not already been lawfully made available to the public.

1.4. The provisions of the HCA 2022 relating specifically to reports and protected material will determine the circumstances in which the HSSIB can disclose information to others. Extracts of the HSC 2022 are provided at Appendix 1.

1.5. Failure to act in accordance with the restrictions on disclosure as set out in legislation may make individuals liable to criminal prosecution. This policy is intended to provide clarity on the requirements related to the disclosure of information, reports, and protected material, therefore protecting both individuals working for the HSSIB and the organisation. It provides key information on the duties of the HSSIB regarding disclosure of information both within the HSSIB and outside of the organisation.

1.6. This policy is issued in accordance with Schedule 14 paragraph 7 of the HCA 2022. This provides for the publication of guidance concerning when it might be appropriate for protected material to be disclosed, the types of protected material that might be appropriate to disclose and the processes that should be used when disclosing protected material. This policy will be updated if any further clarifications are provided by our legal consultants. All our staff, and any contracted organisations / contracted staff, without exception, are within the scope of this policy.

2. Definitions

2.1. *“Authorised Person"* –is defined under Schedule 14, paragraph 1(2) of the HCA 2022 as an Individual Connected with the HSSIB who is authorised by the HSSIB for the purpose of this paragraph.

2.2. *“HCA 2022"* – the Health and Care Act 2022.

2.3. *"Individual connected with the HSSIB*" – is defined under Section 122(3) of the HCA 2022 as a member of the HSSIB, a member of a committee or sub-committee of the HSSIB, an investigator, or an Individual (other than an investigator) who works for the HSSIB.

2.4. *"Individual who Works for the HSSIB"* is defined under Section 122(4) of the HCA 2022 as an individual under a contract of employment with the HSSIB, under a contract of apprenticeship with the HSSIB, under a contract under which the individual undertakes to do or perform personally any work or services for the HSSIB or is an agency worker working for HSSIB under the meaning of the Agency Workers Regulations 2010 (S.I. 2010/93).

2.5. *"PCA 1967"* – the Parliamentary Commissioners Act 1967.

2.6. *"Protected Material"* – is defined under Section122(2) of the HCA 2022 as any information, document, equipment, or other item, which is held by the HSSIB, or an Individual Connected with the HSSIB for the purposes of the HSSIB's investigation function which relates to a Qualifying Incident (whether or not investigated by the HSSIB) and has not already been lawfully made available to the public.

2.7. *"PHSO"* – the Parliamentary and Health Service Ombudsman.

2.8. *"Qualifying Incident*" – is defined under Section 110(1) of the HCA 2022 as an incident which occurs in England during the provision of health care services which has or may have implications for the safety of patients.

3. Statutory Requirements

3.1. It is unlawful to disclose ‘Protected Material’ both internally and externally unless there is lawful exemption.

3.2. Protected Material includes any information, documents, equipment, or any other item which is part of an HSSIB investigation that has not already been lawfully made available to the public.

3.3. It is a criminal offence for anyone working for, or on behalf of the HSSIB, to knowingly or recklessly disclose Protected Material, where the person knows or suspects the disclosure to be prohibited, unless a lawful exemption applies. This includes anyone who discloses Protected Material following the end of their employment.

3.4. It is also an offence for a person, not working for, or on behalf of the HSSIB, who has received Protected Material, to knowingly or recklessly disclose the Protected Material without reasonable excuse when they know it is protected. This includes patients, practitioners, staff members, family members and anyone else who has received Protected Material.

3.5. Interim or final reports should not include the name of any individual who has provided information to the HSSIB or anyone who was involved in the incident being investigated unless they have provided their consent.

3.6. Reports or any other Protected Material may be shared where a lawful exemption applies.

4. Lawful bases for disclosure outside of HSSIB

4.1. Protected Material should not be disclosed unless a lawful exemption can be applied, and the relevant authority has been provided. This section sets out the lawful bases for the disclosure of Protected Material, when disclosing to external bodies.

4.2. The Chief Investigator, or someone appointed by them to act for this purpose, may disclose Protected Material where they reasonably believe that the disclosure is necessary:

4.2.1 for the purpose of carrying out an investigation.

4.2.2 for the prosecution or investigation of an incident into the unlawful disclosure of information or an offence relating to an investigation; or

4.2.3 to address a safety risk to a patient or the public and there is reasonable belief that the disclosure will address the risk. The disclosure must be proportionate and go no further than is necessary.

4.3 The Chief Investigator can delegate the decision to disclose Protected Material to an investigator. Where disclosure has been delegated the investigator may make the decisions about disclosure which would otherwise have been made by the Chief Investigator. Decisions on disclosure will be recorded in a central disclosure log, maintained by the Board, Governance and Records Manager (BGRM).When

delegating duties, the Chief Investigator must provide their approval in writing confirming the investigation(s) to which the delegation applies. The Chief Investigator may delegate decisions in relation to a single investigation or multiple investigations to an investigator. Where the Chief Investigator has delegated duties, the investigator cannot sub-delegate those duties.

4.4. Protected Material may also be shared where one of the following lawful exemptions apply:

4.41. The information has already lawfully been made available to the public by the HSSIB or a third party; or

4.42. The High Court has made an order for disclosure (see below); or

4.43. An Authorised Person or the person making the disclosure may disclose Protected Material to an Individual Connected with the HSSIB if they reasonably believe the disclosure is necessary for the purposes of the investigation; or

4.5 In a final report, Protected Material may be disclosed where the HSSIB determines that the benefits to the safety of patients served by the disclosure outweigh any adverse impact on current investigations, future investigations or the safety of health care services provided to patients in England; or

4.6 The Secretary of State makes a regulation providing for disclosure. When a regulation is made, it is limited to particular Protected Material. The Secretary of State cannot authorise the disclosure of all Protected Material by reference to the incident to which it relates.

4.7 Before sharing any Protected Material, consideration should be given to proportionality and the specific purpose of the request. Requests for disclosure should be managed by only providing material which is necessary to disclose in order to achieve the purpose of the request. This ensures there is a proportionate balance between protecting sensitive material and managing necessary disclosure under the statutory lawful exemptions.

It is important that where there is a lawful requirement to share Protected Material that there is a consistent approach and data protection principles are applied (see section 10).

5. Disclosure Requests to the High Court

5.1. Any person may make an application for the disclosure of Protected Material to the High Court. Where an application has been made to the High Court the HSSIB will receive a copy either by it being sent to us by the person making the application or the court itself. On receipt of the application the HSSIB will be given the opportunity to submit representations before the court decides.

5.2. The HSSIB anticipates that applications for disclosure are most likely to be made by individuals or organisations that are party to or otherwise involved in legal or regulatory proceedings that relate to the Qualifying Incident which has been investigated.

5.3. The High Court will consider applications by balancing the reasons in favour of disclosure against the potential adverse impact to current or future investigations or the improvement of safety in health care services provided to patients in England. Adverse effects will include reluctance by individuals to engage with investigations in future if they consider that information they provided to the HSSIB is likely to be made available to others. It is important to consider this balance when assessing requests for disclosure and making representations to the court.

5.4. Factors to consider when balancing the risks of disclosure include:

5.4.1. Why it is important to the investigation that the material is protected? What benefit does this have to the investigation and would disclosure undermine the outcome of the investigation?

5.4.2. Are the reasons for requesting disclosure justified? Is it possible to disclose the information/part of the material without impacting on the outcomes of the investigation?

5.4.3. Is there a public interest? Is it likely that the disclosure of the requested material would have an impact on the public? E.g. would it potentially impact on the outcome and recommendations resulting in a risk to public safety.

5.4.4. Having considered the risks of disclosure to the investigation and reasons for the disclosure request, is protecting the material necessary for the investigation and does this outweigh the reasons for disclosure? Is there a reasonable expectation that the material should be disclosed?

5.5. An assessment of the risks and reasons for disclosure should be completed for all disclosure requests. This should be documented and included in the investigation disclosure log noting the factors that have been considered and the reasons for the

approval/rejection of the request. It is important that all decisions are logged to ensure there is consistency across requests and to ensure there is documented evidence should it be required following an application to the High Court.

5.6. All investigations should be carried out with the potential for disclosure in mind and steps taken to mitigate risks including:

5.6.1. Making decision makers within the HSSIB aware of potential disclosure challenges;

5.6.2. Documenting decisions with the reasons and information available for the purposes of making the decision;

5.6.3. Securing input from people who are familiar with the relevant investigation, so they can give an informed view of what factors are relevant to the application.

5.6.4. Review and learn from each instance to know how to respond better in future.

5.6.5. Instructing solicitors and/or Counsel to support with responding to an application.

5.7. This information is provided to ensure potential disclosure risks are considered when investigating and to ensure there is general awareness of how the High Court will consider requests for disclosure. It is not expected that anyone subject to this policy will be required to engage with the High Court or prepare representations to an application. All requests received form the Court or an applicant to the Court will be dealt with by a legal representative and any relevant information will be requested as necessary.

5.8. It is possible that an application could be received by an individual or at any premises associated with the HSSIB. Any individual associated with the HSSIB who identifies an application to the High Court or comes to know that such an application is being made should notify the BGRM on ig@hssib.org.uk promptly.

6. Offences of Unlawful Disclosure

6.1. It is an offence to knowingly or recklessly disclose Protected Material if it is known or suspected that disclosure is prohibited. This includes anyone working for, or on behalf of the HSSIB, and applies following the end of their employment.

6.2. It is also an offence for any third parties external to the HSSIB (e.g. witnesses, patients, family members etc) who have been provided with access to Protected Material to knowingly or recklessly disclose the Protected Material when the individual knows or suspects that it is protected. Where Protected Material has

been shared with a third party, you must ensure they are aware that the material is protected and ensure they are clear of their disclosure duties. Please see Appendix 2 which provides a paragraph to use when in correspondence with a third party which requires the disclosure of Protected Material.

6.3. Anyone found liable of an offence will be subject on summary conviction to a fine.

7. Who can protected materials be shared with in HSSIB?

7.1. This section deals with internal sharing at HSSIB. Protected materials can be shared internally with anyone within the HSSIB, or connected with the HSSIB, if it is considered necessary for the purposes of carrying out an investigation. However, they should not be shared any further than necessary. This means that protected materials should only be shared internally where in doing so this is likely to facilitate the investigation to which the materials relate or the effective operation of the HSSIB in general.

8. Working with other authorities

8.1 HSSIB have a duty to co-operate with other authorities when co-ordinating activities in related activities. Whilst there is a duty to ensure that practical arrangements are taken to co-ordinate activities there is no expectation that any Protected Material is shared as this can potentially impact on the purpose of creating a 'safe space' for investigations.

8.2 Similarly, HSSIB has a duty to provide assistance to NHS bodies and other independent providers. It is not expected that this assistance should encroach on HSSIB's investigatory functions, and no Protected Material should be shared with other organisations in these circumstances. Where the provision of any advice, guidance, training, or support in an investigation is impractical and likely to cause issues in relation to disclosure of information HSSIB would not be bound to act.

8.3 HSSIB may be instructed to investigate, or support investigations, within the jurisdiction of the Devolved Authorities in Wales and Northern Ireland. The HCA 2022 has limited application outside of England and therefore requests for disclosure of reports or other Protected Material relating to investigations in Wales of Northern Ireland should be referred to the BGRM on ig@hssib.org.uk for specialist advice.

9. Disclosure Procedures

9.1 All requests for disclosure of Protected Material, and all disclosures in response to such requests. must be recorded on a central disclosure log maintained by the BGRM. A copy of the log template can be found at Appendix 3. The same approach should be taken to an application to the High Court and any Order issued by the court. This ensures that Protected Material is tracked, and risks managed. It also ensures that where information has previously been disclosed it can be managed as public information.

9.2 The disclosure log is managed centrally by the BGRM. Please ensure any disclosure and requests for disclosure are sent to the BGRM on ig@hssib.org.uk as soon as possible. The log can be found here.

9.3 The terms of any request for disclosure, application to court or court order should be carefully considered to determine the precise scope of the information requested or required to be disclosed.

9.4 No Protected Material should be disclosed without the approval of the Chief Investigator (or Investigator where delegated authority has been provided) and details have been shared for inclusion in the disclosure log.

10. Other Legal Obligations

10.1 HSSIB have other legal obligations which at first may appear to compete with HSSIB's duties under the HCA 2022. For example, the Data Protection Act 2018 and PCA 1967 both require the disclosure of information in certain circumstances. However, the HCA 2022 makes it clear that the duty not to disclose Protected Material, except where a legal exemption applies, takes precedence over any competing obligations on the HSSIB to disclose information.

10.2 This includes any requests made under data protection legislation, such as data subject access requests (SARs), or requests made under the Freedom of Information Act. The HSSIB must still handle any requests in line with statutory requirements (for example, the HSSIB must respond to a SAR within one calendar month confirming the legal bases on which it is declining to comply with the request).

10.3 Whilst HSSIB are prohibited from sharing personal data under a DSAR which is classified as Protected Material, it may still be possible where a lawful exemption

applies. For example, an individual who has requested access to their interview transcript could potentially still be provided if it is considered necessary to the investigation and the disclosure has the approval of the Chief Investigator. This may be considered necessary on the basis that the individual needs to check the factual accuracy of the transcript or to support them in providing further information.

10.4 Once a decision has been made to disclose protected materials under a lawful basis as described in HCA 2022, consideration must still be given to data protection legislation. Should you require any assistance on your duties and obligations regarding data protection or freedom of information please contact the BGRM on ig@hssib.org.uk.

10.5 HSSIB also has specific legal obligations regarding safeguarding vulnerable persons. Whilst the HCA 2022 does not make any specific reference to safeguarding it does provide a lawful exemption for disclosure of Protected Material where the Chief Investigator reasonably believes that the disclosure is necessary to address a serious and continuing risk to the safety of a patient or to the public. Whether protected material should be disclosed will need to be considered on a case-by-case basis. Where there are any safeguarding concerns which may require the disclosure of Protected Material, please contact the BGRM on ig@hssib.org.uk.

10.6 The PCA 1967 provides the PHSO with the jurisdiction to investigate complaints made about HSSIB. The PCA 1967 also provides the PHSO with the power to require HSSIB to provide information that it considers relevant to its investigation. The PHSO's focus is on process rather than the substantive or qualitative decision made by HSSIB and in most cases they will not require access to any Protected Material. However, where a request is made by the PHSO, the prohibition on disclosure of Protected Material takes precedence and HSSIB should not disclose any Protected Material unless there is a lawful exemption for doing so. Should the PHSO consider the information relevant to their investigation they will be required to obtain an order from the High Court for the information to be disclosed.

10.7 It is possible that a coroner may request a copy of an investigation report or other relevant information. Where the coroner has made a request which includes the disclosure of Protected Material, HSSIB should ensure the duties regarding Protected Material are made clear and reserve the right to make further submissions should the coroner wish to provide onward disclosure.

11. Contacts

11.1. Should you require any further advice about this Policy, please contact the BGRM on ig@hssib.org.uk.

Appendix 1 – HCA 2022 (Extract)

Health and Care Act 2022

113 Final reports

(1) When the HSSIB completes an investigation, it must publish a report on the outcome of the investigation (the "final report").

(2) The final report must—

(a) contain a statement of findings of fact made as a result of the investigation and an analysis of those findings,

(b) make such recommendations as to the action to be taken by any person as the HSSIB considers appropriate, and

(c) set out the HSSIB's conclusions on the matters it considered in accordance with section 110(3) (but only if that provision is applicable to the investigation).

(3) The final report must focus on ascertaining risks to the safety of patients and any recommendations as to the action to be taken by any person must focus on addressing those risks. (rather than on the activities of individuals involved in the incident).

(4) In particular, the final report may not include an assessment or determination of—

(a) blame,

(b) civil or criminal liability, or

(c) whether action needs to be taken in respect of an individual by a regulatory body.

(5) Information which is protected material (see section 122(2)) may be disclosed in a final report if the HSSIB determines that the benefits to the safety of patients served by the disclosure outweigh—

(a) any adverse impact on current or future investigations by deterring persons from providing information to the HSSIB, and

(b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England.

(6) The final report may not, without their consent, include the name of any individual—

(a) who has provided information to the HSSIB for the purposes of the investigation, or

(b) who was involved in the incident being investigated.

(7) Where an investigation is carried out pursuant to a direction under section 111, the HSSIB must send a copy of the final report to the Secretary of State.

114 Interim reports

(1) While the HSSIB is carrying out an investigation, it may publish a report on any matter relating to the investigation (an "interim report").

(2) An interim report may—

(a) contain a statement of findings of fact made as a result of the investigation to date and an analysis of those findings,

(b) make such recommendations as to the action to be taken by any person as the HSSIB considers appropriate, and

(c) set out the HSSIB's conclusions to date on the matters it has considered in accordance with section 110(3).

(3) Subsections (3) to (7) of section 113 apply in relation to an interim report as

they apply in relation to a final report.

115 Draft reports

(1) Before it publishes a final or interim report, the HSSIB—

(a) must send a draft of the report to any person who the HSSIB reasonably believes could be adversely affected by the report, and

(b) may send a draft of the report to any other person who the HSSIB believes should be sent a draft.

(2) If a person who the HSSIB reasonably believes could have been adversely affected by the report has died, the draft report must be sent to the person (if any) who appears to the HSSIB to best represent the interests of the person who has died.

(3) The HSSIB must notify every person to whom a draft report is sent that the person has an opportunity to comment on the draft report before the deadline specified by the HSSIB.

(4) If a person's comments on a draft report are not taken into account in the final or interim report as published, the HSSIB must explain to the person why that is.

116 Response to reports

(1) This section applies where a final or interim report includes recommendations as to the action to be taken by any person.

(2) The HSSIB must, in such manner as it thinks appropriate, send the report to that person, or make it available to them.

(3) The report must specify the deadline for that person to provide a written response.

(4) Before that deadline, the person must respond to the HSSIB in writing setting out the actions they propose to take in pursuance of the recommendations.

(5) The HSSIB may publish the response.

(6) Subsection (4) does not require a person to do anything that they could be required to do by an Act of Senedd Cymru made without the consent of a Minister of the Crown.

117 Admissibility of reports

(1) A final report, an interim report, and the draft of a final or interim report sent to a person under section 115 are not admissible in any proceedings within subsection (2).

(2) Those proceedings are—

(a) proceedings to determine civil or criminal liability in respect of any matter.

(b) proceedings before any employment tribunal.

(c) proceedings before a regulatory body (including proceedings for the purposes of investigating an allegation).

(d) proceedings to determine an appeal against a decision made in proceedings falling within paragraphs (a) to (c).

(3) But the High Court may order that a final or interim report is admissible in proceedings within subsection (2) on an application by a person who is a party to the proceedings or otherwise entitled to appear in them.

(4) The HSSIB may make representations to the High Court about any application under subsection (3).

(5) The High Court may make an order under subsection (3) only if it determines that the interests of justice served by admitting the report outweigh—

(a) any adverse impact on current or future investigations by deterring persons from providing information for the purposes of investigations,

(b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England.

122 Prohibition on disclosure of HSSIB material

(1) The HSSIB, or an individual connected with the HSSIB, must not disclose protected material to any person.

(2) In this Part "protected material" means any information, document, equipment, or other item which—

(a) is held by the HSSIB, or an individual connected with the HSSIB, for the purposes of the HSSIB's investigation function,

(b) relates to a qualifying incident (whether or not investigated by the HSSIB), and

(c) has not already been lawfully made available to the public.

(3) In this Part "individual connected with the HSSIB" means—

(a) a member of the HSSIB,

(b) a member of a committee or sub-committee of the HSSIB,

(c) an investigator, or

(d) an individual (other than an investigator) who works for the HSSIB.

(4) For the purposes of subsection (3)(d) an individual "works for" the HSSIB if the individual works—

(a) under a contract of employment with the HSSIB,

(b) under a contract of apprenticeship with the HSSIB,

(c) under a contract under which the individual undertakes to do or perform personally any work or services for the HSSIB, or

(d) as an agency worker within the meaning of the Agency Workers Regulations 2010 (S.I.2010/93) in circumstances where the HSSIB is the hirer within the meaning of those Regulations.

(5) An individual who was, but has ceased to be, connected with the HSSIB must not disclose to any person, other than the HSSIB or an individual connected with the HSSIB, any information, document, equipment, or other item held by that individual—

(a) which the individual obtained because they were connected with the HSSIB,

(b) which, at the time they ceased to be connected with the HSSIB, was protected material, and

(c) which has not already been lawfully made available to the public.

123 Exceptions to prohibition on disclosure

(1) Section 122(1) does not apply to a disclosure which is required or authorised by—

(a) Schedule 14,

(b) any other provision of this Part, or

(c) regulations made by the Secretary of State.

(2) Regulations under subsection (1)(c) may, for example, require or authorise disclosures of protected material by reference to—

(a) the kind of material that it is (for example, a particular kind of equipment),
(b) the matters to which it relates,
(c) the person from whom it was obtained,
(d) the purpose for which it was produced or is held, or
(e) the purpose for which it is disclosed.

(3) But regulations under subsection (1)(c) may not require or authorise disclosures of protected material by reference to the qualifying incident to which the material relates.

(4) Regulations under subsection (1)(c) may provide for a person to exercise a discretion in dealing with any matter.

(5) Subject to subsection (6), regulations under subsection (1)(c) may provide that disclosures which are required or authorised by the regulations do not breach—
(a) obligations of confidence owed by the person making the disclosure, or
(b) any other restrictions on disclosure.

(6) Nothing in regulations under subsection (1)(c) operates to require or authorise disclosures which would contravene the data protection legislation (but, for the purposes of this subsection, in determining whether any disclosure required or authorised by the regulations would do so, take the requirement or authorisation into account).

124 Offences of unlawful disclosure

(1) A person commits an offence if the person—
(a) breaches the prohibition in section 122(1) by knowingly or recklessly disclosing protected material to another person, and
(b) knows or suspects that the disclosure is prohibited.

(2) An individual who was, but has ceased to be, connected with the HSSIB commits an offence if the individual—
(a) breaches the prohibition in section 122(5) by knowingly or recklessly disclosing any information, document, equipment, or other thing to another person, and
(b) knows or suspects that the disclosure is prohibited.

(3) Subsection (4) applies where protected material is disclosed to a person not connected with the HSSIB—
(a) in a draft report sent to the person under section 115(1),
(b) under paragraph 2, 3 or 4 of Schedule 14 (disclosures for purposes of an investigation, offence, or safety risk), or
(c) under regulations under section 123(1)(c).

(4) The person not connected with the HSSIB to whom protected material is disclosed as specified in subsection (3) commits an offence if the person—
(a) knowingly or recklessly discloses the protected material to another person without reasonable excuse, and
(b) knows or suspects that it is protected material.

(5) A person who commits an offence under this section is liable on summary conviction to a fine.

126 Co-operation

(1) This section applies where—
(a) the HSSIB is carrying out an investigation into a qualifying incident, and
(b) a listed person is also carrying out an investigation into the same or a

related incident.

(2) The HSSIB and the listed person must co-operate with each other regarding practical arrangements for co-ordinating those investigations.

(3) The following are listed persons—

(a) an NHS foundation trust, an NHS trust or any other person providing NHS services.

(b) NHS England.

(c) an integrated care board.

(d) a Special Health Authority.

(e) the Care Quality Commission.

(f) the Health Research Authority.

(g) the Human Tissue Authority.

(h) the Human Fertilisation and Embryology Authority.

(i) Health Education England.

(j) the Health Service Commissioner for England.

(k) the Parliamentary Commissioner for Administration.

(l) any regulatory body.

(m) the Health and Safety Executive.

(n) the Commissioner for Patient Safety.

(4) The HSSIB must publish guidance about when a qualifying incident is to be regarded as related to another incident for the purposes of this section.

(5) If the HSSIB revises the guidance the HSSIB must publish it as revised.

127 Assistance of NHS bodies

(1) The HSSIB must comply with—

(a) any request by a relevant NHS body to provide it with assistance in connection with the carrying out of investigations into incidents occurring during the provision of NHS services or occurring at premises at which NHS services are provided.

(b) any request by NHS England to provide any other relevant NHS body with such assistance.

(c) any request by the Secretary of State to provide a relevant NHS body with such assistance.

(2) In subsection (1) "relevant NHS body" means—

(a) an NHS foundation trust.

(b) an NHS trust.

(c) NHS England.

(d) an integrated care boards.

(3) For the purposes of this section giving assistance includes—

(a) disseminating information about best practice,

(b) developing standards to be adopted, and

(c) giving advice, guidance, or training.

(4) Subsection (1) does not apply if—

(a) the assistance requested is giving advice, guidance, or training, and

(b) the HSSIB determines that it is impracticable for it to give the assistance.

(5) The HSSIB may give assistance to a person other than a relevant NHS body in relation to any matter connected with the carrying out of investigations if the HSSIB has been requested to provide the assistance by the person to whom it is to be given.

(6) But the HSSIB may give assistance under subsection (5) only to the extent that the assistance does not to any significant extent interfere with the exercise by the HSSIB of its investigation function.
(7) The activities which the HSSIB may carry out in, or in connection with, giving assistance under subsection (5) are not restricted to activities carried out in the United Kingdom.
(8) The HSSIB may impose charges for or in connection with giving assistance under subsection (5).
(9) Charges under subsection (8) may be calculated on the basis that the HSSIB considers to be the appropriate commercial basis.

128 Investigations relating to Wales and Northern Ireland

(1) The HSSIB may enter into an agreement with any person for the HSSIB to carry out an investigation falling within subsection (2).
(2) An investigation falls within this subsection if—
(a) it is an investigation into one or more incidents that have occurred, or are occurring, in the United Kingdom—
(i) during the provision of any of the services mentioned in subsection (3), or
(ii) at premises at which any of those services are, or were, provided,
(b) the incident or incidents have or may have implications for the safety of persons for whom those services are provided,
(c) the investigation is carried out for the purpose of identifying risks to the safety of such persons and addressing those risks by facilitating the improvement of systems and practices in the provision of any of the services mentioned in subsection (3), and
(d) the investigation does not involve the assessment or determination of blame or civil or criminal liability.
(3) The services referred to in subsection (2) are—
(a) services provided for the purposes of the health service continued under section 1(1) of the National Health Service (Wales) Act 2006, and
(b) health care, within the meaning of the Health and Social Care (Reform) Act (Northern Ireland) 2009, provided for the purposes of the system promoted under section 2(1) of that Act.
(4) The HSSIB may impose charges for providing services under an agreement under subsection (1).
(5) Those charges must not exceed the costs incurred by the HSSIB in providing the services.
(6) The HSSIB may enter into an agreement under subsection (1) only if it considers that the provision of the services under the agreement will not to any significant extent interfere with the exercise by the HSSIB of its investigation function.

Schedule 14

1

(1) The HSSIB, or an individual connected with the HSSB, may disclose protected material to an individual connected with the HSSIB if—
(a) the person making the disclosure, or
(b) an authorised person, reasonably believes that the disclosure is necessary for the purposes of the carrying out of the HSSIB's investigation function.
(2) In this paragraph "authorised person" means an individual connected with the HSSIB

who is authorised by the HSSIB for the purposes of this paragraph.

2
The HSSIB, or an individual connected with the HSSIB, may disclose protected material to a person not connected with the HSSIB if the Chief Investigator reasonably believes that the disclosure is necessary for the purposes of the carrying out of the HSSIB's investigation function.

3
The HSSIB, or an individual connected with the HSSIB, may disclose protected material to a person if the Chief Investigator reasonably believes that the disclosure is necessary for the purposes of the prosecution or investigation of an offence under section 121 (offences relating to investigations) or 124 (unlawful disclosure).

4
The HSSIB, or an individual connected with the HSSIB, may disclose protected material to a person where—

(a) the Chief Investigator reasonably believes that the disclosure of the material is necessary to address a serious and continuing risk to the safety of any patient or to the public,

(b) the Chief Investigator reasonably believes that the person is in a position to address the risk, and

(c) the disclosure is only to the extent necessary to enable the person to take steps to address the risk.

Disclosure by order of the High Court

5
(1) A person may apply to the High Court for an order that any protected material be disclosed by the HSSIB to the person for the purposes specified in the application.

(2) Those purposes may include onward disclosure by the person making the application to a person specified in the application.

(3) The HSSIB may make representations to the High Court about any application under this paragraph.

(4) The High Court may make an order on an application under this paragraph only if it determines that the interests of justice served by the disclosure outweigh—

(a) any adverse impact on current and future investigations by deterring persons from providing information for the purposes of investigations, and

(b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England.

Exercise of Chief Investigator's functions

6
(1) The Chief Investigator may arrange for the Chief Investigator's functions under any provision of this Schedule to be exercised by an investigator.

(2) An arrangement under this paragraph may relate to a particular case, a particular class of case or all cases.

Appendix 2 - Precedent for sharing protected material with Third Parties

The paragraphs below are intended for use by HSSIB staff when sending protected materials to any person / organisation outside HSSIB.

Important – please read carefully.

It is important you are aware that HSSIB conducts its investigations into patient safety incidents on a confidential basis. This is to encourage those involved in such incidents to be open with the information they share, to allow us to conduct comprehensive investigations.

Please note that under section 124 of the Health and Care Act 2022, it is an offence for individuals in receipt of "Protected Materials" from HSSIB to disclose or share this with any other individual, or to publish or otherwise make these publicly available.

"Protected Materials" includes any information which we provide to you in connection with our investigatory functions, or in relation to any patient safety incident that we are investigating, which is not in the public domain. For the avoidance of doubt, this [draft report/ disclosure/ notification – delete as appropriate] is Protected Material: disclosing it will mean you may be liable to a fine.

Appendix 3 – Protected Materials Disclosure Log

Protected Materials - Disclosure Log						
Date of Request to Share	**Details of Request to Share**	**Request received by**	**Summary Response**	**Signed off by Authorised Person (Chief Investigator)**	**Date of Response**	**File of disclosed material SharePoint location**

12. Version Control Tracker

Version Number	Date	Author Title	Status	Comment/Reason for Issue/Approving Body
v0.1	16/01/2024	Board, Governance and Records Manager	DRAFT	First draft version for HSSIB. Previous version written in 2022/2023 whilst HSIB and re-developed with new understanding of the HCA 2022.
V0.2	24/01/2024	Board, Governance and Records Manager	DRAFT	Amendments made following comments by Director of Investigations and Deputy Director of Investigations. A) disclosure log noted to be central, not held locally by investigators and b) Appendix 3 added, disclosure log.
V0.3	09/04/2024	Board, Governance and Records Manager	DRAFT	Amendments made in preparation for Board.
V0.4	24/04/2024	Board, Governance and Records Manager	DRAFT	Amendments made following meeting on 22nd April with Chief Investigator, Chair of RemCom (NED), Director of Investigations and Deputy Director of Investigations.

Forward Planner

Upcoming Meetings & Proposed Agenda Items

27 June '24
Board Meeting
Sessions / Topics
Annual Report and Accounts Sign Off
Final Criteria and Strategy
Performance Report
Sub-Committee Updates
Freedom to Speak Up
Investigations Management System
Procurement Project
CEO Report
Education Presentation
Business Plan and Budget Sign Off

14 August '24
Board Meeting
Sessions / Topics
Performance Report
Sub-Committee Updates
CEO Report
Chair update
Investigation Presentation

16 October '24
Board Meeting
Sessions / Topics
Performance Report
Sub-Committee Updates
CEO Report
Education Presentation
Communications Strategy
Investigations Management System
Procurement Project