

**Minutes of Advisory Panel**  
**Thursday 03 December 20, 14:00-16:00**  
**MS Teams**

<b>Members present:</b>	<p>Chair: Prof. Murray Anderson-Wallace (MAW), Health Systems Innovation Lab, London South Bank University</p> <ul style="list-style-type: none"> <li>• Farrah Pradhan (FP), Patient and public involvement advocate</li> <li>• Richard von Abendorff (RVA), Family Campaigner and Advocate for learning and robust action in health care after avoidable harm</li> <li>• Dr Joe Rafferty (JR), Chief Executive of Mersey Care NHS Trust</li> <li>• Steve Clinch (SC), General Secretary, Marine Accident Investigator's; International Forum (MAIIF)</li> <li>• Keith Conradi (KC), Chief Investigator, HSIB</li> <li>• Patrick Vernon (PV), Citizens Partnership Chair</li> <li>• Dr Mike Durkin (MD), Visiting Professor in Patient Safety, Imperial College London and the University of the West of England</li> </ul>
<b>In attendance:</b>	<ul style="list-style-type: none"> <li>• Lynne Spencer (LS), Director of Corporate Affairs, HSIB</li> <li>• Dr Stephen Drage (SD), Director of Investigations, HSIB</li> <li>• Dr Kevin Stewart (KS), Medical Director, HSIB</li> <li>• Alison McLellan (AM), Head of Patient &amp; Public Involvement/E&amp;D</li> <li>• Cassandra Cameron (CC), Head of Policy ad Strategy, HSIB</li> </ul> <p>Minutes: Julia Blomquist (JB), Chief Investigator Office Manager, HSIB</p>
<b>Apologies:</b>	<ul style="list-style-type: none"> <li>• Jennie Stanley (JS), Previous Lead Nurse at Patients First supporting whistle-blowers and Managing Director of a healthcare training company</li> <li>• Dr Suzanne Shale (SS), Independent Consultant in healthcare ethics, medical education, and patient safety</li> </ul>

No.	Item
1	<b>Welcome and Apologies</b>
	The Chair welcomed those to the meeting and apologies for absence were noted as above.
2	<b>Declarations of Interest (Dol)</b>
	<p>LS gently reminded the Panel that an annual refresh of Dol forms are required. It was agreed for JB to circulate the previous forms to the Panel which they can update accordingly.</p> <p><b>Action: JB to circulate previous Dol forms for members to review</b> <b>Action: Members to provide JB with updated Dol forms</b></p>
3	<b>Draft minutes of the last meeting on 15.09.20</b>
	The minutes of the previous meeting were approved as a true and accurate record.
4	<b>Action Log</b>
	MAW presented the action log which was up to date and all actions completed.

5	<p><b>Chief Investigators update</b></p>
	<p><u>Investigation Directorate update</u> SD provided an update to the Panel. 28 investigations are in the pipeline, this has been reinvigorated after the initial first stages of the pandemic.</p> <p>The backlog has been reduced in maternity and reports are now being completed within a 6-month timeline. Referrals for cooled babies with no harm are no longer routinely investigated.</p> <p>Positive feedback has been received from families who are involved in maternity investigations. SC raised whether as much feedback has been received regarding the national investigations. SD responded that there is a less feedback from families. RVA suggested to engage with the Citizens Partnership on how better to improve engagement with families.</p> <p>KS added there have also been several themed reports produced.</p> <p><u>Chief Investigators update</u> KC gave an update to the Panel regarding the branch. Due to Covid-19 staff are currently still working from home and not in the office. Investigations are still taking place in trusts as well as some family visits face to face but only on a case by case basis. During the first lockdown, seconded staff returned to trusts. A different approach has been taken with the second lockdown as due to covid related activity, we have needed to retain staff at HSIB.</p> <p>Investigations and safety recommendations – KC attended the second National Patient Safety Committee meeting which is led by Aidan Fowler and includes CQC, DHSC, MHRA, NSHI and Royal Colleges. Currently they are working out a process for dealing with responses to safety recommendations we have made that are not adequate so we can escalate the responses. A pilot process has been developed where 10 reports with recommendations contained will be reviewed and where required escalated to various panels. The responses will be graded and published.</p> <p>There is a project being developed on the use of maternity data and how we can make this transparent and what are different ways we can share this. JF felt this was an awareness piece which could provide collaboration and a potential with influence to begin how much an Integrated Care System (ICS) could reward for improvement. RVA commented there are interesting contributions from John Green on the citizen’s partnership. MD pointed out that providers and commissioners are working together in the ICS so this may raise leverage opportunities.</p> <p>There was no update on the bill. The expectation is we will form part of a wider NHS bill. KC is working on the draft bill that saw readings in 2019.</p> <p>HSIB are actively looking at bolder safety recommendations where structural changes can be made to improve the system. On a national scale we do not see evidence of a joined up safety management system working and may make safety recommendations in this space. KS commented that a range of publications have</p>

	<p>been developed and led by intelligence analysts with brief alerts raising safety issues.</p> <p>LS informed the Panel that in terms of staff contracts there are only 20 staff seconded and 120 fixed term. From January 2021 all these staff will be made permanent. The messaging will go out to staff later this month which forms the direction we are taking for equality purposes.</p>
6	<p><b>Lay Person Reimbursement Policy</b></p> <p>LS introduced the policy to the Panel which has been developed to strengthen our governance. The Panel discussed the figures for the attendance fee, and it was agreed for LS and AM to review the benchmarking. FP offered to support the review. It was also suggested to include a timeframe that members would get paid in, for example, within two weeks of the meetings.</p> <p><b>Action: LS and AM to review the benchmarking of the attendance fee for lay contributors</b></p>
7	<p><b>AP Draft Terms of Reference (ToR)</b></p> <p>The draft ToR were presented to the Panel which were reviewed and discussed. AM raised there was no quorum included. LS responded this is due to there being no decision making or external scrutiny required from this group. LM suggested on page 2 under 'Expert Advice' to include horizon scanning on patient safety landscape.</p> <p>LS updated that DHSC will not agree to a shadow board until a business case has been signed off by the treasury.</p> <p>The ToR were approved.</p>
8	<p><b>Health &amp; Social Care Submissions (H&amp;SC)</b></p> <p>CC provided an update on the H&amp;SC submissions to their maternity inquiry and said it will probably be the new year before we are called. There has been a change in description to the inquiry and specific references to HSIB have been removed.</p>
9	<p><b>Citizens' Partnership update</b></p> <p>PV gave an overview of the four newly appointed design panel members. The first Design and Delivery Group meeting was held on Thursday 12 November to discuss what the Citizens' Partnership will be. CC has also joined this meeting. PV advised that by September 2021, the Partnership will be recruited. Usman Khan is currently reviewing the family engagement tool. LS thanked Patrick Vernon for his contributions and efforts.</p>
10	<p><b>Investigation training approach</b></p> <p>The approach has come from the original directions to develop local level investigator skills. Dawn Benson (Acting Head of Investigation Education) has developed a series of courses which will be trialled with NHS trust investigators and patient safety specialists in the next few months. This has been presented to DHSC</p>

	who praised and approved it. There has been global interest outside, and KC advised there could be potential to build a business case to upscale in the future.
11	<b>Regionalisation strategies</b>
	KC updated that the strategy is going to trial investigations at a regional level. We envisage a series of teams around the country investigating complex events within their region. The independent investigations will make a series of recommendations at local, regional or national level. This will provide intelligence to the core national team and also provide focus for a network of Trust safety investigators within that region. This will be trialled in a single region in 2021.
12	<b>AOB</b>
	<b>Action: JB to arrange a date for next meeting in March 2021.</b>  MAW thanked the Panel for their contributions.
	<b>Close</b>
	The meeting closed at 16:02.
<b>Date of Next Meeting: Thursday 11<sup>th</sup> March 2021 10:00-12:30hrs</b>	