

Letter from the Chair

I am pleased to announce that the Healthcare Safety Investigation Branch Expert Advisory Group (EAG) has today published its report outlining recommendations to the Government on the purpose, role and operation for a new investigation function for the NHS.

It was an enormous privilege to be chair of the EAG and to work with a group of individuals who wholeheartedly brought their energy, commitment and expertise to the process of creating this report. The members of the group were chosen for their directly relevant experience and authoritative expertise in the fields of investigations, patient safety, patient involvement, system improvement, organisational learning, and healthcare delivery.

Each and every member brought their own perspective to the process and this report is a result of the honest and respectful debate the group has had since summer 2015. The report has been written by the EAG and represents the views and expertise of its members. I am grateful to all members for their commitment to this journey and thank them all for their time and thoughtful approach.

This report would not be what it is without the wider contributions from patients, families and staff who have spoken to the group and provided evidence to it. These individuals – some of whom have tragic stories to tell – came to us and opened up about their experiences and how they impacted on them.

We heard about the importance of openness, transparency and compassion. The need for patients, families and staff to be at the heart of investigations. The need for investigations to be independent, making judgements without fear or favour. And the need to focus on learning and making access to that learning easier and more simple. I, and the rest of the EAG, want to thank each and every person who made the effort to contact us, come to an engagement event or provide their views.

The report makes 13 recommendations, 10 of which are aimed at the Healthcare Safety Investigation Branch and a further three are aimed at the Department of Health and the wider healthcare system.

One of the primary aims of the Healthcare Safety Investigation Branch is about learning. Being part of the EAG and supporting the establishment of the branch has been a learning experience in itself and on a personal level I have taken a great deal from it.

Sometimes the process felt imperfect and if we started again we would probably do some things differently. But I and the members of the group believe this report provides the foundation for a Healthcare Safety Investigation Branch that will deliver high quality investigations; that finds the best way to listen to staff, patients and families - involving them fully and properly; that serves as an exemplar to the wider healthcare system; and that promotes a culture of learning and improvement - not blame and defensiveness - to support lessons to be learnt and adopted across the NHS.



**Dr. Mike Durkin,
Chair of the Expert Advisory
Group**

12 May 2016