**Independent Patient Safety Investigation Service**

**Expert Advisory Group**

**Terms of reference**

## Background

1. The Public Administration Select Committee report (PASC) in March 2015 characterised investigations into serious incidents in the NHS as "complicated, take far too long and are preoccupied with blame or avoiding financial liability" and falls far short of what patients, their families and NHS staff are entitled to expect. The Committee recommended that that there should be a new independent patient safety investigation body to conduct patient safety investigations in the NHS.

2. In its response, the Government agreed that there should be an independent capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out certain investigations itself[1].

3. Timescales have been set by Ministers to have a new Independent Patient Safety Investigation Service (IPSIS) established by April 2016.

## Purpose and operation of the group

4. An Expert Advisory Group (EAG) will be established to advise the Department of Health and Secretary State for Health on the purpose, role and operation of a new independent investigation function for healthcare. The Group will be relied upon to make use of its expertise in patient experience, safety, healthcare and investigation, to draw on the views and the available evidence from a broad range of stakeholders (including service users and staff) and to reach independent conclusions on how IPSIS should function. Evidence will be gathered through existing evidence as well as a 'call for evidence' and views for each meeting.

5. Its key objective is to deliver independent recommendations as to how IPSIS should operate, taking into account:

    - The IPSIS vision – creating a system which instils confidence and drives improvement in safety;
    - The key principles of operation – objectivity, transparency, independence, expertise and learning for improvement;
    - The views of a broad, inclusive and diverse range of stakeholders as well as available evidence;
    - The system which it will work within;
    - Available resources.

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[1] *Learning Not Blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation* July 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445640/Learning_not_blaming_acc.pdf

6. Its proposed method of operation is to meet every two weeks, with work being progressed between meetings. Each meeting will be based around a theme for which the Secretariat will provide evidence in advance as well as invite speakers to give their views.

7. The Expert Advisory Group will regularly meet and hear evidence throughout July, August and September 2015. At around this point the way in which the Group functions – and how it hears and brings in evidence - will be reviewed.

8. The Secretariat will work to ensure that there are different opportunities for a range of interests and individuals to contribute to the work of the Expert Advisory Group such as:

    - A web presence for key information about the Expert Advisory Group and minutes of its meetings;
    - A digital system which could host the 'call for evidence' for each meeting and collect the information it generates;
    - Open forum, small group and round table events to gather specific views or perspectives; and
    - Social media to reach other individuals and groups.

**Core membership**

9. The members of the Expert Advisory Group are:

- Julian Brookes, Deputy Chief Operating Officer, PHE, and member of the Morecambe Bay Investigation team.

- Alison Cameron, Chair, Patient Safety Champion Network, Imperial College Health Partners

- Fiona Carey, Co-chair of the East of England Citizen Senate

- Deborah Coles, Co-Director INQUEST

- Keith Conradi, Chief Inspector of the Air Accidents Investigations Branch (with David Miller, Deputy Chief Inspector of Air Accidents deputising).

- Mike Durkin, National Director for Patient Safety and Chair.

- Dr Sunil Gupta, GP and Clinical Lead for Quality and on the Governing Body of Castle Point and Rochford CCG.

- Dr Bill Kirkup CBE, Chairman of the Morecambe Bay Investigation.

- Kate Lampard, CBE, former barrister and NHS strategic health authority chairman who provided oversight on the NHS's Savile investigations.

- Dr Carl Macrae, Senior Research Fellow, University of Oxford

- Prof Martin Marshall CBE, Professor of Healthcare Improvement at UCL.

- Prof Jonathan Montgomery, Professor of Healthcare Law at UCL and member of the Morecambe Bay Investigation team.

- Scott Morrish
- Will Powell, NHS Advisor for Mistreatment.com
- Dame Eileen Sills, Chief Nurse and D irector of Patient Experience, Guy's and S t Thomas's NHS Foundation Trust
- James Titcombe OBE, CQC National Advisor on Patient Safety, Culture & Quality.
- Dr Nick Toff, Director for Clinical Quality, Cambridge University Hospitals NHS Foundation Trust

Other attendees:

- Matthew Fogarty
- Donna Forsyth
- Jennifer Benjamin

Secretariat team

- Suzy Powell
- Sheila Evans
- Karen Jones

10. The membership will be reviewed on an ongoing basis to ensure it maintains a broad representation of individuals and interests. Other people may be co-opted or invited to contribute to ensure both appropriate representation and that the relevant expertise and advice is available