Health Services Safety Investigations Body

Annual Report and Accounts 2024/25

HC 1041

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Performance Report

Performance Overview

This section describes the role and remit of the Health Services Safety Investigations Body (HSSIB). It explains what we do, highlights our priorities and sets out our achievements and performance progress in the last year (1 April 2024 to 31 March 2025).

Chair's Foreword

Dr Ted Baker, Chair

This year has been pivotal for the Health Services Safety Investigations Body (HSSIB). We have firmly established ourselves, with strong processes and governance in place to support our vital investigation and education work. We also finalised and published our strategy, a major milestone in our development. Our strategy provides an essential framework that guides our work today and shapes our ambitions for the future. It outlines our key priorities, underpinned by five strategic themes, which offer a strong foundation for decision-making. These themes also enable us to measure our progress consistently, assess impact, and ensure that our efforts remain aligned with our goals

As we continue into HSSIB's second year, we are having a visible impact on patient safety as you will find highlighted throughout this report – there are many case studies and excerpts which clearly show the strides we have made. Our influence and stature as an independent body has grown and our voice on patient safety issues is strong and respected. We hear this in feedback we receive from those working across the complete landscape of healthcare – at a national policy level, from staff at the frontlines of care and from international contacts working to confront safety issues at a global level.

A changing landscape

The complexity of modern healthcare and the increasing pressure on services means that we must remain relentlessly proactive. The work we do in HSSIB demonstrates that safe care does not just happen by chance – it is built intentionally with systems that support collaboration, innovation and a commitment to learning from harm.

This is a time of major reform within healthcare and now that the 10 Year Plan and the Dash Review into patient safety have been published, we have some clarity on the future vision for healthcare in England.

As set out by the Dash review, it is planned that HSSIB will become a discrete entity within the Care Quality Commission (CQC). As this announcement has recently been made, this is still at very early stages. In this time of

transformation, our expertise will still be critical to ensure that patient safety is not drowned out by the noise. We also remain committed to ensuring that all can speak to us openly, within a safe environment, free from the fear of recrimination or blame. Lessons from past investigations should inform future design of policy and delivery of services. We will continue to work constructively with all system leaders to ensure that reform leads to safer, and therefore more efficient and more effective care.

A proactive stance on safety management

Since the publication of the first report on Safety Management Systems in October 2023, we have continued to champion changes in the way safety is managed in healthcare. Other safety critical industries have paved the way and provide principles and learning that should be adopted and adapted for healthcare. There is growing interest in the better management of safety in healthcare, and our education team support the training requirements for the approach taken by the Patient Safety Incident Response Framework (PSIRF). However, we still are not close to other industries in relation to how they manage, plan, and mitigate safety risks. Crucially, they have built a culture around safety that provides a clear framework for accountability without attributing blame. Our second report on the management of safety, published this year, was important in highlighting the lack of co-ordination and accountability when examining the safety activities of integrated care systems.

Through our work and analysis of safety management, we have found that effective safety investigation bodies in other industries issue a small number of high-impact recommendations, which are then implemented and embedded by national regulatory bodies. This is the standard we must achieve in healthcare. We recently published a report about this issue on behalf of a wider group of organisations. It contains several significant findings. The report has already been recognised as key evidence in external meetings and inquiries as was cited in the high-profile Imperial College report on the national state of patient safety. We look forward to sharing further outputs as this work continues.

Ultimately successful management of safety fosters a system wide commitment to prioritise safety. Our existence as an independent, expert body is an essential part of the system and we must consistently reinforce this message. Too often, experience shows us the tragic consequences when warnings are not heeded, and recommendations not implemented. Our role is not only to investigate but to highlight opportunities to prevent future harm, even – and especially – when doing so is difficult.

Embedding patient and family insight

In our first annual report, we outlined our ongoing commitment to ensuring that patients, families, and carers are meaningfully involved in our investigations. This commitment is embedded within our strategic theme of putting people at the centre, but it extends beyond a statement of intent. We consistently demonstrate this approach through our investigative work and our openness to public

and patient consultation, and drive to create a dedicated public and patient involvement plan. Our focus remains on inclusivity, particularly in reaching and elevating the voices of those communities and groups who are often underrepresented in healthcare conversations.

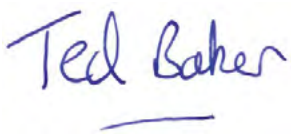
Patients and families are not just witnesses to healthcare harm, they are vital partners in understanding what went wrong and how we can improve. Their voices offer perspectives that no report or dataset alone can provide – as shown in the powerful narratives provided in our set of mental health inpatient investigations. Those affected by incidents must be heard and respected and their insight must remain central to the process of investigations and learning within any area of healthcare.

Looking ahead

Our role in improving patient safety remains crucial and will evolve as the health system reforms – our work must not only continue but grow in ambition and impact. To prevent harm before it occurs, consistent and effective management of safety must become a priority. Effective safety management will reduce patient harm and improve the working lives of staff. It is an enabler for much of the reform that the NHS is seeking to achieve. The health system's ambitions to innovate and improve productivity cannot be achieved without it.

Being an independent voice gives us a unique platform to speak with clarity and purpose, and we intend to use it constructively to support change that benefits patients, families, and NHS staff alike. Our investigations will continue to shine a light on risks and gaps in healthcare delivery, but our findings and recommendations must be translated into meaningful action.

The path ahead is not without challenge, but we remain confident and optimistic. By learning from the past and engaging actively in the present, we can help shape a safer, more responsive healthcare system for the future. I want to thank HSSIB colleagues, fellow members of the Board, our stakeholders and the patients, families and staff that contribute to our investigations, sharing powerful experiences that providing vital evidence. Everyone working at HSSIB or with us are the driving force behind our achievements so far and our future progress.



Dr Ted Baker
Chair

Chief Executive's Perspective

Dr Rosie Benneyworth, Interim Chief Executive

A year of learning and impact

I feel immensely proud of what we've achieved in the last year. Across HSSIB, we have continued to demonstrate the power of listening, learning and acting with integrity to drive meaningful change in healthcare. Through our investigations, education programmes and steadfast commitment to patient safety, we've had a direct and lasting impact on the lives of patients across England and beyond.

What stands out most to me is the way our teams – whether conducting detailed investigations, supporting patients and families or delivering crucial support services – have worked with such professionalism, compassion and dedication. We haven't shied away from challenging conversations or complex issues because we recognise that each insight and lesson will contribute to ongoing efforts to improve patient safety.

We were pleased to publish both our strategy and revised investigation criteria at the end of 2024. These were shaped through public and stakeholder consultation – an essential step that reflects our commitment to learning and to ensuring our work is grounded in the realities of the health and care system. Our investigations do not operate in isolation; they are informed by the lived experiences of patients, families and staff, and are sensitive to the pressures faced by those delivering frontline care, shaping policy, allocating resources and navigating NHS reform.

The five key themes set out in our strategy now offer a clear and purposeful framework for our work. They not only guide our objectives but keep our core vision and mission front and centre – supporting the delivery of high-quality, independent investigations and the continued development of professional education in patient safety.

The cost of unsafe care and our call to action

In our work we meet many patients and families whose lives have been deeply affected by avoidable harm in healthcare. Time and time again, we see the same types of safety incidents recurring across all sectors – clear evidence of systemic issues that remain unresolved. These failures cause human suffering and carry a financial and operational burden.

According to research by the Organisation for Economic Co-operation and Development, safety failures account for 13% of global healthcare expenditure and reduce economic growth by 0.7% annually. And beyond the financials lies the devastating reality: between 10,000 and 12,000 lives are lost each year due to preventable medical errors and safety lapses.

This is a pivotal moment. If we truly want to deliver safer, smarter and more sustainable care, we should treat safety as a reactive concern and start managing it as a strategic priority. HSSIB's investigations play a crucial role in addressing unsafe care by identifying risks and highlighting areas for improvement. We will continue to use our unique statutory remit and system-wide perspective to influence change, working collaboratively with partners across the health and care system to reduce harm and improve safety.

Leadership, innovation and collaboration – the key components of safety improvement

As the challenges facing health services grow – rising demand, workforce pressures and complex care needs – innovation, leading in key areas of change and reducing silo working/increasing collaboration will be crucial to responding to patient safety issues with agility and impact.

In the past year we have continued to take initiative and identify opportunities for innovation in safety science and on issues central to patient safety. While we value our independence and believe this is critical to our ability to improve patient safety in the NHS, we remain committed to collaborating with partners across the health and care landscape.

Over the past year, I have had the privilege of chairing a cross-ALB group focused on addressing a critical and longstanding challenge in healthcare: the overwhelming volume, variable quality, and frequent duplication of recommendations made to the system. Too often, these recommendations are not acted upon, allowing the same safety issues to resurface. This in turn causes preventable harm, straining already limited resources and eroding trust among patients, families, and healthcare professionals. This is not just a health system issue; public confidence is undermined more broadly when important recommendations in any sector go unheeded.

Our report, 'Recommendations but no action', set out the urgent need for change. It confirmed that the current system is unable to absorb and implement the volume of recommendations being made – especially in the face of significant operational pressures. The report presented key findings and practical proposals to enhance the relevance, quality, and impact of future recommendations. Greater visibility of recommendations is essential to identify common themes, co-ordinate change, share best practice, and avoid duplication. We also recognised that we are one of many organisations making recommendations. This year, we have evaluated the impact of actions taken in response to our work and are now developing a dedicated repository of HSSIB safety recommendations to support visibility and collaboration.

Driving meaningful improvement in patient safety requires a broad perspective – one that looks beyond national boundaries and actively seeks out collaboration. While our work within England remains a core focus, our international partnerships are equally vital. Through the International Patient Safety Organisations Network, which we established and continue to chair, we engage regularly with global colleagues to share learning, gain understanding of the common challenges we face and strengthen our collective approach to safety. We have received consistently positive feedback on the influence of HSSIB's work internationally, with our models and approaches being adopted and adapted by partner organisations worldwide. These relationships are helping to shape international thinking on key issues such as systems interoperability and medication safety. As we grow our global connections, we are also building international learning opportunities into our education programme, ensuring our influence continues to expand and support improvements in safety across borders.

We continue to develop and have started to deliver a range of influential projects designed to strengthen impact throughout the investigation pathway, enable rapid responses to urgent patient safety concerns, and contribute to research that keeps safety firmly on the national agenda. At the same time, we have continued to grow our education offer, remaining agile and responsive to learner feedback. This ensures we not only meet the evolving needs of our audiences but also stay at the forefront of safety science and professional development in this space. It has been a privilege to see this work begin to realise many of the ambitions we set out when HSSIB was first established, marking a significant step forward in achieving our long-term vision.

Leading by example – developing a safe, inclusive and compassionate culture

As we advocate for safety-led cultures across the healthcare system, we hold ourselves to the same standard. We are committed to fostering a positive, respectful culture within our own organisation and to creating a supportive, psychologically safe environment during our investigations. Whether working

with patients, families or staff, we aim to lead by example, demonstrating the behaviours, values, and integrity we believe are essential to improving safety across the system.

We have established a clear set of internal values and a supporting values statement to guide how we work together, fostering effective collaboration, open communication and a shared sense of purpose. We recognise that diverse perspectives and individual strengths are essential to achieving our vision. Our commitment to employee wellbeing, equality, diversity and inclusion is at the heart of our organisational culture. We want every member of staff to feel safe, respected, and able to bring their whole selves to work. When colleagues have chosen to share personal experiences, we've welcomed and celebrated their openness. These moments have not only strengthened our connections but enriched our shared experience. What continues to inspire me is the compassion, courage and generosity shown across our teams, whether in facing personal challenges, sharing reflections on culture and religion or going to extraordinary lengths to support causes that matter deeply to them. For us, diversity and compassion are not abstract principles; they are lived values that shape our organisation every day.

In our investigations, we are also committed to engaging with compassion and recognising the complexity involved when discussing distressing events. We have adopted a trauma-informed approach, which has been embedded throughout our work. Our recent mental health investigation reports are a powerful example, demonstrating how acknowledging trauma can help uncover vital insights and ensure that the voices of patients and their loved ones are respectfully reflected in our findings.

Beyond creating a safe and sensitive environment, we recognise that those directly affected by safety incidents play a critical role in shaping patient safety improvement. Their experiences are central to our findings and safety recommendations, and we are taking further steps to ensure this influence begins at the earliest stages of our work. We have started to develop a patient engagement strategy that underpins our safety investigations, ensuring both patient experiences of safety and their perspectives on engagement are central to HSSIB's work. A key part of our strategy is examining health inequalities and identifying how our investigations can contribute to reducing them. In shaping our future investigation priorities, we have engaged with patients from a wide range of backgrounds across England. We have prioritised hearing from those experiencing health inequalities – particularly individuals from marginalised communities and areas of high deprivation – so their voices are not only heard but acted upon.

Positioning HSSIB for the future

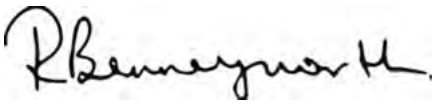
With the publication of the 10 Year Plan and the Dash Review, we see both significant opportunities and critical risks ahead. Remaining at the heart of our mission is the push for a system-wide, proactive approach to safety – one that learns from proven safety management systems (SMSs) used in other safety-

critical industries. We will continue to advocate for this, through the coming years and into our future transition in the CQC. This approach offers a powerful lever for reform and should be central to the strategic redesign of health and care services set out in the 10 Year Plan.

Alongside these challenges lie practical opportunities to support local safety efforts. Many provider organisations and integrated care boards generate meaningful learning but struggle to implement change because of limited capacity. Investing in implementation science and human factors expertise could empower frontline teams to translate learning into lasting improvement. HSSIB is also driving innovation by exploring artificial intelligence, data analytics and intelligent safety tools to advance how risks are understood and addressed.

We have an opportunity to rethink how safety is managed in healthcare. The adoption of SMSs, greater support for local investigation and learning, and stronger collaboration across sectors, including social care, offer us new and promising paths forward. HSSIB is well positioned to contribute to this transformation over the coming year, drawing on evidence-based practice, a commitment to patient-centred care, and a focus on continuous improvement through innovation.

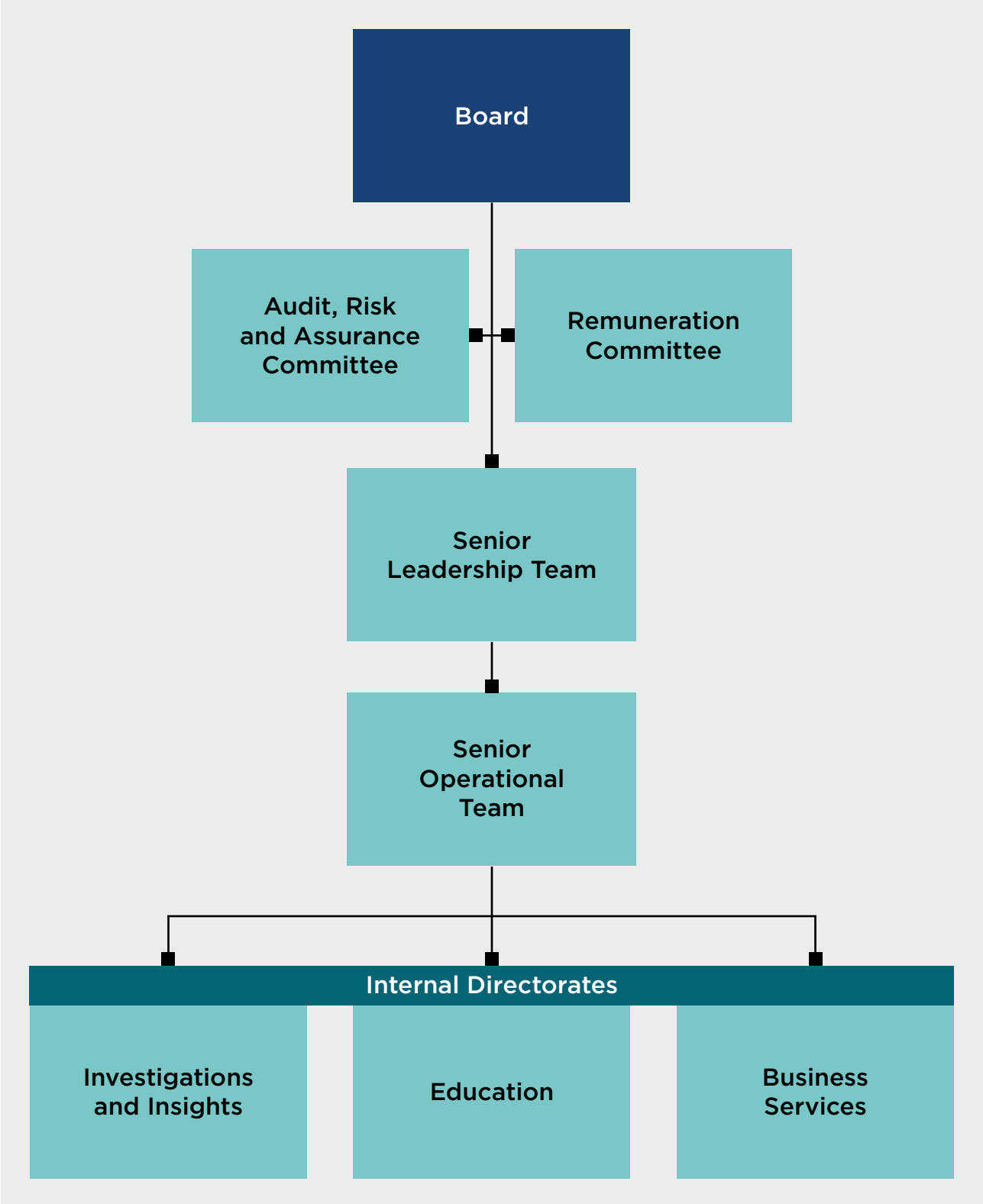
Looking ahead, we remain committed to working alongside patients, families, professionals and partners to create a health and care system where safety stands robustly alongside other top priorities. We will continue to be a strong and inclusive voice for patient safety, and we thank every member of our team and every person who has given their time and perspectives to help shape our journey this year.



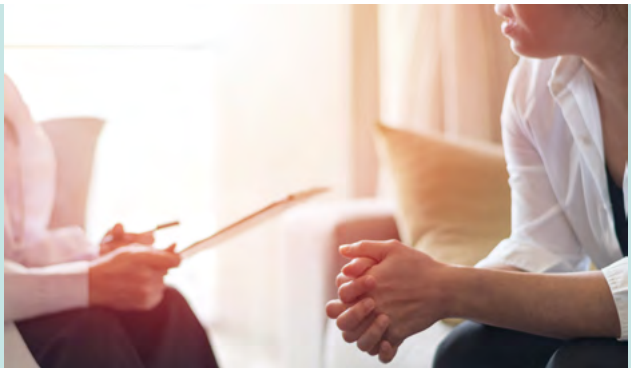
Dr Rosie Benneyworth
Interim Chief Executive

Who we are and what we do

Our structure



Independent safety investigations



We investigate patient safety concerns across the NHS in England and in independent healthcare settings where safety learning could also help to improve NHS care.

Our investigations aim to reduce patient harm by:

- identifying risks to the safety of patients
- supporting the involvement of patients, families and carers in healthcare
- supporting healthcare staff to carry out their roles and care for patients safely
- creating safer healthcare environments and processes
- making healthcare services more efficient
- sharing best practice and innovations in patient care
- addressing risks by facilitating improvement of systems and practices in NHS services or other healthcare services in England.

Our role is to understand why patients may have been harmed or be at risk of harm. Our investigations take a system perspective and aim to reduce the likelihood of patient safety incidents from happening. We share learning and support patient safety improvements across the whole healthcare system in England.

We complete multiple investigations each year. They are carried out by a team of skilled investigators and analysts. Our Investigation and Insights Team bring experience in systems-based safety investigations from safety-critical industries such as aviation, rail, and defence. We have a diverse professional background in healthcare, engineering, psychology, law and human factors. Human factors is a scientific discipline that seeks to understand the interactions between humans and the elements of systems in which they provide or receive care/service. This knowledge is used to optimise system design for human wellbeing and overall performance.

We share learning in our investigation reports and make safety recommendations, safety observations and suggest local learning across the healthcare system.

Education programme

We deliver education programmes across healthcare in England. The programme is part of our strategic aim to professionalise the role of the patient safety investigator. It supports investigators to undertake system-focused investigations and make recommendations at a local level.

The curriculum combines safety science evidence with cutting-edge, practice-based learning and knowledge. Our programme of nine courses covers all three required training elements of the Patient Safety Incident Response Framework (PSIRF) and further builds on the professional development of patient safety investigators. All courses are accredited for continuing professional development and our flagship on-demand programme, A Systems Approach to Investigating and Learning from Patient Safety Incidents, is dual accredited as it is also recognised by the Chartered Institute of Ergonomics and Human Factors as a short course.

We have an expert faculty team to deliver our innovative programme. Its members come from multiple disciplines including human factors and systems thinking, family engagement and occupational psychology. Their backgrounds include other safety-critical industries, healthcare, education and public services.

Performance summary

Over the last 12 months, we have made significant progress towards our aims and vision for the organisation. Below is a summary of our performance from April 2024 to March 2025. Further detail on our performance relating to investigations, education, governance, risk, strategy, our people and finance can be found in the 'Performance analysis', and 'Accountability report' sections.

Last year's annual report covered six months from October 2023 – March 2024, and measured performance against interim Key Performance Indicators (KPI's). Whilst we develop a full business plan and KPI's, the performance analysis is provided within the context of our five strategic themes and demonstrates our expertise and impact across our Investigation and Insights, Education and Business Services teams. As we were keen to avoid trying to measure different timeframes and metrics, we have focused on aligning our work closely within the themes, rather than providing a comparison.

We highlight the progress we have made over the last year, and the systems and processes we have put in place to deliver high-quality core work. Our performance is detailed under each theme but highlights in each area are summarised below.

Strategic theme 1: Deliver high-quality, impactful independent safety investigations

- In the past year, our investigations have covered a range of patient safety concerns, including mental health, medication safety, care co-ordination, workforce, digital tools and technology, education and training, use of healthcare equipment and prison healthcare.
- We sought feedback for our investigation criteria via public and stakeholder consultation and implemented changes as a result. This demonstrates our commitment to ensuring our processes are fit for purpose.
- We continue to address health inequalities and have embedded processes to ensure they are considered throughout our investigations.
- Collaboration with experts, safety leaders, national policymakers and other stakeholders remains central to our work. We balance that collaboration with our independence so that safety recommendations are impactful, delivering tangible change for patients, families and staff working across healthcare.

Impact spotlight: Shining a light on the biggest issues facing mental health inpatient care

In 2023, the Secretary of State of Health and Social Care directed HSSIB to undertake investigations into mental health inpatient care. From October 2024 to January 2025, we published the outputs of the investigations, sharing crucial insights, identifying gaps in care and making safety recommendations for improvements in a number of areas. The four investigations covered the importance of therapeutic care, the harm caused by out of area placements, safety risks in the transition from child and adolescent mental health services to adult mental health services and learning from deaths.

During the investigations our teams visited over 40 mental health care areas spanning 30 mental health care providers. They spoke with and met over 100 patients, families and carers, as well as staff working in mental health services. They also engaged with stakeholders, expert advisors, and other organisations including mental health charities. This gave a full picture of mental health inpatient care and people's experiences across the country.

Each investigation had individual findings, but areas emerged that were common across mental health inpatient care.

- Patients, families and carers often felt their voices were not heard and they were not involved in crucial decision making about the care of themselves or their loved ones.
- Patients are regularly cared for in environments that do not meet their needs and are not therapeutic – such environments are crucial for recovery but providers told us that they are limited in their ability to provide them because of workforce and funding pressures.
- Collaboration between services is an ongoing issue. This is not just limited to mental health care but spans social care, local authorities and education, and leads to competing priorities and friction.

All our reports called for urgent system-wide action to ensure safe and effective mental health care for all. We issued 17 safety recommendations across the four reports directed at national bodies, alongside key observations and local learning to drive improvement at every level of care. The findings highlight critical areas for reform and are intended to support ongoing NHS transformation. We have issued a clear call to action for those receiving the safety recommendations to implement lasting change, turning insight into tangible improvements for patient safety across mental health services.

Strategic theme 2: Place people at the core of our work

- We continue to embed the perspective and voice of patients, families, carers and healthcare staff within our investigations as their experiences are crucial in driving patient safety improvement. The four mental health investigations gathered valuable insights from patients and their families which fed into eventual key findings and safety recommendations.
- We implemented a robust safeguarding process, recognising that we interact and speak to many vulnerable people who may need additional assistance and signposting to other services.
- We launched a landmark project focused on identifying and prioritising issues for investigation. As part of this we have partnered with the Patients Association to gain insight from the public on the safety issues and concerns important to them. The aim of this work is to develop a patient engagement strategy to underpin our investigation work.
- We continued to publish investigations focused on staff wellbeing and its impact on patient safety. We share that learning for the benefit of all staff, from those working on the frontlines to those determining policy changes in national organisations. We do not shy away from difficult topics, as demonstrated by the publication of a short report into sexual safety, which highlighted key issues and prompted important conversations.

> "It felt like a positive experience – my feedback was listened to and taken seriously, and it meant the report was accurately able to reflect trans people's experiences rather than playing into misconceptions."
>
> Feedback from a patient involved in our 'Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults' investigation

Strategic theme 3: Be a strong, inclusive, voice for patient safety across healthcare

- Our Chief Executive chaired a cross-ALB working group focused on examining the quality and volume of recommendations being made into the healthcare system. The report published as a result of this work has been recognised as key piece of evidence to drive improvement.
- We work to spread our key messages on patient safety investigations in several ways. Our senior team, investigators and educators present at events, meetings and conferences across the country. We contribute to research papers and journals and work collaboratively with academic institutions. Our teams also appear on podcasts and in the media, and contribute to blogs, podcasts, newsletters and magazines.
- We have submitted evidence to high-profile health inquiries and consultations on health service plans to ensure we feed into the wider strategic direction and vision for the NHS.
- We continue to innovate in the field of investigation practice and safety science and make sure any resources and information we develop are available to the wider community.

Strategic theme 4: Promote and professionalise healthcare investigations

- There continues to be strong engagement with our education programmes from those working in healthcare. We have implemented a fee-funded programme to allow us to offer as many funded places as possible to the NHS.
- Our course offering continues to expand, and the Education Team looks for new ways to collaborate and exchange knowledge. As people gain more skills in professional safety investigations, we have started to deliver more specialist sessions/courses for more experienced learners.
- We have started to explore the possibility of offering student placements, to embed learning on professional safety investigations at different levels. As part of a successful pilot of the programme, we welcomed a master's student from the University of Reading to help with vital research.
- The international connections we have fostered provide an extensive network, allowing us to share safety intelligence, concerns and priorities at a global level, benefiting both our investigation work and education programme.

Feedback from our learners

"I attended the two-day SEIPs in action course with HSSIB and was pleasantly surprised with how in-depth the course was surrounding thematic analysis in practice …"

"It has given me a useful background and insight to human factors, safety science and the organisation's approach to investigations which will be invaluable in my new role."

"It was an excellent course, one of the best I have attended!"

Strategic theme 5: Embed a compassionate, inclusive culture across our organisation

- Building on last year's work, we now have a strong governance framework in place with a range of polices and procedures agreed and embedded.
- We agreed a set of values and a values statement, and continue to focus on equality, diversity and inclusion (EDI), through our EDI working group.
- We continue to encourage the learning and development of staff in their individual fields and across the organisation to build understanding of other roles and strengthen collaborative working.
- We have put into place a range of wellbeing measures to support staff, and remain responsive to their needs, with feedback mechanisms available.

Values statement: We make a positive difference through inclusion, integrity and collaboration.

Highlights and Achievements

HSSIB at a glance 1 April 2024 – 31 March 2025

Investigations and Insights:

19
investigation reports published

9
new investigations launched

We have made **310** safety recommendations to **61** organisations

Putting patients and families at the centre of our work: we spoke to over **100** patients and families during our mental health inpatient investigations

Education:

We continue to see strong support for our education programmes

8,686
enrolments on our flagship 'Systems Approach' course

5,741
enrolments on our other 'standalone' courses

Communications and Engagement:

Our website pages have been viewed over **205,529** times – with most interest being in our education course pages, our individual investigation pages and our about us pages

In the time period our website users totalled over **77,960**

We have appeared **1,704** times in media articles and broadcasts, highlighting our growing visibility in a public sphere (this includes references to legacy HSSIB reports)

Performance analysis

This section is a more detailed exploration of HSSIB's performance against our five strategic themes. It also sets out our risk profile, and covers key areas such as equality, diversity and inclusion, financial best practice, and our future performance. It also provides further insight into what we have learned in the past year.

How we monitor performance

Each member of the Executive Team reports on performance in their area at every HSSIB Board meeting. This provides a way of tracking performance on a regular basis and tackling any challenges in a timely way. We are also audited on an annual basis by the Government Internal Audit Agency (GIAA) in the areas of governance, risk, investigations framework and the Data Security and Protection Toolkit. The reports that GIAA provide include recommendations for improvements in our processes and systems and provides an internal audit opinion on our performance. These reports and recommendations are discussed at Senior Leadership Team meetings and at the Audit and Risk Assurance Committee.

Our strategy

Our vision: safe healthcare for everyone.

Our mission: to lead and promote healthcare safety excellence and learning through investigation, education and collaboration.

Strategic theme 1: Deliver high-quality, impactful independent safety investigations

To achieve this we will:

- Be experts in healthcare safety investigations and ensure our safety recommendations make a positive impact across healthcare.
- Partner with experts and safety leaders to ensure our safety recommendations address risks effectively.
- Develop new and innovative ways of investigating to address urgent and emerging risks, with capability for rapid action.
- Strive to address and reduce health inequalities through our investigations.

We continue to demonstrate our expertise in healthcare safety investigations. This year we published 19 investigation reports covering a range of areas of care, from mental health to medication harm (see the full list of report titles at the end of strategic theme 1). Our reports provide strong evidence on what patient safety concerns the healthcare system should be prioritising.

Impact spotlight: Providing evidence for the government's 'family doctor' aim

Our report 'Continuity of care: delayed diagnosis in GP practices', published in October 2023, identified that there was no specific requirement within the current GP contract to ensure GP practices provide continuity of care for their patients. As a result, we made a safety recommendation to the Department of Health and Social Care to enable it to examine how it could embed continuity into the contract.

In December 2024, the government announced proposals to reform the current GP contract, which included plans to bring back the family doctor. The safety recommendation in our report was crucial supporting evidence in developing the ongoing strategy for the family doctor aim, and highlights that the change we recommended is now being prioritised at a national level.

This year we put our investigation criteria out to consultation to ensure we are continuing to capture and investigate the most pertinent safety risks. In April and May 2024, we welcomed feedback from the public and stakeholders and implemented changes because of their feedback.

Table setting out criteria for HSSIB investigations

Criteria	Description	Minor	Moderate	Major
Potential harm to patients and staff	To what extent has the issue contributed to actual or potential harm of patients across the healthcare system?	Would result in a low risk of harm including: • minor reduction in quality of life • minor reversible health condition • minor infringement of a person's rights or welfare	Would result in a risk of harm including: • temporary disability • reversible adverse health condition • moderate infringement of a person's rights or welfare • moderate reduction in quality of life	Would result in a serious risk to any person's life, health or wellbeing including: • death • permanent disability • major reduction in quality of life • significant infringement of a person's rights or welfare
Scale of the healthcare safety issue	How widespread and systemic is the safety issue across the healthcare system?	The safety issue occurs across a limited range of healthcare settings or contexts, for example an isolated issue that affects a single healthcare setting	The safety issue occurs in a moderate range of care settings or contexts, for example a regional issue that affects multiple healthcare settings	The safety issue occurs in a wide range of care settings or contexts nationally
Health inequalities	To what extent is the safety issue associated with known health inequalities?	The safety issue is not obviously associated with significant health inequalities	The safety issue could be associated with health inequalities	The safety issue is strongly associated with health inequalities
Potential to drive improvement	To what extent could an HSSIB investigation drive improvement in relation to the patient safety issue?	A HSSIB investigation would be unlikely to highlight new safety learning or help drive improvement	A HSSIB investigation may support the development of existing safety learning and support existing efforts to improve safety	A HSSIB investigation would likely highlight new safety learning and help drive improvements in patient safety

While our independence is critical to our ability to improve patient safety, we work collaboratively to ensure our safety recommendations are effective and can be implemented in a complex environment. We seek insights from subject matter advisors who can provide a balanced perspective, and work with safety leads and policymakers in a range of national organisations to help us shape safety recommendations.

> "I felt valued and quickly developed a relationship with the team, they made me feel listened to and that my thoughts were important. I felt trusted with reviewing the document at several points during its creation."
>
> **Mental health Chair at a Royal College**

Impact spotlight: Encouraging collaboration and improving communication to tackle unnecessary 999 calls from prisons

In September 2024, we published an investigation examining the emergency response to prisons. The report highlighted that ambulance crews lose significant time diverting to 999 calls in prisons that are cancelled or turn out not to be a serious emergency.

The report made a safety recommendation to the Association of Ambulance Chief Executives (AACE) to work with the HM Prison and Probation Service (HMPPS), that for the first time would lead to a formal communication route allowing prison and ambulance services to 'escalate concerns, review risks and improve systems for emergency care response'. The safety recommendation was aimed at ensuring continuous improvement of the service by reducing the number of calls made and resources diverted.

In their response to the recommendation, AACE and HMPPS have already agreed national and regional contacts and established connections between prison group directors and ambulance operations directors. A partnership agreement is also in place.

This work highlights that HSSIB's investigations play a crucial role in establishing connections between stakeholders – we can highlight the most serious concerns to those with influence at a national level. In this case, formalising communications will lead to patients – in prisons and in the community – having the most efficient, collaborative and safe response.

We have strived to be an example of a learning organisation, and we want to understand the impact our work is having and how we could improve our investigations as a result. Over the last year we have conducted an 'impact evaluation pilot' which assessed the impact of HSSIB safety recommendations. The review sampled 11 investigation reports, considering 49 safety recommendations made across 20 different national bodies. The learning from the impact evaluation pilot is now being embedded into the investigation end-to-end lifecycle.

Risks within healthcare evolve and in recognition of this, we are developing a 'rapid response' protocol. This will allow us to better understand and address urgent and emerging patient safety risks via an accelerated investigation governance and delivery process. The aim is that this capability of rapid action will provide healthcare systems with the opportunity to tackle safety risks proactively and help reduce or prevent patient harm.

Tackling health inequalities

Health inequalities are considered throughout our investigations, from being part of our criteria to launch an investigation to the development of findings and safety recommendations. Particular safety concerns will shine more of a light on inequalities and when they do, we ensure that we acknowledge and address those findings within our reports. Some key examples include:

- In our report on safety management systems (published February 2025), we highlighted that patients and carers are an important source of feedback to integrated care boards about patient safety risks, but this can create inequalities as some people are more able than others to make their voice heard.
- The mental health inpatient settings report that focused on out of area placements (published November 2024) found that patients, families and carers rarely want out of area placements and that their choice and opinions are not considered in decision making.
- Our report on paramedic interpretation of 12-lead electrocardiograms (ECGs) found there was variability in the education and training provided by higher education institutions and ambulance services around patient protected characteristics and health inequalities. The investigation highlights this may impact on the undertaking of ECGs and decisions about patient care.
- In April 2024, we published a blog which detailed an observation visit by the team carrying out the workforce and patient safety investigations. The team went to a primary care network (PCN) in the north of England to observe how a PCN organises its services to meet the needs of disadvantaged people.

"Regions must understand their populations and 'reach in' to support people to ensure equal access to care … Strong patient-centred leadership can move the approach towards proactive healthcare services for communities and help tackle health inequality."

Nichola Crust, Senior Safety Investigator, from a blog post titled 'Tackling inequality: observations from an investigation visit'

Reports published between 1 April 2024 and 31 March 2025

- Retained swabs following invasive procedures: themes identified from a review of NHS serious incident reports (April 2024)
- Nutrition management of acutely unwell patients in acute medical units (April 2024)
- Patients at risk of self-harm: continuous observation (May 2024)
- Keeping children and young people with mental health needs safe: the design of the paediatric ward (May 2024)
- Digital tools for online consultation in general practice (July 2024)
- Healthcare provision in prisons: emergency care response (August 2024)
- Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare (September 2024)
- Workforce and patient safety: temporary staff – integration into healthcare providers (September 2024)
- Creating conditions for learning from deaths and near misses in inpatient and community mental health services: assessment of suicide risk and safety planning (September 2024)
- Sexual safety: the implications for patient safety (October 2024)
- Mental health inpatient settings: creating conditions for the delivery of safe and therapeutic care to adults (October 2024)
- Healthcare provision in prisons: continuity of care (November 2024)
- Mental health inpatient settings: out of area placements (November 2024)
- Medication related harm (December 2024)
- Mental health inpatient settings: supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services (December 2024)
- Mental health inpatient settings: creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge (January 2025)
- Safety management systems: accountability across organisational boundaries (January 2025)
- Medications not given: anticoagulants before and after a procedure (March 2025)
- Pre-hospital interpretation of electrocardiograms (ECG) in ambulance services: 12-lead electrocardiograms (ECGs) in ambulance services: paramedic education, training and competence (March 2025)

Strategic theme 2: Place people at the core of our work

To achieve this we will:

- Ensure the voice and experience of all people affected by a patient safety incident are embedded in all we do.
- Support healthcare systems to create a safe, inclusive and secure environment which listens to and acts on people's concerns.
- Recognise that the wellbeing and safety of the entire healthcare workforce is critical to safe care.
- Champion an inclusive just learning culture with a supportive and safe approach for all those involved in the investigation process.

The involvement of patients, families, carers and healthcare staff in our investigations is crucial – they provide valuable insight into how care is experienced and how it is delivered daily. Patient and family voices are vital to improvement because they have experienced safety from a different perspective.

The approaches that we take include:

- Listening to concerns shared with us by patients when we select areas for investigation, to help us focus on the most serious issues.
- Working with patients and families, or representative groups, during our investigations to understand people's experiences of care – this can be in the form of interviews, observational visits or focus groups.

- Sharing our investigation reports for comment and feedback before we publish a final report, to help us check and challenge our findings, safety recommendations and other safety learning.

We recognise that healthcare incidents can cause significant trauma for patients, families and staff. We have adopted a trauma-informed approach to investigations to ensure emotional safety and compassion are embedded throughout the investigative process. We understand how trauma can affect memory, participation and trust, and we train our investigators accordingly. This is so they are able to appreciate the effects of trauma and are less likely to misinterpret trauma-related signs. They can then engage, understanding the nuances and approaching with sensitivity.

For patients and families, we prioritise choice, increasing the control they have in the investigative process, and clear communication to minimise re-traumatisation. For healthcare staff, we create a psychologically safe space that avoids blame and encourages honest reflection. This approach enhances the quality of the evidence we gather, builds trust in our findings, and strengthens learning across the healthcare system. We also support our investigators through reflective practice and peer support, recognising the emotional toll of this work. Ultimately, a trauma-informed approach helps restore trust, protect all participants, and ensure investigations lead to meaningful, lasting improvement in patient safety.

> "The team has always been supportive and kept me fully informed on how the progression of the report was going. The HSSIB team focused on making me comfortable when talking about my experiences and were always willing to take as long as needed as well as explaining each step along the way. They offered compassion and commitment to make my experience amazing."
>
> **Feedback from a patient involved in our report on continuous observation**

The four investigations on mental health inpatient settings are a strong example of how we embed voice and experience. Each report contained sections with powerful narratives from patients, families and carers as well as staff working in mental health care. Their views fed through to eventual findings and safety recommendations. In the report examining learning from deaths in mental health inpatient settings, three key findings related to the experiences of patients and families. Those findings fed into safety recommendations aimed at creating a transparent investigation within a culture of compassion and ensuring clarity on therapeutic relationships to improve patient outcomes.

During the mental health investigations, we gathered insights from a series of focus groups, both in person and virtual. These were facilitated by the mental health charity Mind and were held in multiple locations across England, with a total of 7 focus groups with up to 10 patients, family members or carers in

each one. The collaboration with Mind was very positive, and it supported the publication of the reports, highlighting that we are capturing the most important issues relating to mental health care.

> "This report is an important first step in addressing the crisis in our mental health hospitals. Alongside today's recommendations from HSSIB, NHS England has developed a vision of better inpatient mental health care. Now we need the UK government to take action, delivering the political will and funding to make that vision a reality."
>
> **Dr Sarah Hughes, Chief Executive of Mind, commenting on our mental health report, 'Creating conditions for delivery of safe and therapeutic care to adults'**

We have adapted our approach to ensure all voices are heard. During the investigation into prison healthcare, the team visited prisons across England. However, they identified that it would be a challenge to gain the individual experiences and perspectives of patients who use prison healthcare. To overcome this, we partnered with a specialist patient advocacy group who carried out 120 interviews with prisoners. These interviews covered all aspects of prison healthcare, informing the two investigations published so far and two future investigations.

While we do not provide direct patient care, we do interact with vulnerable individuals, including patients, families and healthcare staff, during investigations and through our patient and public involvement initiatives. At HSSIB we have a Safeguarding Lead and Deputy Safeguarding Lead in place. An Executive Lead for Safeguarding was also appointed. Staff in all three roles have completed appropriate safeguarding training. In March 2024, we developed and approved a safeguarding procedure. This procedure will be reviewed in 2025 with a view to reconsidering role-specific safeguarding training for colleagues across HSSIB. All employees at HSSIB are required to complete Level 2 Safeguarding Adults and Level 2 Safeguarding Children courses as part of their mandatory and statutory training. This is an increased level of required competence from the previous Level 1 requirements. We have a dedicated safeguarding inbox which is publicised on our website and monitored by colleagues with safeguarding responsibilities.

It is crucial that the patient voice is part of investigations as they get underway; however, we have also recognised that it needs to be embedded at an even earlier stage of our work. This year, we started a piece of work known as Project Safety Lens. It is aimed at identifying and prioritising safety issues for investigation. This includes hearing from patients and the public as we identified that their voice needs to be stronger and more diverse at all stages of our investigations. A key part of this work is the partnership we have put in place with a national patient engagement organisation.

Impact spotlight: HSSIB's partnership with the Patients Association to understand experiences of safety

We are partnering with the Patients Association to explore the experiences and views of patients and carers on patient engagement and patient safety, and what areas HSSIB could examine in future. These insights will help HSSIB develop an engagement strategy and plan for patient safety investigations, and contribute towards HSSIB's wider work in determining what patient safety issues it should prioritise in future through our investigation programme.

The Patients Association is one of the oldest health and care charities in the UK. It works with patients directly: they are its members and supporters, and the people who benefit from its support services. Through a series of focus groups, the partnership will invite patients to share their views and experiences of patient engagement and patient safety in the NHS. The patients we have engaged with are from a wide range of backgrounds across England, and we have prioritised engaging with patients experiencing health inequalities, from marginalised communities, and who live in areas of high deprivation, to ensure that these voices are heard.

The overarching aim of the project is to help us develop a patient engagement strategy that underpins its safety investigations, ensuring both patient experiences of safety and their perspectives on engagement are central to HSSIB's work.

Beneath this central aim, the project has the following objectives:

- Facilitate genuine patient and carer involvement in developing a patient engagement strategy that underpins HSSIB's safety investigations.
- Ensure that HSSIB's work is informed by patients' views and experiences of patient engagement and patient safety.
- Give patients the chance to contribute towards the direction of future HSSIB investigations, while being clear that their opinions will be considered alongside a wider stakeholder exercise that will help determine this.
- Help HSSIB better engage patients, particularly those from marginalised backgrounds, those who experience health inequalities, and those living in deprived areas.

Through our investigations we examine the wellbeing and safety of staff, as we recognise this impacts on the safe care of patients. In several reports, we have directly addressed issues relating to staff wellbeing across a number of areas.

In September, we published a comprehensive report detailing the experiences of temporary staff in the NHS. We identified that temporary workers face discrimination because of their work status and sometimes their ethnicity. This in turn creates a barrier to speaking up which may mean they do not share patient safety concerns. Our report made a safety recommendation to the National Guardian's Office aimed at helping all workers contribute to patient safety improvements without fear of reprisal.

> "We will implement HSSIB's safety recommendation … this builds upon our work exploring the barriers to speaking up to improve workplace cultures so that all workers – no matter what their contract terms are – are confident to speak up."
>
> **Dr Jayne Chidgey-Clark, National Guardian for the NHS, responding to our workforce and patient safety report on the day of publication**

Last year we put out a call to healthcare staff to share their experience of fatigue, as part of our investigation looking at fatigue risk in healthcare and its impact on patient safety. This ongoing investigation is considering how any risk can be mitigated by individual staff and healthcare organisations. The team has engaged with staff across different healthcare teams, from executive leadership to clinical staff and trainees working on the frontline of care.

In September 2024, we published a report on sexual safety. We were transparent about the process we undertook to consider the potential of investigating the patient safety risks associated with sexual safety. While we did not take the investigation forward, we shared the findings of our exploratory work to shine a light on the issues, and to encourage organisations to work together to accelerate the pace of change in relation to sexual safety.

In January 2025, we responded publicly to a report from the Association of Ambulance Chief Executives (AACE) on the increase in violence towards ambulance staff. We always aim to be aware of wider wellbeing and safety issues affecting healthcare staff, as these provide context for conversations we have with staff during our investigations.

"When we have spoken to staff during investigations, we have heard just how harmful it is for their wellbeing when they do not feel safe in their working environment … implementing proactive safety measures and talking openly to the public to encourage behaviour change are important steps in reducing occurrences of violence and aggression."

Dr Rosie Benneyworth, Interim Chief Executive of HSSIB, responding to the AACE report on violence against ambulance staff

We aim to be open and transparent as much as possible in all areas of our work. This allows us to share learning through investigation work and fosters trust and collaboration with stakeholders and the wider public. As well as the publication of our investigation reports, we show transparency in a number of ways, for example:

- Our Board meetings are held at host organisations across the country and we encourage our healthcare sector colleagues and the public to attend and observe. For those unable to join in person we now provide access to join online. We ensure that we provide both options of face to face and virtual to ensure accessibility needs are met as much as possible. Ensuring that our meetings are free from jargon and acronyms are clearly explained to members of the public attending.
- We publish on our website redacted versions of responses to Freedom of Information requests, data on any financial transactions above £25,000, Board expenses, and Board papers and minutes. This demonstrates our commitment to ensure transparency and demonstrate integrity to the general public.

Strategic theme 3: Be a strong, inclusive voice for patient safety across healthcare

To achieve this we will:

- Optimise our influence to shape perspectives on safety, ensuring that our safety recommendations make a tangible impact through effective implementation.
- Use the latest developments in safety science to inform our investigation methods.
- Work closely with partners, patients and the public to share insights that advocate for improvements in patient safety.
- Apply and develop pioneering investigation models.

One way we ensure we are a strong and inclusive voice for patient safety is by leading and influencing change at a higher level. A key example is our involvement in a cross-ALB group. The group is chaired by our Chief Executive and focused on improving the quality and effectiveness of safety recommendations made to the healthcare system. We led on the publication of the report 'Recommendations but no action', which highlighted that the volume, quality and duplication of recommendations into the healthcare system is a barrier to implementation. It also pinpointed that failure to implement recommendations impacts public confidence and compounds harm to patients. The report has been recognised as a key piece of work externally. It was submitted as part of the evidence sent to the Thirlwall Inquiry and was further mentioned when our Chief Executive attended a hearing of the Inquiry to give oral evidence.

The Senior Leadership Team, safety investigators and educators attended and presented at a number of regional, national and international meetings, forums and conferences to share insights that advocate for patient safety improvement. These events are also a valuable way to highlight our safety expertise and to gain views and information from different audiences.

We shared vital insight and information with public inquiries and for public consultations. As well as the Thirlwall Inquiry, we submitted evidence to the COVID-19 Inquiry, the NHS 10 Year Plan Consultation, Health and Social Care Committee, a consultation on Duty of Candour and a consultation on the NHS Constitution.

We are also becoming an expert source for journal and media articles that are reporting on patient safety issues or events. Often our reports are referenced in articles long after publication, which indicates recognition of our work as research evidence. Over the past year, several stakeholders have also publicly supported our investigations, sending statements to the media and publishing responses on their websites and social media channels. In our report on medications not given in emergency care, the Royal College of Emergency Medicine (RCEM) provided a quote for our press release.

> "Today's HSSIB report should be essential reading for all emergency clinicians, and RCEM will continue to work to raise awareness of time critical medication to help ensure tragic incidents such as those [the report] details cannot, and do not, happen again."
>
> **Dr Adrian Boyle, President of the Royal College of Emergency Medicine**

Listening to the experiences and concerns of our stakeholders is central to our work. Their insights help us understand which safety issues are having the greatest impact on day-to-day care, and we are committed to being responsive to what they tell us. Stakeholder feedback directly informs our investigation selection process, ensuring we focus on the issues that matter most.

A clear example of this approach is our series of investigations into 'medication not given'. These investigations explore medication safety at a local level, examining the pressures and systemic factors that affect the ability of staff to administer medicines in busy and complex healthcare environments. This enables us to provide NHS trusts with tailored, practical learning and prompts, supporting frontline teams to reflect on and reduce patient safety risks within their own settings.

We use emerging safety science methods to inform our investigations to ensure we are at the cutting edge of patient safety improvements. Importantly, we have contributed to the development of safety science and knowledge sharing. This has included working with partners to develop resources to support staff responsible for responding to safety incidents. Those resources are freely available to download from our website and have been used by trusts across England and colleagues in other countries.

- We developed an **After Action Review (AAR) template** to standardise the reporting of AARs. The structure of the document is purposefully simple so that AARs can focus on reflective conversation and do not become a bureaucratic documentation exercise.
- The **Learning Response Review and Improvement Tool** aims to help staff to write learning response reports following a patient safety incident or complaint. It also aids peer reviewers of written reports to provide constructive feedback and learn from the approach of others.

Impact spotlight: Embedding a proactive approach to safety management

From HSSIB's launch in October 2023, we set out to strengthen safety management across the health and care system. Our first report laid out the foundational principles of safety management systems (SMSs), and our second, published in February 2025, built on this by examining how safety is currently co-ordinated and integrated, particularly through the lens of integrated care boards (ICBs).

With their oversight of multiple healthcare providers, ICBs are ideally placed to drive consistent safety practices. However, our findings revealed a significant gap: there is currently no recognisable or unified safety management system operating across the health and care system. This fragmented approach means safety learning is not embedded as deeply in healthcare as it is in other high-risk industries.

To address this, HSSIB continues to produce evidence that we recommend is incorporated into national strategies and planning. We believe that without a structured, system-wide approach to managing safety, the NHS will continue to face recurring issues where known risks are not being adequately controlled. Our investigations underscore the need for SMSs, supported by strong change management processes, to reduce the risk of serious avoidable harm and preventable deaths.

In 2024, we facilitated visits to British Airways and easyJet for senior NHS leaders and government officials, giving them the opportunity to observe mature SMSs in action. These visits demonstrated the value of structured safety management and emphasised the importance of aligning such systems with robust change leadership and clear accountability. We also continue to learn from safety-critical sectors – including aviation, rail, maritime and space (through ongoing engagement with NASA) – to inform how similar approaches could benefit healthcare. This work has already helped influence thinking at national and local levels. It has encouraged cross-sector collaboration and highlighted the importance of proactive, integrated safety management as a core element of NHS improvement. Safety management is not just a standalone initiative – it is a golden thread running through all our investigations and a key part of our strategic focus.

It is important for us to understand and appreciate how technology, specifically artificial intelligence (AI), could be used within healthcare and therefore may be part of future investigations. This year we have taken a proactive approach to growing knowledge and experience and an AI working group has been set up with representatives from across the organisation. It has two specific work streams:

- External: looking at developments in AI, its potential impact on safety, awareness of research and how we support research.
- Internal: examining how HSSIB could use AI while managing information security and developing our understanding of how to investigate patient safety events where AI systems may be a contributing factor.

Strategic theme 4: Promote and professionalise healthcare investigations

To achieve this we will:

- Establish principles for system safety investigations that drive actionable outcomes and measures.
- Develop and deliver a collaborative healthcare safety investigation education programme.
- Define key attributes and competencies for professional healthcare safety investigators.
- Advance healthcare safety investigation as an evidence-based discipline and profession on a global scale.

Engagement with our education programme continues to be strong and its impact is reflected in the positive feedback we receive from our learners. In particular we have seen the ongoing impact from those who explore and

implement the full range of learning opportunities. We encourage all NHS organisations to allow staff to complete their development. The courses are free to the NHS and represent excellent value for the system – the total value of the courses if they had been paid for has been calculated as more than £2m (over the last financial year). Part of monitoring performance is recognising when we need to tackle challenges. A challenge for the education team was a percentage of learners not attending after enrolling in our free courses. We have worked to understand the reasons behind this and have reduced the number of 'no-shows' by 30%.

This year we launched a programme of fee-funded work to build our capacity to offer as many funded places as possible to the NHS. This programme has led to increased awareness of our education offering, not just in England but across the world. We have had interest from Northern Ireland, Norway, the USA, Australia and New Zealand.

> "Working within patient safety as a Patient Safety Incident Investigator has allowed me to directly apply the skills and knowledge gained through the HSSIB education programme … the key attraction of the learning programmes delivered by HSSIB is the ability to learn from subject matter experts who freely disclose they are also on a journey in relation to applying safety science methodologies within healthcare settings."
>
> **Patient safety investigator at an acute NHS foundation trust**

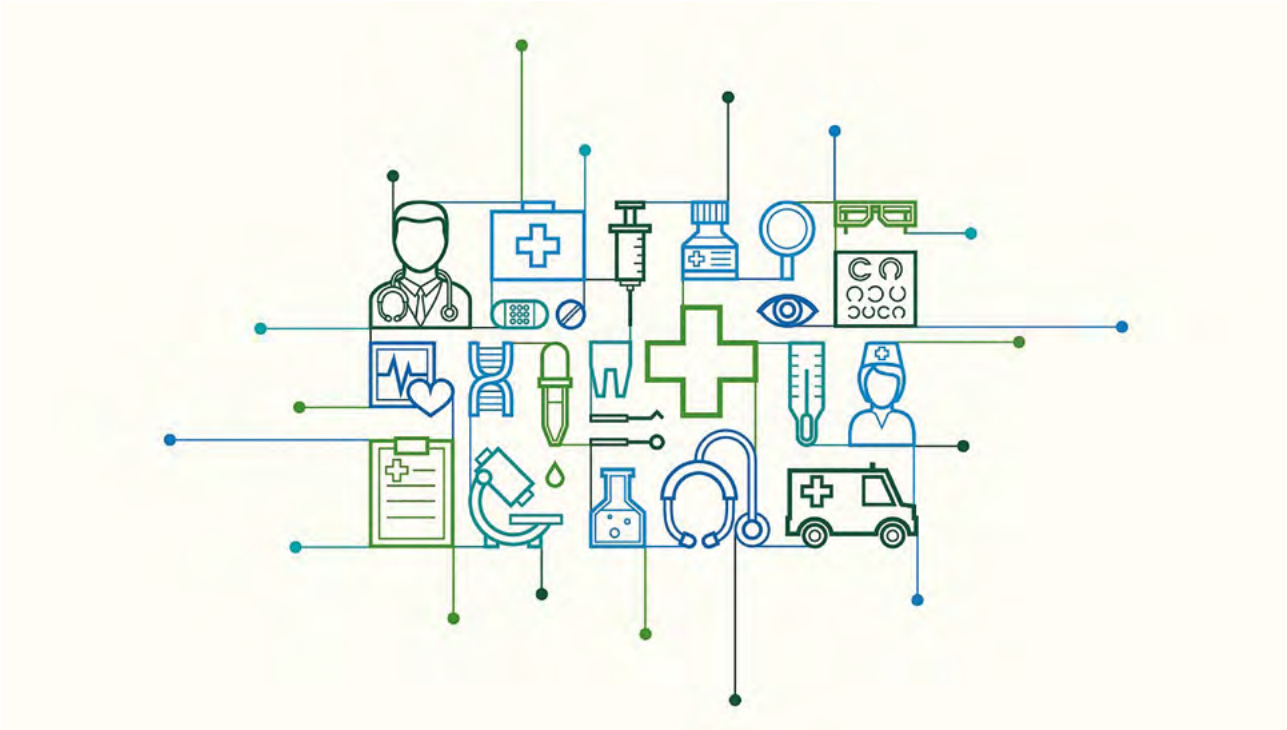
The Education Team continues to collaborate across the patient safety landscape. A key activity has been supporting the delivery of Patient Safety Specialist training which is part of the National Patient Safety Syllabus. The work has been led by Loughborough University with our education faculty developing and delivering two of the five modules, alongside colleagues from NHS England. This is a hybrid model with online training supported by in-person days delivered across the country. The work has provided an opportunity to hear from those delivering patient safety at the frontline and gain deeper understanding of their challenges and their successes.

> "For the past 18 months we have been collaborating with HSSIB to create, develop and deliver the learning package for NHS England which delivers a comprehensive learning project for Patient Safety Specialists across England … [HSSIB's] contribution has been invaluable to achieve the outstanding success of the project. The feedback from online and in-person learning has been incredibly positive and we look forward to continued collaboration in the future."
>
> **Mike Fray, Senior Lecturer in Human Factors Design, Loughborough University**

In January 2025, we launched an internal human factors and ergonomics (HFE) forum to help co-ordinate HSSIB internal HFE mentoring and learning opportunities for staff. This allows HSSIB staff seeking to learn more, or who wish to become a member of the Chartered Institute of Ergonomics and Human Factors, to receive mentorship, support and further information from existing HSSIB chartered members.

The education programme is expanding with the development of new specialist courses. This includes SEIPS in Action, a course which aims to develop safety investigators knowledge and expertise in SEIPS (the Systems Engineering Initiative for Patient Safety). This is a framework for understanding and improving patient safety. The course combines coursework, an intensive two-day workshop, and extended mentoring to support real-world application. Another course, Demystifying Artificial Intelligence in Healthcare, has also been piloted. It aims to provide insights into the current state and future practices within this rapidly evolving area. Our expansion has also been reflected in how we develop new ways of sharing knowledge. We have begun to implement a programme of webinars focused on more experienced learners. The first webinar focused on the increasing use of After Action Reviews (AARs) to learn from and respond to patient safety incidents. The aim of the session was to meet the need to share and learn from the growing community of AAR facilitators and was attended by over 600 learners.

We have also begun to host student placements, providing opportunities for individuals to collaborate on focused projects. A key piece of research is to identify key competencies for safety investigators and recently our first student joined us to complete an e-Delphi study on this topic. The Delphi method uses multiple rounds of questionnaires to gather and aggregate expert opinions on a specific issue.



Education spotlight: My experience as a research student with HSSIB

We hear from Omotoyosi Akanbi, postgraduate student at the University of Reading, about carrying out a student placement with us. This is part of a pilot for HSSIB, with a view to hosting more students in the future.

"For my postgraduate thesis at the University of Reading, I conducted an e-Delphi study as part of HSSIB's project to develop consensus-based competencies for healthcare safety investigators in England. Guided by my project supervisor and co-supervisor at HSSIB, I gathered healthcare safety investigation experts' opinions on a proposed set of competencies. Through structured feedback from experts across England, the study achieved consensus on four key competency domains for healthcare safety investigators: personal qualities; investigation knowledge and skills application; effective and compassionate engagement; and managing investigation lifecycles.

"As a research student working with HSSIB was an invaluable experience, allowing me to contribute to a pioneering project on establishing core competencies for healthcare safety investigators. I had a great chance to enhance my research skills, particularly in the e-Delphi methodology, data collection and analysis.

"Engaging with experienced investigators through collected qualitative feedback provided key insights into healthcare safety investigation practices and its challenges in real life. Additionally, I benefited from exceptional mentoring by experienced researchers and investigation science educators, further enriching my learning and professional growth.

"My remarkable experience working with HSSIB sufficiently piqued my interest in patient safety, and I currently look forward to pursing a doctorate degree exploring the influence of Incident Investigations on healthcare organisations' learning. I believe future research students to HSSIB will benefit greatly from the wealth of experience and expertise being offered by the organisation and its team members."

We continue to share patient safety intelligence and key themes with global counterparts through our International Patient Safety Organisations Network (IPSON) which has representation from 17 countries. The work within this forum demonstrates there are common themes across the world and provides valuable support in approaching patient safety challenges. Some members of IPSON have contributed to a series of blogs (hosted on the HSSIB website) describing the influence of our work on their development.

"HSSIB has significantly influenced Finland's approach at the beginning of its national safety investigation journey – and I might dare to state that in the other countries as well – to social and healthcare safety investigation. By sharing its expertise on the structure and processes of independent investigations, HSSIB has helped all the client and patient safety community to refine its methods to investigate serious incidents reliably and effectively."

Hanna Tiirinki, Chief Safety Investigator (Health and Social Care), Safety Investigation Authority, Finland

We have also signed a Memorandum of Understanding to become the ninth member of the NHS Consortium for Global Health, contributing to the development of relationships and knowledge sharing with health systems across the world. There is a particular focus on South Africa as it becomes the first African nation to have presidency of the G20 in 2025.

Strategic theme 5: Embed a compassionate, inclusive culture across our organisation

To achieve this, we will:

- Ensure effective leadership through strong governance and policies across all teams, promoting and reinforcing our strategic aims.
- Be sustainable, environmentally and operationally.
- Support team wellbeing through listening and reflection and opportunities for development and peer support.
- Create a workplace culture which is inclusive, respectful, and collaborative for all.

The Governance Team has further built on last year's work to develop a strong governance framework for the organisation, which is now in place, with a range of policies and procedures agreed and approved by the relevant forum. This could be the Board, Audit and Risk Assurance Committee (ARAC), Senior Leadership Team (SLT) or Senior Operational Team (SOT). To foster positive collaboration and cross working, the SOT was set up in November 2024. It brings together members of the senior team and provides a good opportunity for each directorate to understand more about work going on in other areas, ensuring that decisions are not made in isolation and that communication is effective among teams. For oversight, the SOT reports to the SLT via a 'highlights' assurance report.

All policies which go to the Board, ARAC, SLT and SOT specify a director to be a sponsor for each policy. This provides assurance before the policy is tabled at the relevant forum. The Governance Team holds a central Policy Register which provides a robust governance process for maintaining oversight of the policy work at HSSIB. The Policy Register includes the following details:

- all approved policies
- all policies in development (with owners and 'due by' dates)
- names of the policy owners
- the dates the policies were approved
- the dates when the policies were communicated to staff
- policy renewal dates.

Since April 2024, we have approved and finalised eight key policies, including the Business Continuity Plan, the Disclosure of Protected Materials Policy, the Raising a Matter of Concern Policy and the Learning and Development Policy.

Following transition from Healthcare Safety Investigations Branch (HSIB) to HSSIB in October 2023 extensive work has been underway to develop our team wellbeing and staff engagement offer for all our employees. During this period the following policies and guidance have been revised, developed and updated to comply with legislation and to support our staff to undertake their roles:

- Managing Sickness Absence Policy
- Flexible Working Policy
- Raising a Matter of Concern Policy
- Health and Safety Policy
- Learning and Development Policy
- Travel and Subsistence Policy
- Volunteering Guidance.

All the revised policies and procedures aim to ensure transparency, consistency and provide policies that are fit for purpose. We will continue to revise policies and procedures to ensure compliance with legislation and staff needs. We are developing line manager training to support policy development and ensure effective leadership. We have developed and revised the Travel and Subsistence Policy to encourage and incentivise sustainable travel to reduce our carbon footprint, for example enhanced bicycle rates, car sharing and reducing unnecessary travel. We ran a series of four webinars to support mental and physical health and wellbeing, and to increase awareness around neurodiversity.

In the past year, we have focused on learning and development to give our staff opportunities for professional and personal growth. Our Learning and Development Policy and Procedure was approved and embedded, with the aim

of providing fairness and transparency for all staff when it comes to requesting learning or development. Staff can request study leave, request to attend learning and development activities and request funding for education purposes. Line managers are empowered to approve requests and be responsive to the needs of their team. We have put these processes in place as we recognise that individual development is crucial to creating a skilled, dynamic and innovative workforce.

We encourage staff to share their learning when they return from courses or events, and we also create opportunities for learning across teams. It is important that our teams know what other roles and workloads entail, to build compassion and understanding across teams but also to foster collaboration and ensure work and projects have the right skill mix. Staff can access our education programme to strengthen their knowledge on patient safety investigations and safety science.

We have upgraded the employee assistance programme to offer additional wellbeing support for employees including up to 10 counselling sessions and one-to-one financial coaching sessions for all staff. We set up a new Employee Advocate Service with four volunteers being available for confidential support and guidance around speaking up or raising a concern, or to provide a sounding board and signposting to other sources of advice or services. We also set up new anonymous reporting mechanisms for any employees to make suggestions and ideas for improvements, raise a concern, or provide feedback through a secure and safe portal.

We held an HSSIB all-team away day in October 2024, with a focus on equality, diversity and inclusion (EDI), and HSSIB values. This session was run by an external facilitator. The EDI Working Group then developed a set of values and a values statement following staff engagement. The final values statement – We make a positive difference through inclusion, integrity and collaboration – and the set of values for HSSIB were agreed in December 2024. The values and values statement will be embedded into all that we do, including all recruitment and selection processes, appraisals, performance management discussions, and policy development.

Feedback from staff about working at HSSIB

"My role encompasses working with the HSSIB Board, producing governance polices and procedures and leading on information governance and records management … it's a varied workload but that's the best thing about my job, no two days are the same."

"Thinking that I could actually be saving someone's life by doing an investigation and making the right safety recommendations is incredibly motivating and is the reason I love my job."

"What I value most about being part of the HSSIB team is the good work–life balance, opportunity to work flexibly and the consideration paid to employee wellbeing."

What we have learned this year

When our first annual report was completed, we had launched less than a year earlier and were still in the process of establishing ourselves as a new arms-length body. This year, colleagues have reflected on and provided insight into what they have learned, relating to HSSIB's work and patient safety overall.

Resilience and inspiration in the face of change

"This year has been unprecedented on global, national and organisational scales. We live in unsettling times, but I have learned that the NHS and our teams are resilient and thoughtful; welcoming and providing challenge in equal measure."

"I have also learned through our international work that we share the same challenges and passion for improving patient safety across the globe. HSSIB is admired and trusted around the world and our influence continues to expand whilst we also learn from those colleagues. Having a supportive global community has been motivating and inspirational."

Enhancing safety understanding

"During the last 17 months in post, I have learnt a lot about safety science, human factors and safety terminology. In particular I have enjoyed hearing from our international colleagues from IPSON (international patient safety organisations network), who share learning and ideas about patient safety from a global lens."

Getting a solid structure in place

"I have learnt that flexibility and adaptability are essential for anyone in this environment. Whilst we still have much to do, and are still a relatively young organisation, we have achieved so much over the last year in terms of getting processes and policies in place and ensuring the smooth running of our Boards, Committees, and leadership / management meetings. I'm very proud of the team we have in place, and we have faced all our challenges and obstacles with aplomb"

The importance of a safe and supportive approach

Reflecting on the training that investigators undertook in relation to trauma informed approach;

"It enabled us to prepare for some very emotionally difficult conversations with people who have experienced trauma and how to avoid creating any risk of re-traumatising them. Importantly the training helped us to keep people as safe and well as possible and have the skills to support many people in sometimes emotional and challenging situations.

"Feedback from people we spoke to (and their representatives where present was positive), despite the compounded harm many people were feeling. Reflecting on these investigations, reinforces that a supportive and safe approach for all those involved in the investigation process is essential and will protect those already suffering the pain and trauma from unexpected patient safety events."

Evidencing our impact

"Measuring impact is difficult in safety in general; but the narratives and experiences of patients and staff are important evidence of the impact we are making. Safe space is a such a supportive mechanism; since legislation I have seen people/organisations being so much more open with us."

A powerful voice of support

"People across the system continue to feel unheard with regards to safety issues, and the repeated experiences of patients means that there is such an important role for us to speak up on their behalf without any political bias.... People trust us an organisation and our work; we have a way of influencing at the highest levels that no other body has got."

Supporting safety investigation as a profession

"There is a real want and need for this [promoting and professionalising safety investigations.] Organisations want mentored support and this is something we should look at in the future."

The importance of tackling health inequalities

"I learnt speaking to patients, families and charities that there is a deep level of frustration relating to inaccessibility to healthcare and health inequalities are a big issue that we need to keep a spotlight on in our investigations. I found through conversations with staff and organisations there is a strong desire to address this but the do not always have the systemic support needed to make those changes."

Closing the technology gap to enhance patient safety

"The use of technology and the gap between healthcare organisations has been an eye opener this year. Some organisations are looking at how they build on already sophisticated IT systems and how AI might enhance their work; whilst others struggle and still use a mix of paper and electronic methods for recording patient data and treatment. The difficulties this can cause organisations in maintaining continuity of care for patients is a concern. Digital systems and how this impacts safety should continue to be a key area of focus for us."

Financial review

Accounts preparation and overview

Our accounts consist of primary statements which provide summary information and accompanying notes. The primary statements comprise a statement of comprehensive net expenditure, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity.

These accounts have been prepared in accordance with the Government Financial Reporting Manual (FReM) issued by HM Treasury. FReM adapts International Financial Reporting Standards (IFRS) for use in the public sector, ensuring the accounts present a true and fair view of HSSIB's financial performance and position.

In line with the relevant International Accounting Standards and HM Treasury guidance and given that the Department of Health and Social Care (DHSC) has confirmed funding for the next financial year, the financial statements have been prepared on a going concern basis.

HSSIB is a non-departmental public body funded primarily by grant-in-aid from DHSC. We also generate a modest level of income through our educational programme.

On 7 July 2025, the Government published the Review of Patient Safety Across the Health and Care Landscape, led by Dr Penny Dash. As part of its 10 Year Health Plan, the Government announced its intention to transfer HSSIB's functions to the Care Quality Commission (CQC) in the future, subject to parliamentary time and primary legislation. HSSIB will continue to operate as a dedicated and independent investigations function throughout this transition. In line with the interpretation of going concern for non-trading entities under FReM, the continued delivery of HSSIB's functions – even under a different organisational structure - supports the ongoing application of the going concern basis in the preparation of these accounts.

Funding

For the year ended 31 March 2025, HSSIB received a resource allocation of £5.826 million (£3.144 million in 23/24) in programme grant-in-aid funding from DHSC. Of this, £5.6 million (£2.9 million in 23/24) was drawn down as cash during the year.

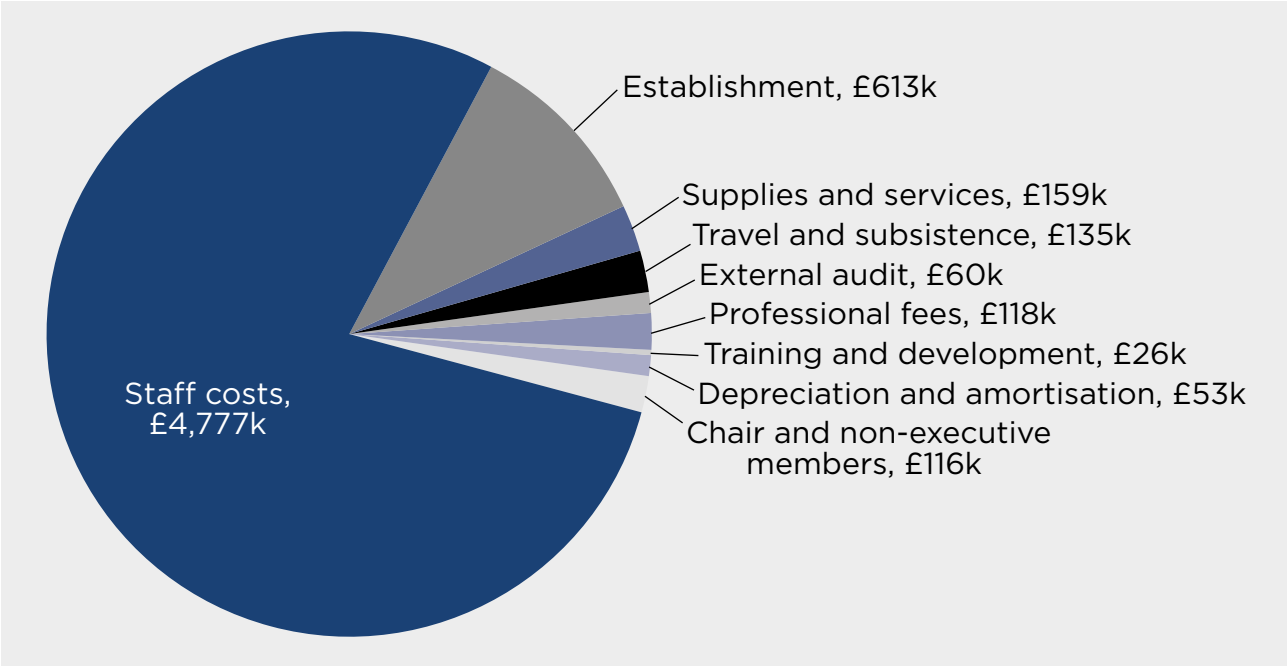
Our net operating expenditure for the year was £5.820 million, which was £6,000 under our allocated resource limit. The underspend reflects small savings from vacancies during the year.

Statement of Financial Position

As at 31 March 2025, HSSIB reported total assets of £376k (2023/24: £631k), comprising £52k in non-current assets and £324k in current assets. The reduction in total assets primarily reflects the planned depreciation and amortisation of assets transferred by absorption during 2023/24, alongside the utilisation of working capital balances.

Total liabilities increased slightly to £614k (2023/24: £599k), with higher social security and pension accruals offsetting reductions in capital creditors and other payables. These movements resulted in a net liabilities position of £238k at year end. This position reflects the timing of expenditure and accruals, and does not impact HSSIB's ability to operate as a going concern, as funding for 2025/26 has been confirmed by the Department of Health and Social Care.

Summary of expenditure



Capital expenditure

HSSIB did not receive a capital allocation for the 2024/25 financial year. In 2023/24 capital spend was £73k.

Better payment practice code

As a public sector organisation, HSSIB is committed to meeting the requirements of the Better Payment Practice Code. The target is to pay 95% of valid supplier invoices either within 30 days of receipt or by the agreed payment date – whichever is later.

Performance against this standard for the year is shown below:

	All	
	Number	**£k**
Total invoices paid	326	2,936
Invoices paid within target	305	2,761
Percentage paid within target	**94%**	**94%**

Social, community, sustainability, human rights, and environmental issues

HSSIB operates as a fully remote organisation. This significantly reduces our environmental impact by minimising travel. Where travel is necessary, staff are encouraged to use the most sustainable and cost-effective options available. We seek to use NHS facilities for meetings wherever possible to retain spending within the public sector.

Our procurement activity incorporates environmental and social considerations, utilising Crown Commercial Service and other approved frameworks that embed sustainability criteria. Staff are also encouraged to take volunteering leave, supporting community engagement.

We are committed to being a responsible and inclusive employer. Our policies are designed to uphold the rights and wellbeing of staff, including those covering bullying and harassment, grievance procedures, whistleblowing, equal opportunities, dignity at work, and anti-fraud (including bribery and corruption). We continue to strengthen our approach to human rights and social responsibility, including our commitment to anti-slavery provisions.

HSSIB has been granted an exemption by the Department for Environment, Food and Rural Affairs from reporting under the Greening Government Commitments, under de minimis criteria. This exemption applies as we employ fewer than 50 FTE staff and occupy less than 500m^2 of floor. As a result, sustainability reporting is not included in this annual report.

Our risk profile

We currently manage eight strategic risks. Our Strategic Risk Register is a standing agenda item at our monthly SLT meetings where it is reviewed and monitored. The Strategic Risk Register is discussed at each ARAC meeting. There are currently two risks which are within risk tolerance level – the remaining six risks are above risk tolerance level and are being managed on a regular basis to bring the risk score down. Two deep dives have taken place with regards to two strategic risks to further understand the risk and its mitigations. The risks are described in full on pages 72–73.

Our Operational Risk Register is discussed, reviewed and monitored at our monthly SOT meetings. These meetings started in November 2024 so we are at an early stage in development.

We recognise that further progress in relation to risk is necessary as the organisation matures. With this in mind, directorate risk leads have been appointed and a Board session focusing on risk appetite is planned for the future.

Equality, diversity and inclusion

Our commitment to equality, diversity, and inclusion (EDI) is integral to who we are and how we operate as an organisation. EDI is a key component of our overall strategy, by fostering a workplace culture that embraces diversity and promotes inclusion, we not only improve the lives of our employees but also strengthen our ability to innovate, collaborate and perform effectively. We are committed to building on our achievements as HSIB, addressing ongoing challenges and working collaboratively to create a more equitable and inclusive future for HSSIB. We recognise the importance of embracing and celebrating the unique perspectives, backgrounds and experiences of all individuals who work within our organisation, and those with whom we work during our investigations. We prioritise equity for all members of our team who may have different protected characteristics, including race, sexual orientation and gender. HSSIB has a comprehensive EDI programme which is led by the EDI Working Group. Philippa Styles, our Director of Investigations, is our executive lead for the programme.

Key aims of the EDI programme are to:

- proactively consider our ability to reduce health inequalities through our investigatory work at HSSIB
- ensure our investigations are free from bias and that we actively involve patients, families and healthcare staff to seek a diverse range of views and opinions
- involve appropriate subject matter experts and people with lived experience in our investigations.

We ensure that equality, diversity and inclusion are at the heart of any policies and procedures we develop and are promoted throughout our workforce and investigations.

We have made significant strides in embedding EDI across our organisation through a range of initiatives, training, and inclusive practices:

- Engaged with external experts to understand how HSSIB can further develop as an anti-racist organisation
- Delivered HR-led workshops on neurodiversity, mental health, and stress awareness.

- Hosted Lunch and Learn sessions, including cultural awareness talks (e.g. Ramadan).
- Commissioned external providers to deliver EDI and unconscious bias training to all staff and board members.
- Developed clear investigation criteria with a focus on health inequalities (HI).
- Created comprehensive Equality Impact Assessment (EIA) guidance for staff.
- Established a set of organisational EDI objectives and a structured programme plan with input from a dedicated working group.
- Appointed both an Executive and Non-Executive EDI Lead to champion and oversee progress at the leadership level.
- Celebrated key religious and cultural events (e.g. Diwali) through internal communications and staff engagement.
- Ensured all organisational communications adhere to accessibility standards.
- Provided translations and easy read versions of public-facing documents upon request.
- Guaranteed DDA compliance for all venues used in face-to-face events, including Board meetings.
- Engaged directly with marginalised communities, particularly through:
    - Investigations within prison and mental health settings.
    - The Patient Safety Lens project pilot in partnership with Press Association

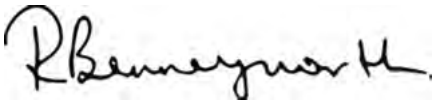
Looking ahead

Following the publication of the 10 Year Plan and Dash Review, HSSIB will continue to function independently in the coming year, carrying out its existing investigative and education work and maintaining its current governance and leadership. In the future it is planned that HSSIB transition to become a discrete unit within the CQC.

Our mission is to lead and promote healthcare safety excellence and learning through investigation, education and collaboration. We have demonstrated how we have delivered this in 2024/25 and we will continue to build and expand on this in 2025/26 by:

- Deepening our collaborations with academic institutions to strengthen the evidence base for patient safety and safety science.
- Continuing to adopt a leadership position in identifying the potential of a more proactive approach to patient safety and also ensuring that recommendations to the healthcare system are implemented effectively.

- Ensuring that our work reaches key audiences by sharing learning through established channels, while actively exploring new and innovative ways to broaden our reach and impact.
- Completing key strategic projects, including Rapid Response, Project Safety Lens, and the ongoing impact evaluation programme.
- Advancing work on AI to support the early identification and monitoring of emerging patient safety risks.
- Expanding our programme of patient and public engagement to ensure the voices of those with lived experience continue to shape our work.
- Broadening the reach and accessibility of our education offer through the expansion of courses and the development of a new education strategy, including commercial opportunities.
- Launching a new responsive training system that ensures we continue to meet the evolving needs of learners across the health and care system.
- Establishing a dedicated Learner Panel and Academic Advisory Panel to strengthen our engagement with stakeholders and experts in the field.
- Continuing essential work in business services, including enhanced information governance and records management processes.
- Strengthening our approach to cyber security, business continuity, and compliance with the Cyber Assessment Framework.
- Further embedding strategic theme 5 with a focus on cultivating a compassionate, inclusive and supportive organisational culture.



Dr Rosie Benneyworth
Interim Chief Executive
Date: 10 July 2025

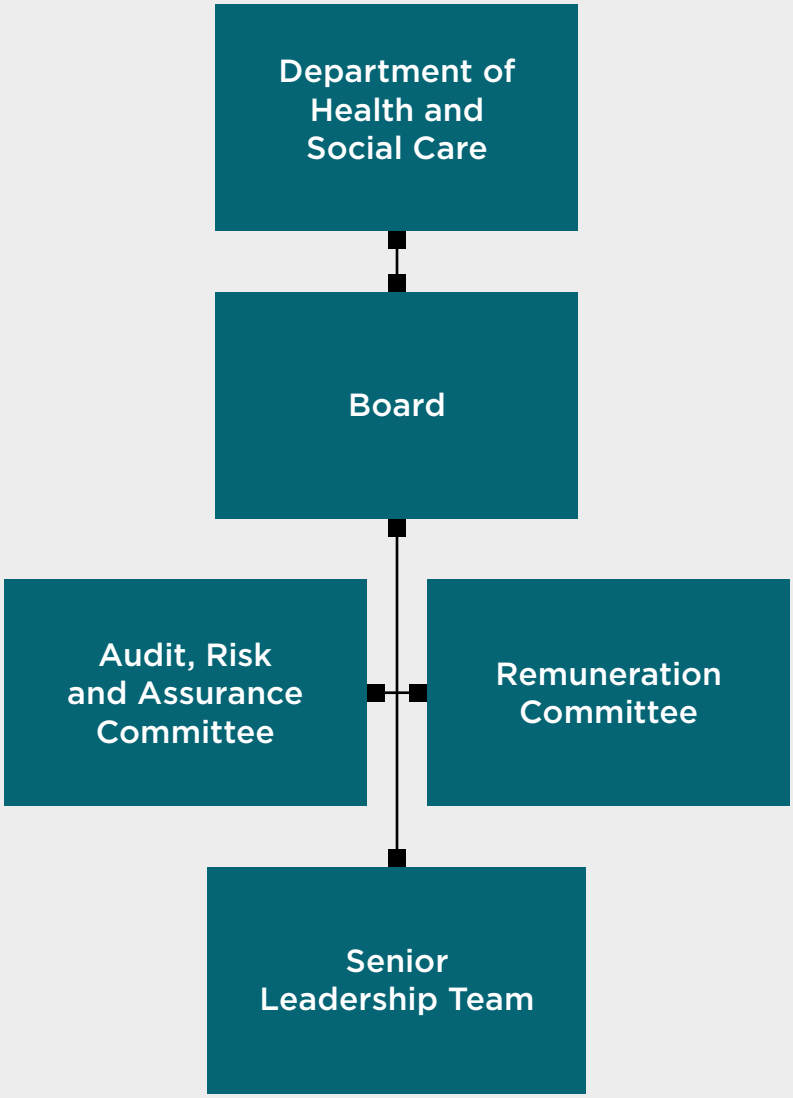
Accountability report

Corporate governance report

The purpose of the corporate governance report is to explain the composition and organisation of HSSIB's governance structures and how they support the achievement of HSSIB's objectives. The corporate governance report consists of:

1. The Directors report.
2. The statement of Accounting Officer's responsibilities.
3. The governance statement.

Directors report



HSSIB's Board

The Board has roles and responsibilities that are set out in our framework document with the Department of Health and Social Care (DHSC).

The Board is responsible for:

- providing strategic leadership and approving our strategic direction
- providing advice, challenge and support on the development and delivery of our priorities
- providing oversight of the management of our resources and shaping a positive culture.

The Board is made up of our Chair, the Interim Chief Executive and at least four other non-executive and executive directors, the majority of whom must be non-executive directors. The composition of the Board as at 31 March 2025, excluding the Chair, was five non-executive directors, our Interim Chief Executive (who is also the Accounting Officer), and three executive directors.

The Board consists of:

Name	Role	Term of appointment
Dr Ted Baker	Non-Executive Director	1 October 2023 to 30 September 2026*
Marc Esmiley	Non-Executive Director	1 October 2023 to 30 September 2025**
Dr Marisa Logan-Ward	Non-Executive Director	1 October 2023 to 30 September 2026**
Mary Cunneen	Non-Executive Director	1 October 2023 to 30 September 2026**
Dr Mike Durkin	Non-Executive Director	1 October 2023 to 30 September 2025**
Peter Schild	Non-Executive Director	1 October 2023 to 30 September 2026**
Dr Rosie Benneyworth	Executive Director	1 October 2023 to 30 June 2026***
Andrew Murphy-Pittock	Executive Director	From 9 November 2023
Maggie McKay	Executive Director	From 9 November 2023 to 31 August 2024
Philippa Styles	Executive Director	From 13 November 2023
Stephen Carruthers****	Executive Director	From 1 September 2024

* The Chair was previously Chair Designate of HSSIB from 1 December 2022 to 30 September 2023.
** The Non-Executive Directors were previously Non-Executive Director Designate of HSSIB from 1 September 2023 to 30 September 2023.
*** Dr Rosie Benneyworth, our Interim Chief Executive, is on a fixed-term contract while the recruitment to the permanent role is finalised.
**** Stephen Carruthers, interim Head of Finance, was on secondment to HSSIB from 2nd September 2024 until 30th May 2025. He was permanently appointed as Finance and Resources Director from 1st June 2025

Visit our website for biographies of our Board members, where you will find their declarations of interest.

Our Chair, Dr Ted Baker, was appointed as Chair of HSSIB from establishment on 1 October 2023; prior to this, he was Chair Designate of HSSIB from 1 December 2022.

Our non-executive directors, Dr Mike Durkin and Marc Esmiley, were appointed as non-executive directors for 2 years; Dr Marisa Logan-Ward was appointed as non-executive director for 3 years, Mary Cunneen was appointed as a non-executive director and Chair of the Remuneration Committee for three years, and Peter Schild has been appointed as a non-executive director and Chair of the Audit, Risk and Assurance Committee for 3 years from 1 October 2023. Before this, all the non-executive directors started in their roles from 1 September 2023 in a designate capacity until HSSIB was formally established on 1 October 2023.

Dr Rosie Benneyworth was appointed as Interim Chief Executive from 1 October 2023. Andrew Murphy-Pittock, our Education Director and Maggie McKay, our Finance and Performance Director were appointed to the Board on 9 November 2023, and Philippa Styles, our Director of Investigations on 13 November 2023. Stephen Carruthers, our Interim Head of Finance, was appointed to the Board on 1 September 2024 following the resignation of Maggie McKay.

The Chair and non-executive directors of the Board were appointed by the Secretary of State for Health and Social Care. These appointments are made in line with the Cabinet Office Governance Code on Public Appointments.

Our auditors

In the area of governance, risk and investigations, our auditors are the Government Internal Audit Agency (GIAA).

Our external auditors are the National Audit Office.

Statement of Accounting Officer's responsibilities

Under the Health and Care Act 2022, the Secretary of State for Health and Social Care has directed the Health Services Safety Investigations Body (HSSIB) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of HSSIB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the government financial reporting manual (FReM) and in particular to:

- observe the Accounts Direction issued by the Secretary of State for Health and Social Care, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the FreM have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis and
- confirm that the annual report and accounts as a whole is fair, balanced and understandable and take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accounting Officer for the Department of Health and Social Care has designated the Interim Chief Executive as Accounting Officer of HSSIB. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding HSSIB's assets, are set out in 'Managing public money' published by HM Treasury.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that HSSIB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I can confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Accounts Direction

The statement of accounts is prepared in a form directed by the Secretary of State for Health and Social Care in accordance with schedule 13 of the Health and Care Act 2022.

Authority statement

The Senior Leadership Team of HSSIB has inputted and reviewed the annual report and accounts. The Audit, Risk and Assurance Committee, on behalf of HSSIB, has reviewed the annual report and accounts.

Governance statement

This governance statement sets our governance and control framework for the period 1 April 2024 to 31 March 2025.

Governance framework

HSSIB was established by the Health and Care Act 2022 as an arm's length body of the DHSC. It is overseen by a board of directors, the non-executive directors of which are appointed by the Secretary of State. The Secretary of State for Health and Social Care is accountable to Parliament for all matters concerning HSSIB.

The Principal Accounting Officer (PAO) is the Permanent Secretary of the DHSC.

The PAO is responsible for advising the responsible minister on:

- an appropriate framework of objectives and targets for HSSIB in the light of the department's wider strategic aims and priorities
- an appropriate budget for HSSIB in the light of the sponsor department's overall public expenditure priorities
- how well HSSIB is achieving its strategic objectives and whether it is delivering value for money
- the exercise of the ministers' statutory responsibilities concerning HSSIB as outlined above.

The PAO, via the DHSC sponsorship team, liaises with HSSIB to:

- monitor HSSIB's activities and performance
- address significant problems in HSSIB, making such interventions as are judged necessary
- periodically and at such frequency as is proportionate to the level of risk carry out an assessment of the risks both to DHSC and HSSIB's objectives and activities in line with the wider departmental risk assessment process
- inform HSSIB of relevant government policy in a timely manner
- bring ministerial or departmental concerns about the activities of HSSIB to the full HSSIB Board, and, as appropriate to the DHSC departmental board, requiring explanations and assurances that appropriate action has been taken.

The Accounting Officer

The Interim Chief Executive, is appointed by the Permanent Secretary as Accounting Officer for HSSIB, and is personally responsible for:

- safeguarding the public funds for which they have charge
- ensuring propriety, regularity, value for money and feasibility in the handling of those public funds
- the day-to-day operations and management of HSSIB, in accordance with 'Managing public money' and other instructions and guidance issued by the DHSC, HM Treasury and the Cabinet Office.

The Board

The Board of HSSIB is responsible for setting the strategic direction and risk appetite of the organisation and is the ultimate decision-making body for matters of HSSIB-wide strategic and reputational significance.

Effective governance facilitates the delivery of HSSIB's purpose and strategy. The Board is committed, through its governance framework, to appropriate decision making within the organisation to ensure there is accountability, long-term added value and fulfilling of our purpose.

The Board currently comprises the Chair and five non-executive members with no vacancies. The Board is advised by the Executive Team who are: the Interim Chief Executive, Director of Investigations, Education Director, Interim Head of Finance and Head of Policy, Strategy and Engagement.

Details of Board members and committee attendance can be found below:

		Attendance		
Name	**Role**	**Board**	**ARAC**	**RemCom**
Dr Ted Baker	Chair of HSSIB, RemCom Member	7/7	N/A	3/3
Marc Esmiley	ARAC Member	5/7	5/5	N/A
Dr Marisa Logan-Ward	ARAC Member	6/7	4/5	N/A
Mary Cunneen	Chair of RemCom	7/7	N/A	3/3
Dr Mike Durkin	RemCom Member	7/7	N/A	2/3
Peter Schild	Deputy Chair and Chair of ARAC	7/7	5/5	N/A
Dr Rosie Benneyworth	Interim Chief Executive	7/7	N/A	N/A
Andrew Murphy-Pittock	Education Director	6/7	N/A	N/A
Philippa Styles	Director of Investigations	6/7	N/A	N/A
Maggie McKay	Finance and Performance Director (to 31 August 2024)	4/4	N/A	N/A
Stephen Carruthers	Interim Head of Finance (1 September 2024 onwards)	3/3	N/A	N/A

Key:
ARAC = Audit, Risk and Assurance Committee
RemCom= Remuneration Committee

NB: Maggie McKay, our Finance and Performance Director, resigned from the board on 31st August 2024. Stephen Carruthers, our Interim Head of Finance, began as a Board Member on the 1st September 2024.

The Board met seven times during the 12 months to 31 March 2025, with all but one meeting open to the public with Board papers made available on our website. Private Board met six times during the 12 months to 31 March 2025. Going forward, board meetings will be on a quarterly basis. The Board monitors and reviews the organisation's performance regularly, based on the management information briefings and commentaries provide by the Executives.

Board activity

During the period from 1 April 2024 to 31 March 2025, the Board discussed a range of different issues and received updates on various pieces of work including:

- the protection of our investigation materials (April 2024)
- the approval of our year-end performance report (May 2024)
- the ratification of the Information Governance and Data Protection Policy and Raising a Matter of Concern Policy (August 2024)
- the approval of final criteria for investigations (October 2024)
- the approval of the HSSIB organisational strategy (October 2024)
- the approval of the Strategy and Investigations Criteria (December 2024)
- review of the Annual Report and Accounts (February 2025)
- updates from the Audit, Risk and Assurance Committee and the Remuneration Committee on their activities.

Audit, Risk and Assurance Committee (ARAC)

The ARAC is made up of three Board members and provides an independent view to the Interim Chief Executive and the Board of the organisation's internal controls, operational effectiveness, governance and risk management. This includes an overview of the internal and external audit services and risk management. The committee can seek legal or independent professional advice and secure the attendance of external specialists.

The committee met five times during the period, in June 2024, October 2024, December 2024 February 2025 (extraordinary meeting) and March 2025.

The ARAC has received updates on:

- finance, governance, and risk management (June, October, December and March)
- GIAA Audit Report and Action Plan (June 2024)
- Cyber Security Assurance Toolkit (June 2024)
- progress of GIAA audit recommendations/actions (October 2024, December 2024)
- emerging risks (December 2024 and March 2025)
- budget update and financial forecast (March 2025)
- Travel and Subsistence Policy (March 2025).
- the Annual Report and Accounts (February 2025)

The ARAC received internal audit reports that covered the following areas across the business.

Audit	Areas reviewed	Assurance rating
Data Security and Protection Toolkit (DSPT)	The review focused on the 13 mandatory assertions and the subsequent evidence references, as extracted from the 2023/24 Version 6 DSPT.	Unsatisfactory/ Medium
Investigations	The objective of this review was to provide assurance over the design and operating effectiveness of the investigative framework, ensuring the consistent application of the investigative framework across the organisation.	Moderate
Governance	• The design and effective operation of the SOT and the interfaces and flow of information between this governance forum and the SLT (the Executive). • The frequency of any Board and sub-committee effectiveness reviews, including how any actions arising from those reviews have been taken forward and actioned. • The Board appraisal process.	Limited/ Moderate
Risk	• The embedding of strategic risk management processes since the conclusion of the previous risk management audit. • Governance of risk management at the operational level, including alignment to strategic objectives, reporting lines throughout the organisation, and oversight of the risk management processes, including the 'tone at the top' on risk management. • Policies and procedures relating to the processes in place for risk management, including the risk framework, organisational risk appetite, and risk reporting. • Roles and responsibilities for risk management across HSSIB. • Risk management processes including identification, evaluation, and mitigation of risks. • Recording risks and related risk management information. • Risk reporting arrangements and respective management information.	Moderate

Remuneration Committee

The Remuneration Committee is made up of three non-executive directors and is responsible for ensuring that a policy and process for the performance review, remuneration and succession planning for the Chief Executive and Executive Team are in place.

The committee met three times (in May and September 2024, and March 2025) during the period. Topics of discussion included:

- ESM pay levels (May 2024)
- arm's length body salary benchmarking (May 2024)
- performance review process (May 2024)
- ESM appraisals (May 2024)
- talent management (September 2024)
- succession planning (September 2024)
- ESM pay awards (September 2024)
- committee effectiveness (September 2024)
- appointment and remuneration of finance director (various)
- appointment and remuneration of (interim) CEO (various).

Senior Leadership Team (SLT)

Our SLT is led by the Interim Chief Executive Dr Rosie Benneyworth. Dr Benneyworth is the Accounting Officer and is responsible for the delivery of HSSIB's strategy and objectives as directed by the Board.

The SLT comprises:

Dr Rosie Benneyworth	Interim Chief Executive
Philippa Styles	Director of Investigations
Andrew Murphy-Pittock	Education Director
Maggie McKay (to 31 August 2024)	Finance and Performance Director
Stephen Carruthers (secondment arrangement from 1 September 2024)	Interim Head of Finance
Minal Patel	Head of Strategy, Policy and Engagement

Senior Operational Team (SOT)

Our SOT is chaired on a rotating basis by members of the team and meets once a month.

The SOT produces an update report to the SLT monthly.

The SOT comprises:

Deinniol Owens	Deputy Director of Investigations
Scott Hislop	Deputy Director of investigations
Kathryn Whitehill	Deputy Director of Investigations
Stephen Carruthers	Interim Head of Finance
Sian Blanchard	Head of Patient Safety Insights
Minal Patel	Head of Strategy, Policy and Engagement
Kay Robertson	HR and OD Business Partner
Sarah Graham	Board, Governance and Records Manager
Neill Thompson	Senior Investigation Science Educator
Luke Paton	Project Manager

Corporate governance

Our relationship with the DHSC, acting on behalf of the Secretary of State is regulated by a Framework Agreement. The framework document:

- sets out HSSIB's core responsibilities
- describes the governance and accountability framework that applies between the roles of the DHSC and HSSIB
- sets out how the day-to-day relationship works in practice, including in relation to governance and financial matters.

The Chair and the Executive Team meet the DHSC sponsorship team for a formal quarterly accountability review and informally throughout the year. Representatives from the DHSC are also present as observers at Board and ARAC meetings.

We continue to develop our system of corporate governance to comply with the requirements of the government's 'Corporate governance in central government departments: code of good practice', in so far as they relate to arm's length bodies. It is designed to ensure that sufficient oversight of operational matters is held by our Board and ARAC, while allowing for clear accountability and internal control systems at executive level. More work on this will be undertaken in 2025/2026, as the organisation matures.

Performance management

We formally report our performance every quarter to the SOT, SLT and Board.

Our performance reports cover financial and non-financial information. They are included in the Board meeting papers which are published on our website.

Quality of data used by the Board

Before the Board members receive their papers, several checks are in place to ensure that the data they receive is robust.

- The Investigations and Insights Team has a meeting to check/review the performance data which is going to Board.
- All papers are sighted by the SLT before they reach the Board.
- Sponsoring directors quality check all papers before they go to the SLT meeting.
- Sponsoring directors quality check all papers before they go to the SOT meeting.

Annual review of Board and committee effectiveness

The Board Effectiveness Review took place in October/November 2024. All nine members of the Board responded and gave feedback.

The review was discussed at a Board development day in December 2024 and an action plan was developed to address the issues raised within the review.

Of the six actions listed on the Board Effectiveness Review Action Plan, five have been implemented and one is outstanding.

Action outstanding	Update
Dedicate a Board session on HSSIB's risk appetite, this will be planned for 2025.	Risk appetite added to the Board forward planner. A risk management/appetite session will be held in July 2025 at our Board development day with an external facilitator.

Risk management

Our Risk Management Manual defines risk escalation and responsibilities in the organisation as follows:

Risk score	Risk response Threat/Transfer/ Terminate	Action	By whom	Escalation
High risk				
12-16	Risks deemed as high require a systems approach to identify the root causes of the risk and thereby help choose an appropriate risk response. Where it is not possible to terminate or transfer the risk a mitigation plan will be in place.	SOT reviews HSSIB Operational Risk Register for addition or removal of risks and recommend to SLT. SLT reviews HSSIB Strategic Risk Register and HSSIB Operational Risk Register for addition or removal of risks and recommend to the ARAC. ARAC reviews strategic risks with residual risk score of 12 or above. ARAC to report risks by exception or of significance to the Board.	SOT SLT ARAC Board	
Moderate risk				
8-11	Risks deemed as moderate to high will require a mitigation plan in line with the risk appetite. Those risks where it is deemed no further mitigation can reduce the risk will be reviewed regularly to assess impact on HSSIB.	Operational Risk Register discussed at monthly SOT meeting. Risks identified as 9 or above reported to SOT. Risks identified as 12 or above reported to the SLT. Mitigation plans for residual risk scores identified as 9 or above to be discussed at SOT. Mitigation plans for residual risk scores identified as 12 or above to be discussed at SLT.	SOT SLT	

Risk score	Risk response Threat/Transfer/ Terminate	Action	By whom	Escalation
Low risk				
1-6	Risks graded as 1 to 6 either require no action or can be managed through individual directorate teams.	Risk is identified. Risk added to directorate risk register. Action to reduce risk where necessary is considered. Risk register discussed at the monthly directorate Risk Management Meeting.	All staff	

The effective management of risks is essential to the delivery of our purpose and key strategic themes. Discussions about risk take place at various levels of the organisation, from Board level to directorate level. This ensures that appropriate escalation and mitigation of risks occur at all times. The Risk Management Manual and risk management processes have been developed in compliance with the Orange Book: Management of Risk, Principles and Concepts.

Our Strategic Risk Register is reviewed and monitored by our SLT on a monthly basis. Risk Management update reports are produced for our ARAC on a quarterly basis, to provide assurance that risks are being monitored effectively.

During 2024, we added another layer of scrutiny to our risk management process by creating the Senior Operational Team meeting – this group considers the Operational Risk Register. Each directorate has a Risk Lead, and the Operational Risk Register is discussed within directorates before it is brought to the SOT meeting.

In addition to this regular monitoring of Strategic and Operational Risks, a deep dive on a high-level risk is undertaken every quarter by the Governance Team. This process began in quarter three of 2024/25 with a review of cyber/IT risk and continued in quarter four with a review of strategic risk.

We recognise that we need to make further progress to develop our approach to risk, particularly regarding risk appetite. A Board session on risk appetite is planned for the future.

Risks we managed in 2024/25

Strategic risks

- We may not be able to demonstrate we are delivering on our organisational strategy and have a positive impact on patient safety.
- We may not be able to embed and maintain a positive, compassionate, values-based culture.

- We may fail to address the health, safety and wellbeing needs of our staff.
- We may have insufficient resources to deliver our strategy.
- We may take on non-NHS funded work that negatively impacts our core business through rapid and unsupported growth.
- We may fail to legally and effectively use powers of investigation granted by the Health and Care Act 2022.
- We may not be prepared for business continuity issues which might arise (for example, failure of IT systems and a backup plan for this).
- We may not be able to protect or securely manage our information in accordance with regulatory requirements, standards and legislation.
- We may be subject to a cyber attack, resulting in data or sensitive information being compromised, or IT services being unavailable.

Operational risks

- We may not meet agreed SLT and Board delivery expectations.
- We may not meet the demand for our courses (both external and within the NHS).
- We may be affected by the nature of our work, impacting on health and wellbeing.
- We may take on commercial work that negatively impacts our core business.
- Operational delivery may be impacted by an IT/cyber attack.
- We may be affected by supplier fraud as as HSSIB may not have the level of scrutiny or expertise in house.
- We may not protect or securely manage our information in accordance with regulatory requirements, standards and legislation.
- We may not follow procurement best practice because we do not have an in-house procurement specialist.
- Procurement of a system for HSSIB (for investigation caseloads) may not go ahead as planned, which will leave the organisation with systems that are not fit for purpose.
- Protected materials may be accidently disclosed while carrying out investigations and insights work.

In all these areas we continue to monitor the risks and work to build assurance and effective mitigation.

Information security

The Senior Information Risk Owner (SIRO) is responsible for managing information risk on behalf of the Accounting Officer and the Board, and for providing the necessary assurance. Our SIRO is our Education Director, and our Deputy SIRO is our Deputy Director of Investigations. Meetings with the SIRO take place on a monthly basis.

HSSIB also has an appointed Caldicott Guardian, who is our Director of Investigations. They are responsible for ensuring that any patient data is used legally and managed confidentially.

Our appointed Data Protection Officer is the Board, Governance and Records Manager and they are responsible for ensuring data compliance in line with the General Data Protection Regulation (GDPR).

Policies and procedures for managing the security of personal data are reviewed by our SLT, considering best practice guidance and relevant standards.

Information governance work at HSSIB is closely aligned to official guidance from relevant bodies, such as the Information Commissioner's Office. Requests for information are responded to in compliance with the Health and Care Act 2022, the General Data Protection Act 2018 and Freedom of Information Act 2000. Any operational requirements which deviate from HSSIB's Information Governance and Data Protection Policy require SIRO agreement. The ARAC receives regular governance reports which provide assurance around HSSIB's compliance with the mandatory sections of the Data Security and Protection Toolkit, and other aspects of information governance including the policies and procedures in place to manage information requests, information breaches/ incidents, responding to data breaches and responding to information requests.

Any data recorded on HSSIB's digital platforms are subject to specific legislative provisions, included in the Health and Care Act 2022, the General Data Protection Act 2018 and Freedom of Information Act 2000.

User access is strictly controlled, including access to our investigation case management system. Audit logs are kept for security checks and audit purposes.

We actively review our cyber security provision, including regular penetration testing on our systems.

In terms of information security training:

- All staff undertake information governance and data security mandatory training on an annual basis. This includes our Board members.
- Our Information Asset Owners have undertaken information asset training, which included sections on the security of data/assets at HSSIB.

- Key HSSIB staff have undertaken bespoke cyber security training (including our SIRO, deputy SIRO, Data Protection Officer (DPO) and deputy DPO). The training was made available as e-learning for all staff.

The Governance Team maintains a central log of all data breaches. There were no significant lapses in information governance arrangements or serious incidents relating to personal data breaches in 2024/25. Therefore, there have been no data breaches reported to the Information Commissioner's Office.

Whistleblowing

We have incorporated whistleblowing within our Raising a Matter of Concern Policy and have included signposts to internal and external mechanisms for the escalation of whistleblowing concerns. We have introduced an Employee Advocate role and currently have four employees who have received training on where to signpost anyone raising concerns, speaking up or whistleblowing.

No whistleblowing concerns were raised in the year to 31 March 2025.

Counter fraud

HSSIB is committed to maintaining the highest standards of integrity and transparency. We have a robust Anti-Bribery and Fraud Policy in place, and all staff are required to complete mandatory fraud awareness training as part of our ongoing efforts to foster a strong counter fraud culture.

We continue to develop our fraud control framework in line with the Cabinet Office Functional Standards for Counter Fraud. This work is being undertaken in collaboration with the DHSC Anti-Fraud Unit to ensure compliance with best practice and to strengthen our organisational resilience against fraud and bribery.

During 2024/25, we undertook the following key activities to support our counter fraud objectives:

- Ensured compliance with mandatory fraud awareness training across the organisation.
- Promoted fraud awareness through regular staff communications and internal messaging.
- Undertook internal audits of our Accounts Payable and Accounts Receivable processes to identify potential vulnerabilities and ensure strong controls are in place.
- Reviewed and approved an updated Travel and Subsistence Policy, reinforcing appropriate use of public funds.
- Began publishing details of all individual transactions over £25,000, as well as Board members' expenses, on the HSSIB website to increase financial transparency.

These actions show our continued focus on doing the right thing, being transparent, and using public money wisely.

Head of Internal Audit opinion

Our Head of Internal Audit has concluded they can give Moderate assurance that the Health Services Safety Investigations Body (HSSIB) has adequate and effective systems of control, governance and risk management in place.

The opinion draws conclusions from the audit work that GIAA have completed in year and observations from attending the Audit, Risk and Assurance Committee throughout the period.

The opinion recognises that the organisation is still in its infancy with processes still being embedded but that some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

The organisation remains in a static position when compared with the previous year. Although progress has been made, there are still some arrangements that the organisation need to ensure are in place to appropriately mitigate unnecessary risks. These are outlined in the individual audit reports.

Review of effectiveness

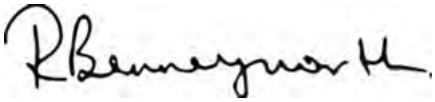
As Accounting Officer, I place reliance on the internal system of control. These include but are not limited to:

- oversight by the Board and its sub-committees including the ARAC
- the work and opinions provided by GIAA, our internal auditors
- senior managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, and
- regular reporting to the SLT on performance and risk management.

I have noted the GIAA's annual report, which in accordance with the Public Sector Internal Audit Standards, concludes that the HSSIB 'remains in a static position when compared with the previous year. Although progress has been made, there are still some arrangements that the organisation need to ensure are in place to appropriately mitigate unnecessary risks.'

GIAA has arrived at this opinion having conducted a detailed risk-based internal audit needs assessment.

In our second year as a new independent arm's length body, we are focusing on strengthening our resilience and efficiency. We recognise that we need to further explore our risk appetite in a rapidly changing landscape, and work on embedding our risk processes.



Dr Rosie Benneyworth
Accounting Officer
Health Services Safety Investigations Body
Date: 10 July 2025

Remuneration and staff report

The remuneration and staff report provides details of the remuneration and pension interests of Board members and the directors. The content of the tables and fair pay disclosures are subject to audit.

Remuneration policy

The remuneration of the Chair and non-executive directors is set by the Secretary of State for Health and Social Care. All remuneration paid to the Chair and non-executive directors is non-pensionable.

The framework for the remuneration of the Interim Chief Executive and the Director of Investigations is set by the DHSC through the executive senior management (ESM) pay framework for arm's length bodies. All other staff are employed on NHS conditions and terms of service and their salaries are subject to direction from the Secretary of State for Health and Social Care.

The remuneration of the Interim Chief Executive and all ESMs is first subject to independent job evaluation and then approved by HSSIB's Remuneration Committee with additional governance oversight from the DHSC remuneration committee. Any salary in excess of £150,000 requires both HM Treasury and DHSC remuneration committee approval. The remuneration of the executives and senior managers is detailed in the table on pages 80 to 83.

The membership of the Remuneration Committee can be found on page 65 within the annual governance statement.

Duration of contracts, notice periods and termination payments

The chair and non-executive directors of non-departmental public bodies hold a statutory office under the Health and Care Act 2022. Their appointment does not create a contract or employment relationship between them and the Secretary of State for Health and Social Care or between them and HSSIB.

The Chair and non-executive directors are eligible for reappointment at the end of their period of office, but only for one further term for up to 3 years. The DHSC will have a view as to who should be appointed to the office. The details of the service contracts can be found on page 60.

The Chair or non-executive director may resign by giving 3 months notice in writing to the Secretary of State for Health and Social Care, otherwise their appointment will terminate on the date set out in their appointment letter unless terminated earlier in accordance with the terms and conditions of their appointment.

Contracts of employment for staff are open-ended and recurrent, unless otherwise specified. Notice periods follow the provisions of the ESM contract of employment of 6 months contractual notice, and 3 months for the senior managers on NHS conditions of service.

There have been no termination payments made in the reporting period (no terminations in 2023/24).

Remuneration, benefits and pensions for the year ended 31 March 2025 (subject to audit)

2024/25

Name and title	(a) Salary (bands of £5,000) * £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £1,000) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Ted Baker	60 – 65	–	–	–	–	60 – 65
Marc Esmiley	5 – 10	–	–	–	–	5 – 10
Dr Marisa Logan-Ward	5 – 10	–	–	–	–	5 – 10
Mary Cunneen	5 – 10	–	–	–	–	5 – 10
Mike Durkin	5 – 10	–	–	–	–	5 – 10
Peter Schild	10 – 15	–	–	–	–	10 – 15
Dr Rosie Benneyworth	165 – 170	–	–	–	30	195 – 200
Andrew Murphy-Pittock	105 – 110	1,400	–	–	24	130 – 135
Maggie McKay***	35 – 40	200	–	–	0	35 – 40
Stephen Carruthers****	50 – 55	–	–	–	119	170 – 175
Philippa Styles	120 – 125	–	0 – 5	–	185	310 – 315

Notes
1. For Pension related benefits, negative values are not disclosed in this table but are substituted for a zero.
*Note: The salaries are for the 12 months to 31 March 2025.
**Note: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual. The benefits in kind represent the monetary value of benefits, treated by HMRC, as a taxable emolument, provided by HSSIB. Andrew Murphy-Pittock and Maggie McKay have lease cars provided through a non-subsidised salary sacrifice scheme that is open to all permanent HSSIB staff.
***Note: Maggie McKay resigned from the Board on 31 August, full-year equivalent salary £110-115k.
****Note: Stephen Carruthers, our Interim Head of Finance, began as a Board Member on the 2nd September 2024. Stephen Carruthers is currently on secondment from NHS North Central London Integrated Care Board. Full-year equivalent salary £95-100k.

2023/24

Name and title	(a) Salary (bands of £5,000) * £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension related benefits (bands of £1,000) £000	(f) TOTAL (a to e) (bands of £5,000) £000	(g) Salary full year equivalent (bands of £5,000) £000
Ted Baker	30 – 35	–	–	–	–	30 – 35	60 – 65
Marc Esmiley	0 – 5	–	–	–	–	0 – 5	5 – 10
Dr Marisa Logan-Ward	0 – 5	–	–	–	–	0 – 5	5 – 10
Mary Cunneen	0 – 5	–	–	–	–	0 – 5	5 – 10
Mike Durkin	0 – 5	–	–	–	–	0 – 5	5 – 10
Peter Schild	5 – 10	–	–	–	–	5 – 10	10 – 15
Dr Rosie Benneyworth***	80 – 85	–	–	–	–	80 – 85	165 – 170
Andrew Murphy-Pittock****	45 – 50	1,300	–	–	16	65 – 70	95 – 100
Maggie McKay****	55 – 60	600	–	–	25	80 – 85	110 – 115
Philippa Styles	40 – 45	–	–	–	11	55 – 60	115 – 120

* Note: The salaries are for the six months to 31 March 2024. The full year salary is shown in column (g).
** Note: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual.
The benefits in kind represent the monetary value of benefits, treated by HMRC, as a taxable emolument, provided by HSSIB. Andrew Murphy-Pittock and Maggie Mckay have lease cars provided through a non-subsidised salary sacrifice scheme that is open to all permanent HSSIB staff.
*** Note: Dr Rosie Benneyworth is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
**** Note: Whilst not appointed to the Board until 9 November 2023, the remuneration has been included from 1 October 2023 in compliance with FReM as 'having authority or responsibility for directing or controlling the major activities of the entity during the year. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or sections with the reporting entity'.

Pension benefits (subject to audit)

2024/25

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2024 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2025 £000	(h) Employer's contribution to stakeholder pension £000
Dr Rosie Benneyworth	2.5 – 5	–	30 – 35	60 – 65	533	20	610	–
Andrew Murphy-Pittock	0 – 2.5	–	10 – 15	–	161	17	200	–
Maggie McKay	–	–	20 – 25	–	285	–	309	–
Stephen Carruthers	5 – 7.5	12.5 – 15	35 – 40	90 – 95	450	102	668	–
Philippa Styles	7.5 – 10	15 – 17.5	30 – 35	75 – 80	423	158	625	–

Notes
1. NHS Pensions can only provide data on an annual basis so the opening CETV value is at 1 April 2024. The real increases are apportioned for the time worked within HSSIB.
2. For Pension related benefits, negative values are not disclosed in this table but are substituted for a zero.

2023/24

Name and title	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2023** £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2024 £000	(h) Employer's contribution to stakeholder pension £000
Dr Rosie Benneyworth*	–	12.5 – 15	25 – 30	60 – 65	391	41	533	–
Andrew Murphy-Pittock	0 – 2.5	–	10 – 15		120	8	161	–
Maggie McKay	0 – 2.5	–	20 – 25		216	17	285	–
Philippa Styles	0 – 2.5	0 – 2.5	20 – 25	55 – 60	341	12	423	–

* Note: Dr Rosie Benneyworth is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
** Note: NHS Pensions can only provide data on an annual basis so the opening CETV value is at 1 April 2023. The real increases are apportioned for the time worked within HSSIB.

Cash equivalent transfer values (CETV) (subject to audit)

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred into the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Public service pensions remedy

In 2015 the government made changes to most public service pension schemes, including the NHS Pension Scheme. These reforms didn't apply to members closest to retirement. The Court of Appeal later found that this discriminated against younger members.

The government is removing this age discrimination from public service pension schemes. It is doing this in two parts.

The first part was completed in 2022 with all active members now being members of the 2015 Scheme, this provides equal treatment for all active pension scheme members.

The second part is to put right, or 'remedy,' the discrimination that could have taken place during between 1 April 2015 and 31 March 2022, known as the remedy period. The Public Service Pension Remedy, sometimes known as the McCloud Remedy will:

- give affected members a choice of whether they receive 1995/2008 Scheme or 2015 Scheme benefits for their service in the remedy period
- return any service that affected members have in the 2015 Scheme during the remedy period back into the 1995/2008 Scheme on 1 October 2023.

Pay ratios (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/member in their organisation and the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but excludes employer pension contributions and severance payments. This disclosure is further broken down to show the relationship between the highest paid director's salary component and equivalent points within the workforce.

The banded remuneration of the highest paid director in HSSIB was £165k to £170k in 2024/25, unchanged from 2023/24 on a full-year equivalent basis. The range of remuneration across the workforce (excluding the highest paid director) was £26,530 to £123,393 (2023/24: £25,147 to £116,960).

The table below shows the pay ratios for both years:

2024-25	25th percentile	Median	75th percentile
Total Remuneration (£)	54,931	93,572	95,694
Salary component of total remuneration (£)	54,931	93,572	95,694
Pay ratio information	3.0 : 1	1.8 : 1	1.8 : 1

2023-24	25th percentile	Median	75th percentile
Total Remuneration (£)	49,032	83,571	91,475
Salary component of total remuneration (£)	49,032	83,571	91,475
Pay ratio information	3.4 : 1	2.0 : 1	1.8 : 1

The percentage change in total remuneration of the highest paid director from 2023/24 to 2024/25 was 0%. The average total remuneration across the workforce increased by 7.9%.

This increase reflects:

- The nationally mandated 5.5% pay award for NHS Agenda for Change staff in 2024/25
- The introduction of additional pay progression points for staff in Bands 8a to 9
- Standard annual pay progression under national terms and conditions

The consistency of pay ratios year-on-year indicates the organisation's continued application of national pay frameworks and commitment to fair and transparent remuneration practices.

Staff numbers (subject to audit)

Average number of employees	2024/25	2023/24
Directly employed	52 (44.6 FTE)	50 (44.1 FTE)
Other*	1	1
Employees engaged on capital projects	0	0

*'Other' includes agency staff and inward secondments from other organisations.

On 31 March 2025, HSSIB directly employed 48 staff at 42.07 full-time equivalents (51 staff at 45.3 full-time equivalents at 31 March 2024).

Of these, 48 were permanently employed and 0 were employed on fixed-term contracts of employment.

There was one additional member of staff seconded in to HSSIB from another organisation and one member of staff employed on a temporary basis via an external agency.

Off-Payroll Engagements

HSSIB used off-payroll arrangements on a very limited basis in 2024/25. No off-payroll contractors were engaged during the first nine months of the year (April to December 2024). In total, we engaged two off-payroll workers: one for a 12-week period and another for 6 weeks.

These arrangements were only used where standard recruitment processes were unable to secure suitable and immediately available candidates. Each engagement was subject to careful consideration and approval, and all necessary checks were carried out in line with government guidance to ensure compliance with relevant legislation, including the off-payroll working rules (IR35).

Number of existing engagements as of 31st March 2025*	**2**
Of which.....	
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	–
Number that have existed for between two and three years at time of reporting	–
Number that have existed for between three and four years at time of reporting	–
Number that have existed for four years or more years at time of reporting	–

*off-payroll engagements as of 31st March 2025, for more than £245 per day

Number of temporary off-payroll workers engaged between 1 April 2024 and 31st March 2025*	**2**
Of which.....	
No. not subject to off-payroll legislation	–
No. subject to off-payroll legislation and determined as in-scope of IR35	2
No. subject to off-payroll legislation and determined as out of scope of IR35	–
No. of engagements reassessed for compliance or assurance purposes during the year	–
Of which: no. of engagements that saw a change to IR35 status following review	–

*off-payroll engagements between 1 April 2024 and 31st March 2025, for more than £245 per day

Consultancy Spend

There was no expenditure on consultancy.

Staff headcount by grade

A breakdown of staff by pay grade is provided below.

Grade	2023/24	2024/25
Band 4	3	3
Band 5	4	3
Band 6	1	1
Band 7	7	4
Band 8A	3	3
Band 8B	4	6
Band 8C	1	1
Band 8D	20	20
Band 9	6	5
Other	2	2

Staff costs (subject to audit)

A breakdown of the staff costs for the 12 months to 31 March 2025 is provided below.

2024/25	Permanently employed £000	Others £000	2024/25 Total £000
Wages and salaries	3,360	250	3,610
Social security costs	379	29	408
NHS pension costs	728	31	759
Total	**4,467**	**310**	**4,777**

A breakdown of the staff costs for the 6 months to 31 March 2024 is provided below.

2023/24 (Oct 23– Mar 24)	Permanently employed £000	Others £000	2023/24 Total £000
Wages and salaries	1,585	157	1,742
Social security costs	181	12	193
NHS pension costs	294	18	312
Total	**2,060**	**187**	**2,247**

Exit packages (subject to audit)

No exit packages were agreed during the year (2023-24: none).

Staff composition

An analysis of gender mix for employees as at 31 March 2025 is provided in the table below.

Gender	Female	Male	Total
Non executive directors (including the Chair)	2 (33%)	4 (67%)	6
Executive directors	2 (50%)	2 (50%)	4
All employees (including executive directors)	29 (60%)	19 (40%)	48

An analysis of gender mix for the headcount as at 31 March 2024 is provided below.

Gender	Female	Male	Total
Non executive directors (including the Chair)	2 (33%)	4 (67%)	6
Executive directors	3 (75%)	1 (25%)	4
All staff (including executive directors)	31 (61%)	20 (39%)	51

Staff mix according to age at 31 March 2025

An analysis of age of employees as at 31 March 2025 is provided in the table below.

Age range	Headcount	%
26-30	1	2.08
31-40	11	22.92
41-50	19	39.58
51-60	14	29.17
60+	3	6.25
Total	**48**	**100.00**

An analysis of age of employees as at 31 March 2024 is provided in the table below.

Age range	Headcount	%
18-29	1	2
30-39	11	22
40-49	21	41
50-59	15	29
60+	3	6
Total	**51**	

Sickness absence data

The sickness absence rate was 4.2% (3.7% in 2024), an average of 9.2 sickness days per full-time equivalent (FTE).

Staff turnover

Staff turnover for the year April 2024 to March 2025 was 12% (6% in 2023/24).

Trade union relationships

We have no members of trade unions.

Diversity and inclusion

The employee disclosures on ethnicity, religion, disability, and sexual orientation did not transfer across in the HR system when HSSIB was established in October 2023 and although we have improved the disclosure rate across all diversity fields the percentages remain lower than we would like. Managers and the Equality Diversity and Inclusion Working Group continue to encourage employees to ensure their records are updated in the HR system so we can report meaningfully on these characteristics, and better understand the makeup of our workforce

Staff engagement

An all-staff away day was held in October 2024 facilitated by an external equality, diversity and inclusion consultant, which helped to shape and develop our own set of values and values statement. All employees were encouraged to attend, and also to contribute to the project by completing a survey before the away day.

We are aware of the difficulty employees can feel in coming forward to raise concerns or issues and so we have four volunteers across the organisation who are accessible to all employees wishing to raise a concern, talk through an

issue, or just seek guidance and signposting to further resources and advice. An anonymous reporting mechanism has also been set up for employees to report concerns, make suggestions and to feed back. It is hoped that these mechanisms will provide a range of tools for employees to engage with the organisation. Regular one-to-one meetings and annual appraisals are also important to ensuring employees are engaged and have dedicated time with their manager to discuss any issues or concerns.

Supporting disabled people

During the year we gained status as Disability Confident Committed (level 1) through the government's Disability Confident scheme, and will seek to obtain level 2 during 2025/26. We have put in place a number of reasonable workplace adjustments for disabled employees and offer an employee assistance programme with up to 10 confidential counselling services. A series of webinars has been run for employees focusing on mental health and wellbeing, and on supporting people who are neurodivergent.

Parliamentary accountability and audit report

Losses and special payments (subject to audit)

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise and are therefore subject to special controls. HSSIB had no losses or special payments in 2024/25.

Gifts (subject to audit)

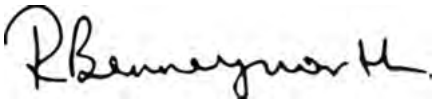
HSSIB did not receive or make a gift of any kind and value in 2024/25

Remote contingent liabilities (subject to audit)

HSSIB does not have any remote contingent liabilities at 31 March 2025

Functional standards

We must apply and adhere to the UK government functional standards in our processes and services. These standards help create a coherent, effective and mutually understood way of doing business within public bodies. They provide a stable basis for assurance, risk management and capability improvement. As a new organisation we are working towards the adoption of the standards.



Dr Rosie Benneyworth
Accounting Officer
Health Services Safety Investigations Body
Date: 10 July 2025

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of the Health Services Safety Investigations Body for the year ended 31 March 2025 under the Health and Care Act 2022.

The financial statements comprise the Health Services Safety Investigations Body's:

- Statement of Financial Position as at 31 March 2025;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK adopted international accounting standards.

In my opinion, the financial statements:

- give a true and fair view of the state of the Health Services Safety Investigations Body's affairs as at 31 March 2025 and its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Care Act 2022 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2024)*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2024*. I am independent of the Health Services Safety Investigations Body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Health Services Safety Investigations Body's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Health Services Safety Investigations Body's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for the Health Services Safety Investigations Body is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report thereon. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the Health and Care Act 2022.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the Health and Care Act 2022; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Health Services Safety Investigations Body and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept by the Health Services Safety Investigations Body or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or

- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the board and Accounting Officer are responsible for:

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within the Health Services Safety Investigations Body from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- preparing financial statements which give a true and fair view in accordance with Secretary of State directions issued under the Health and Care Act 2022;
- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with Secretary of State directions directions issued under the Health and Care Act 2022; and
- assessing the Health Services Safety Investigations Body's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Health Services Safety Investigations Body will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Care Act 2022.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, I:

- considered the nature of the sector, control environment and operational performance including the design of the Health Services Safety Investigations Body's accounting policies.
- inquired of management, the Health Services Safety Investigations Body's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the Health Services Safety Investigations Body's policies and procedures on:
    - identifying, evaluating and complying with laws and regulations;
    - detecting and responding to the risks of fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Health Services Safety Investigations Body's controls relating to the Health Services Safety Investigations Body's compliance with the Health and Care Act 2022 and Managing Public Money;
- inquired of management, the Health Services Safety Investigations Body's head of internal audit and those charged with governance whether:
    - they were aware of any instances of non-compliance with laws and regulations;

  - they had knowledge of any actual, suspected, or alleged fraud;

- discussed with the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within the Health Services Safety Investigations Body for fraud and identified the greatest potential for fraud in the following areas: revenue recognition, posting of unusual journals, complex transactions and bias in management estimates. In common with all audits under ISAs (UK), I am required to perform specific procedures to respond to the risk of management override.

I obtained an understanding of the Health Services Safety Investigations Body's framework of authority and other legal and regulatory frameworks in which the Health Services Safety Investigations Body operates. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of the Health Services Safety Investigations Body. The key laws and regulations I considered in this context included the Health and Care Act 2022, Managing Public Money, employment law, pensions legislation and tax legislation.

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit, Risk and Assurance Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board and internal audit reports; and
- I addressed the risk of fraud through management override of controls by testing the appropriateness of journal entries and other adjustments; assessing whether the judgements on estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain sufficient appropriate audit evidence to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control I identify during my audit.

Report

I have no observations to make on these financial statements.

Gareth Davies **11 July 2025**
Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Financial statements

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2025

	Note	2024/25	2023/24
		£000	£000
Revenue from contracts with customers	3	(237)	(101)
Total operating income		**(237)**	**(101)**
Staff costs	4	4,777	2,247
Purchase of goods and services	4	1,111	739
Depreciation and amortisation	4	53	39
Other operating expenditure	4	116	58
Total operating expenditure		**6,057**	**3,083**
Net operating expenditure		**5,820**	**2,982**
Net (gain)/loss on transfers by absorption	5	0	(114)
Comprehensive net expenditure for the year		**5,820**	**2,868**

The 2023/24 column of these accounts, and the related notes, reflect activity for the period 1 October 2023 to 31 March 2024 only. This is because HSSIB was formally established as an independent organisation on 1 October 2023. Comparatives therefore cover a six-month period rather than a full financial year.

The notes on pages 105 to 123 form part of these accounts.

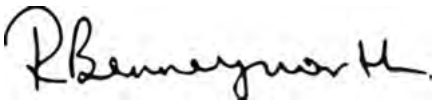
Statement of Financial Position

as at 31 March 2025

	Note	31-Mar-25	31-Mar-24
		£000	£000
Non-current assets			
Property plant and equipment	6.1	49	73
Intangible assets	6.2	3	33
Total non-current assets		**52**	**106**
Current assets			
Trade and other receivables	7	265	309
Cash and cash equivalents	8	59	216
Total current assets		**324**	**525**
Total assets		**376**	**631**
Current liabilities			
Trade and other payables	9	(614)	(599)
Total current liabilities		**(614)**	**(599)**
Total assets less current liabilities		**(238)**	**32**
Non-current liabilities		0	0
Total assets less total liabilities		**(238)**	**32**
Taxpayers' equity and other reserves			
General fund	SOCTE	(238)	32
Total taxpayers' equity		**(238)**	**32**

The notes on pages 105 to 123 form part of these accounts.

The financial statements and the notes on pages 105 to 123 were signed on behalf of the Health Services Safety Investigations Body by:



Dr Rosie Benneyworth
Accounting Officer
Health Services Safety Investigations Body
Date: 10 July 2025

Statement of Cash Flows

for the year ended 31 March 2025

	Note	2024/25	2023/24
		£000	£000
Cash flows from operating activities			
Net operating expenditure		(5,820)	(2,982)
Adjustments for non-cash transactions			
Depreciation, amortisation and impairments	4	53	39
(Increase)/decrease in trade and other receivables	7	44	(224)
Increase/(decrease) in trade payables and other current liabilities	9	16	483
Net cash inflow/(outflow) from operating activities		**(5,707)**	**(2,684)**
Cash flows from investing activities			
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
Net cash inflow / (outflow) from investing activities		**0**	**0**
Cash flows from financing activities			
Grant in aid funding	SoCTE	5,550	2,900
Net financing		**5,550**	**2,900**
Net increase/(decrease) in cash and cash equivalents		**(157)**	**216**
Cash and cash equivalents at the beginning of the period		**216**	**0**
Cash and cash equivalents at the end of the period	8	**59**	**216**

The notes on pages 105 to 123 form part of these accounts.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2025

	Note	2024/25	2023/24
		£000	£000
Opening Taxpayers equity at 1st April		**32**	**0**
Comprehensive net expenditure for the year	SOCNE	(5,820)	(2,868)
Net parliamentary funding	SOCF	5,550	2,900
Closing Taxpayers equity at 31st March		**(238)**	**32**

The notes on pages 105 to 123 form part of these accounts.

Notes to the financial statements

1. General Information

HSSIB is a non-departmental public body established under the Health and Care Act 2022 and came into operation on 1 October 2023. These financial statements are for the 12 months ending 31 March 2025. Prior year comparatives are for the 6 months from 1st October 2023 to 31st March 2024.

Under the Health and Care Act 2022, the Secretary of State for Health and Social Care has directed HSSIB to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

1.1 Accounting policies

These financial statements have been prepared in a form directed by the Secretary of State and in accordance with the Financial reporting manual (FReM) 2024-25, issued by HM Treasury. The accounting policies contained in the FReM follow International financial reporting standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of HSSIB for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Going concern

HSSIB's annual report and accounts have been prepared on a going concern basis, as set out in the International Accounting Standards as interpreted by HM Treasury's Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements, where it is anticipated that the services they provide will continue in the future.

HSSIB is financed by and draws its funding from the Department of Health and Social Care (DHSC). Parliament has demonstrated its commitment to fund DHSC for the foreseeable future, and DHSC has demonstrated its commitment to fund HSSIB.

On 7 July 2025, the Government published the Review of Patient Safety Across the Health and Care Landscape, led by Dr Penny Dash. As part of its 10 Year Health Plan, the Government announced its intention to transfer HSSIB's functions to the Care Quality Commission (CQC) in the future, subject to primary legislation. HSSIB will continue to operate as a dedicated, independent investigations function throughout the transition, and all current investigations will continue. In line with the FReM's guidance for non-trading entities, the going concern assumption remains appropriate, as the services currently provided by HSSIB are expected to continue within CQC.

1.3 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, and intangible assets, where revaluation would have a material impact.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of HSSIB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

HSSIB do not consider any judgements or uncertainties to be critical. The most significant judgements in 2024/25 concern non-current assets useful economic lives and depreciation method.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies within the same department, the FReM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of comprehensive net expenditure and is disclosed separately from operating costs.

1.6 Operating segments

HSSIB does not report on a segmental basis, it reports for the entity as a whole.

1.7 Revenue and funding

The main source of funding for HSSIB is grant-in-aid from DHSC with an approved cash limit, which is credited to the general fund. Grant-in-aid funding is recognised in the financial period in which it is received.

Operating income is income which relates directly to the operating activities of HSSIB. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the amount of the

transaction price allocated to that performance obligation in accordance with the contractual arrangements. Secondment income is recognised monthly on a consistent basis in order to provide a faithful depiction of the transfer of goods or services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Payment terms are typically 30 days after the invoice date.

1.8 Employee benefits

1.8.1 Short-term employee benefits

Salaries, wages and other employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave earned but not taken at the end of the reporting period is recognised as a liability, to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement benefit Pension costs

Employees are enrolled solely in the NHS Pension Scheme. Both the 1995/2008 and 2015 NHS Pension Schemes are accounted for and valued as a single combined scheme. These are unfunded defined benefit schemes covering NHS employers, GP practices and other organisations permitted under the direction of the Secretary of State for Health and Social Care in England and Wales.

The schemes are not designed to enable NHS bodies to identify their share of the underlying assets and liabilities. As a result, they are treated as if they were defined contribution schemes, with the cost to the organisation equal to the contributions payable for the accounting period.

In line with the requirements of IAS 19, as interpreted by the HM Treasury Financial Reporting Manual (FReM), the period between formal valuations of the NHS Pension Schemes is four years, with approximate assessments in intervening years. An outline of these assessments follows:

a) Accounting valuation

An accounting valuation of the scheme liability is carried out annually by the scheme actuary, currently the Government Actuary's Department (GAD), as at the end of the reporting period. This valuation uses data from the previous formal valuation, updated with summary membership data and financial assumptions relevant to the current reporting period. It is considered sufficiently robust for the purpose of financial reporting.

The valuation of the scheme liability as at 31 March 2025 is based on valuation data as at 31 March 2024, updated to 31 March 2025 using summary global membership information and financial assumptions, including discount rates prescribed by HM Treasury.

The results of the latest accounting valuation are set out in the report of the scheme actuary, which forms part of the NHS Pension Scheme Annual Accounts. These accounts are published annually on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

b) Full actuarial (funding) valuation

The most recent full actuarial valuation of the NHS Pension Scheme was carried out as at 31 March 2020. The purpose of this valuation is to assess the level of liabilities based on current demographic experience and to determine the appropriate employer and employee contribution rates.

The latest full actuarial valuation of the NHS Pension Scheme was carried out as at 31 March 2020, and its results informed the revised employer contribution rate effective from 1 April 2024. Following this valuation, the employer contribution rate increased from 20.6% to 23.7% of pensionable pay. This change was confirmed in Scheme Regulations laid by the Department of Health and Social Care.

As a result of the 2020 valuation, the employer contribution rate increased from 20.6% to 23.7% of pensionable pay, effective from 1 April 2024. Although the core cost of the scheme initially fell outside the ±3% cost cap corridor, the revised cost control mechanism included an economic check that determined no changes to member benefits or contribution rates were required. These results were confirmed in scheme regulations laid by the Department of Health and Social Care.

The NHS Pension Scheme is also subject to ongoing changes relating to the implementation of the McCloud remedy, which addresses unlawful age discrimination identified in the 2015 pension reforms. These changes are managed at scheme level and have no direct accounting impact on individual NHS bodies.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Value added tax

Irrecoverable value added tax (VAT) is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets, as appropriate. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT

In December 2024, the organisation received an exemption under Section 33E of the VAT Act 1994, which allows certain public bodies to recover VAT incurred on non-business activities that are funded by public money. From this date, input

VAT that is recoverable under the Section 33E exemption is no longer treated as irrecoverable expenditure but is instead reclaimed from HMRC. This has resulted in a reduction in irrecoverable VAT charges from that point onwards.

1.11 Property, plant and equipment

1.11.1 Recognition

Expenditure on property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to HSSIB
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either:
    - the item has cost of at least £5,000, or
    - collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

1.11.2 Measurement

All property, plant and equipment is measured at initially at cost. HSSIB does not revalue the assets on the grounds of materiality.

Property, plant and equipment at HSSIB consists only of short life and low value assets, such as laptops and mobile phones. In accordance with the FReM (10.1.14) we have elected to adopt a depreciated historical cost basis as a proxy for current value in existing use or fair value for these assets

1.12 Intangible assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of HSSIB's business or which arise from contractual or other legal rights

They are capitalised if:

- it is probable that future economic benefits will flow to, or service potential will be supplied to HSSIB
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either:

- the item has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.12.2 Measurement

Intangible assets are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it was incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, which is the case with all current HSSIB intangible assets, at amortised historic cost. An exercise has been performed to demonstrate that amortised historic cost is not materially different to depreciated replacement cost, which is the valuation method set out in the FReM.

1.13 Amortisation, depreciation and impairments

Depreciation and amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straightline basis over their estimated useful lives. The estimated useful life of an asset is the period over which HSSIB expects to obtain economic benefits or service potential from the asset. This is specific to HSSIB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Estimated useful lives:

Intangible assets

- IT software developments have an estimated useful life of 3 to 5 years.
- Website has an estimated useful life of 3 to 5 years.

Property, plant and equipment

- Information technology has an estimated useful life of 3 to 7 years

At each financial year-end, HSSIB checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are also tested for impairment annually at the financial year-end.

Impairment losses that arise from a clear consumption of economic benefit are charged to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.14 Cash and cash equivalents

Cash is the balance held with the Government Banking Services. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Financial assets

Financial assets are recognised when HSSIB becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or when the asset has been transferred and HSSIB has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

1.15.1 Impairment

All of HSSIB's financial assets are measured at amortised cost, as they are held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes all trade and other receivables.

At the end of the reporting period, HSSIB assesses whether any financial assets are impaired. The majority of receivables are with other DHSC group bodies and therefore we do not expect any credit losses.

1.16 Financial liabilities

Financial liabilities are recognised in the Statement of Financial Position when HSSIB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17 Accounting standards that have been issued but have not yet been adopted

The HM Treasury Financial Reporting Manual (FReM) does not require the following International Financial Reporting Standards (IFRS) and Interpretations to be applied in the 2024/25 financial year. If these standards were applied in the current year, they would not have a material impact on the financial statements:

IFRS 14 – Regulatory Deferral Accounts: This standard has not been endorsed for use in the UK and is therefore not applicable to DHSC group bodies.

IFRS 17 – Insurance Contracts: This standard is effective for accounting periods beginning on or after 1 January 2023. However, it has not yet been adopted in the FReM and is currently expected to be applied from 2025/26. Early adoption is not permitted for public sector bodies following the FReM.

IFRS 18 – Presentation and Disclosure in Financial Statements: This standard applies to annual reporting periods beginning on or after 1 January 2027. It has not yet been endorsed by the UK Endorsement Board and has not yet been considered by the Financial Reporting Advisory Board (FRAB). It is therefore too early to assess the impact on the financial statements. HSSIB will consider the implications of this standard in future years, once further guidance is available

In addition to the above IFRS standards, the 2025/26 FReM introduces two significant changes:

Social Benefits (New FReM Guidance from 2025/26):

From 1 April 2025, the FReM will incorporate additional guidance on accounting for social benefits, aligned to the public sector application of the IFRS Conceptual Framework. These changes clarify the definition and recognition of social benefits in the public sector. However, HSSIB does not administer or deliver any social benefit payments; therefore, this change is not expected to have a material impact on its accounting policies, financial position, or financial performance.

Non-Investment Asset Valuation Methodology (Updated FReM Guidance from 2025/26):

The 2025/26 FReM will revise guidance on the valuation of non-investment assets held for operational capacity, following the thematic review by HM Treasury and FRAB. The key change is the requirement to adopt a quinquennial (five-year) revaluation cycle, with annual indexation and desktop updates in intervening years. These changes are to be applied prospectively from 1 April 2025, with no restatement of prior period balances. HSSIB already operates on a five-year revaluation cycle with interim indexation; therefore, these changes are not expected to materially impact the financial statements.

2. Operating segments

The Board as 'Chief Operating Decision Maker' has determined that HSSIB operates as a single segment. The work is within one main geographical segment, the United Kingdom.

3. Income

Revenue from contracts with customers

All income is programme income

	2024/25	2023/24
	£000	£000
Secondment income	134	77
Training income	103	24
Total revenue from contracts with customers	**237**	**101**

4. Expenditure

All expenditure is programme expenditure

	2024/25	2023/24
	£000	£000
Staff costs		
Wages and salaries	3,610	1,742
Social security costs	408	193
NHS pension costs	759	312
Total staff costs	**4,777**	**2,247**
Purchase of goods and services		
Establishment	613	428
Supplies and services	159	111
Travel and subsistence	135	96
External audit fee	60	58
Professional fees	118	31
Training and development	26	15
Total purchase of goods and services	**1,111**	**739**
Depreciation and amortisation		
Amortisation of intangible assets	29	39
Depreciation of property, plant and equipment	24	-
Total depreciation and amortisation	**53**	**39**
Other operating expenditure		
Chair and non-executive members	116	58
Total operating expenditure	**6,057**	**3,083**

More detailed disclosures of our staff costs is included in the accountability report (page 88).

During the year, HSSIB purchased no non-audit services from it's auditor, the National Audit Office (NAO).

Significant expenditure items include:

Establishment

Establishment expenditure includes the cost of the ongoing administration of HSSIB and includes IT and internal audit.

Supplies and services

Supplies and services is the expenditure on outsourced services.

5. Net gain on transfer by absorption

Business combinations within the public sector are accounted for using absorption accounting principles.

On 1 October 2023, the Healthcare Safety Investigation Branch, a programme within NHS England, ceased and assets and liabilities were transferred to HSSIB and CQC.

Assets and liabilities transferred from NHS England to HSSIB	2024/25	2023/24
	£000	£000
Transfer of property, plant and equipment	0	0
Transfer of intangibles	0	72
Transfer of prepayments	0	85
Transfer of accruals	0	(43)
Net gain/(loss) on transfers by absorption	**0**	**114**

6. Non-current assets

6.1 Property, plant and equipment

2024/25	Information technology	Total
	£000	£000
Cost or valuation		
At 31 March 2024	75	75
Transfer by absorption	0	0
Additions	0	0
Disposals	0	0
Impairments	0	0
At 31 March 2025	**75**	**75**
Depreciation		
At 31 March 2024	2	2
Transfer by absorption	0	0
Charged during the year	24	24
Impairments charged to SOCNE	0	0
Disposals	0	0
At 31 March 2025	**26**	**26**
Net book value at 31 March 2025	**49**	**49**

2023/24	Information technology	Total
	£000	£000
Cost or valuation		
At 1 October 2023	0	0
Transfer by absorption	2	2
Additions	73	73
Disposals	0	0
Impairments	0	0
At 31 March 2024	**75**	**75**
Amortisation		
Depreciation		
At 1 October 2023	0	0
Transfer by absorption	2	2
Charged during the year	0	0
Impairments charged to SOCNE	0	0
Disposals	0	0
At 31 March 2024	**2**	**2**
Net book value at 31 March 2024	**73**	**73**

6.2 Intangible assets

2024/25	Development expenditure	Websites	Total
	£000	£000	£000
Cost or valuation			
At 31 March 2024	174	93	267
Transfer by absorption	0	0	0
Additions	0	0	0
Disposals	0	0	0
Impairments	0	0	0
At 31 March 2025	**174**	**93**	**267**
Amortisation			
At 31 March 2024	160	74	234
Transfer by absorption	0	0	0
Charged during the year	14	16	30
Impairments charged to SOCNE	0	0	0
Disposals	0	0	0
At 31 March 2025	**174**	**90**	**264**
Net book value at 31 March 2025	**0**	**3**	**3**

2023/24	Development expenditure	Websites	Total
	£000	£000	£000
Cost or valuation			
At 1 October 2023	0	0	0
Transfer by absorption	174	93	267
Additions	0	0	0
Disposals	0	0	0
Impairments	0	0	0
At 31 March 2024	**174**	**93**	**267**
Amortisation			
At 1 October 2023	0	0	0
Transfer by absorption	137	58	195
Charged during the year	23	16	39
Impairments charged to SOCNE	0	0	0
Disposals	0	0	0
At 31 March 2024	**160**	**74**	**234**
Net book value at 31 March 2024	**14**	**19**	**33**

7. Trade receivables and other current assets

	2024/25	2023/24
	£000	£000
Amounts falling due within one year		
Contract receivables	5	97
Prepayments	242	191
Accrued income	0	21
VAT	18	0
Trade and other receivables	**265**	**309**

8. Cash and cash equivalents

	2024/25	2023/24
	£000	£000
Opening Balance at 1 April	**262**	**0**
Net change in cash and cash equivalent balances	(203)	216
Closing Balance at 31 March	**59**	**216**
The following balances were held at:		
Cash with Government Banking Service	59	216
Commercial banks and cash in hand	0	0
Short term investments	0	0
Cash and cash equivalents as in Statement of Financial Position	**59**	**216**

9. Trade payables and other liabilities

	2024/25	2023/24
	£000	£000
Amounts falling due within one year		
Trade payables	201	58
Capital creditors – property, plant and equipment	0	73
VAT	0	17
Social security liabilities	103	3
Accruals	244	448
Pension	66	0
Trade payables and other liabilities	**614**	**599**

No liabilities are falling due over one year.

10. Commitments

10.1 Capital commitments

HSSIB has no contracted capital commitments at 31 March 2025 (2023-24: none).

10.2 Other financial commitments

HSSIB has no other financial commitments at 31 March 2025 (2023-24: none).

11. Financial instruments

11.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

As the cash requirements of HSSIB are met primarily through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. The majority of financial instruments relate to contracts for non-financial items in line with the Body's expected purchase and usage requirements and the Authority is therefore exposed to little credit, liquidity or market risk.

Currency risk

HSSIB is a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. HSSIB has no overseas operations. HSSIB therefore has low exposure to currency rate fluctuations.

Interest rate risk

All of HSSIB's financial assets and financial liabilities carry nil rates of interest. HSSIB is not, therefore, exposed to significant interest-rate risk.

Liquidity risk

HSSIB's net operating costs are financed from resources voted annually by Parliament. HSSIB finances its capital expenditure from funds made available from Government under an agreed capital resource limit. HSSIB is not, therefore, exposed to significant liquidity risks.

11.2 Financial assets

	2024/25	2023/24
	£000	£000
Trade and other receivables	5	118
Cash at bank and in hand	59	216
Total Financial Assets	**64**	**334**

11.3 Financial liabilities

	2024/25	2023/24
	£000	£000
Trade and other payables	614	541
Total Financial Liabilities	**614**	**541**

12. Contingent liabilities

At 31 March 2025 there were no known contingent assets or liabilities (2023-24: none).

13. Related parties

HSSIB is an non-departmental body of the Department for Health and Social Care.

The Department of Health and Social Care is regarded as a related party. During the reporting period HSSIB had a number of material transactions with the Department and with other entities for which the Department is regarded as the parent department including NHS England and NHS Foundation Trusts.

In addition, HSSIB has had transactions with other government departments and other central government bodies. Most of these have been with the NHS Pension Scheme relating to our pension costs and HMRC for social security costs.

During the reporting period no Department of Health and Social Care Minister, Board member, key manager or other related parties has undertaken any material transactions with the HSSIB. The compensation paid to key management personnel can be found in the remuneration report from page 78.

14. Events after reporting period

In accordance with IAS 10, events after the reporting period are considered up to the date on which the financial statements are authorised for issue. The Accounting Officer authorised these financial statements for issue on the date the Comptroller and Auditor General signed the audit certificate.

On 7 July 2025, the Government published the Review of Patient Safety Across the Health and Care Landscape, led by Dr Penny Dash. The review highlighted opportunities to simplify and streamline functions across the patient safety system. As part of its 10 Year Health Plan, the Government announced its intention to transfer the functions of the Health Services Safety Investigations Body (HSSIB) to the Care Quality Commission (CQC) in the future, subject to parliamentary time and primary legislation. HSSIB will continue to operate as a dedicated and independent investigations function during the transition, and all current investigations will proceed as planned.

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