House of Commons
Public Administration
and Constitutional Affairs
Committee

Appointment of the
Chief Investigator of
the Healthcare Safety
Investigation Branch

Second Report of Session 2016–17
House of Commons
Public Administration and Constitutional Affairs Committee

Appointment of the Chief Investigator of the Healthcare Safety Investigation Branch

Second Report of Session 2016–17

Report, together with formal minutes relating to the report

Ordered by the House of Commons
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The Public Administration and Constitutional Affairs Committee

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No. 146. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee’s website at www.parliament.uk/pacac and in print by Order of the House.

Committee staff

The current staff of the Committee are: Dr Rebecca Davies (Clerk), Ms Rhiannon Hollis (Clerk), James Harrison (Second Clerk), Dr Adam Evans (Committee Specialist), Dr Henry Midgley (Committee Specialist), Ms Penny McLean (Committee Specialist), Rebecca Usden (Committee Specialist), Ana Ferreira (Senior Committee Assistant), Iwona Hankin (Committee Assistant), and Mr Alex Paterson (Media Officer).

Contacts

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1 Introduction

1. This Report follows our pre-appointment hearing with the Government’s preferred candidate for the post of Chief Investigator of the Healthcare Safety Investigation Branch (HSIB). On 1 April 2016, the Secretary of State for Health published a set of Directions, establishing HSIB and creating the role of Chief Investigator. The Chair of the Public Administration and Constitutional Affairs Committee (PACAC) and the Chair of the Health Committee agreed that it was appropriate for a pre-appointment hearing to be held for the Chief Investigator post. The Chairs decided that the first pre-appointment hearing would be held by PACAC, whose predecessor, the Public Administration Select Committee (PASC), had recommended and championed the creation of HSIB. This report will provide background to the creation of the Chief Investigator post, give an overview of the selection process and outline the Committee’s conclusions regarding the suitability of the Government’s preferred candidate.
2 Background

The creation of the Healthcare Safety Investigation Branch (HSIB)

2. The recommendation for an independent patient safety investigation body was put forward by our predecessor committee, the Public Administration Select Committee (PASC) in its March 2015 report, Investigating clinical incidents in the NHS. The Committee called for

   a new, single, independent and accountable investigative body to provide national leadership, to serve as a resource of skills and expertise for the conduct of patient safety incident investigations, and to act as a catalyst to promote a just and open culture across the whole health system.1

3. In July 2015, the new Government published a response, Learning not blaming, in which it accepted PASC’s recommendation, agreeing that “there should be a capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out certain investigations itself”.2 The Government response outlined five guiding principles for the new body; objectivity, transparency, independence, expertise and learning for improvement.3

4. The July 2015 response also announced the creation an Expert Advisory Group (EAG) to advise the Secretary of State and the Department of Health on the purpose, role and operation of the new investigative body. The EAG is comprised of experts in patient experience, safety, healthcare and investigation and is chaired by Mike Durkin, NHS National Director for Patient Safety.4 The EAG published its report and recommendations on 12 May 2016.5

5. In its report, the EAG states that “[t]he purpose of this new safety investigation body is to act as an enabler, exemplar and catalyst for learning-oriented safety investigation” and that “[t]he primary goal of the Healthcare Safety Investigation Branch is to generate learning and to support improvements in the safety of healthcare.”6 Notably, the role of HSIB is not to sit at the apex of the complaints system or be a final court of appeal for complaints.

6. According to the Secretary of State’s Directions, HSIB’s investigatory functions are:

   a) the investigation of incidents or accidents which in the view of the Chief Investigator evidence, or are likely to evidence, risks affecting patient safety;

   b) the ascertaining of facts relevant to such risks and analysis of those facts;

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3 Ibid.
4 Healthcare Safety Investigation Branch Expert Advisory Group, Terms of Reference
6 Ibid.
c) the identification of improvements or areas for improvement, if any, which may be made in patient safety in—

i) the provision of services as part of the health service, or

ii) the conduct of other functions carried out for purposes of the health service, and where appropriate, the making of recommendations in relation to such improvements;

d) the publication of reports;

e) encouraging the development of skills used to investigate local safety incidents in the health service and to learn from them, including suggesting standards which may be adopted in the conduct of such investigations.7

7. The Directions stipulate that HSIB must be in a position to commence its activities by 1 April 2017.8

8. Since the publication of the Directions, we have expressed through our report, PHSO review: Quality of NHS complaints investigations, our disappointment that HSIB has been established without the necessary primary legislation to guarantee its independence from the National Health Service (NHS).9 It is widely acknowledged that HSIB’s independence is of paramount importance to its credibility and success. The EAG report specifies HSIB’s independence as “the most fundamental principle underlying its function”.10 Without primary legislation, the Government is also failing to provide statutory protection to a ‘safe space’ where all those involved in HSIB’s clinical investigations can speak honestly and openly without fear of blame.

9. We remain deeply concerned that HSIB has been established without the necessary primary legislation to assure the independence of the new body and create a statutory ‘safe space’ and that it has been established inside an existing NHS regulator rather than as an independent body. The Government must take seriously the need to provide HSIB with a legislative base that will enable it to carry out its functions to full effect, and to establish it as an independent body. The Government should bring forward appropriate primary legislation without delay.

7 Department of Health, NHS Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016
8 Ibid.
3 Chief Investigator of the Healthcare Safety Investigation Branch

Overview

10. The role of Chief Investigator was created by the Secretary of State’s Directions on 1 April 2016. The Chief Investigator will be responsible for setting up HSIB and ensuring that it is capable of commencing operations by 1 April 2017. The Secretary of State, in a letter to the Chair of the Health Committee, stated that “[i]t will be for the Chief Investigator, once appointed, to consider the individual recommendations of the Expert Advisory Group, and to decide how these will translate into practice”. The Chief Investigator will therefore play a pivotal role in establishing and shaping the new body.

Recruitment

11. Recruitment to the post was carried out through a process of open competition. The process was managed by Russell Reynolds Associates (RRA), an executive search agency, on behalf of the Department of Health.

12. The selection panel consisted of Mike Durkin, NHS National Director for Patient Safety (Chair of the Selection Panel); William Vineall, Director for Quality Policy, Department of Health; Martin Bromiley, Advisor to the HSIB Expert Advisory Group; Nigel Newcomen, Prisons and Probation Ombudsman; and Bill Kirkup, Member of the HSIB Expert Advisory Group.

13. According to information on the selection process supplied by the Department of Health, thirty applications were submitted for the post, and the selection panel interviewed a final shortlist of five candidates. The shortlisted candidates were also invited to meet with members of the HSIB Expert Advisory Group on 29 April. The EAG gave feedback to the selection panel on each candidate in order to assist the selection panel’s decision. The final interview was held on 18 May. The selection process information is attached as Appendix 3.

Role and Criteria

14. The key responsibilities for the post, as advertised in the person specification, are:

- To establish a new national safety investigation function in healthcare that will improve safety in healthcare by conducting independent, safety investigations and produce conclusions and recommendations that will contribute to reducing risk.

- To lead a team of well trained and highly expert investigators and other staff ensuring that the right knowledge, skills and development are in place to conduct safety investigations in healthcare

11 Department of Health, NHS Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016
12 Letter from Secretary of State for Health to Dr Sarah Wollaston MP, Chair, Health Committee, May 2016
• To seek to continuously refine the approach to investigations in light of experience, feedback, evaluation and learning.

• To oversee all investigations carried out by the Investigation Branch and conduct or assist with some investigations as appropriate.

• To ensure that the investigations carried out are recognised to be of the highest standard, and are seen as an exemplar to others in the NHS conducting local investigations.

• To ensure that the Investigation Branch uses its resources effectively and stays within budget.

15. According to the information supplied by the Department of Health, applicants were assessed against the following criteria:

• Investigations knowledge and experience

• NHS/Health knowledge and experience

• Management experience

• Experience of building an organisation

• Stakeholder engagement

• Public speaking/engagement

The appointment process

16. As HSIB is a newly established body, the post of HSIB Chief Investigator is not listed by the Cabinet Office as being subject to pre-appointment hearing. However, the Chair of PACAC and the Chair of the Health Committee agreed that it was appropriate for a pre-appointment hearing to be held for the Chief Investigator post. The Chairs decided that the first pre-appointment hearing would be held by PACAC, whose predecessor Committee, the Public Administration Select Committee (PASC), had recommended and championed the creation of HSIB. The Chairs wrote jointly to the Secretary of State for Health in May to inform him of their agreement, to note the ongoing interest of both Committees in the role and operations of the new body and to ask that the role of Chief Investigator be placed on the Cabinet Office’s list of public appointments subject to pre-appointment hearing. The letter to the Secretary of State is attached as Appendix 1.

The candidate

17. The Secretary of State for Health wrote to the Chair of PACAC, in a letter dated 26 May, to inform him that the Government’s preferred candidate for the post of Chief Investigator was Mr Keith Conradi. This letter is included as Appendix 2.

18. Mr Conradi has had an eminent career in the field of safety investigation. He is currently the Chief Inspector of Air Accidents for the Air Accidents Investigation Branch (AAIB), a role which he has held since 2010. Mr Conradi has been an Inspector of Air Accidents with the AAIB since 2002, becoming a Principal Inspector in 2009. Prior to
joining the AAIB, Mr Conradi was a pilot for almost 20 years, for the Royal Air Force and then for Virgin Atlantic Airways. Mr Conradi holds a number of positions in the field of transport accident investigation and was the Director of a small flight training company, Jetlinx Flight Training Ltd, for over ten years. Mr Conradi’s CV is attached as Appendix 5. Mr Conradi declared that he was a member of the HSIB Expert Advisory Group but made no further declaration of interests.

The pre-appointment hearing

19. The Committee held a pre-appointment hearing with Mr Conradi on 7 June. We questioned Mr Conradi on the extent to which his experience as Chief Inspector of the AAIB was transferrable to the healthcare sector and about his vision and intentions for HISB. We especially wanted to find out how Mr Conradi would protect the independence of the new body and how he intended to uphold a credible ‘safe space’, as we feel that these will both be of paramount importance to HSIB’s success.13

20. Mr Conradi has had an eminent career in the field of safety investigation, in particular as the Chief Inspector of the Air Accidents Investigation Branch (AAIB), and we believe that his background lends itself very well to the post of HSIB Chief Investigator. We feel that Mr Conradi’s experience in aviation safety will transfer well to the healthcare sector and his proven ability to run independent safety investigations will enable him to strengthen the independence of HSIB’s operations. Mr Conradi demonstrated the fullest understanding of the role he will fulfil, and of the proposal made by our predecessor committee, PASC, at the end of the last Parliament. This includes the need for the independence of HSIB, outside the NHS, and its regulatory framework, and the need for underpinning legislation. He also demonstrated he has a clear concept of operation for HSIB, which he intends will build local capacity for clinical incident investigation, and training and accreditation of personnel within the NHS. We are happy to endorse his appointment as Chief Investigator and we look forward to following his work in the role.
Conclusions and recommendations

Background

1. We remain deeply concerned that HSIB has been established without the necessary primary legislation to assure the independence of the new body and create a statutory ‘safe space’ and that it has been established inside an existing NHS regulator rather than as an independent body. (Paragraph 9)

2. The Government must take seriously the need to provide HSIB with a legislative base that will enable it to carry out its functions to full effect, and to establish it as an independent body. The Government should bring forward appropriate primary legislation without delay. (Paragraph 9)

Chief Investigator of the Healthcare Safety Investigation Branch

3. Mr Conradi has had an eminent career in the field of safety investigation, in particular as the Chief Inspector of the Air Accidents Investigation Branch (AAIB), and we believe that his background lends itself very well to the post of HSIB Chief Investigator. We feel that Mr Conradi’s experience in aviation safety will transfer well to the healthcare sector and his proven ability to run independent safety investigations will enable him to strengthen the independence of HSIB’s operations. Mr Conradi demonstrated the fullest understanding of the role he will fulfil, and of the proposal made by our predecessor committee, PASC, at the end of the last Parliament. This includes the need for the independence of HSIB, outside the NHS, and its regulatory framework, and the need for underpinning legislation. He also demonstrated he has a clear concept of operation for HSIB, which he intends will build local capacity for clinical incident investigation, and training and accreditation of personnel within the NHS. (Paragraph 20)

4. We are happy to endorse his appointment as Chief Investigator and we look forward to following his work in the role. (Paragraph 20)
Appendix 1: Letter from the Chair of PACAC and the Chair of the Health Committee to the Secretary of State for Health, dated 4 May 2016

We are writing to seek your agreement for the new role of Chief Investigator of the Healthcare Safety Investigation Branch (HSIB) to be added to the list of positions subject to pre-appointment hearings with the Government’s preferred candidate before the appointment is confirmed.

Your decision to create HSIB was a welcome acknowledgement of the serious action required to transform the NHS in England “from a blame culture to a learning culture” and to address systemic patient safety risks. The Directions which you issued on 1 April 2016 brought this new body into existence. In doing so they created the role of Chief Investigator, who will have responsibility for making HSIB ready to commence its operations by 1 April 2017, as well as developing and publishing the principles by which its investigations will be conducted, and applying the much discussed ‘safe space’ principle.

It is therefore essential that the successful candidate for this role is of the highest calibre, and commands public confidence. We believe that effective Parliamentary scrutiny in the form of a pre-appointment hearing is the best way to achieve those aims. The Chief Investigator will play a key role in protecting and safeguarding the public’s rights and interests; it is also vital for the reputation and credibility of HSIB that the post holder is, and is seen to be, independent of Ministers and Government. The post therefore meets at least two of the criteria set by Government for subjecting an appointment to a pre-appointment hearing before a select committee.

As your Directions noted, both PACAC and the Health Committee will be interested in scrutinising the Work of the Investigation Branch. HSIB was created in response to a recommendation made by PACAC’s predecessor, the Public Administration Committee, and PACAC has maintained a strong interest in its principles and design, recently conducting a short inquiry into the quality of Clinical Investigations in the NHS in which most of the evidence focused on the new body. At the same time, the Health Committee’s role in scrutinising the work of the Department of Health and NHS England means that it will have an ongoing and essential role to play holding HSIB to account.

Therefore, whilst we expect PACAC to hold the pre-appointment hearing for the first Chief Investigator of HSIB, we also ask that you note the Health Committee’s future interest in the role and operations of the new body. Formally adding the position to the list of public appointments subject to pre-appointment hearings will not only make clear the House of Commons ongoing interest in what is a critical position, but will also ensure that this and future hearings (which may be held either by PACAC, or by the Health Committee, or by the two Committees meeting jointly) are subject to the full protections afforded by the Cabinet Office guidance.

We hope that you will agree that this approach is in the best interests of both the House and Government.

Bernard Jenkin MP, Chair, Public Administration and Constitutional Affairs Committee

Dr Sarah Wollaston MP, Chair, Health Committee
Appendix 2: Letter from the Secretary of State for Health to the Chair of PACAC, dated 26 May 2016

Chief Investigator of the Healthcare Safety Investigation Branch

Thank you for your letter of 4 May seeking agreement to a pre-appointment hearing with the first Chief Investigator of the Healthcare Safety Investigations Branch, which I fully support.

I am now writing to inform you formally that the recruitment process for the appointment for the post of the Chief Investigator has now concluded.

I was advised that we had a strong field of candidates at shortlist stage. The Panel recognised that the preferred candidate would need to demonstrate both a strong and credible background in high quality investigation practice together with excellent qualities of leadership.

The Healthcare Safety Investigation Branch and the role of the Chief Investigator will be the first of its kind not only in the NHS but anywhere else in the world. This post requires an individual who will be at the forefront of a truly ground breaking role in healthcare and I am confident that the Selection Panel has made an appropriate choice.

The final interview was held on 18 May and the Selection Panel was able to reach a recommendation. My preferred candidate for the role is Mr Keith Conradi. Mr Conradi is currently the Chief Investigator of the Air Accidents Investigation Branch.

Mr Conradi has a strong track record of delivering high quality investigations in aviation. I am confident that he will bring this expertise together with excellent skills of leadership to establish a new Chief Investigator as credible and authoritative voice for safety investigations in healthcare.

I would like to thank you for agreeing to hold a pre-appointment hearing with the preferred candidate on 7 June and I enclose relevant details about Mr Conradi that should assist the Committee for the hearing.

Rt Hon Jeremy Hunt MP, Secretary of State for Health
Appendix 3: Selection process information supplied by the Department of Health

Russell Reynolds Associates (RRA), an executive search agency, managed the appointment process on behalf of the Department of Health.

The role description was advertised online on 10 March with a deadline for submitting CVs by 30 March.

Applicants were assessed against the following criteria:

- Investigations knowledge and experience
- NHS/Health knowledge and experience
- Management experience
- Experience of building an organisation
- Stakeholder engagement
- Public engagement/speaking

The Selection Panel reviewed all applications and agreed a list of potential candidates to move forward to be considered for shortlisting. Thirty applications were submitted for the post. The Selection Panel interviewed a final short list of 5 applicants.

The shortlisted candidates were invited to meet with members of the HSIB Expert Advisory Group on 29 April. The EAG provided feedback to the Selection Panel on overall impressions of each candidate and this was used as supporting evidence to assist the Selection Panel’s decision.

The Selection Panel comprised:

- Mike Durkin, NHS National Director for Patient Safety (Chair of Selection Panel)
- William Vineall, Director for Quality Policy, Department of Health
- Martin Bromiley, Advisor to the HSIB Expert Advisory Group
- Nigel Newcomen, Prisons and Probation Ombudsman
- Bill Kirkup, Member of the HSIB Expert Advisory Group

Selection Panel’s conclusion:

Overall the Selection Panel was impressed with the strong calibre of the candidates that had put themselves forward for this post. The Selection Panel was unanimous in its decision to recommend to the Secretary of State Mr Conradi for the post of Chief Investigator. The Panel’s final decision was on the basis that Mr Conradi had scored highly on all the key skills and attributes required for this post.

The candidate made no declaration of interests other than that he was a member of the Healthcare Safety Investigation Branch Expert Advisory Group.
Appendix 4: Person Specification for the post

The Government intends to set up a new Healthcare Safety Investigation Branch in 2016 that will sit in NHS Improvement.

The purpose of the Investigation Branch will be to improve safety in healthcare by conducting independent, safety investigations and produce conclusions and recommendations that will contribute to reducing risk.

It is envisaged that the Investigation Branch will:

- conduct investigations and produce reports that patients, families, carers and staff value, trust and respect;
- generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;
- act as an exemplar for good quality investigation across the NHS.

The Investigation Branch will need to operate independently if its investigations are to be seen as fair and impartial. It will not have a role in regulation, standard setting, enforcement, policymaking or operational or commissioning activities, nor the implementation of its recommendations.

The Investigation Branch will have a budget of £3.6 million. The Branch will be established from 1 April 2016 with a lead in time before it becomes fully operational.

The Role

The Chief Investigator will be the head of the Investigation Branch. His/her main role will be overseeing the Investigation Branch and its investigations, ensuring these are independent in action, thought and judgement.

The Chief Investigator will work closely with patients, families and staff in a way that builds confidence and trust and ensures that all participants in an investigation are treated respectfully and with sensitivity.

The Chief Investigator will need to work with other national organisations and figures to ensure that the Investigation Branch can effectively fulfil its role.

A key Government policy is developing a culture of safety, learning and improvement in the NHS and the Chief Investigator will play a crucial part in this.

Key responsibilities:

- To establish a new national safety investigation function in healthcare that will improve safety in healthcare by conducting independent, safety investigations and produce conclusions and recommendations that will contribute to reducing risk.
• To lead a team of well trained and highly expert investigators and other staff ensuring that the right knowledge, skills and development are in place to conduct safety investigations in healthcare and seek to continuously refine the approach to investigations in light of experience, feedback, evaluation and learning.

• To oversee all investigations carried out by the Investigation Branch and conduct or assist with some investigations as appropriate. Overall responsibility includes ensuring that the investigations carried out are recognised to be of the highest standard, and are seen as an exemplar to others in the NHS conducting local investigations.

• To ensure that the Investigation Branch uses its resources effectively and stays within budget.

Accountability:

• First and foremost, the Chief Investigator will be expected to act independently, and without fear or favour. All decisions relating to the investigations led by the Investigation Branch will sit ultimately with the Chief Investigator.

• As a public officer, the Chief Investigator will be accountable to NHS Improvement for financial oversight, conduct and internal governance. The Chief Investigator will also establish a working relationship with the National Director of Patient Safety who will ensure that recommendations arising from investigations are implemented by the NHS.

• The Chief Investigator will be expected to submit an annual report to the Secretary of State for Health on the processes, practices and outputs of the Investigation Branch’s safety investigations and may be called upon by the relevant Parliamentary Select Committees.

Candidate Profile

Skills and experience:

• A national or international expert in best practice investigation techniques and processes and who can apply their knowledge and skills to lead an investigation team to deliver high quality investigations into safety incidents in healthcare.

• A track record of delivering high quality investigations of complex issues in challenging, high profile circumstances, producing conclusions that can contribute to improved services and reduced risk in the aftermath

Leadership

• Able to build confidence quickly with leaders and senior professionals across the NHS, wider healthcare and Government in order to establish the credibility and the independence of the new Healthcare Safety Investigation Branch.

Knowledge base

• Established credibility as an investigator in their field, and the ability to build a high profile with both the sector and the public.
• Expert knowledge of safety and the human, organisational, social and cultural factors that lead to safety or to harm.

• Access to a strong network of investigation advice and knowledge in other industries that can be called on at short notice

Ensuring accountability:

• Holds staff accountable for performance and builds a high performing, open culture.

• Open and accountable for the performance of the Healthcare Safety Investigation Branch.

• Effective financial management of annual budget of the Healthcare Safety Investigation Branch.

Achieving results:

• Shapes, drives and delivers improvement effectively whilst remaining flexible, ensuring people understand the reasons for change and building support for it.

• Displays corporate responsibility and holds people to account for performance.

• Takes responsibility for own and team results, explaining the rationale for decisions and demonstrating continuous improvement.

• Reflects and learns from experiences.

Personal Effectiveness

• A strong public voice, experienced in building strong relationships.

• Impeccable and unquestioned professional values, capable of creating, leading and inspiring cultural change within an organisation and the ability to do so across a sector.

The attribute listed above are key; please see Appendix 1 [to the Person Specification] for other desirable skills and experience.

**Remuneration and Benefits**

Salary, subject to further confirmation, is £131,301. Terms and conditions will reflect those of the NHS senior managers or NHS medical and dental staff as applicable.

**Location**

The role is London based with national travel

**The selection and recruitment process**

Russell Reynolds Associates has been appointed to assist in the recruitment of this post.
Timetable
Closing date for applications  Noon, 30 March, 2016
Assessment Interviews  Week beginning 9 May, 2016
(subject to panel availability)

Application instructions

Closing date for applications is noon, 30 March, 2016.

All applications must include the following:

- The reference number 1603–015L in the subject line.
- A short covering letter of not more than two A4 sized pages explaining why this appointment interests you and how you meet the appointment criteria and competencies as detailed in the candidate profile.
- A current CV with educational and professional qualifications and full employment history where possible giving details where applicable, of budgets and numbers of people managed, relevant achievements in recent posts, together with reasons for absence within the last two years.
- Names of at least two referees who may be contacted at short list stage, i.e. before final interview.
- Confirmation from you that you are happy for Russell Reynolds Associates or its client to undertake any necessary background checks, including career, credit and qualifications, or similar.
- The willingness and ability to confirm that you are a fit and proper person. http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors
- Notification of any dates you are unable to accommodate within the indicative timetable set out in the previous section.

Appendix 1 [to the Person Specification]

Leadership and change management

- Able to defend the independent nature of the organisation from high level challenge
- Articulates a compelling vision clearly with passion and energy which inspires others
- Demonstrates strong symbolic and practical leadership
- Outstanding strategic skills and effective change management
- Experience in large scale, complex organisations
- Excellent communication skills including, ideally, media experience, demonstrating an ability to engage clinicians, managers and members of the public on complex and sensitive issues
• A high level of integrity and the ability to make independent judgements and give independent advice

Personal Effectiveness
• Experienced in building strong relationships and delivering with and through others
• Ability to professionally challenge and make difficult decisions
• The ability to gain the confidence of clinicians and hospital leaders and the ability to win the trust of patients, families and the public

Achieving results
• Embodies the principles and values of independent safety investigation
• Puts the public at the heart of every decision
• Explains and demonstrate the power and value of HSIB
• Acts in a professional manner
• Ensures team members are clear on what is expected of them in their role, providing constructive feedback and appropriate challenge on performance
• Engages others when leading improvement
• Devolves decision-making, delegates effectively, supporting and challenging people to achieve higher performance
• Constantly scans the environment, anticipating and responding to changes quickly
• Establishes good relationships inside and outside HSIB
• Delivers on the Business Plan, achieving outcomes and targets for areas of responsibility

Ensuring accountability
• Takes difficult decisions at the right time
• Confronts issues of behaviour, delivery and standards
• Displays pace and momentum, ensuring results are achieved with the full commitment of their team
• Highly performance driven, takes initiative to do what is needed
• Ability to take difficult decisions and to balance rather than avoid risks

Building the right culture
• Displays a high degree of self-awareness
• Is visible, approachable and actively listens; displays respect for individuals and encourages and provides constructive feedback

• Maintains clear respect for confidentiality

• Celebrates success

• Encourages a culture of accountability in which individuals are empowered to make decisions but are held to account

• Undertakes lessons learnt activities encouraging a culture of continuous learning and improvement

• Creates a positive open environment where people are involved and engaged and can flourish; where opinions are valued

• Welcomes challenge, encourages a culture of openness and feedback

• Brings ideas from elsewhere, both from within HSIB and external bodies and encourages others to share ideas

• Actively demonstrates and encourages effective teamwork, taking a joined-up collaborative view across NHS Improvement and the NHS

• Creates an environment where equality, diversity and individual contributions are valued and respected

• Understands individual team members and leads on developing staff

• Demonstrates respect and value in differences in personality styles, ideas and experiences
Appendix 5: CV: Mr Keith Conradi BSc (Hons) FRAeS

Career History:

2010– Chief Inspector of Air Accidents

This position, appointed by the Secretary of State for Transport is the head of the AAIB, the accountable manager and holds responsibility for the investigation of all civil air accidents in the UK. I report directly to the Secretary of State for Transport on safety investigations and am responsible for a £8 million budget and 53 employees. I maintain flying currency operating Airbus A320 aircraft with a UK airline. I represent the UK worldwide on all aspects of accident investigation.

2007–2009 Principal Inspector of Air Accidents (Operations), AAIB

This position required the line management of 6 operations inspectors, the co-ordinated response of the AAIB to accidents and incidents and acting as Investigator-in-Charge of approximately 50 accidents a year. I represented the AAIB at European flight safety meetings, at our Overseas Territories and at international accident sites.

2002–2007 Inspector of Air Accidents (Operations), AAIB

This position required the investigation of the operations issues of accidents and incidents reported to the AAIB.

1996–2002 Virgin Atlantic Airways commercial pilot

This position involved flying as commander of Airbus A320/1 aircraft and as a first officer on Airbus A340 aircraft. These operations were worldwide.


Three tours as a squadron pilot on Phantom, Tornado F3 and Hawk aircraft. Qualified Flying Instructor and Instrument Rating Examiner.

1999–2010 Director Jetlinx Flight Training Ltd

Director of a small company which was a CAA approved Multi Crew Cooperation course provider with a staff of 6 part-time pilots.

Positions Held:

2014– International Civil Aviation Organisation Accident Investigation Group Panel Member

This panel is responsible for preparing and amending the global standards and recommended practises for accident investigation

2013– Transport Commissioner for Parliamentary Advisory Council for Transport Safety

2011– President European Society of Air Safety Investigators
Part of the International Society of Air Safety Investigators. Responsible for an annual seminar and leading a committee of 5 members.

2010– Deputy Chair European Network of Civil Aircraft Safety Investigation Authorities

European Commission body responsible for harmonisation of air accident investigation within the European Union

2010– Trustee of Confidential Human Factors Incident Reporting Programme

Independent Aviation and Maritime confidential reporting programme contributing to safety in the UK

2010– Member of the Board of Chief Inspectors

Qualifications

Airline Transport Pilot’s Licence, Helicopter Private Pilot’s Licence

Fellow Royal Aeronautical Society

BSc (Hons) Aeronautics and Astronautics, Southampton University

Pastimes

Triathlon (local club committee member), Adventure Racing, Skiing
Formal Minutes

Tuesday 7 June 2016

Members present:

Bernard Jenkin, in the Chair

Mr Paul Flynn          Gerald Jones
Kelvin Hopkins         Mr Andrew Turner
Mr David Jones

Draft Report (Appointment of the Chief Investigator of the Healthcare Safety Investigation Branch), proposed by the Chair, brought up and read.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the draft Report be read a second time, paragraph by paragraph. Paragraphs 1 to 20 read and agreed to.

Ordered, That the Chair make the Report to the House.

[Adjourned till Tuesday 14 June at 9.15am.]
Witness

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee’s website.

Tuesday 7 June 2016

Mr Keith Conradi BSc (Hons) FRAeS, preferred candidate

Q1–75
# List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee’s website.

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

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