HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Pre-appointment hearing with the Government's preferred candidate for role of Patient Safety Commissioner, HC 565

Tuesday 5 July 2022

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Mrs Paulette Hamilton; Marco Longhi; Rachael Maskell; Taiwo Owatemi; Dean Russell.

Questions 1 - 23

Witnesses

I: Dr Henrietta Hughes, Government's preferred candidate for Patient Safety Commissioner.

Examination of witness

Witness: Dr Hughes.

Q1 **Chair:** Good morning and welcome to the House of Commons Health and Social Care Committee. Today we are holding a pre-appointment hearing for the role of Patient Safety Commissioner. We have with us the Government's preferred candidate, Dr Henrietta Hughes.

Welcome, Henrietta. Thank you very much for joining us. The patient safety commissioner was a key recommendation from the Cumberlege report "First Do No Harm". It will be one of the central ways that we make sure that some of the patient harm that was talked about in that report is stopped, and that patients in a similar situation—whether it is valproate, mesh or whatever it is—will have a better mechanism for flagging concerns that they have about the impact of their medication.

I should say, in the interests of transparency, that I appointed Henrietta to be the NHS national freedom to speak up guardian during my time as Secretary of State, so our paths have crossed before now. I would like to start, if I may, by asking you to talk about what you did in that role and why you think that will help you in this new, very important, role.

Dr Hughes: Thank you very much, Chair. Thank you for having me here this morning. I look forward to being able to answer your questions.

If I may, I would like to start by thanking the patients and the patient groups who have courageously and compassionately been campaigning on behalf of patient safety for up to 50 years. I am pleased that the report has shown that their campaigning is leading to positive effects. I look forward to working with patients and patient groups because their voice is absolutely integral to keeping people safe.

When I look back to my time as national guardian, I see some parallels in the experiences of workers in the NHS and beyond, who felt unsafe to speak up, that their voices were not heard, that they were not listened to and, in fact, that they were discriminated against, bullied, harassed and harangued. They had to leave their post and it had a devastating impact on their life, their family, their career, their employment and their health.

The role that I took there was to look in detail at the experiences of workers, to look at the healthcare system and at what the barriers were for people's voices to be heard. I worked with an incredible group of people—the freedom to speak up guardians—whose courage and commitment to their colleagues meant that over 50,000 cases were heard. Those related to patient safety matters, patient experience, staff safety, staff experience and great ideas for improvement. That is where I think it is not just about raising concerns. It is about all the information and how we can use that for learning and improvement.

I worked collaboratively across the health system and beyond into other sectors, setting up a pan-sector network. This is not something specific to

health. It is not specific to England. There was a lot of learning and sharing of good practice from other sectors as well.

Some changes have happened. Everyone working in an NHS trust, and beyond, has access to a freedom to speak up guardian, somebody who will be there to listen, to thank them, to take on board what they have said, to escalate it so that the right actions are taken and then to give feedback. It is the feedback loop that really matters. It is for senior leaders to understand that they create the culture; whether it is a psychologically safe culture or a toxic culture is down to the leadership.

Q2 **Chair:** The freedom to speak up guardian movement, which you sat at the top of, started from scratch under you. The patient safety commissioner has not happened before, so you are starting from scratch. Could you talk about what you learned about the business of setting up something from scratch that will be relevant to a new and different role?

Dr Hughes: I pay tribute to Dame Eileen, who was the previous national guardian to me. When I started as national guardian there was already a set-up team; 89 guardians had already been appointed in the NHS. When I started there was a great groundswell of enthusiasm and I was able to get some early wins because of that.

The difference with this is that the role has not only not started but is also not entirely defined, I would say. That is where listening to patients and patient groups will be key in understanding what matters to them and in defining the role, establishing an advisory group and setting up the governance to maintain transparency and independence. It will also help with understanding the scale of the issue. I believe that the thousands of people who were affected in the particular patient groups included in the report are merely the tip of the iceberg.

Q3 **Chair:** Could I ask you about the definition of success? I understand that it is the job of the Government to define the role, or the NHS, but what is the definition of success for patients in five years' time compared to now, if you were to be the patient safety commissioner? What would look, feel and be different for those patients?

Dr Hughes: I would like all patients and service users to say, "This feels really different. I really feel that my views are being taken into account and that I am being given the information that I need."

Q4 **Chair:** In which situations?

Dr Hughes: In any situation where they are receiving, or will potentially receive, medicines or medical devices. It is important to make it absolutely clear that that is what the role is about. I understand that there are patients and service users who have safety concerns that are not related to medicines and devices. I do not want their views to go unheard. I believe there will be read-across from the learning and improvements, but it needs to be a situation where patients are part of the team and the information that is needed. We need to hear what

matters to them, and to hear the experience of other people who have had the procedure.

Q5 **Chair:** To be very clear, because it is important for people to understand this, as the role is defined now you are not the person to go to if a surgeon made a mistake taking out your appendix, but you are the person to go to if you have been given medication and you think there are side effects that there should not be. Is that how you see the role?

Dr Hughes: The patient safety ecosystem is already huge. There are many different channels that people can go to. My experience is that, when you speak up at the most local level, that is where problems can be fixed. If that does not fix the problem, there will be other ways for patients to get in touch, but what I am pleased about is that patients will be able to contact me directly. I need to understand how we are going to do that so that it is responsive and people will get a high-quality and timely outcome. My role will not be to investigate or to try to create solutions for individuals; it will be to work with the system so that people get the right response when they raise matters.

Q6 **Lucy Allan:** Good morning and thank you very much for all you have said so far today. One of the big challenges with patient safety is tackling a culture, as you referenced in your opening remarks, particularly with institutional blindness and a defensive approach. What in your previous experience will help you to manage that type of institutional blindness and improve the culture of an organisation and, indeed, the whole ecosystem as you referred to it?

Dr Hughes: I have found that the vast majority of staff working in healthcare want to do the right thing by their patients. You only need to look back over the last few years of the pandemic to see the incredible work of staff in the NHS and elsewhere.

There is a minority of people who have not been challenged. Their views are not in line with modern society. There is defensiveness. There is collusion. There is self-protection. What I want to do, as I did as national guardian, is to seek out and find allies and create upstanders from bystanders so that when the wrong behaviours and the wrong attitudes are displayed, people around them will not be satisfied, whether that is patients, families or other members of staff.

We have found that when people feel empowered to raise matters and when they feel they have safe channels to do so, it can lead to change. For some people, those techniques and behaviours have been successful for them through their entire career. What it takes is for somebody to raise that with them and say, "This is no good." In my experience, that is sometimes absolutely mortifying for somebody; they had no idea, but when they are given that information, they change. If they do not change, I think other things have to change.

Certainly, when I was a medical director, there were attitudes, behaviours and criminal activity, which I dealt with, that had gone untackled for many years. It is about setting the tone from the top. What I know is that there are fantastic leaders across the health system at all levels. It is not just senior leaders or people with director or non-exec roles. There are leaders at every level who want the right thing to happen. It is working with them that will make the difference.

Q7 **Dean Russell:** Dr Hughes, last week I was very fortunate to host an event in Parliament for an organisation called Patient Safety Learning, a national charity that I am sure you are aware of. I spoke to many professionals, patients and families of patients. I am interested to get a succinct, almost elevated, pitch from you about what you see your role will mean to them and patients, should you take the role.

Dr Hughes: If my nomination is approved, I would look to work collaboratively with all of those groups and find shared objectives. I believe we have shared goals. In fact, I spoke to Helen Hughes, and I was very grateful to speak to her, because I believe her work has been absolutely phenomenal.

The time is right for change. People want change. They want the right things to happen. I think there are problems in the system that sometimes prevent that from happening, but, as I said, there are also attitudes, behaviours and cultures that are completely wrong and need to change.

My elevated pitch is that I will work tirelessly to support patients' voices and to ensure that patients' voices, views, experience and expertise are included in all stages, so that we instil the culture of safety from the design to the delivery of healthcare.

Q8 **Dean Russell:** Thank you. What do you foresee as the barriers to that at the moment? Obviously, everyone I speak to in the NHS says that patient safety is at the heart of what they do. They care passionately about patients. Everyone I have ever met who has gone into the profession has gone into it for that reason. What is it that you think will be the barriers you will have to overcome, or perhaps break through, to make sure you can deliver on that tireless effort?

Dr Hughes: The barriers to patient safety are not dissimilar from the barriers to staff speaking up safely. They include psychological safety, conflicts of interest, communication and information, and learning and improvement. Another barrier is the complexity of the whole system. In the NHS alone there are tens of thousands of organisations, and within them they have their own cultures.

There is something about people's desire and willingness to act at speed. There is also something about the regulations. Working with regulators, as I have in the past, I would say that regulators who are forward-thinking and modern want to work to the maximum of their regulatory

powers to get things right for patients. I am pleased that in the time that I was national guardian I worked with the CQC, which included it in the well-led inspection. That is fundamental in improving outcomes for patients, as well as for professional regulators who are becoming more modern in their approach.

Q9 **Dean Russell:** I have one final question. Do you see the primary challenge that you might face being an operational one or a cultural one? How will you address either?

Dr Hughes: I think there are both. They are huge. This is a monumental task. I do not underestimate the challenges that will exist. People say that it takes a long time to change cultures, but in my experience it only takes a long time if people do not change.

Operationally, I need to understand the scale of the problem to create the right operational framework so that when people raise matters they can get a timely response, and a warm handover if that is what is needed. I know that bringing people together is often the best way. As you were saying about your reception, bringing people together and understanding their needs, their roles and what they can do to make a difference is the best way to move forward.

Chair: For the first time, in a contribution to the Committee, welcome to Paulette Hamilton.

Q10 **Mrs Hamilton:** Thank you. My question is around the key themes. What key themes have you personally noted from recent high-profile safety investigations? How do you think a patient safety commissioner can address some of these themes?

Dr Hughes: That is a great question. I despair of the fact that this is about information that is already known and it takes an inquiry and a report to give it credibility. The credibility should be there already. Looking at some of the high-profile investigations, my previous role was as a consequence of the Mid Staffs inquiry and the freedom to speak up review. This was information that people knew about already. It has taken years from the report "First Do No Harm" being commissioned in 2018 to now in 2022.

What I am looking at, first of all, is what people have been doing since 2018. I am really interested in that. With the Mid Staffs inquiry, I found that a great advantage for me was that every organisation in the NHS had agreed to adopt all of the recommendations from the inquiry. That meant that when I approached organisations I could say, "Well, that is interesting. I looked at your board papers from 2015. What have you done about it?"

What I would like to see is organisations that may not be directly included or named in a report recognising the part they have to play, accepting the recommendations and then acting on them. The themes are about people not being heard. The themes are about the system not

learning and not changing, that good practice is not disseminated widely, that poor behaviours go unchecked, that harm persists even when the findings have been made public, and that organisations and people unfortunately are resistant to change.

Q11 **Mrs Hamilton:** You have given me some excellent answers; I will start with that. I have found over many years of doing things like this that we do the reports, and we know what needs doing, and you have highlighted that. What will your role be in going from the report being there, the report being published and identifying what the challenges are, to ensuring that the organisations or people involved actually do the recommendations and that you actually measure what they are doing and the effectiveness of what they are doing? How would you go about that?

Dr Hughes: Perhaps I could go back to one of the quotes in a patient response to the report: "Don't let this incredible report end up in a box in Westminster." It is a three-year term. I am an optimist, but I am also a realist. Three years is quite a short time to set it up, start changes and start measuring the difference.

What I can say is that as national guardian I saw a measurable improvement in the NHS staff survey results. For me, it is the impact on people that matters and will be the measure of success or not. If we ask the right questions of patients, the public and service users and we start seeing a measurable difference in their experience, to me that is the mark of success. Whether that can be measured in three years I do not know, but I would certainly have it as a long-term strategic ambition. That should be the guiding principle to success for me if I was appointed or for a successor who was appointed.

Mrs Hamilton: Thank you.

Q12 **Taiwo Owatemi:** Henrietta, it is great to hear your passion for improving patient safety. In your questionnaire you talked about the importance of the barriers that certain patient groups face, especially those who find it harder to speak up. Drawing from your previous experience, how do you think that you will be able to address those challenges?

Dr Hughes: You are absolutely right. From being national guardian I found that there were groups of people who found it harder to speak up. They were vulnerable groups identified in Sir Robert Francis's report, but engaging with staff groups and with freedom to speak up guardians we found that there were other vulnerable groups that had not necessarily been identified. We can also say from the experience of the pandemic that, if we do not focus on the most vulnerable, we are not going to get it right for everyone.

My goal is for all patients to have the same opportunity to give feedback on their care and to be able to have the right information when care is being proposed or if they have a concern about it. When you get a prescription and you get the box, you pull out the information sheet. It is

written in a font that I would struggle to read, and it is always written in English. That is an obvious thing where we should be saying, "What about people who cannot speak English or cannot read?" How are we supporting them to get the information they need?

I think this is a mindset issue. I have worked with the workforce race equality standard and I am on the Health and Care Women Leaders Network. We have to make it so that we do not just think about people who look like us. We have to say, "Who is the most vulnerable person in my practice? Who is the most vulnerable person that I treat?" Who are the most vulnerable groups where community leaders can tell us, "This group is really struggling because they do not have access to the media or information"? We must then design and build systems. It might not be perfect at the beginning, but there is an iterative process of learning and improvement and then asking people, "Have you got the information that you need? Were your views taken into account?"

As a GP, I know absolutely that if I have a patient whose first language is not English and they struggle, I have access to a high-quality translation service, which I use all the time.

Q13 **Taiwo Owatemi:** How do you plan to monitor that to ensure that it is being done in GP surgeries and wherever patients are getting access to care?

Dr Hughes: It is about looking at what we ask patients in patient surveys and focus groups and through all the architecture of the health system. What are boards asking patient representatives or when they have patient stories at the board? We have to get it right in all these different ways. There was a question earlier about operationalising and culture. The two are interlinked in my view. If we get the culture right, the operational side should follow. I do not think it is going to happen overnight. It will be a mindset process, and that will be an iterative one.

Taiwo Owatemi: Thank you.

Q14 **Marco Longhi:** Dr Hughes, this role is being created from scratch. I would like to get a sense, from your perspective, of how you believe you will be defining what the role might look like in future years. I know you have mentioned that it is only three years at the moment.

Quite obviously, we all know that patient safety is impacted by a huge number of things, sometimes very complex things. The title of the role is patient safety commissioner. It is not patient safety commissioner for medicines and medical devices. There is a very real risk that a perception will be created among the population at large, and the patient groups that you refer to, that you are the patient safety commissioner for all patient safety. How do you see your role evolving, and how do you see your own particular personal leadership qualities, which you have evidenced in other areas, changing how the Government's original establishment of the position might have been set?

Dr Hughes: I will start by thinking about the scale of the problem. That is a really important aspect. I was looking at some stats. There were 237 million medicine errors in a year. That is huge. We know that there have been tens of thousands of patients harmed through the use of medical devices, so even with the remit of medicines and medicine devices, this is huge and a national issue.

How do you broaden it out so that it has impact for all patient safety? I think it is about the read-across. It is about opening mindsets and creating channels, making sure that when patients raise matters, they are heard. In the system, whether it is pharmaceutical companies, the designers of medical devices or the regulators that license their use, the way they are used or the way they are implemented, with new procedures and new medicines, we need to get to a position where it becomes business as usual that patients' voices are included and it would seem strange not to have a patient or a patient representative as part of every group or every panel. That then brings in fresh and different perspectives. From my experience, when you have a patient in your group, people's behaviours are better. There is also something about ensuring that these things stick. I think the way they stick is by getting them into the systems and processes of all organisations across the healthcare system.

I do not want to underestimate the task. I want to make sure that the views of people who are not using medicines and medical devices are not unheard. I think that is a real risk in this role. At the same time, there is potential for improvements in other aspects of patient safety, working with the existing parts of the safety systems but ensuring that patient voices are not just lip service. That is what I was going to say. It should be genuinely included and integral to the design and delivery of healthcare.

Chair: Thank you. Rachael Maskell, welcome.

Q15 **Rachael Maskell:** Thank you and welcome as well. I would like to ask a question about levers to bring about change. Clearly, you need to be an influencer beyond the jurisdiction of your role. How do you see your role in bringing about change? It could be through education. It could be working with other authorities.

Dr Hughes: I think there are some particular levers in the system that have a very big impact. Part of that is around the regulatory framework. I have been working with the General Medical Council on developing the new form of good medical practice, which is extremely different from the old one. It is much more focused around safety. It is focused around systems. It is about behaviours and cultures. With the healthcare regulators, for example the MHRA and the CQC, changes in the way that they license, inspect and regulate are going to make huge differences. I have seen that already from my role as national guardian.

You are absolutely right that there is something about education. I was very fortunate that I had a course when I was a trainee GP about speaking and listening to patients. My training was all about a reductionist approach, trying to get the minimum amount of information to be able to make a diagnosis. What I learnt from the course was actually to have a conversation and to listen to everything the patient says and wants to say, because that is how you get to the right place. We need to work with educators, whether undergraduate or postgraduate, and in a multi-disciplinary way as well. The role of pharmacists cannot be underestimated.

Everyone has a part to play in this. I know that the professional regulators are keen to modernise and improve. I feel optimistic that you can change the system by the levers, but there are some things that are not about levers. It is about getting the right people in a room, listening to the views of patients and patient groups, and individuals changing the way they do things and setting priorities.

Q16 **Rachael Maskell:** I have one more question, which is around feedback loops. Obviously, change takes time, yet the patient who has perhaps raised the concern in the first place will want to know the outcome of the process. How do you see feedback loops being inclusive of the patient community?

Dr Hughes: To go back to the pandemic, I can give an example about when the vaccination was rolled out. I was involved not only in vaccinating but in talking to people who wanted to get more information about the vaccine and when problems were identified. What I saw there was an exemplary system of disseminating information to the frontline and a desire for us to feed back in real time. Because of that, although some of the guidelines changed on a very frequent basis, we were able to give people up-to-date information and keep people safe in that way.

I can look at other ways; for example, when I have been a patient my views were sought. There are apps where people can give information in real time about their symptoms so that the information can be fed back and you have much more detailed knowledge.

The last area, which I think is really important, is about patient groups and people who are planning treatment, or thinking about treatment, being able to speak to others who have already had that treatment. I know from my own experience that your doctors and healthcare providers can tell you so much, but what you learn from people who have had the same treatment as you is absolutely invaluable. People want to be able to share their experiences to help their fellow patients as well.

Rachael Maskell: Thank you.

Q17 **Dean Russell:** Obviously, there is an accountability aspect. Part of that accountability, I believe, is to this Committee in terms of the engagement as part of the legislation. You mentioned an incredible number of medical

errors. Was it 237 million?

Dr Hughes: Yes.

Q18 **Dean Russell:** If, in six months' time, you are back again, do you expect to have made a dent in that? In three years' time, do you expect to have made a dent in that number? I appreciate that you are not going to be able to get it to zero, although we would like that to be the case. What do you see as your target? I suppose my question is: how can this Committee best hold your role to account for effectiveness? What would be the top two or three criteria that we should be asking you about every single time you come back to this Committee?

Dr Hughes: The first six months, I will be honest, will be a set-up phase. I have a responsibility to produce an annual report. I know from when I started as national guardian, also in the autumn, that it is better to do that with the fiscal year rather than from the date I started. I would anticipate that my first report would look to the first six months of the role.

What I would be wanting to know if I was a patient is, "What difference is this making?" There will also be information about what others have done. It is clear from what we have discussed this morning that this is not something that one person does alone. It is working with the system. What others have done is a really important lever, but there is also something about how I have engaged with patients, patient groups and the public. How do people know about the role? It is having clear communication about the role and what its scope and intended purpose is. When there are metrics that we can start to look at, it will be about monitoring those metrics. From my experience, there is something about data and stories. Both are powerful, and we need both.

Q19 **Dean Russell:** In your annual report, in six months' time, is it possible to make a request that within that report you have some very clear metrics that we can measure against so that we can refer back to them in future sessions?

Dr Hughes: Consulting with patients and patient groups and creating the principles for the role, with consultation, is where I would like to be able to get an idea about the metrics.

Q20 **Mrs Hamilton:** I have a simple point. I am very keen on getting all types of patient views, and that with some of our BAME communities we make sure we are getting their views. Sometimes they feel that they are left out of the process. In what you are going to try to do, can you ensure that you get a cross-section of patient involvement, otherwise those with the loudest voices are the ones that tend to get heard? Sometimes they are not the ones with the worst experiences.

You can see that, for instance, around prenatal care for mothers and the number of mothers who have problems during childbirth. Certain groups suffer more than others. I would be very keen that we get a wide cross-

section and that you make sure, within the matrix that you talk about, that you identify some idea of a percentage, not the number, of how you are getting to some of those—I hate the term—hard-to-reach communities. They are not hard to reach; they are there. It is just making sure that we speak to them.

Dr Hughes: Absolutely. I have experience of that with the NHS staff survey and drilling down into groups who have worse experiences. I would include in that not only people from a minority ethnic background but also people with a disability.

Mrs Hamilton: And gay and lesbian people, as well as people with mental health issues who do not have the same experiences because of the illnesses they are living with. Thank you.

Q21 **Chair:** I have a final question. I have absolutely no doubt about your suitability in terms of your background in patient safety. I am a bit worried about the lack of definition in the role. Basically, it seems to me that "First Do No Harm" was looking for a very specific problem to be solved, which is how to stop problems like those we had with valproate and vaginal mesh carrying on for many years when many patients were talking about horrible pain or terrible side effects. There seemed to be a gap in the system. No one was marshalling those complaints and making sure that something happened.

With the name "Patient Safety Commissioner" you are also going to get letters from someone whose baby was born with cerebral palsy because they felt they were pressured into a vaginal delivery and not offered a C-section early enough, for example. You are obviously interested in that too because you have a broad interest in patient safety, but how are you going to avoid a lot of disappointment about your role when you have patients up and down the country saying, "I had this terrible thing that happened to me in the NHS. I wrote to the hospital. The NHS has even set up this thing called a patient safety commissioner. They were no use whatsoever"?

How are you going to set expectations so that what you do, you do really well and everybody understands? You are not going to be resourced to help the person whose child is born with cerebral palsy because that is not part of the job description. How are you going to avoid disappointing a lot of people who are looking to a patient safety commissioner as the knight in shining armour?

Dr Hughes: I think the worst thing you can be told is, "Oh, that's not me. That's someone else who will be there to help you." This was the experience that staff had when they were trying to raise matters. A host of different regulators and organisations were contacted, and people were bounced from pillar to post.

Working with that group, my team developed a process whereby everyone who contacted them had a high-quality, timely response and a warm handover to the right place. If you are a member of staff and you

contact the GMC and it is not them, maybe it should be the CQC or some other part of the alphabet soup that is the NHS, but it is not for the individual to have to be the expert on where to go. I would put the same process and principles in place and treat people—

Q22 **Chair:** That is a very important development in the role as originally conceived, which by the way sounds excellent, but I do not think it was necessarily what was envisaged in "First Do no Harm". What you are saying is that you will specifically deal with the medication and devices issues where there appears to be not just an individual case but some kind of pattern worthy of investigation, and you will also be a conduit with, as you described it, a warm handover to direct patients who have a patient safety concern to the right place in the case of other complaints. That could be a brand-new function that we have not had before.

Dr Hughes: I see that as treating people with care and respect. It is not for patients or the public to be the expert on the NHS and the healthcare system. It is such a complex system. I have been working in the NHS as a doctor for 27 years and there are still new parts of it coming to the fore which require quite a lot of thought as to where complaints systems are going to sit and how that is going to link to individual providers.

I think it is the right thing to do. I do not think it was ever written into the national guardian role, but that was about finding out the gaps and the places where people could potentially fall through the cracks. Part of making sure that people are not ignored or looked over is about treating people with care and respect.

Q23 **Chair:** Thank you. I think that concludes our questions for this morning. Thank you very much for your time, Henrietta. It is much appreciated. We will have a short private meeting to discuss the evidence we have heard, but if you go on to be Patient Safety Commissioner we wish you all the very best of luck.

Dr Hughes: Thank you very much. I look forward, if I am approved, to coming back and giving you an update on the progress that has been made.

Chair: Thank you very much indeed.