

Health and Social Care Committee

Oral evidence: Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB, HC 843

Tuesday 1 November 2022

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Members present: Rachael Maskell (Chair); Mrs Paulette Hamilton; James Morris.

Questions 1 to 14

Witness

I: Dr Ted Baker, Government's preferred candidate for the role of Chair of HSSIB.

Examination of witness

Witness: Dr Ted Baker.

Chair: Welcome, Dr Baker. I am Rachael Maskell, the MP for York Central. I am stepping in as the Chair today. We are pleased to see you before the Committee and have a number of questions that we would like to put to you. We appreciate your attendance.

Before we start formal proceedings, one of the new members of our Committee, James Morris, has recused himself from the process. I will leave it to James to give a brief explanation.

James Morris: It would be appropriate for me to recuse myself from questioning, as I was involved in the interview process for Dr Baker in the Department of Health.

Q1 **Chair:** Thank you very much for that. Paulette Hamilton and I will be putting questions to you, Dr Baker.

We will make a start. Clearly, you come to this role with considerable and quite unique experience. We would love to hear what your vision for the role is to build an effective organisation nationally, with local investigations being part of that. What do you hope to achieve in the three years of this appointment?

Dr Baker: Chair and members of the Committee, thank you very much for inviting me.

This is an important opportunity to drive forward patient safety. Patient safety has been a major theme throughout my career, right from the time that I started in clinical practice up to the time that I was chief inspector of hospitals. The issue is really important, and I am convinced that healthcare can do it much better than it does. This is a real opportunity.

There has been a real change going on in the patient safety landscape over the last few years. I have been involved in that to some extent in my previous roles, but many other people are also involved. That means that the NHS and wider healthcare are in a strong position to move forward with driving improvements in patient safety.

This organisation, the Health Services Safety Investigations Body, will be a pivotal part of that. It will not be able to do it by itself. It needs to collaborate with a lot of other organisations. It needs to collaborate with staff. It needs to collaborate with patients and the public. Having said that, I think that it is a pivotal role.

My vision is to make that a success, judged in several ways. First, the primary purpose of the organisation is to do good-quality safety investigations into safety incidents. My vision for it is that the HSSIB will become the authority on doing safety investigations well. The



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predecessor body, HSIB, has already set some great foundations for that. The work that it has been doing on driving forward safety investigations is very impressive. I want to build on that. It is interesting that, since I have been looking at this job, I have become aware that other organisations elsewhere in the world are looking to HSIB and HSSIB to lead the way in driving forward safety investigations. There is an opportunity to do that really well.

It is not just about doing the investigations; it is about improving investigations across the board throughout the health services. When I was at the CQC, I published a report that was very critical of the standard of safety investigations and called for improvements. I am glad to say that we are seeing those delivered.

A few months ago, NHS England released the new patient safety incident response framework. If that is done well, it can be transformational for the way the NHS manages safety events. HSIB and its educational function have been very supportive of that. I want to build on that so that HSSIB is not only doing great investigations that are producing a real impact on patient safety, but building expertise across the health services so that they are doing good-quality local investigations, driving safety forward.

To come back to your question, my vision for the organisation is to drive those elements forward. It is also to build HSSIB's role as a leader in patient safety. That means building great collaborations with other parts of the system.

It is very important that it is independent, and that has been laid down by statute, but independence does not mean not collaborating, where effective, and not building alliances with other arm's length bodies, professional associations and frontline staff. First and foremost—this is something that I championed at the CQC and that I think is really important—we must build an alliance with patients, their families and the wider general public. One of the problems that we have in patient safety is that it is dominated by patient safety experts. They are great, but they all tend to think alike. Bringing in the diversity of view that you can get by including the public and patients in your deliberations is dynamic in driving forward patient safety expertise and patient safety thinking.

What would I like to achieve? I would like to deliver all of that. As chairman of the board, I need to deliver a board that is effective in oversight of the organisation, both in terms of performance and in terms of culture. Culture is very important in patient safety. The culture of HSSIB will be important. The safety culture that it encourages outside will be really important. That has to start with the right cultural leadership of the board. I see that as an important part of it.

How would I judge my success? My success will be if we are respected, if there is confidence from the general public, the professionals and other stakeholders in what we do, and if there are tangible improvements in



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safety we can point to and say, “The health services are safer because of those investigations,” and we can demonstrate that. Measuring safety is difficult, but we need to set ourselves ambitious goals.

Q2 Chair: Thank you so much for that. Obviously, there are already lots of processes in place within the NHS and other providers. What do you perceive as the main challenges that need to be addressed? How do you intend to manage those challenges, not least the cultural issues that exist? We see that where we have an organisation that can be quite defensive, particularly with a litigation culture. There is a need for candour and to be able to get to the heart of why things go wrong.

Dr Baker: I agree with you. Culture is the basis. We need to do well the technical side of safety science and understanding why things go wrong, but if you do not get the culture right it will never change anything. The culture within healthcare generally—it is not peculiar to the NHS; you see it in healthcare systems in other countries as well—is often very defensive when challenged. We need to get beyond that. One of the things that HSSIB has to do is to lead that culture well.

It has been given some unique powers by Parliament that are really important. First, it is not allowed to make any conclusions about liability or blame. That is a real privilege. It is a real privilege to be able to do an investigation and say, “We are not allowed to blame anyone. We just need to find out why this happened.” That is something that we have often got wrong in healthcare investigation. We have tended to start off by looking for human error and then blaming the human who happens to be at the sharp end of that error, when, in truth, we all understand that human error is commonplace. We know that humans make mistakes.

What HSIB has been doing, and what HSSIB needs to build on, is looking at the systems behind those humans and seeing human error not as the cause of safety incidents, but as a symptom of safety incidents—a symptom we need to look at to understand why an incident has happened. We need to see that through the eyes of the people providing it.

The other important element is what is often referred to as safe space. This is the element whereby people—staff, but also families and patients—can talk to us without fear that what they say to us will then be used in other proceedings, which would undermine their ability to be frank. The freedom that we will have will be really important.

Creating psychological safety such that people can speak to us freely about what has happened, and their concerns about why it happened, will be really powerful. It would be great if we could build that into all investigations. Only HSSIB’s investigations will be protected by statute to start with, but we need to build on that so that there is a culture of psychological safety, talking about when things have gone wrong. In that way, we can learn. We need to move away from the blame culture that is



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so prevalent. The just culture—the restorative culture—has been talked about a lot, and we need to be a major proponent of that.

Q3 Chair: I certainly find from constituents that the issue that is consistently brought to my attention is that people want learning from what has happened and they want the system to change. This is a fantastic opportunity to bring that about.

The outcome of reports should bring lasting change, not just to an organisation but to systems and to the culture. In your application, you said that there would be a strong culture of learning and improvements in safety, but so many times we have been back here discussing similar failures, perhaps with a different provider and a different tragedy. How will you ensure that the governance of the new body brings widespread and sustained change, not least to organisational culture and processes?

Dr Baker: A couple of weeks ago, I was talking to the Norwegian equivalent body. They may be doing this slightly better and we need to learn from them. Something that HSSIB must do is not just put recommendations out there; however good the recommendations, you have to follow through. You have to work with the system to help it to implement the recommendations.

To start with, we have to bring out consultation. We cannot just drop recommendations on people without discussing with them the implications for them, because they may see elements that we cannot see. Recommendations need to be collaborative. Equally, HSSIB needs to follow through. HSSIB has no powers to manage that, but it has a great deal of influence to go to organisations and say, “These are the recommendations we made. How are they working out? What are you delivering?”

At the moment, bodies that have recommendations made to them by HSIB respond in writing in 90 days. That is great, but a response in writing is not what we are looking for; we are looking for real change that will have an impact on patients and patients’ experience of care. HSSIB needs to work with those bodies, but also with the people receiving care, to make sure that real change is taking place. As I said earlier, I want the organisation to drive real improvements in real safety for real patients. We will only know that that is happening if we see the experience of care through their eyes.

Chair: Paulette, would you like to ask some questions at this stage?

Q4 Mrs Hamilton: I would. I note from reading your information last night that your previous job was chief inspector of hospitals for the CQC. What do you see as the similarities between that role and this particular role? Can you draw anything from both roles?

Dr Baker: From my perspective, there are important similarities. I went into the CQC because of my focus on patient safety. In my time at the CQC, I moved the regulation from what I always called a transactional



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approach to safety, which you might regard as a kind of tick-box approach to safety, to one much more focused on culture and learning. One of the four pillars of the latest CQC strategy is safety through learning, which is taking forward the regulatory approach to safety in exactly the way I have described.

HSSIB is not a regulator. To some extent, that gives me and the organisation freedom. CQC was constrained by being a regulator, in that it had regulations to enforce. I wrote a chapter in a book on just culture that was published earlier this year where I talked about the tension between being a regulator and driving patient safety. We have talked already about the importance of getting the right culture, but it is so easy to see regulation as an agent of blame and criticism. I tried not to do that at CQC, but it is very difficult to avoid the perception that it is blame and criticism when actually you want people to grasp the issues and move the culture forward. There is a real tension between the two.

Moving from CQC to HSSIB, there are links, but, equally, there are differences. There are differences because we will be focused not on enforcement and blame, but on moving very much away from that. I am sorry. I am not sure that I have explained that well. There is a kind of logic between them, but they are different roles.

Q5 Mrs Hamilton: Do you think that it will take some time to get that embedded with the new role?

Dr Baker: I have to be very careful that I do not expect the organisation that I am leading to act in a regulatory role. That is not its role. There are plenty of regulators in healthcare. They do not need another one. It is there to investigate and to find out how safety can be improved, and to encourage that, which is a very different role. I need to be very careful that I do not fall into a regulatory role.

Having said that, I think that HSSIB as an organisation needs to work with the regulators to help them to be more effective by focusing on culture. One of the things that I did at the CQC was to bring together a lot of the regulators into fora to discuss how they could align their approach, focusing on culture rather than enforcement activity. I think that they have moved in the right direction, but they have a way to go. HSSIB, as part of collaboration and building alliances with other parts of the system, can work with the regulators to help them to move into the space where they are driving forward cultural change and improving safety in that way as much as by using their regulatory powers.

Q6 Mrs Hamilton: I am not sure about this question, but while reading the notes I was trying to find out whether this is a time-limited process or a permanent appointment. I wasn't sure. Could you enlighten us on that?

Dr Baker: I understand that the appointment is for a term of three years, but HSSIB is a permanent organisation. I would be appointed for three years, but HSSIB would be a continuous organisation.



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Q7 Mrs Hamilton: Brilliant. This is my last point. Within health—I won't say "we", as I am not currently there—they have had some high-profile safety-type cases. I am sure you know all about the recent investigations. How do you think that HSSIB can address some of the issues that you have picked up on?

Dr Baker: Healthcare is enormously complex. We tend to seek simple answers to some of the problems when, in fact, the answer will always be complex. We need to get people to recognise that there is a complex issue to address and that there are no quick fixes for a lot of problems.

If you read the many reports that we have had recently on safety failures, it is interesting that there are some common themes. The common themes are often around culture, which I have talked about already. There is a very strong theme around listening to patients. If you read through them all, you find that again and again patients raised their concerns and were ignored by the system for too long. Eventually, the system listened and recognised that their concerns were valid.

The whole system needs to be much better at listening to the concerns of patients, and HSSIB needs to be part of that. Last week, I met Henrietta Hughes. I said, "If I am appointed to this job, let's work together very closely." I think that the patient safety commissioner's role is going to be really important in making sure that patients' voices are heard, by HSSIB, but also by the rest of the system.

Q8 Mrs Hamilton: I am going to be devil's advocate. What about staff?

Dr Baker: Staff as well.

Q9 Mrs Hamilton: Sometimes staff are crying out for ages, they are not heard, then something goes wrong and they get the blame.

Dr Baker: That is fair comment. When I was at the CQC, I published a lot of critical reports over the last five years on a lot of NHS organisations. When I sit before the boards of those organisations, they often say, "You're being unfair on the staff." I come back saying, "Actually, it's the staff who have told us about these problems. They have told us that they are crying out for someone to fix the problems and our report reflects that." One of the most important things that I learnt at the CQC was to listen to frontline staff, and to patients. The frontline staff were often crying out to be heard. That is really important.

One of the things that HSSIB can do, using its powers—safe space is one of the key elements—is allow staff who have been involved in patient safety incidents to have their voice heard and make sure that our reports reflect their working lives; not some theoretical working life, but their real working lives. Safety science experts talk about work as imagined and work as actually carried out. Often, safety debates are about work as imagined. Everyone is following the policy and doing the protocol correctly, there are always enough staff and there are always the appropriate resources. Therefore, if something goes wrong, it is because



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someone has done something wrong. Work as actually carried out means that often people are very busy. They have a lot of patients to look after. They feel pressurised. Their resources are not as they ought to be. The IT systems do not work as they should. The policies are not practical.

If you want to change safety, you have to look at work as actually carried out, not the theoretical element of work that is held up. You only find that out by talking honestly to frontline staff and saying, "Actually, what happened here? How do you normally manage this problem? Why did it not work today when normally it does work?"

Q10 Chair: Thank you for your answers. We too recognise that there is a hierarchy within the NHS, not least of power. Being able to address that within the structures of investigation will be incredibly important, so that there is a level playing field when looking at patient safety and the participation of other stakeholders, not least patients and their families.

I want to ask you a couple more questions, if I may. One of the important things that is being established around the HSSIB is its independence. However, it is very clear that you will have to work very closely with a number of bodies. We have talked about regulators and inspectors. There is the Department and, clearly, NHS England. We have a new structure in our NHS, with the integrated care system. How will you ensure that there is sufficient challenge within the system to maintain that independence?

Dr Baker: As I said at the start, independence is really important. We have to be authoritative as an organisation. People have to trust what we say, and our conclusions about safety have to carry weight, so they must be seen to be objective, impartial and based on our impartial judgment.

One of the great things about HSIB as it is now is that it includes safety expertise from outside healthcare—people who do not come with preconceptions about what safety should look like. One of the frustrating things is that people working in healthcare often do not look at expertise from outside healthcare. Other high-risk industries have improved their safety much more than healthcare has. It does not mean that there are simple solutions to be imported, but it does mean that we need to listen to what they are doing and understand that. I want independence to come from diversity of opinion and expertise, so that we are not just drawing on NHS or healthcare expertise all the time, but are looking beyond that.

I also want that independence to come from setting a clear strategic direction for HSSIB. We should consult widely on it with the stakeholder organisations that you mentioned—the professional bodies, frontline staff, patients and families—and have a clear strategic direction, but we should use that as a guide to make sure that we keep focused on what we are trying to achieve and do not get drawn into other areas because other people have other agendas. We must be absolutely clear about what our agenda is. We must make sure that we have discussed it and consulted



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on it, but that we are clear about it. Having a very clear strategic direction is important.

One thing that I need to do fairly soon, if I am appointed, is appoint a board, because we have no board. We must appoint non-executive directors with the appropriate background and expertise. I come from a health background. Clearly, I do not want to appoint people who come from the same background as me to be my non-executive directors. I want people who are going to challenge both me, as the chair, and the executive directors of the organisation to make sure that we maintain what we are trying to do in terms of quality, but also in terms of independence. I really think that that is important.

That means bringing in people who can see the bigger picture and are not going to get narrowed down by the health service politics, if I can use that term, but can focus on the bigger picture, who can focus on our strategic direction, but bring expertise from outside. Appointing a group of non-executive directors with the right diversity of background and experience will be important for the quality of the organisation and the board.

Of course, over the next few months, before April, we will also need to appoint a permanent chief investigator. Appointing someone with the right skills, the right background and the right independence of mind will be important for me as chair.

Q11 Chair: I noticed in your application that, in response to a supplementary question, you highlighted the need to focus on safety science. Today you have talked about the global expertise that exists in that area. How will you harness the very best globally to ensure that we end up not just with the safest health system, but with the best investigatory powers to ensure that we really improve patient safety?

Dr Baker: I come from a clinical background. One of the things that I criticise about clinical training and education is that there is not enough safety science in it. Safety science is new to me, but I now realise its importance. The team that set up the HSIB, the current body, brought in a lot of safety science. From talking to those individuals while I have been applying for this post, I am really impressed by the level of expertise that already exists within HSIB. I want to build on that.

I want to do that by bringing in the best safety expertise from within the UK. However, as I said, there are opportunities to work with other organisations doing similar work in other countries. HSIB started that, but it is building as we go forward. HSIB is still seen as a bit of a world leader in this, but other countries are catching up. We will learn from them as well.

Chair: Of course, this is not going to be an HSIB No. 2. This is a new organisation. Paulette, you want to come back.



Q12 Mrs Hamilton: I want to draw you back to the new non-exec board. I am really keen that the board is diverse. It is something I have looked at all my adult life. A board should have enough women, ethnic minorities, people with the right skills and, as you have said clearly, people with broader skills. How will you get those skills? What is your vision? How do you plan to go out there and get the skills that you need to make this thing work?

Dr Baker: The appointment of the board and getting the right people is really important. As chair, I need them to support and challenge me. One of the things that I have found throughout my career is that if you build the right challenging environment it helps you to be your best and will help the organisation to be its best.

We need people who will bring different expertise—we have talked about safety science, but we need other expertise as well—and different experience. They should come from a different part of society or a different background professionally, so that they are not just bringing the groupthink around healthcare to it. We need people who have had a different life experience and come from a different background. We need people who can speak up for different populations and parts of society. All of that is important. We need to get the right mix of people on the board to bring all of that together.

That is quite a challenge, I have to say, because it is not going to be a big board. It will be a relatively small board. Having said that, if we can get the really good people, I am convinced that we can build a really strong team. A team is only strong if it has diversity of view, diversity of background, diversity of opinion and diversity of expertise. A team where everyone thinks alike is not a strong team. It is only as strong as one person. I want a strong team.

Q13 Chair: I have one further question for you, Dr Baker. In your pre-appointment hearing questionnaire, you referred to the possibility of your taking up a special adviser role to Aqua, the NHS health and care quality improvement consultancy. Do you see any possibility of a conflict of interests in your taking such a role, given that you must maintain the independence of the HSSIB, which will still have to have oversight of patient safety? Can you talk us through the politics or the dilemmas of that?

Dr Baker: Let me say first, as I think I say in the application, that if I am appointed to this post it will be my priority and I will not do anything that conflicts with it. I feel strongly about that.

Since I retired as chief inspector of hospitals, I have been invited to go to various trusts to talk to senior leadership about insights that I gained from being chief inspector of hospitals. I have found that useful for me, as a way of staying in touch with the thinking in the NHS, as well as, I hope, useful for them.



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From what I foresee, the role I am talking about and exploring is only a few days a year, so it will not conflict in terms of time. I do not think that it will conflict with this role. In many ways, it might be very helpful, because I would be talking to people at the frontline or in leadership roles in the NHS and would understand the world better from them. I think it would be complementary to this role. If there were any sense that it would be conflicting, I would not do it.

Q14 Chair: Thank you very much for your candour today and for the answers you have given us. We will break now to have our deliberations. We appreciate your coming along and the answers that you have given.

Dr Baker: Thank you, Chair and Committee. It has been great talking to you today.