HOUSE OF COMMONS

Public Administration Select Committee

Oral evidence: NHS Complaints and Clinical Failures, HC 886

Tuesday 3 February 2015

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Written evidence from witnesses:

- Dr Mike Durkin, NHS England Director of Patient Safety, NHS England, and
- Professor Brian Toft, Professor of Patient Safety, Coventry University,
- Michael Devlin, Head of Professional Standards and Liaison, Medical Defence Union, and
- Ed Marsden, Verita

Watch the meeting

Members present: Mr Bernard Jenkin (Chair), Paul Flynn, Sheila Gilmore, Kelvin Hopkins, Greg Mullholland.

Questions 1-154

Examination of Witness

Witnesses: **Keith Conradi**, Chief Inspector of Air Accidents, Air Accidents Investigation Branch, **Dr Mike Durkin**, Director of Patient Safety, NHS England, and **Denis Wilkins**, Founder of CORESS, gave evidence.

Q1 Chair: May I welcome our first panel of witnesses to this first public session on clinical incident investigation in the NHS? It is an inquiry being undertaken as part of our response to the Parliamentary and Health Service Ombudsman, whose case load is very substantially dominated now by clinical complaints, but who is right at the end of the line for the complaints process, often years after the event, and who, as a solution to safety management or redress in the Health Service, should only be a longstop, not a routine part of the system. That is what has drawn us into this inquiry, and we are interested in looking at how the system is working in the NHS and what we can learn from other sectors that have to investigate lapses of safety, and accidents or incidents that cause injury or death. Could I ask each of our panellists to identify themselves for the record, please?

Dr Durkin: I am Director of Patient Safety for NHS England.

Keith Conradi: I am the Chief Inspector of the Air Accidents Investigation Branch.

Denis Wilkins: I am a retired surgeon and representing the Association of Surgeons and CORESS.

Q2 Chair: Thank you. We will keep our questions brief. If you can keep your answers fairly brief that would be helpful. This is not confrontational or a cross-examination; we are interested in exploration and understanding. If you wish to disagree with each other and pick up points from each other, that would be very helpful to us. I just have an ancillary question to ask before we start. Have you ever sat next to each other before to discuss medical safety?

Dr Durkin: I have certainly met Keith Conradi to discuss medical safety, when I visited the Air Accidents Investigation Branch.

Q3 Chair: Was that in preparation for this or was this much earlier?

Dr Durkin: As we may discover, it was part of our inquiry into how to set up a patient safety investigation branch in NHS England, of which we are doing a pilot at the moment. I met Denis when I was medical director of Gloucestershire Hospitals and he was a senior surgeon in the south-west.

Q4 Chair: Mr Conradi and Mr Wilkins, have you ever met each other?

Denis Wilkins: No, but I have met his predecessor.

Chair: That is very interesting. It is encouraging; it suggests we are already on the same page.

Q5 Paul Flynn: There seem to be a great many agencies, bodies and organisations that deal with medical complaints. What hope is there for the person in the street of understanding the system and the complexities? Is the system inefficient because of its turgid nature, because it is so complex and slow?

Dr Durkin: I would certainly agree with you, Mr Flynn, that it is complex and it does not necessarily offer the smoothest entry for patients when they are concerned about the care they have been offered. I would go back to the responsibility that I believe should be held by every clinical professional—the nurse, the doctor, the pharmacist—who is helping supporting a patient. If they believe, when they have recognised that a mistake has been made or an error has been made, then they need to discuss that openly and actively with the patient and then guide the patient through the process by which the patient could understand how that happened, what could be done to help support the patient and what the organisation—whether that is the pharmacist, the hospital or the general practice—needs to learn.

Q6 Paul Flynn: Has the restructure of the Health Service added to the complications or simplified them?

Dr Durkin: In so far as this issue is concerned, if we talk about the front line being the ward, the general practice and the operating theatre, I am less convinced that the orchestration and organisational changes around it, in terms of commissioning and provision, have actually made a material difference to the relationship that should be in place between the clinician and the patient.

Q7 Paul Flynn: How confident are you that those safety issues that have been identified by you have been transmitted to those on the front line of the services?

Dr Durkin: That is our greatest challenge. That is the challenge for the patient safety domain, which sits within NHS England, whose remit is to look and support the improvement of a reporting system through the national reporting and learning system. Our remit is also to identify from that reporting system how we can alert the system to emerging issues and trends across England, and then we also have a specific subject-matter-expert role, in terms of identifying initiatives that should be reducing harm in particular areas.

We brought that system together as a result of the reorganisation. We are a successor but a different body from the National Patient Safety Agency, which was the previous incumbent holding that space, and we have been given the opportunity from Robert Francis's report and Don Berwick's report into improving the safety of patients in England to create a new landscape for learning for all across the NHS. A difference for us is that we see the patient as being at the centre of this conversation about how you create a learning environment, rather than at the periphery. We may want to talk about that later, because that, for me, is a crucial element to how you create a sustainable learning system. Patients have to be at the centre of that, not as a part player in it.

Denis Wilkins: I certainly agree with Dr Durkin about the learning and the lack of an effective mechanism for identifying and putting into practice the learning. The NHS has got very much better at allowing patients entry into making a complaint. There is the PALS system, Patient Advice and Liaison Service, which all hospitals have, and complaints are generally channelled through those. I am a non-executive director of a large hospital in the south-west, so I see these across the board. I sit on the patient experience committee, so we see these complaints; we see them nicely grouped under headings and titles.

Dealing with it becomes sometimes a problem, in the sense that my colleagues—they are busy people—do not always give them the priority that they should. In the States for example, a complaint is dealt with almost on the spot. It is a business, I suppose, but it is actually dealt with like that. Sometimes it takes weeks for a patient to get a decent response from the person in charge who can best answer it, so that there is that sort of cultural gap. I do think we are much better at picking up complaints these days and also picking up incidents. It is what we do with them that is the problem. I do not know whether Dr Durkin would agree.

Q8 Paul Flynn: You say "generally channelled", so clearly you have reservations. Are the problems because of the architecture of the Health Service, so that it is difficult to disseminate new information amongst the structures?

Denis Wilkins: There is a bit of both, but it is a cultural thing. It plays out in the management-clinician type of interface and that is still a journey in process. The result is that the clinicians do not seem to have the ownership of the problems that perhaps they might. Does that make sense?

Q9 Paul Flynn: It does, but "in process" is something that we constantly hear. Everything is in process and work is halfway through. We are not expecting you to come up with a utopian solution, but are you satisfied that progress is reasonable?

Denis Wilkins: No, it could be much quicker.

Q10 Paul Flynn: How do we do that?

Denis Wilkins: There is a reluctance, if I am completely honest—and this is a personal view—to transfer ownership of the clinical domain to those who are actually charged with delivering care. If you look in the hospitals, at the clinicians, they sit on the borderline between their responsibility for the individual patient, where they have professional duty of care above all else, in the same way as a pilot would have the same duty to passenger safety, and on the other side they have the commercial employers, to which they have a professional duty to look after and get the best bangs for their buck. There is sometimes a little bit of a conflict. One gets the impression that actually those strings of ownership are not always relinquished.

Q11 Paul Flynn: Can you tell us something about the genesis of CORESS? Was it established because of a perceived defect in the previous system, and why is your reporting confidential, in the main?

Denis Wilkins: It is an exact mirror of an organisation that has been successful in aviation in this country and the equivalents elsewhere, called CHIRP—the confidential human factors incident reporting programme. We actually use their software, and it came about because the experience of the aviation world was that a key sector of professionals, in other words pilots, were not reporting precursor events—low-level, low-harm events—which, if they were reported, would actually provide insights into system defects and so forth and thereby, with correction, perhaps forestall a major catastrophe. These are precursor events that have the exact significance it says on the tin.

What we did was we said, "Look, this is not really happening. This is 10 years ago. Let us see what we can do." There are a number of us who are pilots, as well as surgeons, and we got together in the association and we put it together. It cost buttons. It cost very little and it is a low-level safety mechanism. It is confidential, in the sense that it aims not to protect; it aims to make it easy and secure for folk who may perhaps feel guilty and may perhaps feel that they could be in the firing line to report on these events.

What was found in aviation was that, if you had an institution that was clearly within the establishment, then it actually put people off. CHIRP fulfils the role of honest broker. That is the phrase and it is seen to be that: it sits in the middle; it has no particular affiliations except to provide objective lessons.

Q12 Chair: CHIRP will never be a substitute for AAIB itself.

Denis Wilkins: Absolutely not. I am sure that Keith would bear this out. It captures a significant set of data that otherwise would be lost. Doctors, I am afraid, are notorious for under-reporting. Nurses are very good at it, but doctors perhaps are not so.

Q13 Paul Flynn: "A significant amount"—could you give us some idea of any measure you have made of improvements as a result of these changes?

Denis Wilkins: We feed our reports through. It is a personal learning instrument. The reports we get are dis-identified and then published as vignettes, as stories. That is significant in the sense that they are not, "This happened. You must do this and that." It is actually a personal story: "This happened to me. I got up in the morning. I was in a good mood, and I went in. The theatre was there, the music was playing and everything was fine, and then… And then whoops." What that says is that this is a very typical scenario. We understand what the situation was and it could happen to anyone. There is a lesson drawn from it and then a set of recommendations of what you should do to mitigate that. We did a survey and it has a good impact but, when you ask, "Can you measure it?" no,

you cannot, but you can say actually it is read; it is assimilated and, in that sense, it probably makes a difference.

Q14 Paul Flynn: Could I ask you, Dr Durkin and Mr Wilkins, how do you think the system would improve by better information from patients or the relatives of patients on clinical failure? How could this be done?

Denis Wilkins: There is an issue of transparency. The public actually are very understanding if the full facts are put out, if they are made available after analysis and they are shown that something has happened as a result of that complaint. The public understand we are all human. Where it gets into a muddle is when they do not feel that their complaints—their voice—are being listened to and that something has happened as a result.

Dr Durkin: It is an essential answer that we are looking for to that question.

Chair: Can you reiterate that point?

Dr Durkin: That is an essential place that we need to get to, to understand the answer to that question. For me, it is where we place the primacy of the patient in our conversations with them, in our listening to them. For many, there is a constant conflict between the place of the patient, the professional and the organisation within which that professional works. That is in stark relief in the general practice versus the hospital.

If we look at the reporting that we have from those various sectors, hospitals are used to a confidential reporting system, so the staff of the NHS report through the national reporting and learning system; we have very few from general practice. The challenge is to allow our patients to start to report, both confidentially and openly. They report openly through a complaints mechanism, which is often at the adversarial side of this. Patients find it very difficult to access, because they are not able to access the national reporting and learning system. That would be a great benefit if we opened that system up to patients.

Q15 Chair: Can I just press you on that point? We are all Members of Parliament and we have people who have had bad experiences from the whole system come into our surgeries. Very often, they do not want to complain, because the connotation of a complaint is criticism, and I think patients have a much more acute understanding of how things can go wrong than we give them credit for. What they want is a system where there is no-fault reporting. So often people say, "I don't want to complain; I just want to make sure this doesn't happen again." We have championed the idea of having more complaints, but I am beginning to wonder whether, in fact, that is the wrong emphasis in terms of where the patient is. It is of course where the Ombudsman is; it is all about complaints and redress, which is automatically into blame and fault-finding, when we want a system that is just learning.

Dr Durkin: Exactly, Chair. I would very much want to see the national reporting system, which currently is the largest in the world for health matters—1.4 million a year, 120,000 to 140,000 a month from the staff of the NHS. It is seen by the rest of the world as an amazing achievement over the last 10 years to collect that, but it is pretty sector-specific. It is pretty specific to the hospital system, because hospital systems have reporting mechanisms that allow staff freely to report confidentially. We do not open it up to patients yet, but we are building a new system and they will certainly be part of that.

In terms of sector, we believe that there are 25 million or so episodes of care that take place in hospitals. We believe that there are over 320 million episodes of care that take place in general practice. We do not get the same level of reporting from general practice that we do from the hospital sector. That in the main is because of the systems that are in place. It is very difficult. It is time-consuming and a lot of general practitioners and staff in general practices do not have the time. We need to open that debate up.

Q16 Chair: It was mentioned a few minutes ago, I think by Mr Wilkins, that surgeons are much more reluctant to report through CORESS, to report themselves or to report each other, than are nurses and other staff. How much of that deficiency in the number of reports from general practices is because we are much more dependent upon senior clinicians making the reporting?

Dr Durkin: I believe that probably is the case. Certainly we know that doctors report less on most of the reporting systems that we have. The reason that we have fewer in general practice is a little bit more complex. Having access to a reporting system in every practice is not in place. We are just launching an electronic form for general practice to start reporting next month, so we are hoping that that will start the debate.

Q17 Chair: Once the report goes into the national reporting system, what happens to it? How is it dealt with and where do we get to the point where there is cross-National Health Service learning produced?

Dr Durkin: If we take the year—1.4 million reports—they are all classified as low harm, no harm, moderate harm, severe harm or death. If we break that 1.4 million down, 1.3 million are low harm and no harm. I would like to come back to that major cohort later. About 80,000 reports a year are classified as moderate harm and about 0.8% of the remainder of the total relate to deaths and severe harm, so under 10,000 would be deaths and severe harm, as reported.

On an average month, we review all deaths and severe harms that are reported through the NRLS and we will also mine and identify through the data significant trends on a number of different major areas. These major areas have either been selected by seven patient safety expert groups that we have, which involve the Royal Colleges in different sectors, associations and other professional groups—our safety expert groups. We take their advice about where we should be looking to use the NRLS to come up with appropriate information to spread and learn.

We then translate our learning from the NRLS into a system that we have designated as the national patient safety alerting system, and we use that alerting system on three levels: to alert the NHS in England as to an emerging risk that has been identified through the reporting system; a second element is to release a set of packages, resources and learning tools to the system to either mitigate or eradicate a particular risk; and the third element of that is to mandate an action that needs to be taking place. That mandate will then be worked and supported by the local commissioner and by the CQC, Professor Sir Mike Richards. That alerting system we use. That is sufficient to alert on an emerging risk that we believe is vital to be out there.

Our second-level order is how we translate that overall learning, which involves both low and no harm, into the fabric of a learning environment. We have posted our colours to the mast, if you like, in that we believe in two initiatives in particular—a third we may come on to later—to spread a learning network across the NHS through 15 patient safety

learning networks across the system. Those learning networks will be using the data from the national reporting and learning system as to what are the emerging priorities for action to learn. We are setting those up. The plan is to fund for the next five years to support that learning network. That goes to support system learning in every sector and every setting, so this is for hospitals, primary care, community settings and mental health settings.

The second level is to develop a system of patient safety improvement fellowships, so those are 5,000 fellows who we want to introduce over the next five years. We are doing this in conjunction with the Health Foundation, and both NHS England and the Health Foundation will co-produce, but also co-fund. We believe that we need that volume of safety improvement fellows, because of the challenge. As Mr Wilkins said, the challenge is not just a subject-matter-expert challenge; it is a cultural challenge. It is a shift. I certainly believe that we need that level of investment and support to make and enable that to happen.

Q18 Paul Flynn: It is a very interesting and full answer, and I am grateful for it, but I think we would all support what the Chairman is saying: that nine out of 10 of the people who come to us with problems are not interested in compensation or in any adversarial fight with anybody. They are interested in ensuring that no one has to suffer the avoidable grief that they believe they have suffered. Just as a final question, what do you think the great strengths are at the moment? What are the weaknesses? How do we engineer a cultural change to make sure that it is a reporting system, rather than one that is increasingly adversarial?

Dr Durkin: I will concentrate on the weakness, if I may. The strengths are that we have a unique system. We need to grow it. We are on that first element of the journey, in terms of understanding the data that we have, I believe. In terms of the weakness, it is pretty sector-specific. It concentrates on hospitals. It does not concentrate on where most of our patients are. We are all patients in this room, to some degree or another. It does not concentrate on where we are experiencing most of our care, either in the home or in visiting general practice. It does not support yet those hundreds of thousands of patients with long-term conditions who are in our 18,000 residential homes, 4,000 of which are nursing homes. There is an issue there. That is a weakness for me there.

The weakness on the cultural side, to share Denis's thoughts, is I do not necessarily think that all our clinicians put the value of their patients' story to best effect, when they immediately may start to think about protecting their local team, hospital or practice, rather than an open spirit of enquiry into listening to why a patient wants to make a comment about the care they have had.

Q19 Paul Flynn: You have provoked another question here, mentioning residential homes, because it has long appeared to many of us that the most defenceless people are those elderly people in residential homes who are subjected to excessive use of neuroleptic drugs. Often they are the silent voices, because they are incapable of speaking for themselves and often they have no one else to speak up for them. Is this a major area where you believe there has to be investment?

Dr Durkin: I believe that we need to invest in how we understand what is happening in our residential homes, absolutely. This would be a very fruitful way of doing it, through a learning inquiry, rather than through exploring further the complaint system because, as you say, it is very hard for those individuals to complain.

Q20 Chair: Is this national reporting system part of the statutory framework? That is an institutional system that has been established under statute. You are getting a nod from behind you.

Dr Durkin: That is helpful. I was going to check with my officials. Yes.

Q21 Chair: It is called the national reporting system.

Dr Durkin: It is called the national reporting and learning system. It was designed and delivered by the National Patient Safety Agency, in its previous environment, and it is the largest confidential reporting system of this type in the world.

Q22 Chair: It does not provide immunity for those who are reporting.

Dr Durkin: No.

Q23 Chair: It can keep secrets and you can shelter all this stuff from freedom of information requests but, if somebody criticises a surgeon to that body and that falls into the public domain, the surgeon could sue the person who has made the criticism or what has been given could be used against the person making the report, in court.

Dr Durkin: All names on the reporting system are redacted.

Q24 Chair: That makes the point, does it not? It is not like the AAIB, where everything is immunised from use in court—privileged.

Dr Durkin: On that point, Chair, we recognised that was an issue and, over the last 18 months, we have designed a system where, if we believe—on our inquiry into the national reporting and learning system—that there is a local issue that has not been addressed because of a particular behavioural issue or a particular adverse event, and we believe that someone was likely to be at fault, which may not have been picked up on, we then have to design a method called "causes for concern", where we go back and triangulate with the local commissioner and local hospital to identify whether action has been taken against that individual, if we believe that is necessary.

Q25 Sheila Gilmore: Mr Conradi, thank you for your patience. Could you explain to us how it is that you try to foster openness in the reporting of accidents or mistakes?

Keith Conradi: The aviation industry has grown up with an open culture. It is a very young industry, relatively speaking. From our perspective, we have very clearly defined definitions of accidents and serious incidents, so everybody knows when there has been an accident. There is not too much subjectivity to that. People, through experience and time, have learned that, if they actually report these things, when they come to our attention, they are dealt with in a very much no-blame environment. We go to great lengths to ensure that our reports and our investigations do not carry any blame or liability. It is just time and experience, and we have been able to demonstrate that over many years. We are 100 years old and that has allowed the industry to understand what we do and give us our credibility.

Q26 Sheila Gilmore: Would you say that is collaboration with everybody involved? How does that actually work?

Keith Conradi: I would not say it was necessarily collaboration. It is just through experience. People have reported things to us. They have seen that, actually, we do hold that information confidentially. We do not release it and they can see that the output is purely safety recommendations back to the industry. Although there is an allowance for the co-ordination in investigations with other parties, they are very much separate.

Q27 Sheila Gilmore: From the point of view of an employee doing their job, how does what you do fit with what might be a disciplinary process or something?

Keith Conradi: Actually, we are one perhaps of several investigations. We are doing ours purely for safety. That does not mean that there will not be another investigation going on, which could be looking at the judicial, or something from the operator or the regulator. They could take place in parallel. In the legal powers that we have that is allowed for, but we concentrate on one half. For instance, if we did an interview with a pilot, we would hold all that information in confidence. If the judiciary wanted to do an interview, they would have to start from scratch, do their own interview and go down their particular route. The perception and the reality of separation are all-important, and that is why we go to great lengths to actually make sure that we are completely separate from that type of investigation.

Q28 Sheila Gilmore: Do you find that that enables people to be fully open in what they say?

Keith Conradi: It is a core part of what we do that actually people will open up to us, whereas perhaps they would be more reserved if they felt that there may be some incrimination that would come across if they said other things. We tend to have the first interview after an event and, as I say, we hold that very much in confidence and we will not release that.

Q29 Sheila Gilmore: How do you ensure that the lessons learned are properly disseminated across the industry?

Keith Conradi: We have some legal powers. All our safety recommendations are made public and it is a requirement for the addressee of a safety recommendation to respond within a set time period. We make that response public as well, so that everything is done transparently. We share a lot of the information. A lot of the good practice in general terms, in aviation, is shared between the various different committees. There is the Flight Safety Committee in the UK. There are international groups—Flight Safety Foundation is one—where, globally, operators, investigators and regulators will get together, on a regular basis, and share good practice.

Q30 Sheila Gilmore: Do you then track to see if these have been followed through in what is actually happening?

Keith Conradi: We make the safety recommendations. When we make them, we do not actually advocate any specific action. We say, "Look, here is the problem. Here is the deficiency," and we look at who is best out there to solve it. We are careful we do not prescribe a course of action. Once we have done that, we analyse the response and decide whether it is adequate or not but, thereafter, we leave it to the industry to run with that. In the UK, the regulator takes an interest and will not close off its investigation, if it is having one, until it has seen that all the action has taken place.

Q31 Sheila Gilmore: Do you think there is anything that the NHS can learn from your type of accident investigation?

Keith Conradi: They could probably learn from the fact that the acceptance of the industry is all-important to us. Without their acceptance of our investigations, I do not think we would be able to get as far as we can into the depth. A lot of that comes from the people who we have. We have very experienced practitioners. They have been in the industry before they come to us as investigators. That gives them huge credibility. We have, for

instance, airline captains who are now investigators so, when they go and interview another airline captain, they can talk the same language and they are speaking at the same level. That is a key element.

I am not sure how it works in the NHS but, if you were to have something like that, you need investigators at a high level, and I also think that you need buy-in at an extremely high level into whatever trust or hospital in which you are placing this investigation team. Safety teams in airlines often report at board level on their findings and recommendations, and that is a key part to making this work.

Q32 Sheila Gilmore: There is a particular tension between using people who have experience, so therefore you have captains interviewing captains, and any perception that that is too close. How do you avoid that perception?

Keith Conradi: We do not have any experience that it becomes too close. It gives them a greater understanding, but they are not doing that in isolation. They are always doing this as part of a team. We will have three or four people on any investigation. That is just one element of evidence that they are gathering towards the final report, so our experience is that that is not an issue.

Q33 Sheila Gilmore: One of the big differences would probably be the scale of incidents comparable from which you are trying to draw any lessons. Do you think that that makes transferability difficult?

Keith Conradi: I could see how that could be a real problem on a national scale. We deal with 300 investigations a year at the Air Accidents Investigation Branch. To scale that up across the whole of the NHS would be quite demanding. I suspect that you might have to look at smaller elements leading up to one larger one or have some way of making a pyramid out of the investigations system. Otherwise, I could see it being a big problem.

Q34 Sheila Gilmore: Do you have direct dealings with members of the public who are affected by something that has happened?

Keith Conradi: Very little. Occasionally we will have a passenger who may have taken a photograph out of the window of an aircraft that they think is very close to them and ask us to investigate, but nearly all the information we get comes from those professionals within the industry.

Q35 Sheila Gilmore: You are looking at it very much from the professional, technical point of view.

Keith Conradi: Yes. Most of our work is with commercial air transport. We do look at general aviation, private pilots, but again they are part of a system that does report openly and, actually, we get just as much information coming from private pilots as we do from commercial ones.

Q36 Kelvin Hopkins: Your answers have been excellent, but I just wonder about the transferability of experience from the aviation industry to the health service. You have pointed out that they are very different. One point that was made at our recent seminar was that, when it comes to pilots flying aircraft, if anything goes wrong, they are at risk, whereas it is not the same in medicine. The other point is that modern aircraft are really like flying computers, especially with automated take-off and landing. I used to work in the aircraft industry, so I know a little bit about these things. When things go wrong, it is a technical failure, it can be a mechanical or electrical failure, or it is terrorism or something of that kind.

It is much simpler, in a way, to investigate an aviation accident, once you have the black box, than it is to deal with medicine. Is that fair?

Keith Conradi: I think that was probably fair more in the past. These days, aircraft technology has got better and better and, more and more often, we do not find anything so much wrong with the aircraft but in the way that the crew have interpreted a situation. That becomes more of a human factors investigation. In a lot of the recent ones, we are very fortunate to have a massive amount of data, as you say, from the data recorders. That allows us to analyse that, more often than not, nothing was wrong with the aircraft. We are then into deciding why the crew took that particular course of action. That is where aviation investigation is going around the world.

Q37 Kelvin Hopkins: You mentioned 300 investigations a year. What proportion of those are private flying, mistakes by amateur fliers, rather than the major concern, which would be airliners?

Keith Conradi: The vast majority are light aircraft incidents where actually nobody was killed, but they may have broken the nosewheel as they landed heavily and things like that. Those are relatively straightforward to investigate. We probably do 50 significant investigations each year into either fatal general aviation events or serious incidents to commercial transport aircraft.

Q38 Kelvin Hopkins: It becomes very clear pretty quickly what has happened and who, if anybody, is to blame, whereas medicine is much more complex.

Keith Conradi: I am sure that probably is the case but, certainly in some of the last few large airline events that we have had—and I am talking globally now—there have been some quite complex human factors investigations that have had to take place to really understand why this perfectly serviceable aircraft was flown into the sea.

Q39 Kelvin Hopkins: One quick point from the earlier questioning was about our constituents coming to see us. It may be your colleagues who answer this. Certainly in my experience, following the Chairman and Mr Flynn, my constituents want someone to say, "Well, it was a mistake by the hospital and we're sorry." After that, they accept it. They are sad often, if a child has died like in one of my constituent's cases, but it took a year for the hospital to say that, yes, a mistake was made. That is what they just want to know. They did not want to take any action beyond that—they cannot bring their child back to life—but they want someone to say, "Yes, it was us."

Denis Wilkins: The recent report by Dalton made clear that transparency now will happen and will be mandatory, absolutely open. That is a big shift that has come all the way through down to the clinicians, but then it still comes back to this business of culture. Many of us have pondered long and hard how you can change that.

I was very much involved in developing the syllabus and curriculum for training in later years and, to my shame, we did not place enough emphasis on training in human factors and the importance of an open culture of reporting. That is perhaps where we would get the best influence. It takes time. I know it is happening now; I know that it is embedded in the training of the young minds, the young people coming through, as it is in the airline industry. It is that shift, where you are open, where you regard it as an obligation, not just an option, to report and to give an honest analysis of what you feel might have gone wrong, could have gone wrong, a near miss and how a disaster actually happened. Training is an area that could well be that area of focus.

Dr Durkin: I just wanted to reinforce that point from Mr Wilkins that the Dalton and Williams review on the duty of candour really is a very useful piece of evidence for this Committee to look at, because it goes to the heart of the responsibilities, both for the organisation and for the individual, particularly for the individual to be able to demonstrate that they have shared with the patient whenever they believed they have made a mistake.

Q40 Chair: Can I just clarify something about the relationship that pilots have with AAIB and with the idea of reporting? It seems to be very much more open and ready than it is with clinicians and patient safety organisations with the NHS. Keith Conradi, why do you think that is? What do you see as an outsider looking into the Health Service? Why do you think that is?

Keith Conradi: Part of it is that aviation is a small industry, in comparison. It is embedded within the industry almost from the word go. Airlines themselves have their own safety teams, which will not necessarily take punitive action. We obviously do not take punitive action. Also, the fact is that, today, so much of it is recorded that there is so much data out there that it is pretty obvious anyway when something has gone wrong and that is looked at, as Mr Wilkins said, by honest brokers within an airline, so that information will already be known. There is plenty of pull for pilots to come and tell us or the airline what has happened. The fact is that, as I said earlier, we have not apportioned blame and people feel comfortable with that.

Q41 Chair: I am very interested in this phrase you use that it is embedded from the word go. That is what we want in the Health Service. How do we get it?

Keith Conradi: Time is one thing that you cannot shortcut to get to that culture.

Q42 Chair: Do you see an institutional structure in the Health Service and the right incentives in the Health Service, and indeed the heath sector generally, that is driving it in the right direction? What do you think is lacking? What seems to be obvious about AAIB is that you provide that immunity, that privacy and that legal protection for pilots. There is nothing equivalent in the Health Service that provides the same for clinicians, nurses or managers.

Keith Conradi: It has had to be worked on. If I take even cockpit voice recorders, people putting a listening device in where people are working, there was a lot of concern when that was first envisaged in the flying industry and it needed co-operation with pilots unions for there to be general acceptance for that to happen. Still we would like to put in image recorders in cockpits and, again, we are not able to do that until we have reached agreements with trade unions. I would not want you to get the impression that everything is absolutely rosy in aviation. There are still plenty of things that we need to work with. It is not just an open door for us.

Q43 Chair: I appreciate that, but I am trying to put my finger on what it is that creates this. There is another conundrum in here. We are talking about transparency, but you do everything in secret. Where is the transparency in that? There is an inherent conflict there, but it is the secrecy that enables the openness and the transparency. Can you explain a bit about that?

Keith Conradi: It is, but what is transparent is the final report that is made public. Everybody who is involved in that report has a chance to comment on it before it goes public, and then we make it public and disseminate it just as widely as we possibly can.

Chair: Prosecutions might well follow.

Keith Conradi: They would have to have their own specific investigation but, yes, they could follow.

Q44 Chair: This last section of questions we have here is about what is missing from patient safety investigation. What do you think is missing, as you look in?

Keith Conradi: Perhaps it goes right back to how you define when an investigation needs to take place. You have so many events in the NHS that you would probably have to make a decision on which ones get investigated at which level, which is something that is already pre-defined in the aviation world. If you go to the other end, it is really important that what comes out is a credible investigation. Therefore, you have people at a high level doing the investigation, and they are listened to by the very top people. I have complete access to the head of our regulator; I report directly to the Secretary of State for Transport, in terms of safety investigations, so there is nobody in the way to either influence or filter any reporting that gets done.

Q45 Chair: Let us just check that point with Dr Durkin. The national reporting and learning system is part of NHS England. NHS England is an activist at the scene of an accident. You do the commissioning; you control the estates. You control a whole lot of aspects that might have contributed towards an incident, so how can we be confident that your national reporting and learning system is as dispassionate and as objective as it could be?

Dr Durkin: The reports come through and generate a national database of avoidable harm from the confidential reports that come in from the staff of the NHS. The responsibility for NHS England then is to ensure that the local system learns from that database. I do not believe that we are part of the generation of those reports and, therefore, we can actually take an objective view about whether or not the local system is responding appropriately. For me, that would be our responsibility discharged through sharing and spreading the emerging risks, where they are attendant. Sharing, spreading and ensuring that the learning is taking place on thematic approaches across the place, but also holding to account the local commissioning system for ensuring that action is taking place where serious incidents are requiring local action plans to be reviewed.

Q46 Chair: I appreciate that is what you do, but it does not quite answer my question, does it? Keith Conradi, what do you think about where the national reporting and learning system is located in its accountability? I do not know what the equivalent would be in aviation; maybe the AAIB would be part of the CAA or more part of the operational structure than it is, because it is completely outside the operational structure and indeed outside the regulatory structure.

Keith Conradi: It is and that is fundamental to the way we do business. We have a relationship with the regulator, but we are totally separate. Even from the Department for Transport, which provides pay and rations for us, we still go directly to the Secretary of State when it comes to safety itself. In fact, we make safety recommendations to the Department for Transport on a regular basis, when we see there is something that they are placed to fix.

Q47 Chair: This is another conundrum, is it not? You say to Health Ministers, "You should take personal responsibility and be personally accountable for patient safety," and they say, "Who would trust that? That would become political. Surely it ought to be in some

arm's-length body that is independent." Is it not better to have it in NHS England than directly accountable to the Secretary of State?

Keith Conradi: I would have thought there are some advantages to that and, in fact, we have even discussed with our own side whether we would be better as an arm's length body, so we did not even have the perception of any contact with the Department itself.

Q48 Chair: Do you sometimes get criticised for being politically influenced?

Keith Conradi: No.

Q49 Chair: What is the concern you are seeking to address?

Keith Conradi: We have discussed it in the past. We now have a European regulation that requires us to be free from influence. I know it is one thing to say that we have a regulation and another to demonstrate it. We have MOUs and protocols just to ensure that the perception is quite clear with industry. Industry does not appear to have a problem with that.

Q50 Chair: Nor do passengers. Is the public concerned about the independence of safety regulation in aviation?

Keith Conradi: I do not think so, no.

Q51 Chair: It is curious that, is it not? You make it answerable to the Secretary of State and then everybody is happy, except the EU.

Keith Conradi: It is a long-term demonstration that actually it does work and that we have not been interfered with politically.

Dr Durkin: Can I just go back to what I took from your question? For me, that is the local assurance that something is being done about a clinical adverse event. For me, that is where the variability exists in our system, of holding to account the local system about following through on action plans to address concerns. If it is part of a complaint that has had some clinical elements, that is where I often see that we have variability. For me, the more important element is to ensure that we have a system of local accountability to address adverse events, particularly when they relate to patient complaints.

Q52 Chair: I will come to you in just a moment, Mr Wilkins. In terms of the branding of your organisation, NHS England gets the blame for a lot of things that go wrong in the Health Service. If NHS England is telling clinicians, "Do this; do that; don't do this; don't do that," because of patient safety, it is not the best branding for a safety organisation within the Health Service, is it?

Dr Durkin: From my perspective, the information we are sharing and the opportunities we are offering to improve are coming from the staff of the NHS.

Q53 Chair: I appreciate that but, in terms of what you find and what you disseminate, it is NHS England that is disseminating it, not a visibly independent body.

Dr Durkin: It is NHS England that is disseminating it.

Q54 Chair: Do you think I am on to something substantive here, Mr Conradi, or am I running after a false hare?

Keith Conradi: It is important to be able to demonstrate independence. That may be different from actually being a totally separate body, if you see where I am coming from.

We maintain this contact with the Department, but we can demonstrate a certain independence from it.

Q55 Chair: The irony is, if there is an almighty safety failure in the Health Service, the Secretary of State goes to the House of Commons and he himself takes responsibility for investigating and remedying that failure, like setting up a public inquiry into Mid Staffs. In that respect, the buck stops with the Secretary of State and the same with aviation.

Dr Durkin: We should not undermine the process of local accountability through the boards of the hospitals of the NHS, which are absolutely responsible for the quality of care.

Q56 Chair: Who is responsible for ensuring that they take local responsibility and they have the best systems? In aviation, AAIB expects all the airlines to have hundreds of safety people collecting data, monitoring safety, taking confidential reports and all that. We take that as a given, and in fact that is what we want. We want far more of that at local level, but it is not in the culture yet.

Dr Durkin: It is not in the culture, but we have a framework of local commissioning with local trusts and we have, as you say, an overarching NHS England.

Q57 Chair: The point I am making is having a departmental body answerable to the Secretary of State, completely independent, is not mutually exclusive with what you are trying to achieve. On the contrary, it seems to have been achieved more effectively at local level, because we have a body located in the Department answerable to the Secretary of State and aviation. Is that not fair?

Keith Conradi: It works okay for us, yes. I would not want to change that system at all.

Denis Wilkins: I think you are right on the money. If you are looking at the aviation industry as a comparator, what is being done by local providers—hospitals, trusts and so forth—being held to account by the commissioners is equivalent to what the companies and the businesses perhaps would do. They would have their own systems. Where we need to really sharpen up is an overarching body that can take a view of really major systems problems and influence those.

Q58 Chair: That includes investigating the regulators. Does the NHS complaints system actually look at the role of regulators and when they screw up? Can you investigate CQC?

Dr Durkin: I have to declare that I am not the director for patient experience and complaints within NHS England or for the overall system, but I understand that the Department of Health is leading that work, in terms of complaints.

Chair: NHS England cannot investigate CQC?

Dr Durkin: I do not think that is within our remit, no, but we will check with you and get back to you on that.

Q59 Chair: The reason we set up a Rail Accident Investigation Branch after the Paddington crash is that we decided that the Health and Safety Executive was not capable of investigating its own regulatory failures. The traffic lights were in the wrong place; the points had been set up wrong. It had all been approved by the Health and Safety Executive.

Dr Durkin: I would have to come back to you on that, about whom the CQC is accountable to for their performance.

Q60 Chair: They are accountable partly to Parliament and partly to the Secretary of State, but can they be scrutinised? Can you go in and interview people in CQC, and say, "Why did you regulate this like this?"

Dr Durkin: I do not believe we have the powers to do that at the moment, no.

Q61 Chair: That means you are not set up to do a whole-system approach in accident investigation. It is just not set up to do it.

Dr Durkin: I would totally agree with that.

Q62 Chair: In terms of where incident investigation ultimately rests, why would we not conclude that it should be in the Department, rather than as part of the Health Service?

Denis Wilkins: It is always going be multi-layered.

Q63 Chair: I appreciate that. It is multi-layered in aviation, but regarding the ultimate responsibility for supervising clinical incident investigation, how do we argue it should not be in the Department? No answer. That is fine; that is very clear. Were you going to say something, Dr Durkin?

Dr Durkin: I believe the whole direction that we have taken over the last few years has been to identify how we can improve care as close as possible to the patient and where the patient has had their care delivered.

Chair: That is not in dispute.

Dr Durkin: I do not think that it is in contra-distinction to being able to independently give a view about how this could happen at a local level. I do not necessarily see the independence having to be at a national level.

Q64 Chair: I do not quite understand what you are saying. I am not saying that we should not have local investigation, a degree of independence at local level, separation within trusts and within general practices, so that they can independently investigate their own regulatory and safety failures. On the contrary, that is the system we want, but it is not incompatible with having ultimate independence for the supreme investigative body at the top. How is that incompatible? On the contrary, one would strengthen the other.

Dr Durkin: I can understand that link. I suppose I am struggling with where that body would sit, in terms of the governance of the current system.

Q65 Chair: Looking at how to decide what to investigate, 300 cases a year at AAIB contrasts with 250 million reports to the national reporting and learning system. How on earth do you sort out what is going to be investigated at national level?

Dr Durkin: We currently look at 400 in-depth reviews a month on the basis of those that are reported.

Q66 Chair: How do you decide the criteria of what you investigate?

Dr Durkin: On the basis of the reporter and on the basis of our expert team, which reviews the reports for those.

Q67 Chair: It sounds a rather subjective process. That does not surprise me. Keith Conradi, in knowing how much more complicated and indeed risky the health sector is

compared to aviation, inevitably, how would you sort out the wheat from the chaff in what you need to investigate and learn from?

Keith Conradi: We have a similar problem in serious incidents and what we do is risk-assess, and look at events where we think that our particular skills will bring an added safety benefit. Sometimes, we look at who else is investigating that and whether we have confidence that they are capable of doing it and coming out with a good conclusion. That gets rid of some of the lower-level investigations and allows us to concentrate on the ones where our powers and our skills are really needed to bring out the big safety lessons.

Q68 Chair: Does the Secretary of State ever ask you to investigate something?

Keith Conradi: No.

Chair: That independence is completely maintained.

Keith Conradi: Yes.

Q69 Chair: Also, you always use experts.

Keith Conradi: Yes.

Q70 Chair: How do you define an expert?

Keith Conradi: People who have been in the industry for many years.

Chair: That would be not just pilots.

Keith Conradi: No. We have engineers. We have flight data specialists. That does not mean we do not use external assistance as well, sometimes, if we do not feel we have the right expertise in-house.

Chair: You cannot just have pilots investigating air crashes; you have to have engineers.

Keith Conradi: Absolutely.

Q71 Chair: How do you do human factors analysis, which is something that we have learned quite a lot about?

Keith Conradi: We do some of that in house.

Q72 Chair: What people do you use for that?

Keith Conradi: We use our pilots and engineers, who all have human factors training, but more often than not we go out to consultants, specialists in the field in the particular area that we are interested in.

Chair: They would be psychologists or even psychiatrists?

Keith Conradi: Yes, they could be.

Q73 Kelvin Hopkins: You have made the important point more than once now that it is important to have skilled people with experience in the sectors they are investigating. You are an experienced airline pilot yourself and clearly respected by people you are making judgments about. In the Health Service, it is equally important, is it not, to have people with the skills to make judgments about surgeons who make mistakes, GPs who make mistakes and that sort of thing? I have recently come across doctors who are reluctant to retire on the

grounds of age and they have been pressed to retire, but perhaps there might be a role for them in investigating. They are people with long experience, but perhaps their skills are slightly in decline and it would be wise if they took a different role, perhaps investigating. Judgments by peers would be much more accepted by surgeons and GPs, I would think, if they are made by people who have been on the job themselves.

Keith Conradi: I agree with that general concept. I think you just have to be wary; you need to use people who are familiar with the current working practice. You have a shelf-life, if you have retired, of only a few years.

Q74 Greg Mulholland: This is particularly a question for Dr Durkin. Do you not accept that the current system is or appears to be very fragmented, in terms of major investigations, the structures, the organisations and the lines of accountability? You have NHS England playing clearly a key role though, as the Chair has already pointed out, a role that is involved in overseeing commissioning as well as then looking at issues and problems. You have the Care Quality Commission. You have the Ombudsman. We have a situation where we have a major report by the Ombudsman into failures with regard to sepsis—a very important, excellent report. We had to have the Francis report into the awful events in Mid Staffordshire, costing £13 million for one single inquiry.

Do you not think there is a better way of doing it? Do you not think that it is an independent body that would be there to investigate major events, in effect to work alongside the Ombudsman to do the investigation in place of the Ombudsman's office, and then not to have to have things like the very costly Francis report, which would do that and have the trust, the authority and the independence? Do you not think that would clarify the situation and make it more understandable, but also more open, accountable and effective?

Dr Durkin: There are two elements for me on that. One is that yes, you are right; we do have a system of multiple players, because it is a complex system that we are all involved in supporting. We have a system of stewardship from the Department. We have a system of regulation from CQC. We have supervisory roles and responsibilities from Monitor and from the Trust Development Authority. We have commissioning responsibilities at a national level from NHS England, and we have CCGs at a local level. We have a mixed playing field of trusts, foundation trusts and NHS trusts, so it is complex. For me, it is more one of, rather than distilling into one system, alignment of activities and understanding of our accountability of how that alignment should work.

On the accountability element, for me our whole discussion this morning is a good one, but it has to go to answer the question about whether we are improving the offer to our patients when they need help. Have we done that? For me, that goes to the issue of however complex the system around us might be, the real answer is about how we improve the care that we offer our patients when we listen to them, in whatever professional role we have for them. The rest of the system we need to make simple for them, but that is the most important element for me to ensure—that alignment of activity.

In terms of how I work with Mike Richards, Steve Field and with Andrea Sutcliffe, in terms of their inspection roles for care homes, general practice and hospitals, it is equally as important for me as in determining how we manage the process of national reporting and learning. We need to work in the same manner and to the same ends. We have to make it de-complicated for our patients and our staff.

Q75 Greg Mulholland: You are talking there about general complaints and we would all agree that they should be started at a local level. Clearly that is the sensible thing to

do, with the opportunity of taking those further. Do you not think that there is a gap when it comes to serious failures and major issues? If you look at the cost, as I say, the Francis report cost £13 million for one single report into one trust. If you look at the cost of other bodies, the cost of the US National Transportation Safety Board Office of Aviation Safety, which did 1,750 investigations last year—they were budgeted £13 million and they cover all those major incidents in that sector. Do you not accept there is a gap, so instead of having to suddenly have these very lengthy costly reports, to address that gap with serious failures by having one single body in that structure that you describe?

Dr Durkin: I certainly agree there is a gap, and we are working at the moment on a pilot of what a patient safety investigation branch would look like within our current structure. We are looking at two elements of those; one is some specific aspects of harm that occur, and the other is the more cultural leadership elements that we know are common to many failings. We are starting our journey on that. The open question is I would be very interested in where you take us in terms of your findings about what you believe would be the next step for that. We are starting down that road now.

Q76 Greg Mulholland: You lead me on to my final question very nicely, which is that this Committee has recommended, and is thoroughly committed to and passionate about, an overhaul of the Ombudsman system, indeed the system of ombudsmen that we have in the country, wanting to have a single citizens' ombudsmen service that would be there for all complaints. It could easily work better to have some expert bodies that are there to do some of the investigative work for serious incidents, such as the AAIB, as well as potentially similar bodies in other parts that apply to the Health Service, for example. Perhaps that is something that NHS England could engage with the Committee on. I just wonder what you think of a system of an ombudsman in that regard to work alongside some of the existing and perhaps new bodies in the Health Service.

Dr Durkin: That would be a very interesting set of ombudsmen to bring together and commissioning roles to bring together. We are currently working with the Public Health Service Ombudsman, particularly on supporting their ability to look at clinical complaints and investigate clinical complaints, because that has been one of the questions in the recent past, about whether they had the specific capability to do that, and we are helping them and working with them on that at the moment.

Q77 Chair: I just have one further question, particularly to Dr Durkin, though the others might like to comment on this question. It is about how you get clinicians to feel that this is something that is going to help them, rather than be another function. Even with your own patient safety investigation capability that you are building up, how do you convince clinicians that this is not something else to burden them, to criticise them, to hunt them down, because a lot of clinicians are feeling pretty beleaguered by regulatory overload already? How do you have that conversation with them and how do you think they are reacting?

Dr Durkin: You are right. There is an increasing burden and expectation on performance of clinicians at every level. When we say "clinician", we need to understand the vast majority of clinicians are not doctors, but there is that increasing expectation. Mr Wilkins mentioned earlier curricula changes, identification of appropriate abilities, how to deal with difficult situations, how to deal with and resolve conflict, how to work our duty of candour and human factors elements. They are all now part of curricula changes.

Q78 Chair: It is about training in how to handle relationships and handle situations, not just how to deal with medical questions.

Dr Durkin: Absolutely, and to learn that we, as clinical professionals, have to be able to communicate and listen. For our trainees, early trained staff and undergraduates, we are working very hard on that. The challenge is for those who are embedded in the service, as we get older. I am always turned around by peer review, by the narrative, by listening to each other and by bringing groups together to learn how to do this in an appropriate way, which is why I am passionate about creating these learning networks and a good example through fellowships.

Q79 Chair: Keith Conradi, how is it that pilots do not feel this negativity about AAIB that clinicians so often feel about medical regulators, or am I looking at it through rose-tinted spectacles? Do they all hate you?

Keith Conradi: I do not think they hate us. They read our reports and they see that we are there to make their industry safer.

Q80 Chair: How do you get that collaboration?

Keith Conradi: Dr Durkin talked about the training. You almost have to go to the other end as well and get buy-in from the boards, from the very highest level as well, and get them to sell it out to the trusts that they are involved with.

Q81 Chair: The trust boards and the senior GPs have to sell it through their organisations.

Keith Conradi: Yes. In the aviation industry, the board will have somebody on there who is banging the drum for safety and they tend to listen.

Q82 Chair: It is still quite a rare thing to find somebody on the board of a foundation trust, for example, whose primary responsibility is patient safety. Would you agree?

Dr Durkin: No.

Q83 Chair: They usually have other responsibilities as well. I have been to one trust where there was a safety officer who only does safety right throughout the hospital, and I thought that was quite impressive.

Dr Durkin: That is impressive.

Q84 Chair: Should that be the case in every foundation trust?

Denis Wilkins: I believe it should be, in the boards. There are two senior medics on our board and we take that on. It is not specific, but we do take it on. Can I also draw your attention to another cultural issue that gets in the way, which I referred to earlier, which is ownership of the problems? That ownership has not really come fully down to the clinical teams. There is great variability in the team cohesions at the clinical interface, and the association is very keen—and a lot of trusts are moving this way—that we bring those problems and say, "We can't deal with it as management. This is your problem. You are the experts. Sort it out. Come back to us with the recommendations and own the problem." That will be the most fruitful thing we can do at local level, the most fruitful change.

Q85 Chair: I have another question forming in my mind. It is about that sense, in aviation, sense of responsibility of pilots—obviously a pilot flying an aeroplane is going to feel responsible for the outcome. Why does that not happen in an operating theatre or a general practice? What militates against that sense of responsibility and that sense of ownership?

Denis Wilkins: It is a culture still of micro-management. General management was brought into the NHS in 1982, and it has taken this length of time to fully embed it.

Q86 Chair: There is not enough delegation and trust?

Denis Wilkins: "Trust" is the key word. That is beginning to become apparent and enacted, but it is taking too long.

Chair: That militates against the collaborative approach?

Denis Wilkins: Absolutely.

Chair: It has all been incredibly helpful and very informative.

Q87 Kelvin Hopkins: A very quick question: we have heard this being raised before in previous considerations, but to what extent does the pressure on clinicians now have the effect of making them be a bit more cautious about undertaking high-risk procedures, which might indeed be life-saving but might also be dangerous?

Denis Wilkins: Absolutely. The personal league tables have driven a much more defensive culture. As a department, they should be big enough to pick these issues up and say, "We take on the risky cases where it is in the patient's best interests." Again, it is a personal view. I believe that the personal league tables, for example for surgeons, are not that helpful, because they do drive a culture of competitiveness and "I am going to have fewer problems than you have."

Q88 Chair: Do pilots have personal league tables of incidents?

Keith Conradi: Not to my knowledge, no.

Q89 Chair: Would you agree that that would drive a negative defensive culture?

Keith Conradi: I cannot see how it would assist the safety of the industry. I just do not think that would happen. I cannot see that happening.

Q90 Chair: If there is a surgeon that does a particular kind of surgery that is inherently more risky, who is a specialist in a particular kind of heart valve replacement or something, presumably that surgeon is going to get marked down, because that kind of surgery is inherently more risky. Why are we publishing league tables of surgeons?

Dr Durkin: Can I just offer a reflection on this as a non-surgeon? Certainly the data being published are case-mix-adjusted, so they should take into account the difficulties that you may think there are, but they are case-mix-adjusted, so that should reduce that in terms of the data.

Q91 Chair: It is an ancillary question and one that the Royal College of Surgeons has reacted in a very restrained way about, because they are committed to the principle of openness and transparency, as much as anyone else. We need to understand what effect it might have. Is there anything else you want to add?

Dr Durkin: Can I just make one clarification from earlier on in the discussion about patient access to the NRLS? Patients can currently—all members of the public can currently—anonymously report through the National Reporting and Learning System. Our challenge is to make it easier for them to do it and make it more available to them, in terms of access.

Q92 Chair: I think that is important, though, in aviation. If the safety of the system was dependent on large numbers of passengers reporting incidents, I do not think you would feel very confident about the system. The system needs to respond to patient concerns, but safety management should be contained within the organisation itself.

Dr Durkin: You are on a time constraint, but I would agree with that. I also believe that the patient is often the best signal of when something has gone wrong.

Q93 Chair: Of course we are in a different field. Is there anything to add?

Keith Conradi: One point to say is that there has not been a public inquiry in aviation accidents since the early 1970s.

Chair: Staines.

Keith Conradi: That is right. That was the very last one, so it has been a long time, and I would like to think that we probably have saved quite a bit of money by our presence in that time, or added to it.

Q94 Chair: It is an indicator of very high public confidence and very low political concern about aviation safety.

Keith Conradi: I believe so, yes. The other thing is that the AAIB would certainly be very happy to assist in any of the findings or any way we could further in this inquiry.

Chair: That is very helpful. Thank you all very much indeed. It has been very helpful.

Examination of Witnesses

Witnesses: **Helen Vernon**, Chief Executive Officer, NHS Litigation Authority, **Professor Brian Toft**, Professor of Patient Safety, Coventry University, **Michael Devlin**, Head of Professional Standards and Liaison, Medical Defence Union, and **Ed Marsden**, Verita LLP, gave evidence.

Q95 Chair: Thank you very much indeed to the four of you for joining us. I am sorry we are running a bit behind. I am very glad you heard the previous session. I think you all were here for the previous session. Could I first ask you to identify each of yourselves for the record, please?

Michael Devlin: Good morning. I represent the MDU.

Chair: The Medical Defence Union.

Ed Marsden: Good morning. I am the managing partner of Verita.

Q96 Chair: Can you just explain, for the record, what your relationship with this question is?

Ed Marsden: Verita does work and independent investigations in healthcare. We also help challenge trusts, manage complaints and deal with serious incidents.

Helen Vernon: Good morning. I am Chief Executive of the NHS Litigation Authority.

Professor Toft: Good morning. I am a Professor of Patient Safety, but also an investigator into serious clinical errors.

Q97 Chair: This first set of questions I have here is about what patient clinical incident investigation should ideally look like.

Professor Toft: The way that I do it is to do every one like a mini-PhD, which may seem a little bit odd, but it seems to work for me. I do background reading. I visit the medical director and see what has gone on. I read their reports, which usually have gaps in them, in my experience. I then set out a whole set of questions—a semi-structured questionnaire. I then go and interview the people, take the interviews and analyse them, go back where necessary and clarify, and then produce a report. That is what I do. I do not know what the other people do, but that is what I do.

Q98 Chair: That is you as an individual conducting an investigation as an individual.

Professor Toft: Exactly so.

Q99 Chair: Do you have enough expertise? Do you need a range of functions available to you?

Professor Toft: For example, I usually have a clinician working with me or I will ask for a clinician to work with me. At the moment, I am doing a review—I cannot say where because it is confidential—but I am working with a professor of cardiac surgery, because I do not know anything about medicine at all. I have trouble putting on an Elastoplast. I have people with me who I can ask questions of if I need it but, generally speaking, very few of the investigations that I have done have required any clinical knowledge whatsoever, because there have been systems problems or human factors, on which I am trained.

Q100 Chair: How quickly are you on the scene?

Professor Toft: Generally, it is quite a while afterwards, because they usually do an investigation of their own first. On the basis of that investigation, they decide if they are going to call in somebody independent or, if there is a big enough stink, then they will call in somebody who is independent.

Q101 Chair: In the case of a serious incident, should you not be the first on the scene, rather than letting the trail and the memories go cold?

Professor Toft: I completely agree with you, Chair. That for me would be the case and way to do it, but that is the way that it is currently done—this is why I said in my written evidence I felt the system was not fit for purpose—and also there is the fact that, very often, the people who do these initial investigations have very little training or no training whatsoever. They have no understanding. Even if it screams at them, "This is the problem," they cannot see it.

Q102 Chair: What should ideal accident investigation look like in the Health Service? Who is next?

Ed Marsden: I am happy to contribute to this. My view is that for all the things that go wrong in health care, the first investigation should happen at the front line, and that complaints and investigations are best resolved at the front line. To that extent, people in trusts need to be equipped to carry out that kind of work to a decent standard. It is not necessary for all things to be investigated independently. That would be entirely disproportionate.

At the moment, we have saddled the NHS, over the last 10 years or so, with something quite complex, in terms of tools like root-cause analysis, which make for heavy weather

for people who are at the front line trying to carry out a practical investigation, finding out what it is that has gone wrong in someone's care and treatment. One of the remedies to better investigating and quicker investigating is better tools at the front line, and some of those would be about helping people tackle simple questions like, "What did we mean to do to this patient? What did we do? What is the gap? What are the things that we can immediately attend to, repair and put right before the clinic next Monday?"

Q103 Chair: In terms of the skills, in aviation they bring a pilot, an aviation engineer and a human factors analyst. What are the skills you need in order to investigate a medical accident or a medical incident?

Ed Marsden: It depends where you were doing that investigation. If you are doing it on the front line, you need firstly people independent of the service. If it is people from within an organisation investigating something that has gone on in their own organisation, it needs to be people independent of the place where it happened. They need to have the time and they need to have the necessary investigative skills, which certainly the NPSA, over the years, has tried to provide to people to carry out an investigation. They may well need clinical expertise; they may need other forms of clinical expertise.

Q104 Chair: Turning to the Medical Defence Union, are you defending patients or clinicians, for the record?

Michael Devlin: We look after the interests of doctors so, when something goes wrong in the treatment of a patient, doctors will come to us for help and advice.

Q105 Chair: What does ideal clinical incident investigation look like to the people you serve?

Michael Devlin: From our perspective, it is ideal if that can happen locally, and there are several good reasons for that. First, those who have treated the patients understand their local systems. You can go to two or three different general practices, and they will all do things slightly differently. It is the same for trusts and foundation trusts. It also helps see the safety culture at a very local level, and our view is that that is inherently helpful in trying to develop that culture where everyone takes responsibility for patient safety.

Q106 Chair: Helen Vernon, by the time it gets to you, what do you find to be lacking in the information and the analysis of an incident?

Helen Vernon: Very often, by the time it gets to us, it may be two or three years after the event itself. Most of the claims that come to us have been through some sort of process, whether that be an incident investigation or a complaint. The best sorts of investigations are the ones that happen quickly, locally and where the patient is at the centre of the investigation as well and given the opportunity to give their perspective. It does depend upon the incident. The sorts of claims we see can range from something very small that has gone wrong, something very minor, to something catastrophic, for example a brain-damaged baby case. Perhaps the scale of the response depends on responding proportionately and appropriately to the nature of the incident itself.

Q107 Chair: How do we ensure that investigations are independent?

Ed Marsden: We have quite a lot of experience of that. I suppose people come to us as an organisation and ask us to investigate something because we are neutral. I think that means, when you are trying to do an independent investigation, making sure that you are using a team of people who have no prior interest in the organisation or in the outcome of the investigation, and who have the right expertise. We always work together as a team, so

that certainly prevents people forming a particular view and allowing that to go unchallenged. Those are important ingredients.

Q108 Chair: Professor Toft, when you pick up the local investigation report and start conducting your own investigation, how often are you concerned about the independence of the investigation that has been carried out locally?

Professor Toft: Generally speaking, I am not. I carry out my own investigation. I am independent. I have no ties to anybody, except to myself. I have no background in medicine.

Q109 Chair: I appreciate that, but I am asking about when you assess the investigation that has been done.

Professor Toft: I have spent 35 years looking at nothing else but failure. I only study failure. I only look at things that have gone wrong. When I pick up an investigation, I will look at what they have said, but then I form my own view of it. I read the literature. I look at an ideal typical methodology. For example, when poor Wayne Jowett died as a direct result of being injected in his spine with chemotherapy by accident, I knew nothing about chemotherapy; I knew nothing about the procedures used. In pharmacy, for example, I have no skills in that way, but I read the literature; I took it on board and found what it was, what the ideal typical things were, spoke to the pharmacists themselves and to the Royal Society, and found out what should have gone on.

Q110 Chair: I understand that. I am asking a different question. When you arrive at the scene of an accident—

Professor Toft: I do not usually arrive at the scene. I am usually brought in—

Chair: You arrive at a later stage, after an investigation has been carried out by the trust?

Professor Toft: Usually.

Q111 Chair: I am asking about how independent you find the investigation carried out by the trust has been. Do you ever find it has been conflicted in some way?

Professor Toft: No, not so far. They usually report it as good as they can, but I usually find or often find that there has been some error in their understanding. I have yet to see anybody put down something that is untrue or that they have massaged the data in some way. That has never happened to me.

Q112 Kelvin Hopkins: Do they not tend to be a bit defensive?

Professor Toft: Defensive is different from massaging the data—if they massage the data and they try to make it look one way, rather than another way.

Q113 Chair: That is a good question. The defensiveness might blind them or distort their perspective perfectly innocently.

Professor Toft: As I say, I have seen lots of examples of people writing the report but, generally speaking, they will bring somebody in like the patient safety manager.

Q114 Chair: They have not lost their objectivity.

Professor Toft: Not completely, no.

Chair: Not completely, but it might be compromised.

Professor Toft: They might be compromised, but it would not be done deliberately.

Chair: I understand that. That is not what I am saying.

Professor Toft: I have never seen it so compromised so far as to there being a problem to me, when I have had to say, "Are these people being defensive or are they massaging the data and the way in which things have happened?" If they have, it will come out.

Ed Marsden: Over the last 10 years or so, there has been a steady improvement in the quality of internal investigations carried out in the Health Service. I do not think they are uniformly good, but they are better. Certainly we see investigations, for example, carried out into mental health homicides, which there is a statutory obligation to investigate independently. We get to see the internal investigations that organisations have conducted into that event, and I have to say that some of them these days are very good and, therefore, the amount of independent scrutiny needed of that death—

Q115 Chair: Do you think the shortcomings you find in some reports are due to a lack of objectivity, because they are too close to it?

Ed Marsden: No, Professor Toft is right. They tend to be people who are less experienced, certainly not people seeking to hide the truth.

Q116 Chair: That is very encouraging. How do we assess the capacity of health care organisations to carry out these investigations? How should those investigations that they carry out locally be monitored and assessed for their independence and their quality?

Michael Devlin: At present, there are systems where reports will go back to NHS England or CQC, through its inspections, as to how well organisations are complying with their duty of safety, how well they are looking at things when they go wrong and investigating them thoroughly, and if that is reflected in the report that goes back at the end of the year, for example to NHS England. There are several bodies that scrutinise just how well the process is running and, from our perspective, we encourage doctors and dentists who contact us at the very earliest opportunity, and what we will always tell them is, "Have you flagged this as an adverse incident or a patient safety incident, and are you following your own local procedures for making sure that that is investigated?"

Q117 Chair: How should we decide what local organisations are fit and capable of assessing themselves and what needs to be elevated to some body outside the trust, in NHS England or some independent body? How is that decided?

Ed Marsden: I do not think there are any clear criteria at the moment. We are sometimes retained because parents or family are very concerned about the ability of an organisation to look at something objectively.

Q118 Chair: It tends to be complaints-driven.

Ed Marsden: Or sensitivity-driven. This is a high-profile issue. It has come to the attention of—

Q119 Chair: It is about how it is going to be perceived. It is a defensive response of one sort or another.

Ed Marsden: Or a recognition that an organisation simply does not have the experience and the expertise to look at something in the right level of detail.

Professor Toft: I would agree. It is driven by perception. If the trust believes that this is going to hit the press and there is going to be a lot of furore around it, then they usually want to have it done to death, in fact. They will bring in somebody from outside so that it is seen to be independent, it is independent and we have kept our hands away from it, and then people can have trust in it. For example, apart from one investigation, all my investigation reports have been published so they have been in the press.

Q120 Chair: Who is best placed to decide whether something should be investigated locally or something should be investigated by a higher authority?

Professor Toft: I am afraid that for me that question is a bit like "Who guards the guards, guards the guards"—it is a bit philosophical. I do not know of anybody who could say who the person is to go out there to earn our trust, and say, "You are fit and proper persons to do your own investigation and, therefore, we consider you to be independent."

Q121 Chair: In aviation, the comparison we keep making today, they have very clear criteria about what they will investigate.

Professor Toft: Would you mind if I just make an observation about aviation, because it irritates me? I do not believe that medicine and aviation are the same thing.

Chair: They are not.

Professor Toft: Absolutely not. Very specifically, an aeroplane is in inanimate object; it is a closed system. People and organisations are an open system. In an open system, you have a property called equifinality, which means an infinite variety of ways of getting to a system state. You have a closed system with an open system working on it, which is quite complex. You have an open system, which is a doctor, working on an open system, which is a patient, so it is infinitely more complex. That is why I do not believe that people should keep on harping back to aviation as being some sort of ideal typical model to work from, because the two things are wholly different.

Q122 Chair: I think we recognise that and I have made the same point to others, though it is about degree. We heard Mr Conradi saying a few moments ago that, actually, most aviation incidents are now about the human factors, not about the technology. I fully accept that there is a gulf of difference between the two worlds.

Michael Devlin: I was going to say, picking up on a point that Mr Marsden made earlier on, that proportionality has a part to play. We heard from Dr Durkin earlier that the vast majority of incidents that are reported to NHS England when things go wrong are of low harm or no harm. Our experience is that those local investigations are carried out very well. Patients are told what has happened; an apology is given; matters are put right, if that is possible. If it proceeds to a complaint, then again they are given a written account of what has happened.

The difficulty, as you have highlighted, is when you move away from that system to something that requires an external body to come and have a look at it. In part, that is due to seriousness. In part also, it is due to the wishes of the patient. Sometimes the patient will say, "We do not want this particular body to be involved in the investigation," and that is where local area teams of NHS England can perhaps help to facilitate someone else to come in.

Q123 Chair: How should incident investigation, rather than complaints, engage relatives and patients?

Professor Toft: I think it should. I always ask the patient, if they are still alive of course, because sometimes they are not, or the medical director if the family wants to be involved directly. In many of the cases that I have dealt with they have not wanted to be involved at all. They have said, "We will leave it to you and show us the report when it is finished," and that has been it. On one occasion, the family did want to be involved and I involved them in the investigation directly, but that was the only case out of 16.

Ed Marsden: From the outset, throughout and at the end too. We have dealt with a number of very sensitive cases where families and relatives have had real concerns about somebody's care and treatment. Our experience is to involve them in the terms of reference; involve them in the process of the investigation without necessarily sharing the findings with them; and tell them the outcome in advance of it being published. If people have confidence in you and the confidence in the organisation commissioning the work, they will probably be satisfied that they have received the best possible explanation as to what has happened, but it is about having a relationship with people.

Michael Devlin: I agree entirely. Patients are absolutely central to the success of any investigation. Sometimes so much of it is about communication and perception. Until you sit down with the patient and their relatives and find out what their perspective of that particular consultation was, you cannot begin to understand why it is that they are not happy. As Mr Marsden has said, right from the outset and all the way through.

Q124 Chair: Helen Vernon, how often do you feel that cases finish up in the courts because patients or relatives have simply not been given the confidence that a proper investigation is being undertaken?

Helen Vernon: I agree that the patient should be involved at the outset, and it is important then to establish what the patient wants from the process. If the outcome that they are seeking is an apology or an explanation, or for somebody to say "sorry" and acknowledge that something has gone wrong, then it is very important that that happens early on. Yes, it is true that, if that does not happen, cases can progress through to a complaint and then on to a claim. It is important to note that there are individuals who proceed to litigation because they are entitled to compensation for their needs. The overwhelming part of our expenditure relates to those individuals who have ongoing care needs.

Q125 Chair: I had a case of a family who thought they were going to a meeting to hear about the outcome of an investigation and they were confronted by a lawyer who made them an offer, which they had not even solicited. They were mortified and devastated by the adversarial approach adopted in that case. How often do you think that sort of thing happens?

Helen Vernon: I think that is extremely unusual. Of the cases that are notified to us, there would have to be family involvement and the family would need to express a wish to bring a claim. It would be highly unusual for the trust to involve a lawyer if the patient themselves had not expressed a wish to pursue the compensation route.

Q126 Chair: Part of the problem at Mid Staffs was that the complaint system was run by a lawyer. I make no criticism of you if you are a lawyer, which I suspect might be the case.

Helen Vernon: I am not actually.

Q127 Chair: Lucky you. Is there not a cultural situation about how we deal with patients and relatives, in respect of clinical incidents, that we do not assume that they have the most aggressive motives? As we MPs frequently find, most people who come to us with a concern about the treatment of them or of a relative are concerned that the same thing does not happen to somebody else, so that there is learning rather than blame or punishment.

Helen Vernon: I absolutely agree with that. Recently we published some guidance to trusts called "Saying Sorry", which highlights the need for an appropriate and clear apology at an early stage, irrespective of what might follow. We would not refuse to indemnify a trust where that organisation had put an apology forward. We would not say that patients should not be compensated for the harm they have suffered and we would not say to the trust, "Because you said sorry, you are not entitled to claim for reimbursement of your expenditure on compensation under the scheme." We have sent out a very clear message to the NHS that saying sorry is the right thing to do, and the sooner it is done, the better.

Q128 Kelvin Hopkins: Professor Toft in particular has emphasised that medical investigations are challenging and difficult, and we want to perhaps touch on some of the key challenges faced by independent investigations. Just going briefly through, what key steps must any independent investigation into serious clinical failure involve? How long does each step take and what resources are involved in carrying out those steps?

Professor Toft: This is a bit like "How long is a piece of string?" I am afraid, but there are steps that you must take. There is the initial gathering of information, then there is the analysis of that, which may take several days. Then there is the setting-up of the investigative interviews in an organisation. Just getting hold of the people to interview can be a very testing time, because they may have gone off sick; they may have gone off on holiday. By the time I get there, often two or three months have gone by. In one case, I did 25 days' work over a six-month period, that kind of thing, before I came out with a final report. There are the steps, the interviewing and the analysis. The interviewing and the analysis for me is where the strongest part is, because that is where you get all the real data. If you miss some of the other steps, for example looking at the literature, looking at the place where the incident took place, you miss things out.

It is a very defined set of steps. First of all, get the information from the medical director. Look at the information that they have, then set up a semi-structured questionnaire; bring the people in; interview them then analyse the data. Go back to them with the data to make sure you have got it right, because you might not have, because sometimes you take things down and you mistake them. That process, always iterative, by the time you get to the final report may have taken another couple of months, so you could be looking at six months. When I did the vincristine inquiry, it took several weeks and that was everybody working flat out. That was exceptional, because every other one I have done has taken much longer.

Q129 Kelvin Hopkins: Clearly the medical profession is sometimes not terribly keen on these investigations. What is the general attitude of the medical profession to your kinds of investigations?

Michael Devlin: Doctors will come to us. We are the first port of call, so we do come across this quite often. My experience, and our experience as an organisation, is that doctors are usually devastated. When something goes wrong, they feel awful. They are usually their own worst critics and what they are desperate to do is work out what they

should be doing, what steps they should follow, who they should speak to and how they should go about beginning to address what has occurred and hopefully be able to put it right.

Q130 Kelvin Hopkins: In one case 15 years ago now, a baby died and the doctor went off to work in Africa very quickly afterwards and never came back. It was a clear admission that something had gone wrong.

Ed Marsden: I was just going to say that, in the time we have been doing work, it a voluntary process, so professional staff in the NHS do not have to participate in these investigations, but, by and large, they do. They actually want to speak, often very openly, about what it is that has happened and, like you, are often concerned about what they have done, if they think that they have made an error, and put things right.

Q131 Chair: Should they not be required to take part in the investigation?

Ed Marsden: Their employer actually can require them to participate in an investigation but it is, in terms that we would use, voluntary. They cannot be forced into the room to give evidence, but they can have a reasonable expectation as an employer that they will participate.

Kelvin Hopkins: By and large, the environment is collaborative.

Ed Marsden: Yes, I would say so, certainly for the work we do.

Professor Toft: I have never known anybody refuse to come and answer an interview, ever.

Q132 Kelvin Hopkins: How co-operative are the other organisations—the organisations that regulate it, the professional bodies and clinicians? Are they co-operative as well in these matters?

Professor Toft: Generally speaking, yes, I have never had any problems at all. In fact, when I ask the other organisations for information, they are very forthcoming. It would be almost impossible, on some occasions, to do the work that I need to do.

Q133 Kelvin Hopkins: I notice all of you, whichever side you are on, are not actually clinicians yourselves. You are legal or some differing kind of experience. Is there a problem of clinicians feeling that they are being judged by people who are not of their profession? Is that a problem?

Michael Devlin: I am a doctor. Sorry, I should have said that at the beginning. I do not think doctors particularly have a difficulty with collaborating and working with other people, both laypeople and other health professionals. It is not unusual, for example in hospitals, for the investigation to be led by a senior nurse, and doctors respect the judgments of other people, but it is helpful for someone to have a health care background usually, simply because it cuts through all the jargon that is often associated with a health care investigation.

Q134 Kelvin Hopkins: In a sense you have touched on this, Professor Toft, already. Do investigations into clinical failure currently occur early enough? You have talked about delays, but are they quick off the mark?

Professor Toft: In the initial investigation, they are straight away usually. They are in very quick. It is just making that decision to call in an independent body or an independent

person that takes a little while. To do that, they need to do the investigation and think about, "Do we need to do this?" Of course, there will be conversations with the patient and with the patient's family. Sometimes the patient's family will insist on an outside person coming in. That all takes time. Even if you went in the very second an incident took place and did the investigation immediately, you would find that chronologically time would pass by before you would come to a decision. It is just not that simple.

Q135 Kelvin Hopkins: Do these delays impact the quality of the findings and learnings? I have to say, in politics, investigations take an incredibly long time. One in particular has been delayed for six years. Memory fades. Information may not be available anymore. Is that a problem?

Professor Toft: For me personally, it has not been. I finished one about 18 months ago that took four years, to do with some knees that were done with Scandinavian surgeons at Weston-super-Mare. That took just gone four years to complete it, but I was not working every single day. There was six months waiting for X-rays to come and then another three months for the other X-rays to come because they had sent the wrong ones. That just built up the time. Generally speaking, you find that it is not being done deliberately; time just passes by.

Q136 Chair: A three-month delay to lay their hands on some X-rays is an intolerable bureaucratic delay, is it not?

Professor Toft: I did complain about it, but they said, "We've got things called patients to look after," and I have to have complete sympathy.

Q137 Chair: Did you not suspect that they were drawing out the procedure in order to blunt the sharpness of the investigation?

Professor Toft: I do not know about blunt the sharpness. They cannot blunt the sharpness of mine, because I was very critical of the British Orthopaedic Association and of the two eminent surgeons that actually ran the investigation, because they got it wrong, and the report was published. I do not think that anybody was deliberately hanging things out to dry, as it were. It was just simply that people were doing other things.

Q138 Chair: Should it not be expected that health trusts should have systems to support investigations that do not involve such delays?

Professor Toft: I think you are right, Chair. The systems are not in place to support investigations. They have an incident and then they try to work around it or they will bring somebody in to do it, in terms of their own local people, but there are procedures in place, in most trusts, to deal with investigations. It is getting somebody on to it quick enough to do it.

Q139 Chair: Who should be responsible for making sure that health trusts and general practices have those systems?

Ed Marsden: I think it is a local responsibility.

Chair: Obviously it a local responsibility. The safety of an aeroplane is the airline's responsibility but, when something goes wrong, somebody from outside comes in and says, "Actually, your systems are not up to scratch." Who should be doing that?

Ed Marsden: Within an organisation, it is usually an executive director. Outside, at the moment, it tends to be the Clinical Commissioning Group, which chases the organisation

for the response to something serious that has gone wrong. We work in organisations at the moment where the Clinical Commissioning Group is saying, "You owe us a number of investigation reports about these incidents."

Q140 Chair: The CCG is responsible for the funding of the trust.

Ed Marsden: Yes, absolutely.

Chair: They might be conflicted in that matter.

Professor Toft: They have a legal responsibility, Chair.

Q141 Chair: I appreciate that they have a legal responsibility, but the safety concern might have arisen because of a resource constraint or a resource decision, in which the CCG itself was a party. How are they going to be objectively supervising complaints procedures in the trust?

Michael Devlin: I was going to say that one of the changes that happened after the Francis report and the Berwick review that followed that was that there were changes made to the CQC. Fundamental standards were brought in and those were distilled down to five—caring, responsive, effective and well led—but principal amongst those was safety. One of the first things that CQC will look at in an organisation that they inspect is how safety is managed. That links very clearly into the well led part of how they look at things. It seems to us that proper scrutiny should be through the CQC to make sure the actual process and procedures are in place to make sure that everything flourishes.

Q142 Chair: Are you of the view that CQC should be responsible for overseeing individual investigations?

Michael Devlin: No, only to make sure that the systems and processes are present.

Q143 Kelvin Hopkins: There is clearly a resource constraint and some of these investigations are resource-intensive, so clearly there is pressure not to instigate investigations, I would think, at the beginning. How should they be instigated? Should it just be a request from the patient's family? How many investigations do not take place because of these pressures?

Professor Toft: At the moment, investigations for deaths and severe harm must be investigated regardless, and there is legislation to that effect. They have to engage in those. It is the other ones—the moderate harm, the low harm and the no harm—where just as valuable lessons might be gained, but clearly are not investigated to the same length.

Q144 Kelvin Hopkins: Has this come about as a result of Mid Staffs or was it in place before?

Professor Toft: It was in place before. It is the serious incident framework. The serious and deaths have to be investigated and always are, and they are done of course at a local level. If you get something like poor Wayne Jowett, which was a national scandal as some called it—it was all over the TV, press and so forth, because he was the 14th young person to die of an injection of vincristine into the spine since 1975. Sir Liam Donaldson, in his report, "An organisation with a memory", from which the National Patient Safety Agency came, said that there would be no more after 2001. Of course, Wayne Jowett died on 4 January 2001, which is why they brought in somebody independent.

Q145 Greg Mulholland: Turning to the legal issues, particularly to Mr Devlin and to Helen Vernon, the first thing that concerns politicians and taxpayers, particularly at a time of austerity, is the vast cost of criminal negligence. When you look at the extraordinary projections—the Treasury provisions for clinical liability currently stand at £24 billion, a quite astonishing sum—clearly there are things that we are not getting right. Clearly there will always be cases of medical negligence, but it is fair to say that there are many cases that are avoidable and surely more could be done through better investigations. The first question along those lines is: do you think there is a way of bringing that enormous cost down by a better system of investigation?

Helen Vernon: It is important to understand how that cost is made up. It really relates to the long-term nature of those liabilities. A large proportion of it, about £14.5 billion, relates to incidents that we believe have occurred in the NHS that have yet to become claims. It is an estimate; it is an actuarial calculation. A large proportion of it also is attributable to long-term care needs of brain-damaged baby cases. The extent to which an improved investigation system would reduce those liabilities is really questionable, because those are individuals who, notwithstanding the nature of the investigation, would need that compensation in order to provide for their long-term care needs.

At the other end of the spectrum though, we do receive a large number of claims at the lower end, which form a much smaller part of that overall figure, which perhaps would not become claims had there been better handling earlier on, but there is a question over the extent to which you can actually tackle that figure by looking at that lower end, rather than those bigger liabilities that relate to claims that would have to be paid in any event.

Q146 Greg Mulholland: You do not necessarily think that having an independent investigative body would help that? If there were to be an independent investigative body of the sort that has been suggested, how do you think that would fit into the overall system legally and what would be the duties upon it?

Helen Vernon: It would depend on its powers, its terms of reference, its status and the point at which it stepped in. We have heard about the huge number of treatment incidents in the NHS and then the huge number of adverse incidents, because of the scale of activity, which range from the very minor to the very severe. The question then is where that body would step in. Would it be targeting only very serious incidents? Would it be targeting areas where there was the most scope for learning and sharing that learning across the NHS, or would it have a very much wider remit? Then you have to think about how it would be resourced and where it would sit as well—whether that was within the NHS or more independently. It really depends upon what it is.

Q147 Greg Mulholland: How do you think that the duty of candour has or will have changed things and how do you think that fits into this whole picture?

Helen Vernon: These are early days. The obligation to be open and transparent has been around for a long time, and exists in the existing professional duties of a doctor. For example, the GMC duties require a clinician to be open and transparent with a patient. That has been around for a long time.

The statutory duty of candour, which was introduced in November 2014, does place an obligation on the organisation and also requires that the candour is accompanied by an apology and an explanation, and a written record of that. It may be that we see more coherence in the way that we are seeing incidents coming through. Certainly the written record will be part of that but, in terms of how it impacts on openness in the NHS, these

are early days. Certainly regarding our experience, as I said, we only see things very much further down the line, so we would not ourselves be in a position to comment on how that is impacting until some years on.

Michael Devlin: To disentangle that a bit and go back to one of your earlier questions, the amounts that appear in the NHS Litigation Authority's reports for what they expect to have to set aside for future claims is enormous. From memory, the most recent report was about £26 billion. Our concerns are not just that figure as it presently stands, but the fact that the rate of increase of damages is about 10% a year and it has been that for the last five years or so. Sometimes it is quite difficult to envisage what 10% means; so what? A useful way is to think how long it is going to take for that amount to double, so when £26 billion becomes £52 billion. In fact, it computes as seven years. In seven years' time, if it continues at the current rate, the NHS Litigation Authority is looking at a £50 billion-odd amount to set aside.

Although improvements in public safety are clearly a part of the solution, they are not a solution in itself because, as Helen Vernon mentioned, one of the problems that you have with claims is that there is often quite a long time between the incident happening and it then becoming a claim. It can be years; it can be decades.

We feel that there ought to be review of the way compensation is calculated in order to try to put the brakes on the increase in damages, but in a way that is fair to patients, so patients do not lose out. One of our suggestions, for example, is repeal of a section of the 1948 Act that means that, in calculating damages, you are not obliged to disregard the fact that you might be able to get that care through the public sector. That is one of our suggestions, but we do feel that reform there is needed.

Q148 Greg Mulholland: My final question is: do you think a shift to a no-blame culture could make a difference to this and, legally, is that something that then would change the very problem that we have just described?

Helen Vernon: There is a distinction between no-blame and what people call no-fault compensation systems. The current compensation system does not seek to attribute blame, so much as decide where legal liability sits. Actually, we defend organisations. We do not defend the individual. The legal defendant in the claims we see is the organisation.

There is often talk of no-fault compensation. When you look at other systems that are referred to as no-fault compensation around the world, it is quite rare for there to be no element of fault involved. Most of those systems have some element of fault within them. When it has been looked at before, you also need to consider the number of incidents that would go into a no-fault compensation system because, in order to make it affordable, you would have to dramatically reduce the level of compensation payable to account for the very much increased number of claims that you would get.

Q149 Chair: Do you have anything else to add, anyone?

Professor Toft: Just one thing, if you do not mind, Chair. If you are talking about keeping the numbers down in terms of the amount of compensation, one of the ways you could do that is to ensure that the recommendations made from investigations are actually implemented across the NHS.

Chair: I am very glad you have said that.

Professor Toft: That would just stop dead the numbers that are going through. A lot of the time, these recommendations are not implemented, and I am going to give you an example, if that is okay, Chair. A few years ago, I did an investigation on some stillbirths at a hospital and I made my recommendations and gave my conclusions. Some weeks later, I read a paper from 1991 and I found the same thing. This is what I found when I did it. I said: "There appeared to have been inadequate foetal monitoring. There appeared to have been a lack of involvement by senior staff. Medical records were not as robust as they might have been. Some women had been ignored and had been given too little information." By the way, this was published in *The Obstetrician & Gynaecologist* in 2005.

The *British Journal of Obstetrics and Gynaecology* in 1991 had this to say: "The review's main criticisms were of inadequate foetal monitoring, lack of involvement of senior staff and inadequate records. Women had complained of being ignored and given too little information." There was a gap between 1991 and 2004, but the same problem was arising. If they had put in place the recommendations from that report in 1991, I might not have had to make my report in 2004.

Q150 Chair: From a clinician's point of view—and I am asking Mr Devlin to speak on behalf of clinicians, if that is fair—why do you think clinicians and hospital systems do not pick up these lessons learned or have failed to pick up these lessons learned in the past?

Michael Devlin: It is one of the most interesting things that you are looking at in your current piece of work. Our concern is that there is a lot of information there that is being fed to various bodies, but it is all really not joined up. It is not joined up in a way that can be comprehensively analysed and then the learning that is developed from that fed back.

Q151 Chair: That brings us back to the idea of some ultimate supervisory body that is not just investigating or overseeing investigations and the quality of investigations, but is actually overseeing the learning process and the dissemination of learning throughout the system, checking that that happens and pointing out when it is not happening. I am sure the Secretary of State will tell us that he now has capacity in the system to do that. Do we believe that that capacity now exists?

Professor Toft: Of course it does not. If it did, we would not be sat here having this conversation.

Chair: I love Yorkshiremen.

Professor Toft: I do try to be diplomatic, Chair, but I find it very difficult. In each trust, they do their best. I swear they do their best. However, the whole system as a system does not work. For example, I am doing a review now. I found some recommendations in a paper for a particular incident. Different hospitals have done different things. Collectively, if it had been published, if they had been told, "You've got to do this," or "These are the recommendations and you will engage in them," in the rapid response reports put out by the National Patient Safety Agency before it got kicked into touch, then a lot of these other things would not be happening. Nobody is insisting on the recommendations, and that includes public inquiries as well.

Q152 Chair: Somebody needs to be made accountable.

Professor Toft: Accountable for it and ensuring that it all takes place and makes sure that it happens, and then you will see a reduction.

Q153 Chair: Who should that be?

Professor Toft: Do you mean in terms of a body?

Chair: Or an individual. Who does Parliament hold to account for the failure to disseminate learning and improvement?

Professor Toft: You would have thought it would be the Secretary of State.

Ed Marsden: It used to be Chief Executive of the NHS, I would have thought, but we do not have one of those responsible for the system as a whole any more.

Michael Devlin: The current function rests at the moment with NHS England. Without Dr Durkin being here, it is not fair.

Chair: We will go back to NHS England—he is behind you and listening. If anybody wants to add anything to what they have heard today or said today, we would welcome any further written evidence on this topic. Is there anything else to add now?

Kelvin Hopkins: Just one minor point: whenever this kind of thing happens at my local hospital, I always write to the Chief Executive and I hope that MPs have a role in this, because MPs do make people nervous, because they might be reporting to the Secretary of State or whatever. There is a role for MPs in this, although it is trying to deal with things when they have already gone wrong, at least trying to improve them.

Q154 Chair: Professor Toft, you wanted to add something.

Professor Toft: I thought it was an interesting notion of having a political person responsible, as it were, for making sure that the local learning takes place. That might not be a bad job to give my local MP.

Chair: Thank you very much indeed for your evidence. It has been very interesting, and I hope you will carry on taking an interest in this inquiry of ours.