HOUSE OF COMMONS

Public Administration Select Committee

Oral evidence: NHS Complaints and Clinical Failures, HC 886

Wednesday 25 February 2015

Ordered by the House of Commons to be published on 25 February 2015

Written evidence from witnesses:

- Department of Health

Watch the meeting

Members present: Mr Bernard Jenkin (Chair), Mr Nigel Evans, Mrs Cheryl Gillan, Sheila Gilmore, Kelvin Hopkins, Greg Mullholland.

Questions 268-336

Examination of Witness

Witness: **Rt Hon Jeremy Hunt MP**, Secretary of State, Department of Health, gave evidence.

Q268 Chair: Secretary of State, I am very pleased to see you, and thank you for coming to this session on clinical incident investigation. Just by way of introduction, the reason we are doing this inquiry is because of our responsibility for the Parliamentary and Health Service Ombudsman, who is the focal point for a wide variety of information relating to a variety of failures, including, currently, clinical incident investigation in the health service. It is debatable whether the PHSO should have such responsibility for the forensic examination of what has gone wrong in operating theatres and hospitals, and it is hoped that this work will reduce the need for people to go to the Parliamentary and Health Service Ombudsman, who, it was recently pointed out to us, is set up to adjudicate rather than to investigate, and I think that was a very interesting point.

Our inquiry is prompted by a paper produced in the *Journal of the Royal Society of Medicine* by Carl Macrae and Charles Vincent. While we have appointed Carl Macrae to advise us on this inquiry, I want to make it absolutely clear that we are not here to champion his proposal and we are not predetermined to support his proposal. I want to make it clear that we may well come to a different conclusion.

Can I start by asking you to confirm who you are for the record?

Mr Hunt: I am Jeremy Hunt, the Health Secretary. I am feeling a bit lonely down this end of the table, but that is what happens when you are Health Secretary.

Q269 Chair: I must also apologise. We have two illnesses and at least one other colleague speaking in a debate, so we are a little shorthanded ourselves, but I am very grateful for your agreeing to make this an open-minded conversation about this issue of clinical incident investigation. I am also extremely aware how much the NHS and the Department is doing around this whole question of whistleblowing, complaints handling and culture change, and we are impressed by the evidence that you gave us on that in this inquiry.

Just to start with, just remind us how many serious incidents are there each year in the NHS.

Mr Hunt: About 30,000 every year, of which 10,000 are severe harm or death.

Q270 Chair: How many never events are there—which is when things, in theory, should never happen?

Mr Hunt: Yes. I do not have the never events figure to hand, but I know that, if you take specific examples of never events, approximately once a fortnight we put the wrong prosthesis onto someone; once a week, we operate on the wrong part of someone's body—wrong-site surgery; and twice a week, we leave a foreign object in someone's body. This is much more frequent than the term "never event" would suggest.

Q271 Chair: To start with the fundamental question, you say that the NHS now does seek out problems, share them with the public and take action to save lives. How well do you assess that the NHS and your Department is doing this now?

Mr Hunt: I do not think that we have cracked the problem at all. I think we have started on a very long journey. As your investigations have uncovered and I have discovered in the course of the last two and a half years, in the end we should not need whistleblowers, because we should have a culture where people want to find out that things have gone wrong and why they have gone wrong, and to learn from them. You only have whistleblowers when you have a system which is not doing that, and so, in the end, it is about culture change and creating a climate of openness and transparency. That is something that takes quite a long time to do, but we have put in place quite a few things that I hope will make that really happen.

Q272 Chair: We have heard that there are over 70 bodies, agencies and organisations that might investigate a medical incident. Ultimately, of course, you are accountable to Parliament for the safety of the health service, but who is the individual who you expect to be responsible for overseeing patient safety and clinical investigations?

Mr Hunt: The NHS is the fifth largest organisation in the world and, in truth, it is an industry as much as it is a single organisation. There are 250 separate hospital trusts. As a result of the Francis inquiry, we set up an independent Chief Inspector of Hospitals, and that person—Professor Sir Mike Richards, who I think you have taken evidence from—is, for me, the person whose job it is to be, if you like, the whisteblower-in-chief for the public: the person who speaks out without fear or favour, if safety standards are not adequate. He has only been in post for just over a year, but he really has started to do that. We have put 20 hospitals into special measures—more than 10% of all hospitals in the NHS—primarily on safety grounds. I think that has been a very dramatic change in the interest in the system in safety, because people recognise that, if they want a good rating from Mike Richards, they have to have a good safety record. The two go together. He is

the person who is, I think, the arbiter of whether there is safety, or whether hospitals are run in a safe way.

I think one of the things that I would like to discuss with you this afternoon is the stage before that: where you have something that has gone wrong, who is responsible. We have often talked about the professionalism of the Air Accidents Investigation Branch at the Department for Transport and, this morning, I met David Miller and Keith Conradi to talk about how that works. In the UK, in 2013, there were 30 aviation deaths; in the NHS, it is about 7,500 avoidable deaths of a total of 250,000 hospital deaths, but we do not know which the 7,500 avoidable are of the 250,000. We know some of them, but not many of them, so we get that 7,500 figure from looking at 2,000 case notes and assessing that around 4% of deaths across the NHS are avoidable.

It is a bit "needle in the haystack", so we could not replicate, but I am very impressed with the structure that they have, which means that, because it is one body that looks into a number of these incidents—they do about 50 serious investigations every year—they then collect the information from those investigations and disseminate them. At the moment, the responsibility is essentially a local one and it is the responsibility of local trusts. We then assemble the information that we get from them. We get, I think, 1.5 million reports from hospitals every year to the National Reporting and Learning System, which Dr Mike Durkin and his team, who you have heard evidence from, collate and assemble.

Q273 Chair: Mike Richards is in CQC, and Mike Durkin is NHS England and is in charge of the Patient Safety Domain.

Mr Hunt: Yes.

Q274 Chair: When we talk about the volume of cases, we are not saying that, therefore, we cannot expect to investigate them all; surely we are saying that they need to be investigated. We are just arguing—or discussing—how they should be investigated and who should be responsible for their investigation. The volume thing, in my mind, appears as a great obstacle to start with but, if you can sort out which ones you are going to investigate, however great the volume requiring investigation, it is just a question of how they are investigated. They all have to be investigated.

Mr Hunt: Yes, but if I just unpick that, if I may, for a moment, we have about 3,500 reports of serious incidents involving death every year, but we think there are probably 7,500 avoidable deaths, so there are 4,000, broadly, that are not being reported. They are being treated as an unavoidable death or one of those things that—

Q275 Chair: There are serious incidents as well—let us just be clear about that.

Mr Hunt: On top of the deaths but, if we just look at the deaths, 3,500 are reported into the NRLS system, but we think that there are 7,500 avoidable deaths, so there is under-reporting. For every death that is reported, there is another that is not but should be, so a very big priority is to create a culture where more of these mistakes are reported, so that we can learn from them. Of those that are reported, they are all investigated very thoroughly at a local level. In the airline industry, however, it is very straightforward: every single death is investigated by the Air Accidents Investigation Branch, and every single death is avoidable. In that industry, as in the nuclear industry and the oil industry, the presumption is zero deaths, and so, when there is a death, it immediately triggers a process.

Q276 Chair: Both organisations investigate far more than just deaths.

Mr Hunt: Yes, we should all investigate, because, of course, we need to investigate the circumstances that might lead to any kind of tragedy—indeed, a death—even if it did not, so near-misses in the airline industry would be an example of that. I do not think you could have, and I do not think you would want—and this is what I tried to express in our evidence for you—a system where all 3,500 of those deaths that are reported in are centrally investigated. That is a massive overhead, when you think that the Air Accidents Investigation Branch is doing 50 a year.

Q277 Chair: Curiously, we were told by the aviation people that, in Australia, where there is a lot of crop-spraying, and a routine accident is an aeroplane flying into power lines, they do not routinely investigate those accidents. There is, then, a way of filtering out. There must be a methodology of filtering out the accidents that are routine or recognised hazards.

Mr Hunt: I think that is right, but the nervousness we had about the straightforward replication of that model into health care was twofold: firstly, it was about the volumes and how we would cope with massively more deaths, but it was also about the responsibility. If we are going to change the culture at a local level, a hospital needs to feel interested in what happened and to want to take responsibility in finding out what happened, and should set up structures where independent investigations can be made into any avoidable harm. We did not want hospitals to feel that it was not their job.

We are shortly going to get the report on the tragedies at Morecambe Bay, where a number of babies tragically lost their lives in the maternity unit. There are situations where there is a complete breakdown of trust between families who have been bereaved or suffered tragedies and a trust, and there are also situations where a trust might say, "Actually, we do not know if we did something wrong or not, but we think, in this situation, we want someone completely independent, who has nothing to do with our trust, to look at this, just so that we can reassure ourselves as well as the families that an independent investigation is being done." That is where I think you might have a situation where, at the invitation of a trust, if there was particular concern in a particular situation, and possibly at the invitation of the Ombudsman, you had a separate independent investigation that was done.

Q278 Chair: Just to summarise, in answer to my first question around which single person is responsible, you have mentioned two names: Mike Durkin in NHS England and Sir Mike Richards at CQC. They are both part of the system. CQC told us in their evidence that they cannot do individual investigations anyway, although I hear what you say that he is the ultimate arbiter. How do you ensure that safety incidents are routinely investigated?

Mr Hunt: They are routinely investigated, but they are just not investigated very well all the time.

Q279 Chair: That was another bit of evidence that we have heard from one of the Royal Colleges. The capacity to investigate locally is very patchy.

Mr Hunt: Mike Durkin's responsibility is to foster and encourage a safety culture throughout the NHS by collating as much information as possible and spreading that information through the system, and he does that job superbly well. Mike Richards' job is to give an objective, independent view of the standard of safety throughout the system, and I think he does that job very well. Any organisation that is going to be available to do independent investigations has to sit somewhere.

Chair: It does.

Mr Hunt: That somewhere is going to be loosely part of the system. The AAIB sits in the Department for Transport. If the equivalent system sat in the Department of Health, we would have a conflict that the Department for Transport does not have, which is that we run the hospitals. The hospitals are ultimately reporting to us in a way that the airlines and the train-operating companies are not reporting to the Department for Transport. I happen to think that a very good place for this safety function to sit would be under Mike Durkin's operation, because I was very struck, talking to the AAIB, that they very much see their job as to be supportive, to foster a culture of learning and disseminate the learning that they make when things have gone wrong, and to get to the truth quickly. That seems to me to fit very squarely with Mike Durkin's responsibility to be the person who encourages safe practice throughout the entire system.

Q280 Chair: I hear that very clearly, though it would be a nice-to-have that this organisation was also available to investigate the private sector, so that there could be learning across the whole health sector.

Mr Hunt: Yes, and, in truth, any structure we set up will be to investigate all care that was paid for by the NHS, whether it was being delivered by the private sector.

Q281 Chair: How important do you think it is to be able to investigate clinical incidents that are not alerted by a complaint of a patient or the relative of a patient?

Mr Hunt: They should all be investigated—all instances—but the trouble is that we do not have that culture of openness and transparency in health care that they have developed in other industries. In the airline industry, I was incredibly struck this morning when David Miller said to me that, in 24 years in his job, he had never heard the word "cover-up" once. They have not had a public inquiry into an airline crash since 1973. If you start to pull up the bonnet, the way they do the investigations is designed to create a blame-free culture, where they are co-opting pilots into helping them understand why things went wrong, in a way that does not penalise or make the pilot feel that it was the pilot's fault. Even the phrase "human factors", if you think about it, is a way of saying to a pilot, "If the reason this accident happened is you forgot check 23 and check 24 of the 50 checks you should do before the jumbo jet takes off, that was human factors". It slightly depersonalises it from the pilot. It is saying, "Maybe we should have made those checks checks 1 and 2, if they were that important because, by the time you get to 23 and 24, your memory is perhaps slipping a bit", or whatever.

The whole methodology around human factors is designed to recognise that everyone is a human being. I do not think we have thought nearly hard enough how that could work in medicine, and I think too many doctors, nurses and midwives think that, if they are found responsible for a death or a serious incident, they will be fired, when the culture that we need is, "If you do not tell the truth and help us to understand what happened, then you will be fired, but you do not get fired for making a mistake, because that is what happens."

Q282 Chair: At the moment, how confident are you that the present arrangements are going to bring about the universal quality of local investigations that you want to see?

Mr Hunt: That is a very difficult question to answer, because we should not underestimate the scale of the changes that have been made, but nor should we underestimate the scale of the challenge. Mike Richards has only inspected half the

hospitals in the NHS so far. Of the 20 hospitals in special measures, we have only got six out; we still have 14 that we have to get out. We are the first country in the world that has tried to do this. All these problems that we are talking about, by the way, are not unique to England. They are problems in global health care. In fact, compared to other health care systems, there is evidence that we may be safer than other countries. I certainly would not say that we are there. I think we have been bolder and braver than any other country that I am aware of, but I think there is a long way to go.

Q283 Chair: You are introducing these new Freedom to Speak Up guardians to try to enable whistleblowers. What role will they play in clinical incident investigation?

Mr Hunt: The whole processes that we are trying to create have been modelled on those in the airline industry, which are designed to make it incredibly easy for pilots to speak up. The first person who a pilot would tell if they had a near-miss, or if they were worried that their rosters were making them work so hard that they were not getting enough sleep, or whatever it is, would be their airline. If they felt that their airline was not going to listen to them, they could talk to their union. If they felt that that was not where they wanted to go, they could talk to the CAA. They could also talk to an anonymous charity, which I think is run by the CAA. There are, then, five different places that they can do it. The Freedom to Speak Up guardians—and, if you can find a snappier phrase for them, please let me know—are designed to be an independent person in a hospital—

Q284 Chair: But part of the organisation.

Mr Hunt: Part of the organisation but just there, so that, if you do not want to tell your line manager, you have someone else you can talk to in the trust. Then the national Freedom to Speak Up guardian or whistleblowing champion is there to check that hospitals are following procedures, so there is someone outside the hospital if you ultimately needed it.

Q285 Chair: The NHS England never events taskforce made a key recommendation, which was to establish an independent incident-investigation panel, but we have been informed that this has not been implemented. Can you say something about that?

Mr Hunt: As I understand it, it has been implemented on a pilot basis right now, and we are looking at it. I think there may be an opportunity, because I think, if you had an independent clinical investigation branch, that could be something that is very attractive to hospitals. At the moment, when they do an independent investigation, they have to start from scratch. In extremis, the Morecambe Bay inquiry is going to cost the best part of £1 million. The Francis report cost £13 million. These are huge costs. If you had a central resource that they could bring in when they wanted to do an independent investigation, they would pay for it, but it would be quick and probably much cheaper than anything that they would do themselves, so I think there could be some merit.

Q286 Chair: How much is the contingent liability for NHS litigation? I think it is about £18 billion.

Mr Hunt: Of my budget, we spend £1.3 billion a year on litigation claims, 40% of which is maternity-related, incidentally. It is a huge amount of money to—

Q287 Chair: If we could save a sizeable fraction of that, we have quite a lot to spend on independent investigation.

Mr Hunt: I think the cost of poor care—and we did a study of it—is probably around £2 billion a year in the NHS. The most expensive thing you can do in the NHS is

to botch an operation. If you think about the impact in terms of the time it takes to investigate it afterwards, the extra time someone will stay in the hospital, and the management time in looking into it, there are huge costs that could be saved by safer practice.

Q288 Mrs Gillan: One way to really save costs is to learn the lessons from the investigations. I am very struck by the evidence that we had from the Association of Surgeons of Great Britain and Ireland, who admitted that "the NHS has made great strides in the way it collects evidence of medical failing…" but—and this is the big "but"—"the big deficit", they said, "is the lack of an effective mechanism through which the information gained from such reports can be used systematically to bring about change." Would you agree with that statement? How on earth do you monitor the sharing of the information that comes from these investigations? As a supplementary to that, how do you also convince the patients and the relations of loved ones that those lessons are being disseminated amongst the rest of the NHS?

Mr Hunt: Do we share the information and the learning points from these investigations as well as we should? No, we do not; that is for sure. If you look at the scale of a system that has up to 1,000 avoidable deaths every month, you cannot look at that and say that we are doing as well as we should at sharing the learning that could prevent so much tragedy.

How could we be better at it? The first thing is that we have made it an absolutely core part of how hospitals are assessed to have a good safety record. Until we had the new inspection regime, you were a good chief executive if you hit your four-hour target in A&E, if you hit your 18 weeks, and if you were in financial balance. All those things matter, but other things matter too. What Mike Richards does is he inspects hospitals in a rounded way, with five domains, including responsiveness—which is your targets, amongst other things—governance, clinical effectiveness, and safety. They are the key domains. Hospitals, now, for the first time, know that, if they want to get a good overall rating—like an Ofsted rating for a school—they need to take safety seriously.

I think the real answer to your question is, if I can put it this way, it is pull and push. It is not just a question of how good Mike Durkin is at pushing out information through the system so that surgeons can see how they need to improve their procedures; it is also about the surgeons on the other end being hungry for that information as to how to improve their own performance. What the new inspection regime is designed to do is to try to create that hunger at the grass roots because, if the chief executive of a hospital is saying, "We have to improve our safety record", and that message is going throughout the whole hospital, then, inside the hospital, where they are very ambitious to get a good rating from the CQC, they will then want to improve their record.

Q289 Mrs Gillan: What you are describing is a current culture that is very defensive. You are talking about completely breaking that culture apart and turning it on its head. How are you going to do that?

Mr Hunt: I think the way you have to do it is by supporting doctors and nurses, recognising that no one goes into work wanting to harm a patient, and recognising that doctors—and surgeons in particular—are some of the bravest people on the planet. They have a human being on a table in front of them, and they are doing something that none of us have ever done, which is taking a knife, cutting into them and doing something that is

really very brave. In that context, people make mistakes, and it is incredibly challenging, emotionally, to make a mistake and to know that a patient has suffered—possibly died—as a result of it. This is an incredibly brave thing for a human being to do.

Because of that bravery, however, I think perhaps in medicine globally—not just the NHS—there is a certain camaraderie that says, "If mistakes are made, we need to look out for each other". They had that culture in the airline industry as well, which is why they had such a high accident rate. They have halved deaths over the last 30 years in aviation, even though airline travel has increased nine-fold. You now have to travel every day for 10,000 years to have a chance of being involved in a fatal accident in a plane, so they have had a very good track record in doing that. We need to learn that in medicine by creating a supportive culture where doctors and nurses feel that they will be supported and encouraged if they talk about worries that they have about things that are going wrong, that they will not be blamed for it, and that they are part of the endeavour to learn how to do things better. It is a big thing to change; I do not want to pretend otherwise.

Q290 Mrs Gillan: The one aspect of this learning from what has happened and the investigations that you have not covered is timeliness. I think we were very struck on the Committee about the death in 2001 of Wayne Jowett. I do not know whether you recall that, but chemotherapy drugs were injected incorrectly into the spine instead of into the vein. That happened in 2001 but the final safety alert from the incident was, apparently, only published in 2014. I have to ask the question: why did it take so long for such a fundamental recommendation from a very high-profile case to be alerted around the system and implemented? What lessons can we learn from that? Are you going to make sure that there is a timeliness attached to the lessons that are disseminated throughout the NHS?

Mr Hunt: That completely sums up everything that is wrong: the fact that it takes that long.

Chair: And the sepsis issue. We are still waiting for NICE to produce the guidance. When they were sitting where you are now and we were cross-examining them on the ombudsman's report, they did not seem to understand the urgency of getting some guidance out there to save lives. Cheryl, you might want to ask something about that.

Q291 Mrs Gillan: I declare an interest in that, because I have been in that position myself, and it was only by rapid reaction from medical staff that I am still sitting here today, I believe. We have been waiting for the results from that report, and I do hope you can do something to urge it along.

Mr Hunt: We have not waited. I launched a big sepsis campaign in December. Sepsis needs to be the next big thing. In fairness, we had tremendous success in reducing MRSA and C. diff rates, and I think sepsis needs to be the next big thing. To answer your question directly, Mrs Gillan, often the reason it takes so long is because the system, rather than wanting to engage and understand exactly what happened, clams up and closes ranks. Someone like Scott Morrish, who tragically lost his son Sam to sepsis, talks incredibly movingly about how he was told initially that this was an unavoidable death, because Sam was three years old. Only six months later did he think that some things did not feel right, and then he started talking to people and the whole system closed ranks. Their GP was the only person who apologised, but everyone else completely closed ranks. It took him years.

James Titcombe, who lost his son Joshua at Morecambe Bay, is going to find out—he thinks—in the next few weeks, when we publish the Morecambe Bay report, about a death that was in, I think, 2008. A system that should be really hungry to learn about what has gone wrong and inculcate it into practice does not do that, because there is a culture where people think they will be blamed for a mistake, when, in fact, what the culture should be is: "The only thing we will blame for you is not telling the truth so that we can learn from mistakes".

Yesterday, I had a difficult conversation with someone who had lost his wife and son because of mistakes made by the NHS, about why it is that you do have to be careful about naming and shaming. If you do accountability in the wrong way, no doctor or nurse will ever want to speak out about problems, and families do understand that. They all say, "All I want to do is to know that the NHS has learned from this tragedy".

Q292 Mrs Gillan: That takes us nicely on to accountability, because you have certainly acted to increase accountability across the whole of the NHS. Do you think there would be any benefit to having a no-fault compensation scheme for clinical incidents, like the one in New Zealand, for example?

Mr Hunt: I know there are countries that do that—I think they do that in New Zealand—and there are merits. There is a practical difficulty, which is that, for the vast majority of even serious incidents, we do not pay any compensation at all, because the vast majority of people are not interested in money. If you were to automatically pay money for every single serious or severe incident, you would end up having to reduce the amount you paid currently to the ones who we do pay money to, which might seem like a great injustice to the families involved. I do not have a problem with the principle of it but, practically, I think there may be some challenges.

Q293 Mrs Gillan: Accountability is such an important thing, and one of the most recent things that have happened is the announcement to hand Greater Manchester control of £6 billion of the NHS budget. Do you think that that is going to help increase accountability or do you think it is going to add another layer to it? We have this Shadow Health and Wellbeing Board. Is this really going to streamline and improve the service, or is this form of devolution going to add complications to the system that you are trying to sort out?

Mr Hunt: It is important to understand what this announcement is and, in fairness, the details are going to be published later on in the week, so I am afraid I cannot go into too much detail today. Essentially, I will be responsible, as Health Secretary, for health care in Greater Manchester, just as I am in everyone's constituency around this table. That is not going to change.

The accountability will still be with me and with NHS England, but what NHS England are saying is that, in different parts of the country, there will be an organisation in the driving seat for making the big decisions about health care in that area, which will then work with other bodies. There needs to be someone in the driving seat. In some areas, that could be the local authority, as in Greater Manchester; in other areas, it could be a very go-ahead trust or hospital; in other areas, it could be some enterprising GPs. We are not going to tell areas which it should be; for most areas, it is fairly natural which it should be. Whoever you choose to be the person in the driving seat, however, they will all be accountable for the same outcomes in terms of the national standards: A and E waiting time targets, elective care waiting times, and so on. That will not change. How well they do will be published and, if they do not deliver, we will step in.

Q294 Mrs Gillan: It is, however, adding a layer of complication, presumably.

Mr Hunt: I do not think it is. I would say that it is creating simplicity, because what we are saying is that, in every part of the country, we are going to implement the changes in care that we need to deal with an ageing population. You need to have an organisation in the driving seat in each area, but we are open-minded as to who that organisation should be.

Mrs Gillan: I would like to come back to you on a record-keeping matter, but I think Mr Mulholland wanted to—

Chair: It is on this question of accountability.

Q295 Greg Mulholland: Jeremy, we have had conversations about this in the past, and we have at the Committee level. Do you understand that there is a concern that the changes in the health service over the last few years have made the NHS less accountable, precisely because, at times, people come to you—including me and other members of the Committee—and the answer is, "Actually, it is down to NHS England"? There is a sense that the buck should stop with you, as Secretary of State for Health, and sometimes it does not and you or your ministerial team will say, "That is nothing to do with us and we cannot get involved in that", so how do you square that circle?

Mr Hunt: I am responsible for health care delivered to your constituents and everyone throughout the country, and the buck ultimately must stop with me and should stop with me and should always stop with the Health Secretary. I think there are times when it is helpful to have some distance from Ministers—helpful for the public as well as for Ministers. We have an independent NICE process, which does not always work as quickly as we want, but I think there are things where you need clinical expertise, and those things are at arm's length. I think there was a very strong feeling in the NHS that, for example, every single hospital reorganisation was being decided by a Secretary of State. They always became extremely political, and so, for things that really should be more operational decisions decided at a local level, the reforms introduced by my predecessor created some distance between the Secretary of State and those reforms. I would say that I am responsible for the outcomes of everyone. In the end, if what those reforms generate are outcomes that are worse than before—which I do not think they are doing—that is my responsibility.

Q296 Greg Mulholland: You are clearly accepting there that the buck does stop with you still, which is constitutionally correct and welcome, but how do you deal with issues when it comes to NHS England and senior figures in NHS England? Without going over old ground—I am not going to reopen all disagreements—when I brought a complaint to you about senior NHS staff, you then repeated to me what they were telling you. Surely, your role is to hold those people to account as well, if there are issues with things that they have done, decisions they have taken or issues within NHS England's failures—and there are failures by that body, as any other public body, as you very rightly and honestly admit. Can we really rely on the Secretary of State—you and whoever your predecessor is—to make sure that they are ultimately responsible and will take action if needed when there are failures, even at the top of NHS England?

Mr Hunt: In some ways, the system we have at the moment makes accountability easier. Under the old structure, where the Secretary of State was sitting at the top of a pyramid, with direct command and control going right the way through the system, the

Secretary of State under that system would have taken advice from their officials and would have repeated that advice back to any MP who asked for his or her opinion on any particular issue. We now have a structure where our requests to the NHS—what we are holding NHS England accountable for—are written in a 35-page document that did not exist before but which is there for the public to see what we are asking about NHS England. If they are failing on that, we can hold them accountable for that.

With the new CQC regime, we have also introduced an element of challenge into the system that did not exist before, because we have an independent chief executive. Just as any Education Secretary in any Government wants to say that standards are going up and that there are more good schools, when you have an independent Ofsted system that creates some objectivity in the system, which is, I hope, what I have been able to introduce into the NHS.

Q297 Greg Mulholland: As a last question, on a very specific point, I have just come straight from the rare disease day reception—it is rare disease day, as you will know, on Saturday. NHS England failed 180 children around the country with tuberous sclerosis, Morquio syndrome and Duchenne muscular dystrophy. They had a process that was clearly discriminatory against people with ultra-rare diseases, which they had to scrap on receipt of a legal letter back in December. Precisely to give you an example of how, I am afraid, I do not think the accountability is working, all that those children and the organisations have been told with regard to that decision, which was clearly the fault of NHS England, is that the decision is now with NHS England. However, what should be happening is that you, as Secretary of State, should be instructing them to put an interim process in place to deal with their mistake and with their moral and potentially legal responsibility to fund the drugs for those children, and it is not happening. Will you convene that and will you hold NHS England to account? Can we have an interim decision to honour that funding before Parliament dissolves?

Mr Hunt: I will have to take that issue away and look into it. The only thing I would say is that I am not sure that that particular issue is an issue that would have happened any differently under previous structures.

Q298 Greg Mulholland: With respect, the replacement body replaced one that was abolished by the Health and Social Care Act, so there is a direct political responsibility as well.

Mr Hunt: I think that those difficult decisions about the funding of drugs for people with rarer diseases are ones that would happen under any structure. The reality is that we do not have as much money as we would like to be able to fund the many rare diseases that there are.

Q299 Greg Mulholland: Indeed, but will you hold them to account for the full process—

Mr Hunt: We do hold them to account.

Q300 Greg Mulholland: Will you intervene? I am asking you to intervene personally.

Mr Hunt: I will look at the issue and I will take it away, and I will write to you when I have had a chance to look at it.

Q301 Mr Evans: You have one heck of a responsibility, Secretary of State. It literally is life and death. You gave that analogy of the airline industry, which I thought was probably quite apposite, that you would have to get on a plane every day for 10,000 years before you would, ordinarily, be involved in an incident. That clearly was not the case in the 1950s. You clearly see what the problem is, but there are still huge issues within the NHS that the airline industry does not face, so what do you think you can do to bring the NHS up to that standard?

Mr Hunt: I think the only thing you can do is to start the long journey of culture change, where the 1.3 million people who work in the NHS feel that, if they speak out with concerns or suggestions as to how to improve patient care and how to avoid the nearly 1,000 avoidable deaths we have every month, they will be listened to and supported, and that is part of their job. Unfortunately, in too many places, the culture is the opposite of that: people think it is safer not to speak out than to speak out. I have been very struck when I have spoken to pilot friends that, if you are a pilot and you are involved in any kind of near-miss, the safest thing to do is to report it. The dangerous thing, professionally, is not to report it. To report it is safe.

I went to what is sometimes thought to be the safest hospital in the world—the Virginia Mason hospital in Seattle. They had an incident similar to the one that you talked about, Mrs Gillan, whereby, in 2004, they injected cleaning fluid into someone's brain by accident, because it was the same colour as the fluid that should have been injected. The lady died an agonising death over two weeks, and that was the start of their journey. When I went to see them early last year, however, they were celebrating because, for the first time in one month, their own staff—and it is only a small hospital—had raised 800 safety concerns. They said, "This is the first it has ever happened and we are really proud of that". I doubt that you would find a single hospital in the NHS that raises 800 safety concerns from staff in a whole year, let alone a whole month, although we do have some very good hospitals that are blazing a trail on safety. That culture, where you really value staff who speak out, is the only way, in the long run, that you will change it, and that is what I think we should do.

Q302 Mr Evans: I totally agree with you. Could you please, therefore, say how we are going to get that culture change?

Mr Hunt: Yes. There is quite a long list of things but I will just give you a random few. We have changed the professional codes of doctors and nurses, so that they get protection if they speak out, and it is much more explicit that they have a responsibility to speak out. We have made it a criminal offence for hospitals not to tell patients when they have harmed them or their families. We are looking at removing hospitals' immunity from litigation fees if they make a mistake but they have not been honest with the family from the start.

Under Mike Durkin's leadership we have set up an initiative called "Sign up to Safety", which over 200 organisations have signed up to across the NHS and is committed to halving avoidable harm and death over the next three years, saving potentially 6,000 lives. We have changed the inspection regime, which we have talked about and put a much greater emphasis on safety.

The last one, which if it works will be the most revolutionary of all, but we have to do it, is we are aiming to be the first country in the world that publishes the number of avoidable

deaths by hospital. Each hospital will know roughly how many avoidable deaths we estimate are happening at that hospital, and then they are going to be asked to write to me, the Secretary of State, every year to say what they are doing to reduce the number of avoidable deaths. That is a very complex process and a difficult thing to do, but we are working on a methodology with Professor Sir Bruce Keogh, who is, by the way, another amazingly inspiring person when it comes to safety.

Q303 Chair: Thank you for that. I just want to bring you back to draw this together, because whatever organisational arrangements you have, you are the individual ultimately responsible for safety in the NHS and you have to resolve that tension between accountability and responsibility and the no-blame culture. It has been said that, to some extent, in our system everybody becomes a victim or everyone feels like a victim. The clinicians feel they are victims of this culture you are trying to promote, because everyone is going to be complaining. The patients feel they are victims because their complaints are not heard. I can tell you even people at the Ombudsman service sometimes feel they are victims because they are unable to resolve the complaints that have been raised. How can we promote this no-blame culture without a safe space for this reporting, which we still lack?

Mr Hunt: It is a very, very difficult thing to do, so the only way that you can do it is, essentially, by going through two stages. The first stage is to be honest about the problems. You have to start with that basic honesty, and I do not believe that we had that in the NHS. I think there was a culture built up over decades that basically where there were problems huge efforts were made to sweep them under the carpet, often on the grounds that it would destroy the confidence of the local population in their hospital if it got out that this terrible thing had happened, and so the best thing to do was to quietly sort it out. Unless you are honest about problems, they do not get sorted out.

We have had dramatic improvements in the hospitals that we have put into special measures, where we have been honest about the problems and then we have galvanised action. There is a pain barrier you go through, though, the first time you start to be open about problems. We went through it in the education system 20 years ago when we put schools into special measures under the new Ofsted regime, but it galvanised change and we have got rid of the sink comprehensives that were a big feature of the education system throughout the 1980s and 1990s as a result of that regime.

The next stage—and people of course are nervous—is about what the consequences of this honesty will be, and we need a system where they see that there are no consequences for you if you help us to understand the mistakes and help us to fix them. This is not about naming and shaming. This is about learning how we can do things better and you create that culture of continuous improvement that you see in hospitals like Luton, which is a fantastically well run hospital. You see it in Salford Royal. You see it in Buckinghamshire after they have come out of special measures. There is a great learning culture starting to develop there. In Scotland, they have done some brilliant work on preventing avoidable deaths. I am just looking around the table and I think even in Colchester they are turning a corner, so you do see change happening in culture, but it does take time to filter down.

Q304 Mrs Gillan: Can I just add to the protections? I hope you will include pharmacists in that, having had a constituency case with a very brave pharmacist. I hope their whistleblowing will be protected and they will be looked at.

I just wanted to come back to you on medical records, because we have had evidence that there are often cases where medical records are inaccurate and incomplete and they are very complicated, and you realise how much we rely on them to have good outcomes from our treatment in the NHS. What have you been doing to improve medical record-keeping and can you give us a reassurance that that is going to be on an upward trajectory?

Mr Hunt: Next month is a very important month in this respect because, for the first time, we are going to give everyone the right to access their medical records online. The first step to improving the accuracy of medical records is to allow the public to see their own records. Where this has happened in America, what they find is that patients come back to their hospitals and their doctors and say, "You have got this wrong", and you start correcting a lot of the mistakes in records, because obviously people know a lot more of the detail of what has happened to themselves than sometimes their doctors do, and so you start to get more accurate medical records.

That is going to be the first step, but medical records is also an indication of how the system has gone so badly wrong, because I am afraid we have had cases where there have been tragedies and the first reaction of staff has been to destroy the medical records. That is an indication of how the culture is wrong and how it needs to change, because the staff should not be afraid of someone, if there is a tragedy, trying to understand. In fact, they should think it is their responsibility to try to understand how things went wrong and that they will be supported on that journey, but I am afraid that shows that there is still a culture of fear when there should not be and that is what we have to tackle.

Q305 Kelvin Hopkins: You have mentioned the difficulties and I appreciate those and I can think of all sorts of reasons: professional reputation, hierarchies, nurses criticising consultants and so on, and also cost—there are cost pressures on hospitals and if they think that if they raise this issue it is going to cost them more money, it is more difficult. Can I ask where in the current system might there be greater capacity for investigating serious incidents and disseminating lessons learned? You talk about the difficulties, but where can things be improved and who is currently responsible for trying to get these improvements?

Mr Hunt: It is Mike Durkin's safety function at NHS England. That is the best place to do it. Mike himself has an extraordinary track record in this area, but that would be the place where the responsibility sits and we need to support it to do its job even better.

Q306 Kelvin Hopkins: I understand that the Government have been resistant to the idea of establishing a single independent body. We have heard a variety of evidence that that would be a very good idea—a single independent body to carry out these investigatory functions.

Mr Hunt: I would not say that we are resisting it, but we are resisting the idea that every incident should be investigated by a single body, just because of the scale. To investigate 250,000 deaths, to be honest, you would end up with all the doctors investigating deaths and they would not be able to operate on patients if you were going to do that. It is such a huge thing compared to the 50 investigations every year that the Air Accidents Investigation Branch does. However, there might be a role for an independent investigations branch that was available for NHS trusts to use if they wanted a swift, independent review of what had gone wrong, possibly available for the Ombudsman to use

in certain situations. That is something that we could look at. The natural place for that to sit would be in Mike Durkin's area.

Q307 Kelvin Hopkins: We understand there is something of a difference of view or a division of view on this. NHS England tell us that they are already working on creating a patient safety investigation branch, but your Department rejects the idea of a new body. Could you elaborate a bit on those tensions and the difference of view?

Mr Hunt: I do not think they are quite as different in substance. The specific idea that we have responded to in the Department's evidence is the idea of a single clinical investigation branch based at the Department of Health that would be responsible for looking into all serious incidents. I do not think that is logistically feasible and I do not think the Department of Health is the right place for it to sit. Hospitals do a lot of local investigations very satisfactorily and well, and we should allow them to continue to do that, because it is important there is local responsibility for safety records. However, there may be something to be said for having a central function of the scale of the Air Accidents Investigation Branch for cases where there is a dispute or where there is a lack of trust or where the relationship has broken down and where you need a rapid expert view.

Q308 Kelvin Hopkins: At a previous evidence session, it was pointed out that of course there is a significant difference between aviation accidents and health accidents, because in aviation if things go wrong the pilot dies too and so they have a very strong vested interest in making sure that everything works perfectly. I am not suggesting that surgeons would be more casual, but on the other hand they do not die if something goes wrong with a patient.

You mentioned Luton and Dunstable hospital, which is a fine hospital and I have been treated by it myself in the last couple of years and they have done a superb job. However, even at Luton problems arise and constituents come to me—I am sure they go to other Members as well—with problems I have to take up with the hospital. If there was an independent body, I could refer these to that independent body and there might be a fairly brief investigation, in fact. However, I have this uncomfortable situation where, with a hospital that I admire and that treats me, I have to raise issues with the chief executive. Sometimes these go on, because they are defensive at first and eventually you get to some kind of resolution, but it is sometimes very difficult and very awkward, and I do not want to be critical of people I know and care about—staff members I know; I know the trade unionists and so on. It is very uncomfortable. If I could just refer it to another body to investigate that would solve all those problems. What happens at the moment if things go seriously wrong, particularly for constituents who do not have any money, cannot afford to go and employ lawyers and so on, they come to their MP, and then I have this uncomfortable situation, not being able to make clinical judgments myself because I am not a medic, although a fairly intelligent amateur in these matters. Another body would be very helpful.

Mr Hunt: There is a logistical challenge, because the average hospital will have between 600 and 1,500 deaths every year and if everyone had the option of getting an independent investigation we would have huge, huge numbers of investigations going on the whole time, which would suck up huge amounts of medical manpower that we do not have, so there is a scale issue. However, there may be a role for a clinical investigation branch in Mike Durkin's safety function at NHS England that in particular situations that are perhaps filtered—if you look at the ombudsman's inquiries, they have to filter the number

of inquiries; they cannot investigate absolutely every single one that they are asked to do—there may be a benefit. It might be something that trusts welcome, because it may offer a service that trusts do not currently have, which is the chance for a speedy, expert investigation into an incident that gets to the truth quickly on a no-blame basis. I think of Morecambe Bay and the families there, where there was a clear breakdown in trust between the trust and the families. That would have been a way that would have meant they did not have to have the Kirkup inquiry that is happening so many years after they have suffered those tragedies, so I think there could be a role there.

Q309 Kelvin Hopkins: We have heard that there are a lot of bodies involved in investigation at the moment and it is quite a jungle of organisations, in some ways. Would better co-ordination between these existing bodies not be one way of improving the performance of the NHS on investigations? If they were to be co-ordinated, who should lead this co-ordination?

Mr Hunt: Mike Durkin's safety function is the central place where all the learning should be assembled and disseminated. That safety function is an incredibly important part of the whole system. That is the supportive bit, if you like, which is trying to help people who want to improve their safety record. You do also then need someone completely independent who is going around calling a spade a spade and saying, "Yes, this hospital is safe", "No, we are not satisfied with the safety in this hospital". That needs to be separate and independent and that would be the chief inspector of hospitals.

Q310 Chair: Just to follow up, I hear you laying great emphasis on Mike Durkin and his proposed patient safety investigation branch, but there will need to be three elements added to his capability. One is complete independence and that includes independence from NHS England. How would you provide that?

Mr Hunt: I do not think he would need that.

Q311 Chair: NHS England is the major commissioning body in the NHS. It might be looking at systemic problems that lead to patient safety issues. It might be itself a contributor and therefore as conflicted as you say you are.

Mr Hunt: Their submission says that they are not necessarily wedded to the idea that that unit should always sit in NHS England, and that is something that one could give further thought to.

Q312 Chair: Right, okay. We are not getting an answer today, but I understand we are just exploring the issues and I acknowledge that you recognise the issue the question raises. It needs to be able to offer legal immunity to people. This is the AAIB case. People who talk to the air accident people are legally immune. Those words they use to explain what has happened cannot be used in court against them. Do you accept that that is part of the no-blame culture that we need?

Mr Hunt: That could well be part of the new clinical investigation branch, if we go down that route. It is also important to say that even the AAIB does not maintain secrecy or immunity if they discover that someone has broken the law.

Chair: Of course, but it cannot be FOI'd, for example.

Mr Hunt: No, but pilots are not immune from gross negligence or wilful negligence and nor are doctors.

Q313 Chair: It does not protect people from wrongdoing, but it does give people freedom to speak.

Mr Hunt: It does give people confidence that if they speak out confidences will be respected.

Q314 Greg Mulholland: Jeremy, I am keen to talk to you about the ombudsman, which is a big issue for this Committee. We obviously have oversight of the Parliamentary and Health Service Ombudsman and have had a lot to say about it, and I am sure that you are aware of our position on it and our call for a radical overhaul of the system. Specifically in terms of the role that the ombudsman has currently with regard to clinical incidents and clinical failures, do you think that that is an appropriate role for the Parliamentary and Health Service Ombudsman? There has been some criticism about the lack of expertise. Do you think that is something the ombudsman, certainly in its current form, should be doing?

Mr Hunt: I do. I think it is perfectly possible. They have clinical experts whom they draw on when they do their investigations. They are investigating and have agreed to investigate many more incidents following the Francis report into Mid Staffs than they were previously investigating, and they need to make sure that they have the expertise to do that. If we had a clinical investigations branch, it is possible that they could work in partnership with the ombudsman and there may be times when the ombudsman said, "Could you do this investigation for us, because we think this is one where you can get to the bottom of what happened more quickly?" and that could be something that we could look at.

However, to be very direct, the concerns that people have had about the ombudsman have not been so much about the expertise but about the culture of openness and transparency. When the ombudsman itself has made a mistake, I think part of that transparency and openness and the way that they will reassure people is if people felt that they were open in that way too. I do not want to make a judgment as to whether that happened or not, but I just relate the sort of feedback you get from some of the families, and they have had those concerns. I know that Dame Julie is very aware of those and very keen to do something about that.

Q315 Greg Mulholland: On the basis that you do think it is an appropriate function for the current ombudsman system to be involved in, how do you square that with your unprecedented, very public criticism, something that this Committee wrote to you about, which was potentially breaking protocol when you publically criticised the ombudsman for their failure that you raised in writing to them?

Mr Hunt: I am not responsible for the ombudsman and I hope I made it very clear in my letter that I do not see myself as responsible for the ombudsman. It is responsible to you, so therefore I had to find a way of trying to make sure, in terms of my responsibility for patients, that some of the concerns that I was hearing would get addressed. It is a slightly unusual thing for a Government Minister to be in the position, if you like, of a campaigner trying to get change, but my view was that I needed to say something publicly if this issue was going to be addressed. I was hearing it from more than one source, and I was very concerned that the changes that we were trying to make in culture in the rest of the NHS, which we have been discussing this afternoon, were not happening at the pace they needed to in the ombudsman. That was despite trying quite hard in private to get these changes to happen, so that was why I did that.

Q316 Greg Mulholland: There are different views as to whether it was appropriate or not for you to do that, clearly, as the Secretary of State for the Department of Health and, of course, therefore, you are accountable and the Department of Health is accountable to the ombudsman. Can I ask you, as a senior Member of the Government rather than in your role as Secretary of State for Health, why are the Government so resistant to what we have proposed as a Committee, which is for the radical overhaul of the ombudsman system that we believe and that so many people in the country now passionately believe needs to happen? We have written to the Government, not to you, on this particular point, but we have just hit a brick wall. Are you not prepared today to say that you share our view that we should have a radical overhaul of the ombudsman system to make it fit for purpose for the health service and the public sector as a whole?

Mr Hunt: I am not sure why you do not just overhaul it then, because it is your responsibility, not mine.

Chair: It requires legislation.

Q317 Greg Mulholland: This is the ludicrous thing. It is down to the Government. It is supposed to be the Parliamentary and Health Service Ombudsman, but the Government are blocking it; the Government have refused to do anything about it and that is a fact.

Mr Hunt: I will look at your report.

Q318 Chair: I think it is slightly unfair to say the Government are blocking it. We are waiting for a comprehensive response to our two reports, on complaints and on the ombudsman.

Greg Mulholland: And we have five weeks left.

Mr Hunt: Yes. I want to see your report on this and I would certainly champion any changes to legislation if they were going to improve patient safety.

Q319 Greg Mulholland: Can I be a little bit cheeky then and say, obviously, with five weeks left there is no chance of legislation to reform the ombudsman service, so is this something that, if you find yourself in Government or not in the next Parliament, you would support?

Mr Hunt: If there was legislation that was necessary to improve the way the ombudsman worked and that led to better support for patients where things have gone wrong, then I would absolutely support that.

Q320 Chair: We are hoping that the response will be clear about that, so that whoever wins the election will take on the responsibility of bringing forward that legislation. We are very clear about that.

Greg Mulholland: Thank you. That is a positive response.

Mr Hunt: To which Secretary of State, by the way, does your—

Chair: It is with Oliver Letwin in the Cabinet Office.

Q321 Greg Mulholland: Thank you for the positive response. To give you a sense of what we believe that would mean or could mean for the health service complaints, which are a particular issue and that is, no doubt, why you yourself raised it, what we see is a citizens' ombudsman service that would be something that could accessed directly by people at any public service at all. There would be specialisms within it and, indeed, the

ombudsman service would then work with other complaints bodies if they were the appropriate one, but it would become the place to go to. Because of the level of concern that there is and you know there is about NHS complaints in particular, do you think there is a potential model there that could assist with some of the things and could help deal with the problems that we all have with NHS complaints?

Mr Hunt: We have to get a whole lot better at the way we deal with complaints in the NHS, and I would need to reflect on the detail of what your proposals are. We have not really talked much about complaints here, and I would just make one brief point about complaints. The issue with complaints is exactly the same as the issue with investigations, which is: what is the learning that happens as a result of the process? In too many parts of the NHS complaints handling is a process, it is a function of a part of a trust because we need to reply to these letters. One of the things that Mike Richards is doing as part of his inspections is explicitly looking for evidence that hospitals are learning from the complaints they receive and making changes as a result of the letters written by members of the public who have used their services, and that is part of that culture change.

Q322 Greg Mulholland: You have pre-empted my final question there, which is about what information is centrally gathered to learn from mistakes throughout the NHS, which you have just basically explained. So there is a real move to try to have lessons learnt from complaints from all sections of the health service brought together centrally to try to improve things.

Mr Hunt: Yes. I do not think there is a shortage in terms of the data we collect. I think there is not enough hunger to learn from that data and there is also a lot of under-reporting of problems, so one of the things that we have done is a report, which Mike Durkin helped me to put together, which is a table that we publish that says whether trusts have an open and honest reporting culture. They concluded around 20% of the trusts in the country do not have an open and honest reporting culture, so I hope that will prompt some change.

Q323 Sheila Gilmore: One of the things that a lot of ordinary people find in complaints procedures is that they are incredibly mechanistic and what they get back is, "This was our stage 1 process. We are now going to pass you on to stage 2." It does not seem very person-centred at all, but the organisation has ticked the box of having procedures, so are you looking at that aspect of things?

Mr Hunt: Yes. In fact, we are following the recommendations made by Ann Clwyd, who did some excellent work on how we could improve complaints procedures with Professor Tricia Hart, and it should not be mechanistic. The best example I have seen of NHS complaints is in my local hospital, Frimley Park, in Camberley. I went to see the chief executive on a regular visit and raised three complaints that I had had from constituents and he said, "Yes, that one we made a mistake; we did not have enough staff on that night. This one we also made another mistake, and this one I have not heard about but I will look into it." There was complete openness. That is the first hospital in the country to be given a CQC "outstanding". I was very encouraged by that, because basically I know that it is run by someone who is very open and very hungry to learn from every mistake that is made in his trust. That is how you get the highest standards.

Q324 Chair: When we started on the question of complaints we heard that a survey conducted by the ombudsman found that very few boards looked at complaints, and that culture has already changed very dramatically. They now tend to look at complaints as a source of learning for the board about what is happening in the organisation.

Mr Hunt: I try to read one complaint every day from a member of the public; it is the first thing I do when I get into work, to try to remind myself of some of the problems, and I do find that that shapes my day.

Q325 Chair: How did officials react when you told them you wanted to do that?

Mr Hunt: I think with quite a degree of surprise and quite a degree of concern, but Department of Health officials have been on this journey just like the NHS is going on this journey. In the last two years they have set up something called the Connecting Programme, where every official in the Department of Health—we have done it now with the most senior and we are rolling it out to everyone—will spend four weeks every year on the frontline, volunteering, understanding what is happening on the frontline, as part of that making sure that we learn the lessons of Mid Staffs, where people in Whitehall had absolutely no idea what was going on in a remote corner of the NHS, so we are trying to build much stronger connections.

Q326 Sheila Gilmore: When we go, often we get a very different response. I know I do from the DWP and my local benefits office. How can you be sure that for the individual who is getting these very formalistic letters it is really happening? If I go and speak to a chief executive, it will be whatever. Is that really the response that ordinary people are getting?

Mr Hunt: It is true. I was warned that if I go and visit a hospital there is a high risk that the ward I am visiting might be repainted before my arrival and so this is a real problem, but in the end that is why it is not what we find out that matters; it is the way our constituents are treated that matters. Of course, what we all see, as MPs, is the letter that the constituent got back that they then show us and say, "Is this satisfactory?"

I would just like to say that it is important to have a degree of optimism in this, because although it is a very big challenge, I have noticed that when I started talking about the safety agenda—and I think I have been more interested in it than previous Secretaries of State simply because I had to deal with Mid Staffs as the first thing that I did—I find you are pushing at an open door in the NHS. I find that doctors and nurses are really interested and really enthusiastic and they want to do this. This is not something where you start to talk to people and they say, "This is a waste of time", "This is health and safety" or "This is procedures". They are really interested and enthusiastic. No one wants to be in a system that is making mistakes, so if you say to people, "How can we build a system that does not make mistakes?" people co-operate, they are supportive and you can get that right culture. If we carry on with this agenda, we really can be the first country in the world that cracks this and that will be something we can all be very proud of.

Q327 Chair: We must end, but just very briefly on the complaints issue, what was your reaction to the Which? campaign that uncovered quite a widespread fear of people in hospitals scared of raising a complaint because they felt that it would affect their treatment?

Mr Hunt: That is an indication of where the culture needs to change. There are definitely people who do not complain as much as they should and where that was at its worst was in Mid Staffs. Julie Bailey, who is one of the main campaigners there, in her book writes very movingly of how her mother, who was treated appallingly badly, begged her not to raise any complaints with the staff. In fact, there was a particular nurse who really treated her mother badly who her mother insisted that she bought a Christmas present for, because she was in hospital over Christmas. She said, "I could not believe this, but my mother was just so frightened of this nurse".

Q328 Chair: Can I give you another example of a GP friend of mine whose relative is being treated for cancer and was given an intravenous fluid overnight, but was given far more than the prescribed dose by accident so that he nearly drowned in the fluid. He did not die. He refused to raise a complaint about it, so his GP relative felt that she was unable to raise a complaint about it because he did not want to complain. It does seem to me that there should be a system for simply making sure that an incident of that nature is dealt with.

Mr Hunt: Yes. The only thing I would say is that the responsibility is as much on the chief executive and the board of a trust to change that culture as the individual doctor or nurse. If doctors and nurses feel that they are going to get into trouble if someone raises a complaint, then they will discourage that process and so the signals that they get are as important as the signals they give to their own patients.

Q329 Chair: How do you reconcile that with the fact that administrators feel perhaps, historically, more beholden and accountable for financial outturns than clinical outturns?

Mr Hunt: Everyone has to be accountable to patients first and foremost.

Q330 Kelvin Hopkins: One of the problems is the excessive use of agency staff, agency nurses. If the nurse is attached to a ward on a long-term basis and there is a sense of esprit de corps amongst the team, you are going to get better treatment than having people drifting in and out of hospital, one hospital one day, another hospital another, having no sense of responsibility to their hospital. Just reducing the level of agency nurses would make a difference.

Mr Hunt: I totally agree. We have had a temporary spike in agency staff because, post Mid Staffs, I asked every trust to count the number of nurses on every ward and publish it online so that we can all see it every month, to make sure that we were dealing with the issue of short-staffed wards. As a reaction to that, trusts thought, "Let us get in staff quickly, because I do not want to be short-staffing my wards". The only way they could get staff quickly was through agencies, but I hope it will be a temporary bulge because I completely agree with you. For continuity of care and for making sure you have proper training and proper procedures you need to have regular, full-time staff.

Q331 Chair: Just very briefly on the PHSO, the PHSO obviously has a very important role to play at the apex of the complaints structure related to clinical investigation, but for the patient lying in the ward who has a complaint, the PHSO is too far away, both physically and in time, to deal with that complaint. Do you recognise that?

Mr Hunt: Yes.

Q332 Chair: There have been periods when the PHSO did not have responsibility for clinical investigations at all. What do you think about that?

Mr Hunt: The first thing is to create a culture where people feel that they can complain to the local trust and be listened to and it should never get near the PHSO in that situation. So the first thing is to make sure we have the right culture at the local level, so that in that ward someone can raise a complaint and it is dealt with quickly. That is the heart of it. When we have to deal with complaints to the PHSO or whistleblowers or clinical investigations done by external bodies, it is a sign of failure when all those things have to happen. However, I do think that in extremis you might find there is someone you need to go to outside the hospital and so that is why there is a role for the PHSO in those situations.

Q333 Chair: In terms of the no-blame culture, the PHSO is about delivering redress for a complaint, so is the PHSO the best person to be the apex of a no-blame investigation process?

Mr Hunt: We need to make sure that we have the structures in place so that we have a continuous improvement culture and a learning culture anyway, irrespective of the PHSO, but sometimes there is a situation when someone simply needs to adjudicate: is it the trust in the wrong or is it the patient in the wrong? Some of the disputes that happen are very personal with very strong grievances and very strong emotions, and I think patients do need a system where, in the end, someone makes a judgment as to which side was right and which side was wrong. You will not always get that if you simply are looking to improve clinical practice by identifying things that have gone wrong, so I think there is a role for the PHSO.

Q334 Chair: Finally, this new openness of culture and this promotion of encouraging people to report incidents and complaints are seeing a big caseload increase for the PHSO. Would you rather spend some of your budget on increasing the capacity of the PHSO or on increasing your own capacity in the health service and in your Department so that these complaints are dealt with long before they need to go to the PHSO? Which would you prefer?

Mr Hunt: I think it is not either/or. We probably need to do both, because basically, in the end, we need to make it easier for people to complain; we need to accept that we make it easier for staff to report incidents. We need to have better processes for dealing with complaints and for staff-reported safety alerts, and make sure that there is learning that happens from all of those. That is how you reduce the £2 billion cost of mistakes that happen in the NHS every year. It is a false economy not to learn from our mistakes and it is something we need to do much, much better.

Q335 Chair: I think we are done. You have been with us for a long time and we are very grateful to you for that and for your openness and candour; you practice what you preach. Is there anything you want to add?

Mr Hunt: I think the parliamentary system is equally punishing of mistakes. It is incredibly difficult for Ministers to admit they ever make a mistake, because they know that they will be on the floor of the House of Commons and be utterly castigated for it. There is nothing we can do about that. I would not want to change the way our democracy works, except that possibly, as parliamentarians, there are times when we should accept when Ministers are honest about things that they have done wrong and not immediately seek to make party-political capital, because that is part of the way that we will create more openness through the whole system. Part of the defensiveness throughout the NHS may come from defensiveness by Ministers and that culture feeds its way down. I do not have an obvious solution to that, but I just make the observation.

Chair: That is a very strong point and, if I may say so, I hope the way we conduct this Committee reflects some of your feeling on that question.

Q336 Mrs Gillan: Having been in your position as a Secretary of State, I agree with you entirely, because I think that there are so many instances where it is much better to work cross-party and in an atmosphere of calm rather than the hostility that we get. I hope you would agree with me that you would like to see more cross-party working on issues that we

need to pursue in the interests of our citizens rather than what we have just seen recently in terms of statements like "weaponising the NHS", which I regret terribly.

Mr Hunt: Let me not be controversial and say that I think that this agenda is something that can be shared across all parties. There is absolutely no reason why it could not be. Indeed, the way that you have conducted certainly this hearing, which is the first time I have spoken to your Committee, is exemplary in that respect, because we have had a pretty open discussion.

Chair: I am very much aided by Opposition Members of Parliament, who have not sought to politicise this in any way, and I am very grateful to them. Thank you very much indeed, Secretary of State.