



## Public Administration and Constitutional Affairs Committee

### Oral evidence: Follow-up to Public Health Service Ombudsman's report on Clinical investigations, HC 792

Tuesday 23 February 2016

Ordered by the House of Commons to be published on 23 February 2016

[Watch the meeting](#)

Members present: Mr Bernard Jenkin (Chair), Ronnie Cowan, Paul Flynn, Mrs Cheryl Gillan, Kate Hoey, Mr David Jones, Tom Tugendhat, Mr Andrew Turner.

**Dame Julie Mellor**, Parliamentary and Health Service Ombudsman, was in attendance.

---

Questions 1 - 53

#### Examination of Witnesses

*Witnesses:* **Ben Gummer MP**, Parliamentary Under Secretary of State for Care Quality, **William Vineall**, Director of Quality, Department of Health, and **Mike Durkin**, National Director of Patient Safety, NHS England, gave evidence.

**Q1 Chair:** We are now moving on to our evidence session on the PHSO's report "The review into the quality of NHS complaints investigation where serious or avoidable harm has been alleged". It is worth making the point that we are not looking just at complaints and we are not looking at investigating avoidable harm; we are looking at how local investigations respond to complaints where there is an allegation of avoidable harm. Why there is such a wide variation in the treatment of those cases, what are the solutions and who is accountable for the improvement? I would ask each of our witnesses to identify themselves for the record, please.

**Ben Gummer:** I am Ben Gummer, the Parliamentary Under Secretary of State for Care Quality. I am afraid I am only with half a voice, so I apologise to the Committee.

**Chair:** We can hear you if we are quiet.

**Mike Durkin:** I am Dr Mike Durkin, the National Director for Patient Safety for NHS England.

**William Vineall:** I am William Vineall, the Director of Quality Policy at the Department of Health.

**Q2 Chair:** Thank you for being with us. To start with, how has PHSO's report contributed to your understanding of this problem?

**Ben Gummer:** If I may start off, Mr Chairman. It has been another very helpful contribution to what I think now is a broad-based understanding that the NHS is still not handling complaints as well as it should. I think we all accept that things have got better in the last few years. We can come on to the measurement of that, or the lack of it, at some point in discussions, but we are very grateful for the Ombudsman's report and it is a valuable contribution. We agree with the broad picture that it paints.

**Q3 Chair:** How has it improved your knowledge and understanding?

**William Vineall:** I think it has confirmed some of the things that we thought already, which is that the quality of investigations is not always good enough. The threshold for investigations, the thoroughness is too low even though some of the complaints handling, from the statistics in the report, implies that the NHS thinks it is sufficiently thorough; and therefore the need for better guidance and principles—the sort of things we want to do through the Healthcare Safety Investigation Branch—is illustrated by the report, as well as the need to share learning from investigations once the findings have been made public.

**Q4 Chair:** It is a bit depressing to hear that it confirms what you already know. If an aircraft crashed and the Air Investigations Branch of the Department of Transport said, "I am afraid this crash doesn't tell us anything new, we already knew we had this problem," there would be a bit of a kickback on that, I would imagine. Mr Durkin?

**Mike Durkin:** It is salutary as well as confirming. So it identifies quite clearly that there are things still to do. For me what came out of that report that was much stronger than in previous reports was the fact that patients are not involved early enough in the conversation that needs to happen.

**Q5 Chair:** You have never heard that before?

**Mike Durkin:** I have heard that several times but the system still fails to acknowledge that, so at local level we do have an issue with the fact that we do not run a particularly professional and thorough service, as William says. I think that is something that we need to concentrate on. I know the PHSO has said this in previous reports, and we have discussed this here before, that the investment in support for both the clinical complaints element as well as the clinical investigation element at local hospital level is insufficient for the task.

**Q6 Chair:** Why does NHS England not accept that there is a single root cause for a serious incident in the same way that the PHSO seems to accept it?

**Mike Durkin:** Our view is that although we accept that in some cases there is a single root cause, the majority of serious incidents have a number of different elements to them. This goes back to some of the prepositions around the anatomy of an incident, and the anatomy of an incident often is based on the fact that a system does not come together. So at some stage during a clinical journey, a clinical pathway, a number of different elements combine

to create the scenario or create the conditions by which a serious incident can happen—for example, the wrong medication is provided. We have a number of checks in place, but it is when those checks do not work together that you end up with a serious incident. So I think our theoretical view would be that it is rarely the fault of an individual, the root cause; it is nearly always the fault of a system around that individual.

**Chair:** Can I bring in PHSO on this point?

**Dame Julie Mellor:** I think PHSO would agree with the witness. There may have been a grammatical error in how we phrased it, but we would not be assuming there is one root cause. The human-factor science suggests it would very often be a range of factors and we would agree with that.

**Q7 Chair:** Thank you for that. NHS England does question how PHSO assesses its own competence and investigation. Why is that?

**Mike Durkin:** NHS England would probably question everyone's competence in this field. This particular area is a very difficult terrain to understand. While I applaud the efforts that PHSO has made in recent years—certainly in recent years it is a much more defined organisation with regard to how it looks at clinical incidents—it would also acknowledge that it has had help from other organisations to support it in looking at root-cause analysis and looking at the clinical components of complaints and investigations.

**Q8 Chair:** How will PHSO's recommendations be taken forward? Minister?

**Ben Gummer:** The timing of the report could not be better. How could I put it? I would like to repeat this conversation in a few months' time because we are mid work in trying to take forward the specific issues on complaints. You will know, Chair, in large part because of the instigation of this Committee and the work that you have done on it—on an investigatory branch—that we are working very hard at the moment in getting that set up. I know you will want to ask some questions about that.

My next phase of work, which we have just begun in the department, is to do work on complaints, which I have talked to the PHSO about on several occasions. That, I think, is our one bit of unfinished business. It all works as a piece but it has to be done sequentially and I hope that we will be able to come back to you with some really good policy in a few months' time.

**Chair:** PHSO, you wanted to make another comment?

**Dame Julie Mellor:** Again, just a technical point, Chair, if I may for the record. There may have been a misunderstanding in NHS England's response to the nature of our investigation. We do not do the clinical incident investigations. That is for the provider. We are simply looking at was there service failure that led to injustice that has not been put right. So we would not need to use the same guidance, although our staff, as Mr Durkin has indicated, have been trained on that method so they can assess the quality of the investigation done. But we do not do that; we are looking at was there service failure in this instance, was there avoidable harm, what was the injustice and has it been put right. It is a different kind of investigation.

**Q9 Chair:** Mr Durkin, do you accept that?

**Mike Durkin:** Absolutely.

**Chair:** Thank you. Moving on, Cheryl Gillan.

**Q10 Mrs Cheryl Gillan:** Looking at the improvement of the investigations, what do you think are the main changes we need to see local investigations improve? How are you going to ensure those changes are made and when are we going to see results?

**Mike Durkin:** Thank you. First and foremost, we need to set out, I believe, an exemplar model of clinical investigation. We know from our work looking across the 250 or so trusts in England and also in general practices through NHS England's commissioning role that there is variability to the model of clinical investigation that takes place. We think that in itself is an inherent fault in the system and so one of the first challenges we think we need to introduce is an exemplar model in a clinical investigation that we would then hold the system to account to follow.

We do have a serious incident investigation framework that clearly sets out the timelines for setting up an investigation and that is two days to report it, three days to agree the level of seriousness and 60 days to complete the report to the satisfaction of the local commissioner. But that in itself is not good enough, because the actual model for investigation is the second or third stage in that. So we believe that an exemplar model is key.

**Q11 Mrs Cheryl Gillan:** On that, isn't it right to say that serious incidents are not being reliably identified by trusts as well, which is part of the problem?

**Mike Durkin:** Absolutely, and there are some examples in the PHSO report that highlight that.

For me there are two elements here. First—this goes back to my very first point to the Chair—are we really sure that the denomination of the serious incident has taken into account the impact on the family or the patient? Often a serious incident and the categorisation of the incident is a professional one, and the patient or the family comes in later. I think something we need to look at is how we engage with families and patients at an earlier stage in that process but at the same time not create a parallel process; it needs to be part of the same process.

That would go to my second point in terms of what we need to do, and that is to really understand the role of the family and patient in this process of investigation. There are some ideas that we would be looking at and looking to the expert advisory group on the investigation board to come up and support those changes.

**Q12 Mrs Cheryl Gillan:** How should the organisations that fail to support and equip their staff around effective investigations be tackled? What is the role, for example, of CQC and NHS Improvement in dealing with those organisations?

**Mike Durkin:** I can't talk for CQC and the inspector system there but in my mind there is a process that once we have identified through good investigation the causality of a particular incident, and if we were talking putatively for the role of Health SIB, once you have identified the causality there is then a responsibility on both the commissioning

system and the regulatory system to introduce elements of learning, deduce elements of learning and then produce improvement packages that are pertinent to that task.

**Chair:** Can we bring Mr Vineall in on that question?

**William Vineall:** As Mike says, the root problem is the quality of investigations locally and one of HSIB's key roles will be to improve that. The thing that the CQC does already is when it is doing its inspections it samples a number of serious incident investigations as part of its safety domain, and we know that the score that trusts generally do worse on is safety. So in a sense it is another piece of corroborative evidence to what we are all saying. CQC isn't responsible for the quality of investigations but it does provide a mirror to what the quality is. It is really going to be for the trust locally, as supported by HSIB, in the future to improve that quality. What a lot of them need—this is based on my experience when I was the point person in the department for the Jimmy Savile investigations—is they need clear advice about what the process is and then they need to follow it. Some people do not know that.

**Ben Gummer:** To be clear, we are looking in the Department at a whole number of levers at the moment to see what we can do to incentivise or encourage, by various means, trusts to undertake investigations, not just in instances of serious untoward instances but also with near misses. I am not quite yet in the position to be able to share most of that yet with the Committee because we have not got it to a sufficiently advanced stage but we are looking at as many levers as possible.

**Q13 Mrs Cheryl Gillan:** Will we end up with a clear line of accountability for ensuring the quality of investigations both at national and at local level? If so, who will be accountable?

**Ben Gummer:** I will allow Mike to answer specifically on investigations but I want to say that on complaints we absolutely need to achieve that because at the moment it is too opaque. What I don't want to do is to create a massive great superstructure that first of all takes away responsibility from trusts but also stops internal learning.

**Q14 Mrs Cheryl Gillan:** But you are giving me an impression that all of this is very much work in progress and that you will have something quite exciting to tell us say in a couple of months' time?

**Ben Gummer:** I hope so but we—

**Q15 Mrs Cheryl Gillan:** Are you saying you would like to come back in front of the Committee?

**Ben Gummer:** We would very much like to come back; we love coming back to PACAC.

**Q16 Mrs Cheryl Gillan:** When? Could you put a timeframe on it?

**Ben Gummer:** What we can talk about with more definition is HSIB, which Mike and William have been heavily engaged with and the expert advisory group. We are at quite an advanced stage on that.

**Chair:** We will come to that.

**Ben Gummer:** I know you will come to that, but on the broad superstructure of complaints, investigations, relationship with litigation, we have a lot more work going on.

**Mrs Cheryl Gillan:** That sounds very exciting. You are whetting our appetite.

**Mike Durkin:** Shall I come in here? For me there are two levels of accountability, which I know is difficult for us all. The primary accountability route for clinical investigations is at a local level with the trust board, with the trust that is responsible for the employment and delivery of services for the patient that has been affected or their family has been affected. So that is a clear line of accountability.

In terms of accountability for setting the standards, for setting the conditions across England, then I see that as currently sitting within NHS England and I exercise that role as the Director of Patient Safety for NHS England.

**Q17 Chair:** Moving on to the changes that have taken place since we produced our report on complaints—and indeed the Health Committee had raised their concerns about the culture of complaint handling—what evidence is there that there is a changing attitude towards complaints in the NHS?

**Ben Gummer:** Well, if I can just paraphrase this and I can then hand over to William who I know will want to say more, in short, Mr Chairman, very little evidence because one of our problems is being able to measure competence in more than an anecdotal or subjective manner of complaints across the system.

**Q18 Chair:** Presumably CQC will be measuring the effectiveness of complaints handling?

**Ben Gummer:** To a degree, and their competence in doing that has improved significantly in the last few years but I am not yet able to give you a definite answer; that is one of the purposes of the work that we are doing. I can say, and I am sure that you have picked this up, that anecdotally—and it is very patchy—there are significant improvements in some parts of the system. Those who are at the cutting edge of work in this area in the NHS understand what other great organisations understand, which is that you must love complaints. You must embrace them and encourage them when they arise because that is how you learn. There are some organisations that really are living that at the moment, but there are some, right at the other end of the scale, that hate them, that have significant problems with them. What we have to do, like in so much of the NHS, is to level up the worst to the best. It is that piece of work that we are engaged in working out how we can do that in the next few months.

**Q19 Chair:** How do you spread the good practice? How do you get the best practice or how do you get the people around the health service to see the best practice and adopt the best practice? How do you do that?

**Ben Gummer:** This is a challenge for the NHS as a whole no matter where you look, whether it is cost savings—

**Q20 Chair:** But who is accountable for making this happen?

**Ben Gummer:** It does not matter what part of the NHS you are looking at, we have to find an answer that has not, frankly, in its whole history ever been identified. One of the areas I am interested in looking at at the moment is the Carter model hospital, which is providing that in terms of financial best practice. The key is to enable people to see very easily what good looks like—it is a horrible phrase but it is a useful one—and to have clear levels of accountability.

**Q21 Chair:** So in the NHS Leadership Academy, how is this being addressed?

**Ben Gummer:** The leadership academy has just moved over to Health Education England and we are looking carefully at what improvements need to be made to the leadership academy for precisely the reason that you have inferred. Again, I hope to be able to answer these questions in greater definition in a few months' time. I apologise for not being able to do so precisely at this moment.

**Q22 Chair:** I have to say, this is very frustrating and slow. I am referring to reports that were produced more than a year ago and the speed of learning is slow. I think this is a problem of the medical profession globally but it is inexcusable in our NHS.

**Ben Gummer:** Before Mr Vineall comes in, we will soon be launching the Healthcare Safety Investigation Branch, which I acknowledge has been a joint work between this Committee and the NHS. It is one of the most radical innovations in world healthcare. For the NHS, becoming a learning system is a cultural change probably unprecedented in its period of existence. So this is very rapid change to get to the point of HSIB. I completely accept your contention that we should be moving as quickly as possible.

**Q23 Chair:** How can the role of NHS complaint managers and investigators be better recognised than it is at the moment?

**William Vineall:** One of the things we have been trying is we have had a complaints culture improvement partnership working group, and one of the things that has come out of that is we need to do even more work on support and training. Health Education England and the Royal College of Nursing have produced tools on handling complaints. We have started to publish data quarterly. There has been a requirement on trusts for a number of years to produce an annual report listing complaints, the number that are well founded, the number that are reported to the Ombudsman, and all the rest of it. But we still need to do more, in the same way as the investigations, to make the base quality of complaints handling better. It appears, from the soundings we get from the NHS that they do require more support and training to do that, so I think we have to take that forward as quickly as we can.

**Q24 Chair:** Another task for the NHS Leadership Academy?

**William Vineall:** Potentially.

**Q25 Chair:** What about the Complaints Board, what effect has that had since it has been established?

**William Vineall:** The guidance by HEE and the Royal College of Nursing came out of that board and came out of the commitment from the Francis review, was not to say "Let's have a new structure for complaints," but, "Let's just get better at actual complaints

handling locally.” I think the NHS does understand that the ball is in their court. There isn’t a magic bullet. It is good in some places and not in others and we need to do all we can to improve it.

**Q26 Chair:** But it all revolves around systems, procedures and communication—I have just read the most fabulous little book called “The Checklist” by Atul Gawande, and I do recommend it if you haven’t read it. If you could improve those three things so much would change. Why is it so hard?

**William Vineall:** I think it is difficult to be honest because some organisations understand what the Minister was saying about a cultural improvement and learning from your mistakes, and some others still don’t. It is very variable in the NHS.

**Q27 Chair:** Okay, but the CQC, for which you are the sponsoring official—

**William Vineall:** Yes.

**Chair:** CQC is capable of inspecting hospitals to death, literally. Why isn’t CQC promoting these simple systems, procedures and communication solutions?

**William Vineall:** Well, I think in the feedback that CQC gives in its report, as I said, it does look at a sample of serious incident investigations and if they are performing poorly then it says so. We know that the safety domain is the one in which the hospitals perform worse. We would not have known that two and half years ago. So there is obviously more they can add to their guidance. They can look at that, they are completing the first round of hospital inspections this summer, but I think they have made quite a significant point in this area.

**Q28 Chair:** But what are we doing to ensure inspection is a positive learning experience rather than just an exercise in exposing failure?

**William Vineall:** Well, following a CQC inspection there is a return to look at the improvements they have made, and obviously we have a pretty stringent process of special measures. We have put 27 trusts into special measures in two and half years; 11 have come out, 16 are still in. That gives us clarity about the quality of the NHS that we did not have before. So I think it is quite a tight loop in terms of how CQC follows up on its inspections.

**Mike Durkin:** Undoubtedly for me there is a key link between your commentary on Mr Gawande’s book and the climate that exists to create an improving system. A pressurised system, a system that is constantly in churn, creates a compression and one of the elements that I think we are working hard on is to move our system, learn from the findings of CQC and develop a learning culture, a learning system in this ongoing process. This is moving into a process of learning as a whole cultural shift. To do that, one of the key elements to take away that compression is a reduction of fear. The fear that exists currently is an inadvertent one and it is an unintended one but it exists nonetheless. So one of the key elements that I would add to Atul’s work is the other triumvirate of trust, honesty and respect; those are just as key to creating a climate of improvement at a local level and a climate where the patients and the clinicians are working together to the ends of supporting the patient. Too often we see that we are in an organisational construct rather than a caring construct.

**Q29 Mr David Jones:** How will NHS Improvement ensure that trusts demonstrate clear objectives for the organisation and staff to be open and honest, and to learn from investigations?

**Mike Durkin:** NHS Improvement, as you know, will be commencing its activities as an organisation from April. It is currently bringing together Monitor and the Trust Development Authority as well as elements of NHS England of which my patient safety is one. We firmly see the existence of a new operating model by NHS Improvement in terms of its role to develop this learning organisational culture for the whole of the NHS in England. Currently we concentrate a lot on hospitals and that is the regulatory experience, if you like, coming out of Monitor and TDA, but we also have to acknowledge that the NHS as an organisation represents the needs of 55 million or so people, the vast majority of whom receive their care in primary care and community settings so we have just as much work in terms of developing this approach to improvement in those as well.

But going back to the hospitals, I think we will start to see a very different climate in terms of the role and responsibilities assumed by NHS Improvement in setting the climate, setting the conditions but without taking away the responsibility and accountability of delivery from the hospitals themselves, and with one regulator, as the CQC, defining both quality and the efficiency of the use of those resources.

**Q30 Mr David Jones:** This comes back to Mr Gummer's point about embracing complaints and learning from them rather than being defensive?

**Mike Durkin:** Absolutely, I couldn't agree more.

**Q31 Mr David Jones:** What will the CQC's role be?

**William Vineall:** The CQC's role will really be what it is now, which is to carry on inspecting and reporting, producing that information for trusts, expecting the trusts to respond. As Mike said, with NHS Improvement coming together and bringing together Monitor and the TDA, NHS Improvement will be providing support when necessary for the trust to respond as quickly as possible. I suppose one of the things we have learnt from two and half years of special measures is that when you go into special measures some trusts need particular support, and NHS Improvement is there to do some of that, as the name implies, but it is very much the responsibility of the trust to take forward the changes. So we envisage that CQC will continue to be, in a sense, providing the diagnosis of problems in trusts, and the trusts, with some support from NHS Improvement where necessary, will then respond.

**Ben Gummer:** In the manner of your questioning, Mr Jones, you have identified, as has the Chairman, a lacuna in the architecture at the moment, I am aware of that. A great deal has been done in the last year to tidy up the infrastructure that governs and helps improvement across the NHS. I think NHS Improvement is going to be a really significant change for the service, but we still do not have right the ability to ensure that the handling of complaints is consistent across the service and we have the means by which to ensure that. Now, quite how that is done is something that we are trying to work out at the moment. I want to accept the thrust of your questioning, which is that the CQC can't encompass all of that and neither can NHS Improvement, there is space for something else.

**Q32 Mr David Jones:** The Ombudsman's review highlighted that staff perceived a lack of an open and honest culture despite the introduction of the duty of candour. Is the duty of candour working?

**William Vineall:** I think the duty of candour is working, although it is still early days. It was introduced at the end of November 2014. The intention—picking up on Mike's previous point a couple of moments ago—was to try and get trust, honesty and respect in the system, get prompt responses and apologies to the patients where necessary and to try, in a sense, to stop the culture of closure and fear. Now, the number of duty of candour incidents that have been raised through CQC's reporting framework since it came in are pretty few. I don't think that is because they are not being thorough; I would say it is because people are somewhat taking the hint about the duty of candour—that you have to go away and think about being open. I know quite a lot of trusts and colleagues in the teams have been out and done training and support and people are genuinely thinking about the duty of candour. The way it is pitched is it is a requirement on the organisation so the trust board can't avoid it. There is obviously some training and support which staff then need, but I think the duty of candour is having an impact.

**Q33 Chair:** Can I just pick up on that before we move on? Openness, trust, honesty and candour in an organisation will reflect how candid the leadership of that organisation are. Just creating a duty on the frontline staff to be candid is not going to work. The candour has to be led by example throughout the culture of the entire NHS. There is not a culture of candour in the NHS. It is very difficult for senior officials to tell Ministers and advisors, special advisors, the truth at all times and that affects the entire system. To what extent do you recognise that challenge?

**Ben Gummer:** I am not sure it affects the entire system. I accept the premise of your point, which is that candour requires leadership, but I think we have to step back sometimes to see the distance travelled. A large part is as a result of the Secretary of State's focus on this, which is that had we had this conversation four or five years ago I would have sat here playing you a defensive bat, trying to explain how everything was all right with complaints and with a bit of touch here and a change there would make all the difference, and you now have two senior officials and myself saying, "No, things are not good enough and we are making changes where we can and where we need to in order to address the problem." If you see the way the Secretary of State approaches this about candour on never events, his openness about avoidable mortality, not uncontroversial I would posit at the moment, all of this suggests that the leadership from the top at an official and at a political level is there. But has that yet permeated through the entire organisation? No.

**Q34 Chair:** I guess I am getting more impatient because I see hints of progress but would you accept that you cannot make people behave in a good way? They have to want to behave in that way and it has to be rewarded—not financially, but it has to be recognised and approved of from above in every circumstance.

**Ben Gummer:** This is a profound philosophical point that you make and I agree with you. That is why we are both Conservatives and we might disagree with Mr Flynn on that point.

**Q35 Chair:** I do not confine this quality of candour to my own party, let me just say that.

**Ben Gummer:** Whether you can make people good or not, I was probably pointing to.

**Chair:** Yes, I can understand that.

**Q36 Mr David Jones:** In 2015 the Health Committee recommended that trusts should be required to publish at least quarterly details of complaints made against them, how the complaints had been handled and what the trust has learned from them. Do you think that publication of complaints data would provide an incentive to trusts to improve their complaints handling and their investigations?

**William Vineall:** I think it would give a bit of an incentive. It would give an incentive if they genuinely felt the information that was being published was useful, so I think, yes, it is a step in the right direction. But, frankly, if all they publish is data of the quality of complaints that just remains a bit substandard in places, it does not change very much. I think it is helpful but I don't think it is the thing that is going to make or break trusts' approach here.

**Q37 Mr David Jones:** So if you think it is helpful would you commit to requiring trusts to publish these details quarterly?

**William Vineall:** They have published it twice since April 2015. I think as the Minister said earlier, we have a lot more to do to work out what is useful to publish and what is going to have most traction with public, and whether we can get more granular. It is something we have to look at again in more detail and more carefully but I think the principle of publishing information is sensible.

**Mr David Jones:** Thank you.

**Q38 Chair:** Is that a commitment, a policy commitment?

**Ben Gummer:** In general summary, yes.

**Q39 Chair:** Would you like to take that away and make it into more of a commitment—

**Ben Gummer:** Of course.

**Chair:** —because I think it would be a very good one?

**Ben Gummer:** Yes.

**Q40 Chair:** Finally, can we just look at where we are with the recommendations we made in our clinical incidents investigation report last year? I note that the expert advisory group has now completed its work.

**Mike Durkin:** Completing.

**Q41 Chair:** Completing. Your patience is becoming legendary. The name of the body is to be changed from the Independent Patient Safety Investigation Service to Healthcare Safety Investigation Branch, which is more in line with what we originally preferred. What other recommendations do you think you are going to be making from this group? Mr Durkin?

**Mike Durkin:** This is caveated on the basis the expert advisory group hasn't yet completed its work and is due to furnish its advice to the Secretary of State next month, but we have been publishing on a regular basis the minutes of this meeting. It is important to recognise some of the key principles. First and foremost is that—and I do not apologise for saying this again—patients are not a bit-part player when things go wrong; they are core and essential to the investigation process and they are core and essential to how the investigation branch would set out its exemplar model for learning. The other elements that are key are that this branch should act without fear or favour, allied with the learning that has taken place from transport investigation branches such as aviation, marine, rail, that it should be held accountable and I think it should be held accountable by the system to both highlight its independence but also to ensure that it is doing its job as it is supposed to be doing.

As you know, it will be sitting as an entity for pay and rations, if you like, within NHS Improvement as the vehicle to support the financial governance of the role of Health SIB, but we are quite clear that it will be acting in a very independent manner in terms of deciding its tasks. Although I think the first task will be to discuss how to set up this exemplar model of investigation. We are due, fairly soon, to go through the appointment process for the leadership of the branch and we hope to be able to announce that in the next month or so.

**Q42 Paul Flynn:** Having been provoked out of my thoughtful silence by Mr Gummer, can I point out that probably the main difference between us is that I lived the first 13 years of my life without a health service and I have a vivid memory of what that situation was in poverty stricken families. That was about the age, I believe, that you, Mr Gummer, were being force fed a beef burger to prove some political point. I think we should be grateful to the three witnesses for the way they have very candidly presented their evidence. Like everybody else, I was shocked by the Francis review and the Mazars report and there must be improvement.

What I see at the moment—I think there is a great danger in this—as I read my papers is half-page adverts encouraging people who might have acquired bedsores to sue the National Health Service. We might be creating a risk-averse health service as they have in America where the physicians, in order to protect themselves from legal claims, fall into the temptation to over medicalise, to use all procedures instead of possibly what they think is the best procedure, to use all the drugs available rather than those that are the ones designed to do something else. Are we in danger of slipping into a service where we are not only undermining people's confidence in their health service, but encouraging them to see it as a source, like car accidents, of making income, thus deteriorating it to the level of much of the American health service at the moment, which is seen as very much a service in which they have to guard themselves against legal claims after their operations?

**Ben Gummer:** Well, in answer to the first point of your question, Mr Flynn, it should be pointed out for the record that you are wrong, not for the first time in raising that point. In answer to the second—

**Q43 Paul Flynn:** In what way am I wrong?

**Ben Gummer:** We discussed it outside but I am just pointing out you are wrong.

In the second point, yes, there is always a risk of that. The Chancellor notified in his autumn statement his wish to proceed with reform of clinical negligence legislation, and that is something the Government will be consulting on shortly. So I agree with you that it is not a place where we want to end up. None of us wants to find ourselves in the position that the Americans have done with many aspects of their healthcare. I think in that we are in concord.

**Q44 Paul Flynn:** Do you think the health service that I, my family, my seven grandchildren use is the one that was described in four leading articles in *The Daily Mail* as underperforming—a service that was attacked and the people that work in the Welsh health service told that they were rubbish? This was done because of a political agenda of your party. Don't you despise their tactic? Having seen the recent reports by Nuffield and the OECD, there is very little to choose between the quality of the Welsh health service, the English, the Scottish, the Irish—they are very much the same, they all have terrible weaknesses and they have all strengths? Don't you feel that undermining the confidence in people in the health service, which is so important in the healing process, is a despicable political act?

**Ben Gummer:** *The Daily Mail* will be delighted to know that you have been quoting them in Committee, I am sure. I am the Minister responsible for the English health service and I and my fellow Ministers will only point to the data, the figures and the outcomes that show the significant underperformance of the Welsh health service. Part of the—

**Paul Flynn:** What attention do you—

**Chair:** Order. Minister?

**Ben Gummer:** If I could finish? Part of the premise of the investigation you are doing as a Committee is about openness, transparency and honesty, and what we have tried to do in this country is to be very clear about where we are failing, where we can do better and where we don't work and to be open about it. I hope the other health systems, the Welsh one included, take a similar tack because it is the only fair thing to patients. It is also the only fair thing to taxpayers.

**Q45 Paul Flynn:** There have been two stories on the health services in the four countries in recent weeks. One has been about the improvements and the advanced status of the Welsh health service in dealing with cancer patients, and indeed with mental health care—that England is behind Wales on this. Did you make a statement on either of those two matters? If the Welsh service had been behind, you would be screaming from the rooftops.

**Ben Gummer:** Well, in three minutes there is an urgent question to my fellow Minister of State about mental health in this country so no doubt he will be speaking about it in greater length. It is not part of my ministerial responsibilities.

**Q46 Chair:** In the three minutes available, can I just make two other points about HSIB? Does the Government recognise that there is a long-term solution; that to have HSIB

as part of an NHS quango is not implementing this Committee's recommendation; that no other safety board or accident investigation board in any other Government Department doing a similar role is part of the system in that respect? Does the Government recognise that?

**Ben Gummer:** Well, the Air Accident Investigation Branch is a branch of the Department of Transport. We recognise that however—and I can ask my colleagues to talk about the detail of this—it is a very difficult position to come to, balancing the needs of an overall Government imperative not to be creating new bodies where—

**Q47 Chair:** Well, that suggests a bit of party political dogma if I may say so. After the Paddington rail crash and in the aftermath of all those dreadful rail crashes, we would not have a Rail Accident Investigation Board if we had been tied to this little bit of manifesto commitment saying, “We must not create any new bodies.” I’m sorry, but it is not good enough and this Committee is not going to regard it as good enough.

**Ben Gummer:** You call it dogma; it is a policy to which we are all committed. The question is how does one vest it most efficiently but appropriately and Mr Vineall can lay out why we have come to the decision that we have in the meantime, but we believe that we have a solution that is analogous to the Air Accident Investigation Branch, if not one even further removed because it is not direct branch of a department.

**Q48 Chair:** I hear what you’re saying. We are very pressed for time, do you want to make a—

**William Vineall:** I was only going to say that we need the new branch to have traction on providers so we think NHS Improvement is a good place to put it. We do think it can operate independently and the fact is we need to get the thing up and running from 1 April, so it is quickest and we think it is sensible to put it in NHS Improvement.

**Q49 Chair:** I appreciate the urgency and that you appreciate the urgency, but if CAA owned the Air Accident Investigation Branch it would not be considered to be independent and that is the challenge you are going to face if you set it up in this way.

Secondly, how are we going to provide a safe space for people to talk to each other and for the system to investigate in if there is not primary legislation to provide that safe space?

**William Vineall:** Well, safe space is complicated. We have not done it before. We need to see what the EAG says and then we need to have a look at that carefully and give it consideration.

**Q50 Chair:** Does EAG yet understand that unless there is this safe space for patients, clinicians and investigators to talk to each other, then EAG will not be accepting the recommendations of our report?

**Mike Durkin:** As you know, Chair, this has enjoyed considerable debate within the EAG on a constant purpose about how is a safe space going to be created, what are the support mechanisms around that space that the whole system will buy into if there is no primary legislative vehicle for that?

**Q51 Chair:** That leads me to that last point. I hear there is going to be legislation on complaints handling in the NHS. Maybe that is a premature announcement and I shall not take it as an announcement of policy, but presumably that would be an opportunity to legislate for whatever we need in respect of clinical incident investigation?

**Ben Gummer:** To be clear, lest there be misunderstanding, I am not sure we pledged ourselves to legislation on complaints handling. We face an issue, which is that the safe space created for air accidents is one that is permitted and instructed by European legislation.

**Q52 Chair:** No, it long preceded European legislation. I am sorry, you cannot get away with that. We set up AAIB, it has existed since 1919 in some form or another.

**Ben Gummer:** It has done but the current regulations—

**Chair:** I understand but it has nothing to do—it would exist—the Americans have the National Transportation Safety Board; they are not in the European Union, they set it up themselves. It has nothing to do with European requirements.

**Ben Gummer:** I was merely stating the fact that currently they are vested in European regulation. Now, we can leave aside the fact that we would have to reinvent that were we to exit in a few months' time. We have to find a similar way if we were to create a safe space, and that is one that the expert advisory group is looking at at the moment. So we have to wait for their report.

**Q53 Chair:** Does the Government understand you will not be implementing our recommendations, which you have all accepted, if there is not primary legislation to set up a safe space?

**Ben Gummer:** We understand that like the Air Accident Investigation Branch to create a safe space requires legislation.

**Chair:** We will return to this topic, but thank you for being so open-minded and proactive, albeit at a frustratingly slow pace. Frustration will drive progress.

**Ben Gummer:** Thank you for your interest.

