HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Follow up to the PHSO report: Learning from Mistakes, HC 743

Tuesday 22 November 2016

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Watch the meeting

Members present: Mr Bernard Jenkin (Chair); Ronnie Cowan; Paul Flynn; Mrs Cheryl Gillan; Kelvin Hopkins; Dr Dan Poulter; Mr Andrew Turner.

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

Questions 71-125

Witnesses

I: Mr Philip Dunne MP, Minister of State for Health, William Vineall, Director of Quality, Department of Health, and Chris Bostock, Policy Leader for NHS Complaints, Department of Health.

Examination of witnesses

Witnesses: Mr Philip Dunne MP, William Vineall and Chris Bostock.

Q71 **Chair:** Welcome to this second evidence session on the PHSO's report in the NHS on "Learning from Mistakes". Could I ask each of our witnesses to identify themselves for the record, please?

Mr Dunne: Good morning, Mr Jenkin. Philip Dunne. I am the Minister of State for Health.

William Vineall: I am William Vineall. Good morning. I am the Director of Acute Care and Quality at the Department of Health.

Chris Bostock: I am Chris Bostock. I have policy responsibility within the Department of Health for the handling of NHS complaints.

Q72 **Chair:** You will have to speak up a little bit. I can't hear, but that has gone on the record. We have an hour; in fact we have 55 minutes

because you have to be at Westminster Hall.

Mr Dunne: I regret I have a Westminster Hall debate at 11.00 and I must be there.

Chair: We will let you go at 10.55. As quick as we can, question number 1.

Q73 **Kelvin Hopkins:** Good morning. Can you clarify the extent and nature of the role you expect HSIB to play in building local capability beyond its own limited capacity for investigations?

Mr Dunne: I can start with that. Clearly the HSIB will be operational from 1 April and as a new organisation its focus will be on setting up the criteria by which it will decide which cases it wishes to investigate. You will be aware that the intent is that it will focus on a small but important group of cases—we are thinking about 30 a year. The role that it will have in helping the wider NHS undertake better investigation of itself is something that will evolve over time. We are not anticipating that it is going to hit the ground running with a prescriptive set of changed procedures. We anticipate that it will undertake investigations, each one will generate some learning and that will then inform how other investigations happen across the NHS.

Q74 **Kelvin Hopkins:** Thank you. Could you clarify who is responsible for making sure that the standards HSIB sets are taken up at local level?

Mr Dunne: William might like to come in here. I think the intent is that the HSIB will set standards for itself and those may change as it undertakes more investigations. As far as informing other investigations is concerned, as I said earlier I think this is going to be an iterative process. In relation to an individual trust that has been investigated, the reports will be published so they are available for learning across the NHS. For the trust itself there will be the opportunity to inform inspections of that trust. With both the CQC and in regular monitoring through NHS Improvement that trust will be monitored to see that the recommendations are followed. More widely, that will be a matter for us to spread the culture of improved investigation across the NHS and that will take some time.

William Vineall: Then there is a question in the consultation that is live at the moment about whether safe space should be extended to local investigations.

Q75 **Chair:** We will come to that later. Can I ask why does the Department think it knows better than HSIB what it should investigate when all the counterparts in other Departments that do incident investigation are left to decide for themselves what they should investigate? Keith Conradi last week made it quite clear to us that he thought he should be deciding what is investigated.

Mr Dunne: We agree with that too. The Department does not think that it should decide which cases should be investigated.

Q76 **Chair:** There was a suggestion that the Department wanted him to look at maternity cases.

Mr Dunne: There has been a suggestion by the Secretary of State that that might be one area that they consider first.

Q77 **Chair:** But the discretion is going to be left to HSIB?

Mr Dunne: Yes, indeed.

William Vineall: In the directions it says that the criteria should be set up by HSIB by next April to determine how they decide what to investigate.

Q78 **Mrs Cheryl Gillan:** I want to turn now to communications and co-ordination, which is the next set of questions. I need to declare an interest that I chair the All Party Parliamentary Group on Sepsis because I am just about to ask a sepsis-related question.

In his evidence to this inquiry, Scott Morrish said he felt he had been pigeonholed as a problem from the very beginning by the healthcare system when it looked into Sam's death. I would like to know what is being done and what needs to be done to improve the engagement with patients and families during investigations, bearing in mind that the PHSO specifically mentioned in their "Learning from Mistakes" report that there was insufficient involvement of the family and staff in NHS investigations. I don't think this is an isolated case, in my experience.

Mr Dunne: I am sure it is not an isolated case. There are close to 200,000 complaints across the NHS and there is a great deal of learning as to how we should be handling complaints that go beyond the most serious ones. We all, as constituency MPs, have examples of poor conduct of complaints and investigations in the past and I am well aware of some in my own trust. There is a great of learning to be done. The work that this Committee has done to prompt the HSIB establishment is very valuable. This entire process of establishing HSIB and the consultation we are having at the moment on safe space will help to inform how we go about improving investigations across the board. It is a really important piece of work. I think it would be wrong to sit here and say today that we have solved all the answers about patient involvement in investigations; there is no question that we have not. I would like William to give you some examples of what we have been doing.

William Vineall: In terms of what you have said about the pigeonholing, one of the things that we want to ensure that HSIB popularises is the fact that patients and families should be routinely involved in what goes on in investigations and listened to. There should not be a presumption among organisations that they immediately know what is right. We should try to get to investigations where you move away just from blame and you try to get the learning and the systemic learning out in order that you can recognise where things are going wrong and you can move to putting things right. That is all positive and front foot whereas in a sense the

story from the investigation you put out was that everything was the other way round, which led to a number of failed investigations. Indeed your starting point was they were not sufficiently co-ordinated. Some of the investigations that HSIB is likely to undertake will require a degree of co-ordination that will hopefully act as an example to the wider system about how you can do these quite complex things well.

Q79 **Mrs Cheryl Gillan:** There is a saying, isn't there, that the road to hell is paved with good intentions? I can hear that there are very good intentions coming through on this but I am not hearing what I really want to hear, which is that the family and the staff will be central to investigations. You are saying they will be routinely included in. I would have thought—

William Vineall: Maybe that was a poor choice of words. I think we agree with you that they should be central.

Q80 **Mrs Cheryl Gillan:** I am looking for a bit of passion and a positive move forward on this because I think it is really key. It is a justified criticism from the PHSO but it doesn't feel as if it is going to be a central tenet of what is happening moving forward. Can you give me that reassurance?

William Vineall: Yes, I think we can. It should be—"routinely" is not a good word—and patients should be centrally involved.

Chris Bostock: With regard to complaints, we know this is an issue but there is a legislative duty on NHS providers when a complaint is received to discuss the handling of that complaint and the timescale within which the handling will take place with the person making the complaint. That was specifically introduced to enable the person making the complaint to have a say and to try to explain what they are seeking to get out of the complaint, why they are looking to get appropriate remedy and to take that forward. We are aware that in certain instances a legislative requirement is not being followed and we are looking at a possibility of clarifying the duties on individual organisations arising from that set of regulations simply so they are aware of the duties that they have when someone makes a complaint.

William Vineall: The directions themselves talk about that in conducting investigations the investigation branch should involve patients and family members or representatives, providers and individuals. We have tried to get down some specificity in the directions to give that sense of momentum that you are after.

Q81 **Mrs Cheryl Gillan:** Again, it is a question of language. Mr Bostock, you said you are interested to know what complainants are looking to get out of the complaint. I would start from a different direction and say anybody who is complaining about the death of a close relative is looking for answers to why, what went wrong, how did this happen, not what are they looking to get out of it. It sounds as if you are almost referring to a culture of compensation, where in many cases it is not about

compensation. It really is about wanting to know what went wrong.

Chris Bostock: I agree entirely but with a complaint, of course, it runs from I was late for an appointment, staff rudeness, through into the more serious complex complaints of patient safety. An apology in many instances, plus a guarantee that action will be taken to prevent it from happening again, will satisfy many people who make a complaint. In other instances, you are right, there may be systemic failure. The NHS needs to get to grips with that systemic failure and work at a higher level to put it right.

Mr Dunne: If I may, what we are endeavouring to do is to change the entire culture of the NHS towards a learning culture and we start with the experience of the patient that went wrong who is making the complaint. Any complaint starts with the patient and what we need to change is the way in which all complaints are handled but in particular the most serious complaints so in the event of a death in particular clinicians have the opportunity to learn what the experience was like for the patient and their families, to the extent that they can be described. That is the starting point not the end point.

Q82 **Mrs Cheryl Gillan:** Mr Morrish also pointed out to this Committee that there was an NHS awareness campaign about sepsis, a leaflet entitled "Sam", undertaken in response to his case and it didn't receive proper evaluation or follow-up. He went on to say that the leaflet's publication was followed by "a period of inertia and underwhelming evaluation". How fair is that criticism and who is responsible for sustaining momentum when this type of learning is initiated? Otherwise it is seen as a sop rather than a way of spreading best practice and awareness of something, and I believe that the Secretary of State is now very keen on spreading awareness of sepsis.

Mr Dunne: Indeed. Sepsis is now becoming one of the primary hospital-acquired infection areas. Alongside C difficile, MRSA and gram-negative, within the same category it is getting the same level of attention. We are now looking to spread awareness and best practice to minimise instances of sepsis right across every hospital ward.

Q83 **Mrs Cheryl Gillan:** Is it a fair criticism that the leaflet entitled "Sam" was not dealt with in a thorough fashion? I appreciate you were not the Minister at the time.

Mr Dunne: I can't talk to the leaflet. I think it is fair that the way the response initially came to that was probably not as swift as it should have been and we have tried to take measures to put that to rights and develop a new leaflet to more effectively raise awareness of sepsis.

Q84 **Mrs Cheryl Gillan:** Do you think the ongoing communications with people like Mr and Mrs Morrish are good enough as well? Do you not think that there is a point where you put "case closed" on it prematurely? Do you not think there should be ongoing communications and co-ordination?

Mr Dunne: I am sure there are many cases where the conduct of the case could have been handled better. Again, I can't talk to the specifics of the Morrishs' case. They have been very brave in coming forward in the way they have and pushing as well as they have. It is one of the reasons why we are all here, so we must thank them for their efforts. As I said earlier, many of us have other constituency cases that we are aware of that were not handled well and that the families didn't feel that they had the follow-up service to understand what happened as a result of the learning from their case. There are clearly some limits that one has to place around continuing engagement, but there needs to be a mechanism for families to be able to respond to understand whether a particular trust has done what it said it would do.

Q85 **Mrs Cheryl Gillan:** What I am suggesting is that your communications packages should embrace in some instances a far longer engagement with the original complainants. Not only is that of benefit to the original complainant, particularly if there is a loss of life involved, but also of benefit to the NHS.

William Vineall: Part of the learning from the Morrish case was had there been something thorough, robust and relatively swift at the start it would not have generated into all the other things that should have happened. That is where we want to get with investigations in the future.

Q86 **Ronnie Cowan:** Minister, you were asked about the "Sam" leaflet and your answer was that you are going to produce a new leaflet, but have we learned the lessons from the first leaflet, which was underwhelming?

Mr Dunne: I think it is in discussion with Public Health England about how we can improve what we are doing about sepsis on that front.

Q87 **Ronnie Cowan:** The point is that the first leaflet went out there with good intentions but proved to be inadequate and your answer to the question was, "We are going to do a new leaflet". Surely to make the decision to do a second leaflet you must already have the ideas of how you are going to make that second leaflet effective.

Mr Dunne: I think that is what is being looked at.

Q88 **Dr Poulter:** Just picking up on that last point, you talk about Public Health England have a responsibility for the leaflet but we have a Minister here who is not the Public Health Minister. How effective is the co-ordination and integration within the Department in delivering on this agenda, given that some of it is delivered through other bodies like Public Health England?

Mr Dunne: The intent of the cultural shift that we are trying to introduce is that it is wide ranging and affects the entire NHS and the support bodies that surround it. There is no lack of ambition from the Secretary of State down to try to ensure that we change the culture. Precisely how we are going to do that, and getting back to Mrs Gillan's point about communications, is a big challenge. It is always a challenge, given the

scale of the NHS across the country, of how one spreads best practice. It is not just about publishing a leaflet. It is about finding as many ways as practically makes sense to spread awareness and practice. We have a number of specialist groups, investigative partnerships across the NHS to spread the good practice that emerges.

Q89 **Mrs Cheryl Gillan:** I think I heard you say that the Department of Health is now putting sepsis on the same level as hospital-acquired illnesses such as MRSA or C diff. The UK Sepsis Trust, that the APPG works with, has been at the forefront of this and has obviously been a driving force but it was always as if we are pushing the ball uphill. When you have this level of what is believed to be preventable deaths, when does the whole of the NHS roll in behind the subject, as they did behind MRSA and C diff and the FAST campaign for stroke? I feel as if there is always a dragging of the heels and again good intentions, but we need some really fast action or else we are going to see more Sams.

Mr Dunne: I have been in the Department for four months. I met the Sepsis Trust in October. I have seen a huge effort by the Department to understand, first of all, the scale of the problem and once the understanding has been there, to take steps to minimise and find ways to improve. There is a big effort and the Department is mobilised to mobilise, through NHS Improvement and NHS England, a large campaign to get sepsis under control. I have not been there long enough to know how typical this is and whether the drive for sepsis was, as you say, from campaigning groups. There has been an awareness of the problem for some time because of the scale of the problem. It may well have been highlighted by some individual cases.

Q90 **Mrs Cheryl Gillan:** The problem is that this is just one small example. The pattern of communication and the way in which the Department addresses this type of situation needs to be templated and spread across into other areas as well. I am very much hoping that this will be a pathfinder for improving the way in which the NHS deals with these things. Do you see there being any way in which this example surrounding sepsis and the communications can be used to be such a pathfinder for other problems within the NHS?

Mr Dunne: Perhaps it might be best to answer that by talking about how it worked with MRSA and or C difficile.

William Vineall: MRSA and C difficile, which is going back some way, was recognised as a problem that had not been addressed. It was something where we took specific actions and enhanced the messages out to the NHS about what they needed to do. There was follow-up with monitoring and there was an improved public recognition that shortcomings in this would not be tolerated at all. I think there is a template that we have had in other things under previous Governments where we have got much more specific and granular about how we monitor these things, how we press the NHS to do it and how we expect improvements, and hopefully sepsis will fall in that category.

Chair: We have spent a long time on this subject. Daniel, very briefly.

Q91 **Dr Poulter:** On that point, C difficile and MRSA are specific, they are hospital-acquired infections. We know there are routes of transmission for hospital-acquired infections, so there are fairly easy routes dealing with that. Sepsis is multifactorial and a much bigger problem, so I am not sure that the analogy holds. What I wanted to press you on slightly is the co-ordination across the various arm's length bodies and the Department. You have Health Education England, which is involved with training. Staff training is obviously a key part of this and the budget for Health Education England has been considerably squeezed. You have Public Health England, which is involved in the sepsis leaflets, and you have a whole host of Ministers in the Department with responsibility for different areas. How is this issue going to be addressed and co-ordinated properly in the future?

Mr Dunne: If I can take us back to the inquiry to talk about communication more widely in relation to complaints, you do raise a valid challenge to us of how we are going to communicate the change in culture right across the NHS.

Q92 **Chair:** We are very short of time. Could you write to us on this subject in a bit more detail than we have time for now?

Mr Dunne: On sepsis or on the complaint?

Chair: On sepsis. It is evident to me that the system felt: "Sam" leaflets issued; job done; let's go back to the day job. There is that mentality to overcome in the health service and we have yet to see or have confidence in a co-ordinated NHS-wide plan that is going to raise the issue of sepsis comprehensively. Can I just leave it at that? I look forward to your letter.

On the question of capacity building and improvement of safety investigation across the NHS, across the healthcare system, the Expert Advisory Group recommended that there should be a co-ordinated programme. What does this co-ordinated programme look like for improving investigations across the NHS?

William Vineall: The first thing we are doing is taking forward the establishment of HSIB and we want to have it up and running by April and doing the investigations. As you heard last time, NHS Improvement is looking at complaints handling; CQC looks more carefully now at the learning from investigations and how that is then followed up in some of their inspections. We want HSIB to be, as we said at the start, an exemplar of good investigations so that better quality investigations, serious incident investigations can be taken forward locally. We asked a question in the consultation about the just culture and what people felt about taking that forward, with a particular emphasis on getting away from individual errors as the focus within investigations and looking much more at systemic factors and how that can be translated into learning.

All of those things as a package take us some of the way. They don't take us the whole way, clearly, because you don't generate a culture overnight but that is why we want HSIB as an exemplar. It will be important for other organisations to follow up on the recommendations they make in reports.

Q93 **Chair:** HSIB clearly has to work with CQC and NHS Improvement. How quickly can we clarify HSIB's position in the landscape of the NHS?

William Vineall: I would hope that HSIB's position in the landscape is reasonably clear in that it is going to do the investigations; it has to publish its criteria; it is advertising and interviewing for the investigators at the moment; it will be up and running by April; it will produce the reports. Clearly the fundamental responsibility for responding to the report is with the trust because that is who it has investigated. NHS Improvement is there, for this and other things, to support trusts and to ensure that recommendations are taken up and to try to group the learning. CQC, as it does further investigations when it goes into a trust, will need to know what has been said in an HSIB report. In a sense, HSIB will be producing significant new material of a high quality that can be utilised by the other bodies to take forward the learning and improve services as a result. I think that is how the three sit together.

Q94 **Chair:** Chris Bostock, what is clear from PHSO's report is that if the PCT was attempting to co-ordinate the investigation locally, it dismally failed to do so in the Morrish case. Who at local level do you expect to be co-ordinating a local investigation before HSIB is involved?

Chris Bostock: Ultimately at the moment with serious incidents the CCG has co-ordination responsibility in those cases. In complaints in general, I think the Morrish case demonstrates that there is far more work to do on co-ordinating across a range of organisations.

Q95 **Chair:** What work is that? When is it going to be completed?

Chris Bostock: We are discussing this at the next meeting of the Complaints Improvement Partnership, which will be January. We are hoping that it will be chaired by one of the members of the PHSO staff, because I know Dame Julie is taking a specific interest in complaints across organisations. I hope the end point will be a single investigation. The mistake in the Morrish case was seeking to look at what happened in individual organisations, but a mistake early in that particular patient pathway would lead to errors further down the pathway that would best be addressed by looking at the whole of that patient pathway in a single investigation rather than trying to divide it up. It may well be that the CCG takes responsibility for that and that is something we will be discussing in January.

Q96 **Chair:** Why should we have any confidence in this rather laborious process of setting up a new co-ordinating or learning body and then planning a meeting months in advance when presumably there are some CCGs who are doing this more effectively than others and we ought to

just be learning from each other? There doesn't seem to be much urgency if you are not planning a meeting until January.

Chris Bostock: We have recognised for some time, as indeed has the PHSO, that the nature and standard of investigations for complaints handling needs to be improved. We have been working together. We have produced a number of actions as a result of "Hard Truths" to seek to improve that, but we accept there is further work to do on it and we shall do that. We shall take that forward. It has become a priority now in order to improve investigations. If we don't have a robust investigation two things will fail. The first is we will not provide appropriate remedies for the person making the complaint.

Q97 **Chair:** Okay. Which CCGs do you think conduct their complaints best in England?

Chris Bostock: I don't have data on the handling by individual CCGs.

Q98 **Chair:** But hang on, your job is policy lead on NHS complaints. Why don't you know?

Chris Bostock: At a high level policy. I don't get involved in the individual workings of CCGs.

Q99 **Chair:** So you are not interested in actual performance of CCGs conducting NHS complaints. That seems a little odd from your point of view. Surely there are some CCGs who are doing a good job, better than others, and we should know about them and we should be able to use their example to inform learning across the NHS. Why aren't you doing that?

Chris Bostock: It is something I will take forward.

William Vineall: I think there is a variety of practice across the NHS and we need to corral it. One of the things HSIB will do when it looks into investigations is probably shine some light on what people have done previously and what the general attitudes were locally, which is why we want to get it up and running as soon as possible.

Q100 **Chair:** This case, as far as I am concerned, is now as old as the hills and we are still trying to learn from it. Can you understand the frustration that people feel, not least the Morrish family themselves, that the learning process is so desperately slow? Why aren't the CCGs given a much clearer steer that their job is to learn from each other about how to investigate complaints? Why are they waiting for somebody to tell them what to do?

Chris Bostock: The investigations will usually be undertaken locally. The CCG will have the co-ordination responsibility across.

Q101 **Chair:** Yes, we know that. That doesn't add any information to the sum total of what we know.

William Vineall: As I said before, we are moving as fast as we possibly can to get HSIB established in order that it will then show the way about best practice in investigations.

Chair: I think you have got the message. Moving on.

Q102 **Dr Poulter:** Just talking about the impact of some of this on frontline staff, the 2015 NHS staff survey showed that 43% of respondents felt that staff involved in near misses, errors and incidents were not treated fairly. What is your thoughts on that?

William Vineall: I don't think it is too surprising because one of the things we have identified in taking forward the work on HSIB is that there is often a tendency in investigations not to distinguish clearly enough between a very bad individual error and an individual error that is a function of the system and to move to a blame position immediately rather than trying to learn. One of the things that the CQC's recent report and the Ombudsman's report say is that staff should be much more involved in investigations in terms of being interviewed and involved, so you can do the finding out and hopefully use it as a basis for moving forward not just for feeling a sense of blame and error. If we were to bring that 43% figure down, it might be an indication that that approach was starting to improve.

Mr Dunne: I would add that I think this is one of the pieces of evidence as to why we are currently consulting on a safe space. The primary objective of safe space is to enable members of staff involved in an incident to be able to discuss the circumstances surrounding the incident without such a threat overhanging them, which in the past has constrained their ability to speak perhaps.

Q103 **Dr Poulter:** I am sorry, it is actually 57%. I apologise. It is the other way round, so a higher proportion of staff, more than half, didn't feel they were being treated fairly when something untoward had happened. The Minister raised the issue of safe space. Do you feel that the culture in organisations is in the right place at the moment where staff feel able to open up in a local process for safe space, given the fact that it may well be the organisation that employs them that is overseeing some of those discussions that will be taking place?

Mr Dunne: I think that is one of the challenges about spreading safe space throughout the NHS, but again this is one of the cultural issues that we need to address. It is clearly not right that members of staff feel bullied or harassed as part of their employment. In the event of getting involved in a complaint or investigation, ideally we would have a culture in which people feel free to speak openly and that is one that we should encourage but it is going to take considerable efforts to turn that culture around.

Q104 **Dr Poulter:** Part of change may be having some parameters of measure. How would you quantify culture or how do you aim to measure progress in changing NHS culture in this respect?

Mr Dunne: We rely quite heavily on the staff surveys for measuring how people feel the organisations are changing. I would envisage that we would use that survey to test staff members' sense of change in relation to culture for investigations. It would be a good tool.

Q105 **Dr Poulter:** You touched earlier on the issue of political pressure or political priorities about what the NHS should be investigating or prioritising investigating and there was some discussion about maternity care in that. To what extent do you feel that perhaps politicians chasing news headlines in this respect and good PR and good press releases impacts on staff morale on the frontline? In terms of a blame culture, frontline staff may feel blamed by Ministers and politicians making those sorts of statements or directing the agenda in that way rather than letting it be an NHS process that addresses internal mistakes.

Mr Dunne: The NHS is a taxpayer-funded organisation, so there is a role for the custodians of taxpayer interests, Parliament and Ministers, to provide some impetus, direction, initiatives to get going. I think it would be a complete dereliction of duty if Ministers were to absent themselves from encouraging the NHS to look at particular areas where we are aware of problems. Maternity happens to be an area where we believe the nation's performance is not as good as it should be on preventable, avoidable deaths. I think it is entirely reasonable that we should encourage HSIB to look at that area, among others, in determining those which they wish to take forward in the first year or so of their existence.

I think the point you were making was more about the relationship that Ministers have with members of staff in the NHS and the degree to which we impact on morale. Improving morale within the NHS is incredibly important for all us, for the patient experience and improving performance within hospitals. I think Ministers do have a role to play in congratulating staff for doing the great job that they do and encouraging them to persist with that work.

Q106 **Ronnie Cowan:** Following on from the political headlining, in March 2016 the Secretary of State for Health said the NHS needs to become "the world's largest learning organisation". It is a nice headline but it doesn't tell us very much. What are the guidelines on investigations doing to take us there?

Mr Dunne: The whole purpose of this inquiry, the work that has been done to establish HSIB, is on that journey. It is to try to change the culture of the NHS from the one of blame that we have been talking about into one of learning from mistakes. That is what we are about.

Q107 **Ronnie Cowan:** Going beyond the blame culture, if we can tackle the blame culture, what is the next step after that?

Mr Dunne: The next step is to use what we learn from inquiries by HSIB to encourage best practice across the NHS so that we don't go through these appalling incidents again. It is about learning from the results of investigations.

Q108 **Ronnie Cowan:** Are you satisfied that we are learning from the people who are at the grassroots of the organisation? Rather than having committees, groups, advisory boards and taskforces talking to each other, are we talking to people at the grassroots of the organisation?

William Vineall: I think one of the points about HSIB is it is very much meant to get to the grassroots, partly because you will have the safe space and partly because it is going to be talking to families, staff and getting down to the incident and those who were involved within a safe environment.

Q109 **Ronnie Cowan:** When is it going to start?

William Vineall: April.

Ronnie Cowan: April next year?

William Vineall: Yes.

Q110 **Ronnie Cowan:** My naivety but why not now? Why next April? What is taking so long?

William Vineall: It was established in directions in April. The chief investigator started in September. They are recruiting for staff at the moment and they will be up and running from April. In the original directions it said they had to be up and running within a year.

Q111 **Ronnie Cowan:** What is their first task once they are up and running? When do we expect to see any level of results?

William Vineall: Their first task will be starting to select the investigations they look at against the criteria they have published and then starting to do them from April. They will have a complement of staff and they will be able to take forward investigations from then on.

Mr Dunne: They are due to publish by 1 April their criteria for selecting cases.

Q112 **Ronnie Cowan:** Obviously there is never a bottomless pit when it comes to money, so these organisations cost the taxpayer. We are trying to prevent problems happening in the future and ideally we should be boosting the number of nurses and healthcare professionals who are the people at the sharp end of this. Is that part of the consideration, to solve the problems as well as opposed to sitting on bodies to investigate the problems?

William Vineall: We deliberately set up the body to do about 30 investigations a year. It has a budget of about £3.8 million and part of the reason for not setting it up huge, if you like, was to make sure that messages went back to the NHS for them then to improve and to take forward better local investigations themselves. The alternative would be just suck up all the investigating activity to a central body and then the budget would burgeon. We have tried to keep it as a quite bespoke body

that will exert, in a sense, a downward pressure on the NHS to improve its own quality of investigations.

Q113 **Mr Andrew Turner:** When can we expect to see primary legislation brought forward to secure HSIB's independence and in particular when to enshrine the safe space principle under which it will operate?

Mr Dunne: As you know, we are undertaking a consultation at the moment into safe space. We are midway through; it concludes on 16 December. We have asked questions in that consultation that would require primary legislation to satisfy, so it is something that we will be making determinations on once we have seen the responses to that consultation. We will not have primary legislation at the time that HSIB goes live on 1 April but we will be responding to the consultation in the new year.

Q114 **Mr Andrew Turner:** How can you expect people in the NHS to be open about things that may lead them into courts?

Mr Dunne: This is the whole rationale for safe space and that is what we are consulting on at the moment. There is a strong argument for there to be primary legislation. Sitting here today, I can't answer your question because I am not determining what goes in the Queen's speech, but we are well aware that it would be required in order to deliver safe space in the optimum way.

Q115 **Mr Andrew Turner:** But things have to go into the Queen's speech because the Department of Health requests that. Are you saying it won't necessarily be in the Queen's speech next year?

Mr Dunne: What I am saying, Mr Turner, is it is not for me to determine what goes in the Queen's speech and we will have to wait and see what emerges.

Q116 **Mr Andrew Turner:** What about the lower-down safe spaces?

William Vineall: There is a question in the consultation document about extending safe space to local investigations and we will have to wait and see what comes from the responses. The advantage of doing that is that you would have more safe space investigations. You would hopefully get more learning and you would get improvements as a result, so you would have a virtuous circle. The issue that we also flag in the consultation is the pace at which that might be introduced, which is why one of the suggestions within the consultation is that you might look at doing this in relation to maternity services first at a local level. We will have to wait and see what comes from the consultation response on that.

Q117 **Chair:** Keith Conradi is very clear that the safe space, at least in legislative terms, should be reserved to HSIB alone and should not be somehow extended to local investigations. How do you think staff can be offered that safe space in local investigations?

Mr Dunne: I think that is an interesting conundrum. You are right that the intent initially would be that safe space would apply to HSIB investigations. Mr Turner's point and your point about how we spread that down to the local area may depend on whether or not there is legislation. It may depend on whether or not HSIB were to find a way of accrediting organisations to undertake investigations at a local level. We will have to see what comes out of the consultation before we give you a formal response.

Q118 **Chair:** How about, in order to keep the legislation simple, confining the legislative safe space to HSIB but giving HSIB the capacity to put someone's presence in a meeting in order to make it an HSIB meeting and a safe space meeting in a local investigation so that it becomes an HSIB meeting under the framework of the legislation for the purposes of that meeting? Involving staff, and indeed involving families, becomes much easier if people are free to speak and free to hear without prejudice.

Mr Dunne: Your suggestion is one that has been noted.

Q119 **Chair:** Noted, okay. But are you determined to address Keith Conradi's concerns that we might be over-complicating things if we legally extend the safe space to local investigations?

Mr Dunne: We are in discussion with Mr Conradi through the consultation. He is responding into the consultation and undoubtedly we will be talking to him in preparing our response.

Q120 **Chair:** You will be aware from a previous question how much importance we attach to this legislation and the urgency with which it is required, but I think urgency is the thing that we need to see more evidence of. How does the Department of Health intend to intervene in this policy development process in order to make sure that we have a coherent system more quickly?

Mr Dunne: I think you are right to press us on this. You are also right to say that there are things that we can do without legislation and we need to be pressing ahead in making our case to see whether we can secure legislation. I can assure you that we will be responding promptly once this consultation on safe space concludes with a view to finding mechanisms to spread the cultural change that we need to see as fast as we can.

Q121 **Chair:** Can I make clear I am implying no criticism personally of Mr Bostock? It is you we will hold accountable for any lack of urgency in your Department over this matter not your officials.

Mr Dunne: I hear what you say, Mr Jenkin. CCGs report through NHS England, which reports through another Minister. I hear what you say and NHS Improvement, which does report through me, has the task of ensuring that the provider trusts act responsibly in dealing with inquiries and investigations that come through.

Q122 **Chair:** Is there some kind of split ministerial responsibility that is not helping here?

Mr Dunne: No, I don't think so. I was just explaining why I didn't feel well qualified to talk on how CCGs are behaving in undertaking investigations, but your point has been very well noted and I will take it upon myself to look at that.

Q123 **Chair:** How will we define and measure success in the months ahead?

Mr Dunne: Our priority is getting HSIB functioning. In relation to the current consultation, I think the priority is for us to respond to that promptly in good time ahead of the April commencement of HSIB.

Q124 **Chair:** Keith Conradi was very clear that HSIB cannot function properly without legislation.

Mr Dunne: I hear what he says and what you say.

Q125 **Chair:** Are there any further questions? PHSO, is there anything else you want to add?

Dame Julie Mellor: I think the only one, given what I have heard from the Committee, is in addition to the priority of the legislation, how more broadly might you define and measure success in improving the quality of competence, culture and co-ordination of investigations locally. Beyond the HSIB legislation, how would you define it?

William Vineall: There is a number of ways you could define it. It is quite difficult. One is looking at the amount of reporting that takes place through things like NARLs that has gone up over recent years and is quite a good sign that people are reporting. Over time, hoping that people pay more attention to that, the numbers eventually go down because people are investigating those harms that have been raised. The other thing we need to look at, going back to a bit of the earlier discussion, is ensuring that complaints are handled by senior people and they are taken seriously by chief executives and boards. As an example, I spoke to a chief executive last week who said they had had a very bad incident. They had changed their pattern so the chief executive and the board read the complaints, the amount of reporting had gone up and four years down the line the amount of—as they calculated it—litigation claims had started to go down because they had started to address the issues and change the practice within their organisation. That virtuous circle probably does not exist as widely as it should do.

Chair: Thank you. As you know, we attach great importance to this work. Can I thank each of you for the effort you are putting into this and can I thank PHSO for this extremely important report? We will be issuing our own report in due course, to which I hope you will respond extremely positively. Thank you very much indeed.