



HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

Oral evidence: Draft Health Service Safety Investigations Bill, HC 1064

Wednesday 6 June 2018

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Members present: Mr Bernard Jenkin (Chair); Baroness Billingham; Baroness Chisholm of Owlpen; Baroness Eaton; Lord Elder; Mr David Jones; Lord Kirkwood of Kirkhope; Andrew Selous; Dr Philippa Whitford; Dr Paul Williams.

Questions 1-32

Witnesses: **Sir David Behan CBE**, Chief Executive, Care Quality Commission, and **Dr Kathy McLean**, Executive Medical Director and Chief Operating Officer, NHS Improvement, gave evidence.

Q1 **Chair:** I welcome our two witnesses to this public evidence session on the HSSIB draft Bill. First, I apologise that we kept you waiting a while. Secondly, you might be relieved to hear that we will finish just before 12 o'clock, so we will try to keep this very crisp. If we need to come back to you with further questions, we will probably do that in writing. May I ask you to introduce yourselves for the record?

Sir David Behan: I am David Behan. I am the chief executive of the Care Quality Commission.

Dr McLean: I am Kathy McLean. I am the medical director and chief operating officer at NHS Improvement.

Q2 **Chair:** Thank you very much for being with us today. Can you each give us a view on the draft Bill and the proposal that we are discussing?

Sir David Behan: We fully support the setting-up of a body that is independent and that can carry out investigations. We think its independence is critical to public trust and confidence in the work that is taken forward. A body that is focused on learning and driving that learning into improvements in practice is to be welcomed.

There must be great clarity about the role, purpose and powers of the new body, and particularly how that body works with other bodies and, in our case, the CQC. We think that having a safe space is important and we can see how that drives learning—the learning that you can take from other industries and other sectors is critical to that—but it needs to sit alongside a duty of candour. For patients who have experienced harm or who have been the

subject of an accident, that duty must continue to operate alongside that safe space. Indeed, if there was an investigation by the body, once it is established, and if the CQC were to go in to inspect a service, we would need to ensure that we were aware that a concurrent review was taking place.

What I mean by that is that the bodies need to co-operate. I do not think that one body's duties should fetter another body's duties in the way that they are discharged. Our view is that there should be a clear duty of collaboration in the Bill. I think there is a section on a duty of collaboration on logistics, but I think there should be a general duty of collaboration. Thereon after, we need a memorandum of understanding between ourselves and the body once it is established—as we have with NHS Improvement as it is now, the Parliamentary and Health Service Ombudsman—as a way of codifying and defining what the various bodies do when reviews are taking place and we are involved such as, for example, when a hospital trust is in special measures. Our approach is generally to welcome it and work alongside it, as we do now, in relation to the way it carries out its responsibilities. I could say more about the accreditation.

Chair: We will come to that. Dr McLean, do you have anything to add?

Dr McLean: We also welcome this, particularly the independence. At the moment, HSIB is set up so that it is hosted by our own organisation. I agree with Sir David around the collaboration, but we would be particularly keen to see collaboration around the recommendations that are made, so that they are put into action. The patient safety function within NHS Improvement is a key part of that, because it has a huge amount of expertise about what good practice is and what will work. We would not want to see recommendations landing without actually being implemented, so we feel that that is extremely important. We are very keen to see independence. Again, as Sir David said, safe space is something that we see as being important in terms of developing the learning culture, which is a very important part of overall safety, but we would also say that HSSIB is part of the safety approach to healthcare. It is not all of the answers and we will obviously only be doing a segment of the investigations. There are currently 24,000 or so serious harm incidents a year, so there are a lot of investigations already going on and HSSIB will only be able to do a fraction of those—obviously there are particular ones it selects. But we would certainly support it being wholly independent, but with that collaborative element with other bodies, so that we can take the learning.

Q3 **Chair:** We are a little confused as to why there is a mutual duty of co-operation. What is the duty of co-operation on HSIB, which you regard as essential?

Sir David Behan: From our point of view, if we just take the case of our regulatory oversight of the trust that was rated inadequate and was in special measures, there was a decision taken by HSIB, quite properly and in quite an appropriate way, to carry out an investigation of something that had happened in that trust. We were due to go back to do an inspection because it was in special measures. Let's say it was in maternity services, for the sake of argument. Regarding the exchange of information—not the detail of what the investigation was on—it would be important that we knew, before we went in to do an inspection, that there was an HSIB review taking place of a particular incident. We wouldn't need to know the incident, but if it was in maternity, we would need to know that there was a review taking place in maternity, because otherwise we wouldn't be able to discharge our responsibilities

about accessing how well led a trust was, if there was information about its information, openness and culture that we were not aware of because we had not been advised and informed.

Q4 **Chair:** You seem to be saying conflicting things. On the one hand, HSIB should have a duty to disclose information to you, but it should not have a duty to disclose anything that would be detrimental to the safe space.

Sir David Behan: If I can just stick with the example of maternity services, where clinician X had caused harm of injury to patient Y, I don't think we need to know any information about clinician X or patient Y. We would need to know that there was an incident in maternity that was subject to a review. So I draw a distinction between the detail that should be within the safe space and the general issue, which should actually be shared. That is why I would say there is a general duty to collaborate. That is the distinction I would make.

Q5 **Chair:** In the parallel organisation, AAIB, everybody has a duty to co-operate with AAIB, but AAIB does not have a duty to co-operate with anybody.

Sir David Behan: I think there is a question—I am sure the Committee has explored this—about how and whether aviation and health are similar industries and whether they are different industries. I would put it to you that health is a slightly different industry and is more complicated and there are more actors in the area of safety, the CQC being one—there is also the work that Kathy and her team do at NHSI. We just need to be clear what the respective roles are of the different bodies. That is the point I would make.

The model that runs through my head is our engagement with a Morecambe Bay hospital, Furness hospital. I have tried, knowing that case as I have done over the six years I have held this job, to say: if HSSIB had existed when the deaths began to take place at Morecambe Bay, how would that have worked and how would it have worked alongside our regulatory oversight? I think there is an important issue about the exchange of information between those bodies so that we can each discharge our responsibilities, because we have slightly different responsibilities, in the common interest of patient safety.

Chair: We will reflect on that.

Q6 **Mr Jones:** What would you say is the gap in the current inspection and investigatory system that requires filling by the creation of HSSIB?

Sir David Behan: That is a really important question, if I may say so. In the six years I have been doing this role, a number of individuals have come to us wanting their individual circumstances investigated. The CQC does not have the powers to carry out individual investigations of circumstances. Potentially, the ombudsman might have those powers, but if the ombudsman chooses not to exercise some discretion about individual investigations, the individual might not get satisfaction—there might not be an individual investigation. One thing that is being done is the filling of a gap around individual investigations. The other is the creation of the space that is about learning and how system-level messages or practice-level messages can be assembled, identified, codified and then distributed. That's the gap that's being filled.

Dr McLean: The other thing is the quality of the investigations that currently take place. HSSIB's processes and learning around investigations and having high-quality investigations will improve the quality of investigation across all organisations, because of the way they will share their information and then, potentially, train and advise people on how to do it. That will gradually push up the level of overall quality. As I said, if 24,000 incidents need investigating, they are never going to do all of those.

Sir David Behan: May I add something on your question, Mr Jones? One thing that we found in a piece of work we did last year on the deaths review was that the standard of investigatory skills across trusts is quite low. It is not a regulatory gap, but one of the advantages—this is the point that Kathy has just made—is that there will be a general levelling up of investigatory skill as a result of a body that is set up to set an example of how investigations should take place.

Q7 Mr Jones: The Bill contemplates the accreditation of local trusts to carry out work on a devolved basis from HSSIB. What are your views about that?

Dr McLean: I think the accreditation is particularly around being accredited to have safe-space investigations and I think our view would be that, in the first instance, HSSIB can do some work on safe space themselves and learn how that works before it is actually rolled out. We should not underestimate the amount of time, resource and effort that will need to go into accrediting individual trusts, but I think it's a direction of travel that we would support. We would, I think, support the idea that HSSIB should do this themselves first and then work out how best to do it in an organisation. You would need the right culture in a trust before you could even start to do it.

Q8 Mr Jones: In terms of culture, do you have concerns about what might be perceived as a conflict of interest by the wider public?

Dr McLean: A potential view from the public could be: how could an organisation independently investigate? That, again, is around the culture and developing that, and it's variable across the NHS at the moment, of course. Some organisations have more of a learning and safety culture than others, so again, I think you would start with the better ones.

Q9 Mr Jones: Do you believe that the accreditation of local trusts will change their approach to addressing and resolving patient concerns?

Dr McLean: Yes, I think so, but I think that you need to try it and see what happens and build up the experience. In principle it should do, but it needs to be built into the overall learning culture.

Q10 Mr Jones: And rolled out first to the better trusts?

Dr McLean: Yes, so start with HSSIB itself and then select a small number of trusts that already have a track record of good safety culture—probably partly based on David's organisation's assessment and other things that we know around them.

Q11 Mr Jones: What additional resources do you think that trusts would require to develop their investigatory powers?

Dr McLean: If they are to do really good, high-quality investigations, they will need some more dedicated resource. At the moment they have a lot of people doing investigations, not all of whom are trained, so they would need time for training. One thing that HSSIB brings is people who are highly trained investigators. This would need to be gradually developed within organisations.

Q12 **Mr Jones:** If I may say so, you sound a bit lukewarm toward the whole idea of actually devolving this to trusts.

Dr McLean: No, I am not lukewarm to it, because trusts are already doing investigations. They will have to continue doing them—that is the nature of things—and I am very keen that we raise the quality. I am not lukewarm, but I just think that we need to be realistic on the timeframe for the roll-out. It is better to do it well than to do it fast.

Sir David Behan: I support that, if it helps, Chair. The key issue, in our experience, from the perspective of many patients and service users, is having trust and confidence in the body carrying out the investigation. The challenge of trusts being accredited is that they will actually carry out investigations into their own work, which I think will erode public trust and confidence.

On Kathy's point, establishing the standard to which investigations should be conducted is the important first step that HSSIB can bring through. I think there is a general requirement to develop the capability and skills at a local level to carry out investigations to that standard, and I think HSSIB can assist people in raising that standard. The permission for local organisations to carry out these investigations should be on the back of public trust and confidence in the general raising of the level of investigations.

As Kathy said earlier, the NHS is notified of something like 24,000 serious incidents each year. It is not possible for one body to investigate 24,000 incidents, so we have to look at how trusts themselves can grow the capacity and capability to do that work, with HSSIB doing a number in a year of the more difficult, complicated and contentious investigations alongside a general improvement in the culture. Local activity is key, and in a way the 1,000 maternity investigations being done at the present time keep HSIB's badge of independence and can generally lead to an improvement in the way that investigations take place.

Peer reviewers will be used. They will come in from the service and will be trained to the standard of investigation. When they have finished that review they will go back to their jobs. That should generally help to raise standards. We have experienced great progress from specialist advisers—current clinicians—being members of our inspection teams. They help us, and they then take their learning back to their trusts, which drives improvement in those trusts as well. A model that gets at people going backwards and forwards between review and service practice can lead to a general improvement in the overall quality of investigations.

Q13 **Dr Whitford:** Obviously we are talking about the interaction with the CQC. You mentioned that you would expect HSSIB to let you know that a review was happening, although not the guts of it. If you had inspected and then hear that there is a review, would that be likely to lead you to doing a re-inspection?

Sir David Behan: It could well do; that might be one of the triggers. The incident that should trigger a review would be a notifiable incident, so we should know about it anyway. It might have been the incident itself that triggered a further inspection. That would be one of the possibilities.

Q14 **Chair:** Can I just chip in? You have a category of notifiable incidents?

Sir David Behan: Yes. If there is a serious incident in any of the services that we regulate—

Chair: Who defines what a serious incident is?

Dr McLean: The patient safety team, which sits in our organisation, oversees all of that. Serious incidents are defined and reported through a system called StEIS, which you may have heard of, so therefore they become visible and available for us and CQC to see. They are put in by the trusts themselves, there are definitions that are set out—

Q15 **Chair:** Do you share that information with HSIB?

Dr McLean: Yes, they have access as well.

Sir David Behan: We make sure they have access to it.

Q16 **Dr Whitford:** Obviously, in our discussions with HSIB themselves, they talk about how sometimes it will not be those notifiable major incidents, but a theme of moderate or even accumulative minor ones. They may still be doing an investigation that would not automatically have triggered your attention. Would that tend to bring you back? Some of the big issues around a Mid Staffs or Morecambe Bay are a kind of simmering failure going on in the background.

Sir David Behan: It could do. I can think of many examples where a number of incidents, rather than one single incident, have triggered us to go back and do an inspection in a trust. I would say that a duty to collaborate—a memorandum of understanding that said under what circumstances we would exchange information—is exactly what needs to be in place. There are the memorandums of understanding that we have, for instance, with the Parliamentary and Health Service Ombudsman, the Local Government and Social Care Ombudsman, NHSI and the GMC. It may well be that an incident like the ones you are referring to might sit alongside some other information that we hold about what is happening in a trust, and we need to assemble that intelligence. It is that intelligence that triggers whether we should go back and inspect.

Among all of us who operate in the area of patient safety, the responsibility to exchange information is absolutely essential if we are to discharge our responsibility. Going back to Morecambe Bay, we were criticised in the reviews that took place for not sharing information. What we need to do, as we introduce another body into this area, is to ensure that all the bodies collaborate with each other and share that information, without breaching the confidentiality and trust of that safe space. That is difficult to do, particularly if patients want accountability—“Who is to blame for what has happened to me?”—but it is nevertheless essential if we want to drive a culture of improvement and learning. That is a balance to be struck.

Q17 **Dr Whitford:** Most people who have worked in the NHS recognise that, in actual

fact, patients really want to know that learning will come—often, surprisingly, more than blame. It is when they feel that that does not happen, or they do not get answers, that they then pursue people.

Sir David Behan: That is absolutely our experience. That is why the point about the importance of the duty of candour and not being fettered is essential. The evidence, not just from here but from other countries, is that if that duty of candour is used and people are told at a very early stage what happened, why and what the consequences are, many people are often satisfied with that understanding and that sense that there will be learning that will benefit others. It is when they feel they have had to fight to get the truth that they then want to know who is accountable.

Q18 Dr Whitford: You have referenced this, Dr McLean, but can I ask you how the learning will actually come, and how it will change practice on the frontline? My concern about the Bill is that we will just end up with acres of information about incidents, but how do we make things change right at the coalface, in wards and theatres?

Dr McLean: Absolutely. That is one of the things we are concerned about, with all the things and recommendations that come out of investigations now, and patient safety alerts and so on: how are things implemented? There are a number of aspects to this. First, HSSIB needs to make sure that the recommendations are clear and simple, and straightforward to do, but also that they involve our patient safety expertise early on as they are developing their recommendations, so that we can be clear what good practice is and whether it will work, so there is some chance of it actually happening.

Then, there is a range of things that need to happen. If it is for a trust, we need to be clear that boards are held to account for the implementation, and we have a role within that, but CQC have a clear role as well in ensuring that things have taken place and they can inspect against that. It is a challenge that we all have on this. Quite recently, we set up a new committee to look at all the alerts that go out, to try to ensure that they go out in a single way and that we have a follow-up. We need to work closely; again, it comes back to collaboration and co-operation with HSSIB and having them share that information with us so we can help them to make it as doable as possible, and then we follow up between us on whether those things have actually happened.

Q19 Dr Whitford: Obviously if there are too many alerts, they stop being seen. It is like a snowstorm. Do you have patient safety champions in wards and on the frontline who are there to receive them and turn them into reality? That is what made the difference in the Scottish patient safety programme. We had theatre nurses, ward nurses and so on involved in the whole mechanism.

Dr McLean: Again, it is probably slightly variable in different organisations, but certainly at board level in a trust, clearly the medical and nurse director—and the whole board, of course—will usually have the responsibility to ensure that those things happen. Then, through the different parts of the organisation, they need people who take on that responsibility themselves. The word “champion” is really important, isn’t it? It is people who are really enthusiastic and passionate about it, and who do it not just for the sake of compliance, but because of a commitment and a genuine sense of patient safety. We have examples of organisations that have been working on the Virginia Mason-type approach—we were just

talking about some of the trusts—which is a culture of constant safety and putting the patient first. That sort of thing, where we are building that up, is really important and it will land better.

Chair: My colleague Mr Jones has very kindly said that he will remain, so we have a quorum and we can continue to ask questions. If anybody else wants to ask a question, please carry on.

Q20 Lord Kirkwood of Kirkhope: Because this is the first public session, I would like to register my interest as an adviser to the General Pharmaceutical Council. I am chair of its advisory revalidation committee. That is not relevant to the question I have to ask.

Chair: You might ask about that, though.

Lord Kirkwood of Kirkhope: Actually, that is a good point. I wanted to ask whether you believe that the impact of the Bill will have some bearing on the way that we deal with NHS staff shortages, particularly in practice settings where junior doctors are being asked to do things that are not safe in terms of the scope of work they are doing. Do you think the Bill will produce learning points that will deal with that effectively? That is quite a big issue within the culture of the NHS.

Sir David Behan: My personal view is that we will need to wait and see how HSIB discharge their responsibilities. They have been going for a while and they are just about to publish some of their reports, as I understand it, so I can probably give a more informed view then. The way I would answer your question is that I think they should have the freedom to do that. The point of this is to look at what are the influences on safety. If staffing levels are an influence on safety, and they are independent, they should be free to make those recommendations. That goes back to your question, Dr Whitford, about how we might need to change some of our methodologies based on some of their recommendations at a national level. Equally, it might be something that we would follow up with a trust at a local level. But you cannot say there are no-go areas. If you want to look at safety, they have got to be able to look at the way that organisations are operating, the culture, the openness—a lot of the things that we have flagged up.

If you look at the work that we have done over the last six years, the biggest issue that we flag in NHS trusts is: what is the culture of safety? That does not mean that trusts are unsafe, but what are the systems by which, when something goes wrong, learning takes place that then drives improvement? That goes back to the previous question. I would expect them to do that, and, in fact, I suspect you would have something to say in these two Houses of Parliament if they did not.

Dr McLean: Yes, I agree. We will know more when they have published a few of their investigations, and we will see whether they touch on that. I would be very surprised if, as part of the systemic findings around safety, they did not come up fairly soon with something related to staffing, whether that is doctors, nurses or other staff, and they should be able to make recommendations related to that.

Q21 Chair: I think it would be a good idea to ask about pharmacies. You do not inspect

them, do you?

Sir David Behan: No. We inspect pharmacies that are in trusts, but we do not inspect independent pharmacies.

Q22 Lord Kirkwood of Kirkhope: That is an interesting question, because community pharmacies get NHS grants, directly or indirectly, so there is public money in community pharmacies and people can get killed by inappropriate dispensing decisions. It may not be systemic and it may be unlikely, but I think there is an element of confusion about whether the Bill extends to them. It certainly covers hospital pharmacies—

Sir David Behan: Sorry, I thought the question was: do we cover pharmacies? We do not cover pharmacies. I entirely agree with the point that you are making.

Dr McLean: My understanding of the Bill is that anywhere that is delivering services funded by the NHS is potentially covered.

Q23 Lord Kirkwood of Kirkhope: Where the writ runs? It is the delivery of the public money.

Dr McLean: Yes. If it was care being delivered in a nursing home that was being funded by public money—the NHS—that would potentially be part of it. We do have to remember that HSSIB are being set up to do up to 30 investigations a year, so there are likely to be ones that cover a range of issues that come to their attention initially.

Q24 Chair: I have one more question. Sir David, you have talked about the need for the CQC's regulatory model to shift its focus to entire health systems. Why is that?

Sir David Behan: For clarity in the record, this is not to shift from and to, but to expand into, so this is as well as.

What do we do? We look at services that are delivering services to people with complex conditions. These are older people with two or three complex co-morbidities, or seriously disabled children who are being treated by three, four, five or six services at the same time. Very often, it is not just one organisation or one institution. I think Lord Kirkwood's question is behind this as well—what is the scope of the Bill?

If we look at how people with complex co-morbid conditions are going to be served by health care and social care services in the future, it means that more than one agency needs to operate together. Where care breaks down, it is often in the hand-offs between different bits of the system. The reason we want to be given the power to look at the system is so that we can look at how the system is operating as a whole and those hand-offs are taking place. If you are an 84-year-old with dementia and a fractured neck of femur who lived at home until that fracture, how does that take place? Or you have a profoundly disabled child and you are caring for that child and they are in the education system and they need acute care, community health care and some social care support—how does that operate? Does that system operate in the interests of those individuals and those families or in the interests of the people providing the service? That is why I have asked for that power.

I think Kathy's point and Lord Kirkwood's question around following the money is critical, because as we read the Bill as proposed, it is proposing to follow the money—the NHS money. That is something that we were just talking about as we prepared to come in. Well, the NHS money buys continuing healthcare in care homes. It buys nursing care in care homes. So, if it is going to follow the money, it means the scope is open, which is much more of a system rather than looking at the system.

Q25 Chair: So HSSIB should have the same scope.

Sir David Behan: I think you need to look, in setting up a body, at how you future-proof it. The difficulty with any legislation, which is not a criticism as it applies to us, is that the minute the legislation is passed, it is out of date. How do you future-proof something that anticipates development? The development is that in order to meet complex need in the communities that they serve, health and care systems will need to collaborate. If they need to collaborate, you are going to get safety problems at the interfaces between those institutions.

Q26 Chair: It has been put to us that HSSIB should be able to investigate any incident where the investigation would have a patient safety benefit. That seems to be a fairly good yardstick.

Sir David Behan: I think there is an issue about scope and, as Kathy said, about the scale and size, and what it is you want a national body to do and what it is you want the organisations themselves to do to embed that learning. It is not for me to suggest what you should do, but I think what you are trying to do in the Bill is to strike a balance between a national body that will take a lead in some of this, while embedding the culture in the local bodies—

Q27 Chair: In terms of what HSSIB should investigate, it should be the whole system.

Sir David Behan: I think the scope should be that they have the freedom to look at the whole system, because that is how an 84-year-old with complex co-morbid conditions experiences the system.

Q28 Dr Whitford: This is to Kathy, coming back to the idea of learning and champions. Obviously, in Scotland we have the national patient safety system. Because it started in theatres I saw the biggest changes right at the start: the pre-flight checks, the time out, and all of those kinds of things. This is talking about investigating when things go wrong and, hopefully, learning from them, but as NHS Improvement, would this be balanced by actually trying to create a different culture at the frontline, so that we had fewer things to investigate?

Dr McLean: Yes, absolutely. The clue is in the title of improvement. That is the space that we operate in and support organisations to improve, particularly those that are most challenged, to be fair. We share good practice. We do that by a range of things: events, the internet and so on. We go out and visit, not inspecting in the way of David's organisation, but we visit an awful lot and support organisations to share that practice.

Q29 Dr Whitford: Do you have a national programme? That is obviously what made the difference in Scotland, getting ordinary frontline people involved and creating a national culture change at the frontline.

Dr McLean: I am familiar with the Scottish situation; I have been up to visit. We have something called safety collaboratives; we have 15 of those that cover the whole of England. They have been in place for about five years now. They are endeavouring to try to do some of that but we have multiple different methodologies. I have to say that I like the way that you do it in Scotland. I think we are developing as we go along and it is a big job. We are rather larger and that is one of our challenges. I do take the point, yes.

Q30 **Dr Whitford:** Breaking it down—you are talking about 15 collaboratives—does make more manageable sizes. It was just to confirm that there was something happening from the frontline back, whereas unfortunately—

Dr McLean: Oh, yes, definitely. There is a tremendous amount of engagement at the frontline, and also sharing within and across collaboratives. A very good example is the checklist for emergency care that came out of the south-west and has been used across the whole nation this year.

Sir David Behan: We see this in our inspections. I was sharing with Kathy that I had been down with Ted Baker, the chief inspector of hospitals, on Friday to Surrey and Sussex Acute Trust to look at their quality improvement work. A significant number of their initiatives were in relation to patient safety and they were engaging everybody from the ward clerk through to the chief executive. I have to say it was both inspiring and stimulating to see what they were doing. These were the people themselves describing how they were making a contribution to making that place a better hospital with better care and better job satisfaction for the people who work there as well.

Q31 **Dr Whitford:** It is important to empower the whole team, which is very much what the theatre end of our patient safety does; everyone has to be happy that we are about to do the right thing to the right person.

Sir David Behan: The risk is that national organisations take that away from local organisations. Striking the balance to keep it locally as well as getting the satisfaction nationally—I think that is the balance that needs to be struck.

Q32 **Chair:** Thank you very much indeed. I think we have covered everything we wanted to but, if you have other points that you would like us to take into account, please do drop us an email and we will certainly do so.

Sir David Behan: I think you have asked for written evidence, Chair, so we will supply that as well.

Chair: Thank you very much indeed.

