



HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

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

Monday 11 June 2018

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Written evidence from witnesses:

- [NHS Providers \(SIB0023\)](#)

Members present: Sir Bernard Jenkin (Chair); Baroness Billingham; Baroness Chisholm of Owlpen; Lord Elder; Diana Johnson; Mr David Jones; Lord Kirkwood of Kirkhope; Andrew Selous; Baroness Watkins of Tavistock; Dr Paul Williams.

Questions 33-92

Witnesses: **Niall Dickson**, Chief Executive, NHS Confederation, and **Chris Hopson**, Chief Executive, NHS Providers, gave evidence.

Chair: Welcome to this session of the Joint Committee of both Houses looking at the draft legislation for the Health Service Safety Investigations Body of the Department of Health and Social Care. Can you introduce yourselves for the record, please?

Niall Dickson: I am Niall Dickson, chief executive of the NHS Confederation.

Chris Hopson: I am Chris Hopson, chief executive of NHS Providers.

Q33 **Chair:** Can you each explain, in a nutshell, what your reaction to this proposal is and how you expect HSSIB to fit into the wider architecture of health services in England?

Niall Dickson: I am happy to start. First, adding to the constellation of national bodies regulating the health service is unlikely to cause wide cheer. This is a crowded regulatory space and it is important that we don't impose more unnecessary burdens on the healthcare system. The key question is what are we trying to achieve? Certainly, from all that I have read of the background to the Bill and everything else, a lot of this is about trying to change the culture within the healthcare system. The way in which HSSIB operates will be critical in terms of whether it is able to achieve that cultural change. Our tentative view is that the creation of HSSIB could help, but it needs to do three things. First, it needs to improve the quality of investigations within the national health service, which we would acknowledge is

patchy, variable and sometimes not very good. Secondly, it needs to foster that culture of openness. That is quite difficult, because it is something that is nationally set up and may feel imposed on the system, yet you are trying to achieve a culture the other way round. Through those it needs to help to create a safer healthcare system.

I will make two other two brief points. The medical profession is in an extremely difficult place at the moment. In answer to the underlying question of whether the draft Bill will help to create a more open and transparent culture—I accept that it has a long way to go before eventually becoming legislation—at the moment it could not be a worse time. I actually think that we have regressed in how people feel about both being a whistleblower and about raising concerns about themselves. Both those areas are now more problematic as a result of the Bawa-Garba case.

Chair: We will follow that up in a moment.

Chris Hopson: There is a clear gap that the draft Bill could fill, and which Ministers originally said it was set up to do, which is effectively to conduct a small number of systematic reviews that look at serious incidents where there have been failures across a number of trusts. For example, trust A, trust B and trust C might have the same problem, but it might not be apparent to the system unless somebody is looking at that systemic level. That is an obvious gap.

Clarity on what this organisation is going to do seems to us to be really important. One observation I would make is that there is a distinct lack of clarity on exactly what casework this organisation will take on. There are five or six different answers to that question, and to be frank, that makes it very difficult to ask where exactly this organisation will fit.

Chair: Right, okay. Those are very interesting challenges for us.

Q34 Lord Kirkwood of Kirkhope: The witnesses may want to body-swerve this question, because it is a bit unfair to ask. The Committee will be interested to study the report published today by Professor Sir Norman Williams. Do you have any immediate reactions to that, in terms of corporate manslaughter and the important recommendations that that report seems to make?

Niall Dickson: I gave evidence to the Williams inquiry. I have only had a chance to look at it. My response would probably not be as the chief executive of the NHS Confederation but from my previous role. For very obvious reasons I do not think the recommendation on the right of appeal is the correct one.

As I reflected in my opening remarks, the challenges that the Williams inquiry and Dame Clare Marx's inquiry are attempting to begin to address are very serious and affect the organisations Chris and I represent very significantly at the moment. Any industry that has a group of individuals who actually do the work and in many ways spend most of the money and are affected as deeply as they are at the moment would be a real cause for concern. That is something that we all need to address collectively.

Chris Hopson: We have a real worry at the moment that, for perfectly understandable reasons, and as is reflected for us in the underlying thinking behind the Bill, everybody is

focusing on the needs of patients, which are clearly paramount in the health service, but nobody is thinking about the requirements of trusts and the obligations placed on them. If you ask a trust about what it does when something goes wrong, learning from that event is clearly pretty fundamental. However, we seem to forget that trusts have a number of other obligations that they have to meet, which it seems to us are potentially cut across by the draft Bill and by some of things said in the Williams review.

If you ask a trust's chief executive about what they need to do as a trust when something goes wrong, they will say that, although of course they need to learn, they also have duties as an employer and need to ensure that they can be confident that the people providing care can carry on providing the right quality of care. They have a set of statutory duties to liaise with, for example, the police, the coroner's court, the Health and Safety Executive, the Nursing and Midwifery Council and the General Medical Council. They also have duties to the patients in answering complaints, as well as—because they are managing public money—to assess and manage the liabilities that may be incurred as a result of an incident.

What worries us is that the Bill and some of the activities that HSSIB is now being asked to undertake seem to focus on the view that this is all just about learning from incidents. Of course that is important, but a trust is trying to balance a number of different statutory obligations that come from a number of other different Acts of Parliament and regulations. Unless we enable trusts to discharge those responsibilities effectively, we are in danger of preventing them from meeting other bits of law that they are required to meet. At the moment, in all the documentation around the Bill and in some of the stuff that has come out today, there is, for us, very insufficient reference to and understanding of the fact that those trusts have a broader range of responsibilities. Certainly, HSSIB is purely focused on learning from incidents, but trusts have a much broader range of responsibilities. We are worried that the Bill does not reflect that, and that improvements are needed to reflect the fact that those obligations are placed on trusts.

Q35 Baroness Billingham: I have struggled in our previous meetings, because I have no history at all in healthcare, but the article that appeared in *The Times* today is the sort of thing that will raise public interest. This is the first time I have been able to get hold of something that I fully understand and have sympathy with. I want to know how this very good article, which has appeared in most of the national press today, is going to affect the future of the inquiry that we are taking part in.

Chris Hopson: We know that what currently goes on is that a number of incidents happen inside trusts. Chair, when your Committee did its report in, I think, 2015, it identified that there is uneven handling at the trust level of how those incidents are then investigated. If I may, I want to keep coming back to the point that trusts have a number of different things that they are trying to do when there is an incident and something goes wrong. We need, collectively, to ensure that when the Bill is passed, trusts can continue to discharge those responsibilities.

Q36 Baroness Watkins of Tavistock: Medicine mistakes and equipment mistakes are reported centrally, so you would pick up if the same piece of equipment was not doing its job in Rotherham or in Caterham. Are you suggesting that that is what you would want from this Bill and this structure—that you would get your human factors reported centrally, and the investigation would be into human factors against a

particular incident?

Chris Hopson: What we are suggesting is this. The Bill gives HSSIB a wide range of enabling powers to do a number of different things. We believe that the way those powers are potentially exercised means that trusts cannot fulfil their accountabilities and responsibilities under other parliamentary Acts.

Q37 **Chair:** Could you give me an example of that?

Chris Hopson: It was announced recently, in November 2017—since the Bill was published—that HSIB would undertake investigations into a complete category of incidents.

Q38 **Chair:** It is 1,000 prenatal deaths.

Chris Hopson: The maternity incidents. It is all cases of intrapartum stillbirth, early neonatal deaths and severe brain injuries from 37 weeks' gestation, as well as direct or indirect maternal deaths in the perinatal period. Crucially, those investigations, to be undertaken by HSIB, are intended to be the primary and, as far as possible, the only investigation of the individual case. If something goes wrong in a hospital, the hospital is no longer allowed or enabled, as part of what is happening under maternity deaths, to do its own investigation. Its ability to make a decision about whether the staff are continuing to provide safe care, its ability to liaise with the coroner's court and the police, and its ability to argue a complainant's response seem to us to be, potentially, put in jeopardy.

Q39 **Chair:** What discussion have you had with HSIB about this?

Chris Hopson: We have had a number of different discussions with HSIB. To be fair, at the moment it is in the process of rolling out the maternity death investigations. As you know, that was starting in April 2018. The issue for us is that those investigations have arisen as a result of Secretary of State directions. Effectively, the Secretary of State appears to have been able to direct that HSIB should undertake those investigations instead of the trust—not in addition to the trust. No one is arguing about the need to do the 30 investigations that look across multiple instances of outcome impact, systemic risk, and learning potential.

We all agree that HSSIB has an important role in that systemic learning, but if it has the power, as a result of the Secretary of State exercising his power under clause 4(2) effectively to ask HSSIB to undertake investigations, to say that it will take responsibility for those investigations and the trust is deprived of the opportunity to undertake those investigations, we believe that trusts cannot discharge their other statutory responsibilities.

Q40 **Chair:** I detect two issues in what you are saying. First, if it is the intention that HSSIB should preclude any other investigation, that needs to be made much more explicit and the other obligations that you have need to be lifted from you to allow that to happen.

Chris Hopson: Absolutely right, Chair.

Q41 **Chair:** Secondly, to what extent should the Secretary of State direct HSSIB?

Chris Hopson: There are two different issues, and they are both important. First, I was surprised when I read the impact assessment, because I assumed that the Department of Health would say that these are the impacts of the way in which the Bill and the

organisation are intended to operate and this is how that will affect trusts in the exercise of their other statutory responsibilities. I was expecting to see somewhere in the impact assessment a list of all the things that a trust needs to do if there is an incident, as well as how HSSIB, working in its way, might cut across those. We think—and we would like to send you a formal letter on this—that the Committee should ask the Department to do a piece of work that has not been done, to set out very clearly where the Bill and the operation of HSSIB might cut across, and in our view will cut across, activities undertaken by trusts.

Q42 Chair: That is all very clear, and I am going to press on. I am grateful that you are going to write to us.

Chris Hopson: Can I deal with the second issue very quickly? We believe that there is a strong case to amend the Bill to make HSSIB responsible to Parliament, rather than to the Secretary of State. We are concerned, particularly given the broad power in clause 4(2) that allows the Secretary of State effectively to suggest inquiries to HSSIB, that there is a potential conflict of interest. It is better, as is the case with other arms-length bodies in the health service, to report to Parliament, not to the Secretary of State.

Q43 Chair: I think that that was the original intention of the PASC report. Can we move on? The next question from me is about the relationship that HSSIB would have with trusts outside the investigation process. What kind of relationship do you think that it should have?

Niall Dickson: I think that the relationship outside the investigation process has to be around the improvement of investigations and the quality of investigations. That is where a clear need has arisen. It is important that HSSIB is not seen as a body that is trying to impose something on the system—rather, it is something that would work alongside and be supportive. It is more formative than summative in its relationship with those organisations. Strangely, if you look at the accreditation proposals, the idea is that people might be developed to do external investigations first, then allowed to do internal investigations, but it might be possible to look at that the other way round and develop them to begin doing internal investigations, and have those accredited, before they begin to wander around telling others what to do.

The relationship needs to be formative. We need to be really clear about the speed with which you can roll out any form of accreditation, what the funding is, and what the workforce availability is to do this. If it went too fast, there is a danger, particularly in the climate that I described at the outset, that this could not achieve what it aims to achieve. Taking it in steps and enabling it to do the 30 investigations—to get itself established first, before rushing ahead—and, secondly, acting supportively, perhaps setting frameworks and the like, to enable trusts to do better internal investigations, maybe accrediting those, might be better than having something that is seemingly imposed.

Q44 Chair: What about the idea that HSSIB staff should be embedded within trusts, and should therefore oversee the HSSIB investigations or the accredited investigations? In fact, what about doing away with the accreditation idea, and just having HSSIB doing the investigations from a local branch office, so to speak?

Niall Dickson: Again, I think there is a question about how far you want ownership. I think there are problems with one trust investigating another. Certainly, neighbouring trusts could

cause problems with that. In a way, if more investigations are badged with the HSSIB name—if it has that status—I think that is a good thing.

Chris Hopson: If a trust is to take responsibility for liaising with the coroner's court and the Health and Safety Executive, if it is to deal with a patient complaint effectively and if it is to exercise its judgment about whether its staff can continue to provide safe care, it surely must have responsibility for conducting the investigation itself.

The whole point about the 30 cases is that they are in addition to, and on top of, the original investigation that was carried out by the trust. What really worries us about the 1,000 maternity reviews that are effectively now proposed, and other investigations, is that they basically prevent the trust from exercising its other legal accountabilities. We would be nervous about HSSIB staff sitting inside the trust and doing investigations on behalf of the trust—

Q45 **Chair:** Unless the confusion that you talked about was cleared up.

Chris Hopson: One way in which it could be cleared up is by making it very clear on the face of the Bill that any HSSIB investigation is not intended to replace a local trust investigation, for example. There are a number of different ways you can do that, but at the moment, our members are seriously concerned about the fact that they cannot do the other things that Parliament has asked them to do.

Chair: Okay. I have got that.

Niall Dickson: There is a difference between doing the investigation and either accrediting something or kitemarking it—I think that might well be acceptable within trusts—and HSSIB coming in and doing the investigation. If you had a kitemark system, where a trust would aspire to follow this particular model and therefore their investigation and their safe space and all those kinds of things that we are trying to achieve were approved, as it were, by HSSIB, I think that is different from their coming in and actually running it themselves.

Q46 **Chair:** Sorry to pursue this, but do you think that trusts would be trusted with the safe space, which we will come to later, unless there is a—

Niall Dickson: If trusts are not trusted with the safe space, we might as well pack up and go home. That is the whole point: we have to change the culture.

Q47 **Baroness Watkins of Tavistock:** The draft Bill limits the scope to NHS services. How appropriate do you think it would be to extend the scope to privately funded and provided care, partly because some NHS care is contracted?

Niall Dickson: We are concerned with the safety of patients. Whether it is provided by an independent sector provider or an NHS provider, if it is NHS care it comes under the NHS. It should be a level playing field and they should be treated the same.

I think there is an issue about “private” private, as it were. I still think the scope should cover it, but you may want to charge them appropriately for those things. We are not experts on social care. Certainly you would want to talk to the social care sector about it, and so forth. Maybe, again, it is a question of learning how to walk before we start running.

Chris Hopson: The issue is that many care pathways go in and out of NHS private providers through social care. Effectively, we are saying that HSSIB cannot do its job unless it has the ability to follow that whole care pathway, but that does not mean that somehow it should become a body that is equally concerned about social care. Our view would be that the scope should allow it to follow the pathway, wherever the pathway goes.

Q48 **Baroness Watkins of Tavistock:** From the learning disability problems in the south of England that would be very clear, wouldn't it? You would not get at it otherwise.

Chris Hopson: Yes. That is the way we organise and run the NHS effectively: with the ability to follow the pathway. Not allowing HSSIB to follow the pathway does not make sense to me.

Q49 **Baroness Chisholm of Owlpen:** Following on from that, do you feel that the private providers would be willing to engage with HSSIB? Do you think they will be happy to be involved in that?

Chris Hopson: If you look at some of the powers inside the Bill, they are fairly clear that the private providers would need to engage with them. I would hope that they would do the same as NHS trusts. As we were saying earlier, we think there is a very important role for HSSIB to play in training, educating and developing investigators. If you talk to our chief executives, they say that that investigation task is complex and difficult and requires specialist skills. I think they would be the first to admit that they are finding it difficult to consistently train investigators to the required standard. We think that is where HSSIB has got a helpful role to play. To be frank, we would far rather the money that would otherwise be spent on the accreditation scheme was spent on doing that kind of training and educating and establishing best practice so that the quality of local investigations can rise. For me, that applies equally to private providers and NHS providers.

Niall Dickson: I think that people generally will want to engage with this. I do not think there is any question that people will try to move the other way, especially if it is seen as a positive or a badge of honour, rather than some kind of terrible thing. It is the same with any kind of safety thing; the places you worry about are where there is no sign of anything happening—the places where there are no investigations because they are not being open and transparent. I know that our members from the independent sector are and would be keen to engage in the process. If the accreditation idea goes ahead, they would be keen to be accredited as well as visited upon.

Q50 **Baroness Chisholm of Owlpen:** So one of the most vital things is the training up of investigators so they can investigate, which is not the case at the moment with a lot of trusts—they are not capable of doing their investigations.

Niall Dickson: There are a few who are doing really good things, but overall, we are at an early stage. There is the Royal College of Physicians training in the review process they have. Generally speaking, again reflecting on my experience at the GMC, the quality of investigations was extremely variable. We have got a significant way to go.

Chris Hopson: I just think we need to make the point that one reason why the task is so complex is that if you are in a trust, you have got a number of different things to do. If it was

just about learning, which is what the HSSIB role is, it would be much easier, but you have got all those other different things that you need to do. People understandably complain, “This process was handled badly, because it looked like the trust was trying to minimise its legal obligations. It looked like it was trying to protect itself in relation to dealing with other third-party bodies. It looked like it was wanting to work out whether its staff were able to provide safe care or not.” The reason why the processes do not just focus on the patient and are not just about learning is precisely that the trust has to do a number of different things at once.

Q51 Baroness Chisholm of Owlpen: I understand what you are saying, but as a humble nurse—Baroness Watkins was not a humble nurse; she was much grander than me—I remember that when you felt something was going wrong, one of the most difficult things was working out who to go to and ensuring that it was being listened to.

Niall Dickson: I think, to be fair, the professions, their regulators and the system as a whole have made an awful lot of progress. We should not ignore that. The days when, for example, a surgeon would have terrible results week after week and nothing was done about it—those days have gone. The professions themselves are more open. As I said, we are in danger of moving back. I know a lot of managers are concerned about what is happening now. Attacking that culture will be really important.

Q52 Andrew Selous: We are trying to move to more integrated, community-based preventive care. Earlier, you said that you thought HSSIB should be able to follow the patient, but you did not seem very keen on extending its power to social care. Is that your position?

Chris Hopson: I was arguing that if the pathway goes into social care, HSSIB should be able to follow it. We would be nervous about it somehow picking up a whole load of new cases that originated solely in social care, so that it became a health and social care investigation body. Our view would be that it makes sense to be able effectively to follow the pathway as needed.

Niall Dickson: I think we are in exactly the same place, but at this stage we need to get this bit right, and then, in time, we may be able to extend it later on and make it bigger, as it were.

Q53 Andrew Selous: But within the scope of the Bill, it should be able to go into social care, even if we just go cautiously at this stage.

Chris Hopson: If the pathway goes that way.

Chair: I think you are all saying slightly different things.

Q54 Mr Jones: You have touched on this already, but could you briefly summarise your views of the Government’s proposal that a small number of trusts should be accredited to investigate other parts of the health service?

Chris Hopson: I think we would be nervous about that, because it seems to us that the principle of the accreditation is the extension of local safe space. That is specifically, in the Bill, the reason for accreditation. If you go back to my argument that trusts have to do a number of different things when something goes wrong, I think there is a real degree of

nervousness among trusts about the extension of local safe space to investigations, because it could well compromise their ability to do the job that is required of them.

When a trust is dealing with the coroner's court or the police, it has a duty of candour, a duty of transparency and a duty or responsibility to fully reveal everything that it has, so that it cannot be accused of hiding things. I think that trusts are very nervous about what extending local safe space to trusts would mean in terms of any information that a trust, or any other organisation, might be gathering as part of that process. Will it effectively cut across the trust's ability to do the job that it is required to do? We are nervous that trusts will somehow be fettered from exercising those accountabilities properly.

It is not a problem if HSSIB is up there doing its 30 cases a year, where it builds on the local investigations. It feels to us like a different issue if you say, "Actually, another organisation is going to do that local investigation work," and potentially it will be doing it under safe space rules, which effectively mean that the trust cannot then use the information that is gathered to meet the other accountabilities that it has as an employer needing to account to third parties.

Q55 Mr Jones: Does that criticism still prevail in respect of investigations of parts of the health service other than the trust itself?

Chris Hopson: I cannot really answer for other parts of the health service; all I can say is what the trust perspective is. I just think we need to be careful about this. There is virtual unanimity across the piece that the HSSIB role of doing the national 30 cases a year and reviewing a bunch of investigations that have already taken place to find the common themes makes sense. We all agree there should be a national safe space to enable the learnings to really come out of that. I have had two or three conversations over the last week to 10 days with medical directors who have gone through that process, and who say, "Without that national-level safe space, we would not have got the learning that we needed." That is very different from a local investigation where the trust has an obligation to do a whole bunch of different things. I won't keep going on, but it is a really fundamental point.

Q56 Diana Johnson: Following on from the point you have just made, why would trusts put themselves forward for accreditation under the legislation as currently drafted? You have just explained to us all the reasons why it is not a good idea. Why would they? The note that we have had seemed to imply that a small number of trusts would be willing to put themselves forward.

With the pressures that trusts are under at the moment—everything they have to deal with—why on earth would they decide that they wanted to do this, unless, as you said, Niall, they saw it as a badge of honour? Do you have to persuade them of that in order for them to come forward and do it? What resources would they need, in addition to what they are getting at the moment, to do this effectively?

Niall Dickson: I do think it needs to be a badge of honour as opposed to avoiding shame, but I also think it has to be the right thing to do. I think there is a question mark over the whole accreditation model and how it might be rolled out. For example—Chris knows this well—there is a peer review system within local government that is very well established and operates well. When things go wrong, they get in teams from other local authorities to look at them. The difference here is that this is a different model. It is being imposed on the system and that will make it more difficult for it to be attractive. That is why, as I say, I would like a

form of accreditation of internal investigations that might have an element of safe space. I accept Chris's point that there are difficulties in how that safe space operates and how the other accountabilities work, but if we could improve the standards of internal investigations and improve the culture within organisations themselves, that is the key that we are trying to get to. I am not sure whether the current accreditation model necessarily gets there. It might do, but you would have to take it slowly and certainly first establish HSSIB itself. The 30 would be the gold standard that people could aspire to.

Chris Hopson: I don't think there is any evidence out there that we have seen of trusts expressing an interest to do this role. There are notes in the impact assessment that imply there might be a small number of CQC outstanding-rated trusts. However, there are some real complications around this. Exactly as you say, there is a real question about whether people have got the skills and expertise to do it. Again, we need to be careful here.

Chair: Just to be clear, I am going to stay in the Chair and we will finish this session. There is too much important stuff coming out. If one or two people have to leave, they have to leave, but I am staying.

Q57 **Mr Jones:** Mr Hopson has addressed this, but I would be interested to hear what assessment Mr Dickson has made of the response that the trusts have made to the suggestion that they may be called upon at some stage to investigate other trusts.

Niall Dickson: From our members we have not had an enthusiastic response and people wanting to come forward. We did have one trust where they already have a well-trained team of investigators and so forth, but they were not rushing to say that that is something they wanted to do.

Q58 **Mr Jones:** So it was a possible business opportunity, but no huge enthusiasm. Is that fair enough?

Niall Dickson: Yes, and the reason they had set up that team was to do their own internal investigations, not to start investigating others.

Q59 **Baroness Chisholm of Owlpen:** This leads on from that. Do you think trusts would rather be investigated by HSSIB or by another accredited trust?

Niall Dickson: We don't know the nature of the investigations.

Q60 **Baroness Chisholm of Owlpen:** Would they interact better with HSSIB?

Niall Dickson: It depends on the nature of HSSIB and how it behaves itself. From a patient's point of view, I suspect HSSIB would be a better model than one trust investigating another, because the perception would be, "Oh, well, it's all part of the club." I don't think that would be fair, but I think that is how it would be viewed.

Q61 **Baroness Chisholm of Owlpen:** Why don't you think that would be fair?

Niall Dickson: I believe that if a trust was setting itself up and it was accredited and it had the right people, they would do a thorough job, but I think the perception from patients of one NHS trust investigating another would not be the same as a fully independent inspectorate undertaking it.

Chris Hopson: Part of the problem is that it is not clear what HSSIB’s casework is going to be. We all know of the 30 cases that they talk about, which are there to identify systemic learning and to identify risk, particularly the cases of the highest potential risk. That is very clear. There has then been this announcement subsequent to the Bill, which I would just point out runs a coach and horses through the impact assessment and is directly contradictory to paragraph 51 of the impact assessment, which effectively says they are now going to do 1,000 cases of maternity deaths. There is then an implication in the impact assessment that HSSIB will replace the Francis review into Mid Staffs and the Morecambe Bay review. I noticed that when you had David Behan come before you last week, he implied that they would also look at particularly contentious or complicated cases. As I have already said, a power under clause 4(2) of the Bill allows the Secretary of State to ask HSSIB to look at cases. All I am saying is that we all thought this was just going to be the 30 cases, and we all agreed it filled a very important gap. We were all up for it, and we were all up for national safe space, but this organisation’s potential caseload seems to be mushrooming.

Can I make one very important point in relation to replacing the Francis review, the Kirkup review and the Morecambe bay review? It seems to us that a key part of those reviews was to establish accountability—who was responsible for the mistakes. They weren’t just about learning. There is a real question about whether HSSIB is actually able to do the job that a big national inquiry ought to be doing to establish accountability, when clause 2 of the Bill, I think, makes it clear that it can’t establish who is to blame. “Blame” is a difficult word, but if you hold a big national inquiry into something as big as Morecambe bay, Liverpool Community or Mid Staffs, it is absolutely vital that you can identify who is accountable. If HSSIB is prevented from doing that job—we think it might be under the Act—you have to ask whether that is a proper role for it.

The bit that worries us is that what HSSIB will be doing is not specified anywhere. Suddenly in November 2017, after the Bill was put before you, we get this massive extension of its powers. It is meant to be doing 1,000 cases, and it is recruiting loads of extra people. It has moved on from what we were all told it was—a small accident investigation board doing a small number of cases.

Chair: You are actually saying the same thing again.

Andrew Selous: But very powerfully.

Chair: We have got the message. Thank you very much.

Q62 **Baroness Billingham:** Both of you have touched on this question, but I would like to come back to it because I think it is very important. Bodies such as the Care Quality Commission include private sector providers and adult social care. The implication of this limited scope is that HSSIB would not have full powers, as you have said, to undertake investigations into incidents that occur in the provision of deeply integrated services. You have already touched on that.

Chris Hopson: We would agree—follow the pathway.

Niall Dickson: We would agree, too—absolutely.

Q63 **Lord Elder:** The issue of safe space seems critical. Should an employer be told that

one of their employees has contributed to a safe space investigation? It seems that, almost inevitably, if a report comes in in a safe space, the employer will begin to think, “I wonder who did this. I wonder where it came from.” How certain are you that, for employees giving evidence against their employer, or raising issues about their employer, the safe space is absolutely safe?

Chris Hopson: It goes back to the real issue of extending safe space locally. We think it is incredibly confusing for both the trust and the staff potentially to be trying to operate two different investigations under different rules. The trust has to be able to find out from its staff what has happened, and it has to be able to exercise its judgment about whether those staff are capable of providing safe care. In our view, it must be able to do that investigation without local safe space applying, because otherwise it won’t be able to do its job properly. Then you ask the question, “Okay, so it does its job. Can we run alongside that a parallel investigation, which is just about the learning and is just using the local safe space?” It feels to us, first, that that puts an intolerable burden on the investigators who may be trying to do both and creates potential confusion.

Secondly, staff will have to remember what they said to their employer in their local investigation, which is not covered by local safe space, to another investigator—potentially the same one—under local safe space. It is much clearer if you just say that local safe space investigations do not apply unless there is an extremely good reason for them. Again, one of the bits in the Bill where we feel there is a real question mark, is where—we were very surprised to see this—in the maternity investigations I have been going on for too long about HSIB effectively appeared to be able to turn off safe space. It is not clear to us whether there is a power in the Act to turn on and turn off local safe space, so our view would be that the safe space stuff is absolutely fine for the national 30 cases but you need to be really careful about applying it to local investigations, whoever does them.

Q64 **Lord Elder:** But do you not need some kind of mechanism to ensure that people who are willing to go and report what is going on with their employer are protected?

Chris Hopson: The reason safe space applies is that if you are doing something that is purely about learning, learning from mistakes and ensuring that you really get to the root of it, and something dreadful goes wrong inside a trust, if the trust conducts a local investigation and HSSIB decides that it is one of those 30 cases it wants to look at, in our view it is perfectly acceptable for them to then come in and say, “Right, just to really get to the bottom of this, we are going to conduct this investigation under national safe space and therefore you’re perfectly at liberty to come and talk to us”. But you cannot confuse the local investigation by the extension of the local safe space. It has to be kept in that national space for the purposes of finding out what has really gone on, or else you risk causing confusion.

Niall Dickson: I agree with that, but I think there is something about internal investigations as they are currently being run seemingly being simply around blame. So there is a need to improve the way—it may not be pure safe space, but we have had whistleblowers who have found themselves in the position they have been in and say that the culture of the organisation is not such that they are able to share or speak out, or indeed an individual who has made a mistake and feels that the weight of everything will suddenly come down on them. Those are very fundamental things that we have to try to tackle. That may not be pure safe space in the sense that it is defined in the Bill, but enabling trusts to create an environment in which

people feel able to do that and that will be looked at without it resorting to blame, is very, very important.

Chris Hopson: But just to make the point, if we start extending powers in a way that cuts across the trust's ability to, for example, ensure that its staff are providing safe care, we do so at our peril.

Q65 **Baroness Chisholm of Owlpen:** But do we not also have a danger here that we are talking about everything the trusts have to do but the point is that we are trying to improve where things have gone wrong? We cannot always think about how the trusts are going to feel.

Chris Hopson: Agreed—absolutely.

Q66 **Baroness Chisholm of Owlpen:** We also have to feel that we are creating an environment where people can come forward and talk about things that have gone wrong.

Chris Hopson: I completely agree with you, and that, as the Chair's Committee report showed, we are not very good at that. We need to improve it dramatically, and HSSIB, potentially, in its activities, particularly in training, education and improving local investigations, is providing a real opportunity to do that. However, if that is at the expense of trusts being able to meet their other formal accountabilities, that seems to us to be really dangerous and that is where we think we are potentially heading.

Q67 **Baroness Watkins of Tavistock:** We believe that having a safe space concept will enable people to be more open about what they have seen, and we know that that has worked in air traffic control and in the oil industry. I cannot understand why you are quite so protective of trusts. I have been a non-executive director for 10 years in two trusts. Surely it is about enabling the trusts to do their first investigation and put it to bed. I can see the complexity of the two happening at the same time. The real question is whether somebody, if they are the contributing to the national review or raising an issue to the centre, saying, "Our trust has come to a conclusion on this but I am still uncomfortable about it as a professional," should be protected, or whether they should tell the trust. That is what we are trying to get from you, which is slightly simpler.

Chris Hopson: We would agree entirely: if the trust has conducted its investigation and is able to meet its broader accountabilities, and then HSSIB comes in and says, "You are one of the cases we have identified where we want to do more," we would be perfectly happy for the safe space to then be extended, including to those local staff. The key issue is giving the trust the ability to do the work it needs to do, to meet its broad range of accountabilities.

Q68 **Baroness Watkins of Tavistock:** We have accepted your point on that. My question is this: say I am employed by this trust—maybe I am a ward sister—and you have done an investigation, but I still do not think that the trust has really taken it as seriously as it should. I believe that I have the right to tell HSSIB about this. HSSIB might then choose to look at our trust.

Chris Hopson: And so would I. I would agree with that.

Q69 Baroness Watkins of Tavistock: My question is, should I have to tell my trust if I am going to HSSIB? That is what we are trying to identify.

Chris Hopson: I am going to answer in a personal capacity: no, I think that is fine. I do not see why you should be required to tell your trust that that is what you are doing. Everybody has the right, if they think things are wrong, to whistleblow and to refer to the CQC.

Niall Dickson: Especially if you have raised it before.

Chris Hopson: Especially if you have raised it before, yes, of course.

Niall Dickson: If you have raised it before and you have not got a satisfactory answer.

Q70 Baroness Watkins of Tavistock: Absolutely; I don't think it should be your first choice.

Niall Dickson: No, but you absolutely should have the right.

Chris Hopson: I misunderstood your question the first time round—apologies.

Q71 Chair: I think we have nearly covered this. It has been a very interesting discussion about safe space. It seems to me that any clinician or member of staff who starts to be investigated by their employer—that could be a trust or, indeed, it could happen in a general practice setting or any other setting—has a duty of candour, but they might think, “I can't say anything, because I might be incriminating myself or this information might be used against me.” That person should be able to say, “I won't speak to you, but I will speak to HSSIB.” We have a question on the paper here about how a trust should treat an employee who raises a concern with HSSIB outside an investigation, but the safe space should exist all the time. If somebody goes to HSSIB and says, “I've got a concern,” that should be safe space.

Chris Hopson: Yes.

Q72 Chair: And if the trust demands information from somebody after an incident, and they say, “I'll speak to HSSIB, but I'd rather not speak to you. Can I go straight to HSSIB?”, what would you say to that?

Chris Hopson: Everybody should have the right to refer a case or a concern to HSSIB, the CQC or the Parliamentary and Health Service Ombudsman without any fetter, if that is what they want to do. I do not have a problem with that at all.

Niall Dickson: But they are all failures. Every one of those is a failure, because the trust has not—

Chris Hopson: Yes, I agree, because the trust has not done the—

Niall Dickson: The thing we should be concentrating on is, “How do you make internal investigations work much more effectively?” That is why I say it may not be safe space, but when I raise a concern about something, it should not necessarily trigger the world to come down upon me.

Q73 Chair: Why would it be a failure if somebody wants to talk to HSSIB and not the trust?

Niall Dickson: Because the trust has not listened to what they are saying.

Q74 Chair: Maybe the trust would listen, but the person concerned does not feel safe.

Niall Dickson: Because the person does not feel safe.

Q75 Chair: But once you are in possession of information that is not protected from freedom of information requests, not protected from subpoena by a court—unlike the HSSIB safe space—why is it a failure for somebody to say, “I’d rather speak to HSSIB, because I know I am protected there.”?

Niall Dickson: It depends, again, on whether they are talking about something they have done themselves, or something they are reporting. There may be a distinction.

Q76 Chair: Maybe something they do not want to accuse other people of doing in an incriminating environment, which is inevitably what a trust is because you do not have a safe space.

Niall Dickson: What I am trying to suggest is that, if we are going to tackle this, creating an artificial national safe space on its own will not solve the problem. What we need to do is to change the culture within internal investigations so that while, as Chris says, they may not be an absolutely pure safe space, they still enable organisations to fulfil their other statutory obligations. You need to change the culture in the way that that is done, so that I feel, as a ward sister, that I can raise that and that it will be dealt with fairly.

Q77 Chair: This is absolutely crucial: what you are saying is that the national safe space may well be necessary, but it is not sufficient.

Niall Dickson: Correct.

Chris Hopson: If we are going to change the culture, there is a whole bunch of activity that needs to follow—training, education, improvement of quality of investigations—and I do not think that necessarily means that local safe space is the right answer.

Q78 Lord Kirkwood of Kirkhope: It really is about staff shortages and people being asked to do things that they know are not safe practice—to be particular, junior doctors being invited to do a shift overnight with three bleepers when they should have one, because one bleeper is on holiday and the third one is off sick. Can safe space deliver effective remedies to situations like that, which are clearly unacceptable, where you are putting pressure on recently qualified junior doctors, whose career, if they say, “No, I’m not doing that. I’m going to report you”, will be—

Chris Hopson: Part of the problem here is that safe space means lots of different things to different people. Effectively, it is a global concept that can be used, like “integration”, to mean anything. If you talk specifically about the terms of the Bill, what the Bill is saying is that if you look at the information that HSSIB collects, it cannot be divulged to other parties unless a specific reason is triggered—that surrounds stuff about safeguarding and about

criminal offences being undertaken. So the reason why local safe space is really important and potentially dangerous is that, effectively, if the trust is not able to get to the bottom of what has happened because an investigation is being conducted under local safe space—I fear your wrath again, Chair—it is not able to discharge its other statutory responsibilities.

Q79 Chair: But that assumes that somehow the HSSIB is going to be obstructing the investigation of the trust. Actually, the HSSIB will be conducting the investigation and then reporting it to the trust. HSSIB would carry out the investigation better than the trust might be able to carry it out itself, because it has the access to the safe space.

Chris Hopson: But, as I hoped I had been able to convince you—

Chair: I understand your other points about conflicting investigations.

Chris Hopson: When you conduct an investigation—if you are in a trust—it has got a number of reasons that can apply. HSSIB does not have the same set of statutory accountabilities; all it is looking at is the learning. If you have a bunch of people looking at incident A from the perspective of “Let’s work out what the learning is,” and you are saying that that is the only way you can investigate—which is effectively what the 1,000 maternity deaths suggestion is—then the trust is prevented from doing all the other things that it needs to do, because it is relying on somebody who is just looking at the learning.

Q80 Chair: I am still a bit confused. Given that you want to investigate incidents for a patient-safety benefit, what other reasons might there be other than the patient-safety benefit?

Chris Hopson: Because you have a statutory duty to liaise with the coroner’s court and the police, you need to gather the evidence that you need as the trust to meet that obligation. You have a role as an employer to ensure that the staff who are involved are—

Q81 Chair: Okay. My understanding is that in other sectors where such bodies exist everything else waits; for example, in the aviation sector, the AAIB investigation of the Shoreham air crash pre-empted everything else. In the police investigation, the coroner’s court, everything else waited for the information to come out of the AAIB report. How happy would you be with that kind of power?

Chris Hopson: Let us assume that there is an incident and a suspicion inside the trust that the individuals involved are incapable of providing safe care. If the rules are as they are currently intended to operate—as far as we can see they are under the maternity deaths—you cannot do any investigation of that case because you have to wait for HSSIB to come along and do it. What we are basically saying is that HSSIB, when it undertakes its investigations, is purely looking from a patient-safety perspective.

Let me be even more pointed. This is slightly more difficult territory, so if you will indulge me, I would like to point out that the accounting officer for the trust essentially has the duty to limit the liabilities of the trust in the effective management of public money. Effectively, if we are saying that there is the potential for the trust to be taken to court, it is the trust’s job to ensure that it gathers the information that it needs in order to discharge that responsibility. If the investigation is being done by somebody else, the trust cannot fulfil that responsibility—

particularly if it is being done by somebody else for the sole purpose of gathering information to do learning.

Chair: I want to say something myself, but Baroness Chisholm has a question.

Q82 **Baroness Chisholm of Owlpen:** To me, this is all about the trust, not the patients or the person who has suffered.

Chris Hopson: Agreed.

Q83 **Baroness Chisholm of Owlpen:** That is not what this is about. This is about making sure that patients and people being looked after in hospital or in care or wherever it happens feel safer.

Chris Hopson: I agree completely.

Q84 **Baroness Chisholm of Owlpen:** You are coming from a different angle from where I think we are coming from. You are coming from a board-type angle, rather than a patient angle.

Niall Dickson: I do not think that these things are mutually incompatible.

Chris Hopson: They may be. Under the way that HSIB currently operates, we believe that they are incompatible. That is partly the problem.

Niall Dickson: I do not think it is at all clear at the moment how HSSIB will operate. That is the first point. The second point is, looking at how trusts behave and their obligations to manage public money, they also have an absolutely paramount obligation to protect patient safety. That is where the safe space stuff can actually run against that, as it were. Clearly, a trust would want to know if a doctor or a nurse of whoever else was not competent and should not be allowed to practice. If that stuff came up within a safe space environment, what could trusts do about it? That raises a question.

The fundamental question is how to get investigations and a process within trusts that enable people to feel that they can raise concerns without the wrath of God falling on them. That remains the fundamental question.

Q85 **Chair:** Can I just come back on two points? One is that I find it inconceivable that HSSIB would want to withhold information from a trust that might result in patient harm. It absolutely would not want to do that; that is completely counter to its remit. As soon as it came across information that was relevant for the trust to know, it would want to issue a statement or a report on which the trust could act in order to reduce patient harm.

The second thing, Mr Hopson, is that we have noticed in all the ombudsman investigations we have looked at that there is a terrible dilemma in healthcare. There is a trade-off between how much the country can afford and how safe our hospitals are. The accounting officer philosophy tends to put balancing the books ahead of patient safety. That is just a fact of the way that things are set up. I am not blaming anybody for this at all.

However, the fact is that you are arguing for an ability to protect your balance sheet from, say, litigation, which I think is a misplaced fear and which would go against the patient safety benefit of HSSIB conducting the investigation. Any litigation would have to wait in the queue until HSSIB had done its investigation, so I do not think it is a risk. I think this will save trusts money, because people resort to litigation when they think they are being flannelled.

Chris Hopson: I recognise that. The point I am trying to make is that, when an investigation takes place, from a trust's perspective there are a number of different responsibilities that it needs to balance. If we take away the right of trusts to conduct that investigation, bearing that balance in mind, we effectively prevent them from exercising other accountabilities that you in Parliament have given them.

Q86 **Chair:** I think it is a very important point and we want to understand it better. I think you have agreed that you will put something about it in writing to us. This will be extremely helpful to our inquiry and will help us to understand more deeply the points that you are making. I am very grateful to you for making that point. Do either of you want to add anything else?

Chris Hopson: Can I say one other thing? I hope you would allow me a degree of latitude, in that I recognise that the argument I am making is quite difficult and pointed. I recognise that I am easily capable of caricature as somebody who is obsessed by trust responsibilities, who does not think about patients, who is only interested in money and who is only interested in the law. That is absolutely not the case. The bit I am really nervous about is that the people who are drafting this Bill and you who are scrutinising it are fully aware of the issues that are involved, which, it seems to us, are not mentioned anywhere in any of the commentary.

Q87 **Chair:** This has been very helpful and I do not see a caricature in front of me at all. I see someone who is deeply concerned to make sure that if we are going to produce this legislation we get it right and we make things better, not more complicated.

Q88 **Baroness Watkins of Tavistock:** I really understand what you are saying. I think the balance that the Chair has referred to about patient safety and finance is true in other areas too. For me, British Airways can suspend a pilot while there is an investigation, so there is absolutely no reason why, while HSSIB was doing its investigation, a trust could not say, "I suspend these two practitioners on full pay while it goes on." There is no way you can take away that authority from a trust as an employer. I understand the litigation issue, but I just can't see that that would ever—

Niall Dickson: They would also have an obligation, if they were professionals, to refer them to the regulatory body, which would equally suspend them immediately anyway.

Baroness Watkins of Tavistock: Exactly, so I think it will work.

Chris Hopson: If I can make an observation, in order to get to the answer on this question, it is our view is that—again, maybe it is not for me to suggest this—it would be helpful if you, as a Committee, wrote to the Department of Health and Social Care and asked them to list what the responsibilities of a trust are when it needs to do these things and to point out where local safe space, in particular, or HSSIB undertaking its own investigations instead of a local investigation would cut across those accountabilities, how serious the cut across might be,

whether they can be mitigated and therefore whether there was a problem left. Our view is that if that work is being done—as I said, I expected to see it in the impact assessment, but it wasn't there—then we will know whether there is an issue here, but there is a piece of work that needs to be done and has not been done. That is the argument I am really making in the end, hopefully.

Q89 Chair: We will make sure we get hold of that information. Whether we allow the Department of Health and Social Care to be the fons et origo of all wisdom on this matter is another question.

I have some tidying-up points. Can you envisage any circumstances in which trusts would be unwilling to co-operate with HSSIB?

Chris Hopson: No—and in particular not with these powers—unless, as I said, they were really nervous about all the stuff I have been talking about, which I will not repeat.

Niall Dickson: No, I do not think they would be, but I repeat the point I made before: if this is actually going to work, it should be engagement on a positive note rather than defensive and negative.

Q90 Chair: The Bill has penalties for non-co-operation. Is that necessary or appropriate?

Niall Dickson: I am not sure they are actually necessary, because I cannot see a situation in which a trust, if someone else was ordering it—NHSI or whatever—would say, “No, no, you can't come in.”

Q91 Chair: It is about the authority of HSSIB.

Chris Hopson: Yes, that would be my view, too.

Q92 Chair: The Bill requires HSSIB inspectors to apply for a warrant before entering premises. The Bill does not envisage unqualified access for HSSIB staff. Do you think that creates the right sort of atmosphere? Is that appropriate? Again, there is the aviation parallel, where there is just the right to enter premises, full stop. If there is an aviation safety benefit in their minds, they have the right to enter any premises. What do you think?

Niall Dickson: I agree. That is perfectly sensible.

Chris Hopson: Yes.

Chair: I think we are done, unless anyone has any other questions. I am so glad that you came and that we gave you the extra time you needed. I apologise for suggesting that you might not have the extra time. That was obviously a bad judgment of mine. That was a really excellent evidence session—thank you very much—and we look forward to any further written information.

Chris Hopson: If we could give you some, that would be very helpful.

Chair: Thank you very much.