



HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

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

Wednesday 13 June 2018

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Written evidence from witnesses:

Panel 1

- [Mr Simon Fleming \(SIB0026\)](#)

Panel 2

- [Professional Standards Authority for Health and Social Care \(SIB0031\)](#)
- [General Medical Council \(SIB0030\)](#)
- [Nursing and Midwifery Council \(SIB0032\)](#)

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

Questions 93-164

Panel 1

Witnesses: **Dame Donna Kinnair**, Director of Nursing, Policy and Practice, Royal College of Nursing; **Dr Simon Fleming**, Trauma and Orthopaedic registrar; and **Dr Chaand Nagpaul**, Chair of Council, British Medical Association, gave evidence.

Q93 **Chair:** I welcome our first panel to this session of the Joint Committee on the draft Health Service Safety Investigations Bill. May I first invite you to identify yourselves for the record?

Dr Chaand Nagpaul: My name is Dr Chaand Nagpaul. I am a GP and I chair the British Medical Association, which represents about 160,000 doctors of all specialities across the UK. Prior to that position, I chaired the BMA's GPs committee for four years.

Dame Donna Kinnair: I am Dame Donna Kinnair. I am the director of nursing, practice and policy at the Royal College of Nursing, which has 450,000 members. Prior to that, I worked as a clinical director in A&E.

Dr Simon Fleming: My name is Mr Simon Fleming. I am the immediate past president of the British Orthopaedic Trainees Association and the vice-chair of the Academy Trainee Doctors Group—the trainee arm of the Academy of Medical Royal Colleges. I am currently an orthopaedic trainee surgeon. I am doing a PhD in medical education as well.

Q94 **Chair:** Thank you very much for being with us. We have a lot of questions to get through and we have another panel. Your organisations have submitted evidence in writing. Because there are three of you, there is no need for you each to repeat what the other person has said, just because you agree with it. If we can short-circuit that, that would be very helpful for us. We will ask questions that are as short and crisp as possible, but I will pull you up if you are going on for a bit too long, because we have another panel after you and we need to be done by 12 at the latest, and preferably by 11.30.

May I start by asking what the main flaws are in the current investigatory and inspection system that contribute to such unsatisfactory outcomes for investigations?

Dr Chaand Nagpaul: The first thing is that we all know that staff in the NHS are working in an extremely pressurised environment. The starting point is that before we even get into whether there is error or not, our own surveys of doctors have shown that more than eight in 10 GPs say that when they go into work every day they do not feel confident that they can provide safe care. The RCP did a similar survey. I do not think these surveys are about scaremongering; it is how people feel. They feel they are working in an environment where there should be two of them. They feel they are working in an environment where they may not have the facilities to provide the sort of care they want to under their professional duty of care to patients. That is the starting point.

The problem is that the system at the moment does not encourage reporting of those pressures and the impact on individuals, because we have a system that is performance managing outcomes and not performance managing systems. There is a systemic culture that does not address this. It starts right at the top, as opposed to a system we have at the moment that seems to regulate the performance of providers. We have an environment that is judgmental, and how we currently look at provision of care by individual providers is based on a regulatory judgment and not on an assessment of the system. That, I think, is the ultimate issue we need to be grappling with.

Q95 **Chair:** Thank you for such an interesting answer to that question. You opened with the fact that investigations are looking for error, and yet in safety-critical systems you are looking for where safety can be better managed; you are not looking for error, which attributes blame. Part of this whole project is about moving away from the blame culture that everybody talks about, but that is very difficult to achieve.

Dame Donna Kinnair: That is an important point. If you think about the aviation system, which we are modelling this on, it sees itself as a safety-critical industry. Medicine and nursing are equally safety-critical industries, and we never start from that point. We always immediately go to look at the individual, because that is where we limit our liabilities. For us,

it is welcome that this is being set up, because we need not to have that disproportionate focus on the individual, but to look at the systems, the staffing levels and the hours people are working. We know, with something as simple as a 12-hour shift, that by hour 10 people are flagging. We have known that for some time, and yet we have moved from a system of three shifts to two shifts.

We equally know that nurses are raising concerns that there are not enough staff on their shifts. We did a survey, and 71% of our nurses on an acute ward said that they did not have enough staff to deliver safe care. That means care is left undone. Yet when we investigate some error or judgment error, we do not look at those issues; we look at how we can limit liabilities and how we can hold somebody individually to account for that.

I could use further examples such as drugs. We have known, ever since I was a wee nurse many years ago, that we can make drugs safer. Why do we have sodium chloride and potassium chloride in the same coloured bags? Why do we have deadly doses of drugs? Because everything is seen on an individual level and there is nothing in the system that knits these together and challenges: “Why are we not working with the drug industries? Why do we have lethal doses of drugs being given to patients still?”

Q96 Chair: That is a very interesting point; thank you. I will pick up on one thing: of course, in other safety-critical industries, you can just stop doing something if it becomes dangerous, but you cannot just close your A&E because you do not have enough staff, because that would create safety consequences and patient harm in other ways. They might not be directly due to the staff shortages in your own department, but there will be effects. How do we recognise that in this very difficult safety-critical industry?

Dame Donna Kinnair: I believe, having been a nurse at 2 o’clock in the morning when my department has been overwhelmed, and not having had the power to look after the people within my care, I have created an unsafe system within the hospital. Then I am individually held accountable. There are better ways of looking when the system comes together.

Q97 Chair: So it is about understanding that dilemma?

Dame Donna Kinnair: Absolutely, because it is within as well as without. If you create more safety issues within when you have a department with four times the amount of people that it should have, that is an unsafe system. The recognition is that it is easy to say that you cannot close the doors or you cannot ask people to go elsewhere, but that does not make a safe system. Until we understand it as safety critical, we won’t be able to put plans in place to do other things. At the moment you get an edict that says, “No, you cannot look at sending someone somewhere else,” but they are equally unsafe if you cannot get to them.

Chair: I understand. I should just add that although the Bill refers to persons, in terms of its investigation, legally, a person can be a corporation or a body or anything that is a legal entity.

Dr Simon Fleming: The issue with the current system is that it works within a culture that is not set up to do anything but attribute blame. The NHS has a problem with negative workplace behaviours, namely bullying, undermining and harassment. We know that in

surgery, which is my world, negative workplace behaviours lead to about 67% of adverse events, 71% of medical errors and 27% of perioperative deaths. Our surveys show that 60% to 70% of junior doctors in surgery, for example, have witnessed these negative workplace behaviours. If you are in a culture where there is a hierarchy, there is no drive to report, because it is a blame system, as you said, rather than a just system, where people are assessed commensurate with the level of their training. The current discussion we are having is around fire alarms, but actually our house is on fire. So we really need to sort out the system rather than looking at the minutiae of a Datix report—our error reporting system—which is fine but never really addresses the wider cultural issues of why people don't report, or why they use reporting as a tool of power in and of itself. It is a threat: "I will error report you unless you do x or y." It is often a weapon within the bully's arsenal, whereas we need to create a culture whereby I say, "You know what? You should report me. Maybe I need some more training, maybe the system needs to be better and maybe the IT system needs updating." That culture does not exist at the moment.

Chair: We will come to the culture later on, but that was another very interesting answer. Thank you very much. On this question, do your answers reflect the views of your members?

All Witnesses: indicated assent.

Q98 **Dr Williams:** I have heard what you have said about negative workplace behaviours. How will an investigation branch—as opposed to people who are experts in changing workplace culture—contribute towards changing those behaviours? The investigation branch is clearly not sufficient, but is it necessary in order to try to change the culture?

Dr Simon Fleming: I think it is not only necessary, but compulsory, because I do not think they are mutually exclusive. An investigation branch might look at why someone gave the wrong drug, but if you do not look at why there is a culture in which no one felt they could speak up about the prescribing errors—why the culture itself is an issue—you are going for the easy wins. You will be saying, for example, "There is a problem with blood bottles, so we need more blood bottles." But actually you need to look at the wider system.

An investigation branch that looks at culture, which I know is harder to look at and, by definition, harder to change, will be a far more powerful entity. I think it will get more buy-in from stakeholders, because it will feel less like a tick-box exercise, less target driven—"We've done our investigation"—and more like someone saying, "You are clearly having a problem in this department, unit, hospital or patient sub-type. How can we help you?" Often, when you look at the root cause, culture and system come up, but because it is hard to change or we do not yet have a system whereby we are able to change it, it is sort of pushed to one side. A Bill like this would need to look at culture as part of the investigation—for patient safety if nothing else.

Q99 **Dr Williams:** My next question is to all three of you. What does success look like in order for HSSIB to secure the trust of professionals and patients?

Dr Chaand Nagpaul: I think it is important to go beyond just looking at organisations—by healthcare providers, I mean not just NHS trusts, but GP surgeries. We need to look at the rules of the environment in which they operate and whether the environment that is created

and set, starting from Government and implemented through NHS England, is the right approach. Otherwise, if we just start looking at those that provide care I think we are missing perhaps the most important bit, which is that you set the culture from the top in any organisation. I am going to suggest that the messages that go down from the top to those that provide care do not harness or support a learning culture.

If you are responsible for an acute trust, you have an edict that says, no matter what, you have to achieve financial balance, and if you don't achieve financial balance you are somehow lacking in expertise in how to run your hospital. If you don't achieve the four-hour target, you are somehow lacking. I would argue that a trust that actually wanted to provide safe care might breach its four-hour target, precisely because it is looking after patients who need to be in an A&E unit rather than in a corridor. We have such a perverse system that in fact we are crediting expedience, not crediting what is the right thing to do. We are using very crude proxies.

If that is the sort of pressure a provider is under, everything beneath it is going to feel a very crude sort of culture. It filters down, so I think this has to come right from the top. I would suggest this is what success would look like. It would look at the sort of messages that come out, the sort of KPIs that are put forward, whether context is understood and whether you recognise that some cannot do as well because they have had three different chief executives in the past four years. Are you then going to stamp on them and say, "You are worse than someone else," or are you going to say, "I am going to understand why you are the way you are"?

There was a question earlier about GP surgeries. Although it is not easy for hospitals to close their doors, you can under extreme situations divert patients elsewhere. GP practices have got no ability to close their doors. We have, at the moment, a system where practices may be three partners down, so you can have one partner from a four-partner practice who goes into work feeling quite unsafe and says that they need to close their list—that they cannot take more patients. But NHS England does not allow those practices to close their lists, so you just carry on fuelling it. The reason they don't do that is because they feel, "Where will the patients go?"

When we talk about resources, we don't do so from a sterile point of view. The fact that we are experiencing an NHS that is under-resourced is not just a monetary issue. It is because we don't have enough facilities, enough doctors and so on, and the system does not allow those who are under such pressures to call a halt. Moreover, it has a culture where you are scared to speak out. One in four GP practices told us in our surveys that they would not speak out about pressures because they were scared of a CQC inspection following, telling them that they are actually inadequate. That is not the right culture.

Chair: You gave us a very full answer that was quite long. I might not let you do that again.

Q100 Dr Williams: What are the success factors for HSSIB to be able to secure the trust of patients and professionals?

Dame Donna Kinnair: I would welcome HSSIB looking at the thorny issues. I know that when you do any investigation, the real issues are sometimes what we are not looking at.

Nobody ever voices the real issues, such as absence of staff or enough staff, because we immediately resort to saying, “There is nothing we can do about that.”

I happen to think that if HSSIB is going to be successful and get credibility among both patients and staff, it will have to tackle those thorny cultural issues. It will have to ask the question of why we believe immediately that we cannot solve these issues. Very often we can, but actually the system, as my good friend has said, becomes more and more perverse as we tend not to deal with the things that are sitting in front of us.

Dr Simon Fleming: For me, for it to be successful, as an entity it needs to role model the behaviours that it aspires to, which will mean working towards a just culture and creating evidence that its goal is to create a safe place both to work and to be a patient. When we have asked junior doctors in our surveys why they do not report, they say basically that they don’t think reporting makes a difference, while it simultaneously has a negative impact on their careers and work experience.

If you are going to have a Bill that works, it needs to demonstrate in a very transparent way that it aspires to create a culture whereby we are safe to report and must report. As said before, it should actually look at the really difficult things that take a little bit longer to fix, such as culture, while protecting those who do speak up, either in their reflective practice or through a reporting system.

Q101 Andrew Selous: Simon, may I go back to one of your earlier answers, in which I think you said that there was a lack of reporting by junior staff because of the hierarchical nature and fear of repercussions? Dr Whitford has helpfully told the Committee about the system in Scotland—about the huddle, as I think it is described, where everybody gets together on first-name terms and a culture of challenge and openness is accepted. Forgive me—I should know this—but does that happen in England in the way it happens in Scotland? If not, why not? Is the evidence for Scotland better than England if it is happening there and not here?

Dr Simon Fleming: That is the joyous bit about culture. I know about the Scottish system, and we do have huddles in some units in England as well.

Q102 Andrew Selous: Why not everywhere? Is there evidence that it works in Scotland, and if there is, why is it not universal in England?

Dr Simon Fleming: That is the perfect example of culture—why not everywhere? Some cultures do not like that. Some people do not like a flattened hierarchy because, by definition, hierarchy is power. It is very difficult to ask some people—I think that positive change is good, but recently, I was informed that I have to remember that by definition, any change will mean that someone loses something. If you are flattening a hierarchy, by definition, someone is having to give up some power or their place in the hierarchy. There are some units and some cultures where they do not like that, because not everyone—

Q103 Andrew Selous: I am asking your opinion on that, because I am pretty astounded that people would take that view. If we see this as a zero-sum game in terms of giving up power, that is very sad.

Dr Simon Fleming: I would agree. That is the thing about what I am saying here, and when I have presented this elsewhere. You would think that you were pushing against an open door and that it would be obvious, but it is not obvious to some people, who would always want to be referred to as Professor so-and-so. I recently had someone say to me, “You will call me Professor so-and-so, because I have earned that title.” I said, “Well, how would you feel if I made you call me Dr Fleming?” He said, “I would think that you were a supercilious little—”, and I said, “I rest my case.”

Dr Whitford: When it came in in Scotland, there was obviously exactly the same reaction. People struggled with the idea of Professor Sir whatever being called Mike by the orderly who was cleaning theatre, but that was the advantage of it being a national patient safety programme. It was, “Get over yourself. This is happening.”

Dr Simon Fleming: Once it is everywhere, it is a lot harder. You then become the exception. Imagine banning smoking in some pubs but not others.

Q104 Baroness Watkins of Tavistock: In addition to establishing HSSIB, what wider actions will be necessary to support the development of a just culture of learning within the NHS? To some extent, you have given us a flavour of that, but how do you think your organisations would work with HSSIB to support such a change in the culture, and do you think there is potential for confusion about where it will sit in relation to other organisations?

Dame Donna Kinnair: We would work with HSSIB, because one of the things that we are very clear about is that we have an understaffed health service at the moment. Whether we pitch quality against finances, we have to get the messaging right. We know for every one nurse—research tells us that in risk-adjusted mortality rates, the fewer nurses you have, your mortality rises by 7%. Therefore, we know that we have a health service without enough staff delivering the required care. To be honest, nursing is most of that care. We deliver 70% of the care to our patients. If we do not have enough staff, that would be our starting point.

We would work with HSSIB to ensure that safe staffing legislation is enshrined in law. That gives us a starting point to work to, because we have not shied away from the issue. Yes, there will be thousands of reasons why we cannot achieve it, as I have seen over my career. There are thousands of reasons why we have not managed to separate sodium chloride and potassium chloride, because we failed to work with manufacturers to make those differences explicit or failed to do the things that save lives. That is important to me, and we would work with them to enshrine that safe legislation.

Dr Chaand Nagpaul: I think HSSIB has the opportunity to deliver what the Berwick review told us five years ago, which we have not delivered. It was very clear that systems and constraints affect patient safety, not individuals. I think HSSIB has the opportunity to move the spotlight away from simply looking at those that provide care and shifting it right to the top and looking at the environment, which I think will be critical.

Chair: You have made the point.

Dr Simon Fleming: Junior doctors will engage in any process that makes patient care better and the NHS a better place to work. I will say that any system that is introduced needs to be designed so that it is not hugely onerous for said understaffed nurses or doctors to engage

with. There is a pragmatic side to this, in that it will be engaged with more by all your stakeholders if it does not require two and a half hours to engage with it.

Q105 Baroness Watkins of Tavistock: You are very clear that you want to engage. What do you think about any potential difficulties of HSSIB's relating to professional bodies and your organisations, or do you think we need not worry about that?

Dr Simon Fleming: Which professional bodies do you mean?

Dr Whitford: The CQC.

Baroness Watkins of Tavistock: The CQC, the NMC, the GMC. Regulatory bodies.

Dame Donna Kinnair: I think we have to be very clear about the role of HSSIB. As we sit here, we see it as driving through those recommendations on a national level. We have to be very clear about what HSSIB will investigate, as opposed to the CQC and other regulators in the system, because there is the potential for confusion. I personally, and we at the RCN, see it as being able to drive those recommendations through on a national level and giving us a system overview to correct some of the issues that we see that are wrong in the system.

Dr Simon Fleming: More than that, I would have real concerns if HSSIB were to feed in to regulatory bodies, because people will not report. People will not report someone speeding if they know that they themselves will have to then speak to the DVLA. It is human nature. If your goal is to create a safe culture, perhaps feeding into regulatory bodies is not necessarily the way to go. Whereas the CQC has a role to play in assessing culture in the workplace, HSSIB can assess everything else.

Dr Chaand Nagpaul: The regulatory systems are different in the four nations; I chair a body that covers the four nations. The CQC is very different from what happens in Scotland, Wales or Northern Ireland, because it takes a judgmental approach. Its use of "inadequate" does not support a learning culture. You do not have that in Scotland, Wales or Northern Ireland. You are starting from a position where the regulatory system in England, I believe, is not creating a positive culture, and you are wanting to make up for that. I would like this to feed into changing the way regulation operates. Regulation should be for competence, not to create judgments.

Q106 Lord Kirkwood of Kirkhope: Your evidence about staff shortages is very powerful. I believe that we are not having an honest, open discussion about the pressures that people face in a professional setting. However, we have to be realistic. We are a Joint Committee looking at what is really quite a small piece of the healthcare perspective, mainly across England. Do you think that it is really realistic for us to be able to frame a terms of reference for the safety investigation body that reflects the scale of problems you are having with mass staff shortages and the coercive, bullying treatment that Dr Fleming has talked about this morning? How realistic is it that we will get that right in this minor piece of legislation that we are supposed to be helping to draft?

Dame Donna Kinnair: This is a journey, and if you set the tone right, the journey can be undertaken. I believe that it is definitely quality versus resources. When I say resources,

people will automatically think of money, but actually the culture has to be right for us to grow the right amount of staff. To be honest, if you do not do that, it will only backfire in the end. These are the people that deal with you when you are sick, so if you undercut training, they will not have the right knowledge base and we will suffer in the end. If we do not invest in the right things, it is our system and patients who suffer at the end of the day. We will not solve anything overnight, but it is the start of a journey if we get the focus right, and the focus has to be those honest conversations, those thorny issues that everybody shies away from, because it is cheaper and easier to deal with the individual and the liability on the individual's head. If we look at the system, in the long term it becomes cheaper.

Dr Simon Fleming: I would say that actually you do yourselves and the Bill a disservice; I think this is the perfect Bill to do this. ACAS has said that negative workplace behaviours have a huge impact on recruitment and retention. We know that medical school applications nationally are down; London tends to be relatively plateaued, but there have been places in clearing. We know that competition ratios for my specialty—trauma orthopaedics—have gone from 10:1 to less than 2:1, and that is probably one of the most competitive specialties. If we want people to work in the NHS, the fifth largest employer in the world, we have to turn the NHS into a place where people want to work, and to do that, we have to change the culture. Our sixth-form colleagues that we speak to say already, from work experience, “Well, I saw this, I saw that, and I thought, ‘Not for me.’” If we want people to work in the nation's health service, we need to make it a place where people want to work, and to do that, we need to improve the culture.

Q107 Lord Kirkwood of Kirkhope: The ambition is very impressive, but the impact assessment that we are working with says that this body will do 30 investigations a year. Let's have the ambition—this is very important; I understand that—but can you realistically expect the level of cultural change that you are laying in front of us as necessary?

Dame Donna Kinnair: Absolutely. Thirty sets the direction of travel. If you are investigating properly, others will follow. Those 30 will stop people looking at going straight to the bottom, as we have seen. We can make the system safer; I truly believe that.

Dr Simon Fleming: That is what Dr Nagpaul was saying. This will be the Government role-modelling that this is the standard that is set, and that is how you start this tectonic change—small, slow steps that change something much bigger.

Dr Chaand Nagpaul: You also asked about the system pressures and the role of HSSIB. I think HSSIB could be the one body that is not trying to score political points; it is not about politics. And if you really find that there are some system constraints in terms of staffing and facilities, you have to say so. You wouldn't want to board a plane knowing that they were two engineers down. I think it is a duty for the public to understand—not to be dramatic, but I do think that unless we have one body that is outside the politics but is being clear about safety and what needs to change to improve safety, we are not going to move forward, because it's being concealed otherwise.

Lord Kirkwood of Kirkhope: That's very helpful; thank you.

Q108 Chair: I am a little concerned that we might be expecting HSSIB to be able to get

new clinicians to grow on trees.

Dr Chaand Nagpaul: No, but I think what HSSIB can do is describe how care may be affected when an organisation is trying to cope without the facilities it needs.

Chair: And how systems need to respond—

Dr Chaand Nagpaul: And how systems need to respond—

Chair: To staff shortages if that is what is identified. Yes, I hear what you're saying.

Q109 **Dr Whitford:** Concerns have been expressed about the tensions between safe space, the duty of candour and the reflections of doctors. Do you think that HSSIB will manage to strike a workable balance between the needs of the healthcare professional, the patient, the family and the other stakeholders?

Dame Donna Kinnair: HSSIB needs to do the right thing. In my experience, a system that does the right thing impacts positively on all those issues, because we know that no health professional gets up and goes to work to cause any harm, and actually, when you talk to a health professional in the first instance, they are often taking the blame for every single thing that has gone wrong; that is their immediate reaction. So what HSSIB can do is lead the way in making sure that there is a safe place and a duty of candour and that people can have that discussion. Sometimes, when we are talking about individuals—when people immediately are immersed in an incident, their reflection changes over time, and then we call them liars because they have not recalled it in exactly the same manner, as would be the case with any normal person. So, while it can't be all things to all men, HSSIB certainly needs to do the right thing so that those things can work alongside each other.

Dr Chaand Nagpaul: I think this is probably the most difficult issue about the place of HSSIB, because we know that the medical profession is very worried about reflecting and that their reflections could be used against them. We know that is the way they feel, and it would be great to have an organisation where you feel that you can safely speak openly about what you may have learned or what you may have not done right, without its being used against you. That is really important. There will need to be some very clear criteria used by HSSIB for what cases to investigate. You have said 30; 30 is a limited number. There will also need to be some process of deciding. You have three criteria for when you may need to disclose information; I understand the criminal bit, but also where you feel there may be continuing danger to a provider or where you feel there is gross negligence of a doctor or a nurse and it should be passed on to the regulatory body.

My question would be: who in HSSIB would decide whether a person should be referred to the regulator, and how would that happen? It would be unfortunate if doctors and nurses were scared to go to HSSIB—in fact it would defeat the whole object. What would be disclosed to a regulator if you felt there was negligence by a professional? Would it just be the fact that you felt there was negligence, or would you then reveal content of what the doctor or nurse has provided to HSSIB? If you have provided that content, we will then go backwards.

Q110 **Dr Whitford:** This leads into the other thing I was going to ask. You have clearly looked at the proposals and the issue of prohibition of disclosure. That is modelled on

AAIB, which is very much about systems and about learning; anyone else who wants to investigate or challenge an individual or an event is doing their own thing and AAIB does not provide that information. It will only do so through the High Court. At the moment, there is a much longer list. What is your view of that? Dr Nagpaul, you suggest that that would inhibit people from engaging in the safe space. That is also my impression as a doctor.

Dr Chaand Nagpaul: That is also borne out by recent events. The BMA and others have responded to the Williams review, where we believe that reflections should be legally privileged. It is absolutely consistent. We have thought about it, we have surveyed and we have understood where the profession are on this.

Dr Simon Fleming: As a junior doctor, I have to echo that. I know you have said we should not just say the same thing, but I need to be on record as saying that we think reflections should be legally privileged. You cannot learn unless you are in a safe space. Anywhere there is a fear of recrimination or of your own reflections being used against you, by definition people will not reflect. You cannot ask people to talk openly and honestly about their experiences, knowing that that will then immediately be visited upon them. I am perfectly willing to admit that I have made mistakes, and undeniably will make mistakes again in the future.

The example I was once given was that reflection is a bit like engaging with social services, in that you want to talk to them enough that they help you, but not so much that they take your kids away. That is kind of the problem. What you want is someone to say, “This is the system I am working in, these are the mistakes I have made. Help me to make things better,” rather than by definition giving some of the truth, but having to hold back for fear of someone then saying, “So you made the mistake?” “Well, yes, because of these system problems.” “But you made the mistake.” It needs to have that sort of legal protection to create a safe space both legally and psychologically for people, whether patients or staff, to say, “These were my experiences, these are the mistakes that were made or the errors I witnessed. Help me to rebuild,” rather than being used as a stick to beat people.

Q111 **Dr Whitford:** At the moment, it is suggested that actual information could be disclosed to the police and regulators. Do you think that undermines the principle of safe space as it is used in the airline industry?

Dame Donna Kinnair: I think we could have a presumption of safe space, but there will be some critical areas where we might need to come to an agreement between the profession, the public and HSSIB on what is to be shared. There is always the ability to have dialogue. Of course people need a safe space to be able to reflect and improve, but there may be some things where, between the professions, the public and HSSIB, we could come to an agreement about where that is breached.

Q112 **Dr Whitford:** How do you think it is that in the airline industry, where the investigation board is very much a safe space, and it is very difficult to access what happened inside until they publish the report, the public do not say, “This pilot should be on the front of the *Daily Mail* and we should pillory them.”? Do you not think that we should try to model it more on that? Because we do not have HSSIB at the moment. HSSIB, as you have said in evidence so far, should be about systems

and learning. Is it not that we really need to create a pretty comparable safe space to the airline industry for it actually to be safe?

Dr Chaand Nagpaul: I absolutely agree. The way one would want to present that to the public is to say, “If you really want to see an improvement in safety, as we have seen happen in the aviation industry, why would you not want to model it?” This is not about keeping anything away from the public. It is about doing what would work to improve the public’s health and safety.

It is in the public’s interest to enable a system where you can properly look at issues and systems when they go wrong with the aim to improve them. It would need to be presented to the public in the right way. Modelling it on the aviation industry and showing the objective success of that is the way that I believe this needs to proceed.

Q113 **Dr Whitford:** Do you think it would be reasonable if it is seen as being quite separate from the regulatory GMC and other bodies that we already have that can investigate?

Dr Simon Fleming: It has to be.

Dr Chaand Nagpaul: It must be because the current system is not a safe place to be in terms of reporting.

Dr Simon Fleming: And it needs to be a safe place for the public to speak up in as well, of course. For every patient who thinks that their complaint will bump them up a list or get them slightly faster treatment, you will get another patient who goes, “I don’t want to make a fuss because I don’t want my doctors, nurses, consultant or people in the booking office to think I am that person.” They are just as afraid of speaking up as well.

It is about empowering the public as well as patients to speak up. Again, it is that understanding. I spoke to a pilot recently about this and he said, “The issue in the aviation industry is that if I make a mistake, everyone suffers, including me.” That is the mentality that you have to say, which is actually, if you use this system properly everyone wins: the public, the staff, the NHS as an entity. Whereas, if the plane goes down, everyone goes down with it.

Dame Donna Kinnair: That is equally true in health, because if you make a mistake you are equally as devastated about any potential harm you may do. You can actually die as a doctor or a nurse. It is exactly the same.

Dr Simon Fleming: Surgical trainees demonstrate the exact same levels of PTSD as returning servicemen. Everyone comes to harm if there is a problem.

Q114 **Andrew Selous:** Dame Donna, in your evidence you expressed some concerns about the adoption of the safe space principle for NHS trusts. I want to ask you about accreditation and whether it is sensible for NHS trusts to be given that role.

Dame Donna Kinnair: I believe that the accreditation method could cause more disharmony in the system. We know that safety investigations are not done well. I think there needs to be

an appropriate time to bed down good system safety investigations before we start accrediting bodies.

It could lead to a fracturing of relationships between healthcare trusts and healthcare organisations because it could be more disruptive to the whole approach, in terms of a smaller trust not trusting a larger trust. Equally, we need to get the methodology of investigations right, so that it is widespread throughout the NHS and care.

Q115 Andrew Selous: You would see this purely as a role for HSSIB rather than for trusts to become accredited to do it.

Dame Donna Kinnair: Initially, I would say yes. It is really difficult and that is part of the problem. When Scotland did their patient safety they did it collectively. They did not say, “You do this bit and you take that.” Everybody did it. I think that is the beauty of HSSIB; it could make recommendations across the system that are effective for the whole system, as opposed to this trust thinking it is better than this trust.

Q116 Dr Whitford: Do you think there would be an increased risk to whistleblowers if this was being investigated—particularly when it would eventually be a trust investigating itself—as opposed to them giving information in a safe space to a completely independent body? One of the real injustices within the NHS is how some whistleblowers have suffered.

Dame Donna Kinnair: I think it might impact on the neutrality and the transparency of how a trust conducts an investigation, because of course, as was clear from the evidence that has been given to you previously, a trust is vested with many things. One of those things is about managing its reputation and limiting its liability—there are a whole host of things. We would have to be a mature system for some of those things to rise to the top.

Dr Chaand Nagpaul: There is no doubt that if a trust is considered to be accredited to investigate itself, there will be a perception that it is conflicted. You cannot get round that perception. The idea that one trust could be accredited to investigate another trust would suggest there is capacity in the system, and I have not met a single doctor who feels that their trust has the capacity to look at itself, let alone look elsewhere, so that is a very serious issue.

I would like to reframe the idea of accreditation and suggest that this is not about selecting a few trusts to be accredited. Why not create a concept of accrediting every trust to create a learning culture when looking at any issue that comes to them? That would be a far more powerful approach, where you almost make it part of the requirement of every trust that every single board member, and every medical director, is accredited to understand that your response to a complaint is not to be defensive and think about your reputation or to try to apportion blame, but to change the culture. That could be the accreditation. The accreditation is to change the culture of every single provider in the NHS, as opposed to a stand-alone.

Q117 Baroness Eaton: So far, we have spent quite a lot of the discussion talking about systems and professionals, but I would like to move the questioning slightly to be more about patients and their families. How do you think HSSIB should involve families and patients in its investigations?

Dame Donna Kinnair: Any investigation should discuss the issues with all parties, and therefore families and the individuals who have suffered some harm must be a component part of the investigation—that is what makes it a whole investigation. For me, it is vital that they take the views of families into consideration. We exist because people pay for the health service to exist, and therefore they are a vital component of anything that we do. They are also essential for us to make it a safer place.

Dr Chaand Nagpaul: We know that the one thing that families or victims of medical error all want is to feel assured that the system has learned and that the same error will not happen again. At the moment, most victims of medical error or families do not have the opportunity to do that, and before they know it, they are drawn into an adversarial issue where the only way that they feel they can have justice is by holding someone to account. But what they all want is to prevent error from occurring in the future. If we do not have that system at the moment, and if HSSIB becomes—you articulate that it is—the opportunity to prevent an error from happening again, I think that patients and the public would feel that it is a really worthy opportunity that is not open at the moment. It could create a whole culture where they feel that their misfortune can help to prevent future misfortune, which is not the current approach.

Dr Simon Fleming: If done correctly, I think the Bill will empower patients. They are a key part of creating a just culture, and we can empower them to speak up and to feel like they are really part of making the NHS better. It is a powerful thing to say to them, “By speaking up and telling us how to do x or y better, and how to learn from the thing that has happened, you will improve care across the NHS.” It is not, “You will improve the appointments system in St Elsewhere”; it is, “By telling us how we can do better in St Elsewhere, you will improve the health service.” That empowers patients and, again, makes them part of the team and part of the solution, rather than making them feel like they are on the outside shouting in.

Q118 Diana Johnson: I would like to ask about private providers. The recent CQC report revealed that 41% of independent hospitals require improvements in safety. We know that at least one private provider has said that they would like to be able to refer cases to HSSIB. Do you think it is right that the private provider should be covered? If so, how should that be funded?

Dame Donna Kinnair: It has to be right, because the statistics I talked about were not just for the NHS. Our members are spread right across the independent sector and private providers. We recognise that the same system issues can exist right across the system. It is vital that the system does at least start by following the patient, wherever they are. In terms of payment for investigations, I think that it is a system where that probably could be brought in.

Q119 Diana Johnson: So the private providers should pay something?

Dame Donna Kinnair: It is possible that that might be one mechanism to use, but I am not an expert on that. It is best to leave that to accountants or economists.

Dr Chaand Nagpaul: This is a particular problem in England. It does not apply to the devolved nations because we have a system that has allowed a market of providers, so long as they charge the same tariff. We have a problem. We have always been concerned by this opening up to private providers that do not have assurances of safety, care and integration

with the rest of the NHS. I can say as a GP that it happens all the time. Patients who have a hip operation in a private hospital do not have the same full package of care, and they then have problems and go into the NHS as an emergency. There is a real issue here. Private providers should be subject to the same safety approach. They should have to fund assurances that they are providing care properly. From a political perspective, we think that the English approach to outsourcing or having private providers in the way that they currently operate is not something we support anyway, but certainly investigations should be funded by the private sector. It is NHS money for NHS patients.

Dr Simon Fleming: I would say that culture goes with people. If the consultant or nurse is working in one culture in one place, they will take that culture with them down the road to the private sector. Any piece of work here that is trying to create a safer, more just culture in the NHS by definition must try to do the same in the private sector. I wouldn't dare to comment on funding.

Q120 Chair: That would suggest that HSSIB should be investigating private patients in private settings funded privately as well, because clinicians are working in that culture and they need to be in the same culture. Do you all agree with that?

Dame Donna Kinnair: If we want optimum safety, we want it across wherever a person is or an individual is being treated. Of course I would agree with doing those investigations, but we might not be able to do everything at once.

Q121 Chair: I would totally agree with that. That is a very wise comment. We would like evidence on how HSSIB should be recompensed for investigating the private sector, because we do not want another accusation of the NHS subsidising the private sector, if HSSIB is funded by the NHS or taxpayers and is then investigating the private sector. A direct charge for each investigation would create a rather odd relationship between the investigator and the private sector. What do you think the answer is to that?

Dr Chaand Nagpaul: The first thing, as you rightly say, is that we cannot and should not have the NHS subsidising private providers. Since NHS patients are currently seen in private units and private providers, we have to ensure that those patients receive the same levels of care, but also are part of a system where safety is addressed in the same way. Logic tells me that the private provider has a duty to ensure that that happens, and therefore the funding should come out of the private provider. I cannot see why the NHS should fund it.

Q122 Chair: Perhaps by a levy, rather than a charge for each investigation.

Dame Donna Kinnair: I think we are investigating the private sector, even if we just took a NHS approach. The NHS is everywhere. It commissions from the private sector. If you are looking at a system, you will be automatically looking at some of the private providers anyway. It may be that a levy is an opportunity to at least get some funding back, because the recommendations you make will be to make them a more effective system culturally.

Dr Simon Fleming: I would only mirror what my colleagues have said.

Chair: Wonderful. Thank you very much. It has been an interesting and informative session. I think we are struck by your enthusiasm for HSSIB. We have heard the concerns

you have about making it work effectively. If you have any other information or reactions to other evidence that you want to send to us in writing, please do send it to us; we would be very interested to hear that, too.

Panel 2

Witnesses: **Harry Cayton**, Chief Executive, Professional Standards Authority; **Paul Buckley**, Director of Strategy and Policy, General Medical Council; **Matthew McClelland**, Director of Fitness to Practise, and **Clare Padley**, General Counsel, Nursing and Midwifery Council., gave evidence.

Q123 **Chair:** I will very briefly repeat myself: welcome to this session, and if we can keep answers as short as possible—we will ask short questions—we will get through all that we need to in the time available. If you have further information or evidence for us, please send it to us in writing. Could I ask each of you to identify yourselves for the record, please?

Clare Padley: My name is Clare Padley. I am the general counsel of the Nursing and Midwifery Council, and I lead on legislative issues for the NMC. I have also been there a number of years, and led on their revalidation programme in a non-legal role, which obviously is relevant in terms of reflections and candour.

Harry Cayton: I am Harry Cayton. I am the chief executive of the Professional Standards Authority. We oversee the nine statutory regulators and 25 accredited registers of health and care occupations.

Paul Buckley: Good morning. My name is Paul Buckley, and I am director of strategy and policy at the General Medical Council.

Matthew McClelland: Good morning. I am Matthew McClelland, and I am director of fitness to practise for the Nursing and Midwifery Council. We regulate 690,000 nurses and midwives across the UK.

Q124 **Chair:** Thank you. There are four of you, so please do not feel the need to repeat what everybody else has already said. What do you think are the main flaws in the current regulatory and inspection system, and why do they contribute to the unsatisfactory investigatory outcomes?

Paul Buckley: I am happy to go first, Chair. In terms of what the problem is, I cannot improve on these words from a Secretary of State, when he said, “No one pretends that adverse healthcare events can be eliminated...Too often in the past we have witnessed tragedies which could have been avoided had the lessons of past experience been properly learned...The challenge is to ensure that the modern NHS is as safe a place as possible for patients...That is a challenge this Government is determined to meet.”

The issue with that is that the Government in question was the first Blair Government, the date was 13 June 2000—coincidentally, 18 years ago today—and the occasion was the launch of a pioneering document called “An organisation with a memory”, which was intended to bring about a transformational culture change in approach to safety within healthcare. I guess that had that succeeded in the way that it was hoped and expected it would, we would not be

sat around the table this morning, so I think we approach this with a certain amount of humility.

This is a very, very difficult issue to make progress on; there are no easy solutions, and that is where we would start from. We have some suggestions for improving the Bill, which I am happy to come to during the course of the session.

Q125 **Chair:** Thank you very much. Who else?

Harry Cayton: Perhaps I can support what Paul has said. It seems to me that one of the issues—it is one of the issues that we have concerns about, in terms of the new structures that we are discussing today—is that we have a completely over-complex regulatory framework, and our approach seems always to be to add something on top of what is already there and is not working. So we have things that aren't working and instead of fixing the things that aren't working, we add another tier of regulation or another organisation or another inspectorate or another quality assurance body.

In a paper that we published a couple of years ago, called “Rethinking regulation”, we found that there are more than 70 different organisations already inspecting and analysing and regulating the health service. And here we are talking about yet another one.

My feeling is that we haven't really unravelled the fundamental problems—people have already mentioned them this morning—about the just culture, transparency and freedom to speak up, all of which are in place but are not working satisfactorily. Adding to what is already an over-weighty regulatory framework seems to me to be part of the problem, not the solution.

Q126 **Chair:** Can I challenge you? I mean, I hear that very, very clearly, and the inspection regime—the scrutiny—is very burdensome on clinicians. But do you see HSSIB as a regulator rather than an investigator? Because HSSIB will not be regulating in any shape or form.

Harry Cayton: It is a very proper point. However, we do have constant muddle between what is inspection, what is quality improvement and what is regulation. Those three those things are intimately interlocked, and one of the discussions that we are clearly going to have about HSSIB is: how will it relate to the regulators?

Q127 **Chair:** But where regulators do their own inspections and then do their own investigations, how is that satisfactory?

Harry Cayton: Regulators have to get evidence from a whole range of different sources. It is burdensome, actually, to say that every separate regulator should have a completely separate approach to information. So it seems to me that one of the issues—I don't want to jump into the detail yet if the Committee doesn't want to—is that relationship. If HSSIB has information that may go to serious risk to patients in the future, what is it going to do with that information and how is it going to share it with the regulators and what threshold will it use to decide—

Q128 **Chair:** We will come to that point. But at the moment, who investigates the effect that regulators have on the safety, or otherwise, of the system?

Harry Cayton: My organisation oversees and reports to Parliament, indeed, on the effectiveness of the regulators. We have just published a fairly critical report, we have to say, of the Nursing and Midwifery Council, in which we made it very clear that there were serious historical issues to do with their communication with patients and families, and to do with their transparency; the NMC is undoubtedly addressing those issues.

The regulators are brought before Parliament and questioned by the Health Committee, so there is accountability through us and there is accountability to Parliament. And in my view, transparency, which is hugely important, creates accountability to the public.

Q129 **Chair:** We are just trying to set up an organisation that is just going to establish the causes of incidents without blame. What is the problem of having that as an extra capability?

Harry Cayton: There is no problem with the intention whatsoever.

Q130 **Chair:** I just wanted to clarify that. But I hear your concerns, and I am very grateful for you putting them on the table in the way that you have done.

Matthew McClelland: From our point of view, absolutely—we support the intentions behind the Bill. We are fully supportive of the notion of a just culture. I do think that we, as professional regulators, have a role to play in that and we are very keen that we shouldn't be seen as part of the problem; we can actually contribute to a solution. I think some of that came out in the previous evidence session, and it might be useful to explore a little bit further.

Q131 **Baroness Chisholm of Owlpen:** Moving on from that, what do you see as the purpose of the HSSIB investigations, and how will they be different from the primary purpose of investigations by professional regulators?

Clare Padley: We have to separate the national picture, which people have discussed, from accreditation, which we will come on to separately. In terms of the national picture for HSSIB, we absolutely understand that it is very different from what we do. We are only concerned, as professional regulators, with individual responsibility and accountability and not with the next step, which is why something has gone wrong.

We see very clearly that one problem with the current structure is that somebody does something wrong on a ward or in a care home, or whatever, and the only question is whether what they have done is so bad that we need to take some action against them, because they create a patient safety risk, or not. It does not explore what other things could have prevented that person's error from resulting in patient harm. We see HSSIB as being in that space.

Where I think there are tensions—we will come on to explore them—is how, when that investigation potentially throws up something very bad by an individual, we then safeguard the public by making sure that we, as a professional regulator, can prevent that person from practising. That is the bit that we need to explore a bit more today. However, we see those as being very different roles. It gets more complicated when we get into the accreditation space, so perhaps we can come back to that.

Paul Buckley: We agree with that. As we heard in the previous session, the issues for us are around independence, having a system-wide view of the issues and accountability to

Parliament, as a non-departmental public body, rather than to the Department of Health and Social Care. Those would be the key aspects for us.

Q132 Chair: So you are not happy with the powers of the Secretary of State to direct? You would rather see the independence more secured than it is at present?

Paul Buckley: In terms of credibility, guaranteeing its independence would be an important building block.

Harry Cayton: I endorse that view. We have seen that accountability to Parliament helps to build public acceptance of these models. There was discussion this morning about the extent to which patients and the public will feel confident in this new model. There is an issue relating to accountability, and the answerability of HSSIB to Parliament would be a preferable model, in my view.

Q133 Diana Johnson: I would like to ask about private providers, and about the CQC's recent report detailing that 41% of independent hospitals require improvement in safety. We know that one private provider has said that it would be willing to refer cases to HSSIB. I wonder what your view is on whether that is right. Should it cover the private sector? How would we fund that?

Matthew McClelland: We regulate nurses and midwives wherever they practise. We would absolutely support HSSIB's remit looking right across providers. We do not have a particular view on how that should be funded. Clearly, we recognise the tensions around the NHS being seen to be funding or subsidising the private sector.

Paul Buckley: I completely agree with that. I think it could be funded—as you said, Chair—through a levy on private providers. We, as an organisation, receive payment from the regulators that we oversee, and if we work with private providers we can charge them in addition to that.

Q134 Baroness Eaton: Mr Cayton has already touched on the issue of co-operation between the professional regulators and HSSIB, which is obviously potentially confusing. How do you think it would work with other investigative bodies and professional regulators? How do you think that the issue you raised should be addressed?

Harry Cayton: To talk about the positives that we have achieved already, one thing that came out of the Francis report was a commitment from regulators to share information, so we now have quite a robust memorandum of understanding and a protocol between all the statutory regulators, including the CQC and the ombudsman, to share information that might alert us to system-wide risk. We have built that over the last four or five years, and I give a lot of credit to Sir David Behan for leading that work and to the GMC and the NMC for doing so.

We now have a pretty robust framework for sharing information, and my concern is that we will suddenly have a different focus in which the preference is not to share information, or to keep it inside a closed box. That concerns me. It seems to me that we need to tease out for this new model—which, as I say, I support in principle—a set of rules that are much clearer about what is to be shared, how it is to be shared and what the threshold is that HSSIB is going to apply. There are clauses in the Bill that say that if it is aware of particular kinds of

information that present particular kinds of risks, it will share them with other regulators. Nevertheless, it is not at all clear to me what that threshold is. In HSSIB's provisional reports, they give examples—for instance of injecting drugs into the wrong vein and so on—which to me would quite likely be issues that a regulator would at least want to investigate at the first level, to see if that is a one-off error or a matter of performance. That needs to be teased out.

Q135 Baroness Eaton: I understand that, but how do you think this impacts on the whole issue of the culture of people being afraid to be open and honest, if everything is going to be clearly disclosed and blame is going to be apportioned? Are we not trying to move away from the blame culture to ensure that we can be creating safer situations?

Harry Cayton: I do not believe we have to have a blame culture. I am not sure that I agree with those who always say we do. I know lots of clinicians who are involved in Schwartz rounds and a whole range of activities of self-analysis and reflection in groups. I know lots of trusts where there is this kind of positive thinking about sharing things that have gone wrong with each other. I have done training sessions with trusts myself, where I have found clinicians extremely willing to be open and frank about past problems. It seems to me we should be building a just culture throughout the NHS and not moving a just culture into a single area of inspection and learning. We should be learning all the time. If you are reinforcing to people the idea that speaking up and speaking truthfully is dangerous, at the same time as trying to encourage everybody to speak up and speak truthfully and saying it is not dangerous, I find that to be an awful contradiction.

Matthew McClelland: We have just been consulting on a new approach to fitness to practice, which is trying absolutely to play our part in contributing to a just culture, where we are saying very clearly that our function in law is not to be punitive, but to look forward and ask whether somebody now poses a risk to the public in the future. As part of that, clearly, we want to encourage people to be open with us about the things that have gone wrong and the steps they have taken to put those things right. That absolutely contributes to a just culture. That is precisely what we are trying to achieve. There are potentially some unintended consequences of having a fixed line around a safe space, which is to imply that what is going on outside the safe space is in some way unsafe. That is absolutely not what we are about. We are about openness and learning, and encouraging professionals to think about the areas in which they need to improve and to talk to us about those.

Paul Buckley: We think that the current threshold in the draft Bill is both too narrow and too low. We think that a better test would be in terms of there being a serious current risk to patients—that is, not just misconduct, but a serious risk. To take the counterfactual, how would it look to the public if it emerged that there was a serious current risk and that the body—the professional regulator that could do something about that by impacting on registration—was not to be told about it? We think that having a slightly higher threshold would provide some reassurance to professionals that the safe space is safe in so far as is acceptable, given the need to balance safety with accountability where necessary.

Clare Padley: We would support that change to the drafting. At the moment there is a distinction drawn between what gives grounds to share with trusts, which is simply continuing risk to the safety of any patient which it considers to be serious. When you come to the regulators, it is changed to the word “misconduct”, which is a very particular legal term

defined by the courts and much narrower than our regulatory remit. It suggests that concerns about health, character, deliberate harm or lack of competence are outwith the things that might then be referred on, which I am sure is not what the Committee want to see achieved. The wider wording suggested by my colleague would certainly be helpful to ensure that it covers all of our regulatory remit.

Q136 **Chair:** Could you very kindly send us a note about that, which might reflect a little more what you are actually referring to?

Clare Padley: Very happy to do so.

Chair: It is a rather complicated issue, and it would be very helpful to have that. Thank you.

Q137 **Andrew Selous:** Mr Cayton, you were telling us about this robust framework and protocol where information is shared, which is excellent. I was going to ask you whether HSSIB should be able to require regulators to provide information, but by the sound of it that is already happening. Do we need that legal power in the Bill?

Harry Cayton: I have to say, I would be very surprised if my colleagues on the regulators said that they would not be willing to provide information. I would have thought that the flow of information both in and out of HSSIB is extremely important, if we are actually to have learning. I will not answer for them, but we already have a group of regulators that meets, called the Health and Social Care Regulators Forum. We have already had representatives of HSSIB come and talk to us about their plans and their work. We are engaged with them already.

Q138 **Andrew Selous:** The GMC—if you were required to give information, would you be happy with that?

Paul Buckley: Certainly we agree that information needs to be shared, and the basis on which it would be shared needs to be transparent. We are in the process of developing an MOU with HSSIB that sets that out in a bit more detail so that people can see what the rules of engagement will be. We think that will be very important.

There will be two types of sharing. One will be sharing in relation to individual investigations. That may be going on, whether by HSSIB or by the regulator. The other would be a broader type of thematic learning, which there can be no question needs to be shared as widely as possible.

Q139 **Chair:** By the by, how has your experience been of developing that MOU with HSSIB? How much confidence do you have in the mutual learning that would come from agreeing such an MOU?

Paul Buckley: We have had very productive discussions with Keith Conradi and his team. We think that those discussions are progressing very well, but some of the issues around, for example, thresholds will be affected by the outcome of the deliberations of the Committee. We think it is important that we understand where that is going before we sign on the dotted line, as it were.

Q140 Dr Whitford: Obviously, all of you have talked quite a lot about the individual and being able to spot that the individual is causing the problem. My understanding from the Bill is that we are wanting to look at the system issues that lead up to the poor person who makes the final error. I think that is the reason HSSIB is seen separately. It will not take away anything that you already do.

Mr Cayton, if I could come to you first, you have said that you cannot see how safe space would cause staff to give evidence differently from the way in which they give it to a regulator. Why do you believe that?

Harry Cayton: Staff have a duty of candour. Again, we have a framework that we created following Sir Robert Francis's review, in which there is a duty of candour both on NHS organisations and on individuals who work in the NHS. We have individual "speaking up" guardians in every trust. We have been building over recent years—I think very successfully—a commitment to transparency in the NHS. I think that has been one of the things that has contributed to improvements in safety, in the most general sense of course.

I have no quarrel at all with the need to have formal investigations where there may be systemic problems, or where there could be system-wide learning and so on. My tension is around the kind of moral hazard that we are in danger of creating, both for health professionals and for patients, in this dilemma of, "What do I disclose openly under my duty of candour? Do I withhold some information because there is going to be a safe space investigation? Do I withhold all the information because there is going to be a safe space investigation?"

If I am a patient, it is an interesting dilemma for me. I think there is a duty of confidentiality once a safe space investigation has commenced. Does that apply to patients who give evidence within that framework? Can they not repeat their evidence in public? Can they not go to their local newspaper and complain? We know, I have to say, that many of the improvements in our health system have come from patients being public about their concerns. It was patients who drove the Mid Staffs inquiry. It is patients who have driven the issues for the NMC recently. I would be very worried if patients were closed down by a safe space investigation. I have looked at the Bill and I cannot understand quite what that confidentiality framework means.

Q141 Dr Whitford: I do not think there would be any suggestion that patients be closed down, but surely you would see Mid Staffs and others, where action was only taken because someone went to the local paper, as a complete failure in a safety system?

Harry Cayton: Of course it is a failure, but we accepted at the beginning of this discussion that the failures still exist.

Q142 Chair: So you would like reassurance that there is no restriction on freedom of speech?

Harry Cayton: I would, and I would like reassurance that that duty of confidentiality does not extend to witness statements, as it were, outside the framework of the investigation.

Q143 Chair: Surely that duty of confidentiality must apply to anything you say in public?

Harry Cayton: In that case, are we not closing down patients' ability—?

Q144 **Chair:** Not in the safe space.

Harry Cayton: So once they have spoken in a safe space, they cannot speak openly again until the investigation is—?

Chair: I understand the point you are making, and we will see if we can clear that up.

Q145 **Dr Whitford:** Do you not think that something that is not taking away from investigations that have already happened but that is happening in parallel, and is very much focused on learning, sharing and system learning, is a different focus from what we have at the moment under regulation, which still tends to end up in blame, whereas this system is talking about learning and sharing elsewhere in the health system?

Harry Cayton: Again, I defer to my regulatory colleagues, but just to reinforce what Matthew has already said, we are all trying to move the existing regulatory framework further away from blame and more towards remediation. That is one of the things the Government have consulted on recently in their paper on reforming professional regulation. In that sense, if we could move it all in that direction, there would be greater harmony between the regulators and the investigations as well.

Paul Buckley: We agree with that, but I will add that we think there is a point in there about needing to start fairly small and modestly in terms of scale, which is a learning from the programme from the 2000s, which, in hindsight, was probably trying to do too much all at once.

Q146 **Dr Whitford:** The idea was that this would be modelled on the kind of learning within the airline industry, which is quite a tight safe space, whereas the Bill lists quite a lot of groups that information could be shared with and just uses terms such as “appropriate”, which seem quite loose to someone who has been in medical practice a long time and, like any person working in the NHS, could be in this situation. Do you think that evidence from the safe space should be disclosable to regulators, beyond ongoing patient danger, other than the report that will come out?

Clare Padley: Perhaps we need to start here: in a perfect world, if we were not in the world described by our colleagues earlier but in a just culture—hopefully we will get there eventually—there should not be that distinction. We all want people to be open, candid and transparent, whatever happens, across the healthcare system, with everybody. What I would have thought we would like to achieve at the end of the process is any healthcare professional being able to give the same account to the patient, to the family who have lost a loved one or had a loved one hurt, to the local trust, to a national investigator and to their regulator—indeed, perhaps to the criminal courts, if it got that far—and feeling confident that they can give the same account and that if they do, and they show the relevant remediation and so on, they will not be punished or unnecessarily put through the mill. We recognise that we are perhaps not there yet.

Therefore, although our initial response to these regulations was very much aligned with the PSA’s and we were concerned that by creating a safe space we might, as regulators, be regarded as an unsafe space, we recognise that this middle stage that HSSIB can develop

probably needs to happen. It should then become a model for good investigation. Eventually, we can almost remove the safe space boundary because people will feel confident that, if they say to HSSIB that they did something wrong, we as the NMC will then recognise that nothing will happen to them because they showed in-site remediation; they don't need regulatory action.

We do recognise we probably need this middle step, and that is where the tension lies. Not to disclose at all to the regulators reinforces, as Harry said, the danger of us being seen as non-safe, which we don't think is sensible when we are all trying to move in the opposite direction.

Q147 Dr Whitford: But you recognise that within the airline industry, if the police, the licensors or anyone else is doing an investigation, they still go ahead with their investigation, quite separately from AAIB. You don't have HSSIB at the moment, so once HSSIB exists there is nothing stopping the regulators investigating in their own way, with a view of regulating or looking at individuals, whereas my understanding of HSSIB's remit is that it is meant to be something different.

Clare Padley: For patients and family members, what we are trying to avoid is them having to give their account more than once. With airlines, you do not often get individual members of the public giving their accounts in that way. Our concern is for a patient or family member who has given a heartfelt account to one hearing and then comes to the NMC and we say, "You now need to give it all over again." They are going to say, "Why can't you just use the account I gave to that organisation?" It would lead to this confusion.

It seems to me that, if we are in the space where we recognise that something needs to be done about an individual, which will not be the case in many cases, we think it must be right that the evidence is then used, so that we do not have different accounts, which leads to difficulty for the reliability of evidence. That is the concern.

Matthew McClelland: I agree with that. One of the things that patients and family members say to us that they find distressing is that they have had to give their account over and over again, often over the course of a long period of time, to different organisations.

Q148 Chair: HSSIB could disclose witness accounts with the consent of the witness.

Clare Padley: Exactly.

Q149 Chair: The other point that arises from this, in conversations we have had with HSSIB already, is that it is clear that they regard it as axiomatic that they must alert regulators to any matter that has a patient safety benefit. They cannot legitimately hold back information about a duff consultant who is screwing up operations just because it is in the safe space. They would have to alert the relevant professional regulator about something that was affecting patient safety. So, you would be happy with that arrangement.

Harry Cayton: If we had confidence that that was happening and that the threshold was, as Clare set out clearly, better defined, then of course that would build confidence and the public would have confidence.

Q150 Dr Whitford: Obviously, this is absolutely central to the Bill. Several of you have mentioned the threshold. There is a danger of information given in one context being used in a different context. What would be the threshold? The Chair and Mr Buckley mentioned a current, ongoing danger to patients. Is that where you would see the threshold or do you see it elsewhere? In the Bill, there are terms such as appropriate, which I do not think would give confidence to medical nursing staff at all.

Harry Cayton: If I could pick up on Clare's earlier point, the word disciplinary is a real problem. Because, in a sense, only the regulator can decide whether there is a disciplinary issue. You cannot really have HSSIB deciding that this is a matter of discipline. The regulator does the discipline. I think some plain English description of a current, continuing or potential risk of harm. I always prefer the phrase "risk of harm" rather than just risk, because risk is only a probability. What we are looking at is the probability of harm. That would allow the regulator to investigate appropriately and see whether action was needed, which it might not be.

Q151 Dr Whitford: Would that perhaps then be when HSSIB, in doing an investigation, found that this was not a system problem at all, or only to a very minor level, but was actually an individual issue? What most of us who have been in the business a long time recognise is that it is often the system, even if there is one person who makes that final mistake at 2 o'clock in the morning.

Harry Cayton: We would agree with that, I am sure.

Clare Padley: Often, it is both.

Chair: To be absolutely clear, if I remember correctly from the conversation, HSSIB is saying that where there is a patient safety benefit, it would feel the need to communicate with the necessary—

Harry Cayton: It is an interesting construction.

Chair: Yes.

Dr Whitford: Was it not a current ongoing risk, as opposed to a patient safety benefit?

Q152 Chair: If a current ongoing risk needs to be addressed, there is obviously a patient safety benefit, but patient safety benefit was the term it used.

The only other question I have is what expectation you would have that HSSIB should release information that would assist the police in an investigation or assist with a prosecution or a regulator striking somebody off. To what extent is that not disclosable, because it is about finding blame and that is not part of HSSIB's role?

Harry Cayton: I think that places HSSIB in a moral dilemma and I am not sure how they would live with themselves if they were obliged to hold back information that they knew would benefit the police. Are we placing them in the same position as priests in the confessional and saying there is a higher moral good? Maybe there is. That seems to me to be a matter for Parliament to decide.

Chair: Certainly, in the AAIB case, protecting the integrity of the safe space is seen as essential to airline safety, because otherwise they do not get the information. So it is a dilemma. There is recourse to the courts to get that information in extremis, but it does require our High Court to make a judgment about that information before it is released.

Q153 **Dr Whitford:** We were talking about the idea of notifying the appropriate regulator about concerns about an individual. That is quite separate from handing over all the information and testimony. Would the regulators not accept that, having had concerns about an individual flagged up, it is then up to the regulators to carry out their own investigation and the police to carry out their own investigation? That is very much how it is seen in the airline industry.

Paul Buckley: I think that is how we would see it as well.

Dr Whitford: So you would find that acceptable.

Clare Padley: The only caveat is about the public and patient witnesses, which we have already talked about. We should also note that HSSIB's own powers to require information from trusts do not include the provision of information that might incriminate the person. That is one of the exclusions.

Q154 **Chair:** We found that rather odd. What is the point of the safe space if you can't require all the information?

Clare Padley: Well, I was going to ask you about that but it has not been raised.

Chair: Thank you very much for raising it. If you could put a little note in writing to us about that too. Free legal advice is always very welcome.

Clare Padley: The only other matter I wanted to raise on the issue of investigations is that it is clear from the guidance notes on the Bill that it is envisaged that the HSSIB investigation would carry on in parallel with any local investigation. We would never want any employer to think that the existence of an HSSIB investigation removed its ongoing obligation to refer to professional regulators any individual in its employ about whom it thought action needed to be taken. So that is another safeguard in terms of things coming to us.

Q155 **Chair:** Can I just ask about the sequencing? In the aviation sector, there tends to be a sequencing that allows HSIB, or AAIB, to conduct its investigation. The coroner's court will adjourn, the police investigation will wait and then, once the report has come from AAIB, the other things roll into action. How does that work with HSSIB? Can it work like that?

Matthew McClelland: I think it is hard to have a hard and fast rule here. I think we have learned lessons around putting our investigations on hold for others in the past. The critical point is not to undermine the role of employers here to look at the issue sensibly and carefully themselves and to make referrals, as Clare was saying, to regulators and others who need to know. I think each case needs to be looked at very carefully to determine whether there is a sequencing or whether they have to happen in parallel. That will just depend very much on the circumstances of the case and the issues that we are looking at.

Clare Padley: We have powers to put interim orders in place to restrict the practice of an unsafe professional while an investigation is going on. In the airline case, sadly, either people are not alive because there has been a catastrophic disaster, or, if it is pilot error, the pilot, who tends to have only one employer, is suspended by his employer. In our case it is very different because the healthcare professional could go and work anywhere else. That is why we as the regulators have the interim order powers rather than that being left to the employers.

Harry Cayton: There has been a lot of criticism of the regulators, both from patients and families and from professionals themselves, for the length of time that investigations can take, if you put off one investigation because another is taking place. There has often been discussion with the police who are sometimes concerned about a second investigation tainting evidence, but, equally, sometimes the police say, “No, carry on with your regulatory investigation. We will do the two in parallel.” As Matthew said, in a way you have to have decisions on each case, but I would hate to see sequencing happen, which means it could be many years sometimes before you get to a conclusion.

Chair: That is very clear. Very helpful.

Q156 **Lord Kirkwood of Kirkhope:** I have two questions to finish off the more general subject area of disclosure. We are very aware of the continuing concerns about the tension between the various safe space, duty of candour and medical reflections and development. Do you think that the current draft of the Bill has got the balance of those different important elements correct? We talked about that slightly earlier. I want to go on after that to ask Mr Buckley if he would talk a little about protecting legal privilege for medical reflection, because the GMC’s evidence is interesting on that and suggests some amendments. Do you have any comments on whether the balance currently in the Bill is workable?

Harry Cayton: We have said in our written evidence that we are not comfortable with the balance. It may be that the balance is right, but it is not sufficiently clear what the balance actually is. Some of the questions that we have been teasing out might suggest that there is likely to be a bigger flow of information out of the safe space investigation when necessary than I had read on the face of the Bill. I would like, particularly on behalf of the public, to have a stronger sense of how patients and the public can be engaged in these processes and have confidence that what happens behind closed doors is not a stitch-up. I am not suggesting that it would be, but there is always a suspicion that it might be.

Clare Padley: Our position is that we are reasonably confident in the balance in relation to the national body being suggested, to HSSIB itself, because of the precautions put in. Our concerns grow when we get into the accreditation space because of the issues that Harry has raised about public confidence, given the long history of local investigations even by neighbouring trusts. We can think of the hyponatremia inquiry in Northern Ireland; Morecambe Bay; Kirkup and so on—they have all outlined the problems when supposedly independent local investigations or local supervisory midwifery investigators are not such, so I think there is an issue there.

Q157 **Chair:** Do we all agree that this idea of accreditation sounds like a leap in the dark and that it is much too soon to think about anything like that? Do we want to see how the system works on its own without accreditation?

Paul Buckley: There is another point about that, Chair, which is that the model has very much a secondary care acute sector feel about it. One of the issues that we have learnt from the 2000 programme, which I keep going back to, is that you must not overlook primary care and the patient journey from domiciliary care to primary care to secondary care. A lot of the risks are in the interfaces and transitions between these various practice settings and I do not think the Bill quite takes us to that place at the moment.

Q158 Baroness Watkins of Tavistock: Do you think risks are also there in learning disability and mental health care?

Paul Buckley: Yes, absolutely. We know that that group of patients can suffer particular disadvantage. We have done quite a bit of work around the Mental Capacity Act and there is an awful long way to go to ensure that those patients have the treatment that they are entitled to expect.

Q159 Lord Kirkwood of Kirkhope: Can I ask Mr Buckley to expand a little on the evidence that he submitted in written form that suggested some amendments? Personally speaking, I am struggling to know and understand why professional reflection is not legally privileged. I am not sure that the Bill is the appropriate vehicle for that, but I think that you were helpfully trying to suggest to us that there might be some method of doing that within the scope of the Bill as it stands.

Paul Buckley: We certainly see a case for that. Dr Fleming was talking earlier about, as it were, a psychological safe space within which an individual healthcare practitioner can reflect. We think it is very important to offer some protection, because reflection is so important for improving care and it delivers patient benefit—this is not just about professional benefit. It is also something that is of great concern to all 240,000 doctors in the UK, so the scale of the problem is very great. We have seen the reaction from the case that is still ongoing—it goes to the Court of Appeal next month.

We think there are two issues. First, there is a need to offer general protection for reflective notes. Secondly, there is a specific issue in relation to reflective notes within HSSIB investigations. There are two issues there. It may be that the Bill is not the right vehicle for a more general protection—it has been suggested that the Law Commissions might be invited to look at that, and we would support that—but on the specific issue of reflection within HSSIB investigations, there could be an additional clause that said that those reflective notes were not usable or disclosable to HSSIB other than by a High Court order. That would also answer the point about doctors being, as it were, above the law. They would not be above the law; they would be subject to the law.

Q160 Lord Kirkwood of Kirkhope: You might need some definitional input in the Bill to ensure that the scope of some of those terms was easily understood. That is hard to lock down in a legal context, but you and your colleagues would be able to help the Government or the Department.

Paul Buckley: Indeed. In the Williams review, which came out on Monday, there is a recommendation that the GMC's legislation should be amended to make it impossible for the GMC to require the production of reflective notes, which we have said that we would never do, so it is not even an issue. I take it that it is thought workable to come up with a way of drafting that covers the technical challenge, so we cannot see why, if that is the case, and we

think it is as well, that that could not be read into the Bill. That would offer some interim assurance to the profession on the way to the wider protection we think is necessary.

Harry Cayton: I will not extend this, but I do not agree entirely with what the GMC have said here. I was a member of the advisory panel to the Williams review, so I support the recommendation in that review, which is that this should not happen.

Q161 **Chair:** To clarify about the safe space: to what extent should anybody be able to go to HSSIB and say, “I have a matter concerning patient safety and I wish to raise it with you within the safe space”? That should be allowed, should it not? Why would HSSIB or anybody want to restrict somebody telling it something that has a patient safety benefit because, “Oh no, we have not opened an official investigation. There is no safe space available to you”? That seems to be unnecessarily restrictive. What do you think about that?

Harry Cayton: I do not think that any of us are suggesting that that would not be possible. Just as now, if a whistleblower comes to us, we do not disclose anything that they have said and we are not overly legalistic about what we define as a whistleblower either. I think that is common good practice.

Clare Padley: I would probably go further. In our MOU, which we are also developing with HSIB, we want a situation where, as we do at the moment, we refer things to the CQC and to the other three countries’ regulators. We might even suggest matters that we think HSIB ought to look at, where perhaps we see something that is not the work or problem of individuals, but appears to be systemic. Absolutely, it should be possible to raise everything.

The point about reflective accounts is a slightly different issue. Again, we are not in the same position as the GMC.

Q162 **Chair:** There is another practical thing. You raised how there is a chill over the duty of candour in the health service at the moment because of the culture. In that event, HSSIB might be the avenue of choice for candour about some issue, although I appreciate that the duty of candour is very much directed at clinicians’ candour with patients. However, where there is a matter of concern to anybody, they can be candid with HSSIB in a way that they cannot be candid with anybody else without fear of the consequences. How happy are we with that as a force majeure?

Harry Cayton: It goes to Clare’s point that we are not in a perfect world. I would just go back to not abandoning the hope that we can create a just culture for everybody everywhere by saying that there is a kind of substitute for that. However, yes, we must live in the real world.

Clare Padley: If you really wanted to look into that seriously, obviously we are all prescribed bodies for whistleblowing purposes. I don’t know whether there is a proposal that HSSIB would become a prescribed body for whistleblowing, which gives stronger protection.

Chair: In the aviation sector they do not have whistleblowers, they just go to the Aviation Investigation Bureau. They don’t have a whistleblowing culture. The idea that you have to have a category of person telling the truth called a whistleblower is itself an indication of the anxiety and distress about candour. I hope we can get beyond the need for whistleblowers.

We have talked about accredited trusts and I do not think we need to spend any further time on that. Andrew Selous has a question.

Q163 **Andrew Selous:** Yes, we have covered the question I was going to asked earlier, but I just wanted to ask the representative of the NMC to reflect on the James Titcombe episode, what you have learned from it and how things will be different in the future.

Matthew McClelland: We are extremely grateful to all the families, including Mr Titcombe, for having taken part in the Professional Standards Authority review. We recognise that that absolutely was not an easy thing to do. The report and its lessons are enormously helpful to us. Our council debated them in significant detail last week and has accepted all its findings and all its lessons.

We acknowledge that we did not deal with things in the way we should have done. We were too slow to deal with things. We did not listen effectively to families, and even when we had heard their concerns, we did not act on them sufficiently swiftly. We acknowledge that that placed a higher degree of risk of harm in the circumstances. We are enormously sorry for that. We have expressed our apologies to all the families.

We are now very keen to move forward. There were some excellent recommendations and lessons in the review that we are determined to take forward. The one that is particularly powerful and relevant is about the role of patients in regulation. There was a question, in your earlier session, about the role of patients in HSSIB investigations, and I think there is a parallel there. It is absolutely critical, in our view, that regulators put patient voices right at the centre of investigations, so that we all really understand the issues and can move forward and take action and encourage learning based on those experiences and voices.

That is where we are at the moment. Our council has absolutely committed to a programme of work to address the lessons learned. We will be going back to them at the end of July with that programme. And of course some of the work that we are already doing around the fitness to practise consultation—it closed last week—setting a new direction of travel for fitness to practise, speaks very much to the issues that the PSA identified.

Andrew Selous: That is very helpful; thank you.

Chair: Are there any other points?

Q164 **Dr Whitford:** Could I ask for input on something? Ms Padley, you referred to the strain on families from giving evidence repeatedly, and the Chair talked about sharing evidence, with the permission of the witness. Obviously, there would be transcripts, and most of these things are probably also videoed. I wondered whether you felt that whoever did that first stage with the patient and their family, that might be a reasonable route to go down—that if the patient and their family were happy that they had given all the evidence they wanted to give, they could give permission for that to be shared with another body, but equally they would reserve the right, when they had had a bit more time to think, to come and say, “Actually, I’ve thought of something else as well,” because that might get us round the onerous pressure on families.

Clare Padley: Anything we can do, as colleagues have said, to avoid confusion for the public and patients and, indeed, registrants and regulated professionals about the different roles and to make sure there is one version of the truth has to be good. All this conversation is because we are worried about people saying one thing and having a consequence from saying what actually happened. What we want to achieve is a situation where people can say what actually happened and be judged fairly and action will be taken only if it is necessary because they are a continuing danger to the public. That is what we are all trying to achieve.

Chair: People do have a right in law not to incriminate themselves. Well, thank you very much. This has been an excellent session. I repeat: if you have anything you want to add or if you have any reactions to other evidence that we receive, please do put it in writing. We want to hear all the relevant points that you have. Thank you very much indeed.