



HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

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

Wednesday 20 June 2018

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Members present: Sir Bernard Jenkin (Chair); Baroness Eaton; Lord Elder; Diana Johnson; Mr David Jones; Lord Kirkwood of Kirkhope; Andrew Selous; Dr Philippa Whitford; and Dr Paul Williams.

Questions 224-328

Panel 1

Witnesses: **Professor Brian Toft OBE**, Emeritus Professor of Patient Safety, Coventry University; **Professor Charles Vincent**, Health Foundation Professorial Fellow (Patient Safety), Department of Experimental Psychology, University of Oxford; and **Dr Carl Macrae**, Nottingham University Business School, University of Nottingham, gave evidence.

Q224 Chair: I welcome our first panel of witnesses for this morning's evidence on the draft HSSIB Bill. Could each of you identify yourselves for the record, please?

Professor Vincent: I am Charles Vincent. I am a professor of psychology at Oxford, but what I have done over the past 25 or 30 years is to research patient safety and be involved in these kinds of activities.

Dr Macrae: I am Carl Macrae. I am a senior associate at the University of Nottingham and also a researcher in residence at the current Healthcare Safety Investigation Branch—for the record, that is a part-time temporary advisory post to help to advise on the set-up phase. I suppose I should also note that I was a specialist adviser to the original Public Administration Select Committee inquiry and a member of the expert advisory group on the Healthcare Safety Investigation Branch.

Professor Toft: I am Professor Brian Toft. I do investigations into patient safety and serious adverse incidents. I have advised Parliament on three other occasions on this topic. I am also a visiting professor of patient safety at the Brighton and Sussex Medical School.

Q225 Chair: Excellent. Welcome. We have two panels and a lot of questions, so we will go as quickly as we can. If you can keep your answers relatively crisp, that will help us. If you want to submit further information in writing after the session, we would very much welcome that. I will start. How do you think setting up HSSIB will

improve patient safety and how will it change the culture, or is that expecting too much of it?

Professor Vincent: I think there are two very important, critical things. If you look at the other safety-critical industries that we all rely on, they all have an independent safety investigator, and one of the critical things about that is that it can make recommendations to any part of the relevant system—aviation, rail or anything. At the moment in healthcare we have no organisation that can make recommendations to the Care Quality Commission and the Department of Health—and that is not necessarily critical recommendations, but actions to take to improve the system. I could expand on that.

The second aspect I would particularly highlight in terms of the culture is this. We developed methods of investigation 20 or 25 years ago in healthcare. Even now, investigations are quite poor. I think it would be enormously powerful not for HSSIB to do a lot of investigations, but for it to model how they might be done, in terms of conduct—ethics, if you like—and methodology, instead of what I see, frankly, as often a quite amateurish approach within the NHS.

Dr Macrae: I certainly echo those points. For me, one of the critical gaps in the healthcare system without an investigator such as the HSSIB put forward in the Bill is an inability to tie together where the sources of risk lie in the healthcare system. At present we have a range of bodies that undertake their own investigations in silos—regulators, public inquiries and the like—but there is no permanent body that can tie together what the entire picture looks like and, as Professor Vincent said, make recommendations to the entire system itself.

Professor Toft: You mentioned culture, Chair. It is interesting. With 1 million people and 30 cases, I think it is highly unlikely that HSSIB is going to make a difference to the culture directly. It is just too big a job. Typically, it takes three to five years to effect any kind of culture change in an organisation. I have published on the subject. Barry Turner, Nick Pidgeon and I were some of the first people to write about safety culture and have it published. In terms of cultural change, it is highly unlikely that it is going to make a big difference at all.

In terms of what they can do—act as exemplars—well, that would be very good. However, as far as I have seen, although the chief inspector was the chief inspector of the air accident investigation branch, I do not know about any of these other people. The thing that really worries me is that he is just about to hire about 130 completely—well, I don't know how well qualified these people are to do an investigation into the Secretary of State's request that they do 1,000 maternity cases, and that's before they even start flying, to use an aviation analogy.

I have some serious concerns about the way things are going. Notwithstanding the fact that the chief inspector of HSIB has sent out a letter to all the national health service trusts telling them that the investigation into the maternity cases that they are going to investigate will be instead of the local investigation. That speaks to patient choice. Patients will have no choice whether it is HSIB that does the investigation or the local people. Before we even start, there are problems to be faced.

Q226 Chair: Your concern, as you said in evidence to my Committee in 2014-15, is about the sheer scale of clinical failures in the NHS, combined with the very limited scale

of this agency. You seemed to be arguing for a much bigger capability at one stage. If we are going to have this capability, it needs to be much bigger.

Professor Toft: That would be true. There needs to be a much bigger capability. It is frankly too small.

Q227 **Chair:** How should it start? Shouldn't it start small before it gets big?

Professor Toft: There is an argument in both directions. There is a good argument for a pilot, which is what I think you are suggesting Chair, and to see how that works and then build it up. There is also a good argument that, if they are going to hire 130 inspectors of completely unknown specification, how does that work? They have got 30 people at HSIB who are "professionals" in investigations, and they are going to hire 130. It is going to be a big organisation to start with, except that 130 of them are going to be an unknown quantity.

Q228 **Chair:** We will take evidence from Dr Conradi next week, when we can ask him about this. To be fair to him, he does not regard this extra request for 1,000 investigations as part of his core work; he regards it as something peripheral that he has been asked to do. But they are not going to be HSIB investigations with the safe space and all the other attributes of an HSIB investigation.

Professor Toft: I went on the website and it looks to me that effectively they are going to do them, but they are having an extra 130 people to help do the investigation.

Q229 **Chair:** They are having to take in people from outside.

Professor Toft: Yes, to help them do the investigation. I don't know 130 investigators in this country.

Q230 **Chair:** So you would be critical that the Secretary of State has required him to do this.

Professor Toft: I would indeed.

Professor Vincent: I would like to add a brief point. Think back to what it was like before you had HSIB. I was involved in Bristol, Mid Staffordshire and many other big inquiries. One key thing about this is that it took about 18 months to get the inquiry started, using Sir Ian Kennedy and Sir Robert Francis. They did a fantastic job and really understood the wider thinking. It took them a long time to get going, not because of them personally. Teams of lawyers were employed at a lot of expense, but given the slowness at the start and the time taken to understand the system, to understand safety, to understand the methodology, it is two years before you really get going on this.

With HSIB, you make a phone call and you start within 24 hours. That is the big plus. If we go back to the other systems, we are still going to have these big investigations that require some sort of independent set-up in healthcare, or indeed in anything else. The advantage of having a small team of pretty cheap people, really—experts ready to go—I think is incalculable when you need to act fast to reassure patients and families, and so on.

Q231 **Chair:** But you would accept Professor Toft's point that this is at the moment a very small capability, and it is going to take time to grow the capability.

Professor Vincent: The principles of what we are talking about need to be separated from what is actually happening. I am not saying that I am in touch as much as Carl and Brian with how it is developing at the moment, but I understood here that you were more interested in the principles of what we are trying to do, and we are not here to judge HSIB's performance at the moment. That was my understanding.

Q232 **Dr Williams:** My question is about how HSSIB is going to operate in practice. In your view, how clear is the draft Bill on the definition of HSSIB's mandate, as compared to the various other bodies, particularly the role of NHS trusts in dealing with complaints and safety concerns?

Professor Toft: It seems to be fairly straightforward. I do not see any difficulty with the drafting of the Bill as such. I have no real comment on that. I think it suits its purpose.

Q233 **Dr Williams:** When we took evidence from some of the NHS providers, they told us that they have obligations that they need to fulfil—for example for coroners' courts—and that there was a bit of a lack of clarity, if HSSIB came in and took over an investigation, where the lines of accountability would be.

Professor Toft: But, if HSSIB's sole purpose is to go in to do investigations in order to learn, surely they won't be taking over the regulator's role. At least that was my understanding: that they are doing an investigation to learn from the incident that took place. The regulator's function is different.

Q234 **Dr Williams:** We have already talked today about the maternity investigations that it is going to be doing. Let us say that there is a maternity investigation in a coroner's court. At the moment it is the NHS trust that has the responsibility for providing information to the coroner's court.

Professor Toft: But the coroner can call HSSIB to give evidence, so I would not see that as a problem.

Dr Williams: We are just checking scenarios, to make sure that—

Professor Toft: I understand the NHS providers' reticence to let anybody else in, but HSSIB are supposed to be specialists in the investigation of serious adverse incidents, so they can aid the coroner in his work and do not have to step on the toes of anybody—at least that would be my understanding of it.

Dr Macrae: Yes, the draft legislation is very clear that the focus of investigations is for learning and not attributing blame, which is absolutely key. There are some elements that concern me, particularly around accrediting local trusts for investigations—and both internal and external, as it is defined in the legislation. I believe I can understand the intent to improve local investigative capacity and performance, but to my mind that is not an appropriate—

Q235 **Dr Williams:** So you would like to see, if there is a need for more investigations, that they are done within the space of HSSIB rather than having trusts accredited to do those investigations.

Dr Macrae: Possibly a bit of both, if you like, so HSSIB having potentially significantly more capacity over time as the organisation develops, but equally there is a great deal of

work to be done at the local level, and having HSSIB essentially act as a regulator to accredit, inspect and review local trusts on their ability to conduct investigations or performance—that to me fundamentally blurs the line of HSSIB needing to be an independent, overarching organisation. Having to accredit and review or inspect trusts that they then might need to investigate independently is, to my mind, a very difficult circle to square.

Professor Vincent: I might just add to your point about the coroner and HSSIB. I doubt very much—this is what I understand is the case—that HSSIB will look at cases where the only learning is within the individual case. If there is a case in maternity that the coroner is dealing with quite properly, I should think that HSSIB will look at that only as a sort of index case if they think that what it reflects is some wider problem in maternity services about the transfer of mothers or something.

Q236 **Dr Williams:** I would agree with that, if we had not had those 1,000 maternity cases given to HSIB. With the original intent of HSIB, yes—it was to do 30 investigations where there was wider learning—but we have already seen this mission creep, and they will be looking at individual cases.

Professor Vincent: I agree that mission creep is a worry, but I think the principle is that HSSIB should exist to help us when we have systemic problems—that is where they should put their focus—and heaven knows, there are plenty of those.

Q237 **Dr Williams:** What do you think the threshold should be for triggering an HSSIB investigation? Should there be a particular threshold, or should HSSIB be able to go anywhere and investigate absolutely anything it wants?

Professor Vincent: There is the question of how you might define a threshold, and the permissions would be much better placed about what they should do. I think they need to have freedom to investigate what they think—the decision should be theirs—but the criteria should be that there is some wider learning and that they should not go around investigating single cases that are probably more properly done by the coroner, the CQC or whatever. If that is not there, I do not think they should be interfering, if you like, in local investigations.

Dr Macrae: Just to build on that point, the core intent of HSSIB is to investigate an area of systemic risk to patient safety. It will use particular incidents to explore that. That is a very different proposition from what local trusts and organisations need to do when they are investigating an incident to understand it for their own organisation and for the family to provide information. HSSIB operates at a system safety level, if that makes sense, which to an extent explains the small number of investigations—they are the top 30 systemic risks each year, essentially.

Q238 **Dr Williams:** But from the evidence you presented to us 10 minutes ago, you think that some learning about the conduct of the investigation will be applicable to the individual trust, but that the circumstances and the reason for the HSSIB investigation will be different, even though some of the methodology may be similar.

Dr Macrae: That is right. Essentially, local investigations stop at the walls of that organisation, so if there is a problem in the design of a piece of equipment or how that equipment was certified in the first place, a local investigation could never address those issues, whereas HSSIB can take that broad sweep.

Q239 Dr Whitford: We have got into something that I was going to come to later, but it is quite clear that you do not agree with the idea of accrediting trusts to do their own HSSIB-type investigations. As you have touched on, trusts investigate complaints, failures and incidents all the time, and will continue to do so. Do you see it, as a previous witness suggested, as not about accrediting to do an HSSIB investigation, but sharing or developing methodology and even providing that kind of training to trusts so they investigate in a similar way, and take the view of an incident of, “How do we prevent it?”, as opposed to, “How do we blame everybody?”?

Professor Toft: On accreditation, I understand that patients’ organisations are very much against accreditation because of the safe space. They do not trust them already, so that will make it a lot worse than it already is. It will create mayhem in my opinion.

The NPSA tried to train the NHS—I see the Chair smiling—and they had a lot more resource than HSSIB, and I mean a lot more, and they failed. HSSIB will face exactly the same situation: lots of people with lots of things to do. No matter how well intentioned it is, they are highly unlikely to ever be sufficiently trained to come to the same standard as HSSIB, because they have other jobs to do. They have their day job—they have to be a doctor, a nurse or a senior person. It mitigates against that. They do a good job—the best job they can do under the circumstances—but the point of accrediting them would be absolutely beyond the pale.

Q240 Dr Whitford: But could the principles of taking a wider system look, rather than blaming the person who made the last mistake in a line, and of taking much more of a learning rather than a blaming look within a trust, not help?

Professor Toft: Recently I reviewed about 20 or 30 different investigation reports, from different places, including Oxford University Trust. There was only one case where a person was wrongly accused of having made that mistake, but for the rest, they haven’t pointed the finger at anybody. They said that where there had been systemic failures, they had spotted them themselves, which I thought was rather good. Often, the people doing the investigations have not got time to sit down and work it all out, but when they have, they usually do a fairly good job.

Professor Vincent: I think Brian is quite right to say that the training is not feasible directly, but there is power in having a model. I am not talking about just the methods, but about the candour and transparency to patients and family, and the public face of the investigations, which gives a very important message culturally. The fact that a national organisation will repeatedly put cases—even if it may be just 30 cases a year—shows that it can be done. You can be open to patients and families, and you can display what you are doing. That will be very powerful. I know a lot of people here share that aspiration for the NHS.

Q241 Chair: May I ask an overlapping question that I do not think we cover elsewhere? It is the Government’s policy to introduce the network of medical examiners. How do they fit into the HSSIB landscape?

Professor Vincent: I don’t think I personally know enough about how the network will work to be sure about that.

Professor Toft: I am the same. I have no knowledge of it to say how it would run in conjunction—

Dr Macrae: I have limited understanding of what that will look like in practice, but my understanding is that it will provide another very valuable source of information for HSSIB to understand where serious systemic risks may lie. If every potentially avoidable death is investigated at local level, that ensures that HSSIB can have a flow of information to understand where it might—

Q242 **Chair:** Its role has been described by the Royal College of Pathologists as “not to investigate but to detect and pass on in the manner of a pathologist”. I imagine that it will be a useful source of information for HSSIB.

Professor Vincent: Yes, among many others. Absolutely.

Q243 **Baroness Eaton:** To what extent does the Secretary of State’s power to request HSSIB to investigate particular things compromise and challenge the independence of HSSIB?

Professor Toft: I think it does. I simply do not believe that it should report to the Secretary of State; I think it should be to Parliament. The Secretary of State is all over the Bill, and I think that leads people to suspect that HSSIB is there for a different reason and being run by the Secretary of State. My colleagues said in a published paper that HSSIB should be free of regulatory and political influence, and that is absolutely right. The impact statement about the Bill said the same thing, as indeed did the past Committee—it should be separate. I do not think that HSSIB should report to the Secretary of State. I think it should be to Parliament.

Q244 **Baroness Eaton:** Do your colleagues have a different opinion or the same one?

Chair: If it’s the same opinion, we can move on.

Professor Vincent: It is similar. I think it would be rather extraordinary if the Secretary of State could control it—I don’t think they should. If Bristol happened again, the fact is that they couldn’t request it—it is about how that is enshrined in law.

Q245 **Baroness Eaton:** If not, who should it be accountable to? You suggest a parliamentary Committee, but is that not likely to have political pressure anyway?

Professor Toft: Under my understanding of Parliament, a parliamentary Committee would have different people from different parties, and therefore it would not be in just one direction. There would be a balance of views about what was supposed to be happening, and that is always good, rather than having one person directing something.

Chair: Parliamentary Committees scrutinise, but they tend not to direct.

Baroness Eaton: That’s right.

Professor Toft: That may even be better, in my opinion.

Mr Jones: Baroness Eaton’s question was essentially about the power of the Secretary of State to request HSSIB to carry out an investigation. Obviously there have been a large number of events where the Secretary of State has set up public inquiries because of public

concern. Is it not right that in circumstances such as that, the Secretary of State should have the right to request HSSIB to carry out an investigation? If that is not the case, you are left with going back to the public inquiry system, which this is intended to avoid.

Professor Vincent: The idea that he or she could request seems very important. I appreciate that that is tricky to lay down in the statute, but I do not think he should mandate or control what HSSIB does. That would be wrong, as everybody agrees.

Q246 **Mr Jones:** As I say, the question was about references to HSSIB by the Secretary of State. Professor Toft, do you not think that is reasonable?

Professor Toft: I think it is reasonable that the Secretary of State could make a request that HSSIB look at something. That is different from being directed, at least in my language.

Q247 **Mr Jones:** Can you draw the distinction?

Professor Toft: The Secretary of State has the powers to do all kinds of things in the Bill, such as change the way in which they operate. That is power in itself. If he was not in charge of it, he could make a request that would be a request, as opposed to a request that is really a direction—"you will do this". As I understand it, the HSSIB could not turn around and say to the Secretary of State, "We're not doing it." That is what I would like it to be able to do.

Q248 **Chair:** Even if you would be left with the Secretary of State setting another public inquiry, with all the attendant cost.

Professor Toft: With all due respect, I think that even with HSSIB in place, public inquiries will not go away when there are lots of people who have been injured in lots of different ways. When their families get together, they will be crying for a public inquiry, not for HSSIB. I have no doubt about that.

Q249 **Chair:** It was very striking that after the Marchioness disaster, the Marine Accident Investigation Branch carried out the investigation, but there was still an outcry and a call for a public inquiry. Eventually, John Prescott called a public inquiry.

Professor Toft: And it took 20 years to get the public inquiry—my evidence helped that in part.

Q250 **Chair:** Would it not have been easier for the Secretary of State to say, "Can you look at this again, marine accidents investigation branch?" But that would not have been a public inquiry.

Professor Toft: They could have looked at it as many times as they wanted. The Marchioness Action Group would have come back and again. They did—they had the River Thames safety inquiry. I remember the secretary to the inquiry, Mr Peacock, said to me, "Well, that's it done then." I said to him, "These people will not be marginalised. They will not be put to one side. They will not patted on the head and told to go. They will keep coming back at you until you give them a public inquiry." That is precisely what they did. Today, I understand a report is being released. That has been ongoing for 20-odd years. That will continue. When people get angry about things and they band together, they ask for public inquiries and they keep going until they get them. That is the way it seems to be.

Dr Macrae: My sense is that there is a strong distinction between the purpose and function of a public inquiry and the function of HSIB as constituted in the current legislation. A public inquiry, in lay terms, is essentially to hold people to public account for actions and events that have taken place in the past.

The HSSIB intent is to identify systems learning, primarily looking not at individual causation or the actions of individuals, but at the systemic underlying risks in the structure, process or practice of the healthcare system. There are two quite different functions. One would hope that with a better investigative infrastructure in healthcare there would be less need to call on the functions of a public inquiry in future. There is that distinction.

To go back to the original question about the Secretary of State, it seems perfectly reasonable for the Secretary of State to make a request or note that they have concerns in a particular area, but my view is that HSSIB needs to be fundamentally independent of any influence or direction from local NHS trusts, the political sphere and regulators.

Q251 Andrew Selous: I am just looking at clause 4, which uses the word “consider”. I don’t know what you make of that. Have you looked at the ongoing relationship between Her Majesty’s inspectorates of prisons, constabulary and probation, as independent Crown appointments, and their Secretaries of State and Departments? Are there any lessons to be drawn?

Professor Toft: The answer to that is no, I’m afraid. I have not looked at them.

Q252 Andrew Selous: It is a different sphere, but they are independent bodies doing the same job.

Professor Toft: But healthcare is extremely emotive. There is a difference between inspecting prisons and probation services, and going in and doing an investigation when you have got parents like those I have had in front of me, with the father going apoplectic because you have killed his son, and the mother in tears.

It is a different way of engaging with an investigation. People have very, very strong feelings about them. That is why I say that the public inquiry will not go away. People become extremely animated when they don’t think they are receiving justice. One of my problems with safe space is that people may not believe they are getting justice because they cannot have access to the data that is being used to derive the report.

Q253 Andrew Selous: I suppose that comes back, in a sense, to whether HSSIB focuses on the high-level thematic inquiries.

Professor Toft: But even when you are doing a thematic inquiry, as I have done—I have some experience in this field—you have to do individual investigations at some considerable depth to pull out the themes. You look at this, you look at this and you look at this, and you need to use abstraction. I understand that there are going to be four in each theme, so they will have to look at each one in turn in some considerable depth, and then pull back to the level of abstraction to find the systemic things. That is known as isomorphism. As a consequence of that, they have got to do in-depth investigations, regardless of what they are doing. That is if they are going to find anything—of course, a superficial investigation will get you exactly nowhere.

Q254 Andrew Selous: We have touched on this area already, so you may not have much more to add. If you don't, that's fine—we can move on. I want to ask you about HSSIB's role in engaging with patients and families during the course of its investigations. How do you think that could and should work?

Professor Vincent: I think it is absolutely fundamental. To my mind, it is one of the most powerful reasons to set up HSSIB. This speaks to the need for independence, and the need to regulate the whole of healthcare.

When Carl and I were thinking about this originally, we tried to imagine ourselves in the patient's shoes. I am not claiming any personal experience, but I have talked to a lot of people who have been in this situation and, as Brian points out, they are sometimes in a shocking state. I hope that HSSIB will model a way of engaging with patients, which is not straightforward.

Patients should be engaged at a very early point in the process—possibly first. Typically, organisations do engage people. Inquiries vary, and it may be different with different people, but it tends to be as the recipient of the report, rather than as a contributor to it. I hope they will take a very different view. Where there are people who are affected—it may be in the first case that comes up, or more widely—I hope they will contribute, not only as a matter of humanity and trust, but on why things went wrong.

If you do an investigation in an operating theatre, it frankly doesn't matter a lot what the patient thinks, because the issues are technical, but we are moving into an era when healthcare is going to be delivered in the home more and more. We already have parents essentially running a small intensive care unit for their children.

Extraordinary things are going on. As citizens we will increasingly be delivering healthcare, and we will be making mistakes. The reason for engaging patients is no longer that it is the right thing; it is actually fundamental to the conduct of the investigation, in many cases. I won't go on further—I could go on for the rest of the session. Those are some of the reasons and my hopes.

Q255 Dr Whitford: Obviously, the idea of HSSIB is not to take away anything that already exists. You have all touched on the fact that you think it should be independent, as the Air Accidents Investigation Branch is, and focused on learning rather than blaming. Central to that is the issue of safe space and, in the Bill, quite a long list of exceptions to the prohibition on disclosure. That strikes many of our witnesses, on both sides of the argument, as quite core to this. Starting with you, Professor, how important do you think the safe space is to giving professionals the confidence to be open, warts and all?

Professor Vincent: It is critical, but we should think, "Why the safe space?" I do not believe in the safe space just because of fairness. The justification for it relates to the fact that I think people should be compelled to contribute to investigations. Again, if I put myself in the families' shoes and I find that somebody has just refused to engage in a safety investigation to learn from the system, I am not going to have any confidence whatever in that if there is even that possibility.

But if you are going to do that, and you are going to hold to the idea that the purpose of it is to learn and improve safety in the system, then you have to protect the people. Of course, as everybody on the panel knows, in other industries it does not protect the member of staff or anyone else from the ordinary disciplinary processes. It is not a free ride. It is just that first you speak to HSSIB, and their concern is the wider system. If you have to face the GMC or whoever it may be, that is a separate matter. Again, it is not a free ride; it is a separation of purpose.

Q256 Dr Whitford: Is that not one of the issues in the Bill and in some of the evidence we have had—that other regulators and the police think that HSSIB’s legwork should then be given to them? We do not have HSSIB at the moment in its proper form, so it is not as if we are taking away something that already exists; it is as if other people are saying, “Yes, you do all the legwork and hand it to us.” That is never going to work.

Professor Vincent: No. Carl will know more about how the relationship works. There may be some circumstances in which it is necessary, but again it relates to the wider purpose of HSSIB, which is really not to investigate particular cases, in a sense.

That may be part of what they do, as Brian was saying, but it is about the wider learning. I think their investigations will quite quickly move from the exploration of single cases to looking at a much wider set of information about, say, the transfer of high-risk women in maternity, or whatever it may be. They will not just look at the single case. They will then quite quickly move to looking at, “Well, what do we know in general about this issue? What is the research? What other data have we got?”—things that go well beyond the individual case. That will also separate them more clearly, and that is not particularly useful to somebody investigating a particular case.

Q257 Dr Whitford: Obviously, in the Bill as it is drafted at the moment there is a long list of exceptions, quite different from Air Accident, where you have to go to the High Court. An equivalent here would be a current and ongoing risk to patient safety, but there is talk that that might be evidence of benefit to patient safety. As a doctor, that certainly strikes me as a much more diluted form of words. I am interested in how high you would set the bar to protect the actual evidence HSSIB has gathered, as opposed to HSSIB having to report to a trust and say, “You have a critical ongoing incident.”

Professor Vincent: Without going through the list, I would say that if you are going to ask everybody, it should be set very high, in the interests of the longer-term safety of all of us.

Q258 Dr Whitford: Which is very much AAIB’s attitude. Could I ask if you have anything to add to that?

Dr Macrae: Yes, building on Professor Vincent’s comments. I believe the intent of the legislation does not change any of the current powers or responsibilities of any of the other actors across the system. In terms of the protection of certain types of information that HSSIB may collect, to me it feels important to hold in mind the key principle that that protection is there only with the intent of ensuring the future free flow of information for further safety

improvement and to reduce the fear that people may feel to participate in an investigation in the future.

In terms of the specific provisions or exceptions, which are along the lines of an offence or an ongoing risk of misconduct of some degree, I have some caution about HSSIB being required to judge what should and should not be disclosed and passed on. As you say, things are more straightforward or simpler in other sectors, where I believe there is a High Court process to access information.

I suppose it is also important to note that all relevant safety information will be published and produced in the report. It is literally, I believe, things like statements that are made to the investigators, with the intent that participants in an investigation should not need to choose their words as carefully as they might if they were speaking to a police officer, for example. My understanding is that that is purely to build that culture of openness.

Q259 Dr Whitford: That is one of the critical things, is it not? If you are giving evidence to the police, you are not required to incriminate yourself. If this evidence would quite often leak out, we would be back in that situation.

Dr Macrae: Indeed. As a final point, there is—or I believe there should be—a quid pro quo, essentially. I do not believe that the legislation, as it stands, has a strong enough requirement to participate in an investigation. My understanding is that in other sectors, such as aviation or rail, it is a criminal offence to essentially obstruct an investigation or to not provide information. As the legislation is currently drafted, there is a fairly low-level fine and the Secretary of State has to be notified. There is a balance.

Q260 Dr Whitford: You would see that as the quid pro quo?

Dr Macrae: Essentially, yes.

Q261 Dr Whitford: The regulators that we heard from were concerned that creating a safe space in HSSIB might give the sense that people should not exercise the duty of candour outwith the safe space. Do you have that concern?

Dr Macrae: Personally, I do not. I do not believe that anything in the creation of HSSIB will change the requirement on local providers or local organisations to fulfil the duty of candour. The individual professionals will still have all their professional obligations to their regulator and their employer. Based on my interpretation and my reading, that is not a concern that I have.

Q262 Dr Whitford: Certainly, in my long experience in the NHS, when things have gone wrong, the most common phrase from relatives is not, “Someone must pay,” but, “This must never happen again.” That is obviously quite an important thing that needs to be clear.

Professor Toft: I don’t like it. Patient agencies—the people who bring action against medical accidents—certainly do not like it. The patients I have spoken to also do not like it; they think it is about covering things up. That may be entirely and completely wrong, but that is their view and their perspective, and that must be respected. Personally, I have never had any problems in getting people to tell me the truth, including one doctor who ended up spending

eight months in jail as a result of being charged with gross negligence and manslaughter thanks to my report. I do not mean thanks in that sense; I mean because I put the evidence in my report.

If people are prepared to commit evidence in the open and have a solicitor with them and are going to jail, why do they need a safe space? I have never found it to be required at all. There is a lot of suspicion that the draft Bill, and HSSIB in particular, is about collecting evidence that can be kept away from patients and their families.

Q263 Dr Whitford: Why do you think people accept it from air investigation or marine investigation and so on—because we see it as pilots being able to come forward and talk openly about near misses or things that did not actually happen, and therefore the vulnerability can be closed?

Professor Toft: I think it is because it is more personal. If there is an aircraft accident and an investigation, generally speaking most people will just read a little bit about it. When you get down to getting people to talk about the things that matter to them, such as, “My son’s been injured, my daughter, my mother, my grandmother,” then you see the kind of investigation that has been going on for 20 years and the report is coming out today. It is very personal to them, and they want to know, generally speaking; in fact, in some cases they want more than that—they want to see somebody put in jail.

Q264 Dr Whitford: The idea, as talked about by Mr Selous, is that patients and relatives will be involved, will be respected in that. Your description means that we could never get away from the blame culture: “Someone must be to blame for my son’s death or injury.”

Having spent a long time in the NHS, I know that often something is a saga, and it is the last person in a white coat who makes a mistake, which may be a relatively small one, but it builds on a whole system of errors that led to somebody’s death.

Professor Toft: I completely agree, and my research, my writings and my publications show exactly that. When you had an aircraft accident, it used to be the case that the pilot got the blame because he was the last one in the aircraft. It is very often the same in a medical accident, but not always.

The fact of the safe space muddies the waters, as it were, because people are thinking, “If you need to keep this secret, why do you need to keep it secret?” Furthermore, it could be argued that when there is a case that has been investigated and they come up with conclusions, I could say, “How did you arrive at that conclusion? How do I know that that conclusion and those recommendations have any bearing on what actually took place?”

Q265 Dr Whitford: But it does not take away anything that people have at the moment, as was described in earlier evidence. It is an additional capability that ensures learning. It does not stop the police investigating; it does not stop litigation or anything else that is available to families at the moment.

Professor Toft: If you don’t mind me saying so, they have already stopped trusts from doing their own investigation into the maternity cases.

Q266 **Dr Whitford:** I was not aware of that until you said that. I am slightly surprised at that, I have to say.

Professor Toft: And this is even before they start.

Q267 **Chair:** Yes, but this is as a result of the Secretary of State's interference. It is not necessarily that HSIB has chosen to do it.

Professor Toft: I appreciate that, Chair, but what I am saying is, "We are where we are." We have got a situation now where they are saying to trusts, "You will not carry out an investigation because we are going to do it." If that is the only investigation done, can I, as a parent or someone who has a family member who has been injured, say to HSIB, "I would rather the local people did my investigation because at least I can use their evidence and know that it is pretty much on the ball, and I can use it in court for liability, whereas if I let you do it, I can't do that"? Where is patient choice and what happens to patient confidentiality? Because there is nothing about that in the Bill.

Professor Vincent: I think a lot of things are being mixed up here. I think you are quite correct to separate; HSIB does not deprive anybody of their current rights. The other critical thing that is perhaps missing is this distinction. If you are a parent and you want to know what happened, do you actually want to know what the doctor said to the HSIB investigator? No, you want to know the story. HSIB is duty bound—and it is absolutely clear—to publish openly the findings of its investigations.

Q268 **Chair:** HSSIB as conceived in the Bill does not deprive anybody of their rights, but the way that HSIB is being directed by the Secretary of State is taking away the right to a local investigation. We have to accept that, don't we?

Professor Vincent: I agree. That is a difference.

Q269 **Chair:** What do you think about that prohibition?

Professor Vincent: That it is being directed away? Yes, I would prefer HSIB to make up its own mind about the issues it should investigate.

Q270 **Chair:** That is a different question. What do think about the local investigations being stopped in favour of HSIB's 1,000 case investigations?

Professor Vincent: I don't understand the justification for it. I do see HSSIB's task and responsibility ideally to do something rather different from local investigations.

Q271 **Chair:** As supplementary, not instead of.

Professor Vincent: Absolutely, particularly with this wider remit.

Dr Macrae: This is perhaps material that could be provided to the Committee at a later date. I believe there are draft directions, or perhaps even final directions, for HSIB regarding maternity investigations. I would like to check but I believe that the maternity investigations are not covered by safe space requirements.

Q272 **Chair:** It can't be because it doesn't exist.

Dr Macrae: Quite. In terms of the intent, the local investigations in maternity being essentially an HSIB methodology but not as constituted within the legislation.

Chair: What is the statutory basis for these directions? That is something we might look into.

Dr Whitford: Is this not going to lead to an even more blurred birth, if you like, in that we may have a thousand investigations with no safe space and already you may have medical or nursing staff who are anxious, yet we have patients who feel that the trust investigation is being stopped.

Chair: At the moment HSIB is part of NHS Improvement, which means that it may be subject to direction under that legislation.

Q273 **Mr Jones:** The Bill, as drafted, provides for HSSIB investigations into events on NHS premises or premises where NHS procedures are carried out. Do you think it is right to restrict HSSIB from carrying out investigations into private procedures carried out on private premises?

Professor Toft: I completely agree with that concern. The private sector should be subject to HSSIB investigations. Professor Colin Leys and I did some research a little while ago for the Centre for Health and the Public Interest, and we published two reports on this. We found that hundreds of people unexpectedly died or were seriously injured while they were patients in independent healthcare facilities. I have no idea of the quality of the investigations into those incidents, or if they even carried out an investigation. They should certainly come under the rigours of the NHS now, as opposed to just doing their own thing, whatever that might be. I completely agree with that.

Dr Macrae: I feel the same. I believe that the private sector should be within the purview of this organisation; otherwise, it seems to create a very odd and unlevel playing field.

Professor Vincent: I think private patients would find it absolutely incomprehensible if they were not given the same opportunities as everyone else.

Mr Jones: That is very clear. Thank you very much.

Q274 **Lord Elder:** I would like to ask one or two things about finance. We may know some of the answers from some of the things that have been said so far. There is a suggested annual budget of £4.1 million, which seems a curiously exact figure for something that has not yet been set up. There are two sides to this. Do you think that will be sufficient for HSSIB to discharge its functions, as set out in the Bill? Secondly, how can the costs be controlled without affecting its ability to fulfil its function? It seems to me that the more important figure may be the 30 cases, rather than the actual cost. I do not see how you can decide which is the more important. As it stands, do you think £4.1 million is sufficient, and how can it be controlled?

Professor Vincent: I think it is broadly sufficient now. If you were to ask what I would like, I would like HSSIB to be given three years just to get on with it, and let us see what happens.

Without too much interference, it should develop a model, make it work and do some investigations. Then, I think, it will be much clearer whether the budget was justified.

Something we have not talked about, which is very important, is that most of these agencies are quite lean. When we conceived it, we did not want to impose a bigger financial burden on the NHS. They operate by calling in people from the health service or wherever to work with them. I am not quite sure what the payment arrangement is, but it would largely, I expect, be on a voluntary basis.

That has a lot of benefits. One is that you get a much larger workforce for a particular investigation without paying for it in the core team. Secondly, you spread the methods of HSSIB and the training, and you develop expertise in the system. That is a very useful function. So it is not a lot of people.

If it is successful in the way we hope, there could well be a justification for expanding the funding, but I would rather see how it works and give it a chance, then make the decision based on an assessment of what the work actually is.

Dr Macrae: I would concur with that. There is a challenge of, as you imply, the tail wagging the dog in terms of the funding and the scope of the investigations. In addition to the need to develop and understand exactly what this will require over a number of years, my understanding is that, for example, in other sectors I believe there is a greater degree of flexibility.

For example, if there is a 747 that ends up at the bottom of the Atlantic, an investigation will not be curtailed due to the annual budget of the organisation. I would certainly like to see some provision for an understanding of what the scope and scale should be and what is required. This is very different from other sectors. Healthcare is far more complex and there is a lot more work that needs to be done simply to decide what to investigate to start with. It is not as simple as having some wreckage in a field. There is a lot of analytical work that needs to be done, which other investigation bodies do not require.

Professor Toft: I think it is an interesting number that they have picked out, if nothing else. Of course, it says they can do up to 30; they could only do three if they wanted, and that would save some cash. It is also interesting that the impact assessment on the Bill, when it was on about challenges being made to HSSIB, said that the legal cost to HSSIB of legal challenges could be as much as £1.2 million. That would take a hole out of your budget, would it not? There ought to be some contingency planning in there.

Risk management does not work on working down to the wire; you put in some contingency just in case. An extra £1 million in there for contingency planning would not be a bad idea. They may well find, as Carl rightly points out, that when you get into an investigation, very often—in fact almost every time—it goes on and on and on and you find more and more as you get into it.

Trying to pick a number out of the sky, quite literally, is exceedingly difficult. I know the people who wrote the impact assessment found it extremely difficult to cost it. It is a number and you can run with it, and Charles is also right that they should run with it and see how it

goes, but if you start seeing challenges coming in that will result in legal costs, then people will have to think again pretty quickly. That is why I would rather see some sort of contingency planning put to one side in case that happens. I would not want the thing to fail in the first year.

Q275 Andrew Selous: Just a small point, relating to the budget and Mr Jones's previous question: if HSSIB is going to investigate the independent sector, presumably it will then charge and have a scale of fees. Would you see that as important?

Professor Toft: Yes, I would see that as correct. They would go in and charge a fee for it. One thing I am a little concerned about with regard to that is that I can understand why you might need a warrant or financial penalties in the commercial part of healthcare. I do not really find the warrants and financial penalties helpful for the NHS. I thought I would just throw that one in while I was passing.

Chair: Thank you very much. That is very helpful.

Andrew Selous: I do not know whether the Bill would need to be amended to give HSSIB the power to charge fees.

Q276 Chair: What do we think about HSSIB charging fees?

Professor Toft: They have the power to do that in the Bill. It says that if they want to give help, advice and training to people, they can charge a fee for it. They set the fee.

Q277 Chair: Should they be able to charge for an investigation?

Professor Toft: In the private sector, I think they should.

Dr Macrae: I would be very uncomfortable with that proposition and the idea that organisations would be required to essentially pay for their own investigation of their accidents. To my mind, it brings in a range of conflict of interest issues about what might be declared or disclosed in terms of the events that have occurred to start with, but it also interferes with the fundamental principle of independence. Clearly there needs to be some funding mechanism to support an expansion across the independent sector, but a direct fee arrangement feels like—

Q278 Andrew Selous: Perhaps a general levy on all independent providers, or something like that?

Dr Macrae: Perhaps something like that.

Professor Vincent: I agree. I would be very unhappy with the conflict in that, and a general levy would seem to meet it well.

Chair: Can I just say that it is incredibly helpful when there is disagreement on the panel? We get a really good insight into the tension and dilemmas. I wonder whether, at the end, I can ask a broader question.

Q279 Diana Johnson: I would like to ask about the recommendations that HSSIB will bring forward in the 30—or however many—reports they produce each year, how

they will be enforced and whether HSSIB needs to be given teeth to perhaps go back and review or to see what is happening. What are your views on that?

Professor Toft: In the Bill, as far as I understand it, there is nothing that enforces HSSIB's recommendations, and that seems to me to be a little odd. If you want learning, and you want the NHS to improve, the way to do it is by implementing the recommendations. If you do not implement, what you have is passive learning—you know lots of stuff and you have done nothing about it.

What you need is active learning, where you learn something, you put in the recommendations and you make the system better. Without teeth to enforce those recommendations, HSSIB will just be a very nice passive learning system doing lots of lovely systemic work but having no real impact on the NHS at all. At least, that is my opinion.

Dr Macrae: Again, I would have a different opinion. The core premise of the investigation body is to be independent. As soon as it is required to enforce and hold to account organisations for recommendations it has made, it is no longer independent—it becomes part of the system it is investigating. It may then have to investigate the recommendations that it had previously enforced, or be seen to comply with them at some future date. The primary principle, to my mind, is that the organisation's authority comes from its being independent.

However, the recommendations clearly need to have teeth. The intent, I believe, is that HSSIB can specify who should enforce the recommendations, whether that is a particular regulator, perhaps the Care Quality Commission, or the Department of Health, which may need to take on various activities. The key element is to maintain that independence. The recommendation needs to not be involved in enforcement or compliance in any way.

That is not to say that it should not keep an eye on how progress is taking place—in the US, the National Transportation Safety Board certainly reports many years down the line on whether they feel that there are still ongoing concerns related to investigations they have undertaken—but the enforcement should be elsewhere in the system.

Q280 Diana Johnson: Just to pick that up, you said that they might be able to state who they think should take up that recommendation and ensure it, but that would just be a request to the CQC or whoever.

Dr Macrae: It would be a request—that is right. One of the challenges in healthcare is that in other sectors, the investigation branch essentially sits at the pinnacle of a very well-developed infrastructure for acting on recommendations, but that will take time to develop in healthcare. There is certainly a challenge there.

Professor Vincent: We all agree on the need for teeth: everyone on the panel—no question. The question is where you want your teeth; that is the key thing, as Carl is saying. I would strongly favour not HSSIB. That is not to soften up on what Brian has said about the need to not just have passive learning; it is a question of who will enforce it. If an organisation has a recommendation by HSSIB and the CQC visits them and says, “I see you have a recommendation by HSSIB”—which would be completely public—“and you haven't done anything about it,” well, there are the teeth. Several other organisations have these kinds of functions.

Q281 Diana Johnson: Can I just ask about disseminating expertise on best practice in incident investigations and how to embed a just culture across the NHS in England? How should the new body do that?

Professor Toft: You wrote the paper, Professor Vincent, so you start by all means.

Professor Vincent: I share Brian's doubt that HSSIB will transform the culture of the NHS—people have been trying that for some decades now—but it is a step in the right direction and there are certain things they can do. As I said before, those are to do with using people in the NHS in investigations, so a cadre of people will be involved in it who will expand the influence, and then those people can train in trusts and so on.

I do not have rosy ambitions about changing the whole culture. I think this will be useful. Some serious expertise that is highly visible in the system, and instant investigation that shows you can involve patients and families and that you can be transparent about your findings and completely open about your process, will be a powerful message, but it will not change everything.

Dr Macrae: Agreed. It can model good investigative practice, it can develop methodologies that can be circulated and it can co-opt and work with people during investigations so they learn what it means practically to do a good investigation, but the entire system needs to take hold of that, and it will take years to shift the culture.

Q282 Chair: How much should HSSIB be responsible for training up and developing a new cadre of professional investigators, which is one of the recommendations we made in our PASC report?

Professor Toft: As far as HSIB goes, I know the chief inspector was in accident investigations in aircraft. I see in the documentation that he has put on his website that he has military investigators. Having served in the military, I can tell you that they have a very particular way of investigating, which is not necessarily in line with HS and NHS ethos. They ask a question and they expect an answer now.

How they are going to set this up and have a methodology, which has been mentioned several times, I am not quite sure. If they develop a methodology that looks a bit like how you do an investigation when you get the police involved, they will not get very far at all. This is a classic philosophical question: "Who guards the guards?" "Well, the guards guard the guards." "So who guards the guards' guards?" What you get here is, "Who is going to credit the HSSIB to be the premier organisation to do investigations in the NHS with an accredited methodology?" Nobody has given me an answer to that yet.

Q283 Chair: Good question. We will ask HSIB.

Dr Macrae: In terms of training and building up a cadre of professional investigators, there are different routes that HSSIB will operate in in that way. One will be the actual undertaking of investigations and co-opting people with active investigations and working alongside local investigators. That is a small, long-term process.

In terms of building up local-level investigations, there is an enormous need for this, as we have discussed. The quality is variable—I think that is an appropriate word for it—at present at the local level, and there are pockets of good practice and pockets of very challenged performance. Developing a strong methodology that can be circulated is at least one first step in training. I do not particularly see any problem with HSSIB helping to train and support professional development across the sector, but there is a potential role, which I know was discussed in the initial inquiry, for HSSIB to develop local or regional networks of investigators.

Somewhat ironically, or challengingly, that is potentially what the maternity programme is beginning to do, but perhaps it has taken a slightly different flavour, given where it has arisen from. There is the potential to draw out regional support hubs or support local-level activities, but as Professor Toft said, you have to be very careful about HSSIB becoming in some way an accreditor of investigators.

Q284 Chair: Do you want to come in, Charles Vincent?

Professor Vincent: No; I agree.

Q285 Dr Whitford: One final thing. In this Bill, we are talking about the investigation after things have gone wrong. Up to a certain level it is internal, and this will be looking at big, systematic things. In Scotland we have had the Scottish patient safety programme for 10 years now, which is trying to bring a culture of safety to the frontline. What do you think we need to be doing out of this to do that?

If this all ends up in a report in a folder on the chief exec's desk and makes no difference on a ward, then HSSIB is just going to be busy and we will never reduce the number of issues they have to investigate. How do we get a safety culture at the frontline?

Professor Toft: With great difficulty.

Q286 Dr Whitford: It has made a difference. It has reduced hospital mortality in Scotland.

Professor Toft: With all due respect, 30 people are hardly going to—

Q287 Dr Whitford: I do not mean HSSIB having to do it, but do we not need something else as well, to be stopping them happening as opposed to all the focus on, “Let's do great investigations.”?

Professor Toft: Yes. I agree. If you look at the never events, there is one that really annoys me—the one where surgeons leave things in people. That happens regularly. If you look at the never events for the last however long have they been published, you will find a good 50 or 60, if not 100. Every year that happens—every single year. There is a way to cure it and the way is to spend some money and get radio tags on the swabs—

Q288 Dr Whitford: There are radio tags on the swabs.

Professor Toft: Yes, radio tags on the swabs. Run a little gadget over it and it tells you whether there is a swab in the patient or not. At the moment, in England, if they do a count and they have lost one, they do another count and another count. Eventually, the surgeon will

just say, “It has clearly been a mis-count,” and send the patient out with a swab in her. The only way to stop that is make sure before the patient leaves to X-ray them or run a scanner over them for a radio tag, but it costs money. I have actually made that recommendation. Has it been implemented? Has it not?

Q289 Dr Whitford: If the count never matches, an X-ray is done.

Professor Toft: Not always.

Q290 Dr Whitford: Because I am a surgeon and the patient safety programme in Scotland has utterly changed how we work in theatre every single day in every single case. Is there not a need for us to do something?

Professor Toft: You have just demonstrated how you do it. You change it by changing the process. If people don’t want to change their processes, it is very difficult to change the culture. A lot of surgeons are very reluctant to change. It would be a lot easier if, with every patient before they went out and had a mis-count, they said, “We will do a plain X-ray now.”

Q291 Chair: Okay. Can I ask one last question? There is a kind of anxiety around the creation of HSSIB, from different parts of the NHS, some of which seems to be expressed in various parts of the Bill. What do you think that anxiety is about and how should that anxiety be allayed? That is probably more a question for Dr Macrae and Professor Vincent because I think Brian Toft is a carrier of that anxiety and some of it may be legitimate.

Professor Vincent: The NHS doesn’t have a great history of setting up learning organisations without a regulatory component. We just did a study of regulation. I think there are more than 20 statutory regulators; we also found 80 other organisations that have regulatory influence on the NHS. No wonder people are suspicious. That is the world they live in: endless regulation.

Obviously, HSSIB could be derailed and so on. As you were saying, it is very counter-cultural. I think trust is going to be slow coming. My plea is to let it go and leave it alone for a few years. We are never going to know now but in time—Carl knows from aviation—repeated reports, candour, decent behaviour on the part of the investigators over a period of years, gradually people are going to say, “Okay. This is not what I thought.” But it will take time and there is no cast-iron guarantee. I think they just need to be given space. I am not talking about what is happening; I don’t know how it is going. The trust will take great time to build.

Q292 Chair: Dr Macrae, what is the anxiety about?

Dr Macrae: I certainly agree with those points. In addition, there is a long tradition and culture of fairly, dare I say, punitive responses when things go wrong in healthcare. Coupled with the very complex national picture and landscape, the idea of just introducing another box on the organisation chart, I can see as yet an unclear history of conducting open, honest and systematic investigations.

I believe this will take a lot of time for people to understand and have it demonstrated why this will work and how it can be different from what has gone before. As Dr Whitford pointed

out, this is not all going to be solved by HSSIB. There is a lot else that needs to happen and in many places is happening, but there are still gaps of how to translate systematic high-quality investigation into frontline improvement and practice.

Q293 Chair: Thank you very much to each of you. We are very grateful. If you have got anything else you want to add, please send us an email. It does not need to be in a formal format. If we want to publish it, we will let you know and we can put it into a more formal format. We are very grateful for your help with this inquiry.

Panel 2

Witnesses: **Dr Michael Devlin**, Head of Professional Standards and Liaison, Medical Defence Union; and **Matthew McGrath**, Partner, DAC Beachcroft LLP (Solicitors), gave evidence.

Q294 Chair: I welcome the two witnesses on our second panel for the pre-legislative scrutiny of the draft Health Service Safety Investigations Bill. Will each of you please identify yourself for the record?

Matthew McGrath: My name is Matthew McGrath. I am a partner at DAC Beachcroft solicitors. I head up the firm's clinical risk department. On a day-to-day basis, I defend clinical negligence claims on behalf of the NHS. I have done that for about the last 25 years.

Dr Devlin: I am Michael Devlin, the head of professional standards and liaison at the MDU. I have done work at the MDU for the last 21 years. Prior to that, I was a doctor in the Army.

Chair: Thank you both for being with us. We do not have a great deal of time, so we will be as quick as we can, if you do not mind. If you have supplementary evidence to send us in writing, we would be very grateful for it. There may be some questions that we have raised on which you would rather send us something in writing. If so, just say so. We like free legal advice.

Mr Jones: It's worth what you pay for it.

Q295 Chair: Generally, what are your views on the Bill, in particular the provisions about disclosure from the so-called safe space?

Matthew McGrath: In terms of the Bill, as somebody who has defended clinical negligence claims for 25 years and has seen multiple similar incidents occur and continue to occur, I think it is a real step in the right direction to have an overarching body look at the wider learning for the entirety of the NHS. From that perspective, I would support it. I think most people involved in clinical negligence litigation, on either side of the fence, would support it as well.

In terms of disclosure, part of my question in response would be: where does HSSIB sit in terms of the priority of inquiry? Claimants will have an incident that occurs in a hospital trust. If serious harm or moderate harm occurs, most trusts would organise a duty of candour investigation almost immediately. Invariably, there would be access to materials, witness statements would be prepared, and the like comments would be obtained from clinicians.

Invariably, if negligence was established, all of that would be disclosable in a clinical negligence claim.

If certain material is not disclosable, prima facie under the Act, it will invariably—and I am sure you have heard from those who act on behalf of claimants—create a suspicion among patients that they are not being told the full story.

On the other hand, if HSSIB is looking at systemic problems within the NHS, rather than at one individual incident—10,000-odd claims are reported annually to NHS Resolution, and I don't think it will be investigating 10,000 incidents a year—it is vitally important, in my view, that there is the ability to have that wider discussion about system problems that might not necessarily involve the individual clinicians involved in the incident. In that respect, it is a positive thing.

Dr Devlin: I agree with a lot of those sentiments. What has struck us over the past 20-odd years is that although new methods of investigation and new ways of handling complaints have been brought in—we have seen those come and go—nothing ever seems sustained; nothing ever seems to make that much of a difference. We genuinely have the sense here that HSSIB might bring a novel approach. That is to be welcomed.

In terms of disclosure, we think that the safe space might provide comfort to some doctors and healthcare workers who might feel inhibited; those who do not feel quite as free as they otherwise might. On the other side of the coin, we don't think that it will actually stop any other process from happening effectively. So the balances are there in the Bill and they won't stop the GMC, the police or anyone else from carrying out full and free investigations.

Matthew McGrath: The exemptions in the Bill seem broadly similar to what I understand applies with regard to the ICO and the DPA; the exemptions are not dissimilar.

Q296 **Chair:** What effect do you think this will have on the NHS litigation bill, which is contingently enormous at the moment?

Matthew McGrath: Anything that contributes to reducing that must be a positive. As I said earlier, a lot of the claims that I see are variations on a theme. Were it to lead to the types of methodology that the experts in the previous witness panel talked about being embedded in the wider NHS, I think that would be very positive and that it would almost inevitably lead to a reduction in the overall number of claims, and in the cost of claims.

Q297 **Chair:** Dr Devlin, do you agree with that?

Dr Devlin: Actually, for once I don't. I take a slightly different view. This will be great for patient safety; if you accept that it will improve overall healthcare for patients, that is great. But we have looked at what patient safety interventions do to rates of litigation and, perhaps more importantly, to the overall cost of damages, and there is very little evidence to show that these changes bring down the overall amount paid out in clinical negligence claims.

That is because the drivers of those claims are quite complex—the market laws and patient expectations. Having said that, it should certainly not be a reason not to proceed with this; just don't expect it to bring the bill down.

Q298 **Chair:** How can we learn important safety lessons and encourage clinicians to be

candid while satisfying patients' legitimate expectation that someone will be held accountable for what has gone wrong and that they will get the information they need to bring proceedings?

Dr Devlin: I think that the way to encapsulate that best is just to look at culture. It seems to me that where organisations are moving towards that, patients get that reassurance and the information they need, but also staff have the sense that they will be treated fairly. That means that they will still be accountable, but not necessarily blamed. There will still be accountability and staff may well face proceedings by their regulator, but they are still able to contribute to the culture of learning.

Matthew McGrath: I agree.

Q299 Mr Jones: Do you think that it is right that HSSIB should be required to disclose anything at all unless it is a case of serious current risk, or what HSSIB might call "patient safety benefit", because there are a number of cases in which disclosure can or must be made?

Matthew McGrath: What the Bill shows quite clearly, from my reading, is that the power to order the disclosure of information will continue to vest in the High Court, so it will obviously be for the judiciary to decide whether a particular patient or organisation should, on the balance of justice, have access to information available within a report or held by HSSIB, even if it falls within one of the provisions for not being disclosed.

Fundamentally, the tension will always remain between patient expectations of transparency, and the need and desire to ensure that every nook and cranny is investigated, and clinicians being encouraged to be as open and frank as possible. I think that tension will continue after the Bill is enacted.

Q300 Mr Jones: Because the disclosures in this case are considerably more extensive than those for air accident investigations, for example.

Matthew McGrath: At the moment, investigations within the NHS are carried out locally, and sometimes with the co-operation of consultants called in from external trusts. All that information, including witness statements, critical incident reports and root cause analyses—and the documentation that is produced as a consequence—is disclosable in any event. Patients are encouraged to see that. I think it is in the interests of the public to see that there is still a lot of information that is potentially disclosable.

Q301 Mr Jones: Do you think that the proposals go too far, in that they permit the disclosure of evidence, as opposed to simply the alerting of regulators or the police?

Matthew McGrath: There is evidence obtained from different sources anyway that forms part of the process. There is the evidence that is obtained initially by the internal trust investigation as part of the duty of candour process that will occur.

If there has been a death, the coroner will carry out an independent inquiry and call for witness statements, so that will create factual evidence. Part of the overall factual matrix will already be available in any event. An issue that is not entirely clear yet in my mind is where

the HSSIB investigation fits in with all those other statutory obligations that other bodies have.

Q302 Mr Jones: Frankly, what you have said makes you wonder whether the safe space is required at all.

Matthew McGrath: To some extent, the question is whether or not having the process of being able to review a matter, perhaps after the initial tension and emotion has dissipated, enables people to look in a wider sense at why an incident has occurred.

As somebody said earlier, incidents rarely occur simply due to the error of one individual; they are more systemic in nature. Once you have dealt with the initial issue, you can look at it in a wider sense and enable people who were not directly engaged in the actual incident that occurred to the patient, but who might have been involved further back in a process that contributed to it, to give evidence without fearing for their job. To my mind, that is something that could work in this situation to encourage a wider understanding of why incidents occur.

Q303 Mr Jones: Do you think it is appropriate that disclosure to the police is contemplated, even where there may be no risk to patient safety?

Matthew McGrath: Again, it comes down to the decision as to who makes that disclosure. At the moment, there are limited powers, outwith a formal court order, for the police to obtain access to somebody's medical records and there are protections built in that prevent the potential for abuse.

If you are talking about a situation where the police were to obtain a formal court order, they could potentially do that through one of the mechanisms in the Bill. The determination of who within HSSIB makes the decision about disclosure to the police or to regulators is an issue in the Bill. I do not think it is as clear as it could be.

Q304 Mr Jones: There has been a suggestion that one way to encourage candour might be to make all information public, but to prevent it from being used as evidence in court or in regulatory hearings. How would you feel about that?

Matthew McGrath: Once the information was out in the public, it would be very difficult in some respects for it not to be used in some way in civil proceedings.

The most obvious reason is that if I were acting for a claimant—a patient, for example—as a lawyer, I would think, “There’s a report that supports my case. It is in the interests of justice as far as I am concerned, in respect of my client, that that thorough investigative report is put into evidence as part of a formal litigation claim.” Therefore, I can see the potential for some challenges. I don’t know whether Michael has a different view about that, but I certainly see that as a risk in terms of the use of the reports.

Dr Devlin: The reports, as standalone documents, are helpful in so far as they distil down a lot of complex evidence. The ability to get behind that evidence will, I appreciate, be frustrating to some people. But we do have precedents. Matthew referred to some organisations that carry out these types of investigation.

The ombudsman is another one. The ombudsman's investigations are carried out under strict codes of confidentiality and the disclosure prohibitions are very similar to those anticipated in the Bill. Ultimately, however, you still have the ombudsman's report, which gives you quite a lot to go on and will probably give you enough pointers to think, "Where do I need to go next to get more detailed information on that point?" I don't think there needs to be disclosure of the information that's collected as part of HSSIB investigations.

Q305 **Mr Jones:** It is possible to reconstitute the evidence obtained at this point.

Dr Devlin: It is, yes.

Q306 **Chair:** To be absolutely clear, a litigant, or the solicitor of a litigant, should not be able to go to HSSIB and say, "My client's now suing the subject of your inquiry, so hand over all the information; we want to sift through it to see what he says."

Matthew McGrath: They should not be able to do that. Their only route to HSSIB should be through making applications to the High Court.

Q307 **Chair:** We do not want the High Court automatically saying, "Oh there's a case now; you've got to hand over all the information."

Matthew McGrath: The Bill suggests the type of reasoning that a High Court judge would have to take into account in determining whether to order disclosure in those circumstances. From reading the Bill, to my mind, there is a risk that this could lead to disclosure of that information.

Q308 **Chair:** Would it be better to apply some more restrictions to the High Court?

Matthew McGrath: Yes, make clearer to the judiciary the importance placed on having a safe space, and the investigations remaining privileged and not being disclosed.

Chair: That is very helpful. Thank you.

Matthew McGrath: Again, perhaps we can provide some written responses.

Q309 **Dr Williams:** To extend this a little bit, is it correct that a safe space does not apply to existing clinical notes or records and that it just applies to information collected or collated for or by the inquiry?

Matthew McGrath: *indicated assent.*

Q310 **Dr Williams:** If we draw a parallel with the airline industry, it puts a black box in every aeroplane, and the equivalent of that might be a camera in every operating theatre that would be there in the event of a safety incident occurring, and accessible to HSSIB. Would you see any problem with that?

Dr Devlin: I think it would be inhibiting to staff working in that environment. If staff thought the cameras were there for a genuine safety reason and could say, "This is going to improve the clinical care that we give because we are going to look back and say 'I didn't do that part of the procedure as well as I should have done'", that is positive. However, it is also about whether patients would have a reasonable expectation of being filmed in that way. You have to have buy-in from patients to roll out that type of environment in healthcare.

Matthew McGrath: I have certainly thought about that in the past. The analogy with black boxes is very good. It could also apply to situations where there is disagreement about whether informed consent was given, because there will be a discussion: a clinician will say, “I raised these issues, but unfortunately I did not record all of them”—we see that problem from time to time—and the patient will say, “He didn’t say that” or “She didn’t say that.” You can imagine a consent process being recorded. From time to time, when trying to defend cases, it would have been useful to have that sort of information.

Q311 Dr Williams: If the purpose of the black box, camera or collection of information were to be just in the event of HSSIB needing to do an investigation, do you think it would be possible to record information for that purpose and for it then to be protected within the safe space?

Dr Devlin: I think it is possible. In theory, that would be possible. Whether you could capture every single contact—as a clinician, you will know that it would be difficult. How do you keep all those discussions on a ward round within earshot? It is incredibly difficult to do, so you may well miss that vital information Matthew mentioned: was that consent informed? It depends on the discussion and whether there was monitoring at that point in time.

Matthew McGrath: And I think that it could take away from the importance of recording those things.

Q312 Andrew Selous: I want to raise the conflict between the duty of candour, which the Secretary of State introduced and is now quite well established and broadly supported, and requiring clinicians to disclose to patients exactly what they have told HSSIB. Is there a conflict here between safe space, which is protected for learning, and the duty of candour, in terms of what is supposed to be told to patients and is a statutory duty?

Matthew McGrath: There will be a tension, but the reality is that clinicians are under that ethical duty of candour, as promulgated by the GMC, as are NHS trust organisations that have a statutory duty when it is by the CQC. There will always be a duty to be open, honest and transparent with patients in any event. One would imagine that in most circumstances, as part of that fact-finding exercise that HSSIB would carry out, it would be broadly similar to that sort of inquiry that would be carried out currently internally at a trust.

Dr Devlin: I do not see there being too many problems as far as conflict goes. If you look at the timings, the guidance from the regulators is really clear. You tell patients as soon as possible if something has gone wrong. The threshold is low: anything that goes wrong that causes harm or distress. You would expect doctors and nurses to be telling patients that straight away, long before HSSIB gets involved. Similarly, the contractual and statutory duties—and they are two separate duties—are also carried out fairly promptly after the event.

My view is that the duty of candour initial phases will be done and dusted by the time the HSSIB comes along. The statutory duty, for example, anticipates that there might be further information that comes along later. That would be one of the circumstances where the trust would say to the patient or relatives, “This may well be investigated by HSSIB, in which case more information will be made available to you after that.”

Q313 Andrew Selous: Does the Bill raise any barriers to clinicians or trusts to passing on information in civil proceedings, if that information has already been shared with HSSIB?

Matthew McGrath: At the end of the day, in a civil proceeding, if somebody was giving evidence, they would be giving evidence in court as to what had happened. Michael just made the point that the way I would imagine we envisage it occurring, is that the duty of candour would kick in almost immediately the incident has occurred, and the involvement of HSSIB would come along some time later, when it decides this is the sort of case it is going to investigate, or falls within the qualification criteria.

Again, I do not see it being a bar to civil litigation occurring in the way that it occurs now. The only question mark would be whether there was additional information obtained as part of a HSSIB inquiry that fell to be protected and did not fall within one of the exceptions to be used.

Q314 Andrew Selous: Does this not negate the whole notion of safe space? How can you call safe space safe, if that is the case? If what you say can end up incriminating you in court, why should you be open about what has happened? Why promote a learning culture if it is going to lead to you ending up in trouble in court?

Matthew McGrath: Well, I suppose it depends. If it is a civil claim, I have dealt with numerous cases where a clinician will say, “I accept that what we did was unfortunately a mistake or inadequate.” From that sense, very early on, trusts will, as part of their initial inquiries, often effectively conclude that there was inadequate care provided. That admission would occur very early on in the process and it would not affect civil litigation.

If we are talking about the wider learning for the NHS, the concept of a safe space, and being able perhaps to raise issues that were not apparent as part of that initial process but have an overall bearing on safety issues, that is something that should be explored and kept within the Bill, to see how it develops over time and the challenges that might occur to it over time.

Dr Devlin: I agree. One thing that HSIB does not change is the facts. What happened happened. As a litigator, Matthew will be able to put together the pieces with reference to clinical records, witness statements and so on and so forth.

As I said initially, the safe space provides a comfort. Perhaps the best example I can give is that, if I were a junior doctor asked to speak to investigators, I would be reassured by the concept that what I say to them will not lead to the instigation of disciplinary proceedings against me by the trust. It might not stop all the things happening to me—I might get referred to the regulator by either the patient or the trust—but at some level, it will stop some things happening.

Andrew Selous: Thank you. That is helpful.

Q315 Diana Johnson: I would like to ask about the accreditation of NHS trusts as envisaged in the Bill. This is to Dr Devlin. Last year, you wrote that it is important that HSSIB seeks to improve standards of patient safety incident investigations generally. I wonder what your views are about the idea of accrediting trusts to

conduct those safe space investigations.

Dr Devlin: We did not call for accreditation, but if that mechanism allows consistency across the board, we would welcome it. One thing we have seen is inconsistent investigations. The witnesses you heard from earlier gave that same sense. We do not have strong views on whether that is done by a process of accreditation or simply through guidance. Perhaps HSIB is best placed to say which might work best.

Q316 Diana Johnson: Obviously we need more detail about how this would work—the criteria of accreditation.

Dr Devlin: Yes, and also the sense that accreditation cannot be an all-or-nothing process. It seems to us that, as HSSIB develops greater expertise, it may well want to change some of its methodology. It is important that those it has accredited have ongoing training, so that they continually follow best practice and improve.

Q317 Diana Johnson: Finally, what do you think the public will think about trusts being accredited to carry out this work? Would they think it is fine?

Dr Devlin: If the public saw evidence—this is why it is important to take it one step at a time—that trusts were doing good-quality investigations and that they were getting full and frank accounts of what happened to themselves or their loved ones, I could see them buying in.

Q318 Lord Elder: I assume that coroners' investigations will carry on on their own timetable?

Matthew McGrath: That is my understanding, yes. They are obliged under statute to do so.

Q319 Lord Elder: It seems to me that it is at least possible that litigation would proceed anyway, and that it would proceed as a result of a report. How does that work?

Matthew McGrath: It is possible. Litigation can proceed simply by a patient obtaining access to their records and then getting an independent consultant to review it and provide a report that suggests that the care provided was inadequate or substandard. That can occur independently of any investigation at the trust or HSSIB.

Q320 Lord Elder: And it could also arise after the report?

Matthew McGrath: Yes, it could. I know from my own experience that claimants in establishing negligence against NHS trusts often rely on internal trust reports that are produced immediately as part of their duty of candour investigations.

Q321 Lord Kirkwood of Kirkhope: We had a pretty robust session of evidence from those representing NHS trusts on the grounds that the introduction of local HSSIB or safe space requirements could conflict with some of their other statutory duties—for example, to balance the budget, to deal with coroner and the rest of it. From your perspective, do you think there is any force in that argument? Can you see any danger of the Bill providing conflicts? You would not want NHS trusts to start doing things that conflict with other existing statutory duties. Do you have any perspective on that that could help us to understand their evidence?

Matthew McGrath: There will always be a tension, in any event, when a number of different regulators are looking at what is predominantly the same situation. Part of the challenge is creating that factual matrix that satisfies everybody as a reasonable assessment of what actually occurred, and sometimes that ends up in litigation—we have talked about informed consent issues, for example. I don't see any huge difficulty with there being an obligation to comply with HSSIB investigations. In a broader sense, having that systemic learning must be something that most NHS bodies, if not all, would support.

Dr Devlin: I agree. I think that what is going to happen is going to continue to happen anyway, so you will still have police investigations into allegations of gross negligence or manslaughter, and there will still be coroners' inquiries and inquiries by the GMC or the NMC. All those processes will continue, but none of them is aimed at improving patient safety. HSSIB is in addition to those. From the trusts' perspective, that must be a good thing, because I cannot think that there is any trust in the country that does not support the idea of making clinical care safer.

Q322 Lord Kirkwood of Kirkhope: That is reassuring. I will turn quickly to another aspect that we have not yet touched on: the professional duty to have "fitness to practise" systems that involve reflections by doctors. Do you believe that there is any case for giving access to the reflective notes in professional development fitness to practise contexts?

Dr Devlin: It is something that happens a great deal anyway.

Lord Kirkwood of Kirkhope: You mean that people get access to those notes?

Dr Devlin: They are given on a voluntary basis. When we are defending doctors at the GMC, their reflective notes are actually very useful, because more often than not they demonstrate insight; they show that they realise where they have made mistakes and how they would avoid repeating them in future, and also that they take responsibility for their mistakes. The GMC has said that it won't ask for disclosure of such statements in its proceedings, so that will continue to be on a voluntary basis.

My final point in this regard is that in most cases the notes wouldn't actually be terribly helpful to the GMC or to the police, because although they do tend to show that the individual accepts what they did and what happened, they rarely show that they had a wilful or reckless state of mind. The doctor will not write a report that says, "Do you know, I knew that what I was doing was grossly wrong, but it didn't matter; I went ahead and did it anyway." More often they are balanced and thoughtful.

Matthew McGrath: I agree.

Lord Kirkwood of Kirkhope: Great.

Q323 Mr Jones: Clause 7 provides for a power to compel a person providing NHS services to supply information to HSSIB. Would you say that that extends to natural persons—i.e. individuals?

Dr Devlin: Do you mean ordinary members of the public?

Mr Jones: No. I mean people, as opposed to bodies.

Dr Devlin: Yes, I think it does.

Q324 **Mr Jones:** Do you think that it is right that it should extend to individuals?

Dr Devlin: It begs the question as to what HSSIB thought it was going to achieve by trying to compel a reluctant witness to speak to it. Even in police interviews you are not obliged to say something; inferences may be drawn, but they cannot force you to give information orally that you are not willing to give. Again, I wonder what benefit there would be to HSSIB in trying to extract that type of information, because it would not be given voluntarily and it may cause the general public and doctors to mistrust them if that power was used in that way.

Matthew McGrath: I would agree with that. If you compel somebody to provide oral evidence, which is what clause 7 suggests would occur, perhaps they will not be open and honest. The idea of having the safe space is to encourage openness and honesty about situations. With compulsion, I suggest that is less likely to come from people who are required to attend and provide evidence against their will.

Q325 **Mr Jones:** Clause 33 envisages that the High Court could, by order, make an HSSIB report admissible in proceedings. Would that be a worry to the MDU if clinicians could be compelled to assist the HSSIB?

Dr Devlin: Our advice would be to assist any inquiry into your clinical practice. That would include HSSIB. That would be our starting point. We would be very surprised if doctors did not, of their own initiative, want to do that. If they contacted us for advice, we would be quite clear that they have an ethical obligation to take part in those investigations and to give whatever assistance or whatever evidence they can.

Q326 **Mr Jones:** But there is a fairly heavy erosion of the concept of safe space here, isn't there?

Dr Devlin: I would accept that, as envisaged, it is a relative safe space; it is not an absolute one. If you wanted an absolute one, you would have to have an absolute prohibition on disclosure. That would be a policy point. It would not be for us to comment on; it would be for Parliament to decide. If you did want an absolute safe space, it would have to be in the legislation.

Q327 **Mr Jones:** Penalties can be applied for failing to co-operate with HSSIB, as you know. There is a right of appeal to the first-tier tribunal. Would you say that is a sufficient means of challenging the investigator's issue of a penalty notice for non-compliance?

Matthew McGrath: It is consistent, as I understand it, with other legislative functions. Broadly, yes, I think it is.

Dr Devlin: I would agree.

Mr Jones: Thank you.

Q328 **Chair:** Just to be clear, anybody should be able to say anything within the safe space, without fear or favour. That is the whole point about the safe space. A court can compel somebody to give information. Shouldn't HSSIB be able to require somebody to give information without qualification, given that it is a safe space?

Matthew McGrath: There is the compulsion to come and give evidence. Michael's point might have been that you might get somebody who is less than forthcoming in giving that evidence. I don't know if that is what you meant.

Dr Devlin: That was partly the point.

Chair: We don't do thumb screws, ultimately.

Dr Devlin: I would worry both about the quality of the evidence given and, more importantly perhaps, about the broader message that it sends out. If you have to compel people to come along and give you evidence, it will worry a few people. They will not see you as an impartial, independent investigator, but as someone who may go to great lengths to get them to turn up and speak to you. The default position is that if you are a healthcare professional, you should be doing this anyway because it is your professional duty to do so.

Chair: Thank you very much. That was very interesting technical evidence. We might write to you with further questions if that is all right.

Matthew McGrath: Certainly.

Chair: If you have anything else you want to offer us spontaneously, please do not hesitate. If you have read any of the other evidence or if you read subsequent evidence that you think merits comment, we would be very grateful to have it. Thank you very much indeed.