HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

Oral evidence: Draft Health Service Safety Investigations Bill, HC 1064
Monday 25 June 2018

Watch the meeting

Written evidence from witnesses:

– Department of Health and Social Care (SIB0034)

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

Questions 329-501

Panel 1

Witnesses: **Caroline Dinenage MP**, Minister of State for Care, Department of Health & Social Care, **William Vineall**, Acute Care and Policy, Department of Health & Social Care, and **Jennifer Benjamin**, Deputy Director, Quality, Patient Safety and Investigations, Department of Health and Social Care, gave evidence.

Q329 **Chair:** I welcome the Minister and her officials to this session on the draft Health Service Safety Investigations Bill. I wonder if you could just identify yourselves for the record.

William Vineall: I am William Vineall. I am director of acute care and quality policy at the Department of Health and Social Care.

Caroline Dinenage: I am Caroline Dinenage. I am the Minister of State for Care at the Department of Health and Social Care.

Jennifer Benjamin: I am Jennifer Benjamin. I am deputy director for quality, patient safety and investigations at the Department of Health and Social Care.

Q330 **Chair:** Can I just say first of all that we are extremely grateful for the help and support we have received from your Bill team? They have been very helpful and informative. There is a very good relationship between the Committee and the Bill team, and that has helped us with our inquiry a lot.

To ask the top-level question to start with, what do you understand the purpose of HSSIB to be, and how will it achieve that?

Caroline Dinenage: First of all, I thank you, Chairman, and all of you for inviting us to give evidence and, more specifically, for all the incredible work that the whole Committee has put into this important Bill. To us, it is important because we want to ensure that our NHS is the safest and most transparent healthcare system in the world. To achieve that, it is absolutely fundamental that those who work in the NHS must feel safe to speak up when safety incidents occur. They must feel free to do that without any fear of blame and feel confident that there will be system improvements that result. The Bill represents a real opportunity for us to provide a step change in the way that we look at patient safety in the NHS.

As you all know, the aim is to create an independent body that will carry out the investigations to identify the systemic issues that they find and make recommendations for improvement, but also to drive improvements in the standard of investigations as well. That is very important to underline.

In the same way that a cover-up culture has hampered learning, a blame culture can prevent staff from being open when things go wrong because of a fear of retribution, so getting the culture right is absolutely critical in this. That is why we want the new body to operate using the safe space philosophy so that people can be confident that they can be open and honest in investigations and so that we can continue to learn and improve. Over time, we would also like the body to be able to accredit other NHS trusts and foundation trusts so that they can carry out their own safe-space investigations, so that this culture of learning and openness can continue to spread up and down the country.

I also wanted to say that I know you have spent a lot of time taking a lot of evidence and gathering views from a number of different professionals, in person and in writing. We are very keen and open to hear all the thoughts and feedback from the Committee as we move forward with the Bill.

Q331 **Chair:** Thank you very much indeed. How do you expect HSSIB to be able to contribute to an improved system of investigation and to provide resolution for patients and their families, who often are the ones who most want the answers, not in order to punish people but in order to help make sure that the same thing does not happen again?

Caroline Dinenage: Yes, that is where HSSIB has such a unique role. We know that where a problem is identified quite quickly, processes can be put in place quite quickly to identify what went wrong and what needs to happen to stop that ever happening to any other families and patients again, and to stop others having to suffer in the same way. We know that that is what drives the families, and is at the heart of everything they are concerned about.

When things go unresolved and go on for years and years—I speak as the Member of Parliament for Gosport—that is when people are less concerned about the lessons learned and become very focused on accountability and who to blame, because for so long they are not listened to and their issues go unresolved. That is where HSSIB has a really important role—to drive that systemic change and improvements to make a massive cultural difference.

Q332 **Chair:** Are you concerned to an extent that HSSIB might raise expectations among patients and their families beyond what HSSIB can deliver, particularly at the outset, because obviously it is a very small organisation?

Caroline Dinenage: I am not sure how well known HSSIB is at the moment. I don't think many people are actually aware of it. It is really important that it starts in a very slow, controlled and measured way, and is able to do all its investigations fully and in its own time and build up that reputation. As you know, it will take only a very small sample of things from which we think the most learning can be gleaned and the most systemic change can be brought about. It will not be a panacea to all the problems of patient safety across the national health service and beyond, but we would like to think that it fulfils a very important role in driving that patient safety ethos across the NHS.

Q333 **Dr Williams:** Minister, you just said, very sensibly, that it should start up slowly and build up its capacity, so why was it asked to conduct 1,000 maternity investigations in addition to being asked, when it was conceived, to conduct 30 investigations a year, with the budget given for 30 investigations?

Caroline Dinenage: They are slightly different investigations. The 30 are, as you know, full investigations above and beyond anything else that has happened within the hospitals. Later on—a year later—the 1,000 maternity cases came about.

Q334 **Dr Williams:** Tell us the rationale for why.

William Vineall: Part of the rationale for doing it is that we felt as part of the maternity safety strategy that, as well as the royal colleges looking and learning from these 1,000 cases, we needed to investigate them for the same general purposes of HSSIB—to have systemic learning across the system and to get that out as quickly as possible. We felt that there was a particular case to do that in maternity services.

Q335 **Dr Williams:** Will they be a safe space?

William Vineall: They won't be in a safe space. They are not in safe space, because they are meant to be the single investigation that covers both the clinical uncovering of the information and satisfaction for the families. Also, there is a slight difference—without getting into too much detail—that if you have a small child who has died there is an obvious thing that you keep it contained in that way. So we did not think safe space was necessary in those instances.

Q336 **Baroness Chisholm of Owlpen:** Caroline, leading on from what you said earlier about taking only a small sample, how did the Department establish that it should undertake only approximately 30 cases per year? What was the reason for that?

Caroline Dinenage: We were very keen that the investigations carried out were incredibly focused and very effective. There are 24,000 safety incidents every year across our NHS. It is very different from the accident investigation procedure. If that number of safety incidents were happening in aviation there would be planes falling out of the sky all the time. We had to choose a number where we felt that we could make the biggest learning—the incidents that have the biggest learning across our health service. It is not about finding the root of individual cases. It is more about a systematic change and the greatest potential for learning

across the system. We wanted that to be to a very high standard. I take it that Ministers took advice and 30 was the number that was decided upon.

Q337 **Baroness Chisholm of Owlpen:** Do you feel that the reason for that is that the 30 most serious incidents that happen each year will also be those incidents from which people will gather the greatest prospect for learning? Is that the reason?

Caroline Dinenage: That is right. HSSIB will choose what it looks at, but they will be things where it feels that there is massive potential for learning and change across the health service.

Q338 **Lord Kirkwood of Kirkhope:** I was curious as to why the power was not given in the draft Bill to the investigations board in cases where there are no specific complaints but where there were wider issues that the organisation could take on of its own accord. Was that deliberate? Is it a resource-related issue? Why are we not giving HSSIB more jurisdiction over what it investigates?

Jennifer Benjamin: The new body will have jurisdiction to decide what it investigates. As with the current Healthcare Safety Investigation Branch, we anticipate that it will be notified of incidents, but that it will also operate a surveillance system that allows it to understand what incidents are being reported by the NHS. It is reactive and also has a proactive way of identifying concerns.

Q339 **Lord Kirkwood of Kirkhope:** But they need a complaint or an approach or evidence being submitted. It cannot of its own accord decide to undertake a piece of work on a wider basis, under the power given to it in the draft Bill—if I understand it properly. Is that correct?

Jennifer Benjamin: We can come back and clarify exactly how the Bill is drafted, but certainly our intention is that the new body should not be constrained in any way in terms of the type of incidents that it chooses to investigate, so it does not have to be notified or it does not have to receive a complaint, but we are more than happy to clarify that if it is not particularly clear in the Bill as it is drafted.

Q340 **Lord Kirkwood of Kirkhope:** Let me tell you why I am asking the question in precise terms. One of the biggest concerns that I personally have in this area is the result of staff shortages coercing junior doctors and nurses in a workplace setting to do things that are unsafe—to do shifts of work, when they are understaffed to the extent that they are risking patient safety—and that they are obliged to do because they are coerced by their consultants or senior management to get on with it—a "We are where we are—we did it in our day; you get on with it now or else we will see you in your annual review" kind of approach. Presumably if we are looking for a safe and transparent system, Minister, the investigations board should be able to deal with that. Am I right?

Jennifer Benjamin: Absolutely, yes.

Caroline Dinenage: That is the intention. The intention of the Bill is that the branch should be able to choose what it investigates and that is why it is independent of the Government. If the Bill is not worded to reflect that, I am grateful that you have drawn that confusion to our intention. We certainly would intend to rectify that.

Q341 **Chair:** Of course, in the draft Bill, nobody has actually got any obligation to notify HSSIB of any particular matter

Caroline Dinenage: Two systems currently exist—

Q342 **Chair:** I appreciate that, but it has got to use its own resources or own devices to discover what is going on. That may be fine, but what we are trying to add to that is that whatever HSSIB feels should be investigated, it should be able to investigate. That is your intention.

Caroline Dinenage: Indeed, that is the intention.

Q343 **Chair:** So we could clarify that in the Bill if we wanted.

Caroline Dinenage: We will, yes. Absolutely.

Q344 **Mr Jones:** As you know, health is a devolved competence in Northern Ireland, Scotland and Wales. Particularly in the border areas, healthcare is frequently delivered for patients from one jurisdiction in another jurisdiction. What discussions have you had with the devolved Administrations to develop a policy whereby HSSIB can investigate in those areas?

Jennifer Benjamin: The first thing to say is that health is a devolved matter, but when we were drafting the Bill and developing the policy, we were very much aware of the practices, particularly Scotland and the national patient safety programme they have initiated in that country. We also consulted the devolved Administrations on the draft Bill itself. We certainly engaged with devolved Administration officials and Ministers, but the Bill has been drafted with the intention that the body should operate within England.

Q345 **Mr Jones:** For example, the Countess of Chester Hospital in Chester is the principal general hospital for people who live in Flintshire, just across the border. If there were an incident at the Countess of Chester that affected a patient from Wales, how would HSSIB approach that?

Jennifer Benjamin: In principle, the new Health Service Safety Investigation Body would be investigating incidents that occurred on NHS premises or services that were funded by the English NHS. It would have scope to investigate providers that provided care for NHS-funded patients. There should not be a restriction in terms of geography. However, responsibility for the new function would follow where NHS funding occurred.

Q346 **Mr Jones:** Frequently it is not quite as simple as that. For example, in Wales you can get a course of treatment that starts in Wales and then goes to Shropshire or Liverpool and then comes back to Wales. If you look at that course of treatment as a whole, is that not something of a quandary for HSSIB?

Jennifer Benjamin: We recognise that the Bill as drafted at the moment only enables the new body to investigate services for patients who are provided with care funded for the English healthcare system. I do not think that would entirely restrict it from looking at a patient pathway, and if that patient pathway meant services outside the English NHS, I would imagine that there might be some flexibility there. We have not drafted that into the Bill because, as I have said, healthcare is a devolved matter, but we are more than happy to consider the Committee's views on that and to consider that at some point in time.

William Vineall: If you are saying that HSSIB should have the ability to follow a patient who starts treatment in England, goes into Wales and then comes back, that sounds pretty logical and we can take that away and check it. There is a difference if people are Welsh patients starting their treatment in Wales; that is a slightly different matter, because health is devolved, so it would be for Wales or Scotland or Northern Ireland to decide whether they wanted an equivalent body to do similar things. If they did, one would hope that the principle would apply across the border as well.

Q347 **Mr Jones:** Ms Benjamin referred to building some flexibility into the system. I am intrigued to know how you can achieve that flexibility, given the fairly rigid devolution settlements we have in this country.

William Vineall: I think we would go away and see, within the bailiwick of the English NHS and HSSIB, where there are patients treated in that country, whether they come from England or Wales, who then moved over a border to receive a component of that treatment, whether there was a way that HSSIB could follow those people through logically, using common sense. I am saying that we cannot make any decisions about the reverse journey, because that is a matter for the devolved Administrations.

Mr Jones: What discussions have you had with the devolved Administrations?

Q348 **Chair:** Before we move on to that, can I just highlight something? Very often it is the patients who are reluctant to speak out, because they do not want to criticise the clinicians. They do not want bad things to happen to the people who cared for them or their loved ones. They need the safe space. If something has happened in an English jurisdiction, but the patient comes from somewhere else, do they have to come across the border to be able to speak in the same safe space? It is the same for a clinician who might want to speak out about a safety issue. Do they have to come across into England to be protected by the safe space?

William Vineall: The honest answer is that I cannot tell you categorically, but the fact is, I suppose, if somebody were in Wales and they had a concern about the Welsh health service and they were employed there, you would expect them to speak up in Wales, because health is devolved.

Q349 **Chair:** But there is no safe space in Wales.

Caroline Dinenage: We can only really deal with complaints about care pathways that start in English hospitals, regardless of whether they are concerned with Welsh patients or anyone else. Therefore, that would be where the complaints procedure would happen and they would be protected by the safe space.

Q350 **Mr Jones:** These are not infrequent occurrences.

Caroline Dinenage: I understand that.

Q351 **Mr Jones:** Most of my constituents who seek specialist care will actually receive it in England.

Caroline Dinenage: Exactly right, but the inquiries will not be about the patient or where the patient comes from. The inquiries will be about the hospital or the care provider and where they are located.

Q352 **Mr Jones:** I appreciate that. My concern is that, frequently, as part of a course of treatment, some is delivered on the Welsh side of the border, some in England. Take, for example, Walton, which is the centre of excellence for neurosurgery and is based in Liverpool. Walton also has a satellite unit in north Wales. You will have the same physicians, the same doctors, treating patients both in Liverpool and in Bodelwyddan. I am wondering how HSSIB would deal with a surgeon who may be carrying out a course of treatment, part of which is in Liverpool and part in north Wales.

Caroline Dinenage: I think the answer is it would depend on where that care pathway started and who was paying for it. If the care is being paid for by NHS England, that would come under HSSIB, and if it were NHS Wales, they would have their own system.

Q353 **Mr Jones:** But it is Walton that is delivering the treatment. It is a satellite of Walton, the same hospital, but it is delivering it in north Wales. It is the same hospital; it's just that it's a satellite service.

William Vineall: We will have to come to back to you on that specific example. We have established the principle—

Caroline Dinenage: Presumably, it's a satellite of a hospital that is based in England, in which case—

Q354 **Chair:** When you come back to us, can you at least clarify that HSSIB's investigation functions can be conducted in relation to any incidents occurring in England, including where a significant causative factor takes place in England?

Caroline Dinenage: Yes.

Chair: That is the intention, but we need—we have this wider question as well.

Q355 **Dr Whitford:** If you could clarify, Minister: you talked about it depending on who was funding the original pathway. Is it not really that it will relate to where the incident is? Regardless of whether it's an English or a Welsh patient, if the issue happens in an English hospital, HSSIB isn't going to ignore it because it is a Welsh patient.

Caroline Dinenage: No, but in the case of a situation funded by NHS England but part of it was delivered in Wales, because it was a satellite—

Q356 **Dr Whitford:** Obviously, this issue is about a satellite hospital. I don't know whether this satellite counts as an English hospital in Wales or—

Caroline Dinenage: I would have thought so.

William Vineall: It does, if it is under the aegis of the trust that is registered with the CQC in England, but we can check that.

Q357 **Dr Whitford:** That is a very unusual situation that you can look into.

Caroline Dinenage: That is why I am so pleased we came.

Q358 **Dr Whitford:** But in a general situation, it would be the site of the incident, as opposed to the patient moving around.

Caroline Dinenage: Exactly right. It is not to do with the patient; it is to do with the site.

Q359 **Mr Jones:** I hate to take issue with Dr Whitford, but in north Wales it is not an unusual occurrence. It happens very frequently and a lot of clinicians who are based in England, with high degrees of expertise, carry out their services both in England and in north Wales. It does seem to me that this is a grey area and we would appreciate more detail on that.

I am just wondering what discussions you have had with the devolved Administrations about establishing HSSIB. Certainly so far as the Welsh Assembly Government are concerned, they would be fully aware of the sort of issues that we are discussing now.

Jennifer Benjamin: I am sorry, I did not get the first part of your question.

Mr Jones: I was just wondering what discussions you have had with the devolved Administrations and I was making the point that so far as the Welsh Assembly Government are concerned, they would be very much aware of the sort of issues that have just been outlined.

Jennifer Benjamin: We can come back to you with more detail on how we consulted the devolved Administrations, but as I said, we have fully consulted the devolved Administrations. The issue, as you describe, with regards to some of the issues around boundaries and where patients may be treated, as far as I understand—and I can confirm this—did not come up as a particular issue as we were developing the Bill. We can come back and clarify that for you.

Q360 **Mr Jones:** Do you anticipate that any of the devolved Administrations will want to replicate HSSIB domestically?

Jennifer Benjamin: It is difficult for me to know if they want to replicate it.

William Vineall: We don't know.

Caroline Dinenage: Scotland are considering setting up their own.

Q361 **Mr Jones:** Do you know whether any of the devolved Administrations might want to opt in to the HSSIB process, which might be sensible, given the sorts of issues we have been discussing?

Caroline Dinenage: As I said, I think Scotland are considering setting up their own investigating branch. I don't know the conversations that have been had.

Jennifer Benjamin: We don't know. We are more than happy to come back to you. We haven't had the sorts of discussions you are alluding to as to whether, first, the other devolved Administrations—with the exception of Scotland—would want to replicate this type of functions, or secondly, whether they would want to opt in. That is not the level of discussions we have had with the devolved Administrations.

Q362 **Mr Jones:** Do you think that those discussions should take place?

William Vineall: I know exactly what you are driving at. It is quite important that the devolved Administrations make their own decisions, because they are devolved Administrations. That is not just an official's answer, it is a fact of the governance that we have.

Mr Jones: One does not want to intrude on the boundaries of the devolution settlement, but by the same token one wants to make sure that patients actually get—it is not exactly redress—their particular issues investigated, especially when it is a cross-border issue, as we have talked about.

Dr Whitford: Obviously, Scotland have expressed that they might be looking at something similar. I don't think they would opt in, given that, with our national patient safety programme, Health Improvement Scotland, our whole system is different and is much more front-loaded on prevention. We don't have the CQC. It is a very different system. I think there are also probably slightly fewer cross-border issues as there clearly is between England and Wales, although there are some, particularly in Carlisle. However, I don't see Scotland opting in.

Chair: But we want the capability of cross-border co-operation.

Q363 **Dr Whitford:** I would hope that there would be, particularly if there was clinician working on both sides whom there were suspicions around. The GMC is UK-wide, and one would hope that Governments and agencies would co-operate.

Caroline Dinenage: That is a very good point, because people move around a lot in health.

Chair: And indeed across the Northern Ireland border.

Q364 **Dr Whitford:** As Care Minister and the local MP for Gosport, how do you think the events in Gosport might have been prevented if HSSIB had already been in existence?

Caroline Dinenage: I have to be very careful at this point, because when I became Care Minister in January I took steps to recuse myself as Care Minister from this particular issue because I wanted to be able to speak up on behalf of my constituents. I knew that the document was ongoing and would be published in June. I am unable to speak specifically about Gosport myself, for reasons that you will understand.

Q365 **Chair:** Can your officials take these questions?

Caroline Dinenage: My officials can definitely take them. They know how I feel.

William Vineall: I was the official in the Department responsible for establishing Gosport in the first year, up to the terms of reference. Obviously, the fact that the report came out was very good, even though the report was shocking. I read some but not all of it over the weekend. Two things struck me. First, there were a number of occasions a long time ago when quite a lot of people were inclined to do some kind of investigation or other, but one reason why they didn't was because there wasn't a body that was effective at doing investigations, so it pinged around a lot of different agencies. I think a first learning point is that an investigatory body like HSSIB, with an established and well-known expertise, would be useful in situations like that.

Secondly, whatever else it does, HSSIB would be able to get the facts of the situation out in relatively real time. As the Minister said at the start, one thing that we have suffered from in the health service in recent years is that whistleblowers have often been the route to uncovering problems, but it has taken a long time for the bureaucracy to respond. I think that my second learning point is that, if you had HSSIB there, it could be more responsive. Clearly, something like Gosport would then not have to be an historic review; it could be something that was current. Those are my two main learning points.

> **Dr Whitford:** From your first point, you would obviously hope that HSSIB being able to react more quickly and with expertise would have made a difference. You referred to whistleblowers, which is something I have quite a lot of concerns about generally. As a clinician, all of us see people who have tried to speak up and who have lost their career. Unless that injustice is dealt with, it is all very well talking about a duty of candour or anything else, but for somebody literally tussling with their conscience, it will be about feeding their family and having a career. Will whistleblowers be able to ask HSSIB or report an issue to HSSIB? Is it envisaged—it is not particularly in this Bill, but perhaps in a separate piece of work—that the suffering that whistleblowers currently face will be reviewed? They do not have the protection that they often think they have when they set off to raise an issue.

Caroline Dinenage: Absolutely. Whistleblowers will be able to raise their concerns. Those who do so will be protected by safe-space provisions. More widely, in answer to the second bit of your question, we are really committed to move forwards in the NHS and see whistleblowers as a massive asset, and to people receiving the proper support that they need at a time when they are doing something that is incredibly brave and courageous. We rely on people who are prepared to speak up and express concerns at a time when it is incredibly difficult for them to do so in order to improve patient safety. That is why it is key to everything we want to do.

Q366 **Dr Whitford:** Obviously, whistleblowers should not be the basis of a patient safety system—they are a sign that the patient safety system has failed—but they can prevent it going over the cliff. Unfortunately, at the moment, there are reams and reams of them who feel that PIDA does not protect them and that they suffer detriment at work and so on. Do you envisage that as a separate piece of work? It is not in here.

Caroline Dinenage: Separate work is already ongoing with regards to whistleblowers. We have the local Freedom to Speak Up system, which is growing. The guardian network has

560 people in its ranks and is growing all the time. It is an ongoing piece of work that we are very passionate about.

Q367 **Dr Whitford:** Would you look at the reform of PIDA, which is 20 years old, to give people the protections that are available in other countries?

Chair: PIDA?

Dr Whitford: It is the legislation that is supposed to protect disclosure—the Public Interest Disclosure Act. In 1998, it was kind of a great thing, but the tide has moved on and it is actually very weak. A lot of whistleblowers think that they will be protected, and then suddenly discover that they are not really.

Caroline Dinenage: All Government legislation could do with the occasional once-over to ensure that it is still up to date and protects the people it set out to protect.

Dr Whitford: It is clear that people came forward years ago and were ignored, and if people are not ignored, they seem to suffer detriment. We just do not have a good attitude to it.

Q368 **Andrew Selous:** What role will HSSIB have in looking at mortality data and taking action on it?

Jennifer Benjamin: As I said, at the moment, the Healthcare Safety Investigation Branch aims to gather a range of intelligence from a variety of different sources. I would envisage that mortality data would be another form of intelligence for the new body. Primarily, it will focus on incidents where, as the Minister explained, there is the greatest opportunity for learning. If the mortality data was a source of intelligence that would help in its investigations, I would imagine that the branch would use it.

Q369 **Andrew Selous:** This is a question I raised with the Secretary of State when we had the urgent question last week. He confirmed that the mortality data for Gosport very clearly showed a huge rise in mortality and then a drop. Over the weekend, it also came out that when people had tried to draw the attention of the Department of Health to that mortality data, it was almost as if the Department did not want to know. To rephrase my question, if there is a significant and sustained spike in mortality data, what will HSSIB do in future? There is only any point in setting up HSSIB if alarm bells ring and action is taken. For me, the most shocking thing is that the mortality data clearly spiked and clearly came down, and actually no one in the Department of Health seemed to want to do anything about it.

Jennifer Benjamin: I would envisage that this new body would be interested in whether there are unusual variations or outliers in terms of mortality data. That would be a source of information of interest and relevance to the new body. I see no reason why that body would not want to investigate. Its focus will be on providers, so it will need to be able to identify the relevant providers where those occurrences might be. It would go through the usual processes, including making sure that that information fulfilled its criteria for investigation, so this is all very much dependent on what criteria the body operates on and whether that fits with the criteria. I would not say that the new body would rule out investigating mortality data. If it is appropriate, it certainly would pursue that kind of inquiry.

Caroline Dinenage: Don't forget that a lot has changed in 20 or 30 years. We now have medical examiners. From April next year, every trust will have a medical examiner to look at every death, so we hope that there will be sufficient checks and balances to pick up anything at an individual trust level before HSSIB potentially has to look at a broader trend many years later.

William Vineall: Mortality data was not the acknowledged smoke signal that it is these days, so I think it would be a very useful piece of information for HSSIB when covering the piece and looking at investigations, and not ignoring it, as you said on Wednesday, for such a long time.

Q370 **Diana Johnson:** I understand the sensitivities around the Gosport independent panel, but I want to ask you, Minister, about the contaminated blood scandal, which the Department of Health is no longer responsible for; it has been moved to the Cabinet Office. Looking back, do you envisage that HSSIB would deal with it if we were ever faced with something like that again? Do you see how this could stop it becoming so prolific and widespread?

Caroline Dinenage: I am grateful to you for raising that. As you know, I have a number of patients in my constituency who are affected by contaminated blood. It is a national scandal that so many people died as a result of infected blood products. I would anticipate that if we had had HSSIB around in those days, as soon as somebody had drawn its attention to this it would have had the capacity to start an investigation and stop anything like contaminated blood or anything else being such a prolonged situation that happened over such a long period of time and affected so many people. The key is to pick up the learning early on so that others do not have to suffer.

Q371 **Dr Whitford:** Does the Department of Health review hospital standard mortality ratios and publish those? You said that HSSIB could look at them, but I assume that that is one of the standard data releases.

William Vineall: We receive them and CQC get them. They use them, maybe in a parallel to how you might expect HSSIB to use them, as a piece of information when they are going in and doing inspections.

Q372 **Dr Whitford:** But if someone was an outlier outside a funnel plot?

William Vineall: That would be one of a number of factors that might inform CQC, but it would not be the sole one.

Q373 **Dr Whitford:** So it would be CQC rather than your side?

William Vineall: Yes.

Q374 **Dr Williams:** Minister, a few moments ago you understandably expressed a wish that whistleblowers be granted safe space protection when they flag concerns with HSSIB. As the draft Bill is currently constructed, though, it provides that protection only to people who provide information to HSSIB investigations—technically, it is only if HSSIB decides to do an investigation that that person is protected.

There is a risk that somebody might provide information to HSSIB and not be protected. Do you therefore think that perhaps the wording of the Bill should be changed to protect whistleblowers in the way that you have just described that you would like to see them protected?

Caroline Dinenage: That is something we can definitely look at. I am grateful to you for bringing it to my attention.

Jennifer Benjamin: I think you are absolutely right. At the moment, safe space allows for information from staff as well as patients and other witnesses to be protected during the course of an investigation. The Bill is very explicit about that, and has not looked at going beyond that in terms of protecting whistleblowers or other individuals in any other way. You are right: that is how the Bill is currently drafted.

Caroline Dinenage: That is a really interesting point, thank you.

Chair: There will be a recommendation coming your way of some description.

Q375 **Baroness Eaton:** The Secretary of State is said to have made some rather critical comments about independent providers. One independent provider has said it would welcome being part of this scheme where HSSIB could investigate. Why is the remit of HSSIB not extended to include the private sector?

Caroline Dinenage: That is a really good question. As the Bill is written, HSSIB can look at independent providers where they are providing work that has been commissioned and paid for by the NHS. You are looking more broadly. It is certainly something that we would be keen to hear the Committee's recommendations on.

Baroness Eaton: Presumably, there would need to be a suggestion of how that should be funded.

Caroline Dinenage: Exactly. That needs to be taken into consideration. The Care Quality Commission can inspect independent providers so I suppose the jury is out on that. That is why we would be very keen to hear your thoughts on it.

Baroness Eaton: I am sure you will.

Chair: Thank you, Moving on, Lord Elder.

Q376 **Lord Elder:** I have a couple of questions on resources. How did the Government arrive at what looks like a suspiciously exact figure of £4.1 million for this organisation? In doing so, it looks roughly like what might be saved if we got rid of or managed to avoid public inquiries in health. It is a suspiciously exact figure.

My second question has already been alluded to by another Committee member: that figure was arrived at before the decision was taken in some way to involve the 1,000 possible midwifery cases. Are there really no resource implications of that decision at all? Are you saying that the £4.1 million was set up anyway, and you can add in these further investigations without any implications for resources?

William Vineall: I can answer the maternity part and have Jennifer to answer the first bit on resources. The maternity investigations come with additional resources of about £9 million or £9.5 million. There is a separate calculation for those, because there is 1,000 of them.

Q377 **Lord Elder:** Sorry. Does the £9.5 million go into HSSIB? So the resources of £4.1 million have been more than trebled by that decision.

William Vineall: Yes.

Lord Elder: That is nice to note.

Caroline Dinenage: It is £9 million in addition to the £4.1 million, so the two are separate.

Q378 **Lord Elder:** That is quite a substantial change. Is the £4.1 million a legitimate figure that can stand up?

Jennifer Benjamin: It is approximately £4 million for the 30 investigations that the body is investigating at the moment. That is the current funding arrangement. You are absolutely right that there is additional funding to support the 1,000 maternity investigations, recognising that it would need that additional capacity to do so.

Chair: Baroness Billingham, my apologies, because we jumped to your question.

Q379 **Baroness Billingham**: Serious incidents requiring investigations that present the potential for learning are likely to be limited to one type of provider. How does the draft Bill ensure that all aspects of a care pathway can be examined by HSSIB? There is even greater integration between health and social care, but HSSIB does not extend to private or local authority-funded adult social care. Why on earth is that?

Caroline Dinenage: As you say, there is greater integration, but where care is funded by the NHS and a patient is taken into the social care sector, the HSSIB investigation can follow that care pathway. Currently, there is no provision in the Bill for there to be an entirely separate review purely into an adult social care provider if it is privately or local-authority funded.

Q380 **Chair:** There was a supplementary to Lord Elder's question. What plans do the Government have to expand the capacity of HSSIB and to fund it in order to expand that capacity?

Caroline Dinenage: To start with, we want to work towards 30 investigations a year. As you know, HSSIB has just completed its first investigation and so it will take a while to get up to that sort of level. I think they are doing that with exactly the right approach—with a very slow, steady and professional attitude.

Once they are up to the level where the 30 a year have been rolled out and all the learning from that has been secured, we are very keen to look at how that learning can be rolled out more broadly by having accredited trusts around the country—not millions of them initially, maybe just a handful that has been picked by HSSIB because they have the right sort of culture, who will be trained by HSSIB to be able to carry out their own investigations on their peers—and then, in the fullness of time, to carry out their own investigations on their own trusts. That is obviously looking quite a long way down the line, but we wanted to be make

sure that the Bill was future-proofed, so that we were not coming back to you in five minutes asking for a different Bill.

Q381 **Chair:** That is an extremely interesting answer and I am sure it will provoke some discussion.

Baroness Watkins: I am sorry I was late—we had the amendment order on nursing in the House and I had to speak. We have had a lot of people say they are very concerned about a whole trust having a team that then goes and investigates somewhere else. They are not in any way anti the concept of people being accredited by HSSIB as investigators, but they believe that teams should be taken from different places and work together—not one trust looking at a particular issue. I have been fairly convinced by that argument, so perhaps you could respond.

Jennifer Benjamin: The way in which the new body will accredit organisations to carry out investigations—we have allowed for flexibility within the Bill to allow the criteria for accreditation to be consulted on. That will be a public consultation. Therefore at the moment there is no prescription as to how the accreditation process and the criteria for accreditation is going to work. That is open; there is scope for development.

The principle of accrediting a trust to carry out investigations, specifically safe space investigations, is to enable local providers to build up that capability and capacity to carry out those investigations in the same way—a model of the type of investigations that the national body will be carrying out. That is about raising the standard and quality of investigations, developing a just culture of learning and allowing staff to be open and candid in those investigations. The principle is to spread a culture and practice of investigations that we believe will be successful and currently is being successful in other sectors.

Q382 **Baroness Watkins:** I completely follow that, and therefore follow that you would do that in a trust that would then look at its own problems. Let us imagine that it has five accredited people who are good at that. The concern is sending those five, say, from trust A to go and look at trust B. People are telling us very clearly that if people are looking at another trust they want the teams drawn from more than one trust.

Caroline Dinenage: That is definitely allowed, to put the protection in the Bill, but we have not been prescriptive about how that would come together.

William Vineall: The critical thing for us, as Jennifer said, is that before anybody could investigate themselves, they had to prove the capability to investigate other people, and that judgment would be made by the people who are the experts, which is HSSIB itself. So the accreditation process would not be operated by us, but by them.

Caroline Dinenage: We just see this as having the potential—HSSIB itself, with the 30 investigations a year, can make some really great moves forward towards changing patient safety and addressing issues that might be substandard across the whole health service, for all we know.
Actually, though, if you really want to change a culture within a trust—if you have got individuals on the ground who have had that experience of those investigations and understand what a difference it can make, who think there can be some real moves forward, a culture change, and embracing patient safety changes in individual trusts.

Q383 **Chair:** Thank you very much. I am bound to say that we have had a lot of evidence suggesting that this idea of accreditation of non-HSSIB organisations to conduct HSSIB-style investigations with HSSIB-style safe space is not very popular.

There is great concern that trusts investigating themselves or each other presents conflicts of interest and will undermine the concept that HSSIB is pioneering. I am interested that you should say this is future-proofing the Bill. We are all in favour of trusts and other organisations in the health service being much more capable of doing objective investigations, but that is different from conducting an HSSIB investigation.

Caroline Dinenage: Yes.

Q384 **Chair:** How wedded is the Government to this idea of accreditation?

Caroline Dinenage: The reason we are here is that we are very keen to hear the views of your fantastic Committee, but also all the different experts that you have taken advice from, so we are always open to any kind of suggestions.

The reason I say we want to future-proof it is that we recognise that HSSIB is incredibly well qualified at what it does, but will, by the remit that we have given it, do only 30 investigations a year in the initial period. As I have said, there are 24,000 serious incidents a year in the health service and I don't really want to come back in front of your Committee in a few months' time and you say to me, "Caroline, how are you spreading this practice more widely across our health service? How are you making sure that there is that HSSIB accredited training out there in our trusts where people actually spread that learning and embed it in their culture?"

We are not sure we can really achieve that by having one centrally based organisation. It keeps our options open and enables us to look long term at how we want this culture change to be effective.

Q385 **Dr Whitford:** Is it not a matter of degree in that all hospitals will always be investigating significant adverse events that happen? For that investigation to be of a higher quality than it is now, better learning/sharing would be an advantage.

The problem is that the Bill makes it sound like we are only going to pay HSSIB for 30 and therefore we will get trusts to do some to save money, whereas if you are talking about something that is as serious as an HSSIB investigation, surely that cannot be a trust investigating itself. That is where the concern is. We have lots of near misses, minors, moderates.

Q386 **Chair:** To reinforce the point, NHS Providers told us in its written evidence, "The intention behind accrediting trusts, that of developing a learning culture, would be better directed towards investing in the HSSIB's role in setting standards of investigations and of training and accrediting local investigators to support its own work." What is your response to that?

Caroline Dinenage: As I say, I am very happy to take on board all the recommendations that you as a Committee and all the experts come back to us with. I suppose, as Dr Whitford says, there are investigations happening in hospitals up and down the country all the time—some

on incidents that are more serious than others. We want those investigations to be as robust as possible. If they can benefit from HSSIB training and learning, there is no disadvantage as far as I can see.

Q387 **Dr Whitford:** I do not think the public would think that, but I think the public are afraid that the way it is worded in the Bill is kind of doing your own thing.

Caroline Dinenage: That is certainly not the intention.

Q388 **Dr Whitford:** After the scandals that have happened, and obviously the most recent one, people would be afraid that that could lead to a cover-up of something very serious.

William Vineall: We certainly did not draft the Bill with the intention of giving them the message that because HSSIB is quite a bespoke body doing 30 investigations we would therefore as quickly as possible get the NHS to do a bunch of similar style investigations. That is not the intention of the Bill.

Chair: That is very helpful.

William Vineall: If it has come over like that, it was not our intention. As the Minister said, we think HSSIB is right for all the reasons we have rehearsed. With the right checks and balances, if we think it is right for HSSIB, in the fullness of time it could be right for the trusts as well, but we did not draft the Bill to do one in lieu of the other. If it appears like that, it was not our intention.

Mr Jones: How would it be determined whether a particular investigation should be an HSSIB investigation or an accredited trust investigation? Who will make that determination?

Caroline Dinenage: HSSIB will decide which investigations they want to take on. They are independent and they will decide which ones they want to take on. My understanding is that they will do that based on which they feel have the broadest potential for learning across health.

Q389 **Mr Jones:** So an accredited trust could not do that of its own motion?

Caroline Dinenage: An accredited trust could to it, but HSSIB will—

Mr Jones: Yes, but of its own motion? Would HSSIB make that decision, or could a trust make a decision itself that it wanted to carry out an HSSIB-style investigation?

Caroline Dinenage: Given the number of serious incidents, HSSIB will only ever be able to pick a very small number which they—

Mr Jones: I understand that. I am just wondering who makes the decision about who carries out the investigation.

Caroline Dinenage: HSSIB will decide which ones they want to carry out.

Mr Jones: In every case?

Caroline Dinenage: Yes.

Mr Jones: So a trust could not make that decision of its own motion.

Caroline Dinenage: Individual trusts will only be carrying out investigations where they are specific to their individual area. They do not have the remit to go more broadly.

Q390 **Mr Jones:** I understand that, but it could not make the decision itself. Are you saying that it could not, of its own motion, make a decision to carry out an HSSIB-style investigation?

Caroline Dinenage: Yes, of course it could. An individual trust can do their own investigation, but HSSIB will choose 30 a year that they will—

Mr Jones: I understand that.

Q391 **Chair:** That cross-references with another aspect of this, which is that the existence of HSSIB is not intended to prevent any other body from carrying out its own functions.

Caroline Dinenage: No, not at all. This is in addition, and it is really driven by the culture of learning. Chair, you directed me to a really interesting presentation by James Titcombe on the experience of his son's death. He said something that really resonated with me when he said that human error is inevitable and we must not normalise the failure to learn. That is at the heart of this.

Q392 ***William Vineall:*** When new NHS structures have been set up, there is quite a long history of saying they are going to be specialist, so the NHS sends everything of a particular ilk to that organisation. The reason for setting up HSSIB at a particular size was that we said we wanted it to do a specific set of investigations that are complex, systemic and all the other things we have mentioned, and we also wanted to use it as an encouragement for the NHS locally to get better at doing investigations itself, many of which will be for things that are not as complicated as Gosport or the other things, but for which it is none the less important to improve the investigative capability.

Chair: That was certainly our intention in the recommendations we made in the 2015 PASC report. We will think about how that should be reflected in the Bill, because at the moment, we think there is a bit of confusion. Baroness Chisholm, I think we have dealt with the 30—

Q393 **Baroness Chisholm of Owlpen:** Yes, I think we have, more or less, except it is interesting that HSSIB will do only 30 investigations, considering there are 24,000 investigations. A two-tier system could easily happen. What will happen to all of them? No change will ever happen, because 30 is such a minute number.

Caroline Dinenage: It is a small number, but it begs the question, what would be an appropriate number when you have 24,000 serious incidents? It is very difficult to set the goalposts for this, but we chose it based on the number to which we feel we can do justice and from which we can find the most amount of learning that we can use across the board.

William Vineall: We have a one-tier system at the moment, and it does not work absolutely well, because you get a situation where Gosport was not picked up—all right, it was a long time ago—and where you get a Morecambe Bay and a Mid Staffs. Our view was that having a one-tier system where everything was treated the same without the expertise for complex cases was not the right thing to do. The original recommendation, as well as coming from your Committee, was from the Morecambe Bay investigation, and it was that there should be a standing facility in the NHS to pick up the more complicated cases to ensure that we do not get to the position of having five-year-long inquiries or public inquiries or all the other things we saw with Mid Staffs and Gosport.

Q394 **Chair:** But it is also quite obvious that if we allow clinicians and patients to avail themselves of the safe space, a great number of patients and clinicians are likely to do that, and that will increase the demand in terms of the number of investigations that HSSIB conducts. Can I just be clear that, in the longer term, the Government are not ruling out a growing capability that can take on more investigations?

Caroline Dinenage: I don't think it has been ruled out, but the intention at the moment is for there to be 30.

Q395 **Diana Johnson:** Can I just follow up on that? Is it that the budget was set and out of the budget you think you can do 30, or is it that you came to the conclusion that 30 was the number, and if so, how did you reach 30? What is the logic behind that?

Caroline Dinenage: It does seem a bit of an arbitrary number. I think that it's impossible to choose; when you are starting off with a figure of 24,000 incidents, it is very difficult to choose a number that would do justice to that, but I think it was within the constraints of what this really professional organisation would be able to look at. They tend to be much more complex cases from which there is wide learning that has massive potential to change the culture across the health service and more broadly than that. Jennifer, I don't know whether you have anything to add.

Jennifer Benjamin: That is absolutely right. This is a new function; it is a national investigation function. It is set up to look at the most serious incidents. It was right to focus on a small number. We've got to have—

Q396 **Diana Johnson:** But why 30? Sorry to interrupt, but I don't understand why it's 30. Is it that the budget is leading to 30, because that is what you think you can do with the budget you have?

Jennifer Benjamin: I think it's thinking about the professional capability of the team that is required and what scope it has to look at a number of investigations—to run high-quality, professional, independent investigations over a year, to produce high-quality investigation reports over a year and to make sure that the learning from that is significant and relevant enough for the system to be able to adopt it and implement it. We think that we have got the balance right at the moment.

William Vineall: A lot of people think 30 is quite a lot in the professional investigation world.

Chair: It is a very interesting strand of discussion, and we will try to address that in our report. Moving back to more detail on the safe space, we will now hear from Dr Whitford and then Mr Jones.

Q397 **Dr Whitford:** There has been discussion about HSSIB having the ability to highlight, to police or to act as a regulator—in essence, simply to start a train of inquiry—but equally there is talk about whether evidence and witness statements should then be shared. In the Bill as drafted, there is actually quite a long list of exceptions to protection when we consider that it was paralleled to air accident investigation. So whereabouts, Minister, do you envisage that it would actually sit?

Caroline Dinenage: I will get Jennifer to talk about this in more detail, but I think there are some really big differences between this and the air accidents investigation branch. They have some really quite sharp teeth: they have the ability to compel witnesses to give evidence; there is no right to remain silent.

Q398 **Dr Whitford:** But do those two not go together, in that if the safe space is airtight, it becomes easier to say, "You need to speak up to us," whereas if someone is not under caution, if the safe space is quite leaky, you are asking someone, perhaps, to incriminate themselves?

Caroline Dinenage: We felt that we had to get a really careful balance. We were mindful of the fact that we don't want to drive out honesty and openness; we want to encourage it. We don't want people to find this is an organisation that they fear; we want people to feel this is an organisation that they can come to, that they can work with. It does have teeth; it has the power to command equipment, documents and information, but it does not have the power to compel people to attend an interview and give evidence. That was a deliberate decision, because we felt that we wanted to very much put the duties on an organisation rather than an individual, because when HSSIB is making its final recommendations, they will be to organisations and not to individuals.

William Vineall: This came up quite a lot—Jennifer might want to add something—in the consultation. What is the right balance in terms of ensuring we introduce a safe space that is something new to the NHS and that allows you to speak up, as people say, and are there exceptions where it will be necessary, at HSSIB's discretion, to pass over information if it is so important that it is felt that one of the other regulators, the GMC or the police need to see it? It is about drawing a balance, with the predominance being on having a strongly sealed safe space, but with exceptions where necessary.

Q399 **Dr Whitford:** But there are quite a lot of exceptions. Many doctors, whistleblowers and people who have been at the wrong end of this feel that it looks very leaky and not terribly safe at all. If somebody asks at the High Court about an air accident investigation, the High Court will be asked to weigh up the risk of damaging safe space in the future. HSSIB doesn't exist at the moment, so the police, the GMC and everyone else have to do their own investigations. The concern is that people are saying, "Yeah, yeah, you do it, and then we'll use your work." Surely it would be better to make the safe space more airtight, and then compel witnesses, as they do in the airline industry, by saying, "You are protected—you are in a safe space—but you actually have to come here and tell us what happened." I think it is the worst of both

worlds.

Jennifer Benjamin: What we are trying to achieve is something that would be appropriate for the healthcare context and setting. We have had representations about having a safe space that protects that information and allows staff, patients and other witnesses to be open and candid not only about their own practices but about the practices of others in the organisation. There can also be representations from families and patients who believe they should have access to all the relevant information about their treatment and care. That was the balance we were trying to weigh up.

The exceptions apply only where there is a significant risk or an ongoing concern about patient safety. It is then for the body to alert the relevant organisations, which then carry out their own investigation. There is no expectation that this body's investigation report can be used by the police, the GMC or any other regulatory body. That jurisdiction then falls to the appropriate organisations.

Q400 **Dr Whitford:** Is there not a difference between a report and evidence? Witness statements and detailed evidence that has been heard are quite different from a report. Again, that seems to be quite blurred. Of course the report will say, "We need to do x, y and z to make this never happen again," but that doesn't mean you are saying, "Doctor B said this, said that and did the other." Those are quite different things. The report will be used, so surely it will be published and will be in the public domain.

William Vineall: The report absolutely will be published. One of the learnings from AAIB—I am sure Keith can talk better about it than we can afterwards—is that the reports must be of a quality that satisfies everybody and tell the full story of what happened. To go back to your question and others about whistleblowers, any kind of information has to be more or less dragged out of the NHS at the moment. We are saying that, in having a pretty sealed safe space, we will be able to produce reports that get to the bottom of things in the way that the NHS isn't able to at the moment, and should satisfy the organisations and the individuals concerned. To protect a safe space, we do not think the details of the safe space and the particular conversations and pieces of evidence will be admissible to individuals. That is the balance we have tried to strike so the product you get at the end is a report that is satisfactory and timely and gets to the bottom of things to everybody's satisfaction. If it does that, safe space has performed its purpose.

Q401 **Dr Whitford:** But would you not then want to use a similar approach—going to the High Court to get evidence, witness statements, etc., released?

William Vineall: Well, you would need to do that.

Q402 **Dr Whitford:** In the draft Bill—sorry, I haven't got it in front of me at the moment—there is a big, long list of exceptions.

Jennifer Benjamin: There are exceptions for the reason I explained. It is to enable the body to alert the relevant organisations if there is a serious concern about patient safety so they can take action. It is designed to strike a balance. It protects the information the staff hold, but if there is a concern—

Q403 **Dr Whitford:** I don't think there is any controversy about raising concern. I think

that is not at all clear in the draft Bill, and I think it should be about continuing ongoing patient risk or danger. The phrase used somewhere is "patient benefit", which is much softer than saying, "There's ongoing clinical risk here that we need to raise with the GMC." That is still quite different from handing over HSSIB evidence to someone else.

Q404 **Chair:** Can I chip in? Mr Jones is going to come in. At the outset we are keen to create a no-blame culture and this body is about finding the causes of incidents without blame. Then it is required to hand over information to do with professional misconduct. How is that consistent with the main objective?

Caroline Dinenage: I think there is a balance, isn't there?

Q405 **Chair:** I don't think there is a balance. I think it is an absolute.

Caroline Dinenage: Do you? Because if everything is driven by—If you think about the situation of HSIB's first investigation around prosthetic hip replacement. There are a number of failings in that system that allowed that to happen and a lot of learning that could be done. If, at some point in the future, they happened to be investigating something that was as the result of one person, one negligent professional who should not be allowed to continue to practise because people's lives were at risk, I think there is a difference.

Q406 **Chair:** That is absolutely right; there is no question about that. Where there is a patient safety benefit in releasing information, then obviously HSSIB should report the information.

Caroline Dinenage: Yes.

Chair: But that has got nothing to do with misconduct. It might or might not.

Dr Whitford: I still think there is a difference between information and report. If there is a person or an item, the item can be reported to MHRA, the person can be reported to the GMC. That is still different from saying, "Okay. There are all of our papers that we have gathered." The problem is that the person was not under caution or represented. They may have indicted themselves. GMC and CQC should be getting on with their own job. It's just that in and of the moment it still sounds as if the legwork that HSSIB would do could be handed over lock, stock and barrel to another regulator of any kind, whereas surely it should be that you raise a concern, "We have real worries about Doctor X, GMC please investigate."

Q407 **Chair:** Can I tangentially raise another bit of evidence that we have received, which has not been published, though I hope we will publish it? It is an email from Dr Clare Gerada, who is medical director of the NHS Practitioner Health Programme that looks at, among other things, why clinicians commit suicide. One of the main reasons is the stress of dealing with complaints and having this obligation to disclose things and put themselves through the very invidious process of investigation by a professional body. Isn't HSSIB an opportunity to relieve some of this stress because they can speak freely?

Caroline Dinenage: Yes.

Q408 **Chair:** How is that helped if that safe space is then compromised by all these exceptions?

Caroline Dinenage: I am happy to take on board the Committee's comments. We will go away and have a look at that. There is a difference between human error—honest mistakes—and somebody who intentionally sets out to harm somebody. It is very different from an air accident investigation. Sad as it is, 99 times out of 100, when an aeroplane falls out of the sky, the person who was piloting that plane has gone along with the plane. There are instances, we know, where that is not the case but in many cases that happens.

Whereas, in this it is very different. We need to ensure that there is the capacity to be able to deal with all the different outcomes, meanwhile holding on to that concept of safe space to protect those who, as you say, are just drawing attention to something that has gone wrong.

Chair: And indeed where the families may wish to have something exposed because it will increase their knowledge of what has happened. I understand that pressure. It is another issue that we are wrestling with.

Q409 **Dr Whitford:** Obviously, the phrase "no blame" is misleading. It is a just culture. There will not be a promise to someone who is involved in an HSSIB investigation that, if they were utterly negligent or worse, they will not be prosecuted, investigated, struck off. It is this issue of whether the legwork of HSSIB, which has been taken inside a safe space, should be used for that. Those other organisations already exist. In air accident, the police have to jolly well go and do their own investigation. Air accident does not hand it over to save them the bother. I think that that is the concern. It still looks as if investigative materials would be handed over to these bodies and therefore, in actual fact, the safe space is not safe.

Q410 **Mr Jones:** Does the Government intend that those who answer questions in the safe space should subsequently be able to disclose what they have told an HSSIB investigator?

Caroline Dinenage: Sorry, could you say that again? I missed the first bit.

Chair: Perhaps it is one for Ms Benjamin.

Jennifer Benjamin: There is nothing to stop an individual who has shared information with the body from then sharing that information with anybody else. The purpose of safe space is to give the witnesses or those who share information with the investigation body the confidence that that information will be protected, but if that individual felt that they needed to raise concerns outside of that remit, I think that is entirely—

Q411 **Chair:** It does not have a gagging effect.

Jennifer Benjamin: No.

Q412 **Mr Jones:** We will be discussing the duty of candour in a minute, but how does this interface with the duty of candour?

Jennifer Benjamin: The statutory duty of candour applies at the moment to organisations. There is an equivalent for professionals in terms of the professional code and conduct. That

will still continue. This new body will carry out its investigations. It will carry out those investigations with the protections of safe space. It will publish its reports, and the relevant and full facts of those findings, and the recommendations in learning. The responsibility in terms of the duty of candour will still apply to the trusts and other organisations. They will still have the obligation to be open and provide an explanation and an apology to the patients and the families. We believe that the two operate quite well in parallel.

Q413 **Mr Jones:** If there is material in an HSSIB report that tends to exonerate a clinician, how do you feel the High Court, on an application, should balance the interests of justice? That is, allowing the report to be used in court on the one hand against the potential impact on future HSSIB investigations. Which do you think should have priority in a case such as that?

Jennifer Benjamin: As the Minister explained a moment ago, the purpose of this body is not to investigate individuals, but to try to understand what the systemic risks and issues were which pervaded the organisation and the wider system, and to benefit from that. This body is not in the business of exonerating individuals, or attributing any fault or blame to individuals.

Q414 **Mr Jones:** Forgive me, I did not ask that. The question was about where there was material in an HSSIB report that tended to exonerate a clinician as a by-product, if you like, of a report.

Jennifer Benjamin: The intention is that that level of information about an individual's practice would not be reflected in the report. That is our policy intention.

William Vineall: Because this is about organisation and learning, not individuals and failure, to put it at its simplest.

Mr Jones: Thank you.

Q415 **Chair:** Has that addressed the duty of candour issue as well?

Q416 **Dr Whitford:** I just have one supplementary question. We have covered a lot of it, but I want to go back to the whistleblowers. There is a suggestion by people who work in the NHS that if they are the ones who raise issues about a trust, they will face reprisals, as we talked about at the start of the session. How do we get away from that?

William Vineall: I suppose the simple answer is that they should not, because every message we are giving out is that we do want people to speak up and we want to facilitate that through things such as having a safe space.

Part of what HSSIB has to do is help us to change the culture whereby people do not have to be whistleblowers banging their head against a brick wall, but that there are systems and arrangements that make it easier for them to speak out in a safe way—hopefully early on when the incident is occurring—and that the response of the organisation is constructive, to learn from that, rather than lurching into something that quickly becomes litigious, which I know is quite often what happens with whistleblower issues.

Q417 **Dr Whitford:** Jennifer referred to the patient safety programme in Scotland. There is

still a need to have something at the front end. If a whistleblower raises something and there are only 30 investigations, they will not be in a safe space environment unless this is quite an advanced programme. If they are raising an issue early because there is concern, it will not be investigated by HSSIB.

William Vineall: As the Minister said, we have "freedom to speak up" guardians who are trying to shift that culture. We hope it will be easier for people to speak up in a way that it is not at the moment. That is what we want to achieve. We cannot do that alone with HSSIB, but hopefully it is making it that much easier still, because a safe space facility will be available.

Q418 **Dr Whitford:** You are aware that quite a lot of whistleblowers do not feel safe with the guardians and that it makes enough of a difference.

Caroline Dinenage: That will be quite a cultural change. It is quite new and we really need it to bed in and for people to have seen others have a good experience, to give them confidence to enable that fully to live up to its intentions.

Q419 **Dr Whitford:** That will be the key thing, will it not? Seeing people have better outcomes as opposed to the examples in front of clinicians at the moment.

Caroline Dinenage: That is exactly right.

William Vineall: And things that work more swiftly.

Q420 **Dr Williams:** I have a couple of brief questions. Some of our witnesses have suggested that in order to really enshrine the independence of HSSIB, it should be directly accountable to a parliamentary Committee rather than the Secretary of State. What is your response to that?

Jennifer Benjamin: The new body will be set up as non-departmental public body. Therefore, it will be accountable to a parliamentary Committee. That is absolutely right.

William Vineall: But we want it as an independent body so it is a way for many of the existing NHS organisations. There is no question but that it can work independently. Currently, for the purpose of setting it up, it nestles in NHS Improvement. Obviously, there is a compromise inherent in that because it oversees trusts. We want it to be separate in the same way that the CQC is separate and not in anybody's pocket, and can therefore do things openly and transparently and ask the difficult questions. That is what we want to try to achieve.

Q421 **Dr Williams:** Is the CQC not directly accountable to the Secretary of State rather than to Parliament?

Jennifer Benjamin: All non-departmental bodies are accountable to the Secretary of State. Each Government Department will have a sponsorship function, to have oversight of that non-departmental body. Equally, as for the CQC, Parliament can call it and hold it to account for its business and conduct, which it does on an annual basis.

William Vineall: But critically, in the same that the CQC chooses where it goes to inspect, HSSIB will choose where it does its investigations. That is not dictated by the Government Department.

Q422 **Dr Williams:** You say that, but the Government decided to give HSSIB 1,000 maternity investigations. So before HSSIB has been even set up, we have already seen that. The idea of keeping it independent would be to stop that potential political interference.

William Vineall: I am not sure I would call it political interference.

Caroline Dinenage: I would not call it political interference.

Chair: Order. One at a time. Let us have the panel first, then I will bring in Baroness Chisholm.

Caroline Dinenage: I would call it saying something that has a real chance of improving patient safety and outcomes and wanting it to happen more broadly across healthcare.

Q423 **Chair:** We have heard that that might be all right with this Secretary of State, but who knows who will be Secretary of State at some stage in future?

Caroline Dinenage: That is why, largely, it is independent. It is quite a hands-off role for the Secretary of State, not a day-to-day role.

Q424 **Baroness Chisholm of Owlpen**: Except the Secretary of State seems to have the power to stop an HSSIB investigation. That does not seem to be very independent to me. What sort of investigation would he or she have the power to stop?

Caroline Dinenage: My understanding is that, in practice, that would not happen.

Q425 **Baroness Chisholm of Owlpen**: Why is it in the Bill then?

Jennifer Benjamin: We need to double check, but the Secretary of State does not have the power to stop an investigation. The Secretary of State has the power to revoke the functions of the body in extreme cases—for example, should it not be performing, delivering or complying with the appropriate governance arrangements. The Secretary of State does not have the power to stop the organisation from carrying out an investigation.

William Vineall: There is an equivalent power in CQC legislation. If the body turned out to be rogue, the Secretary of State would have the ability to withdraw the power. It is not the intention of the power that the Secretary of State can use that to intervene on a regular basis.

Caroline Dinenage: Or in an individual investigation.

William Vineall: It is fairly typical for ALBs that you have that, just in case it went very badly wrong. You could revoke it and bring the public money back in and all the rest of it.

Q426 **Chair:** Exactly; if the thing was falling into the sand, you could do something about it. I am old enough to remember the introduction of the rate-capping of local authorities. The power was only to be used in the most exceptional circumstances,

rather like income tax during the Napoleonic Wars.

William Vineall: That is not a function of HSSIB.

Caroline Dinenage: No, we will not be issuing any rates.

Q427 **Chair:** What is a little confusing about this is that the Secretary of State early on in this whole process was very keen to be very hands off this organisation, because he felt that patients and clinicians would not have confidence in it if it was not seen to be independent of him or his office. These bits of the Bill are not what we expected.

Q428 **Baroness Chisholm of Owlpen:** There seems to be a power also through the composition of HSSIB's board. Is that right, through the appointments?

Jennifer Benjamin: Yes, there is, but that is not unusual in terms of setting up a non-departmental public body.

Q429 **Chair:** You see, this is not a normal non-departmental public body. It is more like, say, the Electoral Commission or the National Audit Office. We are wondering whether there are different Government arrangements that would not sideline the Secretary of State, but would give the public more confidence of the direct independent accountability to Parliament, which I think is what he originally wanted.

William Vineall: Certainly, the purpose of the Bill as it is structured is to give HSSIB the full independence in comparison with its current status, which is within the system.

Q430 **Chair:** That is certainly true. We are achieving a lot in that direction. Dr Williams, do you have anything to add here?

Q431 **Dr Williams:** There are some HSSIB investigations that are going to be safe space and some that are going to be non-safe space. Obviously, the Bill will need to be drafted in a way which allows some safe space and some non-safe space. Who is going to make the decision about whether an investigation falls within or outside the safe space provision. Will that be HSSIB's decision or the Secretary of State's decision?

William Vineall: The policy assumption at the moment is that all HSSIB investigations are carried out with safe space and the exception to that is maternity.

Q432 **Dr Williams:** There might be another set—it might be paediatric cardiology investigations that HSSIB next gets given or there might be deaths in custody or mental health deaths under the care of mental health trusts. There are a lot of very serious investigations that may be considered to be worthy of HSSIB. Who will make that decision about whether they are safe space or non-safe space?

William Vineall: It is the same answer that I gave before. The policy position on HSSIB is that its investigations should be safe spaced, because that is so integral to its establishment. Maternity is an exception to that for the reasons that I have given, but it is not an exception that is meant to imply that if anything else happened to HSSIB down the line, there would be further exceptions introduced on the safe space principle.

Q433 **Chair:** After the Bill is enacted, how would the extra 1,000 cases have been dealt

with under the Act?

William Vineall: They would have to be dealt with in a situation where safe space was exempted for those investigations. It would have to be in a separate category.

Q434 **Chair:** But actually, also, HSSIB would have to want to do that. There is this representation, as we see, from the Secretary of State and others, but HSSIB could have refused to do those, under the Act. Is that acknowledged?

William Vineall: To enable HSSIB to do maternity investigations within the Act, we would have to write it in, and then it would be established that they would do those investigations without safe space.

Q435 **Chair:** What is the point of HSSIB doing investigations if it cannot do them in such a manner that protects its relationship with clinicians and patients by virtue of the safe space?

William Vineall: It should be able to do that but, as I said before, we felt that there were good reasons to do the maternity investigations without the safe space.

Q436 **Chair:** I think we accept the inconsistencies of this prior to the legislation being enacted, but I hope that we will recommend a kind of logic that will satisfy everyone, and a more logical arrangement under the legislation once it is enacted, because it does not sit comfortably at the moment.

William Vineall: Okay. We will take that away.

Q437 **Andrew Selous:** Just a general point about the impact of HSSIB's reports and changing the culture. Paul Buckley of the GMC reminded us that Governments have been on this trail for quite some time—at least since 2000, and probably before.

Could you give us a little more detail on how you believe that HSSIB reports will actually change the culture within the NHS? The tragedy would be if these illuminating and incisive reports lay gathering dust on shelves. Changing the culture in the NHS is not easy to do, as many witnesses have told us. Could you just give us some detail about the mechanics of how the culture will be changed, please?

Caroline Dinenage: HSSIB has the responsibility and the power to make recommendations. It falls to NHSI to make sure that those recommendations are implemented. Also, HSSIB can request a response from the Department, and can request a date by which it wants us to respond to the recommendations and say how we will implement them and when. There is also one person whose name I have forgotten because they are about to change.

William Vineall: Aidan Fowler.

Caroline Dinenage: Aidan Fowler. He will have that overall responsibility and will be answerable to the NHS. What have I forgotten?

William Vineall: Nothing. At the moment, investigations are not timely, so we will make them timely because we have HSSIB. There is not a place for whistleblowers to go that is safe. We will make that clear and we will give them safe space. We will publicise the

recommendations and ensure that people act on them—that does not happen now—and we will have CQC include them in inspections in the future.

I know that that is quite a lot of bureaucracy to change the culture, but compare it with a situation like Gosport many years ago where none of those things existed. All right—it was a different age then. We are hoping that that will help to move the NHS on. It is explicit. It is a function that exists in law. It is something that will, as the Minister says, gain a profile as it proves its worth. Those things will help to contribute to not having things laying on the shelf and will enable us to deal with things more in real time, rather than having concerns many years afterwards that people's issues have not been addressed. I agree that it is, on occasions, too late by then.

Q438 **Dr Whitford:** I am just, as usual, banging on about the patient safety programme that we have. As a surgeon, that made a total change to our theatre practice. The problem with this, and obviously to improve it and to share learning, is it is still at the back end when things have gone wrong. What change of culture is there to be at the front?

We interviewed a panel and had an orthopod who talked about the huddle, as we have in Scotland, being done in some places but not in others. Is there any plan to try to put patient safety at the front, so that we have fewer than 24,000 investigations?

Caroline Dinenage: I would start by saying that obviously this will be a reactive system, but the whole point of it is to make recommendations that will prevent these sorts of never events from happening. In that light, HSSIB can be seen as something that is proactive—changing a culture and stopping these sorts of things happening in the long run.

Q439 **Dr Whitford:** Will such things as using first-name terms be compulsory? Obviously it was challenging for very senior older surgeons to suddenly be referred to as "Jim" by everybody, but that was national and they had to get on with it. Where HSSIB sees cultural things that are barriers, do you see it being able to enforce its recommendations on the frontline?

Caroline Dinenage: HSSIB's role is not as an enforcer; it is to recommend improvement. NHSI's role, in principle, is to carry out the recommendations. Aidan Fowler will be the national director of patient safety from next month. He will be the man with that responsibility.

William Vineall: I have two answers to your question. The human factors element has heavily influenced the establishment of HSSIB. As you were implying, that has not been particularly common in healthcare and is becoming more common now, so we very much wanted to publicise that approach.

The other thing you said was about how we can get things right at the start. Obviously, we have the GIRFT programme in England—getting it right first time—which is very much about saying to clinicians, "Look, this is the way of doing things and this is the way we have agreed you should do it."

One of the recommendations that came out of the first report last week was a point of detail about the national joint registry and how they use particular pieces of equipment. Over time,

you could see that some of the recommendations that come through a patient safety front could be some of the things that could be established through the systemic professional improvement route of things such as GIRFT.

Chair: You have all been terrific. Thank you very much indeed.

Panel 2

Witness: **Keith Conradi**, Chief Investigator, Healthcare Safety Investigation Branch, gave evidence.

Q440 **Chair:** Could you identify yourself for the record, please?

Keith Conradi: I am Keith Conradi. I am the chief investigator at the Healthcare Safety Investigation Branch.

Q441 **Chair:** Thank you very much for being with us. I have just been given a bunch of very quick extra questions that I will come to at the end, if we have not covered them, about alterations we are threatening to recommend to the legislation. First, how is what HSIB investigates determined?

Keith Conradi: I see us setting the criteria for what we investigate. I see us having a mix, of people being able to refer things to us and us proactively looking as far as we can into the problems that exist, and then making our own decisions against set criteria on what we decide to investigate.

Q442 **Chair:** We have heard an awful lot about HSIB doing thematic and systemic investigations. How will you deal with individual cases? How much can you separate individual cases from system problems?

Keith Conradi: Potentially, we can look at both. The system-wide ones are where we will really make the bigger difference. Individual cases will still be investigated locally. Bear in mind that the idea with the 30 investigations is that they are done on top of the local serious incident investigation that will almost certainly have taken place or be taking place, which will perhaps help trigger our 30 investigations.

Q443 **Chair:** To be clear, is it quite practical for HSSIB's remit to extend to the private sector?

Keith Conradi: Yes. I would welcome that.

Chair: But that is perhaps a policy issue above your paygrade rather than something I am going to nail you on. Should HSSIB require the consent of patients and families before deciding whether to investigate a particular incident?

Keith Conradi: I don't think so. I think it is very helpful, and to date we have had a healthy relationship with the families who will talk to us, but ultimately, if we are looking at a system-wide problem, we have to look at the big picture. Sadly for us, when there is a system-wide event to investigate, we have a choice of quite a large number of events as what we call the reference event that we anchor the investigation on. It is beneficial to us to select

one that we can easily attain the information for, so we are not pushing somebody who perhaps does not want to give it from a patient family perspective.

Chair: I was going to go on to question two.

Q444 **Baroness Eaton:** You have asked it, in a way, but I would like to extend it a little bit. Families may look to HSSIB to resolve individual cases. How will you communicate with them about what the remit is and what the difference is between what they expect and what you do?

Keith Conradi: It is a good point, because managing expectations has become quite a large part of what we have to do. We will try to clarify on the website that, "These are the criteria. We can only do 30 a year. Therefore, if you think you have a case that meets those criteria, please tell us about it, but you must recognise that we are getting loads and loads of cases and we have to choose what we think are the top 30, so the chances are that we are unlikely to investigate an individual event."

We would try to say that we are still interested in getting the information, because part of the intelligence gathering tries to join the dots between that event and another family somewhere else. They are not connected to each other, but the event is still part of the same system problem.

Q445 **Baroness Eaton:** Would it really hinder your work if the Bill specified that you had to consult with patients and families before the investigation? Would it be helpful or a hindrance?

Keith Conradi: I do not see it either way, quite frankly.

Baroness Eaton: You do not think it would be problematic.

Keith Conradi: I do not think so. We will talk to families and say that we are thinking of having the investigation. Many of the investigations that are referred to us are referred by the families anyway, so it takes that away from the get-go.

Chair: I am so sorry I trespassed on the question.

Baroness Eaton: It is all right. It needed a bit more.

Q446 **Dr Whitford:** In the earlier panel, we touched on the issues around the culture in the NHS regarding candour and openness when things go wrong. What is your interpretation of where it is, and how do you think HSSIB will really change that when you are talking about such a huge scale and a relatively small organisation?

Keith Conradi: From my experience to date, when we turn up somewhere, I characterise it as defensive curiosity. Generally, people are defensive but we have to do a lot of education every time we go somewhere because not many people have heard of us. By the time we have gone through the education, people start to open up a bit. By the time we actually start to do the investigations, the response is generally very positive. We have had several clinicians who have said, "Actually, for the first time, having spoken to you, I feel able to sleep at night." We bring that different approach. Unfortunately, it almost takes the intervention to go

into somewhere before people recognise that this is what we will bring to the party. We probably need to work out how we can get that message out there ahead of time.

Changing a culture is not an overnight process. We have to do it by being very consistent and putting out professional investigations time and time again. Over time, from the reports that we produce, people will start to understand that they have less to fear from us coming in and doing an investigation.

Q447 **Dr Whitford:** Do you think the Government are placing too much of a burden on you by expecting you to change the culture? How can we move patient safety to make it central on the frontline, as opposed to waiting for it to go all the way through a problem and for something to come back in a report?

Keith Conradi: It is managing expectations again. We are but a small part of the safety system, and that is a really important message for us to get over. We are here to do highly professional investigations and make recommendations to the system. We play our part, but it needs everybody to play their part for the whole system to work.

Q448 **Baroness Chisholm of Owlpen:** Leading on from that, after making those recommendations, how will you then make sure that they are implemented? Leading on from the implementation, how will you make sure that it has worked, that the culture has changed and that people have learned?

Keith Conradi: I am keen that our recommendations are not mandated. Our expertise is only in the investigation. We would use subject matter experts to assist us. The key thing for us is to identify who the right people are to bring about that change. One of the mantras that we have is that there should be no surprises to the addressee of a safety recommendation. Throughout the investigation, we are already discussing what we think needs to be done and what the problems are. By the time we make it—this is certainly so for the ones to date—we have had an understanding from the addressee of what it is we are after. The key thing then is that we make them public. We require response. I like in the draft Bill where it talks about us being able to dictate the time within which there has to be a response back to us. We make that response public. We have to be careful about taking HSIB any further than that, because we are not an enforcing branch or a regulator. It is important that we have the distinction between the two.

Q449 **Mr Jones:** Have you yet made an assessment of the sort of establishment you will need? How many investigators do you think you will require?

Keith Conradi: To do the 30 investigations a year, we currently have 18 investigators. I think that that is probably on the limit of how many we will need. The thing is that when we take on an investigation, it is quite difficult to know just how complex it will be. We are still developing the way we investigate to understand, "Do we have to draw something in? Do we have to keep the focus tight?" Some of that is about matching the capacity we have. There might be occasions when we need to go wide with it. At the moment, that process is very much under development. We have only got the first investigation just published. It will be some time before we know whether we have got the right numbers for that type of investigation.

Q450 **Mr Jones:** What sort of people do you recruit to be your investigators? What are

their backgrounds?

Keith Conradi: We do have clinicians. We have professional investigators from other parts of industry. We have human factors experts. I think that is the majority of the investigators we have.

Q451 **Mr Jones:** It is quite important, I would have thought, that the investigation team should understand the culture and ethos of the health service. Where they have not got that sort of background, what do you do to help ensure that they develop that understanding?

Keith Conradi: When we go out on a new investigation, we do not send one investigator; we try to send two or three investigators if we can, one from each of those different disciplines. They will see things that the others do not see. Clinicians will go into somewhere and see something and say, "That is how we do it. That is what always happens", but the other two bring a fresh set of eyes and quite a different perspective. They will ask, "Why do you do that? What is it about this that you feel is necessary to do each time?" Particularly when you have the human factors people coming in, they are sometimes looking at the culture and what it is that leads to people behaving in a particular way. The mix of all those different types of backgrounds is what makes this a particularly professional investigation.

Q452 **Mr Jones:** Where do you find these people? Is there a recruitment process that you go through? Is there a sufficiently large pool of potential investigators that you can draw on?

Keith Conradi: I am trying to think how many applications we had for the first set. We had well over 200. We have just gone out for recruitment for another two, and we have had just under 100 applications. We go far and wide. It is not just within the NHS. It is that mix that is so key to the success.

Q453 **Mr Jones:** Clearly there are a lot of people interested in doing this sort of work.

Keith Conradi: There are, yes.

Q454 **Mr Jones:** You have obviously had a considerable extra burden placed on you by these 1,000 maternity investigations that you have to carry out. How many extra staff do you need for that? How much progress have you made identifying them?

Keith Conradi: We are recruiting 126 maternity investigators in a regional set-up. We have already recruited about half of those. We are going through training courses. They are all going to get a four-week training course. The first two sets have already been through that and are starting to do investigations already. Most or a great majority are seconded from trusts. Part of this model is that they will come with us for a year or so and they will then go back to the trust. That is one of the ways in which we think we can start to put some of that learning and some of that HSIB investigation experience back into the trusts.

Q455 **Mr Jones:** When you say it comes from trusts primarily, are we to understand therefore that these are primarily people with a clinical background?

Keith Conradi: Yes. On the maternity side, they are heavily clinician-biased—midwife-biased. Probably 70% are midwives.

Mr Jones: Once the new HSSIB has been set up, how do you anticipate that it will operate on a day-to-day basis, that is, not carrying out investigations? What sort of work would your investigators and staff be doing on a day-to-day basis?

Keith Conradi: I think that every member of staff is likely to have a portfolio of probably three or four investigations at any one time. They would all be at different stages of the process. Part of it is going out; in fact it is actually intelligence-gathering before we even go out to visit a site. Each investigation is going to last anywhere between six and 12 months.

Q456 **Mr Jones:** That intelligence-gathering would be an important part of your work, I would have thought. You will have to make an assessment at some stage where you should be investigating, what cases you should be investigating. That, I would have thought, would be intelligence led.

Keith Conradi: It is and, in fact, in addition to the investigators, we have an intelligence section, which is led by our medical director. One of their key roles is to identify from all the information that is given to us, and again where we are proactively looking, whether these events are worthy of the top 30.

It is a difficult call to make. At the moment, we have this remit to go into all the different areas of NHS care, and we are deliberately trying to go into the different areas to see, does the model, the methodology work? Does it work in primary care as well as it does in acute or in mental health? That is part of it. At the moment, it is just trying to get a broad range of investigations. I think anywhere we go with our approach, we will make a difference.

Q457 **Chair:** You have listened to all the discussions we have had about the other devolved jurisdictions. Can I just short-circuit? What do you think the answer is to this problem?

Keith Conradi: I was hoping you wouldn't ask me that. I think we would probably need a good lawyer. Is it where NHS money is spent? This money is spent on a process or procedure. That is the sort of thing that we are interested in. Personally, I would like to go as wide as possible.

Q458 **Chair:** You might have a patient funded by the Welsh health service in an English hospital and you decide that is not in your jurisdiction; you are not going to investigate that case.

Keith Conradi: Our default position is that we would like to take on these things. It will only really be if somebody says, "Actually, you are not funded to do that; you can't."

Q459 **Chair:** If Scotland does develop a Scottish version of HSSIB, presumably you would have some kind of protocol.

Keith Conradi: Yes, I imagine we would have.

Q460 **Chair:** What happens if Wales doesn't?

Keith Conradi: We have already had a lot of dealings with the Welsh Government in bits and pieces of investigations that we are currently undertaking. We see this huge amount of care that does cross the border. It strikes me, without understanding all the politics of the devolved

status, that a much more practical way would probably be for us perhaps to take on that sort of thing, but it is probably outside my remit.

Q461 **Chair:** It is a devolved matter and we have to respect that. Of course, the same applies in Northern Ireland with the Republic. There is no possibility of setting up a body that would cover Northern and Southern Ireland. How do we address that?

Keith Conradi: I don't know.

Chair: You don't know. We will wait and see.

Q462 **Dr Williams:** My question is about safe space. Under what circumstances do you think that HSIB should be allowed to disclose information to police, regulators or a clinician's employer?

Keith Conradi: My view is that we should not have exceptions from prohibition of disclosure. We should be under remit, if we are aware of an ongoing safety issue or potentially a police matter, that we inform the authorities, but I don't think we should have a discretion to hand over information.

Q463 **Dr Williams:** So you would tell the authorities, "There is something that you need to look at here," but nothing more than that.

Keith Conradi: I think we could provide some detail but not the actual paperwork that goes with it. That is the important thing. That is where the protection is important. That is my background from the way it worked in the air accident world and that seemed to be pretty effective.

Dr Williams: So enough information to let the employer, the police or the regulator set off their inquiry, but no more than is necessary.

Keith Conradi: Yes, correct.

Q464 **Chair:** What would you do if a clinician came to you and said, "Yes, I really made a mess of this operation, because actually I am an alcoholic and I cannot control my drinking"?

Keith Conradi: We would tell the trust straightaway.

Q465 **Chair:** So you would disclose that information.

Keith Conradi: We would tell them, but we would not disclose the statement.

Q466 **Chair:** So you would hand over the burden of the information, but not the actual statement.

Keith Conradi: Yes. The whole thing is probably worth clarifying: with safe space or protection of sensitive information, the information that is given to us in any circumstance will be used. There would be no point in us taking this information in, if we did not do something with it. We are saying that we want to improve patient safety with it. We would still use that information. The protected piece is the piece of paper that it is written on and we

don't want that to go. We are using this piece of evidence along with this piece, this piece and this piece, to gather the wider picture of what we think the problem is.

Q467 **Dr Williams:** We had a discussion earlier about whether safe space should apply to people who flag concerns with HSIB, or whether it should only apply once HSIB has decided to do an investigation. Do you have a view on that?

Keith Conradi: We have set up a system where people can refer events to us anonymously. We have started one of our investigations based on that. Nobody has to leave their name. They can just make us aware of something that has happened and we would treat that just as if we had a name. We will go through the standard scrutiny process and if we think it is one of our top 30, we will take it on. So we do not actually need the name of a person to instigate an investigation.

Q468 **Dr Williams:** If you decide not to initiate an investigation, what happens to that information? Could someone do a freedom of information request on that? Is that inside or outside the safe space?

Keith Conradi: Well, they have not left their name in the first place.

Dr Williams: But they might have left enough information for the case to be identifiable.

Keith Conradi: Yes, I suppose that is possible. We would try to protect that, because we—

Q469 **Chair:** So you would like that to be in the safe space?

Keith Conradi: I think that would be helpful.

Q470 **Chair:** If there are 24,000 bad things happening in the health service every year, that is quite a lot of people who might want to tell you stuff. How are you going to cope?

Keith Conradi: We were concerned about that when we first set up this referral system. To date we have had less than a hundred in the year that it has been open. We have not exactly been overwhelmed. Actually, we would encourage more. I might have to eat my words at some point.

Q471 **Chair:** But the complaints system is handling more people, the ombudsman is handling more people and the demand is bound to increase.

Keith Conradi: At the moment, I do not think that will be an issue. It may become a capacity issue at some point. But we do make it really clear, "Look, these are the criteria. Look at those before you make a referral to us."

Q472 **Chair:** How comfortable are you deciding whether an investigation should be in the safe space? Or have we really dispensed with that and it should all be in the safe space?

Keith Conradi: It should all be.

Q473 **Chair:** Should you have the power to require individuals to answer questions?

Keith Conradi: I think that is probably a step that we do not need. When I look back, we had that power in the air accident world. But did we ever use it? When we used it, was it good quality information that we received? I would find it hard to say yes.

Chair: But having it and not using it is different from not having it at all.

Keith Conradi: Yes, but I cannot really think where it would be of huge benefit. I would much rather that we had information that was received freely and given to us. I think that is a much more valuable set of information than something that is coerced out of somebody.

Q474 **Chair:** Should you need a warrant to enter premises?

Keith Conradi: I would like the right to enter premises. How it is done, I do not really mind, frankly—the easiest way possible.

Q475 **Chair:** Do you think you would ever need to enter residential premises?

Keith Conradi: I think there would be ways around that. I would be quite happy without having that power.

Q476 **Chair:** Perhaps you should require a warrant to enter residential premises, but any other premises you do not require a warrant.

Keith Conradi: Yes, that would be fine.

Q477 **Dr Whitford:** Air accident reports, as opposed to testimony and evidence, can be used in civil proceedings and coroners' inquests. Should that be the case for HSSIB reports?

Keith Conradi: We certainly do not have a problem with using our reports in coroners' inquests. That seems to be reasonable and helpful. The difficulty we always have with taking reports into an adversarial system is where we might be required to apportion some sort of blame or come down on one side. We strongly wanted to resist having to do that, and I think the same thing applies. I would be uncomfortable if we got pulled into an adversarial court and then had to make some sort of determination. Once you are in the courts, there is nothing you can do if you are asked the question.

Q478 **Dr Whitford:** But the report is going to be in the public domain; I am not talking about yourselves as investigators giving evidence. The report will naturally have a degree of, "This is what went wrong" in it, in the same way as in the airline industry. As we said, the aim is a just culture, not actually no blame if you are to blame.

Keith Conradi: I don't have a problem with the report being used. It is just important that the caveats that go with the report—the fact that the evidence is not collected in accordance with police standards and the rest of it—are understood when the report is being used.

Q479 **Dr Whitford:** You were quite clear earlier that the evidence, as in the testimony, should be watertight.

Keith Conradi: It is protected.

Q480 **Dr Whitford:** Do you see it as with the High Court, in the same way as in air

accidents? Or should the list of disclosure exceptions in the Bill stay as they are?

Keith Conradi: No, I think the High Court should make the determination each time.

Q481 **Dr Whitford:** If the court decided to disclose, and we would obviously hope they would weigh that up in the same way as they do in terms of the possible destruction of future candour or future disclosure, do you think how that evidence is used further should be up to the High Court?

Keith Conradi: Yes.

Q482 **Dr Whitford:** So you would want to shut down quite a lot of the exceptions that are in the Bill.

Keith Conradi: Yes. I would rather not have that discussion.

Q483 **Dr Whitford:** Do you think that some of it is a blurring in the language between the report, evidence and information? The report will be a public document and no one is trying to say it should be hidden away, whereas my view would be that the raw testimony that someone gives is what should be protected. As you say, they have not been under caution and will not necessarily have lawyers and so on.

Keith Conradi: Yes, we want the report to be made as widely public as possible, but the background information that allows us to make the report should absolutely be protected.

Q484 **Chair:** You heard me raise the questions from the email sent to me by Dr Clare Gerada, the medical director of the NHS Practitioner Health Programme, about the strain that clinicians and others are under when they are being investigated in the system as it is at the moment. Could you describe how the safe space in the aviation sector is actually a support to the pilots and aviation profession in a way that you do not find in the health service at the moment?

Keith Conradi: Obviously, it has been around for a long time so that always helps. We did a lot of work with people such as the pilots' unions for instance, who understand how it could be used. They would advise their members that it is a positive and a benefit—it allows you to be able to tell your story and what happened without pressures and, as far as can be done, it will not be disclosed any further. In aviation, we approached it through the history of dealing with it, and dealing with it sensitively, and getting those people around who would give guidance.

Q485 **Chair:** I think the GMC, for example, inadvertently feels the need to identify individual failures in order to protect the reputation of the profession. Does that go away, or can you deal with that, if you have the safe space and an objective investigation that does not necessarily need to scapegoat a failure on an individual?

Keith Conradi: We have to understand that on some occasions, there is likely to be more than one investigation. There will be parallel investigations, and that is fair and proper. It was the same in aviation. We just have to understand that what we are doing is the safety investigation.

Q486 **Chair:** So you would quite like any reference to misconduct removed from the Bill, because you are not investigating misconduct.

Keith Conradi: We are not investigating it, but we may come across it, so there has to be some provision so that if we do come across it, we will make the appropriate authority aware. Again, there is a similar reference in aviation legislation.

Q487 **Chair:** Would you have any problem with the information in your reports being used to excuse individual clinicians from their mistakes?

Keith Conradi: I don't quite know how you feel that would work.

Chair: I am imagining a situation where a clinician is up in front of the GMC and says, "Yes, I made a mistake, but actually, if you look at this report, you can see that it was because of this, this and this."

Keith Conradi: The report will be public, so if people want to use it for that, they can use it however they want to use it. Our intention is to improve patient safety, but once it is out there and it has been made public, we are not going to put any stops on what it can be used for otherwise. The thing is that the statements we take—I keep coming back to that—have to remain protected.

Q488 **Chair:** We have the dreaded question about accreditation. Can I short-circuit it? We have heard all the debate. Can accreditation be made to work effectively or do you have a different answer?

Keith Conradi: It was interesting to listen to the debate on how we do this. We can only do 30. There seem to be about 24,000. I probably envisage a system where low-level cases are dealt with at trust level, and then there has to be some sort of marker above which they need to come away from the trust, but not up to HSSIB at that stage. Perhaps it is a bit like the maternity programme, which is why it is quite interesting—do you have a regional set-up of investigators who are removed from the trust where it happened and can provide that independent viewpoint on the occurrence itself? I feel that if they are not HSSIB people, we have to be extremely careful about delegating some of the powers, particularly the safe space powers.

Q489 **Chair:** That's the concern that we have—that the confidence in the investigation would be compromised, not just because people were too close to where the incident occurred, but because the investigation would not quite be conducted up to your standards.

Keith Conradi: The danger is that any small abuse of that power will come back and bite us all, so we would all lose out if that happened. That is my concern.

Q490 **Chair:** A couple of other very peripheral things, if colleagues will forgive me: I think we are minded to find that you need to have broader powers to conduct thematic reviews. What is your reaction to that?

Keith Conradi: To having broader powers?

Chair: To conduct your own thematic reviews without there necessarily being a qualifying incident under the Bill.

Keith Conradi: The way I read the legislation, I did not feel that it would stop us from doing that, but actually—

Chair: But we might as well be clear about it.

Keith Conradi: Anything that says we have that ultimate choice, yes.

Q491 **Chair:** To hark back to the way the safe space works, would it hamper your work if people could bring along their union representative or if they were accompanied by somebody representing their profession?

Keith Conradi: No, I think it should be up to the individual whom they want to be in that room. If they want to bring anybody, that is their call.

Q492 **Chair:** Finally, there is a duty of co-operation with other regulatory bodies. Did the AAIB have a duty of co-operation placed on it?

Keith Conradi: No.

Chair: What effect do you think it will have on HSSIB if you are subject to a duty of co-operation?

Keith Conradi: I think particularly perceptually there could be some difficulties. We must have that separation from the system for it to be effective.

Q493 **Chair:** To be independent. So a duty to co-operate you feel might compromise your independence.

Keith Conradi: I think that is a danger.

Q494 **Chair:** But how do we break down the anxiety that other parts of the health service feel about the creation of this new statutory body? You must have sensed it yourself.

Keith Conradi: I think it comes back to what I said before. It is education about what we are trying to do. The aims have to be really clear: this is what we do; this is what we don't do. What I really want over the years is for the investigations to speak for themselves.

Q495 **Chair:** And the fact that you will not stop anybody doing what they already do.

Keith Conradi: No.

Q496 **Chair:** Because we had evidence from the NHS providers who were really concerned that they did not know where the boundaries laid between you and them. How will you address that?

Keith Conradi: Between us and NHS providers?

Chair: I think it was the trusts.

Dr Williams: It was the people representing the trust.
Andrew Selous: They have their own investigations.

Q497 **Dr Whitford:** Is it not the case in the maternity ones that HSSIB as it stands is doing the investigation, instead of the trust doing the investigation and perhaps HSSIB doing some on top? Therefore, they feel they have been elbowed to the side.

Keith Conradi: That is exactly right. In the maternity investigations it is about taking the place as opposed to the national ones. The approach we are taking is very collaborative. When we go into the trust, we work with the risk manager. Often, the whole investigation is done together. We then feed the learning straight back into the system. It is early days, but that seems to be working okay.

Q498 **Baroness Watkins of Tavistock:** One of the things that NHS providers are really worried about is that they have legal liability for things that have gone wrong; therefore, they feel that there is a risk of them ending up having to pay a big bill, which they might have to pay anyway in my opinion, because you have done something and perhaps have taken longer than they would have done. That was really what they were saying.

Keith Conradi: It is an interesting point. To go back to aviation, when we were uncovering something with one of the big manufacturers, they were really concerned because commercially it could have been very damaging to them. We make a big point that as we come across factual information, we share it immediately—we are doing this in maternity. We will not hang on to information until the very end, when the report comes out. It is a shared investigation process.

Baroness Watkins of Tavistock: I think that will be very reassuring.

Chair: It is very reassuring.

Q499 **Andrew Selous:** Just briefly, because we have gone on for a while. In the course of your investigations, do you foresee HSSIB looking beyond the borders of England, just to make the comparison? We have quite rightly had frequent reference to the Scottish patient safety programme. Do you view yourself as being able to lift your gaze beyond the borders of England to other healthcare systems by way of comparison, or even by referencing where things are done differently and where the data supports better outcomes in those other jurisdictions?

Keith Conradi: Absolutely, and not just the UK. We went to Denmark for our first investigation. We try to look at different areas where they are doing things in a different way. We have been to Wales to view some procedures taking place in some hospitals in Swansea to get a kind of comparison—not because it is a different country, but because the process is different.

Andrew Selous: Good.

Q500 **Dr Williams:** I read some newspaper reports, as I am sure you did at the end of last week, that talked about the secret investigations being done by HSIB and how patients would not learn about what had happened because of the safe space. I wondered whether I could give you the opportunity to put your point of view across in response to that.

Keith Conradi: What I say is that that tool is for us about revealing the truth. It is giving people the opportunity to reveal what happened. I come back to the point that the information that is given to us is absolutely used in the report. Otherwise there would not be much point in taking that relevant information in, so all of it will be there. Anything that is relevant to the care that took place will be included in the report.

The reality is that when people talk to us in that protected environment they are generally telling us things about the organisation, and saying, "Oh, this is a pain. We are being asked to do X, Y and Z. We feel that we probably shouldn't be having to do that. The management don't understand this, that or the other." That is the sort of information in general that is presented to us in that sort of confidential environment. We use it with the other information that we collect to gain the bigger picture of what has happened, and then we include that in the final report.

Q501 **Dr Williams:** What is your message to the families who are concerned about this? The language in the report was about a sort of establishment cover-up, wasn't it?

Keith Conradi: My message is that by taking this approach you are going to get a much better picture of what actually happened and the bigger picture of why it happened in your particular case.

Chair: Anyone else? Well, thank you very much for sitting so patiently through the previous session and for your clear dedication to this project. We hope that we will make some suggestions that everybody will be pleased with. Thank you very much indeed.