House of Commons

Public Administration and Constitutional Affairs Committee

Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England

Seventh Report of Session 2016–17

Report, together with formal minutes relating to the report

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Public Administration and Constitutional Affairs

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Contents

Summary

In July 2016, the Public Administration and Constitutional Affairs Committee (PACAC) received a report from the Parliamentary and Health Service Ombudsman (PHSO), *Learning from Mistakes: An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS failed to properly investigate the death of a three-year old child*. This report is the PHSO's second report into the tragic death of Sam Morrish, a three year old child whose death from sepsis was found to have been avoidable. The second PHSO report highlights systemic problems with clinical incident investigations in the NHS in England, where it found that a fear of blame inhibits open investigations, learning, and improvement.

Our further report corroborates these findings. The Department of Health, NHS Improvement, and Care Quality Commission all acknowledged the need for the investigative culture to be transformed into one in which open-minded, learning-focused investigations can routinely take place. However, despite repeated reports, both from PHSO and from PACAC, highlighting this as the critical issue facing complaint handling and clinical incident investigations in the NHS in England, there is precious little evidence that the NHS in England is learning. We found that, while a number of initiatives exist to improve the health service's investigative culture, there was also a distinct lack of coordination and accountability for how these initiatives might coalesce.

PACAC concludes that there is an acute need for the Department of Health to step up and integrate these initiatives into a coordinated long term strategy that will meet the Secretary of State for Health's ambition of turning the NHS in England into a learning organisation. As this report shows, it is critical that this strategy includes a clear plan for building up local investigative capability, because this is where the vast majority of investigations will continue to take place. Ministerial responsibility for clinical incident investigations in the NHS in England is diffused. PACAC therefore recommends that the Secretary of State for Health should be accountable to Parliament for delivering the coordinated implementation of the shift towards a learning culture in the NHS in England.

As part of our inquiry, we also considered the impact the new Healthcare Safety Investigation Branch (HSIB) will have on resolving some of the issues outlined in this report. The Government has accepted PACAC's predecessor Committee PASC's recommendation from March 2015 to instigate such a body. HSIB will conduct clinical investigations in a 'safe space' where people directly involved in the most serious clinical incidents can speak honestly and openly in the interests of learning. PACAC believes HSIB should become a key player in addressing the NHS in England's blame culture. However, HSIB is being asked to begin operations without the necessary legislation to secure its independence and the 'safe space' for its investigations. PACAC reiterates in this report that this is not acceptable. There is a real risk HSIB will start off on the wrong foot, without a distinctive identity and role within the investigative landscape. It will not therefore have the intended impact of developing a learning culture in the health system.

Accordingly, this report urges the Government to bring forward the legislation for HSIB as soon as possible. Furthermore, we believe the Government should stipulate in the HSIB legislation that, first, HSIB has the responsibility to set the national standards by which all clinical investigations are conducted; secondly, that local NHS providers are responsible for delivering these standards, according to the Serious Incident Framework; and thirdly, the Care Quality Commission should continue to be responsible as the regulator in assessing the quality of clinical investigations according to those standards at a local level.

1 Introduction

1. The Parliamentary and Health Service Ombudsman (PHSO) as part of its role makes final decisions on NHS complaints in England, and from time to time reports to Parliament on wider themes emerging from its casework. It is a function of the Public Administration and Constitutional Affairs Committee (PACAC) to examine these reports and to use their findings to hold Government to account. The post of Ombudsman is currently held by Dame Julie Mellor DBE, who was appointed in 2012. She is supported in this role by casework and corporate staff at the PHSO. The Ombudsman announced her resignation in July 2016 and will stay in place until a successor is appointed. This is now expected at the end of March 2017.[1]

2. This Report focuses on the issues arising from the PHSO's July 2016 report, 'Learning from mistakes: An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS in England failed to properly investigate the death of a three-year old child.'[2] This report only addresses the NHS in England, but PACAC hopes that the NHS in other parts of the UK will also use the findings of this report.[3] 'Learning from Mistakes' is the PHSO's second report on the tragic death of a three-year old child, Sam Morrish, on 23rd December 2010 and follows up on their earlier report into this case, 'An avoidable death of a three-year old child from sepsis.'[4] The PHSO's second report, 'Learning from Mistakes,' sets out four key findings:

(1) a defensive culture in the NHS

(2) a lack of competence and sufficient independence in the conduct of NHS investigations into potentially avoidable harm and death

(3) poor coordination and cooperation between NHS organisations involved in investigations, and failure to collectively identify and act on lessons

(4) insufficient involvement of families and staff in NHS investigations.[5]

3. This Committee has considered the systemic issues that plague the health service's complaints and investigations processes before in its June 2016 report 'PHSO review: Quality of NHS complaints investigations.'[6] PACAC's predecessor committee, the Public Administration Select Committee (PASC), also made a number of recommendations in this area in its March 2015 report 'Investigating clinical incidents in the NHS,' including recommending the establishment of an Independent Patient Safety Investigation Service (IPSIS).[7] The intention was that such a body would conduct clinical investigations in a 'safe

1 On 24 January 2017, after this report was agreed, the House of Commons agreed to a resolution approving the appointment of Robert Fredrick Behrens CBE as the new Parliamentary and Health Service Ombudsman.

2 *Learning from mistakes: An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS failed to properly investigate the death of a three-year old child,* Parliamentary and Health Service Ombudsman, July 2016. Henceforth referred to as 'Learning from Mistakes.'

3 Throughout this report, 'NHS' is taken to refer to the NHS in England.

4 *An avoidable death of a three-year old child from sepsis*, Parliamentary and Health Service Ombudsman, June 2014.

5 *Terms of reference Follow-up to PHSO report 'Learning from Mistakes,'* Public Administration and Constitutional Affairs Committee.

6 First Report from the Public Administration and Constitutional Affairs Committee of Session 2016–17, *PHSO Review: Quality of NHS complaints investigations*, HC 94, June 2016.

7 Sixth Report from the Public Administration Select Committee of Session 2014–15, *Investigating clinical incidents in the NHS*, HC 886, March 2015.

space' where people directly involved in the most serious clinical incidents could speak honestly and openly in the interests of learning. The Department of Health has accepted this recommendation and this body, renamed to the Healthcare Safety Investigation Branch (HSIB), is scheduled to begin operations in April 2017.

4. However, as we noted in our 2016 report into NHS complaints investigations, we are concerned that "given this new body's limited capacity, its creation alone will not solve these complex, systemic problems."[8] Indeed, while HSIB is intended to become a key player in reforming the investigative landscape, further changes will be required to effect the necessary cultural shift within the health service that would underpin an effective learning culture. In 'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England,' the Care Quality Commission (CQC), the independent regulator of all health and social care services in England, also writes that "there is currently no single framework for NHS trusts that sets out what they need to do to maximise the learning from deaths that may be the result of problems in care."[9] Our Report is focused on the changes that are required for HSIB to succeed in transforming the way the health service learns from clinical incidents, and on the wider actions that must be taken along with the introduction of HSIB in order for an effective learning culture to take hold across the health service.

5. This Report therefore sets out the wider implications of the PHSO's report and assesses what further actions the Department of Health must take to achieve the ambition set out by the Secretary of State for Health, Rt Hon Jeremy Hunt MP, for the NHS in England to become "the world's largest learning organisation."[10]

6. While PACAC welcomes the creation of HSIB and other commitments made by the Secretary of State for Health, we remain deeply concerned that HSIB currently lacks the necessary legislative underpinning to provide for its independence and for the realisation of the 'safe space' that is so essential for it to achieve its objectives. The Committee is also concerned that the Government has not clarified specifically enough HSIB's position within the investigative landscape, including how its role as an exemplar will work in practice. Indeed, evidence taken during the course of this inquiry suggests that there is a lack of clarity about how HSIB's role as an exemplar for investigations across the wider system will be effected, measured, and evaluated.

7. We are grateful to all those who provided evidence to us. In particular we would like to thank Scott Morrish, father of Sam Morrish and member of the HSIB Expert Advisory Group (EAG), Dr Steve Shorrock, European Safety Culture Programme Leader, Keith Conradi, former Chief Inspector of Air Accidents and now appointed as HSIB Chief Investigator, Helen Buckingham, NHS Improvement, and Prof Sir Mike Richards, Chief Inspector of Hospitals, CQC, who gave evidence to the Committee on 8 November 2016. The Committee is also grateful to Rt Hon Philip Dunne MP, Minister of State at the Department of Health, William Vineall, Director of Acute Care and Quality Policy, and Chris Bostock, Policy Lead on NHS Complaints, Department of Health, who gave evidence to the Committee on Tuesday 22 November 2016. In total 15 written submissions were received from individuals, campaign groups and professional associations.

8 HC (2016–17) 94, June 2016, p. 4.

9 *'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England,'* Care Quality Commission, December 2016, p. 6.

10 Secretary of State for Health, *"From a blame culture to a learning culture"*, transcript of speech given to Global Patient Safety Summit at Lancaster House, 3 March 2016.

Terminology

8. Our report refers to four key terms that have become commonplace in discussions about the need to improve investigations in the NHS in England: 'safe space,' 'just culture,' 'blame culture,' and 'learning culture.' It is worthwhile to set these out at the start of this report, as they are interconnected and reflective of the need for a system-wide shift in how healthcare safety investigations are conducted. As the PHSO's 'Learning from Mistakes' report shows, the NHS in England is currently marred by a defensive culture that often prevents open and learning-focused discussions that could help to define how clinical incidents could be prevented in future. These problems with the investigative culture in the NHS in England are commonly referred to as the 'blame culture.' The ambition of creating a 'just culture' refers to the need to move towards an investigative culture that embodies a more learning-focused approach without thereby losing the ability to determine accountability for individual wrongdoing where that is appropriate. In order to facilitate this shift, our predecessor Committee, PASC, recommended in its March 2015 report, 'Investigating clinical incidents in the NHS,' that a body, now HSIB, should be created that could conduct investigations in a 'safe space' where staff, families, and patients can discuss clinical incidents without fear of reprisals.[11] As PACAC's June 2016 report on the quality of NHS complaints investigations explains, the 'safe space' within which HSIB investigations will take place is a critical step forwards on the path towards fostering a learning culture in the NHS in England, but should be cautiously applied so as not to undermine accountability within the wider system.[12] The rest of this Report explores this tension between accountability and learning in more detail and sets out why the 'safe space' requires appropriate legislation if it is to be effective in the context of HSIB's investigations.

11 HC (2014–15) 886, March 2015.
12 HC (2016–17) 94, June 2016, p. 20.

2 The Investigative Landscape in the NHS in England

PHSO Report 'Learning from Mistakes'

9. The case study of Sam Morrish's tragic death in 2010 is at the heart of the PHSO's report. In summary, Sam Morrish died of sepsis after a series of mistakes were made between his first displaying flu-like symptoms and his eventual death in the early hours of 23rd December 2010. The investigations into his death variously involved 5 organisations, none of which, according to the PHSO's report, satisfactorily determined the root causes of failings in Sam Morrish's case or showed signs of the 'learning' approach that is so essential for incorporating lessons into practice and procedure in order to prevent the same mistakes being repeated in future.[13] As the PHSO's first report in 2014 found, these organisations also failed to conclude that Sam Morrish's death was 'avoidable' in the first place, as it was later found to have been.[14]

10. In its 'Learning from Mistakes' report, the PHSO reiterates the five areas for improvement identified by the recent CQC 'Briefing: Learning from serious incidents in NHS acute hospitals' :

- Serious incidents that require full investigation should be prioritised and alternative methods for managing and learning from other types of incident should be developed.
- Patients and families should be routinely involved in investigations.
- Staff involved in the incident and investigation process should be engaged and supported.
- Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident.
- Using human factors[15] principles to develop solutions that reduce the risk of the same incidents happening again. There are also improvements to be made in communication, coordination and governance within and across organisations.[16]

11. In 'Learning from Mistakes,' the PHSO also reiterates its point from its 2015 report, 'A Review Into the Quality of NHS Investigations,' that training and accrediting sufficient investigators to operate locally is crucial to the long term improvement of local

13 *Learning from mistakes*, Parliamentary and Health Service Ombudsman, July 2016, p. 6.

14 *An avoidable death of a three-year-old child from sepsis*, Parliamentary and Health Service Ombudsman, June 2014.

15 In his evidence to us, Dr Shorrock referred to some of these human factors that influence working conditions in healthcare: "All human work is driven by demand, which results in pressure when resources are inadequate or when constraints are inappropriate. All human work is characterised by basic goal conflicts between, for instance, the need on the one hand to be thorough in checking, diagnosing and executing procedures, and the need to be efficient." (Q24) Human factors principles, in this context, are therefore taken to mean those environmental and organisational factors that influence an individual's ability to do their job without making mistakes.

16 *Learning from Mistakes*, Parliamentary and Health Service Ombudsman, July 2016, p. 7.

investigations.[17] In 'Learning from Mistakes,' the PHSO further says that it believes there is a need for the role of NHS complaint managers and investigators to be better recognised, valued and supported.[18]

12. In their evidence, NHS England, which sets the priorities and direction for the NHS in England, confirmed that they recognised the issues identified by the PHSO's report. The report, they said

> provides robust analysis of issues such as investigative procedures and gaps, communication and coordination between different health organisations, communications between those organisations and the family and how the investigation processes can be improved.[19]

Culture

13. In the first evidence session of our follow-up inquiry into the PHSO's 'Learning from Mistakes' report on 8th November 2016, Scott Morrish outlined his view of the 'blame culture' in the NHS in England, including some of the negative implications of that culture and why it needs to be converted into one in which 'learning' is central:

> We need to shift the whole focus away from the blame and the shame and the worries that go with that and the silence that it leads to. We need to shift that to one where the expectation is learning, no matter what happened. Whether it is good or bad we can learn and improve and have an expectation of supporting staff and supporting families, not pitting us against each other.[20]

14. In 'Learning not Blaming,' the Government's response to PASC's report on 'Investigating clinical incidents in the NHS,' the Government argued that the health service should seek to tackle this blame culture. They said that the NHS "must embrace a culture of learning rooted in the truth, a culture that listens to patients, families and staff and which takes responsibility for problems rather than seeking to avoid blame."[21]

15. When he spoke to us, the Health Minister, Rt Hon Philip Dunne MP, reiterated the Department of Health's ambition to tackle the blame culture in the NHS in England: "what we are endeavouring to do is to change the entire culture of the NHS towards a learning culture and we start with the experience of the patient […] who is making the complaint."[22]

16. It is difficult to monitor and measure this cultural aspect of the healthcare system. In this respect, the CQC's Prof Sir Mike Richards pointed out that the NHS Staff Survey, conducted annually, provides a good basis from which to extrapolate some of the issues with the investigative culture in the health service that the PHSO's 'Learning from

17 *Learning from Mistakes*, Parliamentary and Health Service Ombudsman, July 2016, p. 7.
18 *Learning from Mistakes*, Parliamentary and Health Service Ombudsman, July 2016, p. 7.
19 LFM 21 (NHS England)
20 Q23
21 Department of Health, *Learning not Blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation*, July 2015, p. 12.
22 Q81

Mistakes' report exposes. Tellingly, the survey reports that when asked whether their organisation treated staff involved in near misses, errors and incidents fairly, less than a half of all staff (43%) reported this was the case.[23]

17. We asked witnesses about action being taken to address this culture of fear and blame that inhibits open investigations and learning from mistakes. We sought to probe the extent to which the Department of Health, and the health service more broadly, had a coherent strategy for moving the system towards a learning culture. Within this, the Committee sought to determine which national bodies would be responsible for the different parts of this strategy, including the soon to be established HSIB, NHS Improvement (responsible for driving improvements within foundation trusts and NHS trusts), and the CQC. Central to our concern in this area is how the proposed 'safe space' principle for investigations will be secured in legislation and what the implications of its introduction, both for and beyond HSIB, will be on the attitudes and behaviours that influence the health service's investigative processes. This report makes clear that the 'safe space' for HSIB requires legislative underpinning in order to contribute effectively to the development of a learning culture in the NHS in England. At the same time, it also expresses our severe reservations about the negative impact a premature expansion of the 'safe space' beyond HSIB may have.

Multiple body investigations and the involvement of patients and families in investigations

18. The PHSO's 'Learning from Mistakes' report welcomes the introduction of HSIB as a positive step towards tackling some of the issues it uncovered with regard to the organisation of multiple-body investigations and an overall culture of blame that undermines the ability for investigations to lead to learning. This section sets out the key issues within the investigative processes in the NHS in England. The intended role and place of HSIB within that landscape is set out in the next section.

19. NHS England highlights in its evidence that in 2015, the Patient Safety Team published the NHS Serious Incident Framework (previously published in 2010 and 2013).[24] This framework outlines the process whereby NHS organisations ensure they "appropriately report, investigate and respond to serious incidents so that lessons are learned." This framework was introduced to reflect changes in the NHS landscape in England and improve cooperation between different bodies conducting investigations. The overall aim is to ensure investigations lead to a clear analysis of why clinical incidents occurred and what can be done to minimise the risk of similar incidents occurring in future.

20. Despite this, much of our written evidence for this inquiry points towards continuing failings in the investigations process, including evidence that clinical incidents do not always prompt an open learning-focused investigation, particularly when multiple organisations are involved, as was the case for Sam Morrish's death. In 'Learning, candour

23 The survey is administered annually so staff views can be monitored over time. Participating organisations must, as a minimum, select a random sample of 1,250 employees to take part in the survey. The survey can get a representative picture of views within the organisation by taking a random sample which reduces the burden on staff within an organisation, as not all staff have to take part. Organisations may choose to survey an extended sample of staff or all their staff (a census approach). *NHS Staff Survey 2015 Briefing Note*, p. 10.

24 *NHS Serious Incident Framework, NHS England, implemented in April 2015.*

and accountability: A review of the way trusts review and investigate the deaths of patients in England,' the CQC reports more broadly that "Organisations work in isolation, only reviewing the care individual trusts have provided prior to death."[25]

21. In their written evidence to our Learning from Mistakes inquiry, Healthwatch England, a consumer champion for health and social care, point out a number of perceived flaws in communication and coordination across the healthcare system that they uncovered by conducting a series of national polls. Many of these issues relate to the complexity of the various investigative bodies that deal with complaints, and how those bodies engage with patients and families. The key issues Healthwatch England highlights are that patients and families:

- Were not given the information they needed to complain;
- Did not have confidence in the system to resolve their concerns;
- Found the complaints system complex and confusing;
- Needed support to ensure their voices were heard;
- Needed to know that health and care services would learn from complaints.[26]

22. In our first evidence session on the PHSO's 'Learning from Mistakes' report on 8th November 2016, Scott Morrish focused on how the blame culture in the NHS in England was part of the reason for the inadequate involvement of families and patients in the investigative process:

> In our circumstances, basically the poor governance allowed control to rest in a very small number of hands, and for a number of reasons, including fear and poor process, they basically did not want to be confronted with those other perspectives. It [the Morrish family's perspective] challenged identity and their understanding of themselves, and it was deeply uncomfortable.[27]

23. Healthwatch England further notes that they found that "70 different organisations" dealt with complaints, creating "a complex and frustrating landscape for patients, service users, carers and families to navigate."[28] Their report, 'Suffering in Silence,' offers additional context for these findings. In this report, they also conclude that "despite a weight of reports on the matter," people find the complaints process complicated, frustrating, and ineffective.[29]

24. In its evidence to this inquiry, Healthwatch England picked up on the need for patients and families to be involved more consistently and more extensively throughout the investigations and complaints processes. This was especially important, they argued,

25 *'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England,'* Care Quality Commission, December 2016, p. 39.
26 LFM 12 (Healthwatch England)
27 Q3
28 LFM 12 (Healthwatch England)
29 *Suffering in silence: Listening to consumer experiences of the health and social care complaints system*, Healthwatch England, October 2014, p. 32.

as a means of informing "patients and the wider public about how the NHS is learning" in order to build "wider public understanding and confidence in how feedback more generally is being used to drive improvement, both at a local and national level."[30]

25. Commenting specifically on how the existing confusion surrounding investigations can be tackled for families and patients, The UK Sepsis Trust, a charity founded in 2012 to tackle sepsis, recommended that there should be "a framework against which the design, governance, transparency, fairness, timeliness and effectiveness of an investigation can readily be judged in order to identify areas for improvement."[31]

26. The complexity of the investigative landscape contributes to a wider sense that the NHS in England struggles to coordinate its efforts to learn from mistakes and errors when they occur. Furthermore, given that families and patients find the investigative process difficult to navigate and feel excluded from investigations, their valuable input is not effectively engaged during investigations and they are left unaware of whether or not the system has learned from the incidents it investigates. As Mr Morrish's evidence suggests, the exclusion of patients and families may provide further evidence of the blame culture that permeates the NHS in England. This results in patients and families being treated as problems that must be managed. Instead, as Dr Shorrock's evidence to the Committee suggests, patients should be treated as experts in their own cases and, therefore, as key sources of information to determine why mistakes occurred.[32]

27. **It is clear from the evidence reviewed during the course of this inquiry that the investigative processes in the health service in England remain obscure and difficult to navigate for patients and families. As a result, patients and families are excluded by the system, which must become open and learning-focused if investigations are to lead to positive changes in the system. Families and patients should, as a matter of course, be included in investigations and should feel confident that lessons will be learned as a result of clinical incidents.**

30 LFM 12 (Healthwatch England)
31 LFM 05 (UK Sepsis Trust)
32 Q7

3 HSIB and the learning culture

The role of HSIB and 'safe space' investigations

28. HSIB was explicitly designed to focus on developing a learning practice for investigations in the NHS in England. It is meant to offer support and guidance to NHS organisations on investigations, and function as an exemplar by carrying out a small number (30 per annum) of investigations itself. The concept of a 'safe space,' central to HSIB's investigations, within which parties involved in clinical incidents can speak openly about mistakes is a key component of HSIB's unique role in addressing the blame culture on a system-wide basis. As PASC explained in its March 2015 report 'Investigating clinical incidents in the NHS,' this model largely follows the successful one that exists in the aviation sector, where similar investigations are conducted by the Air Accidents Investigations Branch (AAIB).[33]

29. The Minister placed a strong emphasis on how HSIB's 'safe space' investigations are to become part of the wider shift in the NHS in England from a blame to a learning culture, with the introduction of 'safe space' investigations addressing directly the issue of psychological safety for staff so that they may contribute openly to investigations.[34] This chimes with the Secretary of State for Health's ambition, referred to above, to turn the NHS into the world's "largest learning organisation" in that it would directly address the blame culture in the NHS that we believe inhibits open and frank discussions about why clinical incidents occurred.

30. What remains unclear is how HSIB, including its safe space investigations, will interact with existing bodies in the investigative landscape, such as the CQC or NHS Improvement, to drive improvement to local investigations. Relatedly, there is still uncertainty over who will assume responsibility for HSIB's intended effect of standardising and improving the quality of NHS investigations, particularly at local level.

31. In their evidence to this inquiry, Healthwatch England underscored the role they saw for HSIB in improving local investigations. They imagined HSIB working "with other national partners to ensure that learning from its investigations is not only disseminated but also acted upon locally and improves outcomes for people."[35]

32. However, in their response to our report on NHS complaints investigations, the Government admitted that "HSIB will be unable to oversee improvements at a local level. That responsibility sits with local providers with the CQC checking the results."[36] As such, while it is clear what the intended impact of HSIB is on local investigations, the Department of Health has yet to establish how it will be achieved; it is not at all clear exactly how local investigations will be improved as a result of HSIB's introduction.

33. There was at least some consensus among our witnesses on how HSIB would relate to NHS Improvement and the CQC. Helen Buckingham, NHS Improvement, commented on

33 HC (2014–15) 886, March 2015, p. 34–35.
34 Q74
35 LFM 12 (Healthwatch England)
36 *PHSO review: Quality of NHS complaints investigations: Government response to the Committee's First Report of Session 2016–17*, September 2016.

how she saw the current landscape for investigations in the NHS in England. She sought to clarify how she expects NHS Improvement, the CQC, and HSIB to work together to drive learning and improvement:

> I think it is very easy to say that we have a collective responsibility for this, but once you start talking about responsibility you can then lose individual roles. I think across our three organisations essentially we see the role of HSIB as being setting a standard, setting the bar, the role of the CQC broadly as holding the mirror up to the system and saying, "Are we meeting that bar?", and then for NHS Improvement and NHS England, working with commissioners to work with local organisations—either individually or collectively—to help them to improve where they need to.[37]

34. William Vineall, at the Department of Health, made a similar observation when he said that

> NHS Improvement [will] support trusts and […] ensure that recommendations are taken up and to try to group the learning. CQC, as it does further investigations when it goes into a trust, will need to know what has been said in an HSIB report. In a sense, HSIB will be producing significant new material of a high quality that can be utilised by the other bodies to take forward the learning and improve services as a result.[38]

35. **The intention for HSIB to share learning will not alone guarantee the improvement of investigations across the NHS in England. HSIB's role as an exemplar can only be effective if its relationship to other bodies is clear. There must also be a well-defined process so that HSIB's best practice is respected and shared across the system, including at local level. In order for this to happen, existing investigations and investigative bodies need to understand what to expect from HSIB when it starts operating, and how they are meant to respond to its findings.**

36. An Expert Advisory Group (EAG), of which Scott Morrish was a member, was set up by the Department of Health in 2015 to advise on the scope, governance, and operating model for HSIB. This EAG was chaired by Mike Durkin, National Director for Patient Safety at NHS England, and made up of academics, healthcare professionals, and campaigners. When it reported in May 2016, the EAG made thirteen recommendations.[39] A first key recommendation was the passing of primary legislation setting out HSIB's absolute independence in carrying out investigations as well as establishing the necessary legislative framework for the 'safe space' within which it will conduct its investigations. According to the EAG's report, this legislation is key to ensuring HSIB can function as an independent investigative body whose 'safe space' investigations serve as a strong impetus for the system to learn from serious incidents.[40]

37. A second key recommendation made by the EAG concerned the introduction of a 'Just Culture Taskforce.' As the EAG report explains, the taskforce would work across the health service to embed an open and learning-focused culture. This would seek to ensure that the health service is receptive to the recommendations and learning identified

37 Q36
38 Q93
39 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016.
40 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 7.

by HSIB through its investigations. In this respect, they write that "The Branch should be a leading voice in promoting and modelling just culture, but it cannot be expected to resolve these single-handedly across the entire healthcare system."[41]

38. A 'Just Culture Taskforce' would, according to the EAG's report, seek to lay the groundwork for the cultural shift away from blame and towards learning that is key to achieving the system-wide impact HSIB was designed to facilitate.[42] In its broadest sense, the EAG sees HSIB's 'safe space' investigations as a meaningful step towards reforming a system that is "seen as threatening by staff; untrustworthy by those affected; and fails to identify many opportunities to prevent future harm."[43] An improved investigative culture in the health service would be one that is 'just.' This 'just safety culture' comprises both the learning-focused investigations as conducted by HSIB and the existing investigative processes, which are focused on determining accountability for mistakes. To summarise the EAG's report, a 'just safety culture' thus acknowledges the need for investigations to be focused on how an organisation can learn from errors and incidents, which may include setting up a 'safe space' for involved parties to speak openly about those incidents, without thereby absolving those involved in incidents from individual wrongdoing.[44]

HSIB legislative framework

39. The Committee took a particular interest in the EAG's recommendation regarding the importance of HSIB being fully independent and the 'safe space' being properly established in a legislative sense. In the course of its inquiry, PACAC sought to determine to what extent key stakeholders for HSIB, as well as HSIB itself, felt that HSIB's independence and 'safe space' investigations are dependent upon the introduction of primary legislation.

40. The 'safe space' is currently established through Ministerial Directions made by the Secretary of State for Health under the National Health Service Act 2006, rather than through new primary legislation.[45] This goes against our recommendation, reiterated most recently in our June 2016 report, that there should be primary legislation to secure HSIB's independence and to set out the 'safe space' for its investigations.[46]

41. The Government is currently consulting on the further development of the 'safe space' in an open Consultation. This Consultation acknowledges the problems arising from a lack of primary legislation for the 'safe space':

> The Directions under which HSIB will operate provide some guidance on the 'safe space' principle in the context of investigations by HSIB, but the Directions cannot override existing legislation which allow organisations such as the police, coroners and professional regulators powers to compel the disclosure of information.[47]

41 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 30.
42 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 9.
43 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 6.
44 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 9.
45 *NHS Trust Development Authority (Healthcare Safety Investigation Branch) Directions (2016)*, Department of Health.
46 HC (2016–17) 94, June 2016, p. 17.
47 PACAC's response to this Consultation is appended to this report.

42. Scott Morrish expressed his concern that, in effect, this means that

> HSIB is being asked to go out and conduct investigations fairly soon, while it does not as yet have the powers it needs to do that in the way that we are asking it to. It feels to me like a bit of a jump in the dark.[48]

43. The Minister acknowledged "there is a strong argument for there to be primary legislation" and that the Department of Health were "well aware that it would be required in order to deliver safe space in the optimum way."[49] However, he was unable to commit to this legislation being brought forward in the near future.

44. HSIB Chief Investigator Keith Conradi told the Committee that primary legislation securing HSIB's Independence would be key to ensuring confidence and credibility in its decision making, as it would signal that "when we make a decision to go to investigate something people have confidence that it has come from us, from our system, as opposed to anybody else suggesting it to us or forcing it on us."[50]

45. **The Committee agrees that the 'safe space' established by the Secretary of State for Health's Directions does not match what is provided for other incident investigators in aviation or rail safety. It neither provides sufficient protection for those participating in investigations nor for the information they share. They will continue to be vulnerable to any actions being taken against them. This undermines the 'safe space' principle and negates the intended role for HSIB as an independent investigator.**

46. **While we were encouraged by the Minister's clear assurance that HSIB will have discretion on what it investigates, we believe that unless HSIB's independence is enshrined in primary legislation, its investigations remain open to external pressures and it will be seen as being part of the existing hierarchy. This perception is underscored by HSIB's current position within NHS Improvement. The Directions set up by the Secretary of State for Health are not an adequate substitute for primary legislation formally enshrining HSIB's independence.**

47. ***We agree with HSIB's Chief Investigator that HSIB needs its own legislative basis in order to be independent and that the 'safe space' for its investigations is protected. We urge the Government to bring forward such legislation at the earliest possible opportunity. The Department of Health must cease to defy the consensus now established by Parliament, the HSIB, the Expert Advisory Group, and HSIB's Chief investigator on the need for such legislation. If HSIB is asked to begin operations in 2017 without this legislation, there is a real risk it will fail to establish its authority, or to be effective in developing a learning culture in the health system.***

48 Q12
49 Q114
50 Q63

4 Learning and accountability: implementation of the 'safe space'

A local 'safe space'

48. The Committee noted a common if unresolved tension across the evidence between the need to secure the right environment for openness and learning and the ongoing need for organisations and individuals to be held accountable. This was particularly pronounced in responses to the Government's proposal to extend a statutory 'safe space' to all NHS investigations, including at a local level. In their Consultation, the Department of Health suggest that extending a statutory safe space in this way could furnish all staff involved in safety investigations the sense of psychological safety that is currently lacking.[51]

49. William Vineall, Department of Health, suggested that "You would hopefully get more learning and you would get improvements as a result, so you would have a virtuous circle."[52] However he acknowledged that a key question was the pace at which the 'safe space' process was introduced.

50. Others expressed stronger concerns over the feasibility of extending 'safe space' investigations, given the noted variation in skills, experience, and culture locally. This variability has been discussed in earlier reports by PACAC and the Health Committee.[53] Keith Conradi (HSIB) told the Committee:

> the principle of safe space should be limited initially to the HSIB investigations […] I would be very concerned if people used that principle without really understanding it and being fully trained in it. There is a danger that information could be used inappropriately, and that would then undermine it for everybody, particularly ourselves. HISB will go to great lengths to ensure that we use it very sensitively and appropriately to our investigations.[54]

51. Action against Medical Accidents (AvMA), a UK charity that offers independent advice and support to people affected by medical accidents, questioned the desirability, as well as the feasibility, of the proposal on the grounds that

> There is a huge difference between an independent organisation like HSIB, with no conflict of interest, having the discretion to withhold information and NHS organisations who are investigating themselves being allowed to. The conflict of interest is obvious.[55]

52. There was also concern that the 'safe space' would come into conflict with the statutory Duty of Candour, a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have

51 *Providing a 'safe space' in healthcare safety investigations*, Department of Health, December 2016.
52 Q116
53 See the Fourth Report from the Health Committee of Session 2014–15, *Complaints and Raising Concerns*, HC 350, January 2015, and HC (2016–17) 94, June 2016.
54 Q32
55 LFM 07 (Actions Against Medical Accidents)

led to significant harm.[56] If misused, the 'safe space' could inadvertently preclude the investigative process from determining accountability for serious incidents, particularly where there has been individual wrongdoing. AvMA raised concerns that "Applying the current 'safe space' approach would directly cut across the statutory Duty of Candour adopted following the Mid-Staffordshire public inquiry."[57]

53. Scott Morrish also expressed concern that the Department of Health seem determined to introduce 'safe space' investigations at a local level, even though he did not feel that "the culture is anywhere near ready for anything like that at the moment."[58]

54. **The Committee believes the proposal to extend the safe space locally is indicative of confusion over how to balance learning from clinical incidents with accountability for their consequences. The rationale for HSIB to conduct protected 'safe space' investigations is clear: its role is to support system learning to improve patient safety. Locally, however, effective safety investigations should also provide the key information for settling complaints and legal claims. While these complaints and legal claims should, and often do, lead to wider learning, that is not their primary purpose. There is a wide variation in the quality and competence of local investigations. We therefore support the Chief Investigator of HSIB, Dr Keith Conradi, in his view that the 'safe space' should not be extended to the local level, at least for the time being. It would undermine trust in HSIB before HSIB has had a chance to acclimatise NHS bodies and the public to 'safe space' investigations.**

55. ***We recommend that the Government should not extend the 'safe space' to local investigations without the approval of HSIB. However, the government must establish the 'safe space' for HSIB through primary legislation so that this new body can acclimatise the health service to this new type of learning-focused investigation.***

A system-wide 'just culture'

56. The lack of clarity over how different investigative processes affect NHS organisations and patients raises the underlying question of whether, despite recognition of a need for a 'just culture' by the Department of Health, there is a sufficiently clear understanding of what it is and the tensions that must be negotiated to achieve it.[59] A 'just culture' must strike a balance between accountability and learning. 'Safe space' investigations as they will be conducted by HSIB, while crucial for the latter, would undermine the former if they were to be the only investigation that took place.

57. Mr Morrish told us that, through his work on the HSIB EAG, he

> realised that the lack of understanding about what just culture means and how you nurture it is so deep and at every level […] Asking system leaders to nurture it seems like a tall order until they have figured out what it means.[60]

56 The statutory Duty of Candour was introduced following the publication in March 2014 of *Building a culture of candour*, a report made on behalf of the Royal College of Surgeons by Sir David Dalton and Professor Normal Williams.

57 LFM 07 (Actions Against Medical Accidents)

58 Q12

59 Second Special Report from the Public Administration and Constitutional Affairs Committee of Session 2016–17, *PHSO review: Quality of NHS complaints investigations: Government response to the Committee's First Report of Session 2016–17*, HC 742.

60 Q27

58. Dr Shorrock, much of whose work deals with human error in safety-critical industries such as the aviation sector, described his experience of the development of a just culture in the aviation sector. His evidence underscores the need for the 'safe space' to be accompanied by a system-wide cultural shift towards a 'just culture' to be effective:

> What we have learned in aviation is there has to be consensus on the need for a just and fair culture that is about learning as a whole. If you do not have that consensus from a range of stakeholders—which will include, for instance, prosecutors, judges, frontline practitioners, patient representatives, staff and practitioners—you will always have something in your system that is pushing against it.[61]

59. The role of the 'Just Culture Taskforce,' according to the EAG report, would be to "determine the appropriate policies, practices and institutional arrangements that are required to move the healthcare system firmly towards a 'just culture' of safety."[62] As such, it would help to effect the necessary shift in the attitudes and behaviours across the NHS in England by reinforcing from the top the pivot towards learning in investigations.

60. The need for the cultural shift to be reinforced from the top is borne out by the evidence submitted to this inquiry. Healthwatch England told us that

> there is still more to do to communicate this [shift] to people in practical terms to show how the NHS has learned and what has changed. This is not just important for building public trust in the NHS complaints and investigations process, but also for normalising the behaviour amongst staff and institutions of welcoming feedback.[63]

61. Similarly, in its written evidence, NHS Improvement said that it believes "leadership is the most powerful influence on the culture of an organisation."[64] It added that "Evidence suggests that there is a link between chief executives with a clearly communicated strategic vision, long term goals and organisational plans for patient safety and staff wellbeing and good patient safety performance."[65]

62. There was strong support in written and oral evidence on the need for a nationally led 'Just Culture Taskforce,' as recommended by the HSIB EAG and by this Committee in its 201 report 'PHSO review: Quality of NHS complaints investigations.' This Taskforce would be instrumental in developing and embedding a consensus across the regulatory, legal, and NHS provider landscape on the need for learning to become central to investigations without thereby jeopardising the need for individual wrongdoing to be determined where it has occurred. The Committee heard evidence suggesting that these two aims, focused respectively on learning and accountability, should be pursued in separate investigations. Mr Morrish forcefully articulated this point:

61 Q27
62 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016, p. 9.
63 LFM 12 (Healthwatch England)
64 LFM 19 (NHS Improvement)
65 LFM 19 (NHS Improvement)

> 'Learning' and 'accountability' are both essential for safety, but represent different goals; serve different purposes; require different methodologies; and need separate processes. The balance between them needs to be managed carefully. Striving for that balance is the purpose of a 'just culture'.[66]

63. According to Dr Shorrock: "the world of the judiciary is very different to the world of practitioners, and both of those worlds do need to co-exist."[67] Even though the Committee did not feel there was a consensus on this issue based on the evidence it reviewed, it did get a sufficient sense for the need to preserve both the learning and accountability aspects of investigations. As outlined above, it was clear from the evidence that a premature expansion of the 'safe space' to the local level risks eroding accountability in the investigative process unless it is accompanied by a system-wide shift towards a learning culture.

64. **The Committee commends the Department of Health for articulating the need for the NHS in England to develop a learning culture. However, the NHS must embed the attitudes and behaviours that are necessary for a learning culture to develop. Achieving a 'just culture' within organisations requires the leadership to establish the appropriate balance between learning and accountability. In addition to this, as the next section sets out, the local investigative capacity and capability to conduct 'safe space' has not yet been established.**

65. ***PACAC endorses the HSIB Expert Advisory Group recommendation that a Just Culture Taskforce should be created, to help the leaderships of NHS England and NHS Trusts to embed the learning-focused culture within the NHS in England. In particular the Committee believes the taskforce should seek to establish a consensus on just culture policy across the whole of the NHS in England, expressed in the development of protocols between the legal, regulatory, and complaint handling bodies. Ministers should ensure that these protocols are drafted and communicated by 1 September 2017.***

Improving local competence

66. The Committee sought to understand what national bodies such as NHS Improvement are currently doing to support the NHS to improve the quality of local investigations. The particular focus was on how HSIB would work with NHS Improvement and NHS England to set standards and develop the capability of local investigators. As the previous section shows, a 'just culture' focused on learning requires a system-wide approach, which includes the development of a positive dynamic to share learning between HSIB and the local investigative level.

67. The HSIB EAG was clear that the body should be closely involved in developing a "cadre of expert and professionally qualified investigators working across the healthcare system."[68] The Committee echoed this recommendation in its June 2016 report on NHS complaints handling.[69] In their evidence, Verita Consultants LLP, a group of investigative consultants who aim to improve regulated organisations' services and outcomes, also highlighted the ongoing need for both consistent standards and training for investigations.[70]

66 LFM 20 (Scott Morrish)
67 Q27
68 *Report of the Healthcare Safety Investigation Branch Expert Advisory Group*, May 2016.
69 HC (2016–17) 94, June 2016.
70 LFM 06 (Verita Consultants LLP)

68. The Minister told us that HSIB's role in helping the wider NHS undertake better investigations "will evolve over time."[71] He explained that: "We are not anticipating that [HSIB] is going to hit the ground running with a prescriptive set of changed procedures."[72]

69. William Vineall told us the Department of Health wanted HSIB to be "an exemplar of good investigations so that better quality investigations, serious incident investigations can be taken forward locally."[73] He explained that the Department had deliberately established HISB as "quite a bespoke body" (with a budget of about £3.8 million, undertaking approximately 30 investigations a year) to make sure "that messages went back to the NHS for them then to improve and to take forward better local investigations themselves."[74] The intention was that HSIB "will exert, in a sense, a downward pressure on the NHS to improve its own quality of investigations."[75] For example, Mr Vineall told us he believed HSIB investigations would popularise the routine involvement of patients and families and demonstrate how to effectively coordinate complex investigations."[76]

70. Keith Conradi concurred that "at the moment I see the HSIB setting the example";[77] his focus was on "bringing that professional approach to investigation."[78] He said HSIB "will see where that goes from nationally . . . what we will try to do is make sure that there is a consistent standard that is set at local level."[79] However Mr Conradi told the Committee that he felt not all of the lessons HSIB draws out "will be translatable on to the smaller scale" and "perhaps the overall structure of the local investigations needs to be considered before we can see exactly what we can move across."[80]

71. After we had finished taking oral evidence in this follow-up inquiry, the CQC published 'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England.' This review addresses the issue of local investigations in precisely these broader terms, considering their overall structure and quality. The CQC calls on the Department of Health, supported by the National Quality Board, to review recommendations and coordinate improvement work across multiple organisations. This, they say, should include making sure that "staff have the capability and capacity to undertake good investigations of deaths and write good reports, with a focus on these leading to improvements in care."[81]

72. ***The Committee supports the recommendations made in the CQC's report that training should be provided to staff across the health service in England on how to conduct investigations. Specifically, PACAC recommends that HSIB should work with national education bodies to ensure that training is effective in building up local investigative capacity.***

71 Q73
72 Q73
73 Q94
74 Q78
75 Q78
76 Q78
77 Q40
78 Q40
79 Q40
80 Q34
81 *'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England'*, Care Quality Commission, December 2016, p. 9.

73. A further issue is that the increasingly complex NHS landscape poses a challenge to the coordination of local investigations across organisations. The Committee did not get a clear sense from the Department of Health of where responsibility lay for addressing the overall structure of local investigations. As Keith Conradi explained to us, the overall structure of local investigation may need to be reviewed before HSIB can be effective in sharing learning from its investigations. This includes the capability within Trusts to investigate as well as the capacity of organisations to work together to establish what has happened across a patient's care pathway.

74. On this point, the CQC's 'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England' found

> a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with mental health or learning disability needs.[82]

75. While Clinical Commissioning Groups (CCGs) currently have responsibility for coordinating investigations into clinical incidents across multiple bodies, Sir Mike Richards acknowledged that there may be a need to "see how well that is functioning, and how we could support that and do that coordination role more effectively."[83]

76. In Sam Morrish's case one of the failings identified by the PHSO was that each organisation looked at their own actions in isolation to the others.[84] Chris Bostock said that establishing what had occurred in a clinical incident "would best be addressed by looking at the whole of that patient pathway in a single investigation rather than trying to divide it up."[85] Reflecting on the Sam Morrish case, Sir Mike Richards said that the close involvement of patients and families in the investigative process can provide valuable information that can help the NHS in England to coordinate its investigations across multiple bodies.[86]

77. In order for there to be a single, coordinated investigation across a patient's full experience with the health service throughout a clinical incident, all the organisations involved in delivering that patient's care need to understand the expectation for them to cooperate and coordinate with the investigation. This includes the routine involvement of patients and families in the investigative process. HSIB's creation and the work it has planned is an important opportunity to provide NHS organisations with clear expectations about the level of coordination and cooperation that is expected of them during an investigation.

82 *'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England'*, Care Quality Commission, December 2016, p. 39.
83 Q39
84 *Learning from mistakes*, Parliamentary and Health Service Ombudsman, July 2016.
85 Q95
86 Q39

78. **The Committee agrees that HSIB's investigations will have the potential to produce valuable learning and information for regulatory and improvement agencies. However, we do not believe that HSIB setting good practice alone will adequately address the need to improve the capability to carry out investigations at the local level, which is where the vast majority will continue to take place.**

79. **We have previously called for HSIB to assume unambiguous responsibility for standard setting and for playing a leading role in building the capability of local investigators in conjunction with other national bodies.[87] While we appreciate that HSIB is still being established, we are disappointed at the lack of detailed strategic thinking from the Department of Health on how the quality of local investigations will be improved, and the role that HSIB will play in this.**

80. ***The Committee reiterates its previous recommendations, made in its June 2016 report 'PHSO review: Quality of NHS complaints investigations.' The government must stipulate in the HSIB legislation that, first, HSIB has the responsibility to set the national standards by which all clinical investigations are conducted; secondly, that local NHS providers are responsible for delivering these standards, according to the Serious Incident Framework; and thirdly, the Care Quality Commission should continue to be responsible as the regulator in assessing the quality of clinical investigations according to those standards at a local level. The government must also explain these functions to local Trusts and patients to ensure that confusion does not persist.***[88]

81. ***There is an immediate need to improve investigative capability within Trusts and the coordination of multiple-body investigations. The Department of Health for England must take the lead by bringing together relevant national bodies, including NHS Improvement, NHS England, and Health Education England to determine how they will work with HSIB to improve local investigations. This should include a nationally accredited training programme, approved by HSIB, around investigative capability to raise standards, competence, and the confidence of staff involved in investigations.***

Measuring improvement

82. The Committee also considered how the various initiatives that seek to improve the culture, competence, and coordination across the NHS in England are organised and how their success is measured. As the Government wrote in its response to our June 2016 report, HSIB "will be unable to oversee improvements at a local level."[89] Given that the vast majority of investigations will continue to take place at this level, we sought to determine the Department of Health's wider strategy for coordinating and evaluating the different steps being taken to move towards a learning culture across the system. At the moment, a wide range of organisations are connected to this issue, ranging from NHS England, NHS Improvement, the CQC, CCG's, and local NHS Trusts to the new HSIB. The Committee was also keen to clarify where the ultimate responsibility lay for this issue at ministerial level. Currently, responsibilities are set out across the Secretary of State for Health, the Minister for Health, and three Parliamentary Under-Secretaries responsible for Public Health and Innovation, Community Health and Care, and Health respectively.

87 HC (2016–17) 94, June 2016.
88 HC (2016–17) 94, June 2016, p. 26.
89 *PHSO review: Quality of NHS complaints investigations: Government response to the Committee's First Report of Session 2016–17*, September 2016.

83. In this respect, the Minister said that "There is no lack of ambition from the Secretary of State down to try to ensure that we change the culture."[90] When questioned on how this would be coordinated given the diffuse nature of ministerial responsibilities in this area, Mr Dunne, Minister of State for Health, agreed that it was a "valid challenge" to ask how this cultural shift would be communicated across the NHS in England.[91] Ultimately, he suggested, spreading best practice would be "about finding as many ways as practically makes sense to spread awareness and practice. We have a number of specialist groups, investigative partnerships across the NHS to spread the good practice that emerges."[92]

84. **There are many different organisations and Ministers involved in delivering different aspects of the overall move towards a 'learning culture' in the NHS in England. This includes training and accreditation, awareness campaigns, reforming the investigations process, and the introduction of HSIB. From this, it is unclear who is to be accountable to Parliament for progress on moving towards a leaning culture. There is an acute need for the Department of Health to develop a strategic plan bringing all these initiatives together. PACAC recommends that Parliament should hold the Secretary of State for Health to account for the coordinated implementation of a cultural shift in the NHS in England. As such, PACAC will in future call the Secretary of State for Health to give evidence on the issues highlighted in this report.**

85. We asked what support from national bodies in the NHS was already being offered to local providers, beyond the example that might be set by HSIB, to develop more open and supportive cultures to enable learning. This is a particular area for concern given the earlier point that a 'just culture,' focused on learning, must be instigated in order for HSIB to achieve its intended system-wide impact. Helen Buckingham explained that NHS Improvement had developed a 'culture toolkit,' which it launched in September 2016, working with Trusts identified as 'outstanding' by the CQC. This toolkit aims to help Trusts improve their culture across a number of areas, including creating a learning environment.[93]

86. Professor Sir Mike Richards (CQC) told us that the CQC captures how open organisations are to learning through the 'well led' domain, a grouping term for five culture-related lines of inquiry it pursues within their inspection framework, which is informed by the NHS staff survey results as well as inspectors talking to staff. This "well-led" domain is the measure used by the CQC to evaluate how positive the culture and leadership is within an organisation it inspects. Where the CQC finds that the culture and leadership of an organisation is inadequate, it recommends that NHS Improvement should work closely with those organisations to make improvements.

87. Ms Buckingham shared some of the specific strategies NHS Improvement might recommend to organisations struggling to develop open cultures. These primarily focused on processes for staff to raise concerns, enquiries and suggestions. Examples ranged from formal processes involving board members to less formal processes such as anonymous discussion boards which may be effective in cases where staff are reluctant to identify themselves due to fear of reprisals . However, she acknowledged that "a lot of work with organisations on culture is a slow-burn."[94] In addition to this, NHS Improvement told us

90 Q88
91 Q91
92 Q88
93 Q36
94 Q56

it "is working with the King's Fund to produce resources to help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality compassionate care."[95]

88. While these initiatives are encouraging as a sign that steps are being taken across the system to effect the shift toward a learning culture, these initiatives require meaningful follow-up if they are to be effective. The Committee was particularly struck by Mr Morrish's discussion of how NHS England had responded to the PHSO's first report into his son's death from sepsis with a campaign raising awareness for this life-threatening condition. Mr Morrish showed the Committee a leaflet, titled SAM, NHS England had developed to help parents effectively spot sepsis symptoms in children, and triage to healthcare support. He told us that "what followed when the pressure was off was a period of inertia and underwhelming evaluation that nobody respects and as a result it is going nowhere."[96]

89. We heard from Mr Morrish that a key measure of progress around sepsis had not been achieved as there was still not an effective tool to help parents understand when and how to triage their children.[97] His evidence raises questions about whether there are effective mechanisms for learning from systemic issues, such as sepsis. For instance, Mr Morrish told us that the sepsis leaflet had not been properly evaluated, and had therefore not received the approval of important organisations, such as the UK Sepsis Trust and the medical Royal Colleges.[98]

90. There is evidence that this example is indicative of a wider problem. Evidence from the CQC's thematic review on how deaths are investigated in the NHS sheds fresh light on systemic problems with how learning is shared within Trusts and across the NHS in England. The CQC found that "there are no consistent frameworks or guidance in place across the NHS that require boards to keep all deaths under review or share learning with other organisation," that "most boards do not interrogate information from investigations or have any training do so," and that "robust mechanisms to disseminate learning or benchmarking beyond a single trust do not exist."[99]

91. **The Committee welcomes initiatives by NHS Improvement to work with Trusts on diagnosing and improving their cultures and on enabling clearer leadership. However, we are concerned at the relative dearth of knowledge and experience about how Trusts can develop more open cultures and particularly how Trusts, who are struggling to be more open and to learn from investigations, should develop practical strategies for improvement.**

92. **The Committee notes that there is a range of initiatives taken by various bodies across the system in response to clinical incidents, but without proper evaluation, the NHS in England will never learn what works best. The SAM campaign leaflet to disseminate the lessons from the Sam Morrish case is a case in point; the impact of this initiative appears to have been negligible. HISB and other regulators need to have**

95 LFM 19 (NHS Improvement)
96 Q27
97 Q27
98 Q28
99 *'Learning, candour and accountability: A review of the way trusts review and investigate the deaths of patients in England'*, Care Quality Commission, December 2016, p. 49.

the powers to ensure that individuals are made accountable for taking forward such initiatives which reflect learning from investigations, or the implementation of larger scale initiatives arising from the introduction of HSIB will also fail.

93. ***We recommend that the HSIB legislation give HSIB and NHS regulators the power to set out how plans to coordinate the various initiatives being taken across the health service with regard to improving the investigative culture. HSIB should evaluate the impact of resources being developed within the system, such as the culture toolkit launched by NHS Improvement with respect to organisational culture and clearer leadership. It should have the freedom to concentrate on Trusts that have been identified as inadequate in CQC's "Well Led" domain. This should become part of a wider effort to structure the health service's efforts to tackle the blame culture. This effort should result in a clear set of plans to communicate and coordinate the transformation of the culture at all levels of the health service, with particular reference to how HSIB will contribute to this. The Committee would expect the Department of Health to be able to report on significant progress in this regard by the time HSIB becomes operational in April 2017. Given the diffuse nature of Ministerial responsibilities in this area, PACAC feels that it is the Secretary of State for Health who must take on the coordination and evaluation of efforts to instigate a 'learning culture' in the NHS in England.***

Conclusions and recommendations

The investigative landscape in the NHS

1. It is clear from the evidence reviewed during the course of this inquiry that the investigative processes in the health service in England remain obscure and difficult to navigate for patients and families. As a result, patients and families are excluded by the system, which must become open and learning-focused if investigations are to lead to positive changes in the system. Families and patients should, as a matter of course, be included in investigations and should feel confident that lessons will be learned as a result of clinical incidents. (Paragraph 27)

HSIB and the learning culture

2. The intention for HSIB to share learning will not alone guarantee the improvement of investigations across the NHS in England. HSIB's role as an exemplar can only be effective if its relationship to other bodies is clear. There must also be a well-defined process so that HSIB's best practice is respected and shared across the system, including at local level. In order for this to happen, existing investigations and investigative bodies need to understand what to expect from HSIB when it starts operating, and how they are meant to respond to its findings. (Paragraph 35)

3. The Committee agrees that the 'safe space' established by the Secretary of State for Health's Directions does not match what is provided for other incident investigators in aviation or rail safety. It neither provides sufficient protection for those participating in investigations nor for the information they share. They will continue to be vulnerable to any actions being taken against them. This undermines the 'safe space' principle and negates the intended role for HSIB as an independent investigator. (Paragraph 45)

4. While we were encouraged by the Minister's clear assurance that HSIB will have discretion on what it investigates, we believe that unless HSIB's independence is enshrined in primary legislation, its investigations remain open to external pressures and it will be seen as being part of the existing hierarchy. This perception is underscored by HSIB's current position within NHS Improvement. The Directions set up by the Secretary of State for Health are not an adequate substitute for primary legislation formally enshrining HSIB's independence. (Paragraph 46)

5. *We agree with HSIB's Chief Investigator that HSIB needs its own legislative basis in order to be independent and that the 'safe space' for its investigations is protected. We urge the Government to bring forward such legislation at the earliest possible opportunity. The Department of Health must cease to defy the consensus now established by Parliament, the HSIB, the Expert Advisory Group, and HSIB's Chief investigator on the need for such legislation. If HSIB is asked to begin operations in 2017 without this legislation, there is a real risk it will fail to establish its authority, or to be effective in developing a learning culture in the health system.* (Paragraph 47)

Learning and accountability: implementation of the 'safe space'

6. The Committee believes the proposal to extend the safe space locally is indicative of confusion over how to balance learning from clinical incidents with accountability for their consequences. The rationale for HSIB to conduct protected 'safe space' investigations is clear: its role is to support system learning to improve patient safety. Locally, however, effective safety investigations should also provide the key information for settling complaints and legal claims. While these complaints and legal claims should, and often do, lead to wider learning, that is not their primary purpose. There is a wide variation in the quality and competence of local investigations. We therefore support the Chief Investigator of HSIB, Dr Keith Conradi, in his view that the 'safe space' should not be extended to the local level, at least for the time being. It would undermine trust in HSIB before HSIB has had a chance to acclimatise NHS bodies and the public to 'safe space' investigations. (Paragraph 54)

7. *We recommend that the Government should not extend the 'safe space' to local investigations without the approval of HSIB. However, the government must establish the 'safe space' for HSIB through primary legislation so that this new body can acclimatise the health service to this new type of learning-focused investigation.* (Paragraph 55)

A system-wide 'just culture'

8. The Committee commends the Department of Health for articulating the need for the NHS in England to develop a learning culture. However, the NHS must embed the attitudes and behaviours that are necessary for a learning culture to develop. Achieving a 'just culture' within organisations requires the leadership to establish the appropriate balance between learning and accountability. In addition to this, as the next section sets out, the local investigative capacity and capability to conduct 'safe space' has not yet been established. (Paragraph 64)

9. *PACAC endorses the HSIB Expert Advisory Group recommendation that a Just Culture Taskforce should be created, to help the leaderships of NHS England and NHS Trusts to embed the learning-focused culture within the NHS in England. In particular the Committee believes the taskforce should seek to establish a consensus on just culture policy across the whole of the NHS in England, expressed in the development of protocols between the legal, regulatory, and complaint handling bodies. Ministers should ensure that these protocols are drafted and communicated by 1 September 2017.* (Paragraph 65)

Improving local competence

10. *The Committee supports the recommendations made in the CQC's report that training should be provided to staff across the health service in England on how to conduct investigations. Specifically, PACAC recommends that HSIB should work with national education bodies to ensure that training is effective in building up local investigative capacity.* (Paragraph 72)

11. The Committee agrees that HSIB's investigations will have the potential to produce valuable learning and information for regulatory and improvement agencies. However, we do not believe that HSIB setting good practice alone will adequately address the need to improve the capability to carry out investigations at the local level, which is where the vast majority will continue to take place. (Paragraph 78)

12. We have previously called for HSIB to assume unambiguous responsibility for standard setting and for playing a leading role in building the capability of local investigators in conjunction with other national bodies. While we appreciate that HSIB is still being established, we are disappointed at the lack of detailed strategic thinking from the Department of Health on how the quality of local investigations will be improved, and the role that HSIB will play in this. (Paragraph 79)

13. *The Committee reiterates its previous recommendations, made in its June 2016 report 'PHSO review: Quality of NHS complaints investigations.' The government must stipulate in the HSIB legislation that, first, HSIB has the responsibility to set the national standards by which all clinical investigations are conducted; secondly, that local NHS providers are responsible for delivering these standards, according to the Serious Incident Framework; and thirdly, the Care Quality Commission should continue to be responsible as the regulator in assessing the quality of clinical investigations according to those standards at a local level. The government must also explain these functions to local Trusts and patients to ensure that confusion does not persist.* (Paragraph 80)

14. *There is an immediate need to improve investigative capability within Trusts and the coordination of multiple-body investigations. The Department of Health for England must take the lead by bringing together relevant national bodies, including NHS Improvement, NHS England, and Health Education England to determine how they will work with HSIB to improve local investigations. This should include a nationally accredited training programme, approved by HSIB, around investigative capability to raise standards, competence, and the confidence of staff involved in investigations.* (Paragraph 81)

Measuring improvement

15. There are many different organisations and Ministers involved in delivering different aspects of the overall move towards a 'learning culture' in the NHS in England. This includes training and accreditation, awareness campaigns, reforming the investigations process, and the introduction of HSIB. From this, it is unclear who is to be accountable to Parliament for progress on moving towards a leaning culture. There is an acute need for the Department of Health to develop a strategic plan bringing all these initiatives together. PACAC recommends that Parliament should hold the Secretary of State for Health to account for the coordinated implementation of a cultural shift in the NHS in England. As such, PACAC will in future call the Secretary of State for Health to give evidence on the issues highlighted in this report. (Paragraph 84)

16. The Committee welcomes initiatives by NHS Improvement to work with Trusts on diagnosing and improving their cultures and on enabling clearer leadership. However, we are concerned at the relative dearth of knowledge and experience

about how Trusts can develop more open cultures and particularly how Trusts, who are struggling to be more open and to learn from investigations, should develop practical strategies for improvement. (Paragraph 91)

17. The Committee notes that there is a range of initiatives taken by various bodies across the system in response to clinical incidents, but without proper evaluation, the NHS in England will never learn what works best. The SAM campaign leaflet to disseminate the lessons from the Sam Morrish case is a case in point; the impact of this initiative appears to have been negligible. HISB and other regulators need to have the powers to ensure that individuals are made accountable for taking forward such initiatives which reflect learning from investigations, or the implementation of larger scale initiatives arising from the introduction of HSIB will also fail. (Paragraph 92)

18. *We recommend that the HSIB legislation give HSIB and NHS regulators the power to set out how plans to coordinate the various initiatives being taken across the health service with regard to improving the investigative culture. HSIB should evaluate the impact of resources being developed within the system, such as the culture toolkit launched by NHS Improvement with respect to organisational culture and clearer leadership. It should have the freedom to concentrate on Trusts that have been identified as inadequate in CQC's "Well Led" domain. This should become part of a wider effort to structure the health service's efforts to tackle the blame culture. This effort should result in a clear set of plans to communicate and coordinate the transformation of the culture at all levels of the health service, with particular reference to how HSIB will contribute to this. The Committee would expect the Department of Health to be able to report on significant progress in this regard by the time HSIB becomes operational in April 2017. Given the diffuse nature of Ministerial responsibilities in this area, PACAC feels that it is the Secretary of State for Health who must take on the coordination and evaluation of efforts to instigate a 'learning culture' in the NHS in England.* (Paragraph 93)

Appendix: PACAC response to Department of Health's Consultation on 'Providing a 'safe space' in healthcare safety investigations'

The Public Administration and Constitutional Affairs Committee (PACAC) would like to respond to the Department of Health's Consultation on 'Providing a 'safe space' in healthcare safety investigations.'[100] The Committee broadly welcomes the Government's proposals to introduce 'safe space' investigations as part of its establishing of a new Healthcare Safety Investigations Branch (HSIB), which will become operational in April 2017. These initiatives largely follow PACAC's – and its predecessor PASC's – recommendations that a body be created that could conduct investigations within a safe space to drive learning and improvement within the healthcare system. Most recently, this was reiterated in PACAC's 2016 report 'PHSO review: Quality of NHS complaints investigations':

> We regard the 'safe space' principle as being critical to the effective operation of HSIB. This protection is essential if patients and staff are to have the confidence to speak about the most serious risks to patient safety without fear of punitive reprisals.[101]

As the Consultation notes, the aim of safe space investigations is to ensure "information that staff provide as part of a health service investigation will be kept confidential except where there is an immediate risk to patient safety, or where the High Court makes an order permitting disclosure." The Consultation invites submissions on how a balance can be struck between such 'safe space' investigations and the need to "reassure patients and families that they will be given the full facts of their, or their loved ones', care."[102] The issue at stake is one of balancing the need to determine accountability for mistakes where there has been individual wrongdoing and the need to encourage open discussions about why errors occurred so they can be prevented in future.

HSIB's 'safe space' investigations are thus set to provide a new drive towards learning in the investigative landscape by providing psychological safety for staff to speak about mistakes and thereby promote open and learning-focused investigations.

The importance of the role HSIB's safe space investigations are set to play was underscored by PACAC's recent follow-up inquiry into the Parliamentary Health Service Ombudsman's report 'Learning From Mistakes,' which showed that there is still widespread evidence that the investigative processes in the NHS in England are overly complex, lacking in coordination, and marred by a defensive blame culture. Many NHS organisations in England have not yet fully understood or embraced the fact that safety requires an open discussion of error and hazard not only during investigations but whenever patients are potentially at risk. Achieving a safer NHS in England will require leaders to create a climate of psychological safety in day to day work not only during investigations.

100 *'Providing a 'safe space' in healthcare safety investigations'*, Department of Health, October 2016.
101 HC (2016–17) 94, June 2016, p. 31.
102 *'Providing a 'safe space' in healthcare safety investigations'*, Department of Health, October 2016.

During its inquiry, PACAC became aware of significant concerns about the lack of primary legislation framing HSIB's work. This evidence highlighted concerns regarding the perceived lack of independence for HSIB's investigations, the lack of legislation safeguarding the 'safe space,' and a possible expansion of the 'safe space' to local level. PACAC feels strongly that these concerns must be addressed if HSIB is to be set up to succeed. A false start for this new body risks undermining its distinctive role as an exemplar for the system, for which it must maintain the trust and confidence of the system and wider public in equal measure.

During our Learning from Mistakes inquiry, the Committee took evidence from a range of people who stressed the importance of legislation for the appropriate functioning of HSIB. Scott Morrish, father of the late Sam Morrish whose case prompted the PHSO report, told us that he would like to see the Department of Health

> concentrate on making sure safe space is deliverable within HSIB. At the moment, as far as I understand it, the legislation that is needed to make that possible does not exist. HSIB is being asked to go out and conduct investigations fairly soon, while it does not as yet have the powers it needs to do that in the way that we are asking it to.[103]

The need for primary legislation was echoed by the HSIB Chief Investigator, Keith Conradi, who added that he was concerned about the 'safe space' being expanded prematurely beyond HSIB investigations:

> From my perspective, the principle of safe space should be limited initially to the HSIB investigations. I would be very concerned if people used that principle without really understanding it and being fully trained in it.[104]

The role of 'safe space' in HSIB

HSIB has an important role to play in facilitating the transition towards a learning culture in the health service, both in the specific investigations it undertakes and in providing an exemplar model of investigations for the system as a whole. HSIB will need to earn the trust of both patients and staff to achieve its objectives. Patients, families and the public must trust that safety investigations are impartial, free of any conflict of interest, and have the best interests of patients and service users at heart. Staff, healthcare professionals, and system leaders must equally trust that safety investigations are being conducted fairly and in the interest of improving care. All parties must feel that the investigator is entirely impartial and is acting in the best interests of the public good. Building and maintaining trust is a slow and challenging process. Trust in HSIB will take time to build through its history, its collaborative ethos, and its achievements.

The creation of a 'safe space' during HSIB investigations will provide a powerful support to HSIB in fulfilling its wider mission of becoming a trusted and impartial investigator. In a national agency, inevitably the subject of media attention and wider scrutiny, the statutory protection of information acquired during investigations will provide a necessary assurance to all involved that information they provide will, except in rare circumstances, remain confidential. Patients and families must of course still receive a full explanation

103 Q12
104 Q32

of the events in question and it will be the responsibility of HSIB to develop an effective means of conveying the findings of investigations while protecting the more detailed information on which the findings were based.

The Government's Consultation asks what the statutory status of the 'safe space' should be and whether "the proposed exceptions" would undermine the 'safe space.'

The consultation acknowledges that the 'safe space' may be limited by the fact that "other organisations and individuals have statutory powers to call evidence."[105] Indeed, it recognises that the Directions[106] given by the Secretary of State for Health cannot "amend or modify the application of existing legislation, and cannot require third parties seeking disclosure to apply to a particular court, nor for that court to follow a specific test in considering applications."[107]

Furthermore, the Consultation suggests that primary legislation will only be considered after HSIB begins operations: "Once HSIB has created these protocols and agreements with professional regulators and others, the way in which they are applied, and the learning from this, could potentially be used to inform the development of primary legislation."[108] This developmental approach is reasonable at first sight. However, there is a considerable danger that HSIB's independence and trusted status might be compromised from the start. Negotiating such arrangements would be time consuming and the status of HSIB reduced to being simply one of the numerous agencies involved in investigation in the NHS in England. HSIB needs to build the trust of staff and patients on the basis that it is truly independent and that it can provide an absolute guarantee of confidentiality. Early investigations will be critical in building longer term success and it is especially critical in these early stages that those involved benefit from statutory protection of information shared.

In our recent 'Learning from Mistakes' inquiry, HSIB Chief Investigator Keith Conradi told the Committee that he was in the process of determining

> protocols on how we work with the other authorities who have a right to investigate. We will be the ones who are doing it purely from a safety perspective, but I think there has to be an understanding of what information can be passed to other people who are potentially carrying out parallel investigations and what cannot, and what procedure they may have to go through to do that.[109]

Mr Conradi makes it clear that the principle of 'safe space' might be extended in the future and that there will be circumstances in which information may need to be shared, but HSIB will need time and the security of safe space legislation to develop this understanding and the associated procedures. It is vital that the 'safe space' be enshrined in primary legislation so that it is indeed left to those with expertise on how the 'safe space' operates, HSIB, to decide on when to share information gathered during its 'safe space' investigations so that patients and staff participating in those investigations do not feel

105 *'Providing a 'safe space' in healthcare safety investigations'*, Department of Health, October 2016.
106 Secretary of State for Health (2016), *The National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016*.
107 *'Providing a 'safe space' in healthcare safety investigations'*, Department of Health, October 2016.
108 *'Providing a 'safe space' in healthcare safety investigations'*, Department of Health, October 2016.
109 Q33

the 'safe space' can be overruled. Without strong legislative underpinning, HSIB's 'safe space' investigations will be undermined from the start and the desired impact of those investigations will be compromised.

As PACAC and its predecessor PASC have made clear in the past, the Committee feels strongly that primary legislation is absolutely essential to creating a true 'safe space' akin to the one that governs similar 'safe space' investigations in the aviation, marine, and railway sectors. This legislation should be brought in as soon as possible so that HSIB's 'safe space' investigations can take place with the appropriate legislative underpinning.

Safe space and local investigations

The consultation also reflected on expanding the 'safe space' beyond HSIB to local investigations. There are of course numerous types of investigation and organisations involved in investigations but the most numerous, and arguably the most critical, are those taking place within NHS Trusts. The question of whether a statutory 'safe space' should be extended to such investigations needs to be considered in the context of the wider need to achieve a culture of learning and to support both families and staff in the aftermath of tragic events. The Committee considers that while the psychological safety of both families and staff is critical in these investigations, the specific focus on 'safe space' as the key to improving investigations could have unintended consequences, particularly if backed by legislation.

A culture of learning, as opposed to immediate and unthinking blame for error, can only be built slowly over time by trusted leaders at all levels of an organisation. This culture needs to permeate all aspects of clinical and management practice and not be confined simply to investigations. The dangers to staff, and the negative experiences of whistleblowers, come not so much from their experiences in investigations but from the more deep-rooted failure of some organisations to acknowledge safety problems in the first place and the failure of some leaders to provide staff with the assurances they need.

The Committee believes that the principle of a 'safe space' in investigations is highly desirable but that the focus on this aspect at local level may allow weaker organisations to feel they have done all they need to do by implementing 'safe space.' Organisations need to accept their full responsibilities in creating a climate in which emerging safety issues can be discussed and acted on. After tragic events, organisations need to be proactive in their support for both the families and staff involved. Creating the conditions in which staff can speak without fear of reprisal during safety investigations is just one aspect of these wider responsibilities of senior leaders. To create a statutory 'safe safe' within an organisation dominated by a blame culture could compound the problems by allowing such an organisation to conceal safety information and misuse safe space to evade its responsibilities to patients, families, and staff.

The point that safe space is only one aspect of a wider learning culture emerged repeatedly in the Committee's recent inquiry 'Learning from mistakes'. For instance, Dr Steve Shorrock stated that 'safe space' is only effective when the rest of the culture is receptive to the principle that learning is central and blame is only apportioned where that is necessary (e.g. where there has been serious individual wrongdoing):

> What we have learned in aviation is there has to be consensus on the need for a just and fair culture that is about learning as a whole. If you do not have that consensus from a range of stakeholders—which will include, for instance, prosecutors, judges, frontline practitioners, patient representatives, staff and practitioners— you will always have something in your system that is pushing against it.[110]

The emergence of a learning culture requires an understanding that a safety investigation has fundamentally different objectives from one focused on the assessment of individual performance. In his written evidence, Mr Morrish forcefully articulated this point:

> 'Learning' and 'accountability' are both essential for safety, but represent different goals; serve different purposes; require different methodologies; and need separate processes. The balance between them needs to be managed carefully. Striving for that balance is the purpose of a 'just culture'.[111]

The Committee believes that the premature imposition of safe space as a statutory requirement at local level could have unintended consequences. Senior leaders have the responsibility to create a culture of safety at all times and the particular circumstances of an investigation are just one aspect of this. There is the risk that the statutory imposition of a 'safe space' during investigations may detract from the wider effort to create a culture of learning in that some organisations and leaders may feel that this is all they need to do. The Committee considers that the impact of statutory 'safe space' at local level is uncertain and that it would be prudent to allow HSIB to develop a fuller understanding of 'safe space' and its potential applicability before extending it to other organisations.

Conclusions

Overall, PACAC welcomes the introduction of HSIB and its 'safe space' investigations. However, as this response shows, the Committee strongly feels that HSIB and its 'safe space' investigations must first be appropriately legislated for if it is to have the tools it needs to succeed.

In contrast, PACAC feels that any extension of the 'safe space' to local investigations would be premature and took evidence during its Learning from Mistakes inquiry emphasising this apprehension. Keith Conradi strongly expressed the view that the 'safe space' should initially only cover HSIB and that, if used at a local level by staff insufficiently trained to use it carefully, it would undermine the intended impact the 'safe space' is meant to have on the investigative landscape and the shift towards a 'learning culture' more broadly. The Consultation recognises that the investigative landscape is complex, and that the rules governing information sharing are "equally if not more so, with a number of processes in place which require or encourage the sharing of information across organisational boundaries."

The vast majority of investigations are likely to still take place at local level where training of investigative staff remains insufficient and the quality of investigations varies. In its response to PASC's report on NHS Complaints Investigations in July 2015, 'Learning not Blaming,' the Government acknowledged the variable quality of local investigations and

110 Q27
111 LFM 20 (Scott Morrish)

said that it concurred "that there should be a capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out certain investigations itself."[112] In light of this, an expansion of the 'safe space' before local investigations are standardised and local investigative capability has been improved generally poses a number of risks, some of which are outlined in this response. A premature expansion of the 'safe space' carries the risk that organisations will introduce the 'safe space' as a simple piece of procedure without understanding its place in the wider need to improve investigations and to create a culture of learning and continual reflection on emerging safety issues.

HSIB is fully cognisant that 'safe space' is just one small but critical aspect of its wider drive to become a trusted, independent national investigator. Once properly enshrined in legislation, the 'safe space' should remain in the hands of HSIB until the wider culture is ready for 'safe space' investigations to be conducted on a wider scale. As an intermediate measure, the Department of Health should consider allowing HSIB to instigate a 'safe space' when it chooses to investigate at local level or indeed when local investigations require a 'safe space.' This would allow HSIB, and its investigators with expertise on how 'safe space' operates, to retain control over the 'safe space' even as it provides the option for it to be extended to a local investigation where required.

112 Department of Health, *Learning not Blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation*, July 2015, p. 58.

Formal Minutes

Tuesday 17 January 2017

Members present:

Ronnie Cowan	Kelvin Hopkins
Mr Paul Flynn	Mr John Stevenson
Marcus Fysh	Mr Andrew Turner
Mrs Cheryl Gillan	

In the absence of the Chair, Mrs Cheryl Gillan was called to the Chair.

Draft Report (*Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England*), proposed by the Chair, brought up and read.

Paragraphs 1 to 93 read and agreed to.

Appendix agreed to.

Summary agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 18 January at 9.15am.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 8 November 2016	*Question number*
Scott Morrish, father of the late Sam Morrish and Member of the Healthcare Safety Investigation Branch Expert Advisory Group, and **Dr Steve Shorrock,** Human Factors Specialist	Q1–28
Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission, **Helen Buckingham,** Executive Director of Corporate Affairs, NHS Improvement, and **Keith Conradi,** Chief Investigator, Healthcare Safety Investigation Branch	Q29–70

Tuesday 22 November 2016	
Mr Philip Dunne MP, Minister of State for Health, **William Vineall**, Director of Quality, Department of Health, and **Chris Bostock**, Policy Leader for NHS Complaints, Department of Health	Q71–125

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

LFM numbers are generated by the evidence processing system and so may not be complete.

1 Action against Medical Accidents (AvMA) (LFM0007)

2 Claire Slater (LFM0018); (LFM0022)

3 Daphne Havercroft (LFM0014)

4 Dr Minh Alexander (LFM0013)

5 Healthwatch England (LFM0012)

6 Miss Fiona Watts (LFM0011)

7 Miss Peggy Banks (LFM0003)

8 Mrs Wendy Morris (LFM0002)

9 NHS England (LFM0021)

10 NHS Improvement (LFM0019)

11 phsothefacts.com (LFM0004)

12 Scott Morrish (LFM0020)

13 UK Sepsis Trust (LFM0005)

14 Verita Consultants LLP (LFM0006)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Follow-up to PHSO Report: Dying without dignity	HC 432 (HC 770)
Second Report	Appointment of the UK's delegation to the Parliamentary Assembly of the Council of Europe	HC 658
Third Report	The 2015 charity fundraising controversy: lessons for trustees, the Charity Commission, and regulators	HC 431 (HC 980)
Fourth Report	The collapse of Kids Company: lessons for charity trustees, professional firms, the Charity Commission, and Whitehall	HC 433 (HC 963)
Fifth Report	The Future of the Union, part one: English Votes for English laws	HC 523 (HC 961)
Sixth Report	Follow up to PHSO Report of an investigation into a complaint about HS2 Ltd	HC 793 (HC 258)
Seventh Report	Appointment of the Commissioner for Public Appointments	HC 869
Eight Report	The Strathclyde Review: Statutory Instruments and the power of the House of Lords	HC 752
Ninth Report	Democracy Denied: Appointment of the UK's delegation to the Parliamentary Assembly of the Council of Europe: Government Response to the Committee's Second Report of Session 2015–16	HC 962
First Special Report	Developing Civil Service Skills: a unified approach: Government Response to the Public Administration Select Committee's Fourth Report of Session 2014–15	HC 526
Second Special Report	Lessons for Civil Service impartiality for the Scottish independence referendum: Government Response to the Public Administration Select Committee's Fifth Report of Session 2014–15	HC 725
Third Special Report	Follow-up to PHSO Report: Dying without dignity: Government response to the Committee's First Report of Session 2015–16	HC 770

Fourth Special Report	The Future of the Union, part one: English Votes for English laws: Government response to the Committee's Fifth Report of Session 2015–16	HC 961
Fifth Special Report	The collapse of Kids Company: lessons for charity trustees, professional firms, the Charity Commission, and Whitehall: Government Response to the Committee's Fourth Report of Session 2015–16	HC 963
Sixth Special Report	The 2015 charity fundraising controversy: lessons for trustees, the Charity Commission, and regulators: Government response to the Committee's Third Report of Session 2015–16	HC 980

Session 2016–17

First Report	PHSO review: Quality of NHS complaints investigations	HC 94 (HC 742)
Second Report	Appointment of the Chief Investigator of the Healthcare Safety Investigation Branch	HC 96
Third Report	Better Public Appointments?: The Grimstone Review on Public Appointments	HC 495
Fourth Report	Appointment of the First Civil Service Commissioner	HC 655
Fifth Report	Follow-up to PHSO report on unsafe discharge from hospital	HC 97
Sixth Report	The Future of the Union, part two: Inter-institutional relations in the UK	HC 839
First Special Report	Follow up to PHSO Report of an investigation into a complaint about HS2 Ltd: Government and HS2 Ltd responses to the Committee's Sixth Report of Session 2015–16	HC 258
Second Special Report	PHSO review: Quality of NHS complaints investigations: Government response to the Committee's First Report of Session 2016–17	HC 742