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Public Bill Committee

HEALTH AND CARE BILL

Sixteenth Sitting

Tuesday 26 October 2021

(Morning)

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Saturday 30 October 2021

The Committee consisted of the following Members:

Chairs: Mr Peter Bone, Julie Elliott, Steve McCabe, † Mrs Sheryll Murray

† Argar, Edward *(Minister for Health)*
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
† Double, Steve *(St Austell and Newquay)* (Con)
† Foy, Mary Kelly *(City of Durham)* (Lab)
† Gideon, Jo *(Stoke-on-Trent Central)* (Con)
† Higginbotham, Antony *(Burnley)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Owen, Sarah *(Luton North)* (Lab)
† Robinson, Mary *(Cheadle)* (Con)
† Skidmore, Chris *(Kingswood)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
† Timpson, Edward *(Eddisbury)* (Con)
† Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
† Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 26 October 2021

(Morning)

[Mrs Sheryll Murray *in the Chair*]

Health and Care Bill

9.25 am

The Minister for Health (Edward Argar): On a point of order, Mrs Murray. I put on record through you my gratitude to the Committee, and particularly to the usual channels and the shadow Ministers, for facilitating the adjournment of the Committee last Thursday in order to allow me to attend the funeral of my friend James Brokenshire.

The Chair: Thank you, Minister. I am sure the Committee has taken note of your point of order.

Clause 106

Prohibition on disclosure of HSSIB material

Dr Philippa Whitford (Central Ayrshire) (SNP): I beg to move amendment 86, in clause 106, page 92, line 26, leave out subsection (2) and insert—

"(2) In this Part 'protected material' means—

(a) all statements taken from persons by the HSSIB during a safety investigation or in the course of deciding whether an incident is going to be subject to an HSSIB investigation,

(b) records revealing the identity of persons who have given evidence in the context of the safety investigation,

(c) information that has been collected by the HSSIB which is of a particularly sensitive and personal nature, such as (but not limited to) copies taken by the HSSIB of health records, care records, clinical notes, or personnel records,

(d) material subsequently produced during the course of an HSSIB investigation such as (but not limited to) notes, drafts and opinions written by the investigators, or opinions expressed in the analysis of information obtained through the investigation,

(e) drafts of preliminary or final reports or interim reports, information that would be subject to legally enforceable commercial privileges."

This amendment would define more closely the materials covered by the "safe space" protection provided for by the Bill.

The Chair: With this it will be convenient to discuss the following:

Amendment 87, in clause 106, page 93, line 6, leave out

"information, document, equipment or other item held by that individual"

and insert "protected material".

This amendment is consequential on Amendment 86.

Clause 106 stand part.

Amendment 91, in schedule 14, page 212, line 14, leave out paragraph 6.

This amendment would remove the provision allowing coroners to require the disclosure of protected material.

Amendment 136, in schedule 14, page 213, line 3, at end insert—

"Disclosure to families

6A The Chief Investigator may disclose findings to any patient involved in any incident which HSSIB is investigating, or the family of any such patient, on the condition of confidentiality and any other condition the Chief Investigator sees fit."

This amendment would give the Chief Investigator the discretion to disclose information about an investigation to a patient/family involved if they deem this appropriate, on the condition that the information remains confidential.

That Schedule 14 be the Fourteenth schedule to the Bill.

Amendment 88, in clause 107, page 93, line 17, leave out from "Part" to the end of line 41.

This amendment would remove the ability of the Secretary of State to make regulations authorising disclosure of protected material beyond that provided for in the Bill.

Clause 107 stand part.

Amendment 89, in clause 108, page 94, line 15, leave out paragraph (c).

This amendment is consequential on Amendment 88.

Clause 108 stand part.

Amendment 90, in clause 109, page 95, line 6, leave out subsection (7).

This amendment is consequential on Amendment 91.

Clause 109 stand part.

Clause 117 stand part.

Dr Whitford: We are now discussing the health services safety investigation body, and I rise to speak to amendments 86, 91 and 88, which are the main substantial amendments, with amendments 87, 89 and 90 being consequential on those three. HSSIB will not apply in Scotland, but having been a surgeon for over three decades and having been involved in quality improvement and the Scottish patient safety programme, I will be watching it with interest. We want it to succeed, and I am sure the other nations in the UK will want to learn from it, so it is important that it is not simply drowned at birth and that we get it right at this stage.

HSSIB is based on the principles of the air accidents investigation branch, and we on the prelegislative Committee felt that the most central and important part was the safe space protected materials. The main priority is learning from incidents, mistakes and errors and looking at how to prevent them from happening in future; it is not about blaming individuals. That is because most incidents in the NHS are system-related, rather than individual-related. Errors and mistakes will happen, particularly when NHS staff face workforce shortages and are covering more patients than normal. The pandemic might mean that they are working outside their comfort zone. They also work long hours, and sometimes the system will cause a mistake. We should be designing a system that prevents a simple mistake or error from delivering harm to a patient. That is the critical aim, and that has been the focus of the Scottish patient safety programme, which was introduced in operating theatres in 2007, when I was still working as a surgeon.

That programme made the World Health Organisation checklist compulsory. It involved a discussion at the beginning of operation lists and time out with the whole theatre team before the operation started, so that

patient safety and the responsibility to prevent wrong site surgery, which the shadow Minister raised previously, is made everyone's responsibility. The whole team stops and is quiet, and everyone goes through that final check before the operation starts. A former Health Minister from this place visited Scotland but never made that checklist compulsory in England. I do not understand why not.

This issue is not in need of investigation by HSSIB, but it does demonstrate that it is necessary for someone learning from an incident to recognise and admit candidly that they have made a mistake. Such mistakes could include putting the wrong mark on a patient, putting the wrong side on the consent form, or putting the X-ray up the wrong way around. Whatever led to the error, we need people to be willing to completely admit to their mistakes, and to then create systems to prevent that mistake from resulting in harm to the patient. That is why the safe space is so critical—otherwise NHS staff, clinicians, and anyone else involved will not be candid—and it is why the prelegislative Committee felt it was important to be absolutely focused on protecting it. The aim is to design safety nets to protect the patient.

Amendment 86 seeks to change the orientation of the Bill. The Bill defines protected materials very widely and creates exceptions. It implies that other organisations cannot get on with their investigations because HSSIB is getting in the way. The amendment seeks to define protected safe space materials very narrowly. HSSIB would only hold copies of records. That means that the originals—the safe space testimony of witnesses or others—would still be held by the NHS. Patients and families could still give permission for their testimony to be disclosed, thereby avoiding the need to repeat it to another agency, but evidence could not be forcibly disclosed. Other bodies could not use HSSIB as a substitute and say, "Oh well, if you've investigated it, we won't bother. We'll simply copy what you've found."

Amendment 88 to clause 107 would remove the potential for the Secretary of State to simply expand the disclosure exceptions later on. There is a big list in clause 107 of what could be changed. Schedule 14 lists the authorised reasons and persons who would access disclosure. Amendment 91 seeks to remove coroners from that list. If coroners are given access to testimony, other people do not understand why they should not be given access, too. We have probably all been lobbied about that by the ombudsman and the freedom of information bodies. If that happens—if more people access the safe space raw testimony—it will no longer be a safe space and the system will simply not match the achievements of the air accident investigation branch in getting such frank and candid evidence. People can be summoned and made to respond to factual questions, but will they discuss poor interpersonal relationships in a team, people not working together and all the things that could contribute to a bad atmosphere or system?

In the prelegislative Committee we felt that there were two key reasons for disclosure to go ahead regardless. The first obvious one is if there is an ongoing significant risk to patient or public safety, and the other is if there is a criminal prosecution because of someone's actions or because they have breached the disclosure rules. The Bill states that access can be granted to safe space materials via the High Court. That is how it is for air accident investigations. It is felt that the High Court will weigh up the importance of admitting the disclosed materials versus the chilling effect that could have on future investigations and people giving evidence to them. It is important to keep the High Court provision in place and to trust it as the main route for other bodies or individuals seeking access to safe space testimony or records.

It is important to recognise that aviation is among the safest industries because of the safe space provided when investigating air accidents. It is not always a matter of investigating catastrophes; it is also about investigating near misses and working out why an accident did not happen. Was it by the grace of God, or did something kick in, and should processes and procedures be changed?

The amendments would strengthen the safe space, help ensure the willingness of NHS staff to come forward to give honest testimony, and protect that testimony so that it could be used to reduce any future harm to patients.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to see with you in the Chair, Mrs Murray. I will speak to amendment 136, as well as the other clauses and amendments in the group. I will not repeat the points made by the Scottish National party spokesperson, the hon. Member for Central Ayrshire, in her excellent introduction, but I will draw the Committee's attention to a few salient points.

First, amendments 86 and 87 seek to create a new definition of protected material. We support the amendments because, as the SNP spokesperson said, it is important to turn this around and try to create as much certainty as possible by defining protected materials as far as possible. I suspect that the Minister will tell us that the amendments are unnecessary, but we certainly feel that it is better to over-prescribe now than to undercook the Bill and find out in two or three years' time that some loophole ends up having the chilling effect that we have discussed several times.

I am aware of the counter-argument that there should be no restrictions or protected material if an individual is not capable of being identified, but that is a rather risky strategy. It would not remove the risk of people being able to identify someone simply by working out who was doing what at a particular time and what evidence they gave. It also does not help to build the confidence necessary to deliver the safe space that the Bill is trying to achieve. Certainty and clarity are needed wherever possible, and defining materials that are to be considered a safe space and protected will assist in that aim.

Turning to clauses 106 to 108 on disclosure, it is appropriate to make clear in clause 106 that the disclosure of protected material is prohibited, but we think that clear statement is rather undermined by the ability of the Secretary of State in clause 107 to make regulations to change that. As I have said, the parameters of safe space should be clear, consistent and constant. That is why amendment 86 in particular ought to be supported. The Secretary of State is once again giving himself more powers—a theme we have picked up throughout the Bill—and that is of concern.

Let us not forget that this Bill has been floating around in various guises for about five years, so we do not think it is acceptable or, indeed, necessary for the

[Justin Madders]

Secretary of State to reserve for himself greater ability to move the goalposts at some later date. If we do not know now what protected material and safe space are, we are never going to know. Amendment 88 commends itself on those grounds alone. Any ability for the Secretary of State to change the boundaries risks undermining trust and confidence. If those taking part in investigations do not have trust in the safe space provided, it is likely that they will not feel confident enough to be as candid as we would like them to be. If the Minister feels that exceptions are needed, they should be on the face of the Bill; they should not be slipped in by regulations at a later date.

The independent advisory panel of the Healthcare Safety Investigation Branch has also offered a view and stated that staff would not speak up if there was a risk of exposure of identity, and any issues regarding the limits of disclosure are best dealt with by the High Court, not by the Secretary of State in further regulatory procedures.

A related concern on disclosure is that an HSSIB employer who reveals information showing that the organisation itself is failing to properly discharge its responsibilities would commit an offence if he or she knew or suspected that what they were disclosing was protected information. Given the work that they are likely to undertake, I think we can all see that that is likely to be the case. It would not be needed to show that the disclosure had caused, or was likely to cause, harm, and there would be no reasonable excuse defence and no protection under whistleblower legislation. Yet under clause 108(4) a reasonable excuse defence is available to third parties that disclose information to them provided by HSSIB. Will the Minister explain that discrepancy and what protections might be available to whistleblowers who work for HSSIB?

Turning to amendment 91, it is right that considerable concern has been raised about the proposal to allow coroners to access protected material, because it could mean individual coroners routinely requesting material from HSSIB investigations. I hope it is clear to members of the Committee the ramifications that could have on healthcare professionals' willingness to be fully engaged and open with HSSIB investigations.

Another consideration—and another reason why we think this is a bad idea—is that there is variation in coronial practice around the country. There is a risk that one coroner or region could be more proactive than others, and could undermine confidence in the system as a whole. It is right that coroners have their own discretion and powers, but the chilling effect would be obvious should only one coroner make a stand on a particular issue.

There is also the question of cost. If HSSIB needs to challenge these decisions, which I am sure it will want to from time to time, it will have to spend considerable amounts on legal fees to do so. Surely its resources would be better spent on delivering its core objectives, rather than on trotting off to the High Court every five minutes to deal with inquisitive coroners.

The Joint Committee on the Draft Health Service Safety Investigations Bill concluded:

"We recommend that the draft Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners."

That is why we believe that amendment 91 should be supported.

I also refer to the evidence submitted by the independent advisory panel of the Healthcare Safety Investigation Branch, which said of the proposal that there is in fact no parallel in the transport sector—from which the idea for this body was originally conceived—and nor is there any evidence from its experience of the transport sector that such an approach would be necessary. Obviously, we are dealing with different orders of investigations. Certainly, the number of people who would die in an air accident is very different from an incident in the NHS, and we would also expect there to be a significant number of patient safety issues that do not apply to the air sector. However, HSSIB has been going for a considerable time and it has not had any circumstances or incidents where it thinks this power would have made any difference.

HSSIB's approach to protective disclosures does not limit the powers of coroners to conduct investigations in their own way—there is nothing in there that takes away from their current situation. The independent advisory panel also said that areas of prohibited disclosure should be highly specific and as limited as possible, and expressed the view that disputes regarding the prohibition of disclosure should be determined through an independent judicial process in the High Court, which is already provided for in the Bill.

Finally, I will say a few words on our amendment 136, which is a probing amendment. We want to raise the concern articulated to us that, although it is important that any evidence gathered by HSSIB remains protected, for the reasons we have been discussing, there may be occasions when it would be appropriate for some information to be shared with a patient, or the family of a patient, who has been involved in any qualifying incident. I certainly would not envisage such a power being used routinely. Indeed, the amendment places the discretion entirely in the hands of the chief investigator, who may decide not to use that power at all. However, there may be occasions when certain information, handled correctly—and at the very least on condition of confidentiality, and quite possibly with the consent of the individual or organisation that has provided the evidence—could be passed on to those with a direct interest in the matter, whose knowledge and understanding of what had gone wrong would be improved by the disclosure of the information.

That would still not be considered to be admissible evidence for any proceedings. Given the chief investigator's desire to keep the concept of safe spaces as secure as possible—which should always be the primary consideration—we can see why that might be put at risk, but I want to flag up this as an issue. Patient groups have long-running concerns that the defensive culture that so often pervades the NHS when something goes wrong does little to aid the ability of patients and their families to get to the bottom of what went wrong. There are always concerns about medical negligence or professional competence proceedings, but rarely do families go into these situations looking for compensation. They are far more likely to want an explanation and an assurance that measures are being put in place so that

nobody else will have to go through what they have. In any event, the proposed powers are not too dissimilar to those set out in paragraph 2 of schedule 14.

Dr Whitford: I want to echo that. I have been involved as an external for significant adverse event reviews, and it has always been my experience that what the family wants to find is that it will not happen again. I therefore feel that we have to trust HSSIB that the duty of candour will mean that there is discussion with the family as we go. That should be the culture across the NHS. The problem is that the more threatened clinicians feel by litigation, the more defensive they become. If the whole orientation can be changed to be about learning and preventing rather than blaming, we will probably get better relationships with families and better, open duty of candour discussions.

9.45 am

Justin Madders: I thank the hon. Lady for that intervention, which articulates well what we are trying to highlight. It is a question of culture, which legislation can go only so far in addressing. As a Parliament, we need to address what more we can do to engender greater openness in the NHS. When things go wrong, there are better ways of handling that than what happens at the moment. When we have an £8 billion a year clinical negligence bill, it is incumbent on us all to look at ways that we can reduce that as well as assisting patients and their families to gain a better understanding of what has gone wrong.

Edward Argar: It is, as ever, a pleasure to serve under your chairmanship, Mrs Murray.

I am grateful to the hon. Member for Central Ayrshire not just for her amendments but for the opportunity to debate the issue, which goes to the heart of the challenges we face. I think there is broad consensus on clauses up to clause 119, perhaps with a challenge or a tweak here and there, but the provisions that we are considering are the one bit, as I know from the hon. Lady's work on pre-legislative scrutiny and when the Bill was previously considered, that remains challenging. It is a matter of striking the appropriate balance to ensure the proper functioning of judicial authorities at the same time as achieving the overall objective of what we are trying to do with HSSIB: foster that learning culture, understand what goes wrong and avoid a repetition of it. It ultimately comes down to a subjective view of where that balance is most appropriately struck.

Clauses 106, 107, 108, 109 and 117, and schedule 14, address how HSSIB will protect the material it holds and outline the concept of safe space. Before getting into the detail of the clauses, I want to acknowledge that there has of course been extremely good and well-informed debate outside the Committee about how broad or narrow safe space should be; whether it should be as defined in the Bill with exceptions, or, to use the suggestion of the hon. Member for Central Ayrshire, flipped around to be the converse of that; and the merits of HSSIB sharing or not sharing information with other organisations. I feel it is important to set out how we came to the balance we propose.

The hon. Lady mentioned a previous Minister who visited Scotland. I am very conscious that I have a kind, outstanding invitation to visit from her and I look forward to taking that up at some point soon, I hope. I also spoke to the Scottish Cabinet Secretary for Health and Social Care, who endorsed that invitation. I therefore look forward to being able to come not only to Edinburgh, but possibly to Ayrshire, and finding a way to shoehorn that into the visit.

Key to our vision for a new model for investigations is that they are conducted in a safe space so that patients, families, NHS staff and other participants in an investigation are encouraged to speak freely and candidly and have the confidence that the information they provide will be protected, save in the most exceptional circumstances.

The objective is to encourage that open flow of information and get to the bottom of what may have happened with the best possible information available. Without guarantees that that information will not be shared—again, save in very limited circumstances, which I will come on to—we risk, as the hon. Lady said, eroding the confidence of all those who candidly trust HSSIB with that information.

We propose that information, documents, equipment or other items held by the new body in connection with an investigation will be considered protected material and must not be shared, apart from in certain limited circumstances, such as when necessary to address a serious and continuing risk to the safety of a patient or to the public, and then only to the extent necessary to allow a person to address the risk.

It is also important that people have certainty that the information they provide will not be used for the purposes of blame or liability. The current investigation branch does a good job under the current legislative framework but can only operate a weakened form of safe space. In addition, it has no powers to impose sanctions. We need to address that and put the HSSIB on a par with similar investigation bodies in the transport sector, as colleagues have said. Non-compliance with safe space protections may result in criminal sanctions.

Mary Robinson (Cheadle) (Con): I have listened to the reasoning behind the amendments, and I feel that they are based on an acknowledgement that people in the health service have perhaps so far not found themselves willing to come forward and speak up when they see something wrong. The scope is much wider with this proposed body because evidence can be taken not just from people who work in the health service, but more widely. It is hugely important that we get to that place, because when we look at evidence taken on civil aviation and what happens in the civil aircraft space, we see that people always behave with the best interests of their sector, their workplace and the public at heart. People want to do the same with this Bill, so I am grateful that HSSIB has been set up. Can more consideration be given to how we ensure that people can speak up without feeling that they will blame another person or that they could be singled out for speaking out? That is exactly what we hope to address with the safe space.

Edward Argar: My hon. Friend is absolutely right. I should say that, even now, I am sure that many people in the health sector co-operate voluntarily, even when it is potentially challenging for them to do so. They do so

[Edward Argar]

because they want to foster that culture. This proposal will take that a step further forward and make it even easier for people to do so with confidence and to overcome any reticence that might exist because of, as she said, the fear of blame, the fear of opening up about something and the need to protect their sector and organisation, as they see it. She is absolutely right, and the key is to try to create a learning, rather than a blaming, culture. That is why the balance we strike in the definition of the safe space and exceptions to it is so important. We may or may not reach a consensus on where the balance should be struck, but this debate goes to the heart of the efficacy of the new body and how it will operate.

The Bill therefore sets out, on a statutory footing, a much stronger and more robust form of safe space. Clause 106 is the cornerstone of that. It is key to ensuring that all participants are completely candid with the information that they share, and it enables more thorough investigations and the development of meaningful recommendations. Investigations where protected material is held in the safe space should improve openness and co-operation between all participants and identify risks to the safety of patients, so that patients, families and the wider public can benefit from the experience of better investigations, and improvements can be made to the systems and practices in the provision of healthcare in England.

We believe that we have reached the right, balanced position after a lot of careful thought. In dealing with this legislation, my predecessors and I, along with my right hon. Friend the Member for Mid Bedfordshire (Ms Dorries), who is now Culture Secretary, wrestled a lot with the question of how to strike the right balance. I therefore turn to amendments 86 and 87. I am pleased that there is, I think, a consensus among all Members across the Committee that we need to protect materials, and about the value attached to protecting materials in the safe space, which is a key part of our approach to improving patient safety by allowing individuals to feel able to speak candidly.

Amendment 86 seeks to list in detail the types of material that will fall under the definition of protected material, while amendment 87, as the hon. Member for Central Ayrshire set out, is consequential on that. The definition given in clause 106(2) is intentionally broad. HSSIB will carry out a range of investigations, and it would be impossible to identify prospectively, in advance, all the material that will need to be gathered and should be protected by the safe space. By having a broad definition, we can give greater confidence to those who speak to HSSIB that all the material that it collects will be appropriately protected. There are very specific exceptions, which I will come on to.

As a future-proofing mechanism, the materials that are protected have not been listen in detail in the Bill. New technologies and ways of recording data are developing at a rapid pace. It is vital that HSSIB is able to adapt as these developments reach the frontline, rather than having to rely on returning to this House for further amendments to primary legislation. Listing the types of material in detail would have a number of practical implications. If we had a specified list, we could inadvertently leave out material that should be protected, when the vast majority of material the HSSIB will gather would be protected under the current definition. The Government endeavour to get everything right, but, as we all know, often do not.

Justin Madders *rose—*

Dr Whitford *rose—*

Justin Madders: Does the Minister think that there is anything missing from the amendment that ought to be included?

Edward Argar: I will take the intervention from the hon. Lady, and I will address both together.

Dr Whitford: I want to point out that it is irrelevant whether records, statements or information, all of which are listed in amendment 86, are in a digital form or some different form in the future. We use the words "statements", "information" and "records", and the importance of having copies is that the originals will still be available to other investigatory bodies. I cannot see what the gap is. Whether we are talking about an audio recording or sheets of paper, the technology is irrelevant.

Edward Argar: I am grateful to the shadow Minister and the SNP spokesperson, whose points are not dissimilar. I take the hon. Lady's point that statements and information are recognised legal terms and would catch different mechanisms by which they are recorded. We still think it is prudent to allow not only for developments that we may not have anticipated, but for clarity. We believe that the blanket provision gives greater clarity and certainty without the assistance of the amendment, so we do not share the hon. Lady's view. I suspect she may still wish to test the amendment with a Division to make the point, as she is entitled to do.

Moving on from these amendments, to illustrate the variety and breadth of debate on this subject—we have had a small taste of it this morning—I want to address the argument that keeping protected materials in the safe space would potentially undermine the role of other bodies, such as the Parliamentary and Health Service Ombudsman. This illustrates part of the challenge. There are, understandably, calls from colleagues on the Committee to further restrict the exceptions to the safe space. As has been alluded to, others outwith this place argue for an expansion of the list of those exceptions. Some have argued that the PHSO should be on that list. With all due respect to those who advocate that, I do not agree. I do not think it would be appropriate to add the Ombudsman to the list of exceptions. The PHSO will still be able to fulfil its important independent role. It will have direct access to the same sources as it does now when it needs to investigate a complaint. The HSSIB will not in any way limit its ability to conduct an investigation.

Karin Smyth (Bristol South) (Lab): I am a member of the Select Committee on Public Administration and Constitutional Affairs, which oversees the ombudsman. The Minister will be aware of correspondence between the Committee and the ombudsman. Could the Minister comment on the report from the Venice Commission about how far the United Kingdom will be outwith international consensus on this subject?

Edward Argar: I will do so now for the hon. Lady. I have great respect for the work of the Council of Europe and the Venice Commission around ombudsman services. The Venice Commission has looked at this, understandably, from the perspective of the ombudsman and uniformity of process. We have had to weigh that up—exactly as the Committee is doing in this debate—in balancing the impact of too many exceptions, or exceptions that are too wide, on the candour with which people can contribute their views to further the improvement of patient safety. There is no ideal line on this, hence this morning's debate.

I respect the views that the Venice Commission has set out. I think it formally set out its conclusions a week or so ago, after a number of informal meetings among its members and with officials to gather evidence; I suspect it also took the views of the Public Administration and Constitutional Affairs Committee. The Venice Commission looked at the matter, quite rightly, from the perspective of the ombudsman and the uniformity of the services it provides. We had to strike a slightly different balance, hence why we reached a different conclusion.

10 am

I will turn in a moment to the coroner, because I know that that is a key point. Clause 110 outlines how HSSIB and a number of other organisations, such as the Parliamentary and Health Service Ombudsman, will co-operate on practical arrangements when co-ordinating certain investigations, including arrangements for accessing information from primary sources where cases may overlap. Such arrangements exist already between the current investigation branch and the PHSO, and I expect similar arrangements to be put in place when the new body is set up.

Should HSSIB hold protected material that the PHSO or other bodies wish to access, the other bodies can, as the hon. Members for Central Ayrshire and for Ellesmere Port and Neston said, apply to the High Court for an order allowing its disclosure. The High Court would then apply the legal tests set out in schedule 14 to determine whether an order for disclosure should be made. We heard in evidence that although there was dispute over the extent—particularly around coroners—of exceptions or otherwise, there was a consensus that where there was a dispute, the High Court was the appropriate competent body to resolve such a dispute or determine access. We do not envisage that that will be needed in most situations, but it provides a safeguard to ensure there is always a way to access information should the interests of justice balance test be met.

We anticipate that the new body will carry out about 30 investigations a year, and the focus of the investigations will be to support national learning, rather than looking at individual complaints. Therefore, we believe that there will be very limited times when bodies such as the PHSO would need access to information held by the new body.

Schedule 14 describes some of the exceptions to safe space. It is therefore an important part of how we see safe space working, and it is at the heart of what we are debating today. Clause 106 sets out a general prohibition on the disclosure of protected material held in the safe space. There are occasions, however, when we consider it necessary to allow for disclosure of information relating to an investigation outside HSSIB. Those limited exceptions are clearly set out in schedule 14. For example, it is only right that if HSSIB discovered information that demonstrated that there was a serious and continuing risk to the safety of a patient or the public, as the hon. Member for Central Ayrshire alluded to, it is able to disclose information, to the extent necessary, to a body that can address that clear and present risk. Safe space is not about covering up unsafe practices or putting patients at risk; in fact, it is quite the opposite.

HSSIB can disclose information where needed. First, it can do so to help it carry out an investigation—for example, with a witness in an investigation, so HSSIB can get them to comment on or give their reaction to it. Without the provision, HSSIB might not be able to carry out an investigation properly, because safe space could restrict what it could investigate and how it operated. Secondly, it can disclose information to help it to enable prosecution of offences created under part 4; that is, the very limited offences relating to investigations or offences of unlawful disclosure. In such a prosecution, the disclosure of elements of protected information may be required to demonstrate that the offence was committed in the first place. Thirdly, HSSIB can disclose information to help to address a serious and continuing risk to the safety of a patient or the public, for example where HSSIB has evidence of negligent behaviour by a medical professional that may risk the safety of patients, and it wishes to disclose that information to their employer—essentially, whistleblowers and others. In order to address that risk, HSSIB can only disclose sufficient information to enable the employer to take steps to address the defined risk.

In addition, disclosure of protected information can also occur if the High Court makes an order that such information be disclosed by HSSIB to a person for a specific purpose. The Bill sets out the legal test that the High Court must consider before making such an order. Schedule 14 provides that an order can be made only if the High Court deems that the interests of justice served by the disclosure outweigh any adverse impact on current and future investigations by deterring persons from providing information for the purposes of investigations, and any adverse impact on securing improvement of the safety of healthcare services provided to patients in England. That is, rightly, a high bar, but it is an important safeguard to ensure that the interests of justice can be served where necessary and where that bar is met.

I now turn to the crux of the concerns raised by the hon. Member for Ellesmere Port and Neston and the hon. Member for Central Ayrshire. We have included an exception to allow disclosure if a senior coroner requires the information under certain provisions of the Coroners and Justice Act 2009. I know that some outside this place, and some within it, have concerns about the fact that we have created an exception for senior coroners, and here I turn to amendments 90 and 91 on the matter. Amendment 91 seeks to remove the provision allowing coroners to rely on certain provisions in the 2009 Act to require the disclosure of protected material held by HSSIB in the safe space. That would mean that protected material could not be passed from HSSIB to coroners without the High Court ordering it to be so. Amendment 90 is consequential and linked to amendment 91.

The key point that I would highlight when comparing this situation to that of the PHSO or others is that coroners are members of the judiciary. They are judicial office holders, and they have a very distinct and important legal role in investigating specific deaths. We do not want to hamper that, and throughout various pieces of legislation, including the 2009 Act, we have sought to protect their judicial independence.

The shadow Minister raised a concern about inconsistency in how different coroners in different areas might approach the matter. In a past life at the Ministry of Justice, I had responsibility for the coroners system as a Parliamentary Under-Secretary. Over the past decade, we have seen considerable modernisation of the current coronial system in this country, with the appointment of a Chief Coroner—a role that is assumed by a High Court judge. They have sought to bring much consistency, and there has been training and work with coroners—performance management is the wrong word—from the centre to ensure greater consistency of decision making and approaches. That will reduce the potential for significant inconsistencies or differences of approach—for example, a particular coroner may decide to take a very liberal approach and request all sorts of things, while another may say, "I do not need any of that"—which I think is what the hon. Gentleman is concerned about. A lot of work is being done to secure greater consistency and greater clarity, with guidelines promulgated by the Chief Coroner to deliver that. In this space, I would similarly expect the Chief Coroner to take a very close interest in guiding coroners.

Justin Madders: I appreciate the work that has gone into ensuring greater consistency among coroners. The fact remains, however, that, as the Minister said, these are independent judicial positions, and coroners are entitled to make decisions as they see fit. I do not think that that concern has been adequately addressed yet.

Dr Whitford *rose—*

Edward Argar: I will take an intervention from the hon. Member for Central Ayrshire, because I suspect it is consequential on what the hon. Gentleman has said.

Dr Whitford: I would like to understand what coroners have now that they would lose by the protection of safe space. The provisions on granting disclosure apply to the High Court, not to all courts and not to all judicial positions. Why is the coroners' court specifically being given the right to access, as opposed to applying for disclosure through the High Court? It will be the thin end of the wedge, and other groups will feel they ought to have a right to the same safe space. As clause 107 allows regulatory changes to be made later, this could continue to be eroded. I do not understand what part of what coroners do would be undermined by the introduction of HSSIB and the real safe space.

Edward Argar: I am grateful to the hon. Lady and the hon. Gentleman, and I think the points they made are linked. The distinction we draw with other organisations and individuals is because of the key point that coroners are members of the judiciary. The hon. Gentleman is right to say that that gives them independence in the exercising of their functions, and I will turn in a minute to what the Chief Coroner is doing specifically with these clauses to seek achieve greater consistency.

Coroners are independent and that goes to the heart of their role, which is to determine the circumstances of a death. That is why we believe it is important that their independence, and their existing right to access papers and documents, is not in any way fettered by the legislation. I will try to make a little progress in explaining what we have done with the Chief Coroner, and that may assuage some of the hon. Lady's fears. I fear it will not, but I will try.

As we know, coroners would not have wholesale access to the protected material. They would have access only when it was necessary for them to fulfil their judicial functions in a clear way—for example, in particular individual cases. We expect that the memorandum of understanding between HSSIB and the Chief Coroner, which will be in place, will set out how HSSIB and coroners will work together to minimise the occasions and the amount of material on those occasions that would need to be shared to meet the responsibilities of a coroner that are clearly set out in statute when investigating a particular death.

Although I hope I have provided a degree of reassurance, I fear that it may not be sufficient for the hon. Lady, who has studied the issue over many years in her work. Our aim is that, due to its sensitive nature, the information cannot be publicly disclosed or shared further without an order from the High Court, which is an important safeguard and something that we have considered carefully to balance the needs of coroners and HSSIB. We believe that we can trust our coroners as judicial office holders to behave appropriately.

Dr Whitford: If it is the case that it should be judicial officers, why is it only the High Court, and not other courts in the land that might have an interest in such a case?

Edward Argar: The role of the coroner is very specific, which is why we have singled out coroners, because their role is to investigate deaths. Hopefully, a large number of the investigations that HSSIB will be investigating will not be about deaths but, to use the hon. Lady's analogy with air accident investigations, near misses or incidents that, thankfully, did not result in the death of the patient but may have resulted in injury or other concerns. In the vast majority of cases, therefore, I do not believe that coroners will be involved in HSSIB's work, but they have a specific role in investigating and determining the circumstances and cause of a death. Therefore, we feel that their ability to access it in extremis is the right approach.

The hon. Lady talked about the High Court. For other circumstances, we think that that is the right bar, whether for the PHSO or others, because it is experienced in considering those very complex cases. I suspect, and I think there have been some cases in a similar vein, that the court will consider and debate them over many days because the balance is so delicate.

Because of coroners' historical and defined-in-statute role, specifically around the investigation of deaths, we think that they are the single right exception in the judicial space. The hon. Lady may take a different view and I entirely respect that, as I respect pretty much all her views when it comes to health. We do not always agree on everything but, like the hon. Member for Bristol South, she knows of what she speaks even if sometimes we reach a different political conclusion.

As I have said, an order will be made only if the High Court is satisfied that the interests of justice served by allowing disclosure in those other cases outweigh the impact. As I touched on in my reply to the hon. Lady, I remind hon. Members that HSSIB will be looking at systemic learning rather than individual cases. As I said, thankfully, many instances do not involve deaths, and even if they do, they may not be ones that are scrutinised by a coroner save in a formalistic way. Therefore, we would not expect the power to be used frequently by coroners at all.

We have included the last limited exception because, as I say, we want to ensure that coroners have appropriate access to information to carry out their statutorily defined judicial functions while seeking to balance that with protecting the integrity of safe space by preventing onward disclosure, except by court order. As such, I hope that hon. Members, even if they do not necessarily agree, recognise the amount of thought that has gone into seeking to strike the appropriate balance.

Dr Whitford: I still do not understand from the Minister's explanation what the coroner loses from where they are now. They can still investigate a death, exactly as now, and that was the argument for narrowing what is kept in safe space so that all the original materials are available to other bodies, including the coroner. The Bill adds something extra at the risk of undermining safe space.

Edward Argar: I take the hon. Lady's point, but I do not believe this very narrow exception does or will undermine safe space. What it does is enable coroners to continue to do their job, and if there is information available out there, it enables them to access it from that source. My personal perspective is that we have struck the right balance: if the information is there, we should make it easier for coroners to do their job and access information that facilitates it. I have sat through coroners' court hearings, and I have seen how families cope with them—it is not the easiest experience for them. If there is information out there that would make it easier for a coroner to reach a swift conclusion, and would give them the information that they need about circumstances and cause of death and so on—the other key part, which is not necessarily pertinent here, is the identification of the deceased individual—I believe it appropriate that we give them access to that information.

10.15 am

I take the hon. Lady's point that coroners can do what they do now without hindrance, but if that information were available, I do not believe that giving them limited information, with the protection to prevent onward disclosure, would have the chilling effect that some colleagues are concerned about. It would make it easier for coroners to help with that learning and to give families a clear answer. I suspect that although we may disagree slightly about which side of the balance we fall on, she would acknowledge that it is a delicate balance. We have debated the clauses and amendments for almost an hour, because this is almost the knottiest bit of the Bill, as it was in the prelegislative scrutiny.

Amendment 136 would enable the chief investigator to disclose information to a patient or relevant family member on a condition of confidentiality or another condition. Having mentioned the chief investigator, I will take this opportunity to briefly correct the record for *Hansard* and for the Committee. Previously, when I talked about the pre-appointment hearings by the Health and Social Care Committee, I referred on occasion to the chief investigator rather than the chair, but it is the chair who will have to go through that process.

I imagine that the intention of the amendment is to ensure that patients and families do not feel excluded from investigations or feel that relevant information is withheld from them. I understand the sentiment and intent behind the amendment, but I do not consider it necessary because the Bill already provides for patients and families to be involved in the investigation process. HSSIB will publish its processes for ensuring that, so far as is reasonable and practical, patients and their families are involved in investigations. Clause 99 outlines that when a draft report is produced, HSSIB may share it with anyone it believes should be sent the draft. That would cover patients or family members, who would then be able to comment on it. While the report is at draft stage, it will be subject to safe space restrictions, so although the patient or family members would be able to receive and comment on the draft, they would not be able to disclose the report to others.

I reassure the Committee that, as much as possible, patient and family engagement is intended to be at the heart of HSSIB's work, as far as is possible and appropriate, to create a space in which they can get to the truth of what has happened, just as it is for the current investigation branch. The current investigation branch takes patient and family engagement extremely seriously, and it has published a national learning report that discusses the best way forward for involving patients and families as they move through the investigation process. For those reasons, I ask the hon. Member for Ellesmere Port and Neston to consider not pressing the amendment to a Division, although I think he said that it was a probing amendment to explore how the measures will work in practice.

Clause 107, following on from clause 106, sets out that the prohibition on the disclosure of protected materials—the safe space requirement—does not apply for disclosures required or authorised by schedule 14, by any other provision in part 4 or by regulations made by the Secretary of State. The clause includes a regulation-making power allowing the Secretary of State to set out additional circumstances when the prohibition on disclosure—the safe space—does not apply. We understand that safe space is a wide concept, and we want to ensure that it is operationalised effectively. The intention is that the power will allow us to add to the list of exemptions in future, if needed, as more investigations take place and there is more learning. That builds a degree of flexibility into the clauses.

I turn now to amendments 88 and 89. Amendment 88 would remove the ability of the Secretary of State to make such regulations authorising the disclosure of protected material beyond that provided for in the Bill. Amendment 89 is consequential on amendment 88. As I have set out, HSSIB will carry out a range of investigations, and it would be impossible to identify prospectively the material that will be gathered and should be protected by the safe space. The definition of protected material given in clause 106(2) is intentionally broad. As I alluded to when addressing the clause, it is vital that HSSIB is

able to adapt as clinical and record-keeping practices change on the front line. The hon. Member for Central Ayrshire and I had an exchange on that. She may not quite be convinced by those arguments or explanations, but I think we have probably aired the key issue underlying the amendment.

I have heard concerns—I think they were behind what the hon. Member for Ellesmere Port and Neston was saying—that the regulation-making power could be used as a way of disclosing information in relation to a particular investigation, or that the Secretary of State could exercise it—arbitrarily is the wrong word—in a way that caused that concern to arise. For the avoidance of any doubt, clause 107(3) provides that the regulation-making power cannot be used in that way. The regulation-making power uses the affirmative procedure, so to would of course be subject to debate by this House and the other place before it was made law, providing a degree of democratic scrutiny.

Justin Madders: I understand what the Minister is saying: we need the ability to make regulations to give us some flexibility. Equally, the definition of protected material is broad, to give Ministers and HSSIB flexibility as well. It seems that there is a bit of cakeism going on here.

Edward Argar: I think I know what the shadow Minister means by cakeism. I see his point, but I think the Bill strikes the right balance by building in a further degree of flexibility, but with the safeguard of the affirmative procedure. As he knows, because he has debated such things with me in the past, the affirmative procedure is not always a friend to Ministers in obliging them to come to this House and debate and explain everything. It is, however, an important democratic safeguard when regulation-making powers are inserted into primary legislation, and that is why we have adopted the affirmative procedure in this context. I hope that that gives him a degree of reassurance that the Secretary of State's regulation-making power is simply a future-proofing mechanism, with sufficient parliamentary and democratic safeguards attached to it.

It is crucial, of course, that the integrity of investigations is protected and that we take a careful approach to how information is protected, so that there is public confidence in the work of HSSIB. That goes to the heart of what we are seeking to achieve with this part of the legislation. To ensure that confidence, the Bill provides for the creation of offences for unlawful disclosure. That is the backbone to the creation of statutory safe space. Clause 108 creates three offences of unlawful disclosure. The offences extend to HSSIB and connected individuals, individuals who are no longer connected with HSSIB, and persons who are not connected with HSSIB but receive certain protected material. It is important that we send a robust message that there will be consequences if protected information is disclosed unlawfully. It will be a criminal offence, and the person who commits an offence will be liable on summary conviction to a fine.

Clause 109 prevents a power in any other legislation from being used to require the disclosure of any protected material by HSSIB, or to seize protected material from HSSIB. That is, as we have debated, with the exception of certain parts of the Coroners and Justice Act 2009, which allows coroners to require disclosure in some circumstances due to provisions made in schedule 14 of the Bill. However, that provision respects the devolution settlement agreement and therefore does not apply to any provision that is within the legislative competence of the devolved Administrations. The clause will help to enhance HSSIB's safe space protections by prohibiting the unauthorised disclosure of protected material. It is important to ensure that safe space cannot simply be breached by the use of a power elsewhere in another part of the statute book, and this provision makes that position entirely clear.

As we have debated, safe space encourages all participants to be completely candid with the information that they share with HSSIB, enabling more thorough investigations into what went wrong. That will also help more widely to protect the "learning, not blaming" culture that hon. Members have spoken about and that HSSIB is hoping to embed.

Mary Robinson: I am so pleased to see and hear this balanced argument, and the way that all the considerations have been taken into account. With regard to the penalties for disclosure of information, how does the Bill add to or improve the provisions in the Public Interest Disclosure Act 1998? Does it improve on those provisions, or sit alongside it? Does it protect workers who disclose that there is an issue, not only from penalties such as losing their job, but also from the fine for disclosures put out there deliberately?

Edward Argar: I know that my hon. Friend has done a lot of work in this space, possibly involving the all-party parliamentary group for whistleblowing. I know she is very concerned to make sure that, while these protections are in place, the legitimate rights of whistleblowers seeking to disclose information are not inhibited. This provision sits alongside the 1998 Act, but it is a difficult balance to strike, as she rightly suggests. I pay tribute to her work in helping to foster a culture in which people feel able to speak up and bring matters to the attention of the appropriate body to address wrongdoing.

Finally, clause 117 ensures that the disclosure of information, documentation or other items that are authorised by the provisions I have just discussed does not breach any obligation of confidence owed by the person making the disclosure or any other restriction. The clause also confirms that part 4 does not authorise any form of disclosure that would contravene data protection legislation, which is intended to ensure that where an individual is required or authorised to disclose material, they are protected from violating restrictions on disclosure. A disclosure to HSSIB in those prescribed circumstances therefore does not contravene any restrictions on disclosure, removing barriers that individuals may face in disclosing information to the current investigations branch and helping to instil trust in the new HSSIB investigatory process.

Safe space is an exciting and important development of recent years. What we are seeking to do today is a first for a health body in this country. The clauses are of great importance to the new HSSIB and the vision we have for it. The novelty of what we are seeking to do here, building on what happens in the transport space, and the challenges that that poses, are demonstrated in the debate we have had on what the right balance is. It is an incredibly difficult and, to a degree, subjective judgment for Members of this House and others to make. While I

have set out where we believe it should sit, I entirely respect the perspective of the hon. Member for Central Ayrshire, who has a slightly different and entirely legitimate view. I commend the clauses to the Committee.

Dr Whitford: This is the nub of the entire debate on HSSIB. I welcome that the Minister is struggling with exactly how to achieve that balance. I think everyone on the Committee is trying to do their best to get a good outcome. The Minister talks about clarity, but then we hear about flexibility. It is important that we get this right in the Bill. I wish to press amendment 86 to a Division.

10.30 am

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 9.

Division No. 29]

AYES

Foy, Mary Kelly	Smyth, Karin
Madders, Justin	Whitford, Dr Philippa
Norris, Alex	Williams, Hywel
Owen, Sarah	

NOES

Argar, Edward	Gideon, Jo
Crosbie, Virginia	Higginbotham, Antony
Davies, Gareth	Robinson, Mary
Davies, Dr James	Timpson, Edward
Double, Steve	

Question accordingly negatived.

Clause 106 ordered to stand part of the Bill.

Schedule 14

PROHIBITION ON DISCLOSURE OF HSSIB MATERIAL: EXCEPTIONS

Amendment proposed: 91, in schedule 14, page 212, line 14, leave out paragraph 6.—*(Dr Whitford.)*

This amendment would remove the provision allowing coroners to require the disclosure of protected material.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 9.

Division No. 30]

AYES

Foy, Mary Kelly	Smyth, Karin
Madders, Justin	Whitford, Dr Philippa
Norris, Alex	Williams, Hywel
Owen, Sarah	

NOES

Argar, Edward	Gideon, Jo
Crosbie, Virginia	Higginbotham, Antony
Davies, Gareth	Robinson, Mary
Davies, Dr James	Timpson, Edward
Double, Steve	

Question accordingly negatived.

Schedule 14 agreed to.

Clause 107

EXCEPTIONS TO PROHIBITION ON DISCLOSURE

Amendment proposed: 88, in clause 107, page 93, line 17, leave out from "Part" to the end of line 41.—*(Dr Whitford.)*

This amendment would remove the ability of the Secretary of State to make regulations authorising disclosure of protected material beyond that provided for in the Bill.

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 9.

Division No. 31]

AYES

Foy, Mary Kelly	Smyth, Karin
Madders, Justin	Whitford, Dr Philippa
Norris, Alex	Williams, Hywel
Owen, Sarah	

NOES

Argar, Edward	Gideon, Jo
Crosbie, Virginia	Higginbotham, Antony
Davies, Gareth	Robinson, Mary
Davies, Dr James	Timpson, Edward
Double, Steve	

Question accordingly negatived.

Clause 107 ordered to stand part of the Bill.

Clauses 108 and 109 ordered to stand part of the Bill.

Clause 110

CO-OPERATION

Question proposed, That the clause stand part of the Bill.

The Chair: With this it will be convenient to debate that clauses 111 and 112 stand part of the Bill.

Edward Argar: The clauses address HSSIB's relationships with other bodies, including with the devolved Administrations.

Clause 110 places a requirement on HSSIB and a number of listed bodies, including the Care Quality Commission, NHS England and the commissioner for patient safety, to co-operate with each other when they carry out investigations into the same or related incidents. The duty to co-operate relates to the practical arrangements for co-ordinating those investigations.

Clause 110 would not require the sharing of any protected material held under the safe space. It will also require HSSIB to publish guidance regarding when an incident may be considered related to another incident. That will ensure that there is the necessary clarity across all organisations as to when co-operation is required in often complex investigations. HSSIB will, of course, still be able to co-operate with bodies that are not listed in clause 110, and the current investigation branch has already established many strong relationships with bodies not covered in that list.

However, clause 110 is crucial if we are to ensure that there is a consistent and cohesive approach to investigations in the same area or related areas. It is important that we

[Edward Argar]

encourage organisations to co-operate in this way so as to ensure that multiple investigations touching on the same incident can be delivered in the most streamlined way. For example, the clause would compel two organisations that wished to interview the same individual to co-ordinate. Similarly, if two organisations need to visit a clinical area, it is important that they co-operate to minimise the impact on the day-to-day running of that clinical area.

Clause 110 helps to ensure that information is accessed effectively and efficiently. It ensures that organisations can carry out the important but different roles that they have in an efficient manner and also minimises disruption to patients and to others involved.

Clause 111 places a requirement on HSSIB to comply with any request for assistance from a relevant NHS body. That assistance would be in connection to an investigation into any incident that may have occurred during the provision of NHS services or at premises at which NHS services are provided. NHS England or the Secretary of State may also request that HSSIB provides a relevant NHS body with assistance. Assistance can be provided to trusts, foundation trusts, NHS England and the newly formed integrated care boards. Such assistance may include advice, guidance and training for those organisations in connection with an investigation.

The purpose of HSSIB's investigations is to identify risks to the safety of patients and to address those risks by facilitating the improvement of systems and practices in the provision of NHS services or other healthcare services in England. HSSIB is designed to encourage the spread of a culture of learning within the NHS, and clause 111 allows HSSIB to support others in undertaking investigations and to share knowledge gained from its own investigations. The clause will help HSSIB to promote better standards for local investigations and improve their quality and effectiveness. To this end, HSSIB will disseminate information about best practice and standards to be adopted.

Clause 111 will also enable HSSIB to provide assistance to bodies other than relevant NHS bodies if they request assistance in relation to any matter connected with the carrying out of investigations. That will help to encourage the spread of learning and enable HSSIB to share its expertise across the wider healthcare sector, both within the UK and abroad, if requested. It will be able to charge a fee for such activities. Of course, we would not expect HSSIB to provide such assistance should doing so significantly interfere with the exercise of any of its investigative functions, and protections are included in the clause to ensure this.

Finally, clause 112 enables HSSIB to enter into agreements to carry out certain investigations relating to Wales and Northern Ireland, a provision that the Welsh Government and the Northern Ireland Executive were keen to see included. Those investigations would identify risks to the safety of patients and help to facilitate improvement of systems and practices. Investigations would not assess blame or involve the determination of any civil or criminal liability. It is important that HSSIB has the opportunity to share its expertise and help facilitate greater learning and improvement outside England. The clause allows HSSIB to charge for such investigations in Wales and Northern Ireland but only to cover the costs incurred through the course of the investigation. Of course, we would not expect HSSIB to provide such assistance should it significantly interfere with the exercise of its core investigative functions and, again, protections are included in the clause to ensure that.

These clauses are crucial to ensure that HSSIB has strong working relationships with NHS bodies, as well as regulators and, where requested, the devolved Administrations. I therefore commend the clauses to the Committee.

Justin Madders: As we have heard, the clauses deal with the requirement to co-operate and I will not go over the ground that we have already trodden on in respect of degrees of co-operation and how that might make a material difference to ultimate success. We hope that the many organisations listed in clause 110 will respond not simply because of the legislation but because the no-blame culture to which this body aspires is just as relevant to them as it is to individuals.

Is the long list of organisations in clause 110(3) the totality of NHS bodies or bodies associated with the NHS, or with running NHS services? I think the Minister mentioned that there may be others that have been involved but that are not in this list. Has any of them been excluded from the list and, if so, why?

The power to levy charges on NHS bodies for assistance shows why our amendment requiring the creation of the post of chief finance officer would have been sensible. While there are sanctions for individuals who block investigations and there is a debate about where co-operation ends and obstruction starts, I am unclear whether there is a similar sanction that could be imposed on the bodies listed in clause 110. Has the Minister considered that? Is there a process whereby the buck will stop with a named individual in any of these organisations or is that dealt with later in the Bill?

Karin Smyth: My point concerns the practical implementation, given the examples where the organisations currently do not work together or share, and the issues about real accountability. I have a case that I have dealt with since 2016, which preceded me by some four years, involving an individual going through the complaints system. It resulted in the parliamentary ombudsman's report wanting details to be shared between the trust, NHS Improvement and the Care Quality Commission. In August this year, the trust admitted that it had not provided any such details to NHS Improvement or the CQC. There seems to be no recourse in respect of that lack of communication and accountability between the existing organisations.

My concern on co-operation is about adding HSSIB to a system that does not work now in terms of ensuring that recommendations are shared and acted upon. The intent on co-operation in clause 110 is welcome, but what assurance can the Minister give that that wider culture of co-operation, delivery and implementation of recommendations will be improved by the addition of HSSIB? There is an opportunity for HSSIB to do that, but that would require all those other organisations, named and perhaps unnamed, to also look to their own house to make sure that in the interests of those patients the recommendations are acted upon.

10.45 am

Hywel Williams (Arfon) (PC): I want to ask some questions about clause 112. I have practical questions that the Minister might answer today, or he might wish to write to me. I welcome the clause as a continuation and an improvement, hopefully, on current arrangements. Who might ask HSSIB to carry out an investigation in Wales? Would it be the individual health board or the Welsh Government? Has a mechanism been established yet? Secondly, how involved would the Welsh Government be in any investigation? Would the Senedd, for example, have access to information in an ongoing investigation?

Thirdly, in respect of challenging who would be responsible for paying, would it be the Welsh Government or the individual health board? Fourthly, the Healthcare Safety Investigation Branch has noted that the Bill could be strengthened by the Secretary of State giving a clear mandate for HSSIB to monitor the progress of the response to recommendations. Does the Minister envisage the Welsh Government having a role in monitoring progress, or would it be a matter for HSSIB or the health board?

On clause 107, which has already been debated, I have reservations about extending further exemptions. Would the Welsh Government be able to request or even authorise exemptions where HSSIB carries out investigations in Wales, or is it a matter specifically for the Secretary of State, although health is almost entirely devolved, of course? Finally, will the Minister outline what discussions he has had with the Welsh Government about these provisions? I appreciate that those are detailed questions and he might want to reply to me in writing.

Edward Argar: A number of questions were asked that I will seek to address. If I cannot answer the specific points raised, I will write to clarify them.

The hon. Member for Ellesmere Port and Neston asked about sanctions, and the hon. Member for Bristol South asked about a list of bodies and whether there are any not included—essentially, who was in and who was out. There are two, which I am sure the hon. Gentleman will have noticed, not included in the list of bodies: the Medicines and Healthcare products Regulatory Agency and the National Institute for Health and Care Excellence. I suspect that is the genesis of his asking the question. We recognise the strategically important role that both bodies play in patient safety. Not listing them does not mean that HSSIB cannot co-operate with them. Co-operation across different bodies is something that we encourage. In fact, we would expect HSSIB to develop memoranda of understanding with those organisations, but we focused on specific ones on the list where there is likely to be day-to-day co-operation, particularly with health trusts and others.

On sanctions, we focused on what HSSIB is doing and its being able to progress its investigations. Ultimately, as we have debated, it has the power to seize documents and require information. I very much hope that that will not be needed and that co-operation and memoranda of understanding will be an effective way of moving forward, as it appears to be at the moment, but we have those powers in the legislation, were they to be needed in extremis.

The hon. Member for Arfon mentioned several issues relating specifically to Wales and engagement with the Welsh Government. As I briefly alluded to in my speech, the inclusion of powers to allow the Welsh Government to request the involvement of HSSIB was done at the request of the Welsh Government. We have discussed the issue with them, and I think their request reflects their view that HSSIB involvement could add value in Wales.

The hon. Gentleman sought to understand how the arrangement would work in practice and asked a number of questions about what the fees would be, who would pay them and whether that would be the responsibility of a trust or the Welsh Government. We are still working through those practical matters with the Welsh Government, but we were keen to include the power while we had the opportunity, because the original request came from the Welsh Government. It is a similar case with the Northern Ireland Government. Scotland, to which the hon. Member for Central Ayrshire alluded, has its own well established approach, which works, and therefore a different option was taken in its respect.

Conversations with the Welsh Government have not progressed to the extent that I can give the hon. Member Arfon detailed answers to all his questions, but I will write to him if there is any more that I can add.

Question put and agreed to.

Clause 110 accordingly ordered to stand part of the Bill.

Clauses 111 and 112 ordered to stand part of the Bill.

Clause 113

FAILURE TO EXERCISE FUNCTIONS

Question proposed, That the clause stand part of the Bill.

The Chair: With this it will be convenient to discuss clause 114 stand part.

Edward Argar: The clauses relate to the oversight of HSSIB's functions. Clause 113 enables the Secretary of State to direct HSSIB to exercise its functions within a specified time period and in such a manner as the direction prescribes. That direction-making power, on which I suspect the shadow Minister the hon. Member for Ellesmere Port and Neston will question me, will apply only in the event that the Secretary of State considers that HSSIB is failing or has failed to exercise any of its functions, and that that failure is significant. Directions must be in writing and will ensure that appropriate action can be taken by the Secretary of State in the event of any failure on the part of HSSIB to exercise its functions.

Independence as a concept is fundamentally important, and indeed at the heart of HSSIB, and will be a crucial way to ensure that patients, families and staff have trust in its processes and judgments. However, the clause serves to help to safeguard the trust placed in HSSIB by patients and families in the event of its significant failure to exercise its functions. We believe this is a sensible and proportionate provision, which ensures that HSSIB is performing its vital functions. To maintain the independence of the investigatory process, such directions made by the Secretary of State will not be able to influence the outcome of any HSSIB investigation.

We do not expect to use the power—in fact, I hope that we will never have to use it—but it is right that the Secretary of State has the power to act in the event of

[Edward Argar]

significant failure. That is consistent with similar existing powers available to the Secretary of State in relation to other non-departmental public bodies, including the Care Quality Commission. Should HSSIB fail to comply with such directions, the clause enables the Secretary of State to choose to make arrangements either to undertake the exercise of HSSIB's functions themselves or for another body to undertake them. That will ensure that the important investigatory work is sustained and delivered at the appropriate high standard, should HSSIB have experienced significant failures in achieving that.

Clause 114 requires the Secretary of State to undertake a review of and prepare a report on the effectiveness of HSSIB in undertaking its investigation function. That report must be prepared, published and laid before Parliament within four years of clause 94 coming into force, which sets out its investigation function. Given the trust that patients, families and staff will place in HSSIB's processes and investigations, it is vital that Government is transparent to the public and parliamentarians regarding the performance of the new body. That report will be key to ensuring such transparency and to helping to facilitate learning and improvements within HSSIB. I therefore commend the clauses to the Committee.

Justin Madders: As the Minister has anticipated, clause 113 troubles me somewhat. We have talked extensively about the importance of independence and the need for HSSIB to have the confidence of those with whom it interacts so that it is fully effective. Once again, in common with much else in the Bill, we see that the Secretary of State gets to hand himself extensive powers to interfere with HSSIB. Subsection (1) basically places judgment about the exercise of that power in the hands of the Secretary of State. It is his opinion that counts, and no attempt is required to evidence-proof a failing. HSSIB is apparently unable to challenge that judgment. Subsection (5) states that that failure only has to be a failure to exercise its functions properly. That is qualified a little by subsection (1)(b), which says that the failure has to be significant, but unfortunately that is what the Secretary of State considers significant, nobody else. With all that together, the Secretary of State has pretty much a blank cheque to step in and interfere any time he likes, so long as he considers that there has been a significant failure.

However, it gets worse. Subsection (2) allows the Secretary of State to direct HSSIB in whatever manner he determines, which I would have said is about as far away from independence as we can get—until I read subsection (4), which allows the Secretary of State to step into HSSIB's shoes and do its job himself. I am sure he has other things in his diary at the moment, but the idea that he can come in and undertake the functions of what is meant to be an independent body is simply unacceptable. I can do no better than refer to the evidence that Keith Conradi gave to the Committee:

"Ultimately, we end up making recommendations to the Department of Health and Social Care, and in the future I would like to ensure that we have that complete freedom to be able to make recommendations wherever we think that they most fit."—[*Official Report, Health and Care Public Bill Committee,* 7 September 2021; c. 60, Q78.]

The Secretary of State having the power to effectively step in and start running the body, either directly or indirectly, at a moment's notice, will not help with that freedom. Why does that need to be in the Bill and hanging over the body the whole time?

There is a suggestion that the Health and Social Care Committee would be better placed to administer this function, or at the very least that the Secretary of State should require its agreement before exercising this function. I agree that that Committee might be better placed than one person to have oversight of HSSIB. Perhaps we should consider which group will be best placed to have oversight of HSSIB, to ensure that it is truly independent.

The Secretary of State is tasked with carrying out a review of HSSIB. I am pleased that any subsequent report would be laid before Parliament, but again it is the Secretary of State undertaking that review—his judgment alone. Clause 114 says that the report must be laid within four years of the Bill's passage. Is there a particular reason why four years was chosen? I am sure the Minister anticipated that question, so I hope he will be able to answer. My reading of the clause is that a report is required after four years, and after that there is no further requirement. It seems rather remiss for there to be no ongoing commitment to review HSSIB.

On clause 113, there are concerns that the oversight of HSSIB will be carried out by the same person who appoints its members, can remove them at a whim, sets remuneration, directs investigations, sets the funding and consents to the criteria of processes. There appears to be a clear conflict of interest. While I accept that there is a role for the Secretary of State, it is not necessary for this role to be so far reaching and overbearing. HSSIB is meant to be an independent non-departmental public body, but the role given to the Secretary of State throughout the Bill suggests that that will not quite be the case. The Bill firmly situates its functions under the Health Secretary, which is far from the definition of a non-departmental public as separate body from the sponsoring Department. Non-departmental public bodies tend to be responsible to Parliament, rather than the Government. Placing scrutiny powers with Parliament and ensuring that a framework document is in place to inform the basis of performance monitoring, rather than placing all the power in the Secretary of State's hands, would be the best way to achieve this.

I have to say that the fact that the Secretary of State can pretty much pick all the main players in HSSIB does not say much about his confidence in his own judgment about these decisions, if he needs these sweeping powers up his sleeve just in case. I suspect that he was not the person responsible for these appointments, but the point remains that there are still questions over whether this is needed. I know the Minister said that this power would hopefully not be used, but if that is the case, why does it need to be in the Bill?

11 am

I have not heard any justification of why these powers are needed. We know that the Lansley idea of an independent NHS has now had its day, but HSSIB really is not meant to be considered in that same envelope; it is meant to be independent. We cannot see what the advantage will be of having this on the statute book now. We can only see downsides. It again risks confidence

that those who work with this body will be subject to interference at some later point. I will end on a quote from Keith Conradi. Again, he said that the

"independence of the system is crucial for the success and the credibility of the organisation."—[*Official Report, Health and Care Public Bill Committee,* 7 September 2021; c. 60, Q78.]

I am not satisfied that the provisions of oversight allow for its independence to be maintained.

The Joint Committee on the Draft Health Service Safety Investigations Bill highlighted the need for a mechanism to be put in place to review the effectiveness of the new body, and it put forward the recommendation that

"HSSIB be subject to a post-legislative review, three years after HSSIB starts its work".

I wonder whether that is a better way of doing things, rather than placing all the power in the hands of the Secretary of State, who, even on the Minister's own admission, is not I hope going to have to use it.

Edward Argar: I am grateful to the shadow Minister for his comments. I semi-predicted where I thought he might be going with his challenges, and I hope I can offer him reassurance.

First, at the heart of this is the fact that with an NDPB, an executive agency or any other public body, ultimately the Secretary of State is accountable, quite rightly, to this place for the operation of that—not for the operational decisions, but that it functions as an effective public body. Therefore, we never know, but I suspect that there may be a day—not necessarily in the immediate or near future—when the hon. Gentleman is sitting in my office or the Secretary of State's office, and he would want, quite rightly, where there is a significant failure of an organisation, to be able to take action to address that. That is what the clause provides for.

Those powers would be used only in extremis, and only where

"HSSIB is failing or has failed to exercise any of its functions, and…the failure is significant."

These are terms of which there is a legal understanding. It is not carte blanche for the Secretary of State, as I think the hon. Gentleman suggested in a debate on a previous clause, to get up one morning and say, "Do you know what I feel like doing? I feel like exercising these powers." It is not possible to do it in that way. These are understood terms that set a very high bar for interventions.

Secondly, these powers are analogous to similar powers that the Secretary of State has over other NDPBs, or the CQC, as I said in my opening remarks, and other organisations in this space.

Justin Madders: I am not suggesting that anyone might wake up in the morning and decide on a whim to do this, but the fact of the matter is that, as the clause is drafted, if the Secretary of State was minded to do that, there is nothing that would stop them being able to do it, is there?

Edward Argar: I come back to the point that I have just made to the hon. Gentleman. Terms such as "the failure is significant" are understood terms, and of course public law principles would apply to decisions made by the Secretary of State, such as reasonableness and proportionality. I do think that this is both analogous to powers that the Secretary of State has over similar bodies and also proportionate.

Similarity, I do not believe that the clause questions or brings into question the independence of HSSIB. We recognise that that is fundamental to its success, and that is why it would be used only if the body

"is failing or has failed…and…the failure is significant."

I come back to those understood terms, and that is a very high bar that would be subject to public law principles.

On the report that the hon. Gentleman mentioned, why is it four years—why not three, two or five? We think that four years is an appropriate and reasonable length of time for the new body to become established and to show what is working and what is not, so that we can see a meaningful report on how it has functioned over a number of years. As he said, the House would have the ability to debate that report, if it chose to do so. The report would be laid before the House and he could call a debate, if he was still in the same role at that point. Given that he has served in his Front-Bench role even longer than I have served in mine, I suspect that, much though he enjoys doing so, he may be hoping for a change by then.

The other point is that, just because this is the only report that is formally specified, it does not mean that there would not be the opportunity for other reports or reviews to be undertaken regularly. As the hon. Gentleman knows, we do that with other public bodies from time to time. It is right that Governments of whichever complexion review the NDPB landscape. We talked about ALBs earlier in our consideration of the Bill, and about the ability to move functions around depending on whether they are best exercised by the existing body or elsewhere, which reflects the same point.

I hope that gives the hon. Gentleman some reassurance that there is no desire on the part of the Secretary of State or me to add to our current workload, or indeed, should the day come, to add to the hon. Gentleman's workload, were he to occupy this office—or indeed to that of the hon. Member for Nottingham North, whom I would not wish to exclude. The words used and the public law principles that apply would mean that the provisions would be commensurate with the powers over other bodies, and proportionate. I commend the clause to the Committee.

Question put, That the clause stand part of the Bill.

The Committee divided: Ayes 10, Noes 5.

Division No. 32|

AYES

Argar, Edward	Gideon, Jo
Crosbie, Virginia	Higginbotham, Antony
Davies, Gareth	Robinson, Mary
Davies, Dr James	Timpson, Edward
Double, Steve	Williams, Hywel

NOES

Foy, Mary Kelly	Owen, Sarah
Madders, Justin	
Norris, Alex	Smyth, Karin

Question accordingly agreed to.

Clause 113 ordered to stand part of the Bill.

Clause 114 ordered to stand part of the Bill.

Clause 115

OFFENCES BY BODIES CORPORATE

Question proposed, That the clause stand part of the Bill.

The Chair: With this it will be convenient to consider the following: Clause 116 stand part.

Clause 118 stand part.

That schedule 15 be the Fifteenth schedule to the Bill.

Clause 119 stand part.

Edward Argar: These clauses cover further detail regarding offences created in part 4 of the Bill and interpreting part 4 of the Bill more generally. Clause 115 specifies that when an offence created by part 4 is committed by a company, an officer of that company may also be liable for that offence. This would be the case where it could be proven that such an offence was committed with the consent or involvement of an officer of the company or that such an offence could be attributable to neglect by an officer of the company. Hence the officer and the company who commit the offence are both liable and can be punished accordingly. Company officers who are liable in such a way would include any person who would purport to act in that capacity, including any directors or managers in the company.

It is important that any offences set out in part 4 of the Bill are capable of being fully enforced, and this means ensuring that the right actors are held to account and are therefore also deterred from committing such offences in the first place. Ensuring that both an individual and an organisation can be held to account shows clearly the commitment to maintaining a high standard of investigation and information protection, and to protecting the principles of safe spaces more widely.

Clause 116 specifies that when an offence created by part 4 of the Bill is committed by a partnership, a partner may also be liable for that offence. This would be relevant in an instance where, for example, a GP partnership commits an offence. The clause allows proceedings to be brought in the name of the partnership as well as the individual partners. Similarly to clause 115, where an offence is committed by an partnership and it can be proven that such an offence was committed with the consent or involvement of a partner or could be attributable to neglect by a partner, the partner and the partnership that commit the offence are both liable and can be punished accordingly. The clause also provides that where a fine is imposed on the partnership, it must be paid out of partnership assets. However, should a fine be imposed on a partner, that fine would be paid by the partner as an individual.

The committing of offences set out in part 4 of the Bill would reduce trust in HSSIB's investigatory processes, and therefore it is important that the right actors are held to account should such offences be committed. Ensuring that both the partnership and individual partners can be so held to account is important for the same reasons I have discussed in relation to company officers under clause 115. The corporate structure itself should not make any difference: we want to ensure that the investigatory process and the principles of safe space are always upheld and protected. Both clause 115 and 116 are common provisions in relation to offences. They ensure that the appropriate actors are covered, but also add a further deterrent effect that can help avoid offences being committed in the first place.

Clause 118 inserts schedule 15 into the Bill. Schedule 15 makes the relevant consequential amendments to other Acts of Parliament to ensure that HSSIB, as a new non-departmental public body, is referenced in relevant legislation. This includes relevant public body, health, employment and equalities legislation and means that HSSIB must comply with the relevant legislation, such as the Freedom of Information Act.

Finally, clause 119 sets out the defined terms used in part 4 of the Bill. The clause is crucial to ensuring that the HSSIB provisions are correctly interpreted and provides the necessary clarity on key terms. I therefore commend these clauses and this schedule to the Committee.

Justin Madders: I am not going to spend an awful lot of time on these clauses and this schedule, because the Minister has set them out very well, but I want to come back to his reference to clause 110 and the obligations on those who hold senior positions in NHS bodies. Regarding offences committed, the Minister said that there would not be the same need for punishments to follow failure to co-operate. I wonder whether that is consistent. Could he set out how offences committed by officers of a body corporate could be equated to offences committed by those who are running NHS bodies, or whether there is any discrepancy there that he would like to address?

Edward Argar: I will also endeavour not to detain the Committee for too long. I do not believe there is any discrepancy; I believe there is consistency there. The shadow Minister has highlighted what is essentially a technical point in the read-across between the two, and over the next couple of hours I will quickly check on that to make sure that I am right. I do not think there is any inconsistency there, but he has raised an interesting technical point, and I will review it. I hope he will forgive me if I do not give a technical answer right now, but I may shoehorn it in somehow this afternoon, keeping it in order by relating it to a clause that we will discuss subsequently. That will be a challenge, because we are about to finish the HSSIB clauses, but if there is anything to add to what I have just said, I will endeavour to work it in later this afternoon.

Question put and agreed to.

Clause 115 accordingly ordered to stand part of the Bill.

Clauses 116 to 118 ordered to stand part of the Bill.

Schedule 15 agreed to.

Clause 119 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. —*(Steve Double.)*

11.15 am

Adjourned till this day at Two o'clock.