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Tuesday
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PARLIAMENTARY DEBATES
(HANSARD)

HOUSE OF LORDS
OFFICIAL REPORT

ORDER OF BUSINESS

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The first time a Member speaks to a new piece of parliamentary business, the following abbreviations are used to show their party affiliation:

Abbreviation	Party/Group
CB	Cross Bench
Con	Conservative
DUP	Democratic Unionist Party
GP	Green Party
Ind Lab	Independent Labour
Ind LD	Independent Liberal Democrat
Ind SD	Independent Social Democrat
Ind UU	Independent Ulster Unionist
Lab	Labour
Lab Co-op	Labour and Co-operative Party
LD	Liberal Democrat
LD Ind	Liberal Democrat Independent
Non-afl	Non-affiliated
PC	Plaid Cymru
UKIP	UK Independence Party
UUP	Ulster Unionist Party

No party affiliation is given for Members serving the House in a formal capacity, the Lords spiritual, Members on leave of absence or Members who are otherwise disqualified from sitting in the House.

House of Lords

Tuesday 29 October 2019

2.30 pm

Prayers—read by the Lord Bishop of Durham.

Introduction: Lord Ranger

2.38 pm

Raminder Singh Ranger, CBE, having been created Baron Ranger, of Mayfair in the City of Westminster, was introduced and took the oath, supported by Lord Leigh of Hurley and Baroness Vere of Norbiton, and signed an undertaking to abide by the Code of Conduct.

Introduction: Lord Mann

2.45 pm

John Mann, Esquire, having been created Baron Mann, of Holbeck Moor in the City of Leeds, was introduced and made the solemn affirmation, supported by Lord Clarke of Hampstead and Lord Sacks, and signed an undertaking to abide by the Code of Conduct.

Retirement of a Member: Lord Carswell

Announcement

2.49 pm

The Senior Deputy Speaker (Lord McFall of Alcluith): My Lords, I should like to notify the House of the retirement, with effect from today, of the noble and learned Lord, Lord Carswell, pursuant to Section 1 of the House of Lords Reform Act 2014. On behalf of the House, I should like to thank the noble and learned Lord for his much-valued service to the House.

Electric Scooters

Question

2.50 pm

Asked by ***Lord Naseby***

To ask Her Majesty's Government what assessment they have made of the impact of the use of electric scooters on public roads and pavements on (1) road users, and (2) pedestrian safety.

The Parliamentary Under-Secretary of State, Department for Transport (Baroness Vere of Norbiton) (Con): My Lords, to date, no assessment has been made of the impact of electric scooters on either road or pedestrian safety, as they are illegal to use on public roads, cycle lanes and pavements. However, the department is reviewing regulations that apply to electric scooters and similar vehicles as part of the *Future of Mobility* urban strategy. Safety considerations will be part of that review.

Lord Naseby (Con): Is my noble friend aware that well over 1,000 incidents have been reported to the police—and not all police forces even record the figures involved? Can she assure the House that the department's review will look at specifications of electric scooters to ensure that they have brakes, lights and stability? Will it consider imposing an age limit of 16 or above? Finally, will she ensure that the review is detailed and will not require further legislation over and beyond what arises from it, bearing in mind that when the issue of drones arose, we had to have about four bites at the cherry?

Baroness Vere of Norbiton: My noble friend raises a number of important issues. The strand of the regulatory review that will be looking at micromobility, which covers e-scooters, will look at vehicle requirements, user requirements—for example, age, helmets and insurance—whether they should be used on the roads or elsewhere, and the service provider requirements. On his second point about future legislation, we intend to build an agile legislation and regulatory system, because who knows where we will go beyond these scooters? It is important that legislation can keep up.

Lord Mackenzie of Framwellgate (Non-Afl): My Lords, I cut my teeth dealing with people cycling on footpaths many years ago—perhaps I had more time than most people have now. The Minister mentioned that such use of these scooters was an offence. Does that attract a fixed penalty rather than the full rigour of the law, because that makes it a lot easier for the police to enforce the law?

Baroness Vere of Norbiton: The noble Lord is quite right. As I mentioned, it is illegal to ride e-scooters on any land that is not private. The police can enforce the matter, they can issue fines and can sometimes confiscate the scooter.

Baroness Randerson (LD): My Lords, I have hired electric scooters in countries where it is legal to do so. Dockless bike hire schemes in this country cause similar problems with disposal and parking at the end of the hire period. They are left lying around and cause an obstruction. Do the Government accept that at least part of the answer lies in giving local authorities more power to regulate and manage bike and scooter hire schemes?

Baroness Vere of Norbiton: I cannot guarantee to the noble Baroness exactly where we will end up in the relationship between local authorities and hire scheme providers, but she is quite right to say that different countries and different cities have taken different approaches. For example, in Barcelona, there are only hire shops—you cannot just pick up one of these things from the streets—but in Paris, for example, they are currently legislating to treat e-scooters much like e-bikes. Different countries are doing different things. I want to ensure that we do the right thing for London and other big cities where, no doubt, such schemes would take off.

Baroness Bull (CB): My Lords, can the noble Baroness clarify whether there is currently a requirement for dockless e-bike operators to have any kind of licence, given that they are effectively trading on a public highway? Does it not seem slightly odd that there is no requirement for them to have some kind of regulation in place?

Baroness Vere of Norbiton: I will have to write to the noble Baroness on that point. It is my impression that they do not require a specific licence per se but I will have to check that with officials.

Lord St John of Bletso (CB): Is the Minister aware of the new laws introduced recently in France that ban the riding of e-scooters on pavements and, most importantly, limit the speed, make wearing safety gear compulsory and ban e-scooters altogether on country roads?

Baroness Vere of Norbiton: I am aware that the French are taking matters forward. They have a maximum speed limit of 20 kilometres per hour; in Barcelona, for example, the maximum speed limit is 30 kilometres per hour. Different countries are doing different things. For example, in France, the minimum age to ride one of these scooters is eight, but there is a licensing scheme for the hire scheme. We are looking at all those things but I cannot guarantee that an age limit of eight is the right one.

Lord Elton (Con): Does my noble friend agree that it would be a wasted opportunity if, in the review, something is not done to deal with bicyclists who whizz along the pavement, zigzagging all over the place?

Baroness Vere of Norbiton: I cannot guarantee for my noble friend that that issue will form part of this specific review because, as I said, it is about the future of mobility and urban strategy, and the micromobility types of transport that will come forward in future.

Lord Rosser (Lab): Can the Minister tell us the extent to which people are being fined or charged for using an e-scooter contrary to the law? I ask that as one gets the impression, rightly or wrongly, that that is rarely the case. Are the Government of the view that it is probably better for such action not to be taken against those using e-scooters, pending the outcome of the review?

Baroness Vere of Norbiton: The noble Lord will know that enforcement is an operational matter for the police but I reassure him that over a one-week period in July, 100 people were stopped on the streets of London and were issued with fines; some of them had their e-scooters confiscated. I disagree with the noble Lord that, pending the regulatory review, we should not enforce. We do not know the outcome of the review; it is certainly our view at this time that we cannot guarantee that any changes to regulations will be made.

Lord McNicol of West Kilbride (Lab): I declare an interest as somebody who used one of these e-scooters over the summer while on holiday in Paris. It was actually very enjoyable. May I encourage some proportionality in looking at the legislation and laws when they are brought in?

Baroness Vere of Norbiton: I am so pleased that the noble Lord enjoyed his trip on an e-scooter. I too have ridden one—indoors, at the party conference. He is completely right: we do not intend to shut the door on all these different and new types of transport, which are incredibly important to all sorts of people. Safety is our priority; that is the number one factor.

Net Zero Carbon Emissions

Question

2.58 pm

Asked by ***Lord Berkeley***

To ask Her Majesty's Government what plans they have to give new duties to regulators to promote the achievement of net zero carbon emissions by 2050, as recommended in the National Infrastructure Commission Report *Strategic Investment and Public Confidence*, published on 11 October.

The Parliamentary Under-Secretary of State, Department for Business, Energy and Industrial Strategy and Northern Ireland Office (Lord Duncan of Springbank) (Con): My Lords, the Government welcome the review by the National Infrastructure Commission. There are existing powers and duties in place for regulators in relation to decarbonisation. As we transition to net zero, regulators will need to continue to play their part in delivering this important goal. We are considering the commission's report carefully and will look at what additional guidance may be necessary to support our regulators in helping the UK to meet this vital commitment.

Lord Berkeley (Lab): I am grateful to the Minister for his response, because it is good to know that the Government are looking at this seriously. Does he agree that the three regulators that have been reviewed—Ofgem, Ofcom and Ofwat—have the opportunity to make an enormous difference to reducing our carbon emissions by 2050? Can he explain whether the same duties will be imposed on the Office of Rail Regulation, and on his department in respect of road transport and other transports, because they all have a big role to play?

Lord Duncan of Springbank: The noble Lord raises an important question. All must do their part and, wherever my department is responsible, it will ensure that there is serious communication between the individual agencies, all anchored to the 2050 net zero commitment.

Lord McColl of Dulwich (Con): My Lords, do we have all the scientific evidence to show that we can do anything to prevent climate change?

Lord Duncan of Springbank: We are anchored to the Intergovernmental Panel on Climate Change, and we have our own climate change committee putting the science at the heart of our work. However, the challenge we face is that we alone cannot bring about the necessary steps, so this must be a global endeavour. We are living through a new geological age which has been termed the Anthropocene—we are bringing about change in our very own environment.

Lord Ravensdale (CB): My Lords, I declare an interest as an engineer in the nuclear industry. New nuclear and a reset of the strategy for achieving it is critical to zero carbon by 2050, being the only mature option for the zero-carbon baseload or non-variable power. Can the Minister provide some assurance that the Government will maintain their focus on new nuclear initiatives such as investment in small modular reactors and the regulated asset based funding model to enable new nuclear beyond Hinkley to move forward?

Lord Duncan of Springbank: I am happy to assure the noble Lord that nuclear will remain part of our strategy. It is indeed a low-carbon approach. We are strongly committed to small modular reactors and right now we need a baseload to complement our renewable electricity supply.

Lord Fox (LD): My Lords, when the Minister and his department review the infrastructure report, will he also take into consideration the words of Ofgem, whose annual summary of trends was published this month. It says that the decarbonisation of energy has retracted to its,

"slowest rate of decline since 2012".

There is a disconnect between the Government's target of 2050 and what is actually happening. Can he tell us what Her Majesty's Government are doing to reverse that trend, and when will the decarbonisation of energy start to accelerate again?

Lord Duncan of Springbank: It is sometimes difficult to assess the rate at which we are decarbonising, but I can assure the noble Lord that, as we continue to phase out coal and to work carefully with the domestic heating approach, we are on track to meet our 2050 commitments. It will be a challenge, and all must do their part.

Baroness Jones of Moulsecoomb (GP): My Lords, the Government's terms of reference for the National Infrastructure Commission actually require it not to have a significant impact on the public balance sheet. That seems to me absolutely bizarre, because the Government have an objective to get to net zero emissions but they do not want to invest in the solutions.

Lord Duncan of Springbank: The answer to the point raised by the noble Baroness is that we need to invest very carefully and very substantially. There will be impacts across our entire economy—all will have to do their part. The Government will examine this report very carefully indeed, along with the terms of reference going forward.

Lord Hamilton of Epsom (Con): My Lords, will much of the cost of net zero emissions by 2050 be transferred on to energy prices? If that is the case, will that not make us increasingly uncompetitive in the world and wipe out what remains of our heavy industries?

Lord Duncan of Springbank: We face a challenge going forward to achieve the net zero target by 2050. We have to remember that this is not all about energy regeneration itself because there are other areas that we need to consider, not least the decarbonisation of our transport network. Each of these elements will have a cost that, whether we like it or not, will eventually fall on taxpayers or individual consumers. That is where the money will ultimately come from.

Lord Grantchester (Lab): My Lords, while the regulators need these additional powers to enhance public confidence in combating climate change, can the Minister explain how the net zero target can be achieved by 2050 when the Government's own target continues to exclude aviation and shipping?

Lord Duncan of Springbank: The useful answer to the question is that we rely heavily on the Committee on Climate Change. Only this week, I had a meeting with its chief executive to examine shipping and aviation and to explore the manners and means by which we can ensure that they too are wedded to the necessary decarbonisation. I believe that they will be able to help us deliver on that very difficult and challenging point.

Baroness McIntosh of Pickering (Con): My Lords, will my noble friend explain to the House the contribution that energy derived from waste recovery plants are making to zero carbon emissions? In particular, will he ensure that, rather than the electricity generated by them going to the national grid, it will go to local homes to reduce their heating costs, particularly in the north of England?

Lord Duncan of Springbank: My noble friend has raised a point to which I do not have the exact answer. If she will permit, I will write to her setting out exactly how much energy is generated from waste and whether it plugs into either the local or the national grid.

Baroness Whitaker (Lab): My Lords, the noble Lord will agree that if we want to make a real impact on climate change we have to get fossil fuels out of the system. In that respect, what are the Government going to do about phasing out the use of domestic gas boilers?

Lord Duncan of Springbank: I might ask the noble Baroness the same question. Everyone here is of course available to phase out their gas boilers. The challenge, however, is doing so in a manner that does not increase the cost per household and we must continue to address fuel poverty which remains a challenge. That will be revealed next year when we put together our plan setting out how to decarbonise domestic heating structures.

Lord Elton (Con): My Lords, at the risk of irritating my noble friend, can he answer my noble friend Lord McColl of Dulwich who asked for evidence that all this activity would have the desired result?

Lord Duncan of Springbank: My noble friend is never an irritant. I am happy to put a letter together setting out the evidence which we are using to ensure that we are basing our future prospects in terms of decarbonisation on sound, solid and verifiable science.

Government Spending

Question

3.05 pm

Asked by ***Lord Haskel***

To ask Her Majesty's Government what is the fiscal framework within which they are making their spending promises.

Lord Bethell (Con): My Lords, the Government have brought the deficit down by four-fifths since 2010. With a strong fiscal position and close-to-record low costs of borrowing, we can invest more in our growing economy and public services. The spending round was

[LORD BETHELL]
delivered in line with existing fiscal targets in the *Charter for Budget Responsibility*. The Government are reviewing these and will maintain a clear set of rules to anchor our fiscal policy.

Lord Haskel (Lab): I thank the Minister for that reply, but it does not tell us what we can afford: it tells us the Government's hopes and aspirations. Yet the Office for National Statistics tells that the public finances are getting worse, borrowing is going up, income from taxes is going down and our deficit is increasing. Does he not agree that in these circumstances a constant stream of spending promises and tax cuts without some sort of credible fiscal framework is irresponsible, reckless and not the action of a serious Government?

Lord Bethell: My Lords, the situation described is not one that I recognise. A thousand extra people are in work every day since 2010. The deficit is down by four-fifths from its peak of 10% in 2009-10 to 1.9% in 2018-19, and wages currently outpace inflation. Productivity is a challenge. It is not performing as we would like—it has stalled since the financial crisis—which is of deep concern to the Government. Historic low interest rates for borrowing costs are a big opportunity. That is why the Chancellor has made it clear that the fiscal rules are under review and, when we have a chance to have a Budget, those will be made clearer.

Baroness Fall (Con): My Lords, can we not agree that it was disappointing that the former Labour Prime Minister was not able to get rid of boom and bust? With that in mind, will my noble friend agree that, when the economy is doing well, we must be careful not to ratchet up debt so that when we hit more difficult times we are resilient?

Lord Bethell: My noble friend puts it very well. Debt is central to the Government's plans. We will maintain a clear set of rules to anchor our fiscal policy and keep control of our debt. But we have to face up to the challenge of productivity to invest in education, skills, and the physical and public service infrastructure of the country, and the opportunity presented by low rates of interest is one that we should review and take seriously.

Baroness Kramer (LD): My Lords, the IFS has been very clear that the Government are now set to blow through their fiscal ceiling next year with excessive borrowing. I will pick up the point made by the noble Baroness on the Minister's own side. Having seen that Labour failed to keep an adequate cushion in 2008, therefore setting us into a pattern of bust and austerity, why are this Government going on a spending spree that repeats exactly that pattern—and in a context of Brexit, when the economy would be weaker than it has been in decades?

Lord Bethell: I am not sure that the noble Baroness can have it both ways. The need for investment in physical infrastructure, training and skills is urgent. Keeping a lid on debt is also important. I note that the IFS also recommended in the report to which she referred that the Government should delay setting any fiscal rules until greater certainty over EU exit was confirmed. In the meantime, the Government are pushing hard for a deal and will continue to do so.

Lord Tomlinson (Lab): My Lords, will the Minister agree—I somehow think he might not—that the Chancellor is as frivolous in fiscal discipline and monetary rectitude as his colleague the Prime Minister is in keeping his promises? We have only to look at 31 October —do or die, dying in a ditch, and all the other things that we have had to live with. Does the Minister agree that the Chancellor is following in the very bad habit of making promises that he has no intention or capacity to keep?

Lord Bethell: My Lords, I was desperately searching for something I could possibly agree with in the noble Lord's analysis, but there is nothing. The Chancellor is taking extremely pragmatic, well-judged decisions on investment in infrastructure for the country. These investments have been called for by business, the trade unions and professional groups. His decisions are thoroughly sensible and are supported by many noble Lords on all sides of the House.

Lord Davies of Oldham (Lab): My Lords, how do we know that the Chancellor is involved in judicious taking of decisions? He introduced a spending round without any suggestion about how it would be paid for. He was then given, by the grace of the Prime Minister, a date for a Budget. That has now been abandoned. Meanwhile the Office for Budget Responsibility, which is under an obligation to give an objective analysis of the Government's proposals with regard to the economy and which is likely to produce a very different analysis from that which the Minister has presented to this House today, cannot pronounce until there is a Budget. Are not the Government glib on spending but entirely evasive on how they intend to pay for anything?

Lord Bethell: The last spending round was based on the Office for Budget Responsibility's forecast in March. As the noble Lord said, there will be a further report from the Office for Budget Responsibility when there is the next Budget.

Noble Lords: When?

Lord Bethell: We will find out later today or tomorrow when that Budget is likely to be. It is beyond my competence to predict that date, but I reassure the noble Lord that if there is any review of the *Charter for Budget Responsibility* it will be subject to a vote in the Commons and to a debate here in the Lords. I look forward to being part of that debate.

Prisons

Question

3.13 pm

Asked by ***Lord Lee of Trafford***

To ask Her Majesty's Government what plans they have to replace Victorian-era prisons with more modern facilities.

Baroness Berridge (Con): My Lords, since 2010, 20 prisons have closed, the majority of which were built prior to 1900, and four prisons and 11 house

blocks were opened. Due to predicted changes in the prison population, no further closures are currently planned, save for those that have already been announced. The Prime Minister has committed £2.5 billion to build 10,000 new additional places. I hope the noble Lord is pleased to learn that it is the Government's ambition to close old, inefficient prisons, but we cannot yet commit to closures of specific sites.

Lord Lee of Trafford (LD): My Lords, I am sure that the Minister is personally ashamed of the size of the prison population, the violence, the self-harm, the drugs, the overcrowding and the £900 million maintenance backlog. Appearing before the Select Committee last week, the Prisons Minister, Lucy Frazer, acknowledged that even more prisoners were expected. She said:

"That will mean we need to keep our Victorian prisons in operation".

Clearly the bang 'em up brigade is back in charge. When asked about the number of prisoners who suffer from a mental health problem, she replied:

"We have that number … I do not know whether I can share the number with you; it is way too high".

Parliament is entitled to know that number. What is it?

Baroness Berridge: My Lords, I am grateful to the noble Lord for giving me advance notice. The statistic that I have been provided with from a 2015 Ministry of Justice survey is that 40% of male remand prisoners have a common mental health problem. I agree with the noble Lord that that figure is too high, but I assure him that mental health training and specific self-harm and suicide prevention have been introduced into the basic prison officer training. Over 25,000 new and existing staff have completed at least one module of that latter training and 14,000 have completed the specific mental health module. I am also pleased to tell the noble Lord that the Samaritans were given £500,000 last year, and there is a commitment to give that amount every year for three years to help vulnerable prisoners.

Lord Beecham (Lab): In every year since 2014 the Government have proposed to increase our overcrowded and all-too-often squalid prisons by 10,000 extra places. Despite having among the highest incarceration rates in Europe, they have failed both to achieve their own target, now reiterated by the Prime Minister, or even to replace dismal Victorian buildings as promised. How long are prisoners and prison staff expected to endure what the Prison Reform Trust describes as a policy that is likely to make overcrowding worse and produces an indecent prison system that puts lives at risk—and that is before taking into account the Prime Minister's aspiration to promote longer sentences?

Baroness Berridge: My Lords, I am grateful to the noble Lord for his question. Since 2010 there has been a net increase in the number of places of just over 1,100. It is precisely to avoid an increase in crowding that the Victorian estate cannot be closed at this time. Ten thousand new places will come on line, and an additional 3,000 are committed to at Wellingborough and Glen Parva. Central to the modernisation programme is to get back to the point in 2015 when new prison places came on line without an increase in crowding.

Lord Bird (CB): Would it not be very interesting to spend much more time on rehabilitation? That would reduce the need to put people in prison, as they would not be committing crime.

Baroness Berridge: The noble Lord is correct that, of all crime committed, about three-quarters is due to reoffending. There has therefore been an overhaul in relation to education and employment in prisons. The budget has been devolved to governors so that they can commission the education required for their prison populations. Prisoners are now assessed in basic maths and English when they enter prison, with a view to increasing their educational attainment. In relation to the noble Lord's specific concern—homelessness—some of the money for the rough sleeping strategy has been passed to a project within the Prison Service to identify prisoners who are at risk of rough sleeping when they are discharged. A project to provide a support worker and accommodation for two years upon release has just started in Bristol, Leeds and Pentonville prisons. Therefore, those matters are being taken seriously and rehabilitation is obviously a core part of the prison system.

The Lord Bishop of Winchester: I am sure that many of us will have watched some of the programmes in the "Crime and Punishment" series, which featured Her Majesty's Prison Winchester, a Victorian prison. The programmes highlighted problems of building maintenance, staff shortages and a large number of attacks on staff—441 in the year 2018-19. Can the Minister confirm what action Her Majesty's Government will take to address the staff shortages and training needs among prison officers generally, in addition to the prison improvements announced in recent days?

Baroness Berridge: I am grateful to the right revered Prelate. I happened upon exactly that series and watched with interest the challenges faced by the—at that time—female governor of Her Majesty's Prison Winchester. The recruitment of staff has in fact gone better than expected; 2,500 prison officers were recruited seven months ahead of schedule. However, there are increasing needs in relation to training and, particularly, violence reduction. We are keen to protect staff and have introduced body-worn cameras for them, as well as artificial pepper spray. I do accept that there have been challenges within that estate. More money is now committed to maintenance to ensure that the Victorian prisons, which we need to keep as part of our capacity, will have the repairs that they need.

Lord Cormack (Con): I congratulate my noble friend the Minister on the clarity of her answers. Can she try, before the end of this Parliament, to find out the latest statistics? She quoted statistics from 2015 to the noble Lord, Lord Lee of Trafford, but they are surely a bit out of date.

Baroness Berridge: Yes, I will undertake to obtain more-up-to-date statistics. If there has been a survey since 2015, I will of course provide that information before the end of the Parliament, whenever that may be.

Domestic Premises (Energy Performance) Bill [HL]

3.20 pm

A Bill to require the Secretary of State to ensure that domestic properties have a minimum energy performance rating of C on an Energy Performance Certificate; to make provision regarding performance and insulation of new heating systems in existing properties; and for connected purposes.

The Bill was introduced by Lord Foster of Bath, read a first time and ordered to be printed.

Policing Resources Bill [HL]

3.21 pm

A Bill to make provision to ensure that the police forces in England and Wales have sufficient resources to deliver police services; and for connected purposes.

The Bill was introduced by Lord Wigley, read a first time and ordered to be printed.

Financial Services Duty of Care Bill [HL]

3.21 pm

A Bill to require the Financial Conduct Authority to make rules for authorised persons to owe a duty of care to consumers in their regulated activities.

The Bill was introduced by Lord Sharkey, read a first time and ordered to be printed.

Referendums Criteria Bill [HL]

3.21 pm

A Bill to make provision concerning referendums within the United Kingdom on constitutional or parliamentary arrangements.

The Bill was introduced by Lord Cormack, read a first time and ordered to be printed.

Deputy Chairmen of Committees

Membership Motion

3.22 pm

Moved by ***The Senior Deputy Speaker***

That, as proposed by the Committee of Selection, the following members be appointed as the panel of members to act as Deputy Chairmen of Committees for this session:

Andrews, B, Ashton of Hyde, L, Brougham and Vaux, L, Dear, L, Faulkner of Worcester, L, Finlay of Llandaff, B, Fookes, B, Garden of Frognal, B, Geddes, L, Haskel, L, Henig, B, Kinnoull, E, Lexden, L, Mar, C, McAvoy, L, McIntosh of Hudnall, B, Morris of Bolton, B, Newlove, B, Palmer of Childs Hill, L, Pitkeathley, B, Rogan, L, Simon, V, Ullswater, V.

Motion agreed.

House of Lords Commission Committee

Communications and Digital Committee

Conduct Committee

Constitution Committee

Delegated Powers and Regulatory Reform Committee

Economic Affairs Committee

European Union Committee

Finance Committee

Hybrid Instruments Committee

Liaison Committee

Parliamentary Office of Science and Technology (POST) Committee

Procedure Committee

Science and Technology Committee

Secondary Legislation Scrutiny Committee

Services Committee

Standing Orders (Private Bills) Committee

Human Rights Committee

National Security Strategy Committee

Statutory Instruments Committee

Democracy and Digital Technologies Committee

Social and Economic Impact of the Gambling Industry Committee

Membership Motions

3.22 pm

Moved by ***The Senior Deputy Speaker***

House of Lords Commission Committee

That a Select Committee be appointed to provide high-level strategic and political direction for the House of Lords Administration on behalf of the House and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Doocey, B, Evans of Bowes Park, B, Fowler, L, (Chair), Judge, L, Laming, L, McFall of Alcluith, L, (Deputy Chair), McIntosh of Hudnall, B, Newby, L, Smith of Basildon, B, Wakeham, L.

That Liz Hewitt and Mathew Duncan be appointed as external members of the Committee;

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House.

Communications and Digital Committee

That a Select Committee be appointed to consider the media, digital and the creative industries and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Allen of Kensington, L, Bull, B, Colville of Culross, V, Gilbert of Panteg, L, (Chair) Gordon of Strathblane, L, Grender, B, McInnes of Kilwinning, L, McIntosh of Hudnall, B, Meyer, B, Quin, B, Scott of Bybrook, B, Storey, L, Worcester, Bp.

That the Committee have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Communications Committee in the last session of Parliament be referred to the Committee;

That the evidence taken by the Committee be published, if the Committee so wishes.

Conduct Committee

That a Conduct Committee be appointed and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Anelay of St Johns, B, Brown of Eaton-under-Heywood, L, Donaghy, B, Hussein-Ece, B, Mance, L, (Chair).

That the following be appointed as lay external members of the Committee:

Cindy Butts, Mark Castle OBE, Andrea Coomber and Vanessa Davies;

That the quorum of the Committee shall be three Lords members and two lay members;

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee be published, if the Committee so wishes.

Constitution Committee

That a Select Committee be appointed to examine the constitutional implications of all public bills coming before the House; and to keep under review the operation of the constitution and constitutional aspects of devolution; and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Beith, L, Corston, B, Drake, B, Dunlop, L, Faulks, L, Fookes, B, Hennessy of Nympsfield, L, Howarth of Newport, L, Howell of Guildford, L, Pannick, L, Taylor of Bolton, B, (Chair), True, L, Wallace of Tankerness, L.

That the Committee have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee in the last session of Parliament be referred to the Committee;

That the evidence taken by the Committee be published, if the Committee so wishes.

Delegated Powers and Regulatory Reform Committee

That a Select Committee be appointed:

(i) To report whether the provisions of any bill inappropriately delegate legislative power, or whether they subject the exercise of legislative power to an inappropriate degree of parliamentary scrutiny;

(ii) To report on documents and draft orders laid before Parliament under or by virtue of:

(a) sections 14 and 18 of the Legislative and Regulatory Reform Act 2006,

(b) section 7(2) or section 19 of the Localism Act 2011, or

(c) section 5E(2) of the Fire and Rescue Services Act 2004;

and to perform, in respect of such draft orders, and in respect of subordinate provisions orders made or proposed to be made under the Regulatory Reform Act 2001, the functions performed in respect of other instruments and draft instruments by the Joint Committee on Statutory Instruments; and

(iii) To report on documents and draft orders laid before Parliament under or by virtue of:

(a) section 85 of the Northern Ireland Act 1998,

(b) section 17 of the Local Government Act 1999,

(c) section 9 of the Local Government Act 2000,

(d) section 98 of the Local Government Act 2003, or

(e) section 102 of the Local Transport Act 2008.

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Andrews, B, Blencathra, L, (Chair), Browning, B, Goddard of Stockport, L, Haselhurst, L, Haskel, L, Meacher, B, Rowlands, L, Thurlow, L, Tope, L.

That the Committee have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee in the last session of Parliament be referred to the Committee;

That the evidence taken by the Committee be published, if the Committee so wishes.

Economic Affairs Committee

That a Select Committee be appointed to consider economic affairs and business affairs and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Bowles of Berkhamsted, B, Burns, L, Chandos, V, Cunningham of Felling, L, Darling of Roulanish, L, Forsyth of Drumlean, L, (Chair), Fox, L, Harding of Winscombe, B, Kingsmill, B, Livingston of Parkhead, L, Skidelsky, L, Stern of Brentford, L, Tugendhat, L.

That the Committee have power to appoint a sub-committee and to refer to it any of the matters within the Committee's terms of reference; that the Committee have power to appoint the Chair of the sub-committee;

That the Committee have power to co-opt any member to serve on the sub-committee;

That the Committee and its sub-committee have power to send for persons, papers and records;

That the Committee and its sub-committee have power to appoint specialist advisers;

That the Committee and its sub-committee have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee in the last session of Parliament be referred to the Committee;

That the evidence taken by the Committee or its sub-committee be published, if the Committee so wishes.

European Union Committee

That a Select Committee be appointed:

(1) To consider European Union documents deposited in the House by a Minister, and other matters relating to the European Union;

The expression "European Union document" includes in particular:

(a) a document submitted by an institution of the European Union to another institution and put by either into the public domain;

(b) a draft legislative act or a proposal for amendment of such an act; and

(c) a draft decision relating to the Common Foreign and Security Policy of the European Union under Title V of the Treaty on European Union;

The Committee may waive the requirement to deposit a document, or class of documents, by agreement with the European Scrutiny Committee of the House of Commons;

(2) To assist the House in relation to the procedure for the submission of Reasoned Opinions under Article 5 of the Treaty on European Union and the Protocol on the application of the principles of subsidiarity and proportionality;

(3) To represent the House as appropriate in inter-parliamentary cooperation within the European Union;

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Brown of Cambridge, B, Cavendish of Furness, L, Couttie, B, Donaghy, B, Faulkner of Worcester, L, Hamwee, B, Jay of Ewelme, L, Kerr of Kinlochard, L, Kinnoull, E, (Chair), Lamont of Lerwick, L, Morris of Aberavon, L, Neville-Rolfe, B, Oates, L, Primarolo, B, Ricketts, L, Sharkey, L, Teverson, L, Verma, B, Wood of Anfield, L.

That the Committee have power to appoint sub-committees and to refer to them any matters within its terms of reference; that the Committee have power to appoint the Chairs of subcommittees, but that the sub-committees have power to appoint their own Chairs for the purpose of particular inquiries; that the quorum of each sub-committee be two;

That the Committee have power to co-opt any member to serve on a sub-committee;

That the Committee and its sub-committees have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee and its sub-committees have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee or its sub-committees in the last session of Parliament be referred to the Committee or its sub-committees;

That the evidence taken by the Committee or its sub-committees be published, if the Committee so wishes.

Finance Committee

That a Select Committee be appointed to support the House of Lords Commission by:

(1) Considering expenditure on services provided from the Estimate for the House of Lords,

(2) Reporting to the Commission on the forecast outturn, Estimate and financial plan submitted by the Management Board,

(3) Monitoring the financial performance of the House Administration, and

(4) Reporting to the Commission on the financial implications of significant proposals;

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Colgrain, L, Collins of Highbury, L, Cope of Berkeley, L, Courtown, E, Cromwell, L, Cunningham of Felling, L, Doocey, B, (Chair), Goudie, B, Kerslake, L, Stoneham of Droxford, L.

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House.

Hybrid Instruments Committee

That a Select Committee be appointed to consider hybrid instruments and that, as proposed by the Committee of Selection, the following members together with the Senior Deputy Speaker be appointed to the Committee:

Addington, L, Dykes, L, Grantchester, L, Harrison, L, Jenkin of Kennington, B, Swinfen, L.

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House; and

That the evidence taken by the Committee be published, if the Committee so wishes.

Liaison Committee

That a Select Committee be appointed to advise the House on the resources required for select committee work and to allocate resources between select committees; to review the select committee work of the House; to consider requests for ad hoc committees and report to the House with recommendations; to ensure effective co-ordination between the two Houses; and to consider the availability of members to serve on committees;

That, as proposed by the Committee of Selection, the following members together with the Senior Deputy Speaker be appointed to the Committee:

Bradley, L, Hayter of Kentish Town, B, Howe, E, Judge, L, Lang of Monkton, L, Low of Dalston, L, Smith of Hindhead, L, Tyler, L, Walmsley, B, Williams of Elvel, L.

That the Committee have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee have leave to report from time to time.

Parliamentary Office of Science and Technology (POST) Committee

That, as proposed by the Committee of Selection, the following Lords be appointed to the Board of the Parliamentary Office of Science and Technology (POST):

Haskel, L, Oxburgh, L, Patel, L, Winston, L.

Procedure Committee

That a Select Committee on Procedure of the House be appointed and that, as proposed by the Committee of Selection, the following members together with the Senior Deputy Speaker be appointed to the Committee:

Ashton of Hyde, L, Bew, L, Eames, L, Evans of Bowes Park, B, Harris of Richmond, B, Foulkes of Cumnock, L, Fowler, L, Geddes, L, Judge, L, McAvoy, L, Mancroft, L, Morris of Aberavon, L, Newby, L, Smith of Basildon, B, Stoneham of Droxford, L, Thomas of Winchester, B, Ullswater, V, Warwick of Undercliffe, B,

and that the following members be appointed as alternate members:

Browning, B, Finlay of Llandaff, B, Scriven, L, Turnbull, L.

That the Committee have power to appoint sub-committees and that the Committee have power to appoint the Chairs of sub-committees;

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House.

Science and Technology Committee

That a Select Committee be appointed to consider science and technology and that, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Borwick, L, Browne of Ladyton, L, Hilton of Eggardon, B, Hollick, L, Kakkar, L, Mair, L, Manningham-Buller, B, Patel, L, (Chair), Penn, B, Ridley, V, Rock, B, Sheehan, B, Walmsley, B, Young of Old Scone, B.

That the Committee have power to appoint sub-committees and that the Committee have power to appoint the Chairs of sub-committees;

That the Committee have power to co-opt any member to serve on the Committee or a sub-committee;

That the Committee and its sub-committees have power to send for persons, papers and records;

That the Committee and its sub-committees have power to appoint specialist advisers;

That the Committee and its sub-committees have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee or its sub-committees in the last session of Parliament be referred to the Committee or its sub-committees;

That the evidence taken by the Committee or its sub-committees be published, if the Committee so wishes.

Secondary Legislation Scrutiny Committee

That a Select Committee be appointed to scrutinise secondary legislation.

(1) The Committee shall report on draft instruments and memoranda laid before Parliament under sections 8, 9 and 23(1) of the European Union (Withdrawal) Act 2018.

(2) Paragraph (1) shall lapse upon the expiry of the power to make instruments under sections 8, 9 and 23(1) of the European Union (Withdrawal) Act 2018.

(3) The Committee shall, with the exception of those instruments in paragraphs (5) and (6), scrutinise—

(a) every instrument (whether or not a statutory instrument), or draft of an instrument, which is laid before each House of Parliament and upon which proceedings may be, or might have been, taken in either House of Parliament under an Act of Parliament;

(b) every proposal which is in the form of a draft of such an instrument and is laid before each House of Parliament under an Act of Parliament, with a view to

determining whether or not the special attention of the House should be drawn to it on any of the grounds specified in paragraph (4).

(4) The grounds on which an instrument, draft or proposal may be drawn to the special attention of the House are—

(a) that it is politically or legally important or gives rise to issues of public policy likely to be of interest to the House;

(b) that it may be inappropriate in view of changed circumstances since the enactment of the parent Act;

(c) that it may inappropriately implement European Union legislation;

(d) that it may imperfectly achieve its policy objectives;

(e) that the explanatory material laid in support provides insufficient information to gain a clear understanding about the instrument's policy objective and intended implementation;

(f) that there appear to be inadequacies in the consultation process which relates to the instrument;

(g) that the instrument appears to deal inappropriately with deficiencies in retained EU law.

(5) The exceptions are—

(a) remedial orders, and draft remedial orders, under section 10 of the Human Rights Act 1998;

(b) draft orders under sections 14 and 18 of the Legislative and Regulatory Reform Act 2006, and subordinate provisions orders made or proposed to be made under the Regulatory Reform Act 2001;

(c) Measures under the Church of England Assembly (Powers) Act 1919 and instruments made, and drafts of instruments to be made, under them.

(6) The Committee shall report on draft orders and documents laid before Parliament under section 11(1) of the Public Bodies Act 2011 in accordance with the procedures set out in sections 11(5) and (6). The Committee may also consider and report on any material changes in a draft order laid under section 11(8) of the Act.

(7) The Committee shall also consider such other general matters relating to the effective scrutiny of secondary legislation and arising from the performance of its functions under paragraphs (1) to (6) as the Committee considers appropriate, except matters within the orders of reference of the Joint Committee on Statutory Instruments.

That the Committee have power to appoint sub-committees and to refer to them any matters within its terms of reference; that the Committee have power to appoint the Chairs of sub-committees; that the quorum of each sub-committee be two;

The Committee's power to appoint sub-committees shall lapse upon the expiry of the power to make new instruments under sections 8, 9 and 23(1) of the European Union (Withdrawal) Act 2018 and shall lapse entirely upon expiry of the last such remaining power;

That the Committee have power to co-opt any member to serve on a sub-committee;

That the Committee and its sub-committees have power to send for persons, papers and records;

That the Committee and its sub-committees have power to appoint specialist advisers;

That the Committee and its sub-committees have leave to report from time to time;

That the reports of the Committee and its sub-committees be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee or its sub-committees in the last session of Parliament be referred to the Committee or its sub-committees;

That the evidence taken by the Committee or its sub-committees be published, if the Committee or its sub-committees so wish.

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Bakewell of Hardington Mandeville, B, Chartres, L, Cunningham of Felling, L, Faulkner of Worcester, L, Hanworth, V, Hodgson of Astley Abbotts, L, (Chair), Kirkwood of Kirkhope, L, Lindsay, E, Lisvane, L, Sherbourne of Didsbury, L, Watkins of Tavistock, B.

Services Committee

That a Select Committee be appointed to support the House of Lords Commission by:

(1) Agreeing day-to-day policy on member-facing services,

(2) Providing advice on strategic policy decisions when sought by the Commission, and

(3) Overseeing the delivery and implementation of both;

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Ashton of Hyde, L, Borwick, L, Campbell-Savours, L, Judge, L, Kirkwood of Kirkhope, L, Laming, L, (Chair), Morris of Bolton, B, Stoneham of Droxford, L, Touhig, L, Wheeler, B.

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House.

Standing Orders (Private Bills) Committee

That a Select Committee on the Standing Orders relating to private bills be appointed and that, as proposed by the Committee of Selection, the following members together with the Senior Deputy Speaker be appointed to the Committee:

Fellowes, L, Geddes, L, McColl of Dulwich, L, Naseby, L, Rodgers of Quarry Bank, L, Simon, V.

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee be published, if the Committee so wishes.

Human Rights Committee

That a Select Committee of six members be appointed to join with a Committee appointed by the Commons as the Joint Committee on Human Rights:

To consider:

(a) matters relating to human rights in the United Kingdom (but excluding consideration of individual cases);

(b) proposals for remedial orders, draft remedial orders and remedial orders made under section 10 of and laid under Schedule 2 to the Human Rights Act 1998; and

(c) in respect of draft remedial orders and remedial orders, whether the special attention of the House should be drawn to them on any of the grounds specified in Standing Order 73 (Joint Committee on Statutory Instruments);

To report to the House:

(a) in relation to any document containing proposals laid before the House under paragraph 3 of the said Schedule 2, its recommendation whether a draft order in the same terms as the proposals should be laid before the House; or

(b) in relation to any draft order laid under paragraph 2 of the said Schedule 2, its recommendation whether the draft order should be approved;

and to have power to report to the House on any matter arising from its consideration of the said proposals or draft orders; and

To report to the House in respect of any original order laid under paragraph 4 of the said Schedule 2, its recommendation whether:

(a) the order should be approved in the form in which it was originally laid before Parliament; or

(b) the order should be replaced by a new order modifying the provisions of the original order; or

(c) the order should not be approved;

and to have power to report to the House on any matter arising from its consideration of the said order or any replacement order;

That the following members be appointed to the Committee:

Brabazon of Tara, L, Dubs, L, Ludford, B, Massey of Darwen, B, Singh of Wimbledon, L, Trimble, L.

That the Committee have power to agree with the Committee appointed by the Commons in the appointment of a Chair;

That the quorum of the Committee shall be two;

That the Committee have power to send for persons, papers and records;

That the Committee have power to appoint specialist advisers;

That the Committee have power to adjourn from place to place;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee in the last session of Parliament be referred to the Committee;

That the evidence taken by the Committee be published, if the Committee so wishes.

National Security Strategy Committee

That a Committee of ten members be appointed to join with the Committee appointed by the Commons as the Joint Committee on the National Security Strategy, to consider the National Security Strategy;

That, as proposed by the Committee of Selection, the following members be appointed to the Committee:

Brennan, L, Campbell of Pittenweem, L, Harris of Haringey, L, Healy of Primrose Hill, B, Henig, B, Hodgson of Abinger, B, King of Bridgwater, L, Lane-Fox of Soho, B, Neville-Jones, B, Powell of Bayswater, L.

That the Committee have power to agree with the Committee appointed by the Commons in the appointment of a Chair;

That the Committee have power to send for persons, papers and records;

That the Committee have power to adjourn from place to place in the United Kingdom;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House;

That the evidence taken by the Committee in the last session of Parliament be referred to the Committee;

That the Committee have power to appoint specialist advisers;

That the evidence taken by the Committee be published, if the Committee so wishes.

Statutory Instruments Committee

That in accordance with Standing Order 73 and the resolution of the House of 16 December 1997, that, as proposed by the Committee of Selection, the following members be appointed to join with a Committee of the Commons as the Joint Committee on Statutory Instruments:

Armstrong of Ilminster, L, Colgrain, L, Haskel, L, Morris of Handsworth, L, Newlove, B, Rowe-Beddoe, L, Scott of Needham Market, B.

That the Committee have power to agree with the Committee appointed by the Commons in the appointment of a Chair;

That the Committee have power to send for persons, papers and records;

That the Committee have leave to report from time to time;

That the reports of the Committee be printed, regardless of any adjournment of the House.

Democracy and Digital Technologies Committee

That Baroness McGregor-Smith be appointed a member of the Committee in place of Lord Dobbs.

Social and Economic Impact of the Gambling Industry Committee

That Lord Parkinson of Whitley Bay be appointed a member of the Committee.

Motions agreed.

High Speed Rail (West Midlands-Crewe) Bill

Committed to Select Committee

3.23 pm

Moved by ***Baroness Vere of Norbiton***

Motion agreed.

Brexit: Workers' Rights

Statement

3.24 pm

The Parliamentary Under-Secretary of State, Department for Business, Energy and Industrial Strategy and Northern Ireland Office (Lord Duncan of Springbank) (Con): My Lords, with the leave of the House, I will repeat as a Statement the Answer to an Urgent Question given by my right honourable friend the Secretary of State for Business, Energy and Industrial Strategy in the other place.

"Mr Speaker, the UK has a long and proud tradition of leading the way in workers' rights and for always setting the highest standards. The Government have been clear and consistent that the decision to leave the EU does not change that in any way whatever. The Government have absolutely no intention of lowering standards on workers' rights. To suggest otherwise is scaremongering and is untrue.

The EU traditionally has set minimum standards for workers rights' and, as all colleagues in this Chamber would expect, the UK already exceeds standards in a wide range of areas such as maternity and paternity leave and pay. The UK offers 39 weeks of statutory maternity pay compared with the 14 weeks of paid maternity leave required by the EU's minimum standards. Because this Government believe in the importance of supporting families in every possible way, we have also given fathers and partners an additional statutory right to leave and pay—something that the EU is only now starting to consider.

We are one of the few member states to have introduced shared parental leave, and we are proud that in the UK we have given all employees with 26 weeks' qualifying service a statutory right to request flexible working, which enables so many to better balance their work and life responsibilities. EU law allows workers to make such a request only if they are returning from parental leave.

So, under the terms of the EU (Withdrawal) Act 2018, all existing workers' rights laws will be transferred into domestic law once we have left the EU, making sure that there is no gap or lack of clarity in the minimum set of workers' rights which, as I have already said, is something that the UK exceeds in many areas. We are also including in the EU (Withdrawal Agreement) Bill a new requirement that every Bill brought before this place in future that affects workers' rights will include a statement by the Government of the day on how it impacts on workers' rights. This will ensure that Parliament always has its say. The Government have also published clauses that will require every Government, now and in the future, to monitor new EU legislation covering employment and workplace health and safety standards and to report on those changes to Parliament, so that Parliament can again have its say.

So, in direct answer to the honourable Lady's question, I can absolutely assure her and this House that the Government will not lower standards on workers' rights when we leave the EU. On the contrary, it is the ambition of this Government to make the United Kingdom the best place to work and to grow a business".

3.26 pm

Lord Stevenson of Balmacara (Lab): My Lords, I am very grateful to the Minister for repeating that Answer from the other place. It might be helpful and for the convenience of the House if I make it clear that the references to the leaks that gave rise to this exchange are significant, having been reported at the weekend by the *Financial Times*, which has a good record of picking up government intelligence—very often intelligence that the Government would not wish to see in print.

Three important points are made in these reports. First, the UK is apparently open to some divergence on workers' rights after Brexit. The *FT* has stated that the paper that it was relying on was drafted by DExEU with input by Downing Street, and that the UK's interpretation of the level playing field commitments would be very different after Brexit. It also said that the Government believed that binding arbitration would be "inappropriate"—and binding arbitration was the way suggested in the withdrawal agreement for how the two blocs will work together as we go forward.

This is quite a serious charge. I know that the Government do not normally comment on leaked documents, but it is important to recognise that they responded to this leak, saying that they had no intention of lowering standards, which was repeated in the Statement that we have just heard. They went on to explain:

> "UK Level Playing Field commitments will be negotiated in the context of the future UK-EU Free Trade Agreement, where we will achieve a balance of rights and obligations which reflect the scope and depth of the future relationship".

I put it to the Minister that that is a rather open-ended statement. It does not subscribe to the sense that he was giving in the Statement. How does that guarantee rights if they are to be negotiated, going forward, in the light of the scope and depth of the future relationship? To take a very simple and classic example, we have already set out what our tariff regime would be after Brexit, should there be one. That regime is effectively

the same as that of the EU; it differs only very slightly. So what else is there to negotiate in a free trade agreement?

Secondly, looking more closely at the Statement that we have just heard, it is also very unclear where exactly the guarantee that we are expecting is to be found. The Minister has already said:

"The Government have absolutely no intention of lowering standards on workers' rights"—

but the leaked version absolutely says that no guarantee is available at this stage. It goes on to say that,

"under the terms of the EU (Withdrawal) Act 2018 all existing workers' rights laws will be transferred into domestic law once we have left the EU, making sure there is no gap or lack of clarity in the minimum set of workers' rights".

It also says that,

"every Bill brought before this place in future that affects workers' rights will include a statement by the Government of the day on how it impacts on workers' rights".

A statement on impact is not a guarantee. Can the Minister convince us otherwise?

Thirdly, the Minister said:

"The Government have also published clauses that will require every Government, now and in the future, to monitor new EU legislation covering employment and workplace health and safety standards and to report on those changes to Parliament, so that Parliament can again have its say".

Where is the guarantee in that? "Having a say" will certainly not provide us with the guarantees we are talking about.

This Government are not committing to the future maintenance of standards. I draw the attention of your Lordships' House to the very comprehensive amendment on the non-regression of standards that was passed by the House during the recent passage of the Trade Bill —a Bill which has now disappeared. It was proposed by the Government and accepted unanimously by the House. When will we see that re-enacted?

Lord Duncan of Springbank: I welcome the comments from the noble Lord. One of the important issues is the question about what a future trade agreement with the EU would deliver. I accept that he is saying that there is apparently nothing else to negotiate and perhaps it can be done very quickly indeed. This Government's policy has always been that we can do that trade deal very quickly; it is important to stress that.

As to the elements in the leaked document, it will not surprise the noble Lord to know that I will not be commenting on them specifically. However, having been a member of the European Parliament, what I will say is that the European Parliament and the European Union set minimum standards. The secret to those is how you enforce them. This Government have put substantial investment into enforcing the rights and standards throughout all employment and welfare, which has not been matched by other countries. It is also important to suggest that we can now manage our own affairs in this regard and that it is for the other place and this place to determine what they shall be. My final point is that this Government will not diminish workers' rights whatsoever.

Lord Fox (LD): My Lords, I thank the Minister for repeating this Answer. Nobody doubts his sincerity in reading it out but, given the catalogue of issues set out at length by the noble Lord, Lord Stevenson, I am sure that the Minister will understand that there will be distrust out there; there will be people who suspect that Downing Street has said one thing and done another. So would the Minister agree that the best way of setting people's minds at rest would have been to have an international trade Bill in which all these rights were set out and protected, and to have the scrutiny process enshrined in law? Does the Minister agree that it is a great tragedy that that has been canned by the Conservative Government?

Lord Duncan of Springbank: All the rights that we have accrued as a member of the EU are retained from EU law into our corpus of domestic law. That is the best place for them to be set out. Any changes to that, including any that a future Government may wish to make, must be made with the permission of the other place and this place, using voting procedures in the normal way. There shall be no diminution of the rights of workers as a consequence of this.

Lord Howell of Guildford (Con): My Lords, is not one difficulty with this whole debate that some people are confusing the modernisation of rights, benefits and workers' conditions and protections with lower standards? Is it not a fact that we now have a modern economy, 83% of which is services, and that workpeople face entirely new conditions that require much more detailed attention? A great deal of the EU legislation of the past, which was well intentioned, was conceived in the age of very big business—and largely by big business—and an age of steam and steel that no longer exists. Is there not a new situation which lively, caring economies should be addressing much more vigorously?

Lord Duncan of Springbank: My noble friend makes an important point, which I will answer in two ways, if I may. First, in this country, we have very much a service-based economy. In making rules and laws that affect workers, we can tailor them carefully to the needs of the people of this country. My noble friend also made a point about the situation with regard to the laws and rights that exist in the EU at present. As I recall, for many decades the Benches opposite opposed almost every aspect of what was going on inside the EU, because they felt that it was servicing big business rather than individual workers. We must make sure that our laws are fit for our people.

Lord Howarth of Newport (Lab): My Lords, of course this country ought to maintain, and indeed pioneer, the best standards on workers' rights—but, since the whole purpose of Brexit is to restore parliamentary government to the United Kingdom, how could it make sense for us to pre-commit to endorsing whatever legislation the EU might in future choose to bring in? Should we not have confidence in our own democracy?

Lord Duncan of Springbank: I could not have put that better myself.

Lord Balfe (Con): My Lords, I remind the House that 30% of trade unionists vote Conservative. These Benches are not unaware of their interests. I draw my colleagues' attention to my entries in the register.

[LORD BALFE]
Since the Government have agreed that all existing workers' rights laws will be transferred into domestic law—that deals with my first point—and have moved on to say that we will be consulted and we will look at these laws, is it not about time that we put some trust in our Government?

Secondly, since we are about to come to an election, and bearing in mind that the last Labour Government did absolutely nothing to better trade unionists' position in society, maybe Labour could spend some of the election time saying what it intends to do to help the TUC and the Institute of Employment Rights, whose president joined this House yesterday, to get a somewhat better deal.

Lord Duncan of Springbank: My noble friend makes a point that is definitely worth making. I note that an issue we face constantly in the EU is the discrepancy between the ideal and the delivery. To look at one aspect, the transparent and predictable work conditions that have been passed in directive form will not be brought in until 2022. The Government have already brought in elements of that directive.

Lord Wallace of Saltaire (LD): My Lords, the Minister correctly emphasised that most of these EU standards are minimum standards, and that in many cases we considerably exceed them. Could he therefore explain why the Government have put so much emphasis on having the right to diverge from those standards, when the only argument that many of us have heard in favour of divergence is so that we could lower them? We can always exceed those standards without running into any difficulty—but what is the purpose of this enormous emphasis on divergence?

Lord Duncan of Springbank: I often wonder what will happen when the EU begins to diverge in directions that are not suitable to this country. We must make sure that the laws we make here are suited to our workers. That will not always be the case if we follow in lock-step with the EU. We need to be ready to make laws that are fit for workers in this country.

Health Service Safety Investigations Bill [HL]

Second Reading

3.37 pm

Moved by ***Baroness Blackwood of North Oxford***

That the Bill be read a second time.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Baroness Blackwood of North Oxford) (Con): My Lords, it is a great honour to speak on the Health Service Safety Investigations Bill, which represents a landmark moment for safety and transparency in the NHS and is a major victory for those campaigners who have called for change. Every day, the vast majority of patients treated in the NHS receive safe, effective, world-class care. However, healthcare is complex and sadly sometimes errors occur that lead to harm. It has been estimated that more than 20,000 serious incidents and 8,000 deaths are due to problems in NHS services every year. These incidents have a devastating impact on patients, their families and staff, and cost the taxpayer up to £2.5 billion a year.

The Mid Staffordshire public inquiry and the report of the Morecambe Bay investigation highlighted the variable quality of NHS investigations into patient safety incidents. They also emphasised the many pressures that deter healthcare professionals being frank about failings in patient care and the factors that might contribute to them. In response to these findings, the Government have committed to make the NHS lead the world in providing safe, high-quality care.

In 2015, the Government accepted the central recommendation of the Public Administration Select Committee to establish an independent national body called the Healthcare Safety Investigation Branch. Such a body would conduct a small number of automatic safety investigations and identify areas of learning from healthcare incidents. Lessons have been drawn from the Air Accidents Investigations Branch—an investigative body that has been fundamental to the improvement of safety in the aviation industry.

Our Healthcare Safety Investigation Branch was established in 2016 and started operating in 2017. It currently conducts up to 30 thematic national investigations and up to 1,000 local maternity safety investigations a year. The purpose of the national investigations is not to apportion blame or liability but to share recommendations to prevent similar incidents happening again. The current investigations branch has firmly established itself within our globally renowned healthcare landscape, and is a vital component of a comprehensive plan for safety improvement in healthcare.

Let me give an example of a case that this investigation branch has taken to illustrate the recommendations and the improvement that it can give. The investigation looked into the undetected ingestion of a button or coin-cell battery in children, following an event in which, tragically, a child died after the ingestion of a coin-cell battery. Following this incident, NHS Pathways took action to ensure that NHS 111 staff were prompted to mention coin-cell batteries when asking about the ingestion of anything harmful or poisonous. In addition, the investigation branch also made a series of actionable recommendations to PHE, the Department for Business, Energy and Industrial Strategy and the Royal College of Paediatrics and Child Health. The recommendations addressed issues around the design of button batteries and public awareness about the health and safety of this product. They also focused on the recognition of the ingestion of button batteries in emergency medicine, and the role of ambulance staff concerning the urgent care of young children.

Other examples of investigations at the investigations branch have followed reference events to establish the safety risks associated with patients with special needs and to reduce the risk of prisoners with long-term, chronic conditions being moved without crucial medication. All these investigations have found system-wide solutions to system-wide problems, making this unique in the patient safety investigation system. An investigation into these cases by a local NHS trust would have been unlikely to have had the investigative

ability or reach to determine what happened outside of the trust. Therefore, it is easy to see how similar incidents could happen again to other patients elsewhere in England if only local investigations had been carried out.

However, the current investigation branch is an organisational arm of the NHS Trust Development Authority, which is part of NHS Improvement. It was an important first step, but the story must not end there. It lacks independence and the necessary powers to make its investigations fully effective. The Health Service Safety Investigations Bill addresses these issues in four ways.

First, it establishes a new independent arms-length body, otherwise known as the health service safety investigations body—a snappy name. This body will continue the national thematic investigations work of the current investigations branch, focusing on a small number of significant patient safety issues where there is the greatest opportunity for learning across the NHS. This will be the first independent healthcare body of its kind in the world, leading the way in investigating for the purpose of learning, not blaming. The independence of the new body's investigations from the NHS and Government will give the public full confidence in its investigation processes and its ability to deliver impartial conclusions and recommendations.

Secondly, the Bill will establish safe space protections, prohibiting the disclosure of information held in connection with an investigation, apart from in tightly limited circumstances, as set out in the legislation. The safe space information includes documents, equipment or other items, and is referred to as "protected material" in the Bill. The safe space provisions encourage all participants, such as NHS staff, to be completely candid in the information that they share. This will enable more thorough investigations and the development of meaningful recommendations.

Thirdly, the Bill provides for appropriate powers, so that the new body can discharge its investigative function. These include powers of entry and inspection, powers to inspect, copy or seize documents and equipment, and powers to require information from individuals or organisations, including national public bodies.

Finally, the Bill makes an amendment to the Coroners and Justice Act 2009, to provide a statutory footing for the medical examiners system in the NHS in England. This will underpin the system that is already being rolled out successfully across the country. Medical examiners will ensure that every death in England and Wales is scrutinised, either by a coroner or a medical examiner, to strengthen safeguards for the public. It will provide support to doctors by being able to provide expert advice, in turn improving the quality of the death certification process. It will also be able to provide a service for anyone who has just lost a loved one, by increasing transparency, by offering an opportunity to raise concerns, and ultimately, by avoiding unnecessary distress for the bereaved.

Overall, the medical examiner system is a key element of the NHS safety system and will ensure that any clinical issues and learning are quickly identified to improve patient safety. I take this opportunity to thank the noble Lord, Lord Hunt of Kings Heath, for his continued support over the years in implementing the medical examiner system, and of course the noble Lord, Lord Patel, for his ongoing work on patient safety and leadership in this area.

In preparation for this Bill, a Joint Committee of both Houses was appointed to conduct pre-legislative scrutiny of the Government's draft Bill. I am grateful to the Members of this House who participated in that committee and gave the Bill such careful and thoughtful consideration. They were the noble Baroness, Lady Billingham, my noble friends Lady Chisholm and Lady Eaton, the noble Lords, Lord Elder and Lord Kirkwood of Kirkhope, and the noble Baroness, Lady Watkins. Their expertise was greatly valued by the Government. The committee made a number of recommendations and I am pleased that they were able to accept the majority. It was clear that the new body should not be able to accredit safe space investigations at a local trust level, as it was felt that this would confuse the new body's role and make it part of a system that it is investigating. The Government have listened to this concern and removed this provision from the Bill. We consider that there are other ways to improve local investigating capability, including the provisions in the Bill for the new body to provide training and guidance.

The Government have also listened to the committee's recommendation that the maternity investigation programme for local investigations, undertaken by the investigation branch, should not be part of the new body's remit. We want to ensure that HSSIB focuses only on a small number of thorough, national and thematic investigations, conducted using a safe space approach to ensure the greatest opportunity for learning in the NHS. It is important to note that it will be possible under the Bill for the new body still to carry out national and thematic investigations into maternity; in fact, the current branch has conducted two national investigations relating to maternity care, which are separate from the local maternity investigations programme. I reassure the House that we will also allow the current investigations branch to continue to run the local maternity investigations programme for a period, so that it gets the maximum learning for the NHS.

A lot of recommendations were taken on board to strengthen safe space and we have defined more carefully when exemptions would apply. One recommendation which was not implemented was that the Government should make it clear that the prohibition on disclosure of safe space material applies to coroners and to the Parliamentary and Health Service Ombudsman. In response to this, the Government had extensive discussions with the Ministry of Justice, while also speaking with the Lord Chancellor and the Chief Coroner. After careful consideration, we concluded that the safe space should not interfere with the coroners' ability to carry out their statutory functions. The Bill now provides that a coroner may request disclosure of safe space material from HSSIB, but only if it relates to a matter that is relevant to an inquest or an investigation. However, crucially, the Bill also provides that a coroner may not disclose such information in an inquest or otherwise to another person unless the coroner has obtained an order of the High Court. This ensures that participants in an HSSIB investigation still see it as a safe space. We consider that this is the most

[Baroness Blackwood of North Oxford]
appropriate way for safe space provisions under the Bill to work alongside the powers of coroners, as set out in the Coroners and Justice Act 2009.

The Government have also decided not to accept the committee's recommendation to extend HSSIB investigations to independently funded healthcare. We are sympathetic to this recommendation but do not want to pre-empt the findings of the Paterson inquiry, which is expected to report shortly. The Government have committed to review this recommendation once the report is published. I am sure that we will have some debate as this goes through the House.

Finally, the Joint Committee considered whether the new body's remit should be extended to the devolved territories in Wales, Scotland and Northern Ireland and how it would be devolved across cross-border healthcare pathways. After extensive discussion with the devolved Administrations, the Government concluded that the remit of the new body will not be extended to cover the devolved nations. We want to enable co-operation between the new body and the devolved Administrations where investigations involve cross-border care pathways. We believe that the best way to achieve this is through memoranda of understanding rather than through legislation. I am sure that that point will also be ably tested as the Bill goes through the House.

Overall, the Joint Committee, the CQC, the BMA, NHS Providers and patient representatives have all welcomed the draft Bill. They have looked forward to the introduction of this legislation as soon as possible, stating that they believe HSSIB in its new form will play a vital role in improving patient safety and learning across the NHS.

Having set out the general purpose of this Bill and its broad terms, my priority today is to hear the expertise of the House, so that we can begin the robust process, as ever, of scrutinising and strengthening the Bill. I want to listen as carefully as possible and will seek to engage as fully as possible with all groups across the House, whether by party or by individual, to ensure that we deliver the HSSIB on the best possible statutory footing, so that it can deliver for patients and the NHS in a world-leading way. On that basis, I beg to move.

3.50 pm

Lord Hunt of Kings Heath (Lab): My Lords, it is a great pleasure to follow the Minister, and I thank her for her introduction to this important Bill. I declare an interest as a member of the board of the GMC, a trustee of the Royal College of Ophthalmologists and president of GS1, which has overseen the Scan4Safety programme in the NHS.

I warmly welcome the Bill. As the Minister said in her introduction, the scale of adverse incidents in the health service makes it imperative that we try to develop a systematic approach to safety. In looking for inspiration, I came across something James Titcombe wrote recently. He conducted a remarkable campaign, following the tragic death of his baby under the auspices of the Morecambe Bay NHS Foundation Trust, and he fought and fought to get answers. He wrote:

"Where healthcare professionals perceive a blame-seeking response to incidents and error, the conditions for learning can never exist. It is paramount that the NHS is able to strike the right balance between ensuring there is accountability where appropriate, and fostering a culture where staff can report and openly discuss error with the confidence that they won't be blamed unfairly".

For me, that sets the foundation for the whole concept of the HSSIB. The safe space provisions are so important for the confidence of staff, in ensuring that information they provide will be treated fairly, without them feeling that their employing organisation will come after them because they have disclosed it.

I first became convinced of the need for a systematic approach when the former Chief Medical Officer Liam Donaldson chaired an expert group which produced, in 2000, the report *An Organisation with a Memory*. This then led to the establishment of the National Patient Safety Agency, and I can tell the Minister that that was actually the first organisation in the world to tread this course. The noble Lord, Lord Patel, was its first chair, and I had the pleasure of following him as chair from 2005 to 2007. Very disappointingly, when the coalition Government came to office—it is good to see the noble Earl, Lord Howe, in his place—we had the predictable bonfire of the quangos, which all Governments seem to go through before they set up their own, and the NPSA was abolished. Disappointingly, and remarkably, the decision was made to place the national reporting and learning system, which is the key mechanism by which people reported incidents, within NHS England, with the NHS Commissioning Board. Clearly, putting it within the compass of the organisation responsible for managing the NHS was the wrong thing to do. We should acknowledge that that has now been seen; hence the Bill today and why I welcome it so much.

There are a number of issues. We have the benefit of the organisation having been in shadow form for some time, so we can see the quality of the reports it has already produced. We have also had pre-legislative scrutiny, which has been very helpful in identifying some of the key issues. As the Minister said, the first issue is: what areas should the Bill cover? At the moment, it covers NHS patients, who can be treated in the private sector, but there is a restriction on private health services where patients are not NHS patients. The noble Baroness says that the Government want to await the Ian Paterson report, and I can see why, but I think it would be perfectly possible to provide in the Bill for the right of the Secretary of State, by order, to extend the provisions to the private sector in the light of the Paterson report. This may well be the only stage of the Bill we will take, and we may have another Bill fairly soon, so there might be time to reflect on that. I think it is very odd that the Bill as it is being brought at the moment does not encompass private healthcare. I think it should.

I am very supportive of the safe space concept, particularly as Clause 2(2) makes it clear that the purpose of the HSSIB is to focus on system issues and not to determine individual blame. It is clear though, from the briefs we have received the last few days, that many organisations do not agree with that. I have had briefs from the ombudsman, from the Association of Personal Injury Lawyers, from the Campaign for Freedom of Information and from the News Media Association on behalf of media outlets. All have sent submissions arguing that the restrictions on access to information

held by the board are too strong and ought to be modified. Obviously, we will test this in Committee, but I think there is a clear tension between an approach that looks at systems safety, which tries to learn from errors and mistakes to say how we can put this right by a redesign of equipment or practice, and the absolute right of individuals to pursue cases against the health service and the right of regulators to regulate professionals appropriately.

Clearly, the Bill seeks to get the balance right. Clause 15 enables the Chief Investigator to disclose protected information,

"to address a serious and continuing risk",

to safety. Clause 17 allows for a person to go to the High Court for an order of disclosure. In my view, that is the right balance: the safe space concept is set out in legislation, but there are circumstances where information can be disclosed. Where I question it, I must say, is in relation to Clause 19, which makes specific provision for a senior coroner to require disclosure. The noble Baroness has given some explanation of that. My understanding is that there are 95 coroners' areas in England and Wales, employing 87 senior coroners. That seems rather a lot of people to be given special provision. Again, I think that in Committee we need to test whether coroners should be given this special provision. I remain dubious at this stage.

On maternity investigations, the Joint Select Committee was concerned that the board was being given a different remit in relation to these local investigations. The noble Baroness says that the Government need more time to consider what is to be done with those investigations, but I hope that during the passage of this legislation—however long that takes—there will be some kind of conclusion. Given that we are asking the board to do a specific job in relation to system safety, I wonder whether this is the right place for local investigations into maternity services.

The fundamental question of course is: what happens as a result of the work of the board? One of the NPSA's problems was that it produced lots of reports, but nobody in the system actually took responsibility for implementing them. Here, there is clearly a mechanism whereby the board sends its reports to relevant organisations, and the Bill also makes provision for those organisations to respond to the board. I think that is a very useful suggestion, as is the requirement for a review of the board to be undertaken after four years' work. I welcome that. However, we have heard it said that the board might produce up to 30 reports a year. Looking at the first two or three—on piped air, oxygen and mental health in emergency departments—the responses from the organisations that received them were very positive. However, in the report on electronic prescribing, the recommendations are extensive. They would be costly in money, human resources and managerial effort. I begin to worry that if over, say, four years it really produced 30 reports a year, which would be 120 overall, the risk is that they would tend to lie on the shelf. It would be a tick-box exercise, and the impact would be far less. I wonder whether the board ought to be less ambitious in the number of reports it produces, in order to get a bigger impact.

However, the fundamental question I put to the Minister is this: whose feet will be held to the fire if the board produces a report and it is clear after two or three years, when new safety incidents have emerged, that the health service has not actually responded? It is not at all clear to me who has responsibility for making sure that these reports have bite. In the airline industry, where this has come from, the experience is that when safety reports such as these are produced, they are acted upon. The big risk here is that, knowing the health service as we do, the number and range of adverse incidents is so wide that in the end the reports will become simply good practice guidance which people can take or leave. In the end, at heart this is the most fundamental question.

I will talk briefly about governance issues. I note that there are non-execs to be appointed, and I strongly urge the Government to make sure that NHS commissioners are appointed as non-execs to the board. We know that a lot of the expertise on this board has come from other sectors, and it is vital that there are people around the top table who understand the NHS. The best way to do this might be to appoint top clinicians to the board as non-executives. Secondly, the provision in Schedule 1 is for the Secretary of State to approve the appointment of the Chief Investigator, which is made by the board itself. I do not understand why the Secretary of State has to give his or her consent. This is not normal in the way that we generally do public bodies; I fully understand that the Secretary of State appoints the non-executives, but it should then be just for the non-executives to appoint the Chief Investigator.

Finally, the Joint Select Committee suggested that, because of the importance of these roles, both the chair and the Chief Investigator ought to be subject to pre-appointment scrutiny by the Health Select Committee. That is an excellent suggestion. Have the Government given this further consideration? When they responded to the Joint Select Committee, they said that they would discuss it with the chair of the Health Select Committee. It would be very good to know the outcome of those discussions.

Overall, this Bill is enormously welcome. I wish the board very good luck in the future, but I also look forward to some of the scrutiny that needs to take place.

4.03 pm

Baroness Walmsley (LD): My Lords, I too thank the Minister for introducing this Bill.

I have always believed that, if you want to know what is wrong in an organisation, the best thing you can do is ask the people who work there. They will also very often know what to do about it. If you want to manage change effectively, your first principle has to be to involve in its design those who are going to implement it. I am also, as a keen gardener, a fan of the old saying that the best fertiliser is the farmer's boot. In other words, there is no substitute for getting round the farm to see what is growing well and what is being eaten by caterpillars. The same goes for organisations. If managers do not get out of their offices to see how things are working on the ground, they will miss what is going wrong and lose out on valuable opportunities to hear from staff informally.

[Baroness Walmsley]
Nowhere is that more important than in an organisation where people's lives depend on getting things right the first time.

We therefore welcome the Government's objective of moving towards a learning culture, but in many good NHS organisations this is nothing new. There have been many successes when the principles I have just outlined have been put into operation and staff have embraced change, especially when it was their idea in the first place—or at least they believed it was. Sometimes small management and systems changes can make a big difference to patient safety: for example, the introduction of checklists in surgery has reduced mistakes considerably. These things are not the responsibility of any one member of staff but involve people working together. The Bill deals with thematic or systemic issues rather than individual cases so it has a rather different role from the existing systems for improvement and safety management, but I would like to know how its operation will link with and impact on those existing systems.

Getting to the bottom of problems in the past has often been hindered by staff hesitating to report concerns because of worry about being victimised as a whistleblower —there have been some very bad cases of that—but also because of a lack of confidence that anything will be done. The safe space idea should help with this. However, I agree with the noble Lord, Lord Hunt of Kings Heath, that it has to be seen that the recommendations are put into place for that confidence to arrive.

Currently, the duty of candour means that staff must express concerns when they believe there is an unsafe situation. However, the RCN tells us that half of those who do so are not convinced that any action has been taken. As the noble Lord, Lord Hunt, said, it will be a challenge to the new body to ensure that those who give evidence in the new safe space see that effective safety improvements are put in place as a result of their co-operation. It is also important that those who give evidence are not inadvertently put at risk by doing so. That means that the exemptions to disclosing information to other bodies must be narrow, clearly defined and well understood. I think my noble friend Lady Parminter will say something about the Parliamentary and Health Service Ombudsman, which feels that it should be treated the same as coroners. There must also be clearly understood definitions of what serious professional misconduct means.

Therefore, to fulfil the ambitions for the HSSIB, investigations must look at the whole picture, not just at the individuals involved in any incident. They must consider whether the shift at the time of the incident contained an appropriate number of staff for safe working, with the correct skill mix, training and experience for the situation they find themselves in. For example, we know that there are currently 40,000 nursing vacancies, and half of nurses in a recent RCN poll reported that their last shift was understaffed. Brexit has and will make things worse.

The investigations should also consider local and national policy and report on how they impacted the incident, and should be able to make recommendations to the Secretary of State about the need for structural changes indicated by the investigation. That is why it is so important that the organisation is independent. How do the Government plan to ensure that the recruitment of the board is really independent of government and includes lay members as well as medical professionals? Again, I agree with the noble Lord, Lord Hunt of Kings Heath, about the appointment of the chief investigator and the involvement of the Secretary of State.

It is arguable that all patients, however funded, should be able to benefit from the work of the HSSIB. Are there plans to extend its remit, after a period, to all health services, including those provided by independent providers? Indeed, the BMA has already suggested that its remit should be extended to incidents that affect the safety of healthcare workers as well as patients. In Committee there will be discussions about the potential expansion of the remit. Can the Minister clarify the relationship with other bodies with responsibility for quality and safety in health and care such as the CQC and the various regulators? Also, there are already various pathways that staff can take to express concerns, so there needs to be clear guidance as to which path to take in each situation.

Resources for up to 30 investigations per year are being provided. How has this number been arrived at? What if a serious qualifying incident happens just after the annual budget has run out? Will the HSSIB have to publish the number of incidents referred to it alongside the number conducted, to determine whether further resources are needed in the future?

How will decisions on the criteria for investigations be made? The groups consulted should be as wide as possible, including patient groups as well as healthcare professionals and managers. The Secretary of State seems to have a slightly suspiciously large role in an organisation that is supposed to be independent.

As I said, I welcome the safe space approach, but it is important that staff feel supported when they disclose what happened, especially if their view with hindsight is slightly different from what they might have said at the time. The primary objective of learning from mistakes will be achieved only through full disclosure to the investigators, and that will come only from confidence in the system.

We welcome the plan to put the new medical examiners on a statutory footing. It is important that bereaved families are helped to understand what happened and, if there is any doubt about the cause of death, that further investigations are put in place. Of course, we need the right sort of people for this with the right sort of training. It is essential that the service is properly resourced, particularly if it requires input from staff who are already stretched in their ability to provide good-quality and timely care to patients. Will the Minister say something about the staffing model for medical examiners? If they are to examine all deaths apart from those that go to coroners, there will be times of the year when they are very busy indeed, such as the winter months or in a heatwave. This is the same time when all clinicians are very busy, so if the MEs are clinicians employed elsewhere, doing shifts as medical examiners as well as their other job, they may need to

be in two places at once at some times of year. How will the staffing model be designed to be resilient in that situation?

In summary, one could hardly be against a plan to develop more of a learning culture in the NHS and enhance patient safety, but there are questions to be answered and reassurances to be given, and I hope that the Minister will be able to do that.

4.11 pm

Lord Judge (CB): My Lords, I support the Bill for reasons that have already been given. Nevertheless, I will raise two concerns which I invite the Minister to consider during the long period that we will all have to consider everything.

My concerns arise from a very simple point, which is whether the legislation as drafted offers patients the level of protection to which they are entitled. After all, the new body is being invested with very wide powers indeed, as and when it decides to conduct an investigation. Investigators can enter premises—not people's homes but hospitals, surgeries and so on—and from those premises conduct an inspection and take away documents. They can take away any document, relating to any patient, as the Bill stands. Having looked at such documents and obtained information from them, an investigator may require any person, including anyone who was a patient at the hospital or medical surgery that is the subject of the investigation, to answer questions or provide information or documents, with liability for non-compliance being a criminal offence.

Various exceptions are allowed to the obligation to answer. They include risk to the safety of any other patient, the privilege against self-incrimination—obviously—legal professional privilege and a rather complex contravention of data protected by legislation. But let us be realistic about this. HSSIB will be examining systems. It will have to examine them carefully: there is no point trying to examine a system in a superficial way. It will no doubt check for evidence in the documents which will certainly be—and, no less importantly, will certainly have been believed by the patients to have been—confidential. The documents may reveal, for example, that 27 patients in a surgery or hospital may have been failed by the system. So HSSIB may decide to question all 27 patients about what are essentially private matters.

As drafted, the Bill allows HSSIB to investigate and exercise all its powers over any such patient, whether the patient wishes to answer questions or not. I do not believe that any patient identified by the study of confidential documents relating to him or her should be obliged or forced to discuss his or her case or be at risk of criminal prosecution for choosing not to do so. Indeed, I do not think that any such patient identified through these processes should be obliged to take part in any investigation without his or her personal consent.

Without such consent, the Bill hands a remarkable set of powers to the investigating team. We must remember that there will be patients who do not wish to co-operate, who do not wish to discuss their condition or the circumstances in which they find themselves, having acquired a particular illness or disease, and who believed when they told their doctor or nurse about their condition that it was and would be private and confidential. Many of them will be deeply shocked by the idea that some stranger knew about it and, more importantly, was in a position to demand answers from him or her. I regard this as a totally unacceptable intrusion into what are essentially private matters, and I urge that consideration should be given to some patient consent provision. I regard such a provision as an imperative.

My second concern touches on the same issue. The Bill provides for the protection of the privacy of those whose medical history is, or has become, known in this way during the course of an investigation. Of course, that protection would extend to every individual, including the ones I am concerned about, who had given their consent. So an offence of disclosure is created. Quite right—but the problem is that this should be not merely a criminal offence, punishable with a fine; a more serious punishment should be available.

There may be a case where the criminal offence involves one disclosure about one patient that falls within the ambit of the offence. Obviously, for such a case, a fine might well be an appropriate penalty. However, there may also be cases where the disclose that is the subject of the now criminal investigation covered a number of patients—say, 15 of the 27 patients to whom I referred in my earlier example—and was perhaps offered in exchange for the payment of money. There could be rather more than a single moment of disclosure. In such a case, where somebody received, offered or accepted money and the disclosure affected more than one person, for the person paying the money or accepting it, I respectfully suggest that, in serious circumstances, this should be an offence triable on indictment with a penalty of, shall we say, two years' imprisonment on conviction and six months' imprisonment on summary conviction.

Beyond all this—looking at how this would look to the ordinary citizen whose medical history has been disclosed in the circumstances that we are considering—the availability of such a sentence would seem much more effective as a deterrent if there were the possibility of a prison sentence. I suggest that it would enhance the chances of wider patient co-operation by the very people whose consent is being sought—assuming that my submission to the House about the necessity for consent is accepted. It would thus enable the HSSIB better to fulfil its responsibilities, it would increase confidence in the way it was required to exercise those responsibilities, and what we have called the safe space would be that much safer.

So, in brief, nothing will be done in the next few days, but I respectfully suggest that the Bill is deficient in two respects, both of which should be remedied in the interests of patients.

4.19 pm

Lord O'Shaughnessy (Con): My Lords, first, I declare my interests as set out in the register and I thank my noble friend for introducing this important Bill. I sympathise with the predicament my noble friend finds herself in. Having been in her shoes, I know the amount of work that goes into preparing for a Bill, so it must be somewhat frustrating to think that we might not get to Committee before Parliament dissolves. However, as my noble friend pointed out, the matters

[Lord O'Shaughnessy]
under consideration in the Bill could not be more important and so it is vital that we relish this opportunity to talk about how we can make the NHS the safest it can be.

I also congratulate my noble friend on getting the Bill to Parliament with such strong cross-sectoral support. According to the briefings that I have seen, the GMC, NHS Providers, the NHS Confederation, the Royal College of Surgeons, the BMA, the Nursing and Midwifery Council and the Parliamentary and Health Service Ombudsman have all given their support, although of course with caveats. But I think that in these fractious political times, that is a cause for hope and, whoever is in charge after the election, I hope that they will bring the Bill back soon and that that consensus continues. I thank those organisations for their excellent briefings, along with the Library and the officials for their work, and of course Keith Conradi and his team at HSIB for the work they are already doing to keep us safer.

We are all reliant on the NHS to help us when we or our loved ones are sick, and much more often than not, we receive outstanding care, but accidents do happen. According to the figures in the Library note sourced from NHS Improvement, in 2017-18, there were 52,716 reported incidents of moderate harm and 5,526 incidents of severe harm, and 4,717 deaths were reported from safety-related incidents. I think we all accept that medicine, which is so intimately tied to trying to keep sick people alive, is a risky business and that accidents and harm will happen, whatever the intentions of clinical staff, but surely we would also agree that these figures are unacceptable. By comparison, in 2018, 500 people died in aeroplane accidents across the entire world.

The Healthcare Safety Investigation Branch was set up consciously to mirror the Air Accidents Investigation Branch and to achieve the kinds of gains in safety that the airline industry has seen. Given that, we must be humble enough to admit that we have much to learn from others. At this point, I pay tribute to my right honourable friend Jeremy Hunt, the former Secretary of State, who made patient safety his guiding star and who had the humility and the courage to say, "This is not good enough". It is because of his leadership that we are here today and because of the astonishing bravery of those patients and their families who have campaigned tirelessly for a safer NHS.

I strongly support the Bill both because I think that the HSIB is the right institution to help improve patient safety and because this is a topic which cannot get enough attention. It will seem incredible to people living in the future that as a country we were happy to let nearly 5,000 people a year die from accidents in the NHS. It is akin to smoking; we used to accept it as a normal activity—a part of life and an inevitable cause of death—until collectively we made a decision to say no, that it was not acceptable and that together we must act. The Bill should be a rallying cry for a similar level of concerted action. One patient safety incident causing harm, let alone death, is one too many. It is time to change our culture and change our expectations: enough is enough.

Those are easy words to say, but they are hard to implement. We have had and continue to have scandals too numerous to mention and learned reports on those scandals. Things change a little for a while, but the fundamental cultural change, the shift from blame and denial to learning and responsibility, has not yet happened. That is why the HSSIB and the Bill are so vital. They can bring about a different safety culture, one that has proved so successful in other industries, to the NHS.

That is not to say that the Bill is perfect. There are a number of areas of concern where I would like greater clarity, although I accept that given the likelihood of a general election, those discussions may be for another day. The first area concerns Clauses 13 to 21, which govern the circumstances under which the "safe space" can be violated, as already highlighted by the noble Lord, Lord Hunt of Kings Heath, and the noble Baroness, Lady Walmsley. Clearly, there is disagreement among stakeholders as to what is the right balance. The PHSO wants more disclosure, while the BMA wants less. I understand the need for overrides in certain circumstances and I am sure that when we reach Committee stage, we will examine the merits of each potential case, but my concern is about the overall effect on patients and clinicians. We need them to trust the system. As the noble and learned Lord, Lord Judge, has said, without that trust, the system does not work. People need to be comfortable with being honest and transparent when engaging with it. However well justified such invasions of safe space may be, there is a risk that they may undermine trust.

Has my noble friend's department considered the collective behavioural impacts of these exemptions, and whether they might, not individually but together, undermine the core concept at the heart of the Bill? How do these exemptions compare with those in the regimes in air, maritime and so forth that have proved so effective? A table of comparisons would be helpful for us to consider whether the right balance has been struck.

Regarding the powers of HSSIB as set out in Clauses 5 to 12, again, given how important the experience of other safety investigation boards has been in the design of this one for health, it would be useful to see a comparison with those other boards to understand whether HSSIB has the tools it needs to do the job that we expect of it.

As the noble Lord, Lord Hunt of Kings Heath, has already pointed out, one obvious area where HSSIB does not have the full extent of its potential powers is in regard to the independent sector, as set out in Clause 2. My noble friend has already explained why that is the case—the pending Paterson inquiry—but I simply cannot understand why independent health services are not in scope. The trade body representing independent providers has asked for them to be covered by HSSIB, as have the RCS and the BMA. There is a big crossover of staff between the two sectors, many of whom work in both on a regular basis, and some of the most egregious medical scandals—breast implants, vaginal mesh—have been at their worst in the independent sector. Added to that, data collected in the independent sector may be crucial to an investigation into NHS services. If or when we ever get to Committee, I am sure that this will be a major area of focus for all of us to try to make sure that the Bill reaches its potential.

I would be grateful if my noble friend could give some clarity about the scope of HSSIB's investigations. Will, for example, the systematic misuse of medicines and medical devices be included? I am thinking, in particular, of the topics under consideration by my noble friend Lady Cumberlege's review.

Despite us knowing all about the dreadful dangers of exposure to sodium valproate in pregnancy, around 300 babies are born disabled each year because of inadequate care that contravenes all existing clinical guidelines. It seems unconscionable to me that such practice should not fall within scope for HSSIB, and I hope that my noble friend can reassure me that it does.

As my noble friend pointed out, there has been a change in the position in the Bill in regard to the 1,000 maternity investigations that are currently carried out each year. Initially, the Government resisted the Joint Committee's proposal to remove them from HSSIB; but they have now done so, although, as my noble friend set out, at a systemic level they can fall within the scope of HSSIB if it wants to look at them.

My noble friend Lady Cumberlege is sorry that she cannot be here today, but noble Lords will know how much of her life has been devoted to improving maternity outcomes and reducing harms. Each year, more than 1,000 babies die or are left with severe brain injury because something goes wrong during labour. These devastating incidents represent the single largest litigation cost to the NHS. We need to improve and we need to learn in order to do so. We need a system for investigating such incidents rapidly, both for the sake of the families involved and so that we can identify lessons. The question should not be, "Who is to blame?", but rather, "Was this avoidable?". In Committee, we can consider where the right place for such investigations should be, but can my noble friend reassure the House that, wherever they take place, the right questions and principles will underpin the way that investigations are conducted?

With regard to the powers, like the noble Lord, Lord Hunt, I am worried about the real-world impact that HSSIB will have. I have no doubt that it will carry out, as it already does, superb investigations that deliver real insights and suggestions for how to change practice for the better. But what obligations is the rest of the system under to adopt the recommendations? Clause 28 talks about a duty on HSSIB to provide assistance. The noble Lord, Lord Hunt, has already set out some of the responsibilities on health providers to consider HSSIB's recommendations. That is welcome, but it is only one side of the exchange. Surely, the rest of the NHS should have a duty to implement the recommendations, or how can we be sure that there will be any change at all?

I will end with a brief word on medical examiners. I had responsibility for this policy as a Minister and was proud to have brought about their implementation after such a long period post the Shipman scandal. I want to register my delight in seeing medical examiners put on a statutory basis and the NHS under an obligation to fully fund them. That is wonderful progress, on which I congratulate my noble friend. I hope that it is an augur of good things to come.

4.29 pm

The Lord Bishop of London: My Lords, I am grateful for the opportunity to speak at this Second Reading. I declare my interests as set out in the register. I too am grateful for briefings from the Library, the Royal College of Nursing, the Royal College of Surgeons and the Parliamentary and Health Service Ombudsman.

Like most noble Lords, I welcome the Bill's proposal to create an independent body which will investigate serious patient safety incidents. The NHS is to be congratulated on the way in which it has sought over the years to develop as a learning organisation. Florence Nightingale said:

> "Let us never consider ourselves finished nurses ... We must be learning all of our lives".

The Bill comes as part of the wider changes which we have seen undertaken over many years. I recognise those who work day by day in the NHS seeking to do their best and to provide safe, effective and compassionate care.

At the heart of my clinical practice when I was a nurse, a manager or even the Government's Chief Nursing Officer, and latterly a non-executive director, was my desire to improve the quality of care that people receive. I believe that that is the intention of the majority of the people who work in our NHS, but things go wrong, and when they go wrong, it is often the result of a systems failure, at the root of which is culture. The 2013 Francis report into the Mid Staffordshire NHS Foundation Trust was mentioned by the Minister. It found that misaligned goals and behaviours in a plethora of agencies led to the tragic failure in patient safety. A system failed. It failed people and their families, and the report declared that regrettably it was a preventable tragedy.

The Francis report pointed to the need to develop a culture which was more open and transparent across the healthcare system. Professor Don Berwick, an international safety expert, called on us to embrace a culture of learning, particularly of learning from mistakes, but we have to recognise that when things go wrong, there is often a place deep within us where there is a tension between seeking to learn and wanting to apportion blame. So developing a culture in which we truly seek to learn must be a steel thread which runs through everything, including this legislation.

The stated intention of this legislation is to bring about a whole-system change to how the NHS investigates and learns from healthcare error. However, as the noble Lord, Lord Hunt, said, there is concern that the current drafting fails to do that and that there seems to be a disproportionate focus on the individual person or people involved in the incident. This could be overcome by any process of investigation, starting with reviewing the wide range of the system context, the factors and the conditions in which an incident occurred, well before any discussions with individuals involved take place.

Furthermore, to bring a whole-system change means having a collective understanding of dangerous activity across the board, with NHS and non-NHS patients. I join the noble Lords, Lord Hunt and Lord O'Shaughnessy, in saying that we ought to consider powers to investigate

[The Lord Bishop of London]
non-NHS patient issues in the independent sector. We should do this for the benefit of not just NHS patients but the non-NHS patients in our care.

I also welcome that the HSSIB must review the criteria, principles and processes of the investigation procedure within three years of their publication and subsequently within each five-year period, but I wonder whether the criteria, principles and processes ought to be co-produced with clinical and non-clinical health service leaders. I also wonder whether they should be reviewed in consultation with not just healthcare professionals but families and patients.

The opposite of a learning culture is a culture of fear. Again, I refer to Florence Nightingale, who said:

"How very little can be done under the spirit of fear".

Therefore, I welcome the proposals for the development of safe spaces. The present draft of the Bill, I believe, has resolved some of the concerns of the nursing profession, particularly around the concept of safe spaces, but they will be safe only if the new organisation is able to build trust, as already mentioned. Trust is built only in part by legislation; it will need to be built by those recruited, as part of the HSSIB, to implement legislation. Therefore, I hope that the Minister can reassure the House that everything is being done to ensure that people of the right character are recruited to this new body.

I know that some have asked that the prohibition on the HSSIB disclosing information held within safe spaces to the Parliamentary and Health Service Ombudsman be removed. I would be very unhappy with that. Removing this prohibition will do little to create a culture where people working in the NHS feel safe to speak up when things go wrong. However, I think that further work is required to clarify how the HSSIB relates to and co-operates with the Parliamentary and Health Service Ombudsman and with other national bodies, such as the Care Quality Commission, which hold power and responsibility for reporting on patient safety incidents and the causal factors that impact patient care.

Finally, I know that the relationship between staffing levels and patient outcomes is contested, but it strikes me that an independent body such as the HSSIB may be best placed to begin to shed light on this. I hope that the Minister will ask the new body to consider this as part of its focus.

I support many of the intentions set out in the Bill and I look forward to working with other noble Lords as it progresses through the House. I thank officials and the Minister for bringing this Bill forward for our scrutiny.

4.37 pm

Baroness Parminter (LD): My Lords, my interest in this Bill was drawn by my concern to stop more avoidable deaths of sufferers of eating disorders—sufferers such as Averil Hart, who died aged 19 and whose death, and that of two other women sufferers, was investigated by the Parliamentary and Health Service Ombudsman. The title of the ombudsman's 2017 report says it all: *Ignoring the Alarms: How NHS Eating Disorder Services are Failing Patients*. It concluded:

"Our investigation found that Averil's tragic death would have been avoided if the NHS had cared for her appropriately",

and it went on to make five recommendations for improvements in NHS eating disorder services.

Eighteen months later, in June this year, the Public Administration and Constitutional Affairs Committee in the House of Commons followed up on that PHSO report and concluded that insufficient progress had been made on delivering its recommendations. I echo the comments of the chairman of the PACAC, Sir Bernard Jenkin MP, who said that,

"if the tragic circumstances which lead to avoidable in-care deaths and other serious incidents are to be avoided in the future, lessons must be learned".

Moreover, the PHSO acknowledges many examples in its casework where poor investigations or fear of blame have hampered efforts to understand what went wrong in a patient safety incident and what can be done to prevent similar failings happening again. Therefore, like others, I welcome this Bill, given that investigations by this new independent body that do not attribute blame but ensure a statutory "safe space" for NHS clinicians, patients and their families to speak freely will be a key part of enabling such learning.

I have three issues to raise with the Minister, some aspects of which have been touched upon by other colleagues around the House. First, while helping the NHS to learn lessons is critical, so is supporting the patients and families involved, giving them confidence in the investigation process and thus the recommendations. That way, hopefully, they can move on with their lives or feel that something positive has come from the death of a loved one. Public confidence in the membership of the board is therefore key. As it stands—as the noble Lord, Lord Hunt of Kings Heath, has said—the Secretary of State appoints the chair and at least four other non-executive members of the body. I have the highest regard for the medical profession, and looking around this room I see many experts, but I would be concerned if all the members were from the medical profession or, indeed, were associated too closely with the party in power; let us not forget that this body has the power to make recommendations for the Secretary of State to implement. I therefore add my voice to those of the noble Lord, Lord Hunt of Kings Heath, and my noble friend Lady Walmsley, who asked what plans the Government have to achieve an appropriate level of independence for the body so that it can instil the highest public confidence.

The second issue is ensuring that lasting change happens. As we know, the HSSIB has the power to make recommendations for future action after an investigation, and addressees of the report must, by the deadline given, provide a written response setting out the action they will take in relation to the recommendations. That is welcome but, given the failure to implement recommendations in the PHSO report that I mentioned on eating disorder services, I worry. My understanding is that NHSE and NHS Improvement will be charged with monitoring the follow-up; I would be grateful if the Minister could confirm that in her concluding remarks. However, it would also be helpful if the HSSIB had the power to insist on follow-up reports on the actions and outcomes, to ensure that meaningful and lasting improvements to patient safety will be made.

The final issue concerns the relationship of the new body to other bodies which not only focus on the causes of incidents but provide accountability for individual incidents and, if necessary, apportion blame. This issue has been touched on by the noble Lords, Lord Hunt and Lord O'Shaughnessy, and the right reverend Prelate the Bishop of London, although I think we will all come to different conclusions.

I have talked about the valuable work of the PHSO, which was set up by Parliament to provide an independent service to handle complaints about the NHS in England, UK government departments and other UK public organisations. It is the final stage for complaints that have not been resolved through the organisation's own complaints procedures. In the case of Averil Hart, Averil's father Nic Hart went to the PHSO after making complaints to six organisations: four separate NHS organisations which had provided care and treatment for Averil, as well as a local clinical commissioning group and NHS England. The PHSO is the last resort for the public yet, as the Bill stands, it cannot have access to information held in a safe space by HSSIB, to carry out its own investigations into the complaints that it receives. This could lead to the ombudsman making incomplete or incorrect recommendations for either individual or systemic remedy.

I accept the value of the HSSIB carrying out investigations in a safe space to promote a culture of speaking up and learning from mistakes, but this cannot be the only aim when looking at why incidents in the NHS went wrong. If the PHSO cannot provide assurance that it is able to investigate all the relevant evidence, this could deny patients or families closure and reduce public confidence in the findings of the organisation. The PHSO has a statutory obligation to investigate in private and is protected from disclosure under the Freedom of Information Act, so there is strong assurance that any information given would not enter the public domain. Further, given the parallels between its work and that of coroners—who have been given exemption from restrictions on receiving information from this new body—and in the absence of compelling reasons from the Minister, I would support an amendment to this Bill to provide the PHSO with access to HSSIB information. We need both bodies to be able to do their jobs properly—yes, to deliver change in the NHS but also to give confidence to patients and families that the suffering and loss that they and their loved ones went through will not keep being repeated.

4.44 pm

Lord Ribeiro (Con): My Lords, I too thank Jeremy Hunt for his contribution as Health Secretary and his interest in patient safety, and for driving the Bill to the position it is in now. In the Queen's Speech debate on Tuesday 22 October, I drew attention to the title of the Bill:

"The humble Address refers to new laws to establish an independent body to investigate serious healthcare incidents".—[*Official Report*, 22/10/19; col. 539.]

I pointed out that this was at odds with the title of the Bill, which deals solely with health service safety incidents and those carried out in the private sector on NHS patients. It does not apply to those receiving private treatment in the private sector, a point that has already been made by others.

The Joint Committee of MPs and Peers on the draft Bill made it clear that it should be amended to extend the HSSIB's remit to the provision of all healthcare in England, however funded. It is therefore disappointing that this Bill fails to address the issue with the private sector. I gave the example of the Sellu case, where the evidence of a root-cause analysis of the surgeon's work was not disclosed at the trial. Today I make reference to another case, that of Ian Paterson, a surgeon who was sentenced to 15 years in prison for undertaking needless breast surgery in the private sector. After his conviction, the Royal College of Surgeons called for a review of safety standards in the private sector. Both cases indicate why the scope of the Bill needs to be widened to include the private sector. The apparent exclusion of private healthcare providers and organisations, save for those that are treating NHS patients and providing service and equipment to the NHS, would appear to limit the potential scope and effectiveness of the HSSIB.

In the Queen's Speech I declared my interest as chairman of the Confidential Reporting System in Surgery, CORESS, which serves to support surgeons in providing confidential reports of near misses and adverse incidents in surgical practice, with the aim of disseminating the learning from these incidents to inform the surgical community and prevent further occurrences. One of the committee members, Peter Tait, previously director of flight operations for British Aerospace's commercial section and latterly the CEO of CHIRP, the confidential human factors incident reporting programme, worked closely with the chief inspectors of the Air Accidents Investigation Branch for 20 years. He described the aviation equivalent of the current scope of the HSSIB Bill as restricting the AAIB to investigating air transport operations and their service provision but excluding aircraft, engine and equipment manufacturers, air traffic services and airport providers directly or indirectly involved in the survey safety of the air transport system. It is a whole-system effect that needs to be looked at, not just one area.

I believe that by limiting the Bill to the NHS we are ignoring the lessons learned by the AAIB and others in dealing with rail and marine accidents. The Royal College of Surgeons has similarly expressed concern about the narrowness of the scope of the Bill and believes that the Bill should give the HSSIB the power to investigate non-NHS patient safety issues in the independent sector, as recommended by the Joint Committee. It is not enough to limit the remit of the HSSIB to those who provide NHS services to the private sector.

In its response to the Ian Paterson case that I mentioned earlier, the Royal College of Surgeons published recommendations for assessing standards in the independent sector, including the need for equivalent reporting requirements for independent and NHS hospitals in terms of safety and outcome data. Thus, by extending the remit of the HSSIB to the non-NHS-funded independent sector, errors or potentially dangerous activity identified in the private sector could be addressed, to the benefit of the NHS and non-NHS patients. This is all the more important as the majority of surgeons work both in the NHS and in the private sector.

[Lord Ribeiro]

The Joint Committee enforced this point when it asked for the draft Bill to be amended to extend HSSIB's remit to cover the provision of all healthcare in England, however it is funded. This is likely to require consequential amendments to other parts of the Bill, as well as to the title, and I look forward to introducing these in Committee.

The Royal College of Surgeons is also keen to widen the scope of the Bill to include the regulation of surgical care practitioners in the UK. These practitioners increasingly support routine care of surgical patients under the supervision of senior surgeons and provide continuity of care while surgeons focus on more complex and advanced patient care. The Government believe that surgical care practitioners should be regulated by the Nursing and Midwifery Council. As more surgical care practitioners enter the profession directly, rather than through roles such as nursing, it is appropriate for regulatory oversight to be introduced. Failure to do so may pose an increased risk to patient safety.

The safe space proposals have been modelled on approaches used for many years by the air accident and transport safety investigation bodies, which have contributed to safety in these industries. However, the provision in Part 2(3)(19), on disclosure to coroners, differs from the UK regulation relating to disclosure for the AAIB. The International Civil Aviation Organization sets out regulations relating to disclosure in Annex 19:

> "The State conducting the investigation of an accident or incident shall not make the following records available for purposes other than accident or incident investigation, unless the appropriate authority for the administration of justice in that State determines that their disclosure outweighs the adverse domestic and international impact such action may have on that or any future investigations".

All of this was highly pertinent to the Shoreham air display accident, which noble Lords may recall, as a full statement was given to the Air Accidents Investigation Branch and the judge refused to give the police access to this evidence. It is important that a public interest case should be made by a High Court judge in order to release information, and this approach should be applied similarly to HSSIB.

I am advised that when applications for disclosure have been made in the case of the AAIB, only one successful application for the release of cockpit voice recording data, fitted to a privately owned aircraft, was granted to the estate of the deceased pilot. The High Court judge ruled that the disclosure would not set a precedent for the release of information related to public transport systems and their investigation. Any exceptions to the safe space protection to accommodate coroners will be problematic and the same standards should apply across the board, whether to the AAIB, the Marine Accident Investigation Branch or HSSIB. Otherwise, HSSIB will not hold the same powers or protections and coroners will be able to draw on their access to individual statements to determine how they question witnesses during inquests. Thus, information taken in confidence by HSSIB could be indirectly made public. I am reassured by what my noble friend the Minister said earlier in this respect, but we may need to tease this out in Committee, as the noble Lord, Lord Hunt of Kings Heath, observed.

Safe spaces do not prevent coroners accessing information if they have justification for it and can do so through the High Court. Healthcare staff need to be confident that HSSIB can protect their information in line with the original safe space proposals. Fear of legal, regulatory or managerial sanctions against clinicians is high and recent high-profile court cases such as Sellu and Bawa-Garba do little to reassure the profession. HSSIB must be allowed to enjoy the confidence of the profession, otherwise its work will be seriously compromised.

4.54 pm

Baroness Finlay of Llandaff (CB): My Lords, I am delighted to follow the noble Lord, Lord Ribeiro, who has covered a large part of my concerns about some of the Bill's powers relating to coroners. I will return to those. I declare my interests as in the register, particularly as president of the Chartered Society of Physiotherapy, as vice-president of Marie Curie and of Hospice UK, and as a clinician in Wales. I know that Wales is outside the Bill's remit, but I will come to the cross-border flow issue.

I have a concern, from recognising that the Bill is based on aviation, rail and marine and their investigative processes, as to whether the body will be underresourced in the long term because of the complexity of the NHS. There has been pressure for an open culture of learning. There are death reviews and notification of serious incidents within hospitals, which has been pushed for some time, but unfortunately we do not have the culture of learning that is being called out for loud and clear. The reality works against it. The British Medical Association's chairman, Chaand Nagpaul, said in the *BMJ* this week that the NHS now has a culture,

> "where blame stifles learning, contributing to the vicious cycle of low morale so staff leave. This unsafe, underfunded environment is as damaging for patients as it is for doctors".

In an article on fear and medical practice, David Oliver, who is a consultant in geriatrics and acute medicine, describes:

> "A continually under-resourced, short staffed system, increasingly unable to meet rising demand",

that "begins to feel unsafe". He continues:

> "The sheer number of patients … means corner cutting and workarounds. We have to accept, balance, and mitigate risk to patients, even as systems outside hospital are under even more strain. We work on wards facing epic nursing shortfalls, often with inadequate IT or logistics. Even if our … decisions and communication are sound, there's much else we can't control".

I do not want to sound like a whingeing doctor on behalf of medicine, but I am really concerned that, unless that culture of fear and blame is addressed head on, this proposed organisation will not be able to extract much-needed learning.

I am unclear from the Bill what the threshold will be to trigger an investigation, given that the investigations are meant to be thematic rather than going into an individual case. If we are to have a thematic investigation it has to go across boundaries. I echo the concern of several noble Lords about the private sector, where NHS patients might be treated in the private or voluntary sector, such as hospices. If we cannot investigate the whole part of an organisation we would be ring-fencing a patient who goes into that sector and then saying,

"All these other problems might have been contributed to on the other side the line, therefore we don't have the powers to look at it". If we are to look at thematic change, I do not see how, when we are commissioning services across the nation from non-NHS providers, we can then exclude them from the criteria we are asking for.

My other concern is how recommendations will be audited. How will we know that recommendations made for thematic improvements have been implemented and what are the levers if they are not? It might be that I have missed that, but I do not feel that I am clear on it.

Maternity services have been under HSIB for some time now. There was initially great resistance, but I understand that things have actually been going well and that the trust and confidence of staff and patients have developed so that they feel able to undertake it. In its maternal critical care report, the Royal College of Anaesthetists brought together anaesthetists, obstetricians, midwives, intensive care medicine and the Intensive Care Society. They are very clear that you cannot take maternity services in isolation because they are an integral part of a whole system. They depend on the anaesthetic department being immediately available, on the laboratory infrastructure, on radiology and so on. It cannot be viewed as separate to a whole system. If we are going to have whole system improvement, we must look at it thematically.

In working with others and working across borders, can the Minister tell me whether the memorandum of understanding with Wales has already been written? I have not been able to unearth it. This becomes very important because we have a lot of patients who go from Wales to England for treatment, and a small number who come in the other direction, but for people on the border, thematic changes become very important.

Turning to the safe space concept, this is essential in many ways. In Wales, our revalidation system in medicine is called MARS, spelled like the planet but fortunately not as far away from the realities of this earth. In it, we are asked to describe personal constraints and practice constraints on their practice of medicine. These are visible to the responsible officer in each hospital, who can then analyse them and pick up trends. Everyone was very nervous about this at first, but it provides the beginnings of a safe space, because people are disclosing early warning signals before an incident has happened, rather than once there has been a problem, and they are describing constraints which mean that they are not practising as well as they feel that they should.

However, the concept of a safe space, and access to information in it, must, as the noble Lord, Lord Ribeiro, has so clearly said, be set against a very high bar, with only a High Court judge able to rule that on balance in this exceptional circumstance, such information should be available. Coronial inquests are terrifying for those appearing before the coroner who do not know what is coming, replicating a sense of fear and blame. That has all been worsened by the concepts and accusations of gross negligence manslaughter, for which many of the referrals to the police have come from coroners. That is also aggravated by the fact that there is not a clear definition of what is or is not gross negligence manslaughter. The Williams review asked for it to be clarified. Unless the coroner is undertaking a clean investigation, de novo, and asking questions, if they cannot unknow information that they may have somehow gained from whatever has been in the safe space, they will then be owners of that information, and I fear that what they do with it will completely erode trust in the safe space concept. It sets the safe space up to fail, because those people who have been referred for investigation of gross negligence manslaughter are often so traumatised, having been suspended for one to three years, that they leave medicine, or certainly never practice as thoroughly and as well as they did before.

Therefore, the public interest in having thematic investigations that work well is essential. If I may turn in the last moments to medical examiners, I am glad to see them in place and on a statutory footing. Personally, I wonder whether the Wales system of them being employed through shared services at a national level is going to work better, because they cannot be deemed to have any vested interest in the organisation, the hospital trust or the health board in which they are working. Time will tell. That is going to be one of those interesting experiments where we see what happens across borders with slightly different healthcare systems.

Overall, I welcome this Bill. We have a lot to discuss, and I am glad that it looks as though we will have quite a lot of time to do that in, because we have to get it right.

5.04 pm

Lord Scriven (LD): My Lords, I too welcome the Bill. Like many noble Lords who have spoken before me, I think that the concept of keeping people safe by having a safer health service system, and implementing learning to improve safety, is to be welcomed. However, I wish to raise some issues within the Bill. Noble Lords have already raised some of them but there are one or two in particular which have not been raised so far, and which I want to bring to the attention of the Minister.

The noble and learned Lord, Lord Judge, has already stated clearly that the powers in the Bill are quite wide. In some respects, they make Henry VIII powers look quite narrow. The Bill is constructed in a way that allows the new organisation not only to set its own homework but to do it, then to mark it and be the sole judge of whether it was the right homework in the first place. We therefore need to look at the Air Accidents Investigation Branch and how the Civil Aviation Act 1982 gives a framework for independent investigation, rather than it being more or less carte blanche. You cannot have independence with such a total lack of framework. As we go through the Bill, in the great time that will be available to us in Committee, we should look at whether the framework needs to be a little narrower rather than having such broad powers as the board deciding what triggers an investigation, what the criteria are, who can be brought in and how it should carry out the investigation. We need to be a little sharper and crisper on this.

[Lord Scriven]

One issue that I wish to raise regards Clause 5, and the healthcare provided in Crown interests. The noble Baroness, Lady Finlay of Llandaff, touched on this. A patient's journey is not determined just by the fact that they are being treated by the NHS. If you are a prisoner seeking equivalent healthcare in a prison, then to be honest quite a bit of the care that you receive will not depend on the NHS. If there are no prison guards available to transfer you or, in the same way—because there is a power relationship—if you are not able to raise concerns, these are real issues. The Bill has been written specifically through the prism of health and NHS professionals. That is understandable but the context of where healthcare is given, particularly when it is meant to be equivalent, on a Crown estate means that the Bill has to go much wider.

I think it is Clause 7 which refers to listed persons, but they are all to do with health. There is nothing to do with the Prison Service or the Ministry of Justice, which will be as important as healthcare providers in terms of where healthcare is provided. How have the Government looked at the contradictory legislation which will create problems in places such as the Ministry of Justice, for example on data sharing? There are four levels of data sharing within the Prison Service and health, some local and some national, but there are also rules which the Ministry of Justice is bound by on the use of data which contradict things in the Bill. We need to be much more joined up on how this is done. As I say, there is a real power relationship here between a prisoner and their family and their healthcare. We need to think through the different levels of how investigations will be carried out and have safeguards, particularly for patients and families, in the places where that kind of power relationship happens.

I want to come on to the issue of the independent providers, as other noble Lords have done. The Minister gave her view, right at the beginning, that the Paterson review is the reason for this provision not being brought into this Bill. Let us be clear: the Paterson review is a non-statutory investigation into things that went wrong in the independent sector, and it will make recommendations on what might need to change in that sector. It has nothing to do with independent investigation on a non-blame basis about how future investigations in the private sector will continue. That is what this Bill is about, and the two things are completely different.

I find it unbelievable that a person who is treated in a private sector hospital whose care is NHS-commissioned somehow has a right to different levels of safety, and somebody in the next bed whose care is non-NHS-commissioned does not, within the same institution. It is nonsensical. The provision has to be for both private and NHS patients. Surely this Bill should be about patient safety, regardless of who is commissioning or providing the care. That should be a central tenet.

I am the 10th speaker, and I am surprised that no one has raised the subject of social care: where is it in all this? I refer the House to my interest in the register as a vice-president of the Local Government Association. Thinking about the route and the complexity of care, this is about not just NHS care but social care as well. If an individual is receiving both social care and healthcare, which are meant to be integrated in a care package, what role will this body have to look at issues in social care that have led to a lack of safety? How will such recommendations be looked at? Will safety and the subsequent reports be looked at comprehensively? Will this body have teeth when it comes to social care?

I support what my noble friend Lady Parminter said about the PHSO, the ombudsman. Let me be clear: trust in this organisation means trust among staff who work in the health service but among patients and families as well. The two should not be ranked to make one more important than the other. As the Bill is written, this organisation is the author of the homework and the judge of the homework, but trust will fall down if, where something has happened to an individual, the PHSO is not able to get to vital information. There will be contradictory recommendations and results about what has happened; one systematic and one about the patient. There will then be a breakdown in trust. There is clear guidance already on the use of data between public bodies. There is also the issue that, on many occasions, the PHSO uses anonymised data to be able to come to conclusions. If this is to be a last resort for patients and their families, we need to look again at the way in which the PHSO can access data from the safe space.

My final two issues come back to what a number of noble Lords have said. It is all right having reports and recommendations, but their implementation within the NHS is renowned as being complex because there are so many organisations. I am not clear how this will be audited and its implementation checked. I come back again to how the Bill is written. Some of the recommendations and their implementation will be on the NHS, and all the bodies listed in Clause 28 as having a duty of support are NHS bodies. No bodies are listed that are not NHS, such as social care bodies or the Prison Service, but they will need to implement changes. However, as the Bill is drafted, this new body has no role in supporting them in that implementation. What will be done to ensure that this body can look at organisations beyond the NHS that are vital in addressing the systematic failure in patient safety?

Finally, and I will be very fast on this, I want to reiterate a number of issues. As a former NHS manager and as a patient in the NHS, I am indebted to clinicians, but clinicians have one view of the world. This is not to deride that—their training and their view of things leads them to a certain way of looking at issues and they use their expertise in that—but the non-executive directors have to be a broad range of people. It comes back to trust. Patients, clinicians and even some people who are not within the health service spectrum can bring their expertise to this. We need to think a little more broadly about who the non-executive directors will be.

As I said, I welcome the thrust of the Bill. It can and will contribute to patient safety, but there are issues that have to be thought through. If they are not, the body will not be able to produce the reports, and the NHS—or should I say healthcare and non-healthcare settings where healthcare is provided—will not implement the changes that will mean patients will be safer.

5.15 pm

Lord Hunt of Wirral (Con): My Lords, I begin by declaring my interests as set out in the register, in particular as a partner at the global commercial law firm DAC Beachcroft. I, too, strongly welcome the Bill in principle. The NHS is already a world leader, and the creation of a new statutory arm's-length body in this space will ensure that, in the tiny minority of instances where something goes wrong, all possible lessons are learned. The new Health Service Safety Investigations Body will indeed significantly improve the NHS and enhance patient confidence.

All noble Lords will have received a plethora of briefings from various organisations in advance of this debate. In the very substantial briefing from the BMA, two very important points stood out for me, both being vital matters of both principle and detail. The first is that the criteria in Clause 3 must,

"emphasise the importance of learning from incidents and moving away from the ... culture of blame".

I am delighted to see the noble Baroness, Lady Ashton, in her place, because 13 years ago I persuaded her to include Clause 2 in the Compensation Act 2006, so that we could all say sorry without being held as having confessed that we were to blame. I remember that it sparked a load of letters in the *Times* saying, "At last, we can say sorry". I think we have moved away from the principle she set out in that Act, and the BMA reminds us that we have to learn all the time and move away from that culture of blame.

The second point is the suggestion, which seems excellent to me, that with the advent of the new HSSIB, greater clarity must be provided about the pathways down which health professionals, other staff, patients—and I would add their friends and families too—can go when and if they wish to raise concerns. Directly connected with this question is an area of the Bill that has already enjoyed some close scrutiny in this Second Reading debate, and a degree of criticism, namely the question of the so-called safe space. I well understand the questions of moral hazard behind this, but I suspect that the balance in the Bill may require some fine tuning. As the House knows, I am not a fundamentalist by nature, but I am quite the stickler for free expression, transparency and openness. Indeed, I am delighted to see the noble Lord, Lord Faulks, in his place and look forward to hearing his contribution later, because he has now taken over the mantle of chairing the Independent Press Standards Organisation, which I had the honour of starting, as its founder chairman.

The creation of the safe space around confidentiality of information shared with the new body is potentially a significant step forward in encouraging candour and enhancing potential learning from clinical incidents. However, I find myself wondering just what level of confidentiality will emerge if this Bill becomes law and just how safe the safe space could, would and should truly be. The excellent report of the Joint Committee on the draft Bill, published on 2 August 2018, covered this authoritatively. In paragraph 7 of its conclusions and recommendations, it made the all-important point that the role of the new body will be to promote,

"learning and improvement arising from objective and comprehensive analysis of the causes of clinical mistakes and incidents, leading to better and safer outcomes for users of the healthcare system. We do not think this … is incompatible with obtaining justice in individual cases, which may and should be pursued by other means".

My noble friend Lady Eaton was of course a member of that committee, the report of which has served greatly to improve this Bill. I look forward to hearing her speech later in the debate.

The new body will publish findings, including factual findings, on a non- identifiable basis, and will be subject to a public inquiries-type process of the equivalent of Salmon letters to those impacted by the findings. Under the Bill, protected material would be disclosed to the coroner in fatal accidents, and if the coroner were to assess that material as relevant he or she would then have to apply to the High Court for an order enabling use of the protected material in the inquest setting. This is intended to provide a safeguard for the confidentiality of the material gathered, applying the safe space principle.

At a practical level, however, I find it difficult to envisage many situations in which HSSIB-protected materials arising from an investigation into a patient's death are not going to be regarded as relevant to a coroner's investigation. The question, therefore, is whether the High Court will indeed cherish and protect the safe space principle and the default confidentiality of that material, or whether the need for an order will gradually migrate into a far softer route of access, diminishing that safe space principle over time. Reading the Bill, I am just not sure, and it seems to me vital that we as legislators should be far clearer about our intentions. I am confident that these arguments will be teased out in some detail, here and elsewhere, as we delve into the details of this Bill during the end of this year and, no doubt, for a large portion of next year as well.

There has been a conscious and welcome equalisation of public and independent regulation in healthcare—several speakers have already dealt with this—ever since the creation of the CQC as a single regulator across all health and social care providers. The powers, investigations, reports and enforcement actions of the CQC are intended to be the same for providers irrespective of commissioning or funding back-drop. This is the same for coroners' and police investigations, and for professional bodies such as the GMC and the NMC.

In contrast, the creation of this new statutory body is targeted solely at those providing NHS-funded care—the noble Lord, Lord Scriven, went into some detail on this aspect. I agree that this threatens to create an inequality, which to many informed observers seems somewhat arbitrary and contrary to the public interest. Clinicians working in both public and private patient spaces would face, and indeed feel, different levels of scrutiny and engagement with learning. Investigations would exist in some aspects of clinical practice but not in others. I have no doubt that the Minister and her colleagues will be pressed during the later stages of the Bill's passage on whether we should address risk and learning across the primary healthcare sector, irrespective of provider or funder.

In closing, may I offer one more thought? At a system-wide level, is there any intention to create a read-across between, on the one hand, the new body's

[Lord Hunt of Wirral]
findings around leadership and the consequential management of incidents and learning, and, on the other, the recommendations from the Kark review around the "fit-and-proper-person" test for directors, where management of candour in relation to clinical incidents is relevant? In an interesting parallel, the fitness and propriety approach of the Financial Conduct Authority includes a reference to "openness with self-disclosures". I believe that we could benefit from close scrutiny of the FCA's senior managers and certification regime. I note that the CQC would not have access to the new body's protected material, but on the assumption its investigations would—or at least might—deliver learning around the clinical incident and its management, it is at least arguable that the HSSIB process may, consciously or inadvertently, arrive at findings that flag up specific leadership challenges for organisations concerned. How will that process and the risk associated with it be managed, if this is to be a genuinely blame-free process? This is the devil in the detail, perhaps, but it also seems inextricably connected to the vital principles upon which this admirable Bill is founded.

5.26 pm

Baroness Hollins (CB): My Lords, it is a pleasure to follow the noble Lord. I remind the House of my interests in the register.

I will make two main points about the proposed legislation which I hope will be considered carefully. The first relates to the patient safety issues experienced by those with learning disabilities in accessing healthcare, and the second concerns the safety of the wider healthcare community and the role of fear.

As many of your Lordships know, people with learning disabilities face huge health inequalities, with an estimated 1,200 deaths every year that could have been avoided with better healthcare. Many reports have shown this starkly, perhaps none more so than Mencap's 2007 report, *Death by Indifference*. The groundbreaking but shocking reports from the Learning Disabilities Mortality Review Programme revealed that people with learning disabilities are four times more likely to die from causes amenable to good healthcare. This is clearly unacceptable in the 21st century. However, will HSSIB be the body which will identify and change the system so that it is truly safer for people with learning disabilities? The Bill we are debating is a small but welcome step towards tackling some of these injustices. What could make a real impact are the proposed and welcome powers of this new body, not only to identify risks to the safety of patients but, as emphasised by other noble Lords, to,

"address those risks by facilitating the improvement of systems and practices".

Will the Minister clarify whether in practice the new body will have the powers to ensure that learnings from investigations are implemented, and in a timely manner?

Too often, even when solutions to problems are found, implementation of these solutions is either delayed or forgotten about. A variety of factors can be attributed to this, including institutional resistance and lack of political will. One such example is the delay in the implementation of mandatory, co-delivered learning disability and autism training. While the Government have at last committed to its introduction, it is unlikely that people with learning disabilities, and the clinicians responsible for their care, will see the benefits of this in the near future. Fifty per cent of clinicians responding to a YouGov survey in 2017 said that on-the-job training about learning disability would help them to deliver safer and better healthcare.

The second, increasingly serious, issue I should like to raise is staff safety, support and the role of fear. I hope that noble Lords will forgive me for repeating some obvious points, but I want briefly to consider why we investigate serious incidents. Is it because it is usually easy to find somebody to blame and allow the courts and professional regulators to do the rest, passing convictions and apportioning damages? The problem with this approach is that, in all but the most serious cases of individual failure or malice, it does not stop the problem happening again. Serious incidents occur when systems fail. When investigations focus on individuals, systematic failures go unnoticed, nothing of value is learned and harm occurs again.

The case of Dr Bawa-Garba demonstrated this tension well. She was convicted of gross negligence manslaughter and struck off the medical register for her involvement in the tragic death of six year-old Jack Adcock. But there were system failures too. On the day of Jack's tragic death, Dr Bawa-Garba was covering for two doctors. She had recently returned from maternity leave. This was her first acute shift on call, but she had not received any induction. The GMC says that induction after a period of leave is essential. Furthermore, the IT system responsible for delivering test results was broken.

Whatever her individual failures, it is clear that her criminal conviction and being struck off did little to prevent a similar tragedy in future. It did not address widespread staff shortages. It did nothing to address the way in which the NHS supports doctors returning to work after a period of leave or to fix our broken and outdated NHS IT infrastructure. Out of such tragedies, there should be opportunities to address system failures. Doing so successfully could prevent more deaths and greatly improve the experience of both patients and staff working in the health service.

For those reasons, the placing of the Healthcare Safety Investigation Branch on a statutory footing and the additional investigatory powers granted to it are welcome, but if we are to have a body which undertakes investigations of the systems failures resulting in risks to the safety of patient, could we not include the safety of staff too? After all, the same systems underlie risks to both groups.

I recently heard of a trainee psychiatrist, a young mother working part-time, choosing to wear protective clothing to work to prevent serious injury in the event of a knife assault. Was her fear of being attacked justified? Just the previous week, a colleague had been stabbed, seriously injured and airlifted to a trauma centre. Thankfully he survived. Is not his injury as important to investigate as any other serious failure in the health service? Could his injury have been prevented if both he and the person who injured him had been better supported?

A recent report suggested that in 2016-17, there was an average of 200 assaults on NHS staff every day. The same report found that staff in mental health trusts were more than seven times more likely to be assaulted than staff in other NHS trusts. The most recent NHS staff survey showed that more than one in five workers in mental health trusts had witnessed an error, near miss or incident that could have hurt a member of staff in the previous month.

Fortunately, grave assaults on staff, such as the one I just mentioned, are rare, but they are a grim reality. Last week, I met a young doctor who raised that concern with me. I worry that such young doctors will choose to leave the NHS rather than stay and work in it. We need them.

Incidents involving staff safety provide no less an insight into the workings of our health service than incidents threatening patient safety directly. The same systems failures underlie risks to both, and there can be no doubt that investigating risks to staff could also result to improvements in patient safety. A dilapidated estate, a lack of safe places for clinical assessments to take place and dysfunctional alarm systems in hospitals are just some of the realities that staff working in mental health services face on a daily basis, which no doubt have an impact on both patient and staff safety.

The National Confidential Inquiry into Suicide and Safety in Mental Health, which investigated patient homicides for two decades, had its funding cut recently. It is a great loss that it is no longer able to undertake its important work on homicide. It found that for the 11% of homicide convictions in the UK that involved mental health patients, around half of those patients were not receiving care as intended, either through loss of contact or non-adherence with drug treatment. These observations carry the hallmarks of system failures. The proposed body has an opportunity to pick up where the inquiry left off and investigate the errors, incidents and system failures that result in this worst-case scenario of patient homicide, in particular if the victim was a member of the NHS workforce. Will the Minister therefore consider explicitly including risk to staff in the remit of the proposed new body?

5.36 pm

Lord Colwyn (Con): My Lords, I declare my interest as a retired dental surgeon with more than 40 years' experience of clinical dentistry. I am a fellow of the British Dental Association, and I served on the council of the Medical Protection Society and chaired its dental section, Dental Protection, from 1995 to 2001.

I am pleased to see the Bill return in the current parliamentary Session. It has already had a lengthy gestation period, dating back to a 2015 report from the Public Administration and Constitutional Affairs Committee of another place. I hope that the Bill survives the current political situation, perhaps as carryover legislation.

My remarks will focus on the relationship between the new provisions in the Bill and existing legislation. Many medical practitioners working in the NHS today do so under immense pressure, but it remains one of the safest healthcare systems in the world. Colleagues in the dental profession welcome scrutiny of their practice and are always keen to learn and improve. Yet it must be said that there remains some suspicion about how the regulator, the General Dental Council, operates and that, for a variety of reasons, newly qualified dentists are increasingly deterred from the prospect of a career offering NHS dentistry.

Whether it is the onerous and detested dental contract, which fails to incentivise the prevention of tooth decay, or the fact that government funding for NHS dentistry per capita in England has fallen by 29% in real terms since 2010, we face a genuine recruitment crisis for NHS dentists. Three-quarters of practice owners report struggling to fill vacancies—up from half just two years ago. Practices are closing in large numbers as they struggle to recruit and to make ends meet under the current dental contract. It is important to remember that high street dental practices are run like small businesses. Owners must invest their own funds to set up and operate the practice, all at considerable personal risk. Unless there is a change of direction, we will soon face an even greater exodus of dentists from the NHS. With these points in mind, we must not only ensure that the current NHS contract is replaced and proper investment secured but create an attractive working environment for NHS dentists, where they feel confident that they are valued and supported and they are not treated as scapegoats on the rare occasions when clinical errors occur.

It is sad to hear anecdotal evidence from the British Dental Association that younger dentists increasingly report being more risk averse in their practices by, for example, referring patients to hospital more frequently, thus putting further pressure on other parts of the NHS. Such is the culture of fear in which they now operate. It is crucially important that any learning from clinical incidents takes place without recourse to a blame game. I welcome the spirit of the Bill in this respect, while the references to "no blame" and "improvement of systems" in the text are welcome. Nevertheless, these phrases are thin on the ground, especially as the word "punished" is used in Clause 37. More information is needed on how it is proposed to avoid completely any focus on blame.

When placing dental treatment under investigation, we must act in a proportional manner, particularly in cases of so-called "never events". For example, removing the wrong tooth is of course both unfortunate and alarming for a patient, but it is vastly different from removing the wrong kidney or limb. I therefore hope that any new investigatory framework for clinical incidents would be able to differentiate between the varying severities of incident both fairly and transparently. Additionally, I would welcome some clarification by the Minister on the following three points.

First, how will the proposed Health Services Safety Investigations Body interact with the existing patient safety functions of NHS Improvement, with its national reporting and learning system and the patient safety incident management system? Will it replace those functions or work alongside them? Secondly, how will we ensure that dentists and other NHS staff are not being investigated by different bodies at the same time? I am not sure that the current wording in the Bill is strong enough when it comes to the HSSIB working

[Lord Colwyn]
together with other bodies. We must be sure to avoid completely any risk of "multiple jeopardy" in this regard. Thirdly, how will the HSSIB work with others to ensure that issues are handled by the most appropriate organisation in the first instance? Furthermore, we must consider the threshold at which the HSSIB would investigate. When would an incident be considered serious enough to investigate, and what would be the trigger?

In the Queen's Speech, reference was made to the body being "professionally led". I cannot ascertain whether the clause on medical examiners is intended to address this. It is not clear and seems to be more about local NHS offices. Being "professionally led" would suggest that the chief investigation officer and part of his team are members of the health professions, but I cannot see that this is defined.

Lastly, the Bill relates to the NHS, but issues also arise in the private sector. Given the current discussions and concern about botched cosmetic procedures, is this not a problem that also needs to be addressed? I reiterate that the focus of the Bill really does need to be on learning and improving systems, not on blaming individuals. With that in mind, I welcome the spirit of the Bill and look forward to more detailed scrutiny at Committee stage.

5.43 pm

Lord Turnberg (Non-Afl): My Lords, I should declare my interest after a lifetime spent in the National Health Service and as a past president of a medical royal college, so of course I welcome a Bill on patient safety, even if it may be some time before we see it again. I am sorry to sound a rather negative note, but as I read the Bill, I did wonder how it would work in practice. I became increasingly concerned that, in its present form, it may not have the balance quite right between the major themes of investigation of serious qualifying incidents and the need to encourage local clinical staff involvement—and whether, because of that, it will frustrate its purpose of improving patient safety. This point has been made by several noble Lords who have spoken. So I thought it might be worth trying to see how the Bill would have worked if it had been in operation back in the 1970s, when I was involved in a rather tragic case of my own—I am afraid that I go back rather a long time.

I was a consultant physician in Manchester in 1978 or 1979 when we had an elderly patient in the ward with a gallstone stuck in her bile duct, blocking the flow of bile. She was in her 90s, frail and jaundiced and a very poor risk for an operation. So we decided on an experimental, non-invasive treatment in which we would try to dissolve the stone by infusing a solvent directly into the bile duct via a tube through her nose. All went well until one evening a junior doctor on my unit came in to inject the next dose of solvent. Instead of injecting it through the nasal tube, she put it into a drip going into the patient's vein—a very big mistake, which, I am afraid, caused the tragic death of the poor lady. Noble Lords may imagine how devastated we all were when we realised what had happened.

Now the immediate question was how such a tragic event could happen and who was to blame. These are the questions that might be posed under this safety investigation Bill were it in operation, but then it was me and my team who tried to answer the questions. Was the junior doctor who gave the injection at fault? She might have known better if she had understood what we were doing when she came on our ward rounds. Or perhaps it was the registrar on call, who was not around at the time and should have supervised her in this new type of treatment. Or perhaps it was the nurse, who came with her and handed her the syringe. One might have expected her to have known something about it. Perhaps the pharmacy that sent up the injection was at fault. They should have labelled the solvent more clearly as not for intravenous injection, perhaps with a fitting that could not fit on to an IV line. Or of course perhaps the fault lay with me for not giving clear enough instructions to my junior staff. I was certainly the one who shouldered the burden of breaking the news to the relatives that we had made a huge error that caused the death of their loved one; and it was I who appeared before the coroner.

Forgive me for using this sad case, but it illustrates the catalogue of errors—a multi-system failure—that can have such devastating consequences and where ascribing blame to individuals is so fraught with difficulties. But more important than the blame game is what one should do when it happens to prevent it happening again. I can tell noble Lords what we did and ask what might have happened if the Bill in front of us had been enacted.

First, we did not try to make any excuses to ourselves or to the relatives. We were completely open. I said how sorry I was that it had happened, in the belief, like the noble Lord, Lord Hunt, that saying sorry that someone has suffered is never a mistake; it is an expression of sympathy, and the fear that saying sorry leaves one open to litigation is just untrue. I have never believed that a sense of compassion is a confession of guilt. Then we initiated a full inquiry with all the staff—the doctors, nurses, pharmacists and everyone who was engaged—into the causes of the tragedy, and we made a full set of recommendations that were applied at every level.

The question now is in what way this new Bill would have helped or hindered this process. It is very unlikely that it would have prevented that particular episode from happening, but would it make it any easier after the event? Would it have encouraged us to report to the new statutory body for investigation? And would that have improved patient safety? There was no criminal intent by anyone in our case, yet the Bill seems to hint at that sort of investigation rather than for errors of judgment. Perhaps more important is the question of whether it will inhibit medical and caring staff from disclosure of mistakes.

The Explanatory Notes start off in fine form talking of providing a safe place and the promotion of learning throughout the NHS. They talk of providing advice, guidance and training and of the need to learn from mistakes so that helpful information can be spread. All that sounds admirable and would no doubt have been helpful in our case, but when one reads the Bill itself the accent is on investigation by an external body with little sign of the encouragement that will be so essential if anyone is going to admit to their errors.

If it is going to be effective, it will need to shift its focus from top-down, external, big-brother investigation to providing the safe place where practitioners can really feel free to come forward with their difficulties. Certainly it should be capable of thorough investigation where it is needed, but on many more occasions—we heard from the noble Lord, Lord O'Shaughnessy, about how many occasions—support is needed to help to ensure that the much more common errors of judgment are not penalised and that lessons can be learned from them. The emphasis in the Bill is, to my mind, too far over to the external investigation side and not enough to the encouragement of practitioners to come forward to engage with learning lessons from their errors. I am not convinced that I would have been more or less open than I was all those years ago.

I shall finish with a word about the role of the medical examiner proposed in the Bill. I presume that it is the same person whom the GMC talked of years ago. The important question has always been about where busy doctors will find the time to take on this role. If it becomes a statutory position, will it take, say, one session a week? It probably will not, but it might. If so, will we be able to fund 10% more staff simply to cope with this important duty? Perhaps it will take less time, but it will still take time and staff, and without the funds that will be necessary, it will not happen as we hope. Can the Minister explain?

I fear I may have sounded somewhat negative about this Bill, but that is not because I do not think we need to focus hard on improving patient safety now more than ever. However, I remain somewhat unconvinced that this Bill will fill that need sufficiently well. The accent here is on investigation of serious cases, and that is fine. There is some overlap with the GMC and other regulatory bodies which are doing a good job. What we need, and what I hope we will see in the Bill after the election, is a shift of focus to the encouragement, engagement, involvement and support of those who are directly responsible, at the coalface, across the field, for the safety of patients, so that they can freely admit when things go wrong and learn from their mistakes. It is because these words—encouragement, engagement and involvement—are missing that I fear the Bill will not achieve what we hope for. The Minister used the words "completely candid"; I remain to be convinced that this Bill will encourage candour in the way she hopes.

5.53 pm

Baroness Eaton (Con): My Lords, I am pleased that this important Bill with its overarching aim of improving patient safety is before us today for its Second Reading. According to the 2015 House of Commons Public Administration Select Committee report, there are 12,000 avoidable hospital deaths and 24,000 serious incidents reported every year in the NHS. In 2018, NHS services reported 10,000 incidents resulting in severe harm or death. These are worrying statistics and must motivate all of us to take action. A barrier to full investigation of these incidents is, as we have heard from lots of people, that we have a blame culture rather than a learning culture.

The Healthcare Safety Investigation Branch, established in April 2017 under the control of NHS Improvement, had the aim of improving the learning culture. However, as we know, this body lacked the independence and powers to make it fully effective. The Health Service Safety Investigations Body—HSSIB—established by the Bill will be independent of the NHS and have powers to investigate patient safety incidents that occur during the provision of NHS services.

The creation of a safe space, which we have heard much about, is modelled on the Air Accidents Investigation Branch, which we heard about from the noble Lord, Lord O'Shaughnessy. The safe space was a crucial part of the Joint Committee's discussions and deliberations, and I know that the Ministry of Justice has been asked for advice on this aspect of the Bill. Having heard the noble Lord, Lord Hunt, ask whether the High Court will cherish confidentiality, as well as some of the other issues raised by Members in the debate, I would like to hear more from the Minister about the safety and security of the information and a little more about how the safe space will operate.

Some organisations have raised concerns that the work of the HSSIB would prevent other bodies such as the CQC carrying out their own investigations. However, the gathering of information by the HSSIB using the safe space should not impede any separate investigations by non-HSSIB bodies such as trusts, professional regulators and the health service ombudsman. The HSSIB should aim to work in parallel with them so as not to increase the burden on those giving evidence.

Another important aspect of the Bill is that there is clearly a need to improve the quality of death certification. I am pleased to see in the Bill the amendment to the Coroners and Justice Act 2009 giving the NHS the role of appointing medical examiners and placing a duty on the Secretary of State to ensure that the system is properly maintained. This is a major and essential improvement.

I fully support the recommendations in the Bill but would be grateful if my noble friend the Minister could clarify a number of points. As mentioned by others, it is of concern that the remit of the HSSIB does not cover all healthcare in England, including non-NHS provision. We have heard that the Paterson review will cause the Government to consider what should happen, but can we hear from the Minister whether it would be possible to extend the Bill to cover all providers—that is, NHS and private provision—so that we are all subject to the same patient safety standards? The noble Lord, Lord Scriven, made the rather stark point about the difference between people in adjoining beds where one was getting treatment considered to be necessary for safety and the other was not.

Will the Minister elaborate on the criteria for deciding on incidents that the HSSIB should investigate and on whether these criteria will be developed in consultation with professional and patient bodies? Will the scope of the Bill include safety incidents exacerbated by issues such as staffing levels? Will safe space investigations operate within a time limit? Will there be support for the clinicians involved, and will that support include access to mental health professionals?

During the Joint Committee's deliberations on the draft health service investigation recommendations, the issue of the investigation of the large number of

[Baroness Eaton]
maternity cases was raised. That has been touched on today, but will the Minister clarify precisely what has happened with those investigations, where they will go next and how the HSSIB might, in future, be able to investigate more maternity activity?

I share the concerns of the noble Lord, Lord Hunt, on the reports from the HSSIB and how the reports will be acted on, and I worry that there is a likelihood of limited action, if any, being taken. I have a vision of dusty reports on dusty shelves. I hope for reassurance from the Minister as to how lessons will be learned, actions taken and real, effective improvements made. I welcome the Bill and look forward to the improvements that it will bring.

6 pm

Baroness Meacher (CB): My Lords, along with other noble Lords I very much welcome this important Bill, at least in principle—I think it could go one way or the other. I declare my interest having worked in the NHS for many years; I also have two doctors in my family, which, I suppose, is bound to influence my opinions somewhat.

During my years with the NHS, I was terribly conscious that it was far from straightforward for lessons to be learned across the complex web of organisations within the NHS following an incident; indeed, lessons from excellent practices in one trust somehow failed to get across to trusts around the country. We certainly have a problem. The other tragedy in our health services, in my view, is the appalling toll on doctors' morale of investigations into complaints, so many of which lead to no further action—or in some cases lead to minor or, on occasion, inappropriate recommendations—after months of misery for the professional involved. No account seems to be taken of the huge pressures under which doctors and nurses work these days.

The blame culture that pervades the health service undoubtedly reduces staff morale and therefore the quality of service for patients—which, at the end of the day, is what the NHS is all about. This culture also reduces the willingness of doctors to be open, so we do not learn the lessons that we need to learn.

The Bill is not about doctors and nurses versus patients—quite the opposite. If we manage to reduce the blame culture, and the unpleasantness of this culture, for professionals, that will undoubtedly benefit patients at least as much as it benefits the professionals. Much will depend on the relationship between the HSSIB and other regulatory bodies. The GMC refers to Clause 12, which envisages co-operation between the HSSIB and regulatory bodies. It is not clear what this means. What do the Government intend this co-operation to involve? In particular, would the Minister be interested in exploring the possibility of reducing the blame culture more widely through the work of the HSSIB?

Of course, firm action does need to be taken where necessary. Clause 15 makes this point clear and I welcome the emphasis on limiting disclosure to situations where there is,

"a serious and continuing risk to the safety of any patient or to the public".

The "safe space" for doctors to provide information will need to be protected, as other noble Lords have pointed out. It is absolutely priceless to this Bill.

I hope that we can discuss in Committee the possibility of a restorative justice approach at the very start of certain complaints. Of course, this has worked extremely well in the criminal justice system. It would involve a meeting between the doctor, the patient and an independent person to try to resolve the matter amicably. I think a lot of patients would welcome that approach; certainly, the professionals would. Obviously, if you cannot resolve the matter amicably you have to move on to a further investigation. I would have thought that, in many cases, to avoid the blame matter coming into play, the HSSIB would be a good place for these investigations to go.

The GMC wants greater flexibility to enable it not to waste resources on investigations which lead to no further action. At the moment, it complains, the GMC is required to investigate every one of the thousands of complaints made every year concerning doctors' fitness to practice. I hope we can support the GMC in its wish to reduce that work and reduce the misery for professionals through amendments to the Bill.

As the Minister pointed out, the model for the HSSIB is of course the aviation safety investigation system that has apparently been so extraordinarily successful in improving safety through getting rid of the blame culture. A particularly difficult issue, I recognise, is raised in Clause 25. The clause limits disclosure to other regulators if the interests of justice in a particular case are outweighed by the public interest in doctors' willingness to participate in HSSIB investigations and the need to secure service improvements. This will undoubtedly raise concerns in many parts, but I welcome the assertion of the supremacy of the public interest.

NHS Providers proposes that the disclosure provisions be more tightly drawn, limiting disclosure further than envisaged in the Bill. It is concerned about Clauses 17 and 19, and I am inclined to agree with its argument. It argues that it cannot be right for a doctor to be compelled to give information to the HSSIB when they would be committing an offence if they did not do so, and to give that information on the understanding that they are acting within a safe space, and then for the information to disclosed to other investigating bodies. This seems to me to be a very serious issue, and I am sure we will come back to it in Committee.

The Parliamentary and Health Service Ombudsman argues that the HSSIB should be required to disclose information to it because the lack of disclosure could prevent it carrying out an effective investigation. It seems to have managed fine up to now without the HSSIB helping it, so I have no sympathy, I have to say. I would be very concerned if the safe space aspect of HSSIB were weakened. That would surely negate the whole point of the organisation, inhibit openness on the part of doctors and others, and limit the potential for learning lessons. In my view, we really would have scored an extraordinary own goal. Again, we will no doubt return to this issue.

Finally, I support the call from the Royal College of Surgeons in its helpful briefing for the remit of the HSSIB to extend to non-NHS services in the independent

sector. That proposal is supported by the Independent Healthcare Providers Network. I understand that the Government have a reason for not including this at the moment because of the Paterson report but, like the noble Lord, Lord Hunt of Kings Heath, I hope that at least we would include an enabling power in the Bill. However, I am much more persuaded by the noble Lord, Lord Scriven, who spoke very powerfully on the basis that we do not need to wait for the Paterson report at all and that the remit of the HSSIB should be extended to the independent sector where it is caring for people not under the NHS. My reason for supporting the surgeons' proposal comes from my experience as a Mental Health Act commissioner when I used to visit private and independent hospitals as well as NHS ones. It is so clear in my mind that the very worst services that I ever visited were in the independent sector. If we leave that out, we really have not done very well.

Like other noble Lords, I regard the Bill as having great potential. I just hope that we can play a constructive role in making sure that that potential is achieved.

6.08 pm

Lord Faulks (Non-Afl): My Lords, on the face of it, who could fail to welcome a Bill that, in the words of Clause 2(2), is designed,

"to identify risks to the safety of patients and to address those risks by facilitating the improvement of systems and practices … of NHS services"?

It can hardly be in dispute that things go wrong in the NHS. This is not surprising, given the number of interactions that take place between doctors, healthcare professionals and individuals. I join other noble Lords in my admiration for those who work in the NHS.

I should declare my interests as a barrister who, for the last 30 years, has acted for the NHS, the Medical Defence Union and claimants in medical negligence claims. The amount that the Government spend on these claims is said to be second only to the cost of decommissioning in the nuclear industry. To be more exact, in the 2018-19 annual report and accounts for the NHS, the cost was put at £2.4 billion. However, the NHS actuaries assessed that the true estimate of harm at current prices is £9 billion, 60% of which relates to maternity claims. As of 1 March 2019, it is estimated that £83 billion will be required for claims, to include those incidents which have taken place but have not yet been reported and those that have. Surely this has to change.

The Joint Committee that carried out pre-legislative scrutiny of the Bill did not suggest that there should be any changes to the claims system. Understandably, it might well have thought that this was beyond its remit. However, while this Bill will not reduce the NHS bill to allow more money to be spent on treating patients, that is not my main concern about it. I ask myself two central questions: first, what will it do; and secondly, are the powers that will be given to the HSSIB really justifiable? The body will investigate "qualifying incidents" and the body itself will decide what they are. I ask the Minister: what will the HSSIB be able to investigate which cannot be investigated at the moment?

It should be remembered that hospitals and trusts carry out their own investigations, which are sometimes called root cause analysis. Incidentally, these are routinely disclosed in litigation, which may give a clue as to how the courts are likely to exercise the balancing powers that exist in relation to the safe space provisions. The CQC has powers of investigation. NHS Resolution has a safeguard and learning department, designed to identify themes emerging from claims and lessons to be learned. There are complaints procedures, including the Parliamentary and Health Service Ombudsman. There are claims at inquests and disciplinary proceedings, and there are major inquiries such as those into Mid Staffordshire hospital, Bristol heart surgery, or HIV and haemophilia. Let us not forget the contribution of the royal colleges, or the considerable amount of published literature which contributes to the corpus of learning. I have not even mentioned all the less formal teaching and learning that goes on in the NHS. There is a duty of candour. As the noble Lord, Lord Hunt of Wirral, mentioned, we have Section 2 of the Compensation Act 2006. Then there is the sort of frankness with which we are familiar, as described by the noble Lord, Lord Turnberg.

Do we really need this additional body? It will take over from its non-statutory predecessor, set up in April 2017. Was that body really considered insufficiently independent? Was its work really hampered by lack of statutory powers? At the moment, I have serious concerns that there may be a serious duplication of investigation. Is it surprising that Keith Conradi, the chief investigator of the HSIB, told the National Health Executive that one of the issues in deciding whether to investigate was:

"Do we really want to waste our resources if there are others already involved in this?"

The problem with this new body is that it will understandably feel it is necessary to investigate in order to justify its existence. Will it find 30 matters per year which satisfy the qualifying criteria? Many problems are one-offs, involving rogue practitioners such as the much-mentioned Ian Paterson. I must declare an interest in that I was originally instructed for the NHS in connection with his claims, but I then became a Minister and had to give up that involvement. Problems may involve particular hospitals which have developed bad practices. There may simply not be that many general themes which need investigation. Of course I entirely agree with others who have suggested that if this body is to exist it must include the private sector as well as the NHS if lessons are to be learned.

Clause 33 requires the Secretary of State to publish a review of the effectiveness of the board. How will this be measured? How good a response will it be for it to say, "Well, we did not find much that met our criteria and we were concerned to avoid duplication"? Such restraint is not characteristic of quangos. Surely the measure of effectiveness might be much better to avoid the dust-gathering that we have heard about. In other words, if there has been a report and there have been recommendations, what is being done about them?

The second issue, which I can deal with much more briefly, refers to the HSSIB's powers, which will undoubtedly be probed carefully in Committee; a number of cogent points have been made in the debate

[LORD FAULKS]
about them. The justification for the really quite draconian powers is the need for this safe space. They are not popular with lawyers for claimants, the ombudsman, the Professional Standards Authority, the Campaign for Freedom of Information and the News Media Association. I was going to declare an interest as the chair-designate of IPSO, but the noble Lord, Lord Hunt, has already done that for me. It explains my change of location in your Lordships' House. At the moment, I am not persuaded that the Campaign for Freedom of Information is not right in saying that the Freedom of Information Act, whatever its shortcomings, provides a more balanced mechanism for encouraging candour yet protecting individuals. The NMA is right to point out the absence of any consideration of Article 10 of the ECHR in the HRA memorandum to the Bill.

I am sure that, if the Bill becomes law, the members of the body will perform conscientiously and with the best possible motives. I remain somewhat unconvinced about the analogy with the aircraft industry, although I take the point made by the noble Lord, Lord Ribeiro, about the need to learn from near misses, which was established in that industry. I also think that it is a good idea to learn from other disciplines. I have seen an extraordinary demonstration by a special care baby unit specialist, describing how they had learned how to make themselves more efficient by watching pit stops at Formula 1 races. The co-ordination there was a useful lesson.

Whichever party is in government, the department of health needs to spend some time deciding how it can reduce the huge amount of money spent on claims. Money can be saved to improve patient outcomes, which, after all, is what we should all want. The Bill will result in the creation of an expensive quango. I am afraid it smacks a little of blue-sky ministerial thinking. Despite my reservations, I very much hope that the Minister's optimism is justified and that this body is not in due course placed on some sort of legislative bonfire.

6.17 pm

Lord Patel (CB): My Lords, I am last and probably least. I have a problem: how much do I say? I have been here and I have done this.

It has been mentioned that this will be the first time that a world-class patient safety organisation is developed. That is wrong; it is not the first. We had one. It was called the National Patient Safety Agency, which was established by another Secretary of State. It was internationally respected for the work it did, but another Secretary of State decided that it was a quango and got rid of it. I remember the conversation that I had. He asked, "What has it achieved?" I can tell your Lordships, it achieved a lot and I can give loads of examples. However, it had also failed to achieve a lot, partly because of the volume and the methodology; it was only a drop in the ocean. It was disbanded, and I tried to persuade that Secretary of State that he should give it more statutory powers that it did not have, particularly of investigation.

Of course I welcome this Bill, because it gives the HSSIB statutory powers to investigate incidents that occur within the health service, which is not easy to do. I agree that the experiences of the aircraft industry are not always transferable to healthcare. Healthcare is complex, and many other types of issues can arise.

I should declare an interest. For 37 years I have been a maternity care clinician. I have had other positions in my life connected with patient safety, not only as a chairman of the National Patient Safety Agency but also in Scotland, implementing patient safety across the health service in all its aspects.

The noble Lord, Lord Turnberg, mentioned a case involving medicine being given through the wrong route. There were lots of examples, which have been investigated, of medicine being wrongly given through the spinal route or in long doses intravenously. We also found three cases of wrong-site surgery—but then we found that actually, there were 179 cases over three years. The agency established what is now universally regarded as an excellent idea: the surgical checklist. The Royal College of Surgeons gave it the credit—it does not deserve much credit otherwise—and it took it on board. Usually it is gung-ho, but it has taken on the responsibility of implementing what we developed as a safe surgical checklist. It is now universally accepted. By the way, the learning that we produced was also accepted in Canada, Australia and parts of the United States. Canada and Australia adopted our system in totality. So yes, it is possible to do this, but it is not easy to realise an ambition to stop however many hundreds of thousands of incidents. Neither is it necessary to chase that. It takes a long time to analyse where the system failure is. The safe space is a novel way to deal with it, but whether it is successful will depend totally on the respect that it gains of the profession, the patients and the public. If it does not gain their respect, it will be dead in the water.

There will be lots of challenges. We have already seen reports in the media—in one of the health journals, I think—about the dysfunctionality of the organisation. That will continue. We must also ensure that in its reporting it is fair and proportionate. Where it finds that there is a resource or staffing issue, as the noble Baroness, Lady Hollins, and others, mentioned, then it must say so, even though the Secretary of State and the NHS leadership might not like it. If it gives guidance that is directed to the leadership of the NHS, it must say so. That includes NHS England, the commissioners and anybody else. If it only targets the health professionals, it will fail, because system failures are not necessarily always the fault of the health professional, as we have found in many other areas. For instance, a drug was packaged in a 50-millilitre vial, even though it was always given as 5 millilitre infusion or less. The error occurred because somebody thought that 50 millilitres was the dosage and put that in an infusion, and the patient died. That had happened a couple of times in other hospitals, so we had to persuade the industry to change the packaging. It objected because of the cost, but in the end it was persuaded.

Incidents also occur in intensive care—for example, pneumonia-related incidents. By examining the system, the death rate from pneumonia caused by using a humidifier in intensive care was reduced to less than 30%. I could keep giving lots of examples but the point I am

trying to make is that the systems must be examined. The organisation must also make sure that it gets the respect of the profession.

The key thing is learning; where we failed was in implementing the learning. Here, the organisation must address the issue of who will implement the learning. If that is not done, three years later we will be having the same problems and the organisation will be blamed for not doing much, rather than the people who should be blamed for the implementation. In that respect, you need all the other people: not just the leadership of the NHS but professional organisations and others. I will give the example of an airline pilot's wife who died because of failed intubation during minor surgery, in the presence of an ENT surgeon. They were all concentrating on getting the tube down to intubate while the surgeon, who was completely scrubbed, was standing there and could have done the tracheostomy in 30 seconds. But that patient died, and the Royal College of Anaesthetists took on board how to find a safe system so that that might not happen again. It implemented that through its training procedures; anaesthetists in training practised this on models. I pay great credit to it but there are lots of other examples.

I agree with the noble Lord, Lord O'Shaughnessy, and others who mentioned that a culture change is required whenever a safety incident happens. It is important to work wherever it happened to bring about culture change, so that we grow an attitude and mindset about patient safety. We tried to do that when working with Don Berwick, who was mentioned earlier—I think by the right reverend prelate the Bishop of London. In Scotland, we employed his expertise for three years to bring about the culture change that was required.

Governance was mentioned—I think by the noble Lord, Lord Hunt of Kings Heath—and it is an important issue. When I took over, I faced the problem of poor governance that was making the organisation dysfunctional. I spent nine months trying to get rid of everybody in the leadership of that organisation. I was the bad guy, but it was not respected because of its poor governance issues. In that respect, it would help a great deal to have a chair with experience of patient safety. I am sure that we could find one.

I also agree about the private sector. I know that I commented yesterday to the noble Baroness, Lady Finlay, that maybe the private sector ought not to be involved. However, there should be an all-systems approach. I note that a briefing I got from the private sector says that it would like to be involved.

Maternity care and childbirth injuries are an area crying out for urgent attention. Litigation is to a large degree about money. Any practice that may cause damage to the new-born is horrendous—it should not happen. There should be zero tolerance of a baby that has grown normally having hypoxaemia at birth and brain damage for the rest of its life. It must not happen. We must not talk any more about who should do it and in what way; just have a strategy so that it does not happen. I assure your Lordships that it can be done. I would not like to blow my colleagues' trumpets, but it is possible to do it. I know that the current medical director of the HSSIB is capable of undertaking this exercise—a preliminary study on how to investigate and bring about the change that is needed in order to have zero tolerance of childbirth injury to the baby. It is possible to do that.

I look forward to Committee—whenever we get it—and I hope I can be fully involved then.

6.29 pm

Lord Hope of Craighead (CB): My Lords, I should like to take advantage of speaking in the gap to return to a point that the Minister touched on briefly in her opening speech. It relates to the position of the devolved institutions. The background to what I want to say is provided by Clause 40, which provides that, subject to subsections (2) and (3), the Act is to extend to England and Wales only. There is an exception for Scotland and Northern Ireland in relation to Clause 18, but that does not relate to the point I want to raise.

The National Health Service, thank goodness, extends throughout the whole of the United Kingdom. It does not require a great deal of imagination to suppose that incidents that require investigation could affect the safety of patients in Northern Ireland and Scotland as well as in England and Wales. Although the Bill is very careful in Clause 2(4) to say that the apportionment of blame is not the purpose of the investigation, the fact is that the reports under Clauses 22 and 24 will contain information that may be of close interest to those who are pursuing proceedings in civil courts—possibly criminal courts as well, but mainly civil courts, I think—seeking damages for things that have gone wrong.

That brings me to Clause 25 and the point I wish to draw attention to. Clause 25 provides that, subject to subsection (3), reports under Clauses 22 or 24 are not to be admissible in any proceedings which are determining civil or criminal liability. But that is subject to the ability of the High Court to order that they shall be admissible provided that the balance is properly struck, for the reasons set out in the clause. That clause extends to England and Wales only, not to Scotland and Northern Ireland. The matter of concern to me is that unless there is an equivalent provision in those jurisdictions providing that information contained in these reports is not to be admissible, they will be admissible. Unless there is a prohibition on it, they will be admissible according to the ordinary rules.

The noble Baroness said that memoranda of understanding were being entered into with the devolved institutions, but I would like to be reassured that it goes further than just an understanding. One requires hard legislation to follow the line that Clause 25 very properly takes in these matters. It may be that the Minister can assure us that the memoranda of understanding extend to an undertaking by the devolved legislatures that they will provide equivalent legislation. If not, there may be something to be said for extending Clause 25 to Scotland and Northern Ireland. One understands, of course, the problem of getting any legislation through the Northern Ireland legislature in present circumstances.

My point really is to be absolutely sure that the carefully constructed provisions in Clause 25 are matched in Northern Ireland and Scotland, as well as in England and Wales.

6.33 pm

Baroness Jolly (LD): My Lords, this has been an excellent debate. The noble and learned Lord, Lord Hope of Craighead, has just mentioned the issue of no blame, a theme that has run all the way through the debate. It started with the noble Lord, Lord Hunt of Kings Heath, talking about James Titcombe, who lost a child at Morecambe Bay Hospital and is insistent that there can be no learning from blame. This was echoed by the noble Baroness, Lady Finlay of Llandaff, and the noble Lord, Lord Hunt of Wirral. Another theme running through the debate was picked up by the right reverend Prelate the Bishop of London, who talked about a culture of learning. Those are the two strands: we need a culture of learning in our NHS organisations and one of no blame. I welcome the commitment to learning from incidents involving patient harm and from adverse events. I also welcome HSSIB's independence and I was grateful for the opportunity to talk to the Bill team yesterday.

This need to learn and to share is nothing new: something similar was being done 20 years ago. The noble Lord, Lord Patel, was just talking about it, as I thought he might, and I am sure that those here today will be able to tell the House that learning from such adverse events goes back even further. We heard very moving testimony from the noble Lord, Lord Turnberg, and, with their clinical backgrounds, from the noble Lords, Lord Ribeiro and Lord Colwyn. Will the Minister expand on how this theme could actually be woven into the Bill even further?

The governance of the body is interesting. For a body that will be looking at three or four cases each month, it seems very thoroughly governed. The board of HSSIB will have a chief investigator and chair as public appointments, as well as executive appointments and non-exec directors. The Joint Select Committee recommended that the appointments of both chief investigator and chair should be subject to the scrutiny of the Commons Health and Social Care Select Committee. I welcome the suggestion of the noble Lord, Lord Hunt of Kings Heath, that senior clinicians need to be involved in this, but experienced lay members can also bring welcome independent scrutiny—this was picked up by other noble Lords. It seems an appropriate measure, so why not include it in the Bill? It is something we may return to in Committee.

This is the first time that we know what the concept of a safe space entails. To allow individuals to talk about an event, secure in the knowledge that they will not be reported to others involved, is a powerful move, and I wonder whether it will take time for participants to gain confidence. Does the Minister have any insight into what measures might be taken to help with this? An expert advisory group was set up by DHSC to look at the HSSIB, yet its recommendations were not all followed. I understand that if you make a list of recommendations you can expect that they will probably not all be followed, but it had particular concerns about the duty of candour. The noble Lord, Lord Hunt of Wirral, spoke about candour, but I think he was talking about a slightly different sort of candour to what I think of as NHS candour. Here, we refer to frank and open conversation locally between patients and clinicians, and between different clinicians. Sometimes these are very uncomfortable conversations, where something has gone wrong and you sit down and have a facilitated chat. It can be very difficult to be honest and open, but it is really important.

Professional bodies express the need and the desire for the NHS to be an open, learning body, yet the Bill does just the opposite. How does the Minister see this being resolved? The reasons that healthcare regulators will seek disclosure from the High Court are likely to be linked to the proper exercise of their public protection duties. The proposed test surrounding the interests of justice does not appear to envisage or adequately cater for such applications. I am sure we will return to this in Committee.

My noble friend Lord Scriven brought to our attention the delivery of NHS services in prisons and in conjunction with social care. I welcome that addition, but I am also not sure whether the Bill applies to NHS care for service men and women, either in the UK or overseas. That is perhaps something else that might be looked into. I am sure we will also consider in Committee whether the Bill will include patients in private hospitals whose care is being funded by the NHS, and patients being treated by clinicians who work for the NHS as well as the private sector, but whose care is being provided for privately.

Following on from the point made by the noble Lord, Lord O'Shaughnessy, it is worth noting that NHS Providers recommends in its excellent briefing that all providers registered with the CQC should be part of the HSSIB's remit. I would support that, as a sensible suggestion that would make the situation crystal clear. Regulatory bodies are listed in Clause 2(6), but there is a very large number of people working in the NHS who are not part of a registration scheme. The most obvious are care workers, but it is also true for very skilled individuals such as clinical perfusionists. There are also other qualified technicians within the NHS who have no body with which to register. In my response to the Queen's Speech, I expressed my concern that care workers had no organisation with which to register. Clinicians, as I have just mentioned, are not registered either, and I know that this is not an issue of their making.

Where the incident involves an unregistered member of NHS staff, with whom would the HSSIB co-ordinate the practical arrangements called for in Clause 12? Will the Government consider looking again at the issue of non-registered NHS staff? The Minister may be aware that the GMC has suggested that now would be a time to look again at regulatory reform. Can she tell us whether there are any plans to make that happen?

This Bill is about processes—the Minister said as much when she opened this debate—to determine the truth about incidents during the provision of health services where there arose extreme causes for concern and to make recommendations to avoid repetition. It involves the patient, possibly their family and the clinicians and other staff. Yet in the Bill there is no heed taken of those individuals, or their care and well-being, in what would most certainly be a stressful and difficult time.

This has been an interesting and well-informed debate, but the two most powerful speeches were those of the noble Lords, Lord Turnberg and Lord Faulks. I shall spend the next couple of weeks rereading this Bill and thinking about its future—except perhaps, just perhaps, it will not have one.

6.41 pm

Baroness Thornton (Lab): My Lords, I am resisting using words such as "zombie" in this debate, particularly so close to Halloween. Given the debate taking place in the Commons right now and the fact that a decision might be taken as we speak to dissolve Parliament, this debate may come to naught. However, it seems likely that we will find ourselves discussing this issue again after a general election. I reassure the Minister that, when our positions are reversed, the work that she is leading on this Bill will not go to waste.

I thank all noble Lords for their contributions and the Minister for her comprehensive explanation of the Bill at the beginning of this debate. I agree with the noble Baroness, Lady Jolly, that, in his way, my noble friend Lord Turnberg's wise speech has given the House a test that we need to pass to make this Bill work. He did that eloquently and movingly and I thank him for that.

The noble Lord, Lord Patel, was quite right about the NPSA. I forgive the Minister for not having our historic memory; we had this in the past. I have in front of me quotations from the speech that the noble Earl, Lord Howe, made when he killed it off. He said that we needed to get rid of the arm's-length body of the NPSA and integrate patient safety into the NHS and the social care system. Here we are today setting up an independent arm's-length body to do just that. That is all I am going to say on that matter.

On these Benches, like most noble Lords today, actually we broadly support the aims of the HSSIB—not pretty, that name—and welcome the changes that have been made to the Bill since it was introduced in 2017.

I congratulate the Joint Select Committee on its deliberations and thank the many organisations, including the Library, which have taken the time to send briefings through to assist our consideration of the Bill.

Of course, the test of the Bill's success will be whether it has a significant impact on patient safety and changes culture, habits and working practices. I hope that we will not find ourselves in five years' time realising that we simply added another layer of complexity and bureaucracy to the NHS's existing patient safety regimes and that it had little impact. The reason I say this—again, it was highlighted eloquently by the noble Lord, Lord Patel—is that we know that it is people who need to change their habits, culture and working practices. However clever the structures and however laudable the aims of the HSSIB, if it cannot influence and change those habits, culture and working practices throughout the NHS, it will not succeed. In many ways, that is the most difficult thing we seek to do here.

The concept of safe space is interesting, plucked from the aviation industry, as many noble Lords said, where it has worked well. However, the NHS is not British Airways. In many ways it is a much more complex organisation, and it is full of human beings who do things to other human beings. Whether it is possible to transpose that concept is one of the key questions we will have to address during the passage of the Bill. The safe space provisions need to be balanced with the rights of patients and their families to be involved in the investigative process, and their results being open to public scrutiny—the noble and learned Lord, Lord Judge, said that, drawing the attention of the House to the need for patients to be at the centre of this, which is absolutely vital.

Is there a potential conflict between the proposed safe space powers for the HSSIB and the duty of candour for healthcare professionals? The duty of candour is intended to promote openness and transparency with patients and families within health and care. However, will the proposed powers for the HSSIB undermine that by allowing professionals to share information in private? Perhaps the Minister would like to share her thoughts about whether the duty of candour is helped or hindered by the proposed safe space powers. As the Professional Standards Authority says in its brief:

> "The proposed powers for HSSIB must not be a substitute for further work to embed a learning culture within regulatory structures and ensure that professionals feel safe and empowered to raise concerns within their workplace".

The issue of protected materials was raised with us by several organisations. It is obviously true that newspapers, in print and online, play a vital role in scrutinising the NHS on behalf of the public, so transparency and freedom of information laws not only help to protect the public but are part of the public confidence in the system. That the Bill seeks to impose a statutory ban on the disclosure of information beyond that warranted for its purpose, and backed by criminal sanctions, is very serious indeed. Our job is to scrutinise the breadth of that ban, and to test whether its sanctions could prove counterproductive. The question is whether the Bill could undermine confidence and patient safety rather than improve it. I think we all look forward to probing this issue, particularly when we read the comment of the Campaign for Freedom of Information:

> "The FOI Act's nuanced approach protects the information that the government says this bill is designed to protect, but without the bill's sweeping secrecy. The purpose of the prohibition, and the threat of prosecution, may be to reassure participants that they can assist the HSSIB without jeopardising their own position. But the terms in which this is done will lead to the withholding of information that could be disclosed without undermining that objective and which could contribute both to public understanding of safety issues and the HSSIB's own accountability".

There are serious questions which we will have to address in the later stages of the Bill. How will the public and other stakeholders be able to assess the rigour of the investigation, the propriety of the recommendations or whether improvements are being made, if they do not have access to the information on which the recommendations are based? Is the Bill compatible with Article 10 of the European Convention on Human Rights on the freedom of expression?

I turn to the issue of privately funded care. The HSSIB's investigations are limited to NHS services and do not extend to privately funded care under Clause 2. However, only today, noble Lords will have

[Baroness Thornton]
received a report from the CQC that addresses the safety issues in cosmetic surgery. Of course, most cosmetic surgery procedures are privately funded. The report is very critical and underlines the point about independent hospitals, 41% of which the CQC recently rated as requiring improvement. We must include the independent sector under the scope of the Bill.

The Joint Committee highlighted the restriction to NHS-funded care and asked that it be reconsidered. In 2015, the Public Administration Select Committee said that the exclusion of the independent sector is not consistent with the whole-system approach, which is kind of obvious. The EHRC, in its briefing, asked the Government to look further at extending the HSSIB's remit to privately funded care. I have a great deal of sympathy with the RCN, which said that,

"patients who use both NHS-commissioned health care services, and those who opt to have healthcare provided by private services, should receive the same rights to protections and safety from harm".

Like many other noble Lords, we will be raising this issue at the next stage of the Bill, and we have time to draft the necessary amendments for consideration.

It does not need the setting up of the new structure, or the time and expense that that involves, to know that we have a crisis in our NHS workforce. That of course has an impact on patient safety. Will an HSSIB review consider planned and actual nursing staff levels in healthcare settings during any incident that takes place? Will it do that in every investigation that it undertakes? That will be crucial.

Turning to the exceptions from prohibition, on the High Court order, Clause 17 states that a person may apply to the High Court to disclose protected materials to the HSSIB. It states that:

"The High Court may make an order on application … only if it determines that the interests of justice served by disclosing by the protected material outweigh … any adverse impact on current and future investigations by deterring a person from participating in them, and … any adverse impact on the ability of the Secretary of State to secure the improvement of the safety of NHS services".

Some of the briefings we are receiving express concern that the test for disclosure by the High Court is too vague. They are unclear how the considerations set out in Clause 17(3)(a) and (b) can be evidenced, other than by a statement to the effect that they apply in a case. The reasons that healthcare regulators will seek disclosure from the High Court are likely to be linked to the proper exercise of their public protection duties. Is not the Minister concerned that we might find a high volume of speculative applications to the court in cases where insufficient information is held by the regulators to satisfy themselves that they are aware of all pertinent information regarding their statutory duties to maintain public protection? That is one area where we will need to determine the interests of the different regulators.

As the Minister knows, I serve on the quality and safety committee of my local CCG. Our objective as part of the commissioning landscape in our area is to improve the quality and safety of commissioned services by identifying gaps in and concerns about service provision and to seek assurance related to those issues. If that sounds familiar, that is because it is exactly what is being said in the Explanatory Notes to the Bill.

My point is that many parts of the NHS are looking at patient safety. We look at all the never events in the hospital trusts in our area. We look for patterns; we look to fill gaps. That is exactly what we are there to do. Last night, I put to the Minister the question of how that fits into this new regime because, as the noble Lord, Lord Faulks, said, the question here is one of duplication and confusion.

Finally, what about people? How will we stop people taking a scattergun approach when they are outraged about the treatment of a member of their family and going to everybody—which happens, as we can see—including to this new body? It seems that we will have to be much more concise.

I will not cover the maternity issue. I am confused about that; we will need clarity on it. As I say, we welcome the Bill. We have heard some excellent contributions. The noble Baroness, Lady Hollins, asked what is, in many ways, the most pertinent question: how do we ensure the proper implementation of the excellent reports that the Bill will produce?

6.55 pm

Baroness Blackwood of North Oxford: My Lords, I welcome the almost unanimous support for the Bill. As ever, I am indebted to your Lordships' House for an informed and robust debate on the measures in the Bill, and I pay tribute to everybody who has contributed today. I want to take a moment to thank my right honourable friend Jeremy Hunt for his international leadership on patient safety in recent years. I also reiterate my thanks to the Joint Committee for its thorough pre-legislative scrutiny process, which has clearly been of great benefit to the Bill and has shaped our debate today. As we can see, it has created some important changes in the Bill.

I want to take a moment to reflect on why the Bill is so important. The new Health Service Safety Investigations Body will have the powers and the independence to conduct thematic investigations into patient safety incidents that occur in the NHS, in particular not to apportion blame but to spread systematic learning and establish the trust of NHS staff, patients and the public. Until now, we have not had that on a statutory basis. The noble Baroness, Lady Finlay, and the right reverend Prelate the Bishop of London rightly said that the opposite of a learning culture is a culture of fear. With that culture of fear, we cannot make the improvements in patient safety that we need. In my view and in the view of the Government, the establishment of a safe space system—which previously has been seen only in respect of transport accident investigation bodies—is a big step forward in ensuring that the NHS can go forward and learn from its mistakes, particularly by addressing the concern that, at the moment, NHS workers do not feel that they can speak out when mistakes occur. This new body will play an important role in improving patient safety and creating that vital culture of trust and learning, which will be able to prevent serious patient incidents happening across the NHS. I believe that we have the support of the whole House in achieving that.

As ever, a wide range of issues were raised in the debate, so I will do my best to respond to them as much as I can, but I will write to noble Lords where I

am not able to do so. One of the primary issues of concern was the effectiveness of the body. The best place to look for the answer to that involves looking at how well HSIB has already been performing in its pilot form within NHSI over the past year and a half. HSIB's internal management and staff survey found that the current investigation branch was very positively received. There was an engagement rate of 91%, and 80% of staff said that they are proud to work for the organisation and want to be there in two years' time. The responses are well above the scores of other NHS organisations, and it shows that there is more to be done and that it is progressing well.

In addition, we can measure the impact of HSIB as an organisation outside. The current investigation branch's approach puts patients and families at the centre of its work, and I can quote from the feedback it has received. People say that they found that the "process was so supportive" in the way that it was approached and that it was,

"a great feeling that you've got a voice which is entirely down to the approach",

of the current investigation branch. Another very touching response said that, "Just knowing that my mum's death may not be in vain and may prevent similar instances from happening to other families is the best legacy that I can think of in memory of my wonderful mum. That is what she would have wanted". That is what the HSIB has already achieved, and by putting it on a statutory footing we can ensure that it can do more and that it can do more effectively.

I want to move on to the important issue of the safe space, which was raised by a number of noble Lords, including the noble Lords, Lord Hunt of Kings Heath and Lord Turnberg, the noble Baronesses, Lady Walmsley, Lady Parminter, Lady Jolly and Lady Thornton, and my noble friends Lord O'Shaughnessy and Lady Eaton. I can do no better than to quote, as did my noble friend Lord Hunt of Wirral, from the report of the Joint Committee on the Bill:

"the primary and overriding purpose of this Bill is to put in place arrangements that will lead to learning and improvement arising from objective and comprehensive analysis of the causes of clinical mistakes and incidents, leading to better and safer outcomes for users of the healthcare system. We do not think this second principle is incompatible with obtaining justice in individual cases, which may and should be pursued by other means".

The safe space is central to that, but it does not prevent patients and families pursuing other routes of investigation via the CQC or via the criminal courts. It is very important to understand that.

As the noble Lord, Lord Hunt of Kings Heath, said, we have to strike a balance with the safe space by including an exemption for coroners. Coroners are judicial officeholders and have an important role to play in investigating certain deaths, so we have determined that it is appropriate to allow them to access protected material where this is necessary for them to fulfil their judicial functions, but we have also determined that we should put in place tight prescriptive measures to ensure that the safe space is protected as much as possible. On that basis, if a coroner requires information under the Coroners Act 2009, they are not able to share the information without a High Court order to do so, under Clause 19, and they can disclose only if the court makes an order after deciding, in the interests of justice, that the risk of disclosure is greater than any adverse impact on current or future investigations and the Secretary of State's ability to improve patient safety in the NHS. In addition, Clause 14 provides for a few small exemptions where HSSIB could disclose information if it was needed to help carry out an investigation, while Clause 15 provides that if it is,

"necessary to address a serious and continuing risk to the safety of any patient or to the public".

Those are important criteria because these investigations are not supposed to pose a risk to individual patients.

The noble Baroness, Lady Parminter, raised an issue regarding the PHSO. The Government's view is that the new body's investigations and those of the PHSO are different types of investigation and that the prohibition would be likely to have a limited impact on the ability of the ombudsman to investigate complaints about the NHS and other health bodies. The ombudsman will still be able to obtain information from the relevant trust. In addition, HSSIB will carry out only a small number of investigations—up to 30 a year—so the view is that the impact on the work of the ombudsman will be small. However, I take on board her views and we understand the position of the ombudsman.

The noble and learned Lord, Lord Judge, asked an important question about whether HSSIB has to take into consideration patient consent in order to participate in an investigation. It is required to publish its processes for ensuring that, as far as reasonable and practicable, patients and families are involved in investigations. It would be expected to be sensitive to the circumstances of patients and their families, and we would expect it to seek consent in the vast majority of cases. The current branch has developed very good working relationships with patients and their families, and we would expect the new body to continue that. However, I shall take away the point he has raised.

The noble and learned Lord similarly raised a point regarding a fine rather than a custodial sentence for a breach of information. The sanctions regime was considered following the recommendations of the Joint Committee. We believe that criminal sanctions are appropriate, regarding the seriousness placed on non-compliance with the relevant provisions in the Bill. On his point about whether it is an appropriate sanction, I will also take that away and consider the issue he has raised.

A number of noble Lords, the noble Lords, Lord Hunt of Kings Heath and Lord Scriven, my noble friend Lord O'Shaughnessy and the noble Baroness, Lady Finlay, asked questions about the scope of HSSIB to conduct investigations. HSSIB will be an independent body. It will be able to decide its own priorities and determine what it investigates based on the referrals that it achieves on its own intelligence. It is important that it should be free to do that, but those criteria will be consulted on. There will be an opportunity for patients, the public and the NHS to contribute to that consultation. The Bill is clear, however, that HSSIB may only investigate incidents that have an effect on the safety of patients which occur in the provision of the NHS and do not

[Baroness Blackwood of North Oxford]
involve an outcome that contributes to blame, so there are some parameters within the Bill. But the criteria of how those investigations are chosen will be set by HSSIB as an independent body.

On the question of who will be responsible for monitoring the implementation of recommendations, it is essential, if the body is to be established as effective and gain the trust of the public that it does that effectively. So the National Director for Patient Safety will chair a programme board to monitor the system response to the recommendations made by the new body. We do not believe that that needs to be set out in legislation. The Joint Committee agreed with us and agreed that HSSIB should not be responsible for enforcing its own recommendations. That is to ensure that it remains independent and does not become part of the system that is being investigated.

A number of specific questions were asked about what areas were in scope. The noble Lord, Lord Scriven, asked whether prison services were in scope. They are, providing that they are commissioned by the NHS. Indeed, HSIB has already conducted an investigation into NHS-provided prison services. The noble Baroness, Lady Hollins, asked about learning disability services, which would also remain in scope if they were funded by the NHS.

A number of noble Lords asked about staffing levels and the impact on staffing. Certainly, if the question of staffing and behavioural impact fell within the question and the terms of the investigation, that would certainly be appropriate for HSSIB to report on. The standard question is that the scope of HSSIB's investigations and learning will extend to any patient safety incident that occurred during the provision of NHS services in England, or which occurred at a premises where such services are provided. So that would also include NHS-commissioned services in the independent sector. I will return to the independent sector in a moment.

Dentistry is also covered, which my noble friend Lord Colwyn raised, and maternity, although HSSIB does not replace the local, independent inquiries, which would be done by NHS trusts. I shall return to that in the second. On maternity services, HSSIB will focus on only a small number of thorough national investigations conducted through the safe space for maternity going forward. But we have been clear that we will allow the current investigation branch to continue to run the local maternity investigations programme for a period—the commitment is for 1,000 maternity investigations—so that we can get maximum learning for the NHS. Those will continue but they will not be part of the statutory regime.

I note the strength of feeling in the House about the independent sector and I will take that issue away with me. I answered the question in my opening remarks so I will not go into too much depth now. At the moment, the independent sector is not covered, but I take the point on board and will take it away. In addition, I note the point raised by the noble Lord, Lord Scriven, regarding social care. However, it was the Joint Committee's recommendation that the new body should not be tasked or expected to be an investigatory body for social care. But it should be able to investigate all aspects of the healthcare pathway relating to patient safety investigation, so people should not fall through the cracks. I hope that that reassures him.

On the question of the independence of the body, which will also be critical, and responding particularly to the questions raised by my noble friends Lord O'Shaughnessy and Lord Ribeiro and the noble Lord, Lord Hunt of Kings Heath, the new body is modelled on some features of the AAIB. It will have statutory powers and carry out impartial investigations. But the AAIB sits within a department and we wanted to make sure that the new body was more independent than that and given a statutory, stand-alone role, which is why we are setting it up as a non-departmental body. It will have the powers to conduct impartial investigations and the Secretary of State may request but cannot direct the body to conduct a particular investigation. This is similar to the CQC set-up, and we think it is appropriate.

The chair and the non-executive directors will be public appointments subject to open competition. The process follows a published governance code which is independently regulated by the Commissioner for Public Appointments. This is in line with other public bodies, as is the process for the appointment of the chief investigator, which is in line with NHS England, Monitor, NICE and ALBs. The chief investigator would be appointed by the board, but would then be subject to the consent of the Secretary of State.

We are clear that the HSSIB would need to integrate and work closely with similar regulators in the space so that there is no question of duplication, which was a point of concern raised by the noble Lords, Lord Faulks and Lord Turnberg. We are reassured that that would not be the case given that the effectiveness of the HSSIB has already been demonstrated. We will make sure that it works effectively through the mutual duty of co-operation which has been set out in the Bill, a number of MoUs and the demonstration of the effective working of the body as it stands. It does not duplicate other bodies.

The National Patient Safety Agency was in many ways a forerunner, as noted by the noble Baroness, Lady Thornton, and the noble Lord, Lord Patel. I pay tribute to it for its work in that way. As noble Lords will be aware, in 2012 the decision was made to transfer the main functions of the NPSA to NHS England. Those functions now sit with NHS Improvement under Aidan Fowler. Unlike the NPSA, the new body will focus on only a small number of thematically based investigations that offer systemic learning without any blame attached and will have a statutory footing. I hope it is recognised by those who were involved in the NPSA that this is a step in the right direction.

In answer to the noble Baroness, Lady Thornton, and the noble Lord, Lord Turnberg, I say that these investigations do not replace very important local investigations. There is no intent to replace them in any way. However, there is value in national learning, as sometimes investigations which happen at trust level do not share best practice nationally. This is not a duplication on that basis.

I shall quickly move to the end of my speech, but I want to answer the question regarding the devolved Administrations asked by the noble and learned Lord, Lord Hope, and the noble Baroness, Lady Finlay. Currently the investigative branch has had positive interactions with the devolved Administrations in Scotland and Wales and has worked closely with trusts in Wales in recent investigations involving cross-border care. We think that more formal plans will be developed with the new body which will mean that other Administrations will be able to ensure that effective working can go forward. However, I take on board the concerns that were raised by the noble and learned Lord regarding Clause 25 and will ensure that it is fully tested.

There are a number of issues that I would like to go forward and raise, but I am aware that time is ticking on, that we are at the end of the day and that tomorrow may end differently. I thank everybody who has contributed today. There are some important questions that need to be resolved. As we have a little bit of time to go through it, I am sure we will be robustly tested, but ultimately the Bill is destined to play a key role in helping to prevent the recurrence of patient safety incidents and fulfilling the Government's commitment to ensure that the NHS provides high-quality, safe care. We expect the new body outlined in the Bill and the medical examiner system to be operational from April 2021, subject to the passage of the Bill through Parliament. I heard the support of this House very loudly today.

Bill read a second time and committed to a Committee of the Whole House.

Lord Bethell (Con): My Lords, I beg to move that the House do adjourn during pleasure to await the arrival of a Bill from another place. There will be a message on the annunciator showing when the House will resume.

7.15 pm

Sitting suspended.

Early Parliamentary General Election Bill

First Reading

9.15 pm

The Bill was brought from the Commons, read a first time and ordered to be printed.

House adjourned at 9.16 pm.

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