Joint Committee on the Draft Health Service Safety Investigations Bill

Submission by NHS Providers, June 2018

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We have 99% of all trusts in membership, collectively accounting for £74bn of annual expenditure and employing more than one million staff.

Key messages

- NHS Providers welcomes the creation of the HSSIB as an opportunity to develop a just culture in the NHS and a focus on learning. It is notable though that considerable expectations appear to have been placed on the HSSIB; the complaints and safety mechanisms within the NHS are already complex; and the HSSIB is a novelty to English healthcare. It is vital that HSSIB has a clearly defined remit and that expectations are managed as to what it can, and is intended to, achieve. The HSSIB is an independent body designed to investigate systemic safety risks. It also has a role in training and educating providers and clinicians in support of developing a just culture within the NHS. The HSSIB is not, however, the sole driver of a just culture – rather, this needs to be embedded throughout the NHS.
- Key to the success of the aviation, rail and maritime accident investigation branches has been taking a systemic approach to prioritising safety and embedding a learning culture throughout the given industry. We would note that: (1) they do not accredit organisations to carry out safety investigations or otherwise delegate investigations, and (2) recommendations may be focused across the full range of industry actors, whether on local or national bodies.
- The HSSIB will need to be fully independent of political influence, and maintain consistency of purpose through periods of political change which may impact on the regulatory and commissioning environment. However, its functional independence does not yet appear to be sufficient. The NHS' regulatory bodies – Monitor (now within NHS Improvement), the Care Quality Commission and the professional regulators – are accountable to Parliament, recognising their necessary objectivity. A similar argument could be made for underpinning the independence of the HSSIB. We would therefore suggest that the HSSIB needs to be accountable as an organisation to Parliament, rather than the Secretary of State.
- A legally protected safe space is necessary for the HSSIB's investigations; it is not appropriate for provider-led investigations – their investigations have different purposes, contexts and tools available. The HSSIB's safe space must be designed to build the necessary confidence and trust amongst staff and the public that the NHS is honest, open and transparent when things go wrong – and further consideration is needed as to better defining the boundaries of safe space.
- For the HSSIB to succeed in contributing to improved patient safety, any investigations associated with it must be carried out independently and without conflict of interest, and be perceived as such. Accreditation – wherein lies an inherent conflict of interest in NHS bodies investigating themselves and their peers – would seem to undermine these core requirements and risk engendering further distrust in the NHS' capacity to learn and improve. The intention behind accrediting trusts, that of developing a learning culture, would be better directed towards investing in the HSSIB's role in setting standards of investigations and of training and accrediting local investigators to support its own work.
- The HSSIB will be able to identify where change is needed and make recommendations for a given NHS body to take action. It will not directly effect change or have any enforcement or oversight powers, this being a necessary separation to maintain its independence. This also

avoids turning the investigations function into a de-facto regulatory process with judgment and apportionment of responsibility, as well as greater potential for self-interested obfuscation.

- The HSSIB will be carrying out high-profile investigations and detailed consideration is needed to ensure those involved in an incident and its investigation are not caused further distress. The objective must be learning – any necessary redress should be dealt with through other routes, and future participants should not be dissuaded from being forthcoming because of concerns about reporting on earlier participants.

General issues

Will the HSSIB command the confidence of patients and their families and healthcare professionals?

1. Yes, if built and managed upon the principles of a just culture. The foreword to the draft Bill notes that in the airline industry, *"a learning culture has led to dramatic improvements in safety"*.[1] The causal link described is vital: the HSSIB's investigations need to be based on that objective to learn, rather than to blame – where there are instances of malfeasance or malpractice, there are other existing mechanisms to address these. The HSSIB should focus on where there is the greatest potential for shareable lessons and replicable improvement, maximising public benefit.

2. NHS Providers strongly supports the expansion of human factors approaches, where people are not punished for making mistakes and speaking honestly. Organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety. A commitment to this approach needs to run through the draft Bill, the work of the HSSIB and the interactions of healthcare bodies with the HSSIB.

Should the HSSIB's remit extend to private healthcare?

3. Yes. NHS care and private healthcare interact in a number of ways. For example, capacity constraints may mean that care paid for by the NHS is delivered by the private sector; or where patients being cared for in the private sector require emergency care, this will be provided by the NHS. In the primary sector, particular dentists and opticians, there is a significant mix of NHS and private care undertaken which would be difficult to distinguish in terms of staffing and procedures. Therefore to exclude the private sector from investigations limits understanding of safety risks. We suggest that the HSSIB's remit extends to all providers registered with the Care Quality Commission (CQC). For the same reason, we would also suggest that the Bill refers to "healthcare" rather than the "health service".

Can patients and the public be confident that 'safe space' investigations will remedy the deficiencies of existing NHS complaints mechanisms?

4. No. It is important for the credibility of both complaints mechanisms and safe space / safety investigations – and for the confidence of patients, families, staff and healthcare organisations – that there is clear communication about the distinct remit of each.

5. NHS complaints mechanisms relate to incidents in individual healthcare providers and, as the Health Select Committee found in 2015, they tend to provide a route for patients and their

[1] Draft Health Service Safety Investigations Bill, Department of Health and Social Care (September 2017) https://www.gov.uk/government/publications/health-service-safety-investigations-bill

families *"in a timely manner to have their concerns and experiences understood, failings acknowledged and apologised for, and an assurance that no one else will endure the detriment they experienced".*[2] Responsibility is distributed across a number of local and national provider and advocacy organisations, regulators and ombudsmen, and there are multiple tiers to ensure a proper and fair response as to whether to uphold a complaint and what actions to take. There were 113,989 new written complaints made by or on behalf of patients about NHS hospital and community health services in England in 2017/18.[3]

6. The HSSIB is intended to investigate systemic safety risks and make recommendations to address those risks. It will operate a safe space to encourage those taking part in an investigation to speak freely, and the HSSIB will only disclose information under pre-defined circumstances. The HSSIB does not have a regulatory or operational role. It is expected that the HSSIB will undertake approximately 30 investigations a year. As Carl Macrae and Charles Vincent point out, it is a helpful characteristic of industry investigators that they are relatively small organisations. In describing the design of the investigation branches in the air, maritime and rail industries, they explain that, despite *"important and wide-ranging responsibilities, these agencies are lean organisations that operate with relatively small budgets. They are staffed by relatively small teams of highly skilled investigators who are specialists in incident investigation and safety analysis. To conduct major investigations, these teams co-opt and coordinate the expertise that exists within the industry, working constructively with all organisations and sectors involved in an incident. They lead, coordinate and oversee the work of safety investigation. This collaborative approach not only draws on safety expertise across the industry but actively builds and spreads that expertise too".* [4]

7. There may be trends in complaints data which the HSSIB analyses, for example, the predominant subject areas of complaints and growth in particular subject areas. This should help the HSSIB to identify potential investigation areas and feed into contextual understanding, rather than to replace the complaints mechanisms from which that data originated.

Are there any deficiencies in the drafting of the Bill that would prevent it from achieving the Government's objectives?

8. Yes. Throughout the draft Bill, those organisations and persons listed as relevant to investigations appear to need further consideration. As Macrae and Vincent have argued, *"All the organisations required to improve following an incident need to be involved in the investigative process. The purpose of investigation is not simply to find out what happened but from the very beginning to consider what improvements would be appropriate and to engage with the organisations that might implement them. Learning is a participatory process and begins at the start of an investigation, not at the end of it … Recommendations should be*

[2] *Complaints and Raising Concerns*, Health Select Committee (January 2015) https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/35005.htm

[3] Please note that this is still an experimental dataset and NHS Digital advise that care should be taken when interpreting the results. There may also be a different number of organisations reporting on complaints each quarter so the results may not always be directly comparable. *Data on written complaints in the NHS,* NHS Digital (June 2018) https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs

[4] Carl Macrae and Charles Vincent, 'Learning from failure: the need for independent safety investigation in healthcare', *Journal of the Royal Society of Medicine* (2014, Vol 107(11)), pp. 439–443. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4224654/

targeted at all relevant organisations across the healthcare system, from device manufacturers to regulators to healthcare providers to educators and professional bodies".[5]

9. However, the draft Bill is largely focused on frontline providers, commissioners and patients and families. We would suggest that it is made clearer that:

    a. The HSSIB's work is intended to cover all NHS provision (and, ideally, private healthcare as well). The draft Bill reads as particularly focused on NHS foundation trusts and trusts, but may benefit from greater clarity that primary care – with its variegated and evolving organisational structures – falls within its scope as well. For example, it is unclear whether references to an "English NHS body" should also include GP and dental practices, opticians and pharmacies.
    b. The context within which healthcare is delivered is a relevant consideration for the HSSIB. It needs to be able to take a clear view of the impact of rapid and wide-ranging system changes, and where appropriate recommend the removal of system and regulatory barriers to patient safety improvement, including costly burdens on providers that do not increase safety.
    c. A greater range of organisations should be presupposed as relevant. For example, in clause 3(1d), it may be pertinent to include a catch all phrase to indicate that specific groups need to be considered but are not limited to those listed. In clause 5(6), the list of those who may be interviewed in private excludes several persons those who may have had a direct or significant impact on healthcare provision. Those currently omitted persons may not be subject to the duty of candour and may only have confidence to speak up within the safe space of the HSSIB. Throughout the Bill, consideration needs to be given as to the involvement of any organisation likely to be party to a recommendation.

10. To establish the breadth of the HSSIB's scope more clearly in the Bill, we would urge that the following are able to be brought into an investigation, whether through explicit citation or absence of delineation as appropriate:

    a. Local authorities, as they commission NHS services.
    b. Third sector bodies, as they may be involved in or responsible for aspects of NHS provision.
    c. Social care providers, as they may have significant information about an individual's care.
    d. Partners of and suppliers to the NHS, taking account of the full range of activities around medicines and medical devices, blood and human tissue, and outsourced services.
    e. Other public services and bodies, such as prisons and schools, which may be premises where NHS services are delivered.
    f. Other bodies, particularly the Care Quality Commission and NHS Improvement (along with the intended closer working with NHS England and their regional teams), which can be closely involved in a trust's day-to-day operations.[6]

[5] Ibid.

[6] For example, this may be where regulatory action is being taken or where a particular support offer has been made. Where a trust is in quality special measures, NHS Improvement will appoint an improvement director, may appoint partner organisations and may lead changes to the management team. Where patients are "at immediate serious risk of harm, CQC can use its urgent powers to safeguard the patients". *Special measures for quality reasons: guidance for trusts*, NHS Improvement (December 2017) https://improvement.nhs.uk/documents/2158/special_measures_guide_quality_dec2017.pdf

11. Changing models of care and NHS structures, and increased system working, also need to be considered and the Bill future-proofed as far as possible. For example, sustainability and transformation partnerships and other integrated care models do not currently have a statutory footing, but may do so in the future, and in any case will have a significant bearing on provision of care. Their staff will need to be party to investigations. Meanwhile, it is intended that NHS care will increasingly be delivered in the community, including in people's homes. It is inarguable that the HSSIB cannot and should not enter private dwellings without permission, but consideration needs to be given to nursing and care homes and other forms of long-term care facilities and how they would be defined under the terms of the draft Bill.

Establishment and powers

Will the establishment of the HSSIB add to confusion about the responsibilities of the various bodies currently dealing with complaints and safety concerns in healthcare?

12. Without clearer communication about the objectives and scope of the HSSIB's work, this seems likely. Considerable expectations appear to have been placed on the HSSIB; the complaints and safety mechanisms within the NHS are already complex; and the HSSIB is a novelty to English healthcare. It is vital that HSSIB has a clearly defined remit and that expectations are managed as to what it can, and is intended to, achieve. The HSSIB is an independent body designed to investigate systemic safety risks. It also has a role in training and educating providers and clinicians in support of developing a just culture within the NHS.

13. The HSSIB is not, however, the sole driver of a just culture – rather, this needs to be embedded throughout the NHS. The Department of Health and Social Care, together with its arm's length bodies, needs to role model this approach, and encourage learning from mistakes over assigning blame. Healthcare providers likewise need to invest in developing positive ways of working, including through robust local investigations and complaints mechanisms. Creating the culture to which the Department and the NHS aspire will take commitment, trust, openness, investment and time.

Would the draft Bill equip the HSSIB with adequate powers to achieve the Government's objective of improving patient safety, or the ability of the Secretary of State to secure the improvement of the safety of the NHS? Does it go too far in any respect?

14. The HSSIB will contribute to, rather than achieve, these objectives. As discussed below, the accreditation plans go too far and NHS Providers believes that trusts performing safe space investigations would undermine these objectives.

Would it be appropriate to model the powers and status of the HSSIB more closely on similar bodies which investigate safety incidents in the aviation, rail or maritime industries?

15. Yes. Key to the success of these bodies has been taking a systemic approach to prioritising safety and embedding a learning culture throughout the given industry. We would also note that:

    a. They do not accredit organisations to carry out safety investigations or otherwise delegate investigations.
    b. Recommendations may be focused across the full range of industry actors, whether on local or national bodies.

Does the draft Bill ensure that the HSSIB is sufficiently independent of both the NHS and the Government?

16. No. The HSSIB will need to be fully independent of political influence, and maintain consistency of purpose through periods of political change which may impact on the regulatory and commissioning environment. However, its functional independence does not yet appear to be sufficient.

17. The Healthcare Safety Investigations Branch (HSIB) is currently established as part of the Trust Development Authority and hosted by NHS Improvement. Such an arrangement was an administrative necessity to establish the HSIB under Directions, but it is nevertheless worth being alive to the impact on perceptions of the HSIB's independence while being hosted by the sector's financial and performance regulator.

18. The draft Bill sets out that the HSSIB would be a new body corporate accountable to the Secretary of State. We understand that this may have been recommended and modelled on the approach taken with the Air, Rail and Maritime Accident Investigation Branches. However, we would suggest that it needs to be directed by and accountable to its own board of directors, and accountable as an organisation to Parliament, not to the Secretary of State, the Department of Health and Social Care or a host organisation.

19. Current NHS structures set out that NHS England is accountable to the Secretary of State, being the body responsible for arranging the provision of health services in England on his or her behalf. The NHS' regulatory bodies – Monitor (now within NHS Improvement), the Care Quality Commission and the professional regulators – are accountable to Parliament. The latter lines of accountability recognise the necessary objectivity of the regulatory bodies. A similar argument could be made for underpinning the independence of the HSSIB.

20. The HSSIB bears the heavy responsibility of investigating systemic safety issues in a sector with highly complex accountability and regulatory arrangements. It will be articulating difficult-to-hear messages for the changes which need to be made within the NHS – a totemic political issue in England. It would therefore seem prudent to build a 'firewall', insulating the HSSIB from both party and organisational political pressures. A secretary of state would have incentive and opportunity to influence the HSSIB's work and dampen its communication, but it is paramount that the Body acts without fear or favour and its independence is clearly given pre-eminence.

21. There must be a clear and robust rationale for the Body's accountability lines and appointments processes if it is to be able to develop trust amongst patients, families and NHS staff, and if it is to be able to help embed an open and honest learning culture within the NHS.

Safe space

Is a legally protected 'safe space' necessary to successfully undertake NHS investigations?

22. A legally protected safe space is necessary for the HSSIB's investigations; it is not appropriate for provider-led investigations – their investigations have different purposes, contexts and tools.

23. Following a serious incident, staff, patients and families will be devastated. A complex series of events will have led to the incident, and will be undertaken following it. Staff will be carrying the psychological burden of events, as well as facing uncertain professional and legal consequences. They will want to understand what happened, and will need support while events are examined, potentially by multiple bodies with enforcement powers, and potentially by their own colleagues. They have duty of candour responsibilities to fulfil, but in cooperating over a sustained period may fall foul of appearing as an 'unreliable witness' with memories of events potentially changing. In addition, the NHS has yet to develop a uniformly just culture, with an ongoing hierarchical approach and, at times, an instinct towards blame rather than learning in responding to complaints and whistleblowers.[7] For staff to speak up in this environment is incredibly difficult.

24. There is a wide body of research that evidences the importance of work environments that offer 'psychological safety' for staff to discuss in a confidential setting the circumstances of an incident that has resulted in avoidable harm. It is through a robust application of a safe space that the HSSIB will be able to command the confidence of participants and best understand the safety risks present and make appropriate recommendations.

Will creating a 'safe space' for safety investigations "encourage patients, families, NHS staff and other participants in an HSSIB investigation to speak freely for the purposes of promoting learning and improving safety"?

25. Yes, if implemented appropriately. For investigations to advance learning, they must be supported by a culture that recognises the inherent risk of error in healthcare and that when things go wrong there are often factors involved that relate to the ergonomic, non-human aspects of the work environment (ie, as recognised in human factors approaches to system design for safety in high-risk industries, including healthcare). Staff should not fear punishment for admitting to mistakes or errors of judgment in the course of their duties when there is no evidence of professional negligence, malfeasance, misconduct or other unprofessional practice as a contributory factor.

26. The HSSIB's safe space must be designed to build the necessary confidence and trust amongst staff and the public that the NHS is honest, open and transparent when things go wrong. As such, we do not support the extension of safe space to accredited provider investigations. We appreciate the intention to drive greater openness to learning within healthcare services, but consider that these ends can be met through better means. The extension of the safe space beyond the HSSIB would be a considerable departure from other industry investigation branches.

27. Instead, a cultural shift is required, embodied by trust leadership and supported by the national bodies, to move away from blame and towards learning and accountability. Cultivating an open and blame-free culture will be most important in creating the right conditions for patient safety improvement, but the responsibility for delivering improvement must remain with provider

[7] A number of reviews – such as the Inquiry into Mid Staffordshire NHS Foundation Trust and subsequent Government and Parliamentary reviews, and CQC's investigation into how trusts review and investigate deaths – showed that: there is still wide variation across the NHS in how effectively such responsibilities as the Duty of Candour are implemented to the satisfaction of patient and families; staff still fear bullying, blame and negative consequences locally, and also via professional and system-level regulatory responses, if they speak up about risks to safety; there is wide variation in the quality and capability of local investigations into mistakes and failings of care.

boards. The necessary culture shift will be supported by a balance between the HSSIB making safety recommendations, and provider boards retaining autonomy and accountability for the delivery and outcome of local patient safety improvement activities. Existing local investigatory and complaints mechanisms need to be used both robustly and compassionately, and be complemented by sector-led improvement and the national safety focus offered by the HSSIB.

28. The HSSIB also has a valuable role to play in sharing its expertise, in particular training investigators to ensure rigour, consistency and fairness in their work – but that does not equate to the extension of safe space to local investigations. Doing so is likely to add to perceptions that the NHS is not fully open and transparent in response to failings in care.

Would the draft Bill adequately protect from disclosure [of] information given to the HSSIB?

29. Further consideration is needed as to better defining the boundaries of safe space. For example, in the investigation of air accidents, there are measures for the protection of sensitive safety information, whereby certain specified records *"shall not be made available or used for purposes other than safety investigation"*. This includes the statements and identification records of those giving evidence, particularly sensitive and personal information, material produced in the course of the investigation or in developing reports, information and evidence from other investigations, and certain materials related to the incident.[8] It may be that adding similar clarifications to the Bill may increase certainty amongst staff and confidence in the HSSIB's investigations, so yielding better results.

30. It may also be that the boundaries of safe space can be clarified, and confidence enhanced, through memoranda of understanding with relevant bodies. For example, the Air Accident Investigation Branch (AAIB) and the Association of Chief Police Officers (ACPO) have agreed to work together in the early stages of certain aircraft accidents where there is a 'period of uncertainty' as to which should lead the investigation.[9] A clearer understanding of how the HSSIB will work with the police and regulatory bodies may give those involved in an incident greater certainty about how information they provide may be used.

31. Similarly, this Bill will have primacy over preceding legislation, but it may be prudent to agree with other investigatory bodies – such as coroners' offices and the Health and Safety Executive – that the safe space provisions will be respected according to the spirit and letter of the law. It may be helpful to confirm on the record how this Bill is intended to interact with Freedom of Information and data protection legislation, in order to minimise the potential to frustrate safe space provisions as well as give careful consideration of the rights of individuals in accessing their personal information.

Accreditation

Will the public have confidence in trusts carrying out their own 'safe space' investigations, and will this build public confidence in the NHS safety investigations system more generally?

[8] *Regulation (EU) No 996/2010 of the European Parliament and of the Council of 20 October 2010 on the investigation and prevention of accidents and incidents in civil aviation and repealing Directive 94/56/EC* https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2010:295:0035:0050:EN:PDF

[9] *Memorandum of Understanding between the Air Accident Investigation Branch (AAIB) and ACPO* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/383059/MoU_between_AAIB_and_ACPO_England_and_Wales_September_2012.pdf

32. No. For the HSSIB to succeed in contributing to improved patient safety, any investigations associated with it must be carried out independently and without conflict of interest, and be perceived as such. Any recommendations associated with the HSSIB need to be robust and objective, and perceived as such. Accreditation – wherein lies an inherent conflict of interest in NHS bodies investigating themselves and their peers – would seem to undermine these core requirements and risk engendering further distrust in the NHS' capacity to learn and improve.

33. For example, concerns have been raised recently about a review into deaths at a trust, where the lead investigator was perceived as having had a conflict of interest and whistleblowers have said that the findings of the review did not tally with their experiences. Despite being established as an independent review, its credibility and reliability have been called into question and the learning potential has been much diminished. The potential parallels with accredited trusts carrying out investigations are clear.

34. We recommend that accreditation is removed from the Bill, or at the very least discretion explicitly given to the HSSIB as to when it will begin to accept accreditation applications. Trusts will continue their serious incident investigations, and it is critical that they do so – the HSSIB has a role in improving the quality of those investigations, but they should not be pursued within safe space provisions.

Are the accreditation provisions in the draft Bill satisfactory?

35. No. The intention behind accrediting trusts, that of developing a learning culture, would be better directed towards investing in the HSSIB's role in setting standards of investigations and of training local investigators to support its own work.

36. The HSSIB needs to implement a safe space to test its application in the NHS and build confidence that it can be implemented without undermining accountability and transparency. Meanwhile, NHS leadership must support a just culture through local leadership development, quality improvement capability and national role modelling. Accreditation would seem to place excessive expectations on the HSSIB and weaken the responsibilities of the wider NHS in developing a just culture.

37. Moreover, while it is intended that HSSIB would approve accredited trust investigations, it remains unclear how the work of accredited trusts would fit with that of the HSSIB. The HSSIB will be developing replicable safety recommendations, selecting issues to investigate based on a combination of flashpoint events, trends and risks, whereas the perspective of accredited trusts will necessarily be restricted or potentially informed by its own operational and regulatory considerations. This threatens to frustrate the purpose and process of safety investigations within the NHS, as well as patients, families and staff.

38. There are further issues in the cost and staff burden to trusts of carrying out accredited investigations. It is unclear how accredited investigations will be paid for, and how they will sit alongside existing routes of investigation and complaints resolution – and how the difference will be communicated to patients, families and staff. Staff will also need to be released for training and for carrying out investigations, potentially for considerable periods, adding to the pressures on the frontline, again without clarity on how roles will be backfilled and funded.

Will the HSSIB be able to maintain standards of investigation?

39. No. If a trust is accredited, it is not for the HSSIB to maintain the standard investigations carried out by that trust. If there is doubt about the ongoing ability or appropriateness of a trust carrying out investigations, it should not be accredited. We question the principle of trust accreditation, in particular given the risk it creates for the credibility of HSSIB investigations, which could be diluted or damaged by investigations over which it has no control.

Reporting

Will the HSSIB be able to effect change and ensure its recommendations are acted upon?

40. No. The HSSIB will be able to identify where change is needed and make recommendations for a given NHS body to take action. It will not directly effect change or have any enforcement or oversight powers, this being a necessary separation to maintain its independence. This also avoids turning the investigations function into a de-facto regulatory process with judgment and apportionment of responsibility, as well as greater potential for self-interested obfuscation.

41. An important distinction needs to be drawn between recommendations and solutions. It will be for the persons and organisations identified in the HSSIB's recommendations to determine the solutions. We support the current wording of the draft Bill in clause 34, and would welcome parliamentary recognition of the importance of maintaining organisational autonomy and accountability.

42. Further, it is an unrealistic expectation that independent investigations are sufficient in themselves to prevent incidents happening again. They can identify what went wrong, what the causes were and how the risks involved can be better managed in future, but they cannot lead to risk being eliminated across the sector – rather they raise the potential for better management of those risks.

Would there be adequate safeguards for people referred to in HSSIB reports?

43. The HSSIB will be carrying out high-profile investigations and detailed consideration is needed to ensure those involved in an incident and its investigation are not caused further distress. The objective must be learning – any necessary redress should be dealt with through other routes, and future participants should not be dissuaded from being forthcoming because of concerns about reporting on earlier participants.