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NHS Providers

The Health and Care Bill
House of Lords, Report stage, March 2022

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

The majority of the Health and Care Bill (the Bill) is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement (NHSE/I), and makes changes relating to public health, social care and patient safety.

We support the opportunity the Bill presents to design the right system architecture that will deliver sustainable, high-quality care for the future. However, we also believe there are improvements that can be made which will make this the transformative piece of legislation the government wants it to be. NHS Providers has commented extensively on the Bill since its publication. Our briefings and written evidence to date can be found here. This briefing examines a number of amendments to clauses and schedules tabled at Report Stage.

Amendments covered in this briefing

Amendments related to mental health spending

- Amendment 2 (Insert new clause after clause 2: Spending on mental health)
- Amendment 57 (Clause 20: General functions)
- Amendment 109 (Insert new clause after clause 77: Meaning of "health" in the NHS Act 2006)

Clauses 13 – 15 (Integrated Care Boards)
- Amendment 9* (Clause 14: Establishment of integrated care boards)

Clause 20 (General Functions)
- Amendment 31
- Amendments 34 - 36
- Amendments 55 - 56

Clauses 35-40 (Secretary of State's functions)
- Amendment 80 (Clause 35: Report on assessing and meeting workforce needs)
- Clause 39: General power to direct NHS England
- Amendment 84 (Clause 40: Reconfiguration of services: intervention powers)

Clauses 53-59 (NHS Foundation Trusts)
- Amendments 88 - 91 (Clause 54: Capital spending limits for NHS foundation trusts)

Clause 62 (Joint working and delegation arrangements)
- Clause 62 (NHS Providers' view)

Amendments tabled relating to health inequalities
- Amendments 3 - 6
- Amendment 8
- Amendments 25 - 26
- Amendments 85 - 86
- Amendments 92 - 93
- Amendment 97

Part 3 (Secretary of State's powers to transfer or delegate functions)
- Amendment 115
- Amendments 117- 122

Part 4 (The Health Services Safety Investigations Body)
- Amendments 123 - 125

Mental health spending

Amendments 2, 57, 109

Amendment 2

Member's explanatory statement

This amendment requires the secretary of state to publish any governmental expectations as to increases in mental health spending by NHS England and integrated care boards (ICBs), and requires NHS England to include in its annual report information about such spending.

Amendment 57

Member's explanatory statement

This amendment requires an ICB to include in its annual report information about spending that relates to mental health.

Amendment 109

Member's explanatory statement

This new Clause clarifies that in the NHS Act 2006 "health" includes mental health (unless the context otherwise requires). Although the natural meaning of health is capable of including "mental health" the existing provisions of the Act are inconsistent about whether they
mention mental health expressly which could cause confusion.

NHS Providers' view

Despite welcome investment and focus and some additional investment in recent years on dismantling the stigma of mental ill health to achieve equity between the treatment of mental and physical health, and the best efforts of those working in and leading the sector, the healthcare system is still operating in the context of a mental health 'care deficit' where not all those that need help and treatment will seek or be able to access support. There are now 1.7 million people waiting to access mental health services. Prevalence data suggests there are many millions more who would benefit from services if they were able to meet the thresholds to access them. There are also continuing instances of mental health services not being prioritised. One such example is the under-prioritisation

of investment in the mental health estate, which is having a real impact on trusts' ability to ensure a safe and therapeutic environment. The Prime Minister's announcement on investment in new hospitals almost entirely overlooked the needs of mental health trusts.

The need to replicate the parity of esteem duty is even more important now given increasing levels of, and often more complex, demand for mental health services, at a time when there are growing care backlogs and unmet need across multiple fronts in health and care. The full mental health impact of the pandemic is still emerging, but mental health trust leaders are reporting extraordinary pressures. In particular, a high proportion of children and young people not previously known to services are coming forward for treatment, and they are more unwell, with more complex problems, than the patients previously generally seen by these services. Most mental health trust leaders expect it will take two years or more to tackle their care backlogs and return to pre-pandemic waiting times. But a number of mental health trust leaders told us they could tackle their care backlogs faster if they were given the right support.

We therefore welcome the amendment requiring the secretary of state to publish governmental expectations as to increases in the amount, and proportion, of mental health spending by NHS England and ICBs and include an explanation why NHS England, ICBs and NHS trusts and foundation trusts and their partners have an important role to play in advancing parity of esteem between mental and physical health, but their ability is ultimately reliant on the government prioritising sustained growth in investment for mental health. This is critical to avoiding a widening care deficit in mental health and inequity between physical and mental health care more broadly.

We also welcome amendments requiring NHS England and ICBs to include in their annual reports information about spending that relates to mental health, including an explanation of the statements and calculations. Taken together, these amendments should go some way to ensuring meeting people's mental health needs will be prioritised and funding to deliver mental health care is protected and built upon. We also welcome the addition of a new clause to clarify that in the NHS Act 2006 "health" includes mental health, unless the context otherwise requires.

While we support this focus on transparency and accountability for mental health spending by ICBs, NHS England and the government, it will also be important to ensure that other parts of the provider sector, such as community health services, also get the funding they need to meet increasing demand and deliver on national ambitions.

Clause 14 – Establishment of integrated care boards

Amendment 9*

Member's explanatory statement

This intends to ensure conflict of interest rules that apply to an ICB also apply to commissioning sub-committees.

NHS Providers' view

Each ICB is required to maintain and publish a register of any interests of its board members, committee or sub-committee members, and its employees. The board must ensure that any potential conflicts of interest that may affect the board's decision-making when commissioning services are declared promptly and managed effectively. Schedule 2 also sets out that the constitution must specify that an ICB must not appoint a person as member of an integrated care board if that appointment could reasonably be regarded as undermining the independence of the NHS because of their involvement in the private health sector or otherwise. We also understand that national support and guidance will be available for ICB chairs to advise on specific arrangements and clarify whether, in practice, an ICB member could also be a director / shareholder / employee of any private company. For example, many non-executive directors hold more than one position across different sectors.

The ICB is the accountable body when it comes to allocation of resource, including via delegations to joint committees. These joint committees could refer to place-based partnerships, for example, which bring together a wide range of partners across the health and care system (including the voluntary and community sector, as well as some independent providers e.g. social care or private healthcare providers) to collectively decide how best to design and deliver services at place level that meet local population needs. In line with the general commitment to flexibility and to local / system autonomy, we think there could be circumstances where a local private or voluntary sector provider would be well placed to join a joint committee with a focus on integrated service delivery whereby the usual arrangements to identify and manage conflicts of interest would, and should, apply. There are well established approaches in which board, and committee members declare interests such that they can be managed when they do arise. It does not seem reasonable to us therefore to further restrict the membership of those committees in a way which is prescriptive in law. We therefore do not support this amendment.

Clause 20 - General Functions

Amendments 31, 34, 35, 36, 55, 56

Amendment 31

Member's explanatory statement

This amendment requires an integrated care board to keep under review the skills, knowledge and experience that it is necessary to have on the board and take steps to address or mitigate shortcomings.

Amendment 34

Member's explanatory statement

This amendment requires the joint forward plan for an integrated care board and its partners to describe the health services that the board proposes to commission over the next five years.

Amendment 35

Member's explanatory statement

This amendment requires the joint forward plan for an integrated care board and its partners, in particular, to explain how the board proposes to discharge its duties under sections 14Z34 to 14Z44 (rather than just some of those sections).

Amendment 36

Member's explanatory statement

This amendment requires the joint forward plan for an integrated care board and its partners to set out any steps that the integrated care board proposes to take to address the particular needs of children or young persons under the age of 25.

Amendment 55

Member's explanatory statement

This amendment requires the annual report for an integrated care board to explain, in particular, how it has discharged its duties under sections 14Z34 to 14Z44 and 14Z47A (rather than just some of those sections).

Amendment 56

Member's explanatory statement

This amendment requires the annual report for an integrated care board to state how far it has exercised its functions consistently with views expressed by NHS England in the latest statement published under new section 13SA.

NHS Providers' view

The ethos behind ICBs as set out in the Bill is to allow for local flexibility in structures and methods of working to take account of diverse local circumstances. The amendments on the ICB board and on reporting go against the principles of flexibility and of local autonomy. The effect of this is likely to be to encourage cultures of compliance rather than problem seeking and solving cultures. It is of course right and proper that elements of each ICBs work should be reported, but primary legislation is perhaps not the best means of achieving this given that circumstances change quite frequently, but legislation changes much less so. A way to achieve the same objectives without creating inflexibility or impinging on local autonomy would be through statutory guidance which could be subject to dialogue and consultation before it is finalised and could be adapted to take account of changing circumstances. While the amendments can be accommodated, they are unlikely to facilitate more effective system working.

Trust leaders will support the principle of requiring the five-year ICB plan to address the needs of children and young people. The COVID-19 pandemic has had a significant detrimental impact on this population cohort, with backlogs in children's mental health and community services of particular concern to trust leaders. However, we wonder whether it is appropriate to enshrine a particular focus on one population group in primary legislation, given the significant needs of many other groups. In addition, the recently updated model constitution for ICBs now highlights several population groups (including children and young people) whose health needs must be met. Supporting ICSs to improve outcomes and access to care for children and young people will be important, and should be

supported by NHS England guidance/priorities, but this should not be at the expense of other population groups should the amendment be passed.

Clause 35 – Report on assessing and meeting workforce needs

Amendment 80

Member's explanatory statement

This amendment would require the Government to publish independently verified assessments every two years of current and future workforce numbers required to deliver care to the population in England, taking account of the economic projections made by the Office for Budget Responsibility, projected demographic changes, the prevalence of different health conditions and the likely impact of technology.

NHS Providers' view

While we welcome clause 35 which will place a new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged, we believe this duty needs to be considerably strengthened. We support the position set out by a broad coalition of organisations, which proposes an amendment to the Bill calling for the secretary of state to publish, every two years, independently verified assessments of current and future workforce numbers consistent with the Office for Budget Responsibility (OBR) long-term fiscal projections.

Ensuring we have the right levels of staff to care for patients now and in future is key – recent analysis from the Health Foundation shows that over a million more health and care staff will be needed in the next decade to meet growing demand for care. The gap between service demand and workforce supply is a significant concern which must be addressed if the NHS is to protect its staff from burnout alongside meeting rising demand pressures and recovering from the COVID-19 pandemic. Our 2021 State of the provider sector report found that almost all (94%) trust leaders were extremely or moderately concerned about the current level of burnout in their workforce. Pressing workforce shortages and the resulting unsustainable workload on existing staff can only be tackled with a robust long term workforce plan.

This amendment will give the NHS the best foundation to take long-term decisions about workforce planning, regional shortages and the skill mix to help the system keep up with service user need. Transparency on projections enables the system to plan and policy makers to scrutinise. It is a way to ensure that the NHS has the staff numbers required to deliver the work that the OBR estimates the service will need to carry out in future.

We do not think that a workforce planning document as set out in the Bill will be sufficiently responsive to potential societal shifts and support the two-year reporting cycle put forward in this amendment. We believe that this would allow government and other bodies sufficient time to begin taking action in response to the projected numbers, without allowing too long between reporting cycles.

The amendment also would ensure close engagement with trusts and other key stakeholders in the creation of the assessments, and for the assessment report to be presented to parliament; we support this as it encourages greater transparency and accountability in regard to workforce planning.

Clause 39 – General powers to direct NHS England

NHS Providers' view

Clause 39 of the Bill (General power to direct NHS England), as currently drafted, appears to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions would be much more likely to be swayed by political motivations rather than being objectively evaluated on the basis of the interests of patient populations and quality of care.

Clinical and operational independence must be maintained in order to ensure equity for patients within the service; the best use of constrained funding; and clinical leadership with regard to prioritisation and patient care.

While the intention may be to deploy these powers on rare occasions, the potential impact is so great that safeguards must be put in place. We welcome the decision to add a duty to publish a direction but believe additional safeguards are needed to protect the NHS's independence by defining the power in terms of:

a. The publication of guidance defining an objective "public interest" test, its scope and the areas of decision making and activity where it might apply and, conversely, not apply. As drafted, the language is subjective and unclear. In line with the use of this test in other regulatory settings, there should be clear, proportionate and necessary criteria before the power is exercised.
b. The need for full and timely transparency when the power is exercised – we believe this should include the need for the secretary of state to set out why their use of the power of direction, on each occasion, meets an objectively defined public interest test before giving a direction.
c. The need for appropriate consultation with affected parties before the power is exercised including, as part of the transparency arrangements, the publication of the views of the body being directed.

A lack of safeguards could arguably expose the government, any secretary of state, the service, and patient care to undue, unmanaged risk. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate. We believe that any direction given by the secretary of state should be in the public good, its impact should be understood, and such impacts should be reviewed so that adverse effects can be rectified.

Clause 40 - Reconfiguration of services: intervention powers

Amendment 84

NHS Providers' view

This amendment removes clause 40 from the Bill. Clause 40 (and Schedule 6) relates to local service reconfigurations. As currently drafted, the Bill gives wide-ranging powers to the secretary of state to direct local service reconfigurations and does so without appropriate safeguards leaving open the potential for the most senior political involvement in a range of decision making from relatively small reconfigurations (within and by a single provider for example) to larger schemes which require clinical leadership, objective evaluation of the options and full public consultation.

We would encourage peers to vote in favour of this amendment. Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making.

The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. These proposals will not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services.

Clause 54 – Capital spending limits for NHS foundation trusts

Amendments 88, 89, 90, 91

NHS Providers' view

We welcome these amendments which ensure that an order imposing a limit on the capital expenditure of an NHS foundation trust will only relate to a single financial year rather than spanning more than one financial year. This reflects the NHSE/I's original legislative proposal published in September 2019 which contained a carefully negotiated position which gave NHSE/I a reserve power, to be used only in extreme circumstances, which would "automatically cease at the end of the current financial year".

This set of amendments also enables NHSE/I to impose a limit part-way through the financial year. For example, given monthly reporting data on capital spend, the power may be exercised in-year when risk of breaching the CDEL limit becomes apparent.

It is also our understanding that the use of the power may be used in the financial year immediately prior to the one in which the order relates. The power would be exercised when NHSE/I identifies the profile of spend included within capital plans – submitted to NHSE/I prior to the start of the financial year – risks breaching DHSC's CDEL envelope. Capital plan submissions would therefore enable to NHSE/I to determine whether the CDEL limit could be breached before the financial year has begun. Our expectation is that the power would not be used earlier than the final quarter of the preceding financial year.

Clause 62 - Joint working and delegation arrangements

NHS Providers' view

We would like to seek clarification on an aspect of the wording of this clause. Throughout this Clause the word 'body' is used for both the body making a delegation and the body receiving a delegation. Therefore paragraph (6) could be interpreted as making rights and liabilities accruable by either the body making the delegation or the body receiving it. Clarity about the meaning of the paragraph would be helpful.

However, even if we have clarity, there are possible difficulties. It would seem that the purpose of the clause is to encourage bodies to make delegations to one another rather than to enter into contracts. However, paragraph (6) could frustrate that aim regardless of whether 'body' refers to the maker or receiver of the delegation. If it is the body making the delegation that retains liabilities, there is no advantage to them in making the delegation. In the event that they were sued because of service failure they alone would be responsible even though it might be the body receiving the delegation that caused the service failure. It would also seem that the delegating body would have no right of redress from the receiver of the delegation should they fail to deliver or provide a service that does not meet the required quality standards. So, the delegator would be far better off entering into a contract which would allow the body letting the contract of to exact penalties on the contractor in the event of failure and the courts would decide on liability in the event of a lawsuit.

Conversely if the liabilities accrue to the body receiving the delegation there would be no advantage to accepting the delegation. That body would probably prefer to enter into a contract where they may be subject to penalties if things go wrong, but would not be solely liable for any tort. So, paragraph 6 may well frustrate the intention of the Clause to promote delegation over contracts. If paragraph 6 were to be deleted in its entirety both delegator and the receiver of the delegation could rely on paragraph 4 and it could be left to the courts to decide on matters of liability if and when such circumstances arise. Alternatively, paragraph 6 could be amended to ensure an equitable share of liability, but it would be difficult to draft wording to achieve that end and the deletion of the paragraph offers a neater solution.

Health inequalities

Amendments 3, 4, 5, 6, 8, 25, 26, 85, 86, 92, 93, 97

NHS Providers' view

This group of amendments introduces a specific reference to health inequalities when assessing the impact of decisions on the health and wellbeing of the population. This brings a helpful recognition of the need to avoid a differential impact on different communities when decisions are made at a national level. However, it is not clear how this group of clauses goes beyond existing requirements as part of the public sector equality duty and will not automatically lead to a narrowing of inequalities on its own. Similarly, clause 20 may support an increased focus on population health and align with ICBs' existing duty to plan services in reference to its understanding of the needs of the wider population rather than specific patient groups. This amendment strengthens the link between the health of the wider population and the services they may need in the future. This will need to be supported by improved data infrastructure, however, as there is still variation in how ICBs are collecting and analysing data on health inequalities. Finally, while we support a focus from NHS England on reducing inequalities in access, experience and outcomes as they are intrinsically linked, we have concerns that in enshrining these domains in primary legislation, some flexibility may be lost in how the health and care system prioritises work on health inequalities in the future, particularly given healthcare plays only one small part of the effort to reduce health inequalities as a whole.

Clauses 91-97 – Secretary of State's powers to transfer or delegation functions

Amendments 115, 117, 118, 119, 120, 121, 122

Amendments have been tabled to remove clauses 91-97 (Part 3) from the Bill.

NHS Providers' view

Part 3 of the Bill as it stands would give the secretary of state a wide range of powers to modify the functions of a set of NHS arm's-length bodies without primary legislation. While we recognise the logic of the secretary of state having powers to confer functions on and move responsibilities between arm's-length bodies via secondary legislation these new powers are far more extensive than that. There is a real danger that the application of the powers as currently drafted could threaten the stability, proper management and operational independence of key parts of the NHS. For example,

the Bill currently prevents the secretary of state from making changes that would make NHS England redundant – but there is nothing to define that redundancy.

The House of Lords Constitution Committee report on the Bill, raises serious concerns about the range of secretary of state powers contained in this Bill and concludes that these new powers, coupled with new powers for the secretary of state of oversight, delegation and transfer of function, "could alter the balance between the Government's constitutional responsibility for the provision of health care and providers' ability to function in a manner that can respond effectively to local needs. It also risks undermining accountability by making it more difficult to understand which body is responsible for a particular function of the NHS."

Decisions about abolishing, changing or transferring functions between bodies should be carefully scrutinised by Parliament. In the absence of proper parliamentary scrutiny, we think that it is important to narrow the scope of these powers. If the secretary of state believes that any of the functions of the relevant bodies should be abolished, or removed, then Parliament should have the opportunity to scrutinise those proposals. Should it be necessary and appropriate to make these changes – which would substantially alter the functioning, oversight and regulation of the NHS and health research – the secretary of state would, as is proper, need to find another legislative route and ideally that would be done via primary legislation.

Clause 100 - Deciding which incidents to investigate

Amendment 123

Member's explanatory statement

This amendment seeks to ensure that the HSSIB has sufficient resources at its disposal to mount investigations directed by the secretary of state.

NHS Providers' view

This amendment calls for the HSSIB to be able to request extra funding to carry out an investigation following a direction from the secretary of state. The aim of the HSSIB is to conduct a small number of investigations – if extra investigations are directed by the secretary of state, this could pose a challenge in terms of financial planning, capacity and resources for the HSSIB. A direction issued by the secretary of state could potentially disrupt planned investigations, and the benefit that could be derived from them, if resources have to be diverted. It is important therefore that sufficient additional

funds are made available so that the HSSIB can carry out the direction properly and avoid any adverse impact on any investigations it has already scheduled.

Schedule 14 - Prohibition on disclosure of HSSIB material: exceptions & Clause 114 - Restriction of statutory powers requiring disclosure

Amendment 124

Member's explanatory statement

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

Amendment 125

Member's explanatory statement

This amendment, along with another amendment to Schedule 14, would remove the provision allowing coroners to require the disclosure of protected material.

NHS Providers' view

The impact assessment for HSSIB's provisions in the Health and Care Bill sets out that the intended effects of HSSIB are to:

- "[improve] public confidence in investigations arising from both the independence of HSSIB and the provision of 'safe space' to protect confidential information from disclosure;
- ...make recommendations that improve patient safety across the system;
- encourage a culture of learning and safety improvement throughout the healthcare system; and
- drive greater consistency in the quality investigations."

Achieving these ambitions requires careful design of this new organisation.

This includes:

- A clear focus on learning and safety improvement – there are multiple avenues and bodies which undertake incident investigations in the NHS. These have various objectives, but HSSIB stands alone in having an absolute focus on learning, not blame, and on systemic risk factors.

The evidence and experience of the NHS and across other industries is clear that a learning culture leads to significant safety improvements. HSSIB has a key role to play in fostering and enabling a learning culture within the NHS.

• Evidence gathered within a safe space – this encourages and enables openness and learning. There is a strong connection between 'psychological safety' and a culture of learning – to open up and be candid, people need to feel confident that the information they share will not be used unfairly or passed on.
• Clear criteria for considering an investigation – while HSSIB may carry out an investigation into the same incident as another body, HSSIB will not be duplicating any other given investigation. It will have a systemic risk focus, grounded in a set of criteria used to determine whether there may be a pattern and whether an incident should become a reference event for an investigation.
• Limiting the number of investigations per year – HSSIB is expected to carry out around 30 investigations a year, which will ensure that it remains focused and prioritises effectively and that it carries out investigations to the appropriate depth.
• Independent, expert-led investigations – this enables objective and comprehensive analysis, and robust, credible, systemic-focused conclusions.

There is much to welcome in the ambition, innovation and drafting of safe space in the Bill – and much to improve. For HSSIB to be able to properly investigate the systemic causes of safety issues, and to harness the knowledge and insight of those involved, a legally protected and robustly respected safe space is essential. It is particularly notable that a core part of the design of safe space here is the protection people have in sharing information with HSSIB being counterbalanced by a compulsion to participate in HSSIB's investigations. It is paramount to respect those two aspects of compulsion and protection, and for participants to be aware of the basis on which they are taking part in an investigation and what the implications for them are.

The exceptions to non-disclosure of safe space material, as currently drafted in the Bill, do not sufficiently maintain HSSIB's safe space. The boundaries of safe space must be clear, consistent and constant. If those taking part in the HSSIB investigation do not have trust in the safe space provided, there is a high risk that they will feel unable to share information fully and fearlessly. This will undermine the investigations carried out by the HSSIB, and how the HSSIB is intended to stand apart from other bodies in the health system. Therefore, we are opposed to allowing senior coroners to access safe space materials and support these amendments.

We do not agree that the case has been made for the necessity or appropriateness of their access. It is not the duty or purpose of HSSIB to act as a branch of the coroner. The coroner has multiple other avenues of information and powers of investigation, and it does not need access to the HSSIB's protected material simply thanks to the convenience of the HSSIB's existence. In 2019, the Joint Select Committee which reviewed the draft Health Service Safety Investigations Bill concluded: "We recommend that the draft Bill be amended to put beyond any possible doubt that the safe space cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners".

Provisions have also been made for the High Court to order disclosure (which can include onward disclosure). The bar for the High Court making such an order needs to be much higher. This includes only ordering disclosure in extremis and with appropriate safeguards around the interests of the public, patient and staff safety, current and future investigations and participants. In the current drafting, the door to safe space has been left ajar. This has invited further applications for access to safe space, including from the Parliamentary and Health Service Ombudsman (PHSO). We would expect other organisations to make their own demands, whether on the face of the Bill or through the High Court, to obtain protect material in pursuit of their own investigations. To a considerable extent, investigations of incidents in the NHS to date have been focused on attributing blame and fault. While it is understandable that investigating organisations will want to develop their own robust conclusions, such calls in fact underline the importance of HSSIB having a safe space. A safe space for participant in investigations focused on learning it is a fundamental part of the careful design of HSSIB. It should not be co-opted towards objectives contrary to this. HSSIB has no role in determining blame or liability, or in regulatory action.

It must be remembered that all usual information and investigation channels continue, and HSSIB's final reports – which set out in detail its narrative of events – are publicly available. The convenience of HSSIB's existence is not a compelling reason to require it to disclose information, and it is not the role of HSSIB to act as a branch of the coroner or any other organisation. Finally, it is right for participants to know and be sure of the basis on which, and to what ends they are taking part in an HSSIB investigation.