HOUSE OF LORDS Library Briefing

Health Service Safety Investigations Bill [HL]
HL Bill 4 of 2019–20

On 29 October 2019, the second reading of the Health Service Safety Investigations Bill [HL] is scheduled to take place in the House of Lords.

Summary

The factsheet accompanying the bill states its main objectives are to:

- establish the Health Service Safety Investigations Body (HSSIB) as a new independent arm's-length body with powers to conduct investigations into patient safety incidents that occur during the provision of NHS-funded services;
- create a 'safe space' whereby participants can provide information to the HSSIB safe in the knowledge the information will not be shared with others, and only disclosed under certain limited circumstances as set out in legislation; and
- amend the Coroners and Justice Act 2009 to allow for NHS bodies, rather than local authorities, to appoint medical examiners; and place a duty on the Secretary of State to ensure the system is properly maintained.

The HSSIB would take over the duties of the current non-statutory Healthcare Safety Investigation Branch, which was set up on 1 April 2017. It would effectively put this body on a statutory footing, giving it full independence and statutory powers. However, the Government has stated that the maternity investigations programme currently led by the investigation branch will not be included in the bill. Concerns about this aspect of the body's duties were raised by the joint committee set up to consider a draft bill published in September 2017. Although the Government initially rejected the committee's concerns, it has now indicated that the maternity investigations will not transfer to the statutory body upon its establishment.

The medical examiners system began operation in April 2019 with the focus of ensuring all deaths are independently scrutinised. The bill would seek to put the system on a statutory footing. This provision was not included in draft bill.

As healthcare is a devolved matter, the main principles of the bill apply to England only. However, the bill does allow the HSSIB to enter into agreements to run investigations into incidents occurring during the provision of NHS services in Wales or Northern Ireland.

Russell Taylor | 24 October 2019

What the Bill Does

Part 1: Health Service Safety Investigations Body

Clause 1 would establish the HSSIB as a body corporate, with schedule 1 providing details on its management, structure and membership.

Part 2: HSSIB's Investigation Function

Clauses 2 sets out the body's investigative functions. The HSSIB would investigate "qualifying incidents" that occur during the provisions of NHS services or at premises at which NHS services are provided. Qualifying incidents are defined as those that have or may have implications for patient safety. The explanatory notes explained:

> The HSSIB could investigate an incident that occurred during the provision of NHS services in a private hospital or privately-owned care home. The HSSIB could also investigate an incident such as an assault that occurred not during the provision of NHS care but on premises providing NHS care. However, the HSSIB can only investigate English NHS services.[1]

The bill states that the purpose of investigations is to identify risks to the safety of patients and to address those risks by facilitating the improvement of systems and practices in the provision of NHS services (clause 2 (2)). It may not consider blame or criminal or civil liability (clause 2 (4)).

Clause 3 would require the HSSIB to develop and publish:

- the criteria it will use to determine the incidents it will investigate;
- the principles that will govern investigations;
- the processes that will be used in carrying out investigations; and
- the processes for ensuring that patients and their families are involved in investigations.[2]

Clause 3 also specifies that the HSIBB must review the criteria, principles and processes three years after first publication, and then every five years. It must also consult with the Secretary of State (and any other person it considers relevant) when developing or revising them.

Clause 4 would require the HSSIB to consider representations made by any person the HSSIB considers appropriate before deciding whether to investigate an incident and to consider any request made to it by the Secretary of State to carry out a particular investigation. However, the final decision would lie with the HSSIB.

Clauses 5 to 12 relate to arrangements and powers to carry out investigations. For example:

- Clause 5 sets out powers to enter premises (except those used wholly or mainly as a private dwelling) and to seize or access documents relevant to the investigation.

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[1] *Explanatory Notes*, p 7.

[2] ibid.

- Clauses 7 to 9 contain provisions for how the HSSIB should give notice to individuals requiring them to provide information or to be interviewed regarding investigations.
- Clause 10 creates new criminal offences for obstructing an investigator in the performance of functions conferred under clause 5 or for failing to comply with a notice under clause 7 without a reasonable excuse. It would also be a criminal offence to knowingly provide false or misleading information to an HSSIB investigator.
- Clause 12 would require the HSSIB and any other specified body (such as a foundation trust or the Care Quality Commission) conducting an investigation on the same, or a related, incident to cooperate on practical arrangements. The HSSIB must issue guidance as to what it considers to be related incidents.

Clauses 13 to 21 prohibit the disclosure of any information, document, equipment or other item held by the HSSIB in connection with its investigations, subject to certain exemptions. Exemptions include:

- that the information had already been lawfully disclosed;
- it is reasonably required as part of the investigation;
- if it is believed to be necessary to address a serious and continuing risk to the safety of a patient or the public;
- if ordered by the High Court; and
- if required by a coroner.

Clause 20 sets out new criminal offences of unlawful disclosure under the legislation.

The Government states that the aim of these provisions is to create a 'safe space' for participants during the investigation, enabling them to "speak openly and candidly with the HSSIB".[3]

Clauses 22 to 26 contain provisions relating to the publication and use of the HSSIB's reports. Clause 22 states that the HSSIB must publish a report on the outcome of its investigations. These must contain the facts of the investigation and an analysis of the findings, together with any recommendations as to the action to be taken by any person(s) specified. Clause 23 states that reports must first be circulated to those who may be adversely affected by it and may be circulated to other potentially interested parties. Clause 23 stipulates that the HSSIB should invite comment at this stage. Clause 24 sets out how interim reports may be published during an investigation to address urgent risks, or issues known early in the investigation, and to allow urgent action to be taken by the NHS. Under clause 26, the HSSIB's recommendations would require a written response from any addressee(s).

Clause 25 provides that the HSSIB's reports are not admissible in certain proceedings (including those relating to civil or criminal liability or prior to employment tribunals), unless the High Court makes an order to the contrary.

Part 3: Additional Functions

Clauses 28 to 33 contain provisions on additional and supplementary functions the HSSIB would have. For example, clause 28 would require the HSSIB to give assistance to specified bodies in carrying out

[3] *Explanatory Notes*, p 10.

investigations, if requested by a specified person. The assistance includes:

- disseminating information about best practice in carrying out investigations;
- developing standards to be adopted in carrying out investigations; and
- providing advice, guidance or training (where practical).

It could also provide assistance to unspecified bodies if requested, as long as it would not interfere with the exercise of its main functions. It would be able to charge for this provision.

As detailed under clause 32, the majority of the HSSIB's functions apply only to England. However, some may be extended to other areas of the UK. For example, clause 29 provides that the HSSIB could enter into agreements to carry out investigations connected to incidents with implications for patient safety occurring in the United Kingdom during the provision of Welsh or Northern Irish NHS services. Again, it may charge for these services and may not undertake them if it could significantly interfere with its main functions. It could not provide this service in connection to Scottish NHS services, but could offer assistance under clause 28.

Clause 31 provides for intervention by the Secretary of State should the HSSIB fail significantly to carry out its functions or fail to carry them out properly. Clause 33 requires the Secretary of State to publish a review of the effectiveness of the HSSIB in carrying out its investigative functions four years after formally established.

Part 4: Medical Examiners

Clause 34 concerns the provision of medical examiners across England. It will amend the Coroners and Justice Act 2009 so that NHS bodies may appoint medical examiners and will require the Secretary of State to ensure that:

- enough medical examiners are appointed in the healthcare system in England;
- enough funds and resources are made available to enable them to carry out their functions; and
- their performance is monitored.

The explanatory notes explained the purpose of the provision as follows:

> The purpose of the amendment is to introduce a statutory scheme of medical examiners within the NHS rather than local authorities in England. Following a death that is not being referred to a coroner, medical examiners, who will be registered medical practitioners, will scrutinise the medical certificate of cause of death produced by the attending doctor, and can hold discussions with families. Medical examiners will introduce an additional level of scrutiny to those deaths not reviewed by a coroner. It will improve engagement with the bereaved in the process of death certification and offer them an opportunity to raise any concerns as well as improving the quality and accuracy of medical certificates of cause of death. The level of scrutiny will be proportionate so as not to impose undue delays on the bereaved or undue burdens on medical practitioners and others involved in the process.[4]

[4] *Explanatory Notes*, p 16.

This clause was not in the draft bill (see the 'Draft Bill and Initial Scrutiny' section below for further details).

Part 5: Supplementary and Final Provisions

Clauses 35 to 42 contain miscellaneous and supplementary provisions. The majority of the bill will come into force through regulations made by the Secretary of State.

Healthcare Safety Investigation Branch

The bill would set up the HSSIB, which would take over the work of the Healthcare Safety Investigation Branch (HSIB), effectively placing that body on a statutory footing.

The HSIB was set up on a non-statutory basis in 1 April 2017 to investigate incidents in the NHS and to improve patient safety through recommendations based on these investigations. The HSIB is currently operational under Secretary of State directions as an organisational arm of the Trust Development Authority.[5] The HSIB was set up following recommendations from the House of Commons Public Administration Committee, and a subsequent expert advisory group. Both suggested the establishment of a body focused on investigating and learning from incidents affecting patient safety.[6]

The HSIB can investigate patient safety concerns across any NHS-funded service in England.[7]

HSIB focuses investigations on the cause of incidents, rather than apportioning blame for them. Its purpose is based on bodies such as the Air Accidents Investigation Branch.

It describes that its main responsibilities are to:

- conduct thorough, independent, impartial and timely investigations into clinical incidents;
- engage patients and relatives, NHS staff, and medical organisations throughout the investigation process;
- help the patients and relatives understand 'what happened?' and what's being done to prevent similar events in the future;
- produce clearly written, thorough and concise reports with well-founded analysis and conclusions that explain the circumstances and causes of clinical incidents without attributing blame;
- make safety recommendations to improve patient safety;
- improve patient safety by sharing the lessons learned from investigations as widely as possible; and

[5] *Explanatory Notes*, p 4.

[6] For full background, see: Joint Committee on the Draft Health Service Safety Investigations Bill, *Draft Health Service Safety Investigations Bill: A New Capability for Investigating Patient Safety Incidents*, HL Paper 180 of session 2017–19, 2 August 2018, pp 8–12.

[7] Healthcare Safety Investigation Branch, 'About Us', accessed 17 October 2019.

- raise the standard of local investigations of healthcare safety incidents by establishing common standards and skills development.[8]

Although the HSIB does consider requests for investigations, it is up to the investigators and the body itself to decide what it investigates. Giving further details, the chief investigator, Keith Conradi explained that this is subject to guidelines:

> "We ask ourselves, how bad was the outcome? We are looking for a very serious adverse outcome or the potential for that," said the chief investigator. Then we filter it down and ask, is this symptomatic of a more widespread problem? We really want to concentrate on systemic problems.
>
> Finally, what is the learning potential for the HSIB going in to investigate this? Are there other people who we may have confidence in going in to investigate this? Are there national studies being done on this? Do we really want to waste our resources if there are others already involved in this?[9]

The HSIB was initially resourced to undertake 30 investigations a year. However, in November 2017, the then Secretary of State for Health and Social Care, Jeremy Hunt, announced that the HSIB would also be made responsible for investigating all cases of stillbirth, neonatal death, suspected brain injury or maternal death.[10] This amounted to an estimated extra 1,000 cases a year. It was allocated more resources and was recruiting more staff to meet these extra demands.[11] A factsheet accompanying the Health Services Safety Investigations Bill states that the Government had decided that the maternity investigations programme would not be included in the bill (further information on the maternity investigations proposals is included in the 'Draft Bill and Initial Scrutiny' section of this briefing).[12]

At the time of writing, the HSIB had published reports on 28 completed regular investigations on its website.[13]

In June 2019, the *Health Service Journal* (HSJ) reported some internal concerns about the management and culture at the organisation. It reported allegations of "poor governance and oversight" and "long delays" in the maternity investigations. Other people the HSJ spoke to described:

> A litany of complaints including how money was being spent, the way in which decisions were made, the use of consultants and internal conflicts between teams and the sudden departures of two former directors who left HSIB without warning last year.[14]

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[8] Care Quality Commission and Healthcare Safety Investigation Branch, *Memorandum of Understanding*, accessed 17 October 2019.

[9] National Health Executive, 'What is the HSIB?', 20 December 2017.

[10] Joint Committee on the Draft Health Service Safety Investigations Bill, *Draft Health Service Safety Investigations Bill: A New Capability for Investigating Patient Safety Incidents*, HL Paper 180 of session 2017–19, 2 August 2018, p 48.

[11] ibid, p 49.

[12] Department of Health and Social Care, *Health Service Safety Investigations Bill*, October 2019, p 1.

[13] Healthcare Safety Investigation Branch, 'Investigations', accessed 18 October 2019. Note: This does not include the maternity investigations.

[14] Shaun Lintern, 'Safety Watchdog Hit By Poor Governance and Culture', Health Service Journal, 12 June 2019.

In an interview with the HSJ, the HSIB's chief investigator, Keith Conradi, defended the organisation. It was reported:

> [He] accepted mistakes were made while the body was being established, and rapidly expanding, but argued it was now in a better place and continued to improve. He said it was planning changes that would improve governance, ahead of planned legislation to make it a statutory body. These included a shadow board, an expanded management team and independent evaluations of its work.[15]

The HSIB also acknowledged problems with the maternity investigation process, but said this "was now improving with better feedback to trusts".

Medical Examiners

The NHS patient safety strategy, published in July 2019, explains the medical examiner system as a way of ensuring all deaths are independently scrutinised.[16]

It listed the following aims for the system:

- Provide a better service for the bereaved and an opportunity for them to raise concerns about care with a doctor not involved in that care;
- Enhance patient safety by ensuring that all deaths are scrutinised by an independent medical examiner so that any issues with the quality of care can be identified and acted on;
- Ensure the appropriate direction of deaths to the coroner; and
- Improve the quality of death certification.[17]

The scheme was introduced in April 2019, with the current bill seeking to place it on a statutory basis.

In March 2019, Dr Alan Fletcher was appointed national medical examiner.[18] His role is to provide professional and strategic leadership to regional and trust-based medical examiners. The patient safety report specified that there would be seven regional medical examiners to help implement the system and to support and supervise the medical examiners' work.[19]

Following a 2016 consultation on proposals for the medical examiner system, the Government reported that respondents had been generally supportive of the idea. The consultation response provided details on how the Government would build upon this and set out how the scheme would be implemented.[20]

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[15] Shaun Lintern, 'Safety Watchdog Hit By Poor Governance and Culture', Health Service Journal, 12 June 2019.

[16] NHS England, *NHS Patient Safety Strategy*, July 2019, p 26.

[17] ibid, p 27.

[18] NHS Improvement, 'National Medical Examiner System', 8 October 2019.

[19] NHS England, *NHS Patient Safety Strategy*, July 2019, p 27.

[20] Department of Health and Social Care, *Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Government Response to Consultation*, June 2018.

Draft Bill and Initial Scrutiny

A draft Health Service Safety Investigations Bill was published in September 2017.[21] This contained many of the provisions relating to the statutory establishment of the HSSIB but did not include the provisions relating to medical examiners.

Joint Committee Report

In its report on the draft bill, the joint committee stressed the importance of dealing with patient safety concerns in the NHS. It made reference to figures published by the House of Commons Public Administration Committee in 2015:

> […] that there are 12,000 avoidable hospital deaths every year. More than 24,000 serious incidents are reported to NHS England, out of a total of 1.4 million mostly low-harm or no-harm incidents annually.[22]

The committee highlighted the work of the HSIB in investigating patient safety and making recommendations for improvements but also noted its need for independence and full statutory powers to make it fully effective. It recognised this as the purpose of the proposed legislation to set up the HSSIB.

Analysing the content of the draft bill, the joint committee considered concerns that had been raised by some witnesses (such as lawyers representing patients) that the 'safe space' provisions could "hide information which should otherwise be disclosed". However, it believed that, on balance, the provision was necessary to encourage people to speak out and that the information would still be available through existing avenues. It said:

> At present, there are many pressures which can deter healthcare professionals from alerting the authorities to potential safety problems, or being frank about failings in patient care. These include: a lack of confidence in their own judgement; a culture of deference to senior staff or management; a bullying atmosphere; fear of the damage that may be done to their career if they admit failings; or, a perception that their concerns will be ignored. A common feeling is that it is not safe or prudent to speak out, despite existing obligations to be open, such as the duty of candour […] The vital element of the 'safe space' is the confidence it provides that information given to HSSIB will not be unfairly used to expose any individual, but instead will help to produce factual conclusions and recommendations to improve patient safety […]
>
> The 'safe space' will have no effect whatsoever on any information or evidence already available, or which can still be acquired and made available by existing healthcare bodies and non-HSSIB patient safety investigations. HSSIB's reports will be additional to, not a replacement for, the investigations carried out by trusts, professional regulators, the Care Quality Commission and the Health Service Ombudsman.[23]

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[21] Department of Health and Social Care, 'Draft Health Service Safety Investigations Bill', 14 September 2017.

[22] Joint Committee on the Draft Health Service Safety Investigations Bill, *Draft Health Service Safety Investigations Bill: A New Capability for Investigating Patient Safety Incidents*, HL Paper 180 of session 2017–19, 2 August 2018, p 5.

[23] ibid, pp 5–6.

However, it did not agree with the provision then in the bill that would have allowed the HSSIB to accredit other NHS trusts to carry out 'safe space investigations', both into other trusts and into their own. This provision has been removed from the bill introduced in the House of Lords.

The committee raised concerns about the maternity investigations that the HSIB had been asked to undertake. It noted that these were happening outside of the 'safe space' and replaced the local serious incident investigations conducted by trusts. It also raised concerns about Government suggestions that the HSSIB could carry out non-'safe space' investigations more widely. It believed that non-'safe space' investigations confused the HSSIB's role and would undermine support for the body:

> Much of the concern about HSSIB arises from a fear that it will undermine the duties of trusts, professional regulators, and the courts to investigate harm and provide accountability. There must be a clear distinction between HSSIB's role—focussing on learning lessons of general relevance without finding blame—and that of the investigations run by other bodies: providing accountability for individual incidents and, if necessary, finding fault.[24]

On this basis, the committee recommended that provision for maternity investigations and for other non-'safe space' investigations should not be included in the bill and should not be allocated to the HSSIB. It believed that maternity investigations should instead be recognised as a duty of NHS Improvement.[25]

Similarly, the committee recommended that the statutory duty to cooperate with other organisations should be removed from the legislation, stating that this could also cast doubts on its independence.[26]

Turning to the HSSIB's remit, the joint committee recommended this be extended to cover all care in England and to allow more cross-border arrangements:

> We recognise that HSSIB itself cannot be expected to take on responsibility for social care as a whole but suggest that its powers and the protections of safe space be extended, so that HSSIB investigations can analyse all aspects of the care pathway. With regard to cross-border care, we are clear that the devolution settlements must be respected but recommend that the draft bill should be amended to enable reciprocal co-operation arrangements between HSSIB and the devolved health systems, and to give devolved administrations the choice of participating in HSSIB, if they so wish.[27]

In conclusion, the committee believed the HSSIB had an important role to play, and—subject to its recommendations—welcomed the legislation.

Government Response

The Government welcomed the committee's report and indicated its agreement with several

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[24] Joint Committee on the Draft Health Service Safety Investigations Bill, *Draft Health Service Safety Investigations Bill: A New Capability for Investigating Patient Safety Incidents*, HL Paper 180 of session 2017–19, 2 August 2018, p 6.

[25] ibid, p 50.

[26] ibid, p 4.

[27] ibid, pp 6–7.

recommendations.[28] For example, it agreed with the concerns over the accreditation of 'safe space' investigations and committed to remove these from the bill.[29] It also indicated its willingness to consider how the remit of the HSSIB could be extended to cover privately funded healthcare, social care and devolved healthcare.[30]

The Government did not accept the committee's recommendations to remove the statutory duty of cooperation and maternity investigations from the legislation. Regarding cooperation, the Government believed the "mutual duty of cooperation on purely logistical issues" set out in the draft legislation allowed it to work constructively with other bodies, without comprising roles or principles.[31] It also stated that it expected the body to develop memorandums of understanding with other bodies, as the HSIB had done.

On maternity investigations, although the Government appreciated the rationale of the committee's arguments, it stressed there was a "real need to improve the quality of maternity investigations within the NHS".[32] It stated that it wanted to ensure that the learning and improvements to maternity safety which could be gained through the ongoing investigations programme was secured, and that arrangements were in place to enable high quality maternity investigations to continue. It then set out how it looked to achieve this alongside the new body:

> We believe the best way to achieve this is to allow the current maternity investigations programme to complete its rollout to all healthcare regions in England and continue for a limited period so that the learning and benefit can be gained from these investigations, whether or not the new body has been established in the meantime.
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> We therefore believe there should be provision in the revised bill to allow the new body to undertake the maternity investigations, and that there should be flexibility in how long the maternity investigations should continue under the new body's remit to allow appropriate lessons to be learnt and to determine where these investigations might best sit in the future. We will consider how best to achieve this in a revised bill. This will ensure that the establishment of the new body does not, in itself, bring the programme to a premature end and should allow the benefits of the programme to be fully realised. We do not believe it would be appropriate for the investigation programme to transfer to NHS Improvement, which would not have the expertise or operational independence to carry out these specialised investigations effectively, once the investigative function had transferred to the new body.

Further Developments on Maternity Investigations Provisions

Upon the bill's publication, the Government stated it had decided not to include maternity investigations as a provision in the bill.[33] Speaking to the *Health Service Journal*, a Government

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[28] Department of Health and Social Care, *Government Response to the Report of the Joint Committee on the Draft Health Service Safety Investigations Bill*, December 2018, Cm 9737, p 8.

[29] ibid, p 9.

[30] ibid, pp 12–13.

[31] ibid, pp 22–3.

[32] ibid, pp 10–11.

[33] Department of Health and Social Care, *Health Service Safety Investigations Bill*, October 2019, p 1.

spokesperson said that the HSIB would continue the work "until the new body commences operations, planned for 2021".[34]

This removal of the reference to maternity investigations was questioned by former Health Secretary, Jeremy Hunt, who had initially introduced the requirement. He stated:

> These are vital given we have four neonatal deaths every single day and that maternity mistakes are about 40 per cent of the huge annual litigation bill the NHS pays. We must find a way to allow HSIB to continue spreading the learning from these tragedies by investigating every single maternity death—a world first for the NHS we mustn't throw away.[35]

Although accepting significant improvements were needed in the way maternity incidents were investigated, the chief executive of NHS Providers, Chris Hopson, said the HSIB's work should not be made permanent "without full and proper debate, including recognising the legitimate concerns raised by the joint committee".

NHS Incident Statistics

NHS Improvement publish data on reported incidents in the NHS through the national reporting and learning system (NRLS). However, it stresses that reporting is "largely voluntary, to encourage openness and continual increases in reporting".[36] Therefore increases or decreases in reported incidents may simply reflect changes in the reporting culture. Changes in the figures over time may also reflect policy changes and error or bias in the types of incident reported and in the reporting by different types of NHS organisation.

Despite these caveats, the most recent edition of the data reported a continued increase in incidents reported to the NRLS. It stated:

> The 488,242 incidents reported from July to September 2018 represents a 4.1% increase on the number reported from July to September 2017 (485,156).[37]

The report stated that the four most commonly reported incidents occurring over the last full year (October to 2017 to September 2018) were:[38]

- patient accident (14.7%);
- implementation of care and ongoing monitoring/review (14.2%);
- access, admission, transfer, discharge (including missing patient) (11.8%); and
- medication (10.6%).

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[34] Shaun Lintern, 'HSIB to Stop Maternity Investigations by 2021', Health Service Journal, 18 October 2019.
[35] ibid.
[36] NHS Improvement, *NRLS National Patient Safety Incident Reports: Commentary*, March 2019, p 2.
[37] ibid.
[38] ibid, p 10.

The top four areas of incidents reported by care setting for the same period were:[39]

- acute/general hospital (73.7%);
- mental health services (13.4%);
- community nursing, medical and therapy services (10.7%); and
- ambulance services (0.7%).

The NRLS also reports the "degrees of harm" recorded in connection with report incidents. However, it should be noted that, in some cases, reporters recorded the degree of "potential" harm instead, particularly in the case of "near misses" that could have resulted in "severe" harm. In addition, some reported incidents were not allocated a harm rating.

The number and percentage of incidents reported as occurring in the period October 2017 to September 2018 by associated harm level was:[40]

- no harm: 1,487,988 reported incidents (74.7%);
- low harm: 440,836 reported incidents (22.1%);
- moderate harm: 52,716 reported incidents (2.6%);
- severe harm: 5,526 reported incidents (0.3%); and
- death: 4,717 reported incidents (0.2%).

The number of reported incidents linked with 'death' and with 'no harm' had increased from the previous year, by 6% and 6.4% respectively. The others had remained relatively stable.

Further Reading

- NHS England, *NHS Patient Safety Strategy*, July 2019
- Care Quality Commission, *Opening the Door to Change*, December 2018
- Nuffield Trust, 'Safety in Health and Social Care', 30 November 2018

[39] NHS Improvement, *NRLS National Patient Safety Incident Reports: Commentary*, March 2019, p 11.
[40] ibid, pp 12–13.