Witness Name: Rosie Benneyworth
Statement No. 2
Exhibits: RB/1
Dated: 29/10/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ROSIE BENNEYWORTH
INTERIM CHIEF INVESTIGATOR
HEALTH SERVICES SAFETY INVESTIGATIONS BODY (HSSIB)

I, Dr Rosie Benneyworth will say as follows: -

Background

1. The Health Services Safety Investigations Body (HSSIB) was established by the Health and Care Act 2022 (the Act) on 1 October 2023, replacing the Healthcare Safety Investigation Branch (HSIB). The HSSIB has previously submitted evidence to the inquiry via a witness statement from myself, submitted on 17 January 2024.

2. I was asked by the Department of Health and Social Care (DHSC) to Chair a workstream on how arms-length bodies (ALBs) and DHSC can better manage risks that the system is facing. This became known as the Recommendations to Impact Collaborative Group ('the group') and has been meeting virtually and at in-person workshops since March 2023.

3. In October 2024, I brought the work of the group to the attention of the Inquiry Chair via e-mail. Subsequently, I have been asked to provide an additional statement to the Inquiry outlining the work of this group. Details of the constitution and work of the group are set out below.

4. The group is a collection of organisations and individuals, including a panel of international academics and experts in collaborative governance and the role of evidence in developing policy. The purpose of the group was to look at ways in which to increase collaboration and efficiencies in how safety

recommendations made to the healthcare system are developed, made and implemented.

5. Quality and safety recommendations are made to the healthcare system as a mechanism to drive improvements and/or mitigate an identified patient safety risk. These recommendations are made by many different stakeholders both within the healthcare system and outside of it, and can be directed towards any level of the healthcare system, for example national organisations or individual providers.

6. Quality and safety recommendations are distinct from regulatory actions or requirements, which state that an organisation 'must' do something, and instead highlight a risk or change which can be acted upon.

7. The intention of all such recommendations is to improve outcomes for people who use healthcare services and for staff working within healthcare. However, the sheer number being made and the variance in their quality means that they can be a burden to an already pressured healthcare system which is expected to digest, prioritise, pay for and implement actions in relation to them. This can lead to a lack of action in response to recommendations which means the improvement does not happen or the patient safety risk can remain.

8. The group initially started by looking specifically at recommendations made by ALBs but it was soon recognised that to get the greatest impact from this work it was necessary to include recommendations made by other organisations. The group has therefore engaged with other national organisations who make recommendations to try and ensure that the work being done in this area is widely applicable.

9. The membership of the group is constantly growing and includes representatives from the following organisations:

    - Academy of Medical Royal Colleges
    - Care Quality Commission

- Department of Health and Social Care
- The Health Innovation Network
- Health Research Authority
- Human Fertilisation and Embryology Authority
- Human Tissue Authority
- National Institute for Health and Care Excellence
- NHS Blood and Transplant
- NHS Confederation
- NHS England
- NHS Providers
- NHS Resolution
- National Guardian's Office
- National Quality Board
- Maternity and Newborn Safety Investigations
- Medicines and Healthcare products Regulatory Agency
- Parliamentary and Health Service Ombudsman
- The Patient Safety Commissioner
- UK Health Security Agency Regulatory Agency

The group also included representation via:

- an academic panel of international experts in patient safety, governance and policy.
- provider representatives from acute and mental health trusts.

10. The group agreed that there would be value in publishing a report outlining the work of the group and the findings it had made in relation to how the healthcare system currently makes and responds to recommendations to improve patient safety. The report **[RB/1]** was published by HSSIB, on behalf of the group, on 16 September 2024.

11. The report set out the following findings:

- Failure to implement actions following recommendations can impact public confidence in the healthcare system and compound harm to patients.
- The 'noise' created by the significant volume of recommendations being made to the healthcare system means that providers struggle to prioritise and implement recommendations, concentrating on those which are addressed directly to the provider, or where there are immediate patient safety risks.
- Some recommendations duplicate or contradict others. The development of a searchable repository which includes recommendations made across the healthcare system may help to reduce this.
- It may reduce the 'noise' and help with prioritisation if organisations refer to each other's recommendations, or group together in support of one organisation's recommendation rather than repeating it. The development of an agreed system to identify recommendations for cross-referencing would assist this.
- There is currently a lack of visibility of ongoing work across arm's length bodies that would enable collaborative working on related workstreams. A searchable repository of ongoing work may assist this.
- Recommendations differ in terms of the evidence on which they are based, and their structure and language. This can affect their relevance and how they are interpreted.
- It is unclear how some recommendations are intended to impact the patient, which should be a key consideration in their development where possible.
- Most recommendations made to the healthcare system are not costed, either in relation to the cost of implementing the proposed actions or their longer-term cost effectiveness. This may affect providers' ability to implement them and means there is a lack of information to support prioritisation decisions.

- Some recommendations may be of limited relevance to certain providers and could promote inequalities by negatively impacting certain patient groups if implemented. However, providers can feel they are not empowered to reject recommendations, especially those related to safety.
- Few recommendations require a formal response from the recipient organisation, and there is a lack of monitoring of the actions planned or taken to address recommendations. A monitoring system could help to track actions and identify opportunities for escalation where changes have not been made.

12. As a result of these findings, the group identified further action that could be undertaken in this area to develop:
    - guidance on the creation and implementation of recommendations.
    - a proposal for a repository for recommendations.
    - a proposal for a repository for ongoing workstreams.
    - a proposal for a monitoring system with a multi-agency board feeding into the Department of Health and Social Care to provide oversight and a route of escalation for recommendations that are not implemented.

13. In order to progress the further actions the group is commencing a programme of work to develop these together.

14. The group recognises the importance of the issues being explored and how working together across the healthcare landscape can lessen the burden on providers, and others in the healthcare system, while still highlighting safety risks present across the system.

15. Due to the complexity of the healthcare system there may be other relevant work underway or being scoped that is not linked to the group's work. The group has request that further information that might be relevant from any source be provided to it to help progress this work.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 29 October 2024

Exhibits

RB/1 – HSSIB. (2024). Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare. Report of the Recommendations to Impact Collaborative Group. Available online at: https://www.hssib.org.uk/patient-safety-investigations/recommendations-but-no-action-improving-the-effectiveness-of-quality-and-safety-recommendations-in-healthcare/report/