About this report

Independent report published by the Health Services Safety Investigations Body and arm's-length body (ALB) members of the Recommendations to Impact Collaborative Group.

Executive summary

Background

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. This report distinguishes between recommendations and regulatory actions or requirements, the latter being outside of the scope of this work.

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.

This report is an output of the work commissioned by the Department of Health and Social Care (DHSC). At a meeting of the Arm's-Length Body (ALB) Chief Executives and Chairs in November 2022, areas where joint work between DHSC's ALBs would be valuable were identified. A series of workstreams were set up as a result.

Dr Rosie Benneyworth, the Chief Executive Officer of HSSIB, agreed to Chair the workstream on how ALBs and DHSC can better manage risks that the system is facing. This became known as the Recommendations to Impact Collaborative Group (referred to here as 'the group') and has been meeting virtually and at in-person workshops since March 2023. 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 these meetings is 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.

This report is now being published by HSSIB on behalf of all ALBs who are part of this group.

The following organisations and individuals have contributed to this work:

Academy of Medical Royal Colleges	NHS Confederation
Care Quality Commission	NHS England
Department of Health and Social Care	NHS Providers
National Institute for Health and Care Excellence	NHS Resolution
Health Research Authority	National Quality Board
Human Fertilisation and Embryology Authority	Parliamentary and Health Service Ombudsman
Human Tissue Authority	The Health Innovation Network
Maternity and Newborn Safety Investigations	The Patient Safety Commissioner
Medicines and Healthcare products	UK Health Security Agency
Regulatory Agency	Academic panel of international experts in patient safety, governance and policy
National Guardian's Office	

	Provider representatives from acute and mental health trusts
NHS Blood and Transplant	

This report sets out the findings to date from this work and proposals for further work in this area.

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