Health Services Safety Investigations Body

Report

Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare

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Theme:
Patient safety themes

Contents

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

Sometimes recommendations are made to healthcare organisations that contradict with previous recommendations. The group identified that silo working (that is, organisations and/or the teams delivering workstreams working in isolation) was one cause of this. For example, it is not uncommon for different arm's length bodies (ALBs) to be undertaking investigations or reviews within related areas of healthcare without knowledge of each other's work. The group considered that a searchable repository (central online store) of ongoing work within ALBs would enable collaborative working on related workstreams, which may reduce duplication of recommendations and avoid contradictory recommendations. The group plans to develop a proposal for the creation of such a repository while keeping in mind the need to avoid additional administrative burden.

The group recognised that ALBs were just one set of organisations feeding recommendations into the healthcare system. Many recommendations are made by organisations with no statutory responsibility to do so. In some other industries, recommendations made by those without statutory authority may not be implemented. However, in the healthcare sector organisations are reluctant to not take action on recommendations because of the repercussions for patients and a desire to improve patient safety wherever possible.

The 'noise' created by a significant volume of recommendations has been recognised by other industries and has led to organisations such as the Air Accidents Investigation Branch (AAIB) changing their approach. The AAIB told the group that during the 1980s and 1990s it would produce hundreds of recommendations, many of which were quite direct in their language and the actions they expected organisations to take. It has since changed its philosophy on recommendations and now highlights the risk and outcome without specifying the solution, as the recipient is often best placed to develop this. Also, recommendations made previously which have been rejected are not repeated unless there is additional evidence to support them; in such cases the recommendation is reworded to reflect this.

Making reference to previously made recommendations is possible in the aviation sector, as there are repositories of recommendations that have been made across the sector which hold most of the recommendations for future reference.

NHS England has developed a National Recommendations Register for Maternity and Neonatal Services, which is available from its FutureNHS platform. This repository includes 708 recommendations from 'published national maternity and neonatal reports and audits' and allows users to search these by care setting. The development of this resource over a number of years by NHS England is recognition