POLICY

Public inquiries, patient safety and the implementation gap

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ABSTRACT

A decade on from the Francis report, avoidable patient harm continues to occur and we have continued to see new inquiries and reviews into serious patient safety scandals. A failure to listen to patients or learn from previous investigations, a corrosive blame culture, a lack of effective leadership and an unresponsive regulatory framework are alarming and often reported themes that we review here.

KEYWORDS: Patient safety, implementation, blame culture, healthcare safety investigations, safety management, patient harm, Patient Safety Learning

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Introduction

On 6 February 2013, the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published. Chaired by Sir Robert Francis QC, it detailed a series of major patient safety failings and cases of avoidable harm at the Trust between 2005 and 2009.[1] The report set out how such incidents came about, why they were not identified or acted upon sooner, and how the findings underscored the need for a fundamental change in approach to patient safety in the NHS.

A decade on from this Inquiry, avoidable harm continues to occur. We have continued to see new inquiries and reviews into serious patient safety scandals, such as Morecambe Bay, the Independent Medicines and Medical Devices Safety Review, and the independent review of maternity services at Shrewsbury and Telford, to name just a few.[2–4]

Despite these reports, multiple safety recommendations and hard work across the healthcare system, serious concerns about patient safety continue. A failure to listen to patients or learn from previous investigations, a corrosive blame culture, a lack of effective leadership and an unresponsive regulatory framework are alarming and often reported themes.

The implementation gap

At Patient Safety Learning we believe that the persistence of these issues is due to a failure to address the complex and systemic causes of avoidable harm in health and social care. There needs to be a transformation in approach, whereby patient safety is treated as core to health and social care, not simply as one of several competing strategic priorities to be traded off against each other. In our report, *A blueprint for action*, we look at this in more detail, identifying six foundations of safe care for patients and practical actions to achieve them.[5]

Many of the issues highlighted in *A blueprint for action* will be familiar to those who have read the Mid Staffordshire Inquiry and other reports into patient safety scandals in the last 20 years. However, despite the similar themes and problems identified by such inquiries and reviews, often their insights and recommendations fall through the 'implementation gap' and fail to be translated into action.

The implementation gap, simply put, is the difference between what we know improves patient safety and what is done in practice.[6] This gap can occur for different reasons, including the following:

- Difficulties implementing changes across healthcare; it can be a complex task to change the working practices and behaviour of the many individuals and organisations that make up the whole.
- Patient safety guidance working in theory but not in practice; actions that may appear to address patient safety issues failing to take a wide variety of organisational contexts, cultures and capacities into account.
- Insights and learning remaining in silos; patient safety improvements remaining locked in specific organisations, with a lack of means or commitment to widely share and disseminate new knowledge.

As we detailed in our report last year, *Mind the implementation gap,* published as part of the Safety for All campaign, these issues manifest themselves in a number of different ways. In the case of public inquiries and reviews, they significantly undermine our ability to translate insights and lessons from avoidable harm into safety improvements.[7,8]

Inquiries and patient safety

There have been many inquiries and reviews into serious patient safety failings in the NHS. Table 1 highlights some of the key patient safety inquiries and reviews that have taken place in England since 2013.

Some have taken the form of statutory inquiries, governed by rules set out in the Inquiries Act 2005, with legal powers to require witnesses to give evidence and produce documents, such as Mid Staffordshire. Others have been non-statutory public inquiries,

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Table 1. Key patient safety inquiries and reviews in England since 2013

Inquiry/Review	Publication year
Berwick review into patient safety	2013
The Morecambe Bay Investigation	2015
Independent review into Liverpool Community Health NHS Trust	2018
The Infected Blood Inquiry	2018
The Gosport Independent Panel	2018
The Independent Inquiry into issues raised by Paterson	2020
The Independent Medicines and Medical Devices Safety Review	2020
The Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust	2022
The investigation into maternity and neonatal services at East Kent Hospitals NHS Foundation Trust	2022

which possess a greater degree of flexibility on procedure and rules but are unable to compel witnesses to act. A recent example of this was the Morecambe Bay Investigation.

Inquiries and reviews provide an opportunity to take a deep dive into the most serious incidents of avoidable harm. They provide an official record of events, identify points of learning, hold organisations to account (at least in theory) and make recommendations with the intention of preventing similar failings from occurring in the future.

Recurring themes

However, all too often, inquiries and reviews identifying similar problems have not led to significant improvements in patient safety.

One problem frequently highlighted is the persistence of a corrosive blame culture in parts of the NHS, which leads to staff failing to report the actions that lead to avoidable harm due to fear of personal consequences. Having an open and fair culture, on the other hand, can help enable patient safety issues to be raised, discussed and addressed.

When the Mid Staffordshire Inquiry highlighted this as a key issue to be addressed, it noted that this had also been raised as a concern previously without much evidence of progress having been made:

> *The evidence to this Inquiry has shown that we have still not managed to move successfully away from the culture of blame which Professor Sir Liam Donaldson, in* Organisation with a memory, *and Professor Sir Ian Kennedy, in the report of the Bristol Inquiry, were so keen to banish.*[1]

In 2020, 7 years after the Mid Staffordshire Inquiry, the Independent Medicines and Medical Devices Safety Review also highlighted the persistence of this issue. Last year, the Independent Review of Maternity Services at Shrewsbury and Telford and the East Kent Maternity Review again pointed out that this remained a serious barrier to improving patient safety.

It is not that the problems caused by blame culture have been completely ignored. The creation of a safety culture in the NHS is acknowledged as a core part of the NHS Patient Safety Strategy, published in 2019.[9] However, since being highlighted in *An organisation with a memory* as a serious challenge over 20 years ago, and in numerous reports since, arguably multiple recommendations and insights about this have yet to be translated into a clear set of measures to tackle blame culture effectively.[10]

Furthermore, while examples of good practice are now shared nationally, they are not accompanied by any specific activities to evaluate their impact and reporting and monitoring on safety culture goals by organisations is not widespread. When poor culture and behaviours are identified, there appears to be no clear process to intervene and improve them. The results of the last 3 years of NHS Staff Surveys also reflect a lack of progress here, making clear that too many staff still do not feel safe about speaking up about patient safety incidents and 'near misses'.[11–13]

Barriers to implementing recommendations

So how does the implementation gap relate to this? For public inquiries and reviews, although their publication is often met with commitments to 'learn lessons' and vocal support from organisational leaders to take action on report recommendations, the changes prescribed can often fall through this gap for several reasons:

Inconsistency in responses and implementation

Inquiries and reviews can vary significantly in format, process and outcomes depending on the terms of reference and the preferences of the chair. This variation also extends to how the Government and NHS responds to them.

Even for statutory inquiries, there is no specific guidance on how to approach this; discretion remains with the minister. This can mean that, while some inquiries receive detailed responses, in others there is a lack of transparency and clarity on how recommendations that have been accepted will be implemented in practice. As a result, it can be difficult to ensure these changes take place and assess their impact.

Failures in monitoring and evaluation

There is no framework to assess the effectiveness of patient safety inquiry recommendations. This is an issue that applies to public inquiries more broadly, with a National Audit Office report noting that:

> *Once inquiries have concluded, there is no central repository or responsibility across government for tracking whether recommendations have been implemented and ensuring that inquiries have an impact.*[14]

As a result of this, we often lack the tools to easily check if recommendations have been implemented or ascertain whether their implementation has resulted in meaningful change. This is not only undermines the opportunity to reduce avoidable harm but also fails to provide transparent accountability and value for money. Why commission inquiries if they don't lead to learning, action, and improvement?

Lack of a joined-up approach

Often patient safety inquiries, which may be concerned with distinct aspects of healthcare, identify similar themes and related recommendations. While individual reports will often refer back to points in other inquiries and reviews, there is rarely a joined-up approach when considering how to respond to them.

Even when inquiries are published in close succession, such as the Paterson Inquiry and the Independent Medicines and Medical Devices Safety Review, these are often responded to in isolation. If system-wide concerns are not considered in a holistic and joined-up manner, there is a risk that the full complexity of the issues are not captured, leading to ineffective solutions.

Learning from inquiries

If we are to ensure that we truly learn lessons from patient safety scandals such as Mid Staffordshire, we need a more rigorous approach to implementing inquiry recommendations. Without this, we will continue to see avoidable harm and patient deaths and this knowledge and insights gained go to waste.

These challenges are not unique to inquiries, or to the NHS. The importance of moving from 'resolution' to 'implementation' was key focus of the recent 5th Global Ministerial Summit on Patient Safety in Switzerland in February 2023.[15] This event emphasised the need for patient safety strategies and policies to be accompanied by implementation plans, set within governance structures that include clear lines of accountability and responsibilities for stakeholders at all levels. The NHS Patient Safety Strategy identifies many of the key challenges we face in the UK, but there needs to be a much sharper focus on implementation of this.

As we have noted, the monitoring of inquiry recommendations can vary considerably. There are some cases where, although the process is far from perfect, there is significantly greater focus on this: for example, the Health and Social Care Select Committee holding the Government to account on implementing the recommendations of the Independent Medicines and Medical Devices Safety Review.[16] We believe that such processes could be significantly strengthened and supported more broadly by creating a central repository of recommendations from patient safety inquiries and reviews. If open and transparent, this would provide a simple means for a patient, member of the pubic, parliamentarian or policymaker to assess what recommendations have been implemented, whether in full, in part or not at all, across the whole of the NHS or individual organisations. This would also help situate different inquiries' recommendations in their wider context, potentially identifying helpful trends and areas of overlap.

However, any such process will only be effective if the rhetoric about patient safety following serious harm is matched with a stronger commitment to action, with the necessary resources, leadership, and support to ensure patient safety is placed at the heart of everything we do in health and care. ■

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