

Mind the implementation gap: the persistence of avoidable harm in the NHS

This editorial reviews the ‘Mind the Implementation Gap’ report, which calls for the government, parliamentarians and NHS leaders to take action to address the underlying causes of avoidable harm in healthcare and details specific recommendations relating to the areas of the implementation gap.

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Introduction

The World Health Organization (2019) stated that unsafe care is one of the top ten leading causes of death and disability worldwide, with the NHS estimating that there are around 11 000 avoidable deaths (NHS England and NHS Improvement, 2019) annually as a result of safety concerns. A key reason for this is the implementation gap – the difference between what is known to improve patient safety and what is done in practice.

As part of the Safety for All campaign (<https://shbn.org.uk/safety-for-all/>), Patient Safety Learning with the Safer Healthcare and Biosafety Network has published a report, *Mind the Implementation Gap: The Persistence of Avoidable Harm in the NHS* (Patient Safety Learning, 2022), which includes several recommendations regarding how to bridge this gap.

Avoidable harm occurs as a result of:

- The absence of a systemic and joined-up approach to safety
- Poor systems for sharing and acting on learning
- Lack of system oversight, monitoring and evaluation
- Unclear patient safety leadership.

An inquiry by the Health and Social Care Select Committee highlighted that the cost of settling claims in the NHS in 2020–21 was £2.26 billion, with a further £7.9 billion spent on compensation claims settled in previous years (NHS Resolution, 2021).

Patients continue to experience harm from problems that have already been identified or addressed elsewhere. The recent Ockenden Review (Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust, 2022) into maternity care at Shrewsbury and Telford Hospital NHS Trust highlighted a fear of speaking out within the maternity services team, noting ‘a lack of psychological safety in the workplace’. The report also highlighted that the trust’s maternity governance team ‘inappropriately downgraded serious incidents to a local investigation methodology to avoid external scrutiny’.

The implementation gap

This challenge is not unique to healthcare. In other safety-critical industries, such as aviation, eliminating causes of harm and prioritising safety is also of paramount importance. Although these industries differ from healthcare, they face similar challenges in translating the analysis of safety incidents into practical improvements. However, these industries are often far more effective at adopting a systems approach. The NHS identified the implementation gap in 2000 in the report *An Organisation with a Memory* (Department of Health, 2000). Over 20 years later, it is disconcerting that this report remains relevant, with the implementation gap continuing to undermine the ability to translate lessons from avoidable harm into safety improvements.

The implementation gap acts as a barrier to patient safety improvement across five specific policy areas:

1. There has been a failure to properly implement the findings of public inquiries (statutory and non-statutory) and reviews

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2. The Healthcare Safety Investigation Branch does not have the responsibility to ensure that patient safety recommendations are implemented
3. There are variations in how NHS trusts respond to prevention of future death reports and how this implementation is monitored. When legal action is taken, feedback from clinicians is often not acted on in the interests of patient safety
4. Complaints made against the health service often fall through the implementation gap as they are viewed as a threat rather than an opportunity for learning (Sibley, 2022)
5. Incident reporting systems, such as the National Reporting and Learning System, the Yellow Card scheme and Datix, often place greater focus on the collection rather than use of data to learn from incidents. These systems also pose cultural barriers as they are often misused as a form of reprimand or threat (Hazan, 2020), acting as a detriment to reporting incidents for learning, and feeding into the well-documented blame culture within the NHS.

Common themes

The report (Patient Safety Learning, 2022) identified four common themes within these five policy areas:

1. An absence of a systemic and joined-up approach, whereby there is a lack of coordination in how avoidable harm in healthcare is responded to and the insights and learning that emerge from these events
2. Poor systems for sharing and acting on that knowledge, where solutions to prevent avoidable harm are not shared more widely
3. Lack of system oversight, monitoring and evaluation of the effectiveness of patient safety recommendations (National Audit Office, 2018)
4. Unclear system-level patient safety leadership, whereby structures are fragmented with no clear lead body, such as the Healthcare Safety Investigation Branch or the Care Quality Commission (2018).

Conclusions: bridging the implementation gap

Patient safety is a systems issue, and its importance is often weighed against other priorities such as finances and efficiency. Patient safety should be at the heart of the healthcare system and should involve stakeholders at all levels to show leadership, including but not limited to the government, parliamentarians, healthcare workers, patients, families and staff. This approach should involve a systems-wide debate about how healthcare can reshape its approach to learning and safety improvement, as outlined in the recommendations below.

Recommendations and actions

1. Patient safety inquiries and reviews need system-wide commitment and resources, with effective and transparent performance monitoring to ensure that the accepted recommendations translate into action and improvement
2. Healthcare Safety Investigation Branch reports and their recommendations need system-wide commitment and resources, with effective and transparent performance monitoring to ensure that their recommendations translate into action and improvement
3. The Coroner's Prevention of Future Deaths system needs to be improved so that recommendations for patient safety improvements and organisational responses to the reports can be easily accessed. Assurance should be provided that learning from causal factors of avoidable deaths is captured consistently and the insight from these cases is disseminated and acted upon across all healthcare organisations
4. NHS England and NHS Improvement and NHS Resolution need to cooperate in identifying the causal factors of unsafe care identified through litigation, ensuring this can be disseminated widely and acted on to improve patient safety
5. The introduction of the new NHS Complaints Standards needs to be closely monitored, with clear guidance for organisations on implementation and clarity on responsibility for this within the organisation. This should be accompanied by public transparent reporting by organisations on the roll out, allowing consistent monitoring and comparison

Key points

- Avoidable unsafe care kills and harms thousands of people each year in the UK and costs the NHS billions of pounds.
- System-wide change is needed; patient safety and staff safety should be at the heart of the healthcare system.
- The report forms part of the Safety for All Campaign, which calls for improvements in, and between, patient and healthcare worker safety to prevent safety incidents and deliver better outcomes for all.

6. NHS England and NHS Improvement and the Medicines and Healthcare products Regulatory Agency must ensure that the development of the new Patient Safety Incident Response Framework and changes to the Yellow Card scheme have a core focus on learning for action and improvement to tackle the implementation issues highlighted in this report.

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