Written evidence submitted by Patient Safety Learning (PSN0008)

Introduction

This submission sets out the response of Patient Safety Learning to the Health and Social Care Committee's Independent Expert Panel in their evaluation of public inquiry/review recommendations on patient safety which have been accepted by the Government.

Patient Safety Learning is a charity and independent voice for improving patient safety. We harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm. We believe patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Through our work we support safety improvement through policy, influencing and campaigning and the development of 'how to' resources such as *the hub*, our free award-winning platform to share learning for patient safety, and our unique Patient Safety Standards and support tools.

Summary

In our response to is call for evidence we focus on two areas:

1. **Culture of safety and whistleblowing** – looking at the specific recommendation being considered by the Expert Panel in relation to actively fostering a culture of safety and learning in the NHS, considering its implementation and impact.

2. **Inquiry recommendations and the implementation gap** – considering the broader context relating to evaluating inquiry/review recommendations. Specifically, how these are implemented, monitored, and evaluated.

Culture of safety and whistleblowing

In the first section of our submission, we will consider progress that has been made in relation to the below patient safety recommendation that is being evaluated by the Expert Panel:

> *"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.*
>
> *Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.*
>
> *Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led."*[1]

Before discussing the implementation recommendation however, we will first outline:

- Our organisational position on culture and patient safety.
- NHS England activities to foster a safety culture.

[1] Robert Francis QC, Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS, February 2015. https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150953mp_/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

- Evidence that blame cultures continue to significantly persist in the NHS.

Culture and patient safety

Organisational cultures that seek to assign blame when things go wrong makes patient harm more likely to happen again.

At Patient Safety Learning we believe that it is vital that we create an environment in healthcare that supports raising, discussing, and resolving of concerns, with incidents of avoidable harm responded to with empathy, respect, and rigour. In our report, *A Blueprint for Action*, we identify creating a Just Culture as one of the six foundations of safer care to improve patient safety.[2] A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.

To achieve this, we believe that the following is needed:

- Organisations implementing programmes to eliminate a blame culture and introduce or deepen a Just Culture.
- Organisations developing and publishing goals to develop and sustain a Just Culture.
- Organisations measuring and reporting their progress towards a Just Culture.
- Staff feeling assured that they are working in safe systems. When things go wrong, a system and human factors approach should inform investigations and learning.
- Patients being able raise concerns and provide insights into how to make care safer, confident that their views will be welcomed and acted upon.

NHS England's approach to fostering a safety culture

NHS England has incorporated the principle of establishing a safety culture in the health system as a core part of *The NHS Patient Safety Strategy*. Published in July 2019, this identifies a patient safety culture as one of the two foundations required in working towards its safety vision "to continuously improve patient safety".[3]

In an update in February 2021, NHS England set out several activities for the National patient safety team related to the delivery of this:

1. *Monitor the development of a safety culture in the NHS*

- *Assess whether additional safety culture questions in the staff survey would have value by Q4 2020/21.*
- *Complete a discovery phase for a safety culture data 'visualisation tool' by Q2 2021/22, which includes identifying potential new metrics related to safety cultures in the scope.*
- *Explore the safety culture characteristics of highly safe NHS trusts, and share insights by Q1 2021/22.*

2. *Support the development of a safety culture in the NHS*

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[2] Patient Safety Learning, The Patient-Safe Future: A Blueprint for Action, 2019. https://www.patientsafetylearning.org/resources/blueprint

[3] NHS England, The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, July 2019. https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

- *Establish the safety culture work programme to bring together data, research and practical support for safety culture improvement by Q1 2021/22.*
- *Produce a safety culture guide to help organisations implement specific improvement activities by Q1 2021/22.*
- *Extend the exploration of safety culture processes and infrastructure to mental health, community and primary care settings by Q4 2021/22.*
- *Continue to establish and test safety culture interventions to support local systems, as part of the key enablers objective.*[4]

A new Safety Culture Programme Group met in July 2021 to discuss recommendations to develop a safety culture in the NHS.[5] This led to the decision to create a new Safety Culture Implementation Group to meet every 2-3 months to oversee this work. Subsequently, NHS England has published the following good practice resources:

- *Safety culture: learning from best practice* (November 2022) – this identifies six themes from discussions of good practice and case studies related to this.[6]
- *Improving patient safety culture – a practical guide* (July 2023) – a toolkit intended to give teams an understanding of how to craft and nurture a positive safety culture and provide a theoretical underpinning to how to shift culture.[7]

Further to this, there is also *A just culture guide* available on the NHS England website, which "encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way".[8]

In the first four and half years of delivering its Patient Safety Strategy, NHS England's approach to fostering a safety culture has primarily focused on the production and publication of this new guidance. There may be other work currently being undertaken by its Safety Culture Implementation Group that we are not aware of however, as the group's activities and membership is not information that is shared transparently in the public domain.

Persistence of blame cultures in the NHS

Despite the publication and promotion of new NHS England guidance and good practice, current evidence suggests that blame cultures continue to persist in significant parts of the health service.

This is demonstrated is in annual results of the NHS Staff Survey. These provide a snapshot of staff experiences of working in the health service and include several questions relating to speaking up about safety concerns. Since the publication of the Patient Safety Strategy in 2019, it is hard to see that there has been a significant improvement in this area based on these results. The latest survey

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[4] NHS England, NHS Patient Safety Strategy 2021 update, February 2021. https://www.england.nhs.uk/wp-content/uploads/2021/02/B0225-NHS-Patient-Safety-Strategy-update-Feb-2021-Final.pdf

[5] NHS England, Safety culture programme group (SCPG) report: Overview of safety culture discovery and discussions 2021, Last Accessed 16 March 2023. https://www.pslhub.org/learn/culture/safety-culture-programmes/safety-culture-programme-group-scpg-report-overview-of-safety-culture-discovery-and-discussions-2021-r7693/

[6] NHS England, Safety culture: learning from best practice, 15 November 2022. https://www.england.nhs.uk/long-read/safety-culture-learning-from-best-practice/

[7] NHS England, Improving patient safety culture – a practical guide, 10 July 2023. https://www.england.nhs.uk/long-read/improving-patient-safety-culture-a-practical-guide/

[8] NHS England, A just culture guide, Last accessed 3 January 2024. https://www.england.nhs.uk/patient-safety/patient-safety-culture/a-just-culture-guide/#about-our-guide

results published on the 9 March 2023 showed a decline in all scores relating to raising concerns.[9] Figures that particularly stood out from this year's data included:

- Over 170,000 staff (28.1% of respondents) could not say that they would feel secure raising concerns about unsafe clinical practice, with more than 270,000 staff (43.3% of respondents) not confident their organisation would address clinical practice concerns that they did raise.
- More than 240,000 staff (38.5% of respondents) could not say that they felt safe to speak up about anything that concerns them in their organisation.
- When asked about confidence in their organisation acting on any concerns, this figure drops even further, with over 320,000 staff (51.3% of respondents) not believing their concerns would be addressed.[10]

Evidence from Staff Survey results is reinforced by the themes of blame culture and fear of speaking up appearing repeatedly in patient safety scandals. While the recommendation being considered by the Expert Panel on this topic is specifically drawn from a review by Robert Francis QC in 2015, we continue to see similar issues raised time and time again in inquiries and reviews. Recent cases of this include:

- The Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust (March 2022) – this highlighted significant concerns about culture, noting that there was "a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes".[11] [12]
- The Independent Investigation into East Kent Maternity Services (October 2022) – the inquiry stated that there was a fear of speaking up about patient safety issues, a reluctance to listen to staff concerns and a bullying and blame culture when things went wrong.[13] [14]
- Lucy Letby – doubtless more detail with be uncovered by the Thirlwall Inquiry that is now under way, but the coverage of this to date has already highlighted serious issues about how the hospital responded to clinicians who had raised patient safety concerns in this case.[15]

In addition to Staff Survey results and patient safety scandals, we see further evidence of the persistence of blame cultures in parts of the NHS reflected by the shocking experiences and testimonies of whistleblowers. Cases such as those of Peter Duffy highlight situations where

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[9] NHS Staff Survey, NHS Staff Survey National Results, 9 March 2023. https://www.nhsstaffsurveys.com/results/national-results/

[10] Patient Safety Learning, Still not safe to speak up: NHS Staff Survey Results 2022, 23 March 2023. https://www.patientsafetylearning.org/blog/still-not-safe-to-speak-up-nhs-staff-survey-results-2022

[11] Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust, Ockenden Report: Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust, 30 March 2022. https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

[12] Patient Safety Learning, Initial response to the publication of the Ockenden Review, 30 March 2022. https://www.patientsafetylearning.org/blog/initial-response-to-the-publication-of-the-ockenden-review

[13] Independent Investigation into East Kent Maternity Services, Maternity and neonatal services in East Kent – the Report of the Independent Investigation, 19 October 2022. https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

[14] Patient Safety Learning, Will lessons be learned? An analysis of the systemic failures in the East Kent Maternity report, 17 November 2022. https://www.patientsafetylearning.org/blog/will-lessons-be-learned-an-analysis-of-the-systemic-failures-in-the-east-kent-maternity-report

[15] Patient Safety Learning, Lucy Letby verdict, a future inquiry and patient safety, 23 August 2023. https://www.patientsafetylearning.org/blog/lucy-letby-verdict-a-future-inquiry-and-patient-safety

healthcare professionals raising patient safety concerns are met with a hostile and aggressive response, rather than one open to challenge and scrutiny.[16] [17] [18]

This can include legal threats, vexatious referrals to regulatory bodies, pay cuts, demotions, disciplinary action, and contractual changes. Too many staff continue to face experiences like this when they raise concerns, especially after approaching the Care Quality Commission (CQC) or other external agencies, with their organisation's responses marked by a focus on reputation management over tackling safety concerns.

Expert Panel recommendation

Having outlined the wider context in which the recommendation being considered by the Expert Panel sits, we will now consider the progress that has been made against this by addressing its three component parts:

> *"Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns."*[19]

As detailed earlier in this section, in the last two years NHS England has introduced a number of new good practice resources aimed at helping trusts to foster a patient safety culture. Given the recency of these publications, it is realistically too early to assess the impact that they have had on organisations approaches to fostering cultures of safety and learning.

However, at Patient Safety Learning our current concern is that having issued this guidance, there appears to be no clear system for ensuring that this is implemented across the NHS, and no public plans to monitor and evaluate the success of this. This means that it is difficult to easily ascertain:

- Which organisations are aware of the guidance and committed to implementing this.
- What progress they have made and what impact it is having.

This may be something that is being considered by the NHS England Safety Culture Implementation Group, though there is no indication of this in the public domain that we are aware of. Without any means of monitoring and evaluation, it is hard to see how we can assess the effectiveness of the efforts of organisations to move towards a culture of safety and learning. Furthermore, this makes it difficult to identify areas of good practice, or conversely poor performance, which need to be addressed.

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[16] Peter Duffy, Whistle in the Wind: Life, death, detriment and dismissal in the NHS. A whistleblowers story, 24 July 2019. https://www.amazon.co.uk/Whistle-Wind-detriment-dismissal-whistleblowers/dp/1082231967/ref=sr_1_1?hvadid=80676689312637&hvbmt=be&hvdev=c&hvqmt=e&keywords=whistle%2Bin%2Bthe%2Bwind&qid=1581680255&sr=8-1

[17] Peter Duffy, Smoke and Mirrors: An NHS whistleblower witch-hunt, 28 November 2021. https://www.amazon.co.uk/Smoke-Mirrors-NHS-whistleblower-witch-hunt/dp/B09MCLTF1P/ref=pd_bxgy_d_sccl_1/259-7424705-6119523?pd_rd_w=azmri&content-id=amzn1.sym.40f919ed-e530-4b1a-8d7e-39de6587208d&pf_rd_p=40f919ed-e530-4b1a-8d7e-39de6587208d&pf_rd_r=3XK1QYP6JZB6AEQA9VAE&pd_rd_wg=tGgNU&pd_rd_r=0e301d86-1264-4c9a-9366-eac7d5bcee03&pd_rd_i=B09MCLTF1P&psc=1

[18] Peter Duffy, NHS whistleblowing: the long and winding road, Trends in Urology & Men's Health, 19 December 2023. https://wchh.onlinelibrary.wiley.com/doi/10.1002/tre.952

[19] Robert Francis QC, Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS, February 2015. https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150953mp_/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

We know there are specific organisations, such as Mersey Care NHS Foundation Trust, who have over many years committed to making significant changes in culture.[20] We believe it would be greatly beneficial for the NHS to explore how it can help organisations such as Mersey Care and others share their practical experience of implementing culture change programmes with other organisations. While good practice guidance and theory is helpful, we believe there also needs to be a significant focus on practical implementation of these changes.

In the meantime, without clear means for identifying and monitoring the progress that individual trusts are making in fostering a culture of safety and learning, and the previously referenced evidence from Staff Survey results and whistleblower accounts suggesting significant elements of blame culture remain, we would contend that this element of the recommendation cannot be said to have been successfully implemented.

> *"Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis."*[21]

In its last formal update on work against Safety culture objectives in the NHS Patient Safety Strategy, regarding local systems NHS England suggested that they should set out how they will embed the principles of a safety culture in their organisations.[22]

Given the lack of national monitoring or assessment mentioned above, it is again difficult to gain a clear picture of to what extent individual Boards are undertaking measurement and reporting as part of this process. Furthermore, there are a lack of clear requirements for them to do so, and we are not aware of any process that would trigger intervention if Boards fail to do this.

At Patient Safety Learning we believe that organisation leaders should play a key role in modelling and promulgating patient safety behaviours, and that this is a central component to creating and maintaining a safe learning culture in an organisation. As part of our work looking at the healthcare system in the United Kingdom, we have developed a set of unique Patient Safety Standards centred around seven key foundations for patient safety, one of which is focused on culture.[23] To meet out Standards an organisation needs to demonstrate that:

- Its leadership fosters a patient safety culture that tackles blame and fear.
- The working environment actively supports and promotes a culture of patient safety improvement.
- That the role of HR in an organisation is an active one in reinforcing this.

To accompany this, we set a list of clearly defined Standards that explain what an organisation must do to deliver each of these aims. We believe that these are the type of requirements that are needed to verify if Boards are "creating and maintaining a safe learning culture is measured, monitored and published on a regular basis".

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[20] Mersey Care NHS Foundation Trust, Restorative Just and Learning Culture, Last accessed 3 January 2023. https://www.merseycare.nhs.uk/restorative-just-learning-culture

[21] Robert Francis QC, Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS, February 2015. https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150953mp_/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

[22] NHS England, NHS Patient Safety Strategy 2021 update, February 2021. https://www.england.nhs.uk/wp-content/uploads/2021/02/B0225-NHS-Patient-Safety-Strategy-update-Feb-2021-Final.pdf

[23] Patient Safety Learning, Why Standards, Last accessed 3 January 2024. https://www.patientsafetylearning.org/standards

In the absence of this and no obvious national monitoring, it is difficult to see how this element of the recommendation can be said to have been successfully implemented.

> *"Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led."*[24]

As part of its assessment framework, the CQC under its 'Well-led' category identifies fostering a positive culture where people feel free to speak up as a key aspect of this, and sets out criteria for this.[25] It also considers these issues under the 'Safe' category, which speaks about organisations having a proactive and positive culture of safety based on openness and honesty.[26]

As a result of this, through inspections processes the CQC can potentially identify where good practice regarding creating a safety culture is not being met. However, we would challenge whether this process, and crucially what follows it, results in subsequent improvements in performance.

When an organisation receives negative reflections from a CQC report on its safety culture, or demonstrates a significant downward trend in relevant scores relating to this in its Staff Survey results, what is the mechanism to tackle this? Organisations are told to improve in this area and follow good practice guidance, then progress is re-assessed in the next inspection report. There appears to be no proactive external intervention to help organisations achieve this, for example a scheme to pair up poorly performing trusts on culture issues with high performing ones to share learning and insights.

The existing system relies on an organisation that is advised that it has cultural problems actively making the improvements needed on its own. If the organisation does not, or is unable to do so, local staff are left to work in toxic environments that significantly endanger the safety of patients until the next inspection raises concerns again.

We believe this situation is exacerbated by the complex and fragmented way in which patient safety roles and responsibilities are spread across the NHS. To support and monitor culture change we need different stakeholders, ranging from trusts and Integrated Care Systems to NHS England and regulators, aligning their efforts. However there remains much work that is needed to improve multi-organisation cooperation, accountability and action when it comes to patient safety concerns.

We highlighted this issue in our report last year, *The elephant in the room: Patient Safety and Integrated Care Systems*, when looking at the role that Integrated Care Systems play in patient safety.[27] In the case of persistence patient safety issues, such as problems with organisation culture, a lack of joined-up thinking and working can significantly hinder these concerns being addressed.

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[24] Robert Francis QC, Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS, February 2015. https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150953mp_/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

[25] Care Quality Commission, Key questions and quality statements: Freedom to speak up, Last updated 23 November 2023. https://www.cqc.org.uk/assessment/quality-statements/well-led/freedom-speak-up

[26] Care Quality Commission, Key questions and quality statements: Learning culture, Last accessed 3 January 2024. https://www.cqc.org.uk/assessment/quality-statements/safe/learning-culture

[27] Patient Safety Learning, The elephant in the room: Patient safety and Integrated Care Systems, 11 July 2023. https://d2z1laakrytay6.cloudfront.net/Report_Theelephantintheroom_PatientsafetyandIntegratedCareSystems_prepublicationversion_100723.pdf

While there may be different avenues, such as CQC inspections and Staff Survey results, which highlight concerns, it seems as though there is no mechanism trigger action a change approach if these individually do not prompt organisational improvement. In the case of the most serious patient safety failings, we often see this only occurring following tireless campaigning patients and families consistently raising concerns, by which point significant harm has already taken place.

System regulators therefore may be able to identify departures from good practice, as intended by the recommendation, but this may not effect change or result in improvements on patient safety culture at individual trusts. At Patient Safety Learning we believe that the persistence of blame cultures in healthcare is one of several major systemic failures that result in avoidable harm. We cannot address these issues in silos. If changes are to be sustainable, improves to safety culture require a system-wide approach with patient safety identified as a core purpose of healthcare.

Inquiry recommendations and the implementation gap

In this second section of our submission, we will consider a broader issue that we believe it would be beneficial for the Expert Panel to consider as part of its review, the implementation, monitoring, and evaluation of recommendations from patient safety inquiries and reviews more broadly.

Implementation gap

The implementation gap is the difference between what we know improves patient safety and what is done in practice. This was identified as an issue for the NHS over twenty years ago in the report *An organisation with a memory*:

> *"The NHS record in implementing the recommendations that emerge from these various systems is patchy. Too often lessons are identified but true 'active' learning does not take place because the necessary changes are not properly embedded in practice. Though there is some good evidence of meaningful medium and long-term change as a result of Confidential Inquiry recommendations, for example, these are rarely driven through into practice and the onus for implementation and prioritisation is very much on local services. Takeup can tend to 'plateau' once changes have been implemented by those who are most naturally receptive to them, and there is some evidence that progress nationally can slip back if efforts are not sustained."*[28]

This gap between learning and improvement exists in at multiple levels and in many different areas, as we have previously identified in our report *Mind the implementation gap: the persistence of avoidable harm in healthcare*. In this report we looked at six specific areas where this gap exists on a policy level and acts as a barrier to patient safety improvement. One area we focused on specifically as part of this report was patient safety inquiry and review recommendations.

Recommendations, monitoring, and evaluation

Public inquiries and reviews into serious patient safety issues should function as a key source of insight and learning that we can use to reduce avoidable harm in healthcare. However too often we see recommendations around specific areas of ongoing concern, such fostering a culture of safety and learning, fail to translate into meaningful changes and improvements on the ground.

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[28] Department of Health, An organisation with a memory, 2000. https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4065086.pdf

As set out in *Mind the implementation gap*, different patient safety inquiries and reviews vary significantly in format, process and outcome depending on the terms of reference, preferences of the Chair and their legal powers. This has been highlighted as a broader issue with public inquiries by the National Audit Office in its 2018 report, *Investigation into government-funded inquiries*.[29]

This inconsistency also concerns how the Government subsequently responds and acts on the recommendations that it accepts. As made self-evident by the need for the Select Committee to undertake this specific Expert Panel review, there is no central repository or responsibility across government for tracking whether recommendations have been implemented and ensuring that inquiries have an impact. We lack the tools to assess how effective inquiries recommendations are in addressing the patient safety problems they identify.

Without a publicly available central repository of recommendations and transparent reporting against this, we cannot easily identify how many inquiry recommendations are outstanding and how many have been implemented. We also cannot easily tell whether there are a number of overlapping recommendations on a specific theme or topic stemming from different inquiries, and whether there is a systemic approach in place to tackle these.

Simply put, there is currently no way a patient, member of the pubic, parliamentarian, policymaker, or journalist to assess what recommendations have been implemented, whether in full, in part of not at all, across the whole of the NHS or individual organisations.

As mentioned earlier, this implementation gap does not only relate to inquiries and reviews but can be seen in many different areas. Recognising this, the charity INQUEST started a campaign earlier this year calling for a National Oversight Mechanism, which would be:

> *"A new independent public body responsible for collating, analysing and following-up on recommendations arising from inquests, inquiries, official reviews and investigations into state-related deaths."*[30]

In our report *Mind the implementation gap*, we suggest that:

> *"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."*[31]

While we appreciate that the Expert Panel's remit is focused on the Government's implementation of five specific accepted inquiry/review recommendations it has identified to consider, we would stress that in our view it would be beneficial for their report to also consider this wider issue of how the implementation, monitoring and evaluation of patient safety recommendations is handled.

We welcome the opportunity to submit this evidence to the Expert Panel.

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[29] National Audit Office, Investigation into government-funded inquiries, 23 May 2018. https://www.nao.org.uk/wp-content/uploads/2018/05/Investigation-into-government-funded-inquiries.pdf

[30] Inquest, No more deaths campaign, Last accessed 3 January 2023. https://www.inquest.org.uk/no-more-deaths-campaign

[31] Patient Safety Learning, Mind the implementation gap: The persistence of avoidable harm in the NHS, 7 April 2022. https://www.patientsafetylearning.org/blog/mind-the-implementation-gap-the-persistence-of-avoidable-harm-in-the-nhs