Taking a reading on NHS patient safety: views from the ombudsman

John Tingle, Lecturer in Law, Birmingham Law School, University of Birmingham, discusses several reports where the Parliamentary and Health Service Ombudsman addresses some critical NHS patient safety issues

It is difficult to get an accurate reading on where we are with patient safety in the NHS in England – is it making steady progress towards developing a proper patient safety culture, or is this only an aspirational pipe dream?

The Parliamentary and Health Service Ombudsman (PHSO), Rob Behrens, has expressed concern on several NHS patient safety matters in recent publications. The PHSO occupies a unique vantage point in the NHS from which to view NHS patient safety matters as his office makes the final decisions on complaints that have not been resolved. His jurisdiction also extends to other government departments and public organisations.

PHSO review of avoidable deaths

In his *Broken Trust* report from June 2023, the PHSO reviewed the most serious NHS complaints received by his office where avoidable death has resulted. The review highlighted an implementation gap, noting that there has been a lot of patient safety activity over the last 10 years but when the complaint cases are analysed:

> **'… there is a gaping hole between best practice policy and consistent real-life practice.'**
>
> *PHSO, 2023:7*

The PHSO discussed how we know over the years what the patient safety problems are and how to deal with them but that this does not always feed back into practice.

> **'We found that the physical harm patients experienced was too often made worse by inadequate, defensive and insensitive responses from NHS organisations when concerns were raised.'**
>
> *PHSO, 2023:8*

Four broad themes of clinical failings that led to avoidable death were identified:

- Failure to make the right diagnosis
- Delays in providing treatment
- Poor handovers between clinicians
- Failure to listen to the concerns of patients or their families.

Compounded harm

There is a discussion in the report of what is termed 'compounded harm'. This harm follows on from the death of a loved one, the situation is then made worse by the poor response from the NHS organisation involved. One set of harm then follows another, compounding the original harm done.

This concept of 'compounded harm' is a useful one. It provides a lens through which to view patient safety matters and allows us to better understand the consequences of failures. Several factors were identified in the report that contributed to making the harm worse (PHSO, 2023: 8):

- Failure to be honest when things go wrong
- Lack of support to navigate systems after an incident.
- Poor-quality investigations
- Failure to respond to complaints in a timely and compassionate way
- Inadequate apologies
- Unsatisfactory learning responses.

The failings identified by the PHSO are by no means new, but this report usefully identifies these failings again with evidence and calls for change. Recommendations made focused on two areas:

- Accountability for a robust and compassionate response to harm, which supports learning for systems and healing for families
- Evidencing that patient safety is a top Government and NHS priority.

Deep-rooted problems

This is a thoughtful, hard-hitting report that identifies deep-rooted failings in NHS patient safety. Under recommendation 2, the PHSO calls for a streamlining of NHS patient safety organisation functions and points to overlap, which results in uncertainty about areas of responsibility. I have discussed in previous columns the confusing and fragmented nature of the NHS health regulatory and governance structure. This particular comment is hard to disagree with:

> **'Political leaders have created a confusing landscape of organisations, often in knee-jerk reaction to patient safety crisis points."**
>
> *PHSO, 2023:9*

Broken Trust provides a valuable perspective on acute patient safety issues facing the NHS and the complaint cases discussed are evidence that the failures are causing the most profound of consequences, patient death.

Times Health Commission

The PHSO also gave evidence to the Times Health Commission and expressed several hard-hitting views again, identifying acute NHS patient safety failings requiring urgent action (Sylvester, 2023). The failings identified included sepsis treatment, maternity services, lack of empathy in the medical profession, sexual harassment, duty of candour, whistleblowing and organisational reputation being put above patient safety. These insights from the PHSO are very worrying in terms of NHS progress towards developing a proper patient safety culture. Again, these are not new observations, echoing several patient safety reports in recent times.

The PHSO also warned the Times Health Commission of 'Balkanisation' of health professions, with rivalries between doctors and nurses or midwives and obstetricians harming patient care. Sylvester (2023) quoted the PHSO:

> **'"For all the brilliance of clinicians quite often they're not very good at working together," he said. "Time and again, the handover from one clinician to another, from one shift to another, or the inability to raise the issue at a senior level has been a key factor in what has gone wrong".'**

Guardian Interview

Around the same time, the PHSO gave an interview to *The Guardian* with hard-hitting comments about NHS patient safety (Campbell, 2024). The PHSO talked about a 'cover up culture' in the NHS and how government ministers, NHS leaders and hospital boards must do more to stop this from developing further. He is quoted by Campbell (2024) as saying:

> **'Hospitals are cynically burying evidence about poor care in a "cover-up culture" that leads to avoidable deaths, and families being denied the truth about their loved one…'**

He said his investigations often found that care plans had been altered, or crucial documents disappeared after patients have died. He has also found robust denials of failures in the face of documentary evidence to the contrary. In the PHSO's view the duty of legal candour in the NHS was not forcing hospitals to be open when things went wrong.

A chequered history …

The evidence highlighted and opinions expressed by the PHSO highlight key patient safety concerns in several areas. Tragic failings are identified that have led in some instances to avoidable patient deaths. Other failings identified include health regulatory and governance system complexity, overlap, toxic behaviour of some doctors, cover-up cultures, and so on. All are acutely concerning.

As I have said in previous *BJN* columns, history has not served the NHS well when it comes to NHS patient safety culture development. In some parts of the NHS, staff lesson learning from past adverse healthcare events is palpably bad. This is evidenced by numerous reports that we have seen into NHS maternity failings and in other clinical areas over the years.

I would, however, argue that there is also a lot of good patient safety development work and practice going on, and we need to also factor this in when viewing reports on NHS patient safety. The NHS Patient Safety Strategy (NHS England, 2024a) and the Patient Safety Incident Response Framework (NHS England, 2024b) are two initiatives that I can see are having some good impact in terms of NHS patient safety culture development. More recently we have also had the launch of Martha's Rule (NHS England, 2024c)

… a complex organisation

The context of the care delivered in the NHS also needs to be factored in when viewing NHS patient safety reports and progress towards proper culture development. The NHS is a vast and complex healthcare enterprise in terms of employed staff, treatment, and care episodes. There are no quick fixes, patient safety culture development will take time. The King's Fund provides some useful facts and figures which highlight the complex and busy nature of the NHS:

> **'On an average day in the NHS …**
> **- more than 1.2 million people would attend a GP appointment**
> **- nearly 260 000 people would attend an outpatient appointment**
> **- more than 37 000 people would call 999**
> **- more than 44 000 people would attend a major A&E department, and about 25 per cent of A&E patients would be admitted into hospital**
> **- around 675 patients would go into critical care.'**
>
> ***The King's Fund, 2023a***

In terms of staff numbers the NHS in England currently employs around 1.4 million people, making it the largest employer in England (The King's Fund, 2023b). NHS culture change will not happen overnight, and it will always be a mammoth task given the size and shape and complexity of the NHS with its mission to treat all within its foundation principles.

Where do we go from here?

The PHSO laid out his views, concerns, and recommendations in the sources discussed above. All taken together they amount to a stark, damning indictment of key aspects of NHS patient safety. His criticisms are wide-ranging, covering many issues from system complexity and overlap, toxic behaviour to cover-up cultures. From what he says there is certainly something seriously wrong with certain aspects of NHS patient safety and he shines a powerful light on crucially important matters that need to be urgently addressed.

However, all is not doom and gloom and the NHS can be seen to be making some satisfactory progress towards developing a patient safety culture. We can look at the NHS Patient Safety Strategy, Patient Safety Incident Response Framework and Martha's Rule to name only three initiatives and there are many others. It is also important to view the NHS's patient safety problems within the overarching structural context of the NHS – the size, shape, and complexity of the NHS. As stated above, culture change and development will take some time and there are no quick fixes.

All that said, however, the PHSO does specifically address some unforgivable patient safety failings, which cannot be excused by referring to the general context of NHS care delivery. The failings identified by the PHSO need to be urgently addressed. **BJN**

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