Reflecting on patient safety in 2022

John Tingle, Lecturer in Law, Birmingham Law School, University of Birmingham, discusses some major patient safety reports published in 2022, and considers the lessons to take away from them

All in all, 2022 was a bumper year for the publication of seminal patient safety reports. These reports were highly significant, with major implications for patients and the NHS. Patient safety as a topic is a major one and relentless efforts are needed by all in the NHS to bring about a proper patient safety culture.

This need for relentless action is reflected in the publication cycle of reports. There is a danger that, with the frequency of reports, vital patient safety messages can get lost. In a sense, the adage about 'yesterday's news' applies. Key recommendations are made in one patient safety crisis report. There is then a flurry of media attention and soul-searching by trusts and then another crisis report breaks. The previous report is soon forgotten, consigned to the pile dating back well over 20 years. These reports make excellent recommendations but seemingly many get lost and important changes do not take root.

Acting on the reports

The key issue for me is the extent to which the advice and recommendations made in the reports are acted on in the NHS and whether safer practice results. As we closed the year, the Institute of Global Health Innovation at Imperial College London produced a report looking at patient safety in England (Illingworth et al, 2022). Section 1 gives a 'snapshot' of patient safety, with other sections covering 'data about harm', 'patient perspectives on safety' and 'staff perspectives on patient safety'.

This is an excellent report, which draws some key themes together and makes important recommendations:

- The breadth of patient safety data needs to increase
- The accuracy of key patient safety measures needs to improve
- A workforce plan for the NHS and social care is urgently needed
- Integrated care systems need to play a central role in monitoring safety
- Progress in the safety of maternity services needs to accelerate.

The report reveals a 'mixed picture of patient safety in England' (Illingworth et al, 2022: 6).

When I reflect on 2022, an overwhelming feature has been reports on maternity failings and their continuing, seemingly insuppressible nature. Illingworth et al (2022) drew attention to these maternity cases and I take the view that these reports not only have direct relevance to maternity care but are also relevant to other care areas in the NHS. Care Quality Commission inspection reports and reports of other crises, such as at Mid Staffordshire, often quoted issues such as patient dignity, rights, communication, leadership, team working, professional hierarchies, lack of staff compassion and kindness towards patients, culture issues, attributing fault and blame, poor complaint handling, poor escalation of concerns, management styles and so on. All these are factors that have been identified as contributing to patient safety failings in the maternity reports.

The maternity inquiry reports present a window on these issues in real time and, as such, function as valuable patient safety education and training tools and resources.

Shropshire and Telford

The Ockenden report (2022), published early in the year, set the scene for the rest of it. Thomas (2022a), writing in *The Independent*, introduced the report and its dire findings:

> **'The inquiry covered 1,592 clinical incidents involving 1,486 families between 2000 and 2019, during which time it found there were more than 200 avoidable baby deaths or brain damage cases as a result of poor maternity care, including 131 stillbirths, 70 neonatal deaths and 84 cases of brain damage. It said nine mothers had also died as a result of avoidable poor care. Concerns were raised about a further three deaths, although it was determined care had not been a factor in these outcomes.'**

Thomas also pointed out that, in some cases, fault was placed on mothers for the death of their baby and that others had their concerns and complaints dismissed.

The Ockenden report is thorough and detailed, identifying major lapses in patient safety. Poor investigation procedures were noted and repeated patterns of poor care. There were lost opportunities to learn and to improve care quality and patient safety. Failures in governance and leadership were identified. There is also discussion of bullying and failures in compassion and kindness:

> **'Many families reported to the review team a lack of compassion and kindness shown to them by Trust staff.'**
>
> ***Ockenden, 2022: 116***

Striking at the heart of the NHS

I worry about a statement like this because it strikes at the heart of what good NHS care should look like. Patients should never be exposed to this type of behaviour, which is unthinkable and intolerable in a modern-day service.

> **'Descriptions of physical trauma, pain, lack of attention, vulnerability, unkind words, swearing, sarcasm and bullying towards women as well as unkind treatment of colleagues, amongst midwives and obstetricians have been found to be widespread throughout the review period.'**
>
> ***Ockenden, 2022:106***

The report also highlighted:

'In a surprisingly large proportion of the cases reviewed for this report, common obstetric conditions were not recognised or not managed in line with established guidelines.'

Ockenden, 2022: 132

The report does chronicle some good practices including bereavement care. Good record keeping and care planning were also found in some cases, and 'timely multidisciplinary management' (Ockenden, 2002: 121). There are major patient safety lessons to be learnt from this report. Good practice is identified but is eclipsed by the poor practice found.

Morecambe Bay

We can all question whether Shropshire and Telford was an outlier, that such things described do not regularly happen in the NHS and are exceptional by any meaning of the word. I would disagree, particularly when we reflect on the Kirkup (2015) report and the other maternity care reports. Take the Morecambe Bay Inquiry report's introduction:

'The result was avoidable harm to mothers and babies, including tragic and unnecessary deaths. What followed was a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed, and a series of missed opportunities to intervene that involved almost every level of the NHS. Had any of those opportunities been taken, the sequence of failures of care and unnecessary deaths could have been broken.'

Kirkup, 2015:5

We can see a repetition of patient failure themes with the most recent reports.

East Kent

Later in 2022 we saw the publication of another patient safety maternity crisis report, *Reading the signals* (Kirkup, 2022). This identified four areas of action:

'The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty.'

Kirkup, 2022: v

These four themes can be seen in many past patient safety crises reports. The latest Kirkup report is a harrowing read and the evidence obtained by the review team sadly shows acute patient safety failings:

'We have found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.'

Kirkup, 2022:1

Care outcomes

The report argues that, had care been given to nationally recognised standards, the outcome could have been different in 97 (48%) of the 202 cases assessed by the panel. The outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases. From 2009 to 2020 the panel had not been able to detect what it terms 'any discernible improvement in outcomes or suboptimal care' (Kirkup, 2022: 1):

'We have found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members. In fact, in a significant number of cases, the Panel has found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, when they questioned their care, and when they challenged the decisions that were made. Too often, their well-founded concerns were dismissed or ignored altogether.'

Kirkup, 2022:21

Both Kirkup reports (2015; 2022) reveal unforgivable failures of NHS care, which strike a blow to everybody's confidence in the NHS. These reports require detailed reading as they provide a valuable window on how NHS care can and does go wrong and what is needed to remedy the situation.

NHS patient safety cultures do take time to build and cannot be mandated as something to do overnight. Each trust will be at its own stage of development, some being more advanced than others in this culture-development process. All NHS staff need to reflect on the reports discussed and to ask themselves whether similar failings could happen or be happening in their own clinical area.

At the end of the year

As we move into 2023 yet another major maternity patient safety inquiry is on the horizon. Thomas (2022b) highlighted the scale:

'The NHS could be facing its largest maternity scandal to date as the review into services in Nottingham is now expected to exceed 1,500 cases, *The Independent* has learned. The probe began in 2021 after this newspaper revealed dozens of babies had died or been left with serious injuries or brain damage as a result of care at NUH, which runs Nottingham's City Hospital and Queen's Medical Centre.'

This review is being led by Donna Ockenden, who chaired the Shrewsbury and Telford Hospital NHS Trust maternity inquiry discussed earlier. Once again, the circular nature of these inquiries and the common, sometimes basic care issues they identify are raised. They show that sections of the NHS do not seem to be able to learn the patient safety lessons of the past, placing a sizeable question mark over the speed and direction of patient safety culture development in the NHS. **BJN**

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