Parliamentary and Health Service Ombudsman report – 'Broken trust: making patient safety more than just a promise'

On 29 June 2023 the Parliamentary and Health Services Ombudsman (PHSO) published a new report on patient safety, which asked why services fail to learn from avoidable harms and how to close the gap between ambitions for improving patient safety and the reality in practice. This briefing summarises the key findings and recommendations of the report.

If you have any comments or questions on this briefing or the report, please contact NHS Providers policy advisor for quality, Matt Case (matt.case@nhsproviders.org).

Key points

The PHSO investigates complaints that have not been resolved by the NHS and other public bodies and produces a final decision on those complaints following an impartial investigation. This report analyses the most serious cases it has investigated over the past three years and identifies the common themes which prevent incidents from being learnt from and hinder the development of open, learning cultures. The report makes recommendations relevant for trusts, integrated care boards (ICBs) as well as the government and NHS England, across two themes:

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

Findings

The Ombudsman's report is based on an analysis of 400 cases from the past three years, which found 22 cases where a death was more likely than not avoidable. The Ombudsman carried out detailed interviews with the families who raised these complaints, alongside a review of other patient safety literature. The report identifies three elements of harm based on its analysis:

- 'Clinical failings', which the report defines as clinical care and treatment that a patient should have received but did not receive

- 'Avoidable harm', which the report defines as clinical harm suffered by a patient due to clinical failings
- 'Compounded harm', which the report defines as additional harm suffered by patients and families due to the response of healthcare organisations.

The report's findings detail the most common clinical failings and subsequent organisational responses which cause avoidable and compounded harm.

Clinical failings leading to avoidable harm

The report finds four categories of clinical failings leading to avoidable harm:

1. Failure to make the right diagnosis

The Ombudsman found that a failure to diagnose either directly led to or significantly contributed to an avoidable death. For example, a patient who died of a pulmonary embolism did not receive a specific blood test because doctors reviewing him in hospital failed to follow relevant guidance, while another man who died of sepsis was not monitored at appropriate intervals, leading to a missed diagnosis. The report identified several factors contributing to failures in diagnosis:

- Not seeking more senior or specialist input when appropriate
- Not observing or monitoring at regular enough intervals to recognise deteriorating health or new issues
- Imaging failings such as not effectively following up on an unexpected finding.

2. Delays in the treatment response

The report also highlights delays in providing treatment, and identified factors such as:

- A diagnosis being made but not acted on properly or quickly enough
- Not acting quickly enough on observations.

For example, a woman who died after being diagnosed with vasculitis did not have her medication prescribed until 16 hours after her diagnosis, and did not receive the medication until 11 hours after it was prescribed.

3. Poor handovers

The Ombudsman also highlights poor handovers as a driver of avoidable harm, for example a patient who died of a cardiac arrest after a consultant ordered several relevant tests but these were not

delivered and the information not shared with other treating clinicians, who therefore missed an opportunity to diagnose a previous heart attack. The report highlights several aspects of poor handovers including:

- Communication failures between different clinicians and teams
- Poorly documented handovers.

4. Failure to listen to concerns of patients and their families

Finally, the Ombudsman highlights a small number of cases where not listening to patients and their families had a clinical impact, such as one man with abdominal pain who told clinicians he did not feel well enough to be discharged but was nevertheless discharged, being readmitted two days later and dying shortly afterwards due to gastric aspiration.

Compounded harms

The Ombudsman's report, informed by interviews with complainants, details several aspects of organisational responses which contributed to compounded harm for people affected by safety incidents.

Failure to be open and honest when things go wrong

The report notes the duty of candour applied to healthcare organisations but identifies examples from casework where this duty was not met. For example, a trust which did not disclose the contradictory opinions it had received during an investigation, and an example where staff considered deleting the recording of a meeting in case it was damaging to the trust. The PHSO highlights the need to equip staff to act in a transparent manner.

Lack of support to navigate systems in the aftermath of an incident

The Ombudsman highlights the common experiences of claimants who felt they received a lack of information following an incident, and a lack of support to raise concerns or navigate different complaints processes. The report also highlights patient concerns about access to independent advice and notes positively the work of independent advocacy services.

Poor-quality investigations

The report suggests that trusts routinely fail to carry out sufficiently robust investigations and highlights that in none of the 22 cases analysed did the trust involved reach the same conclusion as the Ombudsman's investigation in identifying the errors that led to an avoidable death.

For example, the Ombudsman highlights an example of a trust responding to a complaint with contradictory accounts a year apart, of written responses to complaints containing factual inaccuracies, and of investigations which fail to interview key personnel involved in an incident.

The report is positive about the potential for the Patient Safety Incident Response Framework (PSIRF) to improve the way that organisations respond to patient safety incidents, though it calls for effective monitoring of its use.

Failure to respond to complaints in a timely and compassionate way

The Ombudsman highlights delays in responding to complaints and a lack of information provided to families about the progress of their case, which causes further distress for complainants. The report also highlights investigations being carried out insensitively. For example, the report references a man who waited two years for a trust to conclude its investigation into the death of his wife, as well as a complainant whose first meeting with the trust took place in the same ward where her mother had recently died.

The Ombudsman acknowledges that staff handling complaints often require staff resource and for these staff to be effectively trained and empowered to resolve complaints effectively and sensitively.

Inadequate apologies

The report suggests that clear and unreserved apologies are rare, with apologies often seen to be insincere, not to accept responsibility for incident, and not to acknowledge the harm caused to the patient or compounded harm caused to the complainant. The Ombudsman suggests that defensive cultures contribute to poor apologies and that these qualified apologies can cause further distress to complainants.

Unsatisfactory learning responses

The Ombudsman highlights that 93% of complainants are motivated by helping to prevent the same mistakes happening again, something that was confirmed in detailed interviews with complainants. However, the report suggests that while many good examples of thorough action plans are produced, the Ombudsman often sees missed opportunities for learning, for example, through a lack of auditing of new processes or insufficient attempts to integrate changes into practice. This feeling of learnings not being applied causes further distress to complainants.

Recommendations

The PHSO makes seven recommendations – noting that healthcare is a complex system in which incidents do not have readily available, easy solutions – across two themes:

Accountability for a robust and compassionate response to harm, which supports learning for systems and healing for families

For trusts, the PHSO recommends that the executive PSIRF lead should review any discrepancies between local investigations and the PHSO or other independent investigations and ensure there is a Board discussion of these discrepancies. The PHSO recommends this includes where local investigations did not take place before a PHSO investigation, or when local and PHSO investigations differ in their findings.

The PHSO also recommends that ICBs should monitor the impact of the PSIRF, including a focus on what balance of patient safety investigations versus other learning responses is adopted in a trust where there are poor CQC ratings for safety and leadership. This is due to a risk identified by PHSO that the flexibility of PSIRF may lead to negative outcomes in trusts where there is not currently a culture of openness and learning.

The PHSO also recommends that the government and NHS England review the operation of duty of candour in healthcare organisations and makes recommendations for improvement, and that the government provides investment for further independent advocacy support for harmed patients, families and carers.

Evidencing that patient safety is a top Government and NHS priority

The Ombudsman argues that NHS leaders and frontline staff should be in no doubt of the priority placed on patient safety, and that currently there are several factors which prevent this being the priority in reality, including workforce shortages, complicated oversight of patient safety, and inconsistent political leadership. For example, the report describes the landscape of patient safety focused organisations – including the Healthcare Safety Investigation Branch (HSIB), the Patient Safety Commissioner, PHSO, NHS England, NHS Resolution, and other health and care regulators – with overlapping functions. It also argues that "we must break down the false dichotomy between the interests of patients and staff, recognising that a system that does not treat its workforce with humanity and compassion will struggle to extend these qualities to patients and families".

The report recommends that the government should:

- Produce a long-term workforce strategy based on independent projections of future workforce requirements, an account of skill mix and plans for both recruitment and retention
- Commission an independent review of what an effective set of patient safety oversight bodies would look like
- Seek cross-party support for embedding patient safety and the culture and leadership needed to support it as a long-term priority.

The report asks for updates from the Department of Health and Social Care and NHSE England to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication of this report.

NHS Providers view

This is an important report which offers valuable insights into where the NHS has fallen short in supporting families who have suffered harms and where it can focus in improving its response to patient safety incidents. The report also rightly recognises the importance of the Patient Safety Incident Response Framework which trusts are working hard to implement and will improve their ability to respond to patient safety incidents.

We welcome the report's acknowledgement of the level of pressure that trusts are currently under because of workforce shortages, and the risk that these shortages pose to patient safety – we welcome the publication of the government's Long Term Workforce Plan, and are hopeful it will deliver on its promise to put the NHS workforce on a sustainable footing.

The report suggests that the government should review the ideal arrangement of patient safety oversight bodies to reduce confusion and fragmentation and strengthen the patient safety voice. It is important to ensure that both patients and healthcare organisations are clear about the roles and responsibilities of different patient safety organisations, and that safety recommendations do not duplicate each other. However, it is nonetheless important to acknowledge where organisations can add specific value (for example, the safe space that HSIB is able to provide participants in its investigations) and hold expertise which might not be as effectively retained in an organisation with broader responsibilities.

It is also important to acknowledge that the issues in the report cannot be solved by more effective oversight alone. We agree that sustained political leadership on patient safety would be helpful to enable organisations to better focus on maintaining safety. Too often, boards are required to focus on politically-defined financial and operational performance with too little regard for safeguarding safety and quality and supporting a culture of openness and learning.

Press statement

Responding to a new report by the Parliamentary and Health Service Ombudsman about patient safety, Miriam Deakin, director of policy and strategy at NHS Providers, said:

"Losing a loved one is a very difficult time for anyone. It's essential that the NHS works with and supports families openly and honestly to understand what happened and how to do better.

"The Ombudsman's report offers important insights into where the NHS has fallen short and the progress it still needs to make in how it cares for patients and their families. We agree strongly with the Ombudsman that embedding and supporting patient safety should be a consistent priority for the government.

"Many of the issues in the report can be traced to a lack of investment in staff wellbeing. It is crucial to recognise we need not just more national oversight but more commitment to creating a culture where NHS leaders, locally and nationally, work together to improve.

"There is a new national approach to patient safety investigations and learning responses (The Patient Safety Incident Response Framework). Top class patient safety and continuous improvement requires clear-sighted national understanding of how to develop and maintain a true learning culture and better ways of working."

Contact: Matt Case, Policy Advisor matt.case@nhsproviders.org