patient safety learning

Patient Safety Learning's response to the Paterson Inquiry

Are there any new lessons for patient safety? Will there be any action?

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The Independent Inquiry into the Issues raised by Paterson, published on Tuesday 4 February 2020, was prompted by the case of Ian Paterson, a breast surgeon who was convicted of wounding with intent some of the 11,000 patients he treated and jailed for 20 years in 2017. More than 200 patients and family members gave evidence as part of the Inquiry and it is estimated that he could have harmed more than 1000 patients.[1]

The Inquiry gave those involved an opportunity to be heard and to learn how this happened, in both the NHS and the independent sector. It found that this "is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson's malpractice were let down time and time again".[2]

Here Patient Safety Learning reflect on some of the key patient safety themes that have emerged from this report. Many are ones that have featured in other inquiry reports. When will healthcare act on inquiry recommendations?

Staff fearful of raising concerns

A key issue raised by this report is how concerns raised about a healthcare professional's conduct are dealt with and the reluctance of staff to report their concerns. In the case of Dr Ian Paterson, these were first raised when he was working at Heart of England NHS Foundation Trust (HEFT) in 2003. Despite concerns being raised on many occasions, Dr Paterson was not suspended by the Trust until 2011. The report found that part of the problem lay with these issues being treated as individual incidents so that "connections were not made, and this was to the detriment of patient safety".

The report also revealed issues with healthcare professionals being fearful of raising concerns and the potential consequences of doing so. It noted that in some cases, staff where aware others had raised them, they felt they did not need to do so, reflecting a "theme of people thinking it is someone else's responsibility to take action".

This is a common issue in many patient safety scandals; organisations have a culture that defaults to blame and discourages staff speaking up.

The Inquiry found it "striking that regulators testified to major improvements which they thought would identify another Paterson, while the clinicians we met believed that … it was entirely possible that something similar could happen now. The testimony of those on the front line is telling".

Patient Safety Learning considers that it is vital and urgent that we move towards a culture in healthcare where staff can feel safe and secure in reporting patient safety concerns, knowing theses will be actively welcomed, listened to and acted on. We have called for all organisations to regularly and independently assess their organisational culture and have programmes of action to ensure a just and learning culture is in place.

[1] The Guardian, Ian Paterson inquiry: more than 1,000 patients had needless operations, 4 February 2020. https://www.theguardian.com/society/2020/feb/04/ian-paterson-inquiry-culture-of-denial-allowed-rogue-breast-surgery

[2] The Right Reverend Graham Jones, Report of the Independent Inquiry into the Issues raised by Paterson, February 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

‘Speaking up’ in the independent sector

A big difference between the NHS and independent sector is also highlighted in this report. All NHS trusts are required to appoint their own Freedom to Speak Up Guardian (FTSUG), who can act as an independent and impartial source of advice to staff at any stage of raising a concern. However, this is only an advisory requirement for independent sector providers when not subject to the NHS Standard Contract.

The roles of FTSUGs are intended to play are important part in developing a more open and supportive culture, one that encourages staff speaking up and reporting concerns.

In our view, patients should be safe whether they receive care in the NHS or the independent sector. An open and learning culture should clearly signposting staff to how they raise concerns and that these concerns are acted upon. The role of FTSUG should be reported both within the organisation and publicly. Patient Safety Learning have highlighted concerns with a specific story looking at how a scrub nurse who reported unsafe care in a private hospital was treated and the nurse has recently published a follow up blog in light of the Paterson Inquiry. We have raised it on *the hub*, our shared learning platform for patient safety, and have followed up with NHS Improvement, Care Quality Commission (CQC), National Guardians Office, General Medical Council and Nursing and Midwifery Council.

Supporting patients when they are harmed

In healthcare it is vital that patients are engaged effectively to understand and learn from concerns. The Inquiry report states that “this tragic story would not have been told in its fulness were it not for a relatively small number of Paterson patients who were determined to prevent other people suffering as they had done, and who pressed for an Inquiry. If patients in the future are safer in both the NHS and the independent sector as a result of this report, it will be due largely to their efforts”.

Not listening to and learning from patients can cause further harm and drive people to litigation if they feel they have no other recourse. HEFT and Spire subsequently needed to recall patients who had been treated by Paterson, to let them know if their treatment had been incorrect and unsafe and whether they needed any further treatment. The report notes that patient experience when recalled could be summarised as “generally inadequate, not patient-focused, and lacked both pastoral support and transparency”.

Patients tell us that they are often not engaged properly in their care, instead treated as passive participants in the process. At Patient Safety Learning we have been working with patients and campaigners to take forward work in the area of patient engagement. We’ve recently launched a new blog series with Joanne Hughes, who set up the website Mothers' Instinct, that outlines needs of patients, families and staff to engage in the safety of their care and if things go wrong. We look at how these needs may be best met and by whom. Patient Safety Learning considers that it is essential that patients receive the support they need when things go wrong and we call urgently for resources to develop ‘harmed patient care pathways’ that outline the provision of advice, guidance, practical and psychological support to patients and families when they harmed by unsafe care.

Learning from complaints

Complaints provide a valuable source of learning, as can investigations into serious incidents. One of the findings of the Inquiry is that patients encountered problems with both these processes; at HEFT and Spire Healthcare.

In the case of the former, it was noted that the process was seen as difficult and not well signposted. The majority of those who spoke to the Inquiry about their complaints were unhappy with the way they were handled. Patients said that HEFT were "too defensive and that responses to complaints did not always address the issues raised". For those making complaints to Spire Healthcare, the majority did not feel that these were handled well; "Spire was described as unresponsive and dismissive of its responsibility for the care patients had received".

This Inquiry also serves to highlight the difference in escalation routes for complaints, should an individual feel this has not be resolved by the organisation in question. In the NHS, a complainant can escalate this to the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied. The PHSO can look into complaints about healthcare services in a private hospital if the NHS have paid for this, but not the independent sector or private patient units within NHS Hospitals.[3] For cases that fall outside of this, patients can potentially escalate to the Independent Sector Complaints Adjudication Service but private hospitals do not have to participate in this. Patient Safety Learning considers this situation unacceptable. We believe that all patients should be able to make complaints feeling confident that they will be listened to, that complaints will be investigated, and that learning will be acted upon to improve patient safety and prevent future harm.

Too often in healthcare complaints processes are variable in their quality and are insensitive and adversarial, frustrating patients further and causing additional harm. At Patient Safety Learning we believe that we need to rethink our approach to this. We need systems where harm is properly investigated, and learning is applied to prevent future harm. Patients and families need to be engaged and supported in this.

On the issue of escalating complaints, the Inquiry recommends that "all private patients should have the right to mandatory independent resolution of their complaint". This is something we strongly support – patient safety should apply to all, irrespective of whether care is provided for in the NHS or independent sector.

#Share4safety

The Inquiry highlighted concerns about how data is shared by the NHS and independent sector, both in relation to patients and to concerns about professionals. It expressed concerns about patient records not being shared, which potentially puts patients at risk. The report notes that it "remains the case that it is not mandatory for patient records to be shared between the NHS and independent sector hospitals".

The report found that there had been a lack of, or ineffective mechanisms for, sharing concerns about Ian Paterson's practice between the NHS and the independent sector. It stated that there was "a failure to clearly communicate concerns between the NHS and independent sector", and that managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb'. The report reflected a "capacity for wilful blindness" and that Dr Paterson, "to a surprising degree … was "hiding in plain sight"".

Healthcare is systematically poor at learning from harm and while organisations may be data-rich, they are often information poor.

At Patient Safety Learning we believe that it is important that organisations develop systems and measurements to improve patient safety, collecting data on patient safety and sharing

[3] Parliamentary and Health Service Ombudsman, Private Healthcare, Last Accessed: 5 February 2020. https://www.ombudsman.org.uk/making-complaint/if-we-cant-help/private-healthcare

learning. We strongly support the recommendation made by the Inquiry that where a healthcare professional is suspended with a perceived risk to patient safety, these concerns should be communicated to other providers that they work for.

A leadership gap

Another common theme in many major patient safety reports is the lack of engagement by an organisation's leadership with issues of unsafe care. This Inquiry has highlighted similar issues both in the NHS and independent sector. The Heart of England NHS Foundation Trust and Spire were considered to be primarily concerned for their own reputation. Their reluctance to take responsibility for predecessor bodies led to a significant loss of corporate memory, an offloading of responsibility and an undermining of accountability.

Regarding HEFT it highlighted concerns about the Board and that 'there was a disconnect between the board and HEFT's healthcare professionals and front-line staff'. There were also concerns raised about the lack of transparency around the Board's response when concerns were raised with them, with key documents around its decision making unable to be located when requested by the Inquiry. It was noted that they were "surprised at the lack of curiosity this suggests on the part of the board, given that Paterson was the subject of many reviews during this period". In the case of Spire Healthcare, the Inquiry also noted that "Spire's corporate team had been remote from the management of its Parkway Hospital, and that the executive team and board were not visible at local hospital level".

From June this year all NHS trusts will be required to identify at least one patient safety specialist. These roles are currently subject to consultation.

We believe that organisations need strong and effective governance for patient safety throughout the organisation including at Board level. This new specialist role relates only to the NHS. But this Inquiry begs the question, should this also be a requirement in the independent sector?

Patient Safety Learning believes that we need a new model for leadership and governance for patient safety, that operates in both the NHS and independent sector. There should high standards and behaviours set for our leaders and they should be supported by specialist patient safety experts in executive and non-executive Board roles. Organisations need clear and published goals for patient safety with Board focus and effective oversight on reducing patient harm.

Who ensures that everyone owns patient safety?

One issue the Inquiry also brought into focus was that Paterson was able to continue harming patients over a sustained period, despite the presence of a significant amount of regulation and large and well-resourced regulatory bodies. Reflecting on this it noted that 'the regulators appeared to be waiting for someone else to act. It is our view that in this case, the regulation of the healthcare system failed'.

This is sadly also not a new theme in healthcare. In the Ministerial Response in the report's publication, Nadine Dorries MP, Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety, acknowledged that this "was not the first time that regulatory failure has been highlighted in an inquiry report" but noted steps had been taken in recent years to make the NHS a safer system.[4]

[4] House of Commons Debate, Paterson Inquiry, 4 February 2020. https://hansard.parliament.uk/Commons/2020-02-04/debates/560C88B9-4C75-483D-ABF2-12951326AE28/PatersonInquiry

At Patient Safety Learning we would challenge whether this regulatory issue has been fully addressed. As recently as 2018, the CQC in their report *Opening the door to change* stated that "arm's-length bodies, including CQC, royal colleges and professional regulators, have a substantial role to play within patient safety, but the current system is confused and complex, with no clear understanding of how it is organised and who is responsible for what".[5]

It is not clear to us what action has been taken by Government and Parliament to respond to CQC's report. Nor is it clear who is accountable for ensuring that the healthcare system operates as one coordinated system with patient safety a core purpose. This is a critical matter that needs urgent attention and should be something for the Health and Social Care Select Committee to consider and report on.

Patient Safety Learning call for a clear regulatory and leadership framework for patient safety, with a common view on roles and responsibilities, showing that patient safety is being treated as part of the purpose of healthcare.

Patient safety as a core purpose of healthcare

Many of the issues highlighted by this Inquiry are not new but persistent themes that emerge time and again in healthcare. Patient safety is a systemic issue, with avoidable harm in healthcare having a complex set of causes. To reduce harm, the recommendations in this Inquiry need to be acted upon alongside actions to tackle the six systematic reasons for patient safety failure that we highlight in our report *A Blueprint for Action*.[6] Patient Safety should be a core purpose of healthcare and action should be taken to reduce the 11,000 annual avoidable deaths.[7]

The Government's response and action needed

The Government's response to the publication of the Inquiry's report advised that they would look at these recommendations and report back "in three to four months' time".[8] When doing this it is vital that these recommendations are considered holistically as part of the wider change that is needed, where patient safety is treated as a strategic purpose of healthcare. Patient safety is currently treated as one of many priorities to be weighed against each other. We think it is wrong that safety is negotiable. Patient safety must be core to the purpose of healthcare, reflected in everything that it does.

We look forward to the Government's response to the Inquiry recommendations. This must include action for change, including:

Culture change

- Creating a culture in healthcare where staff feel safe and secure in reporting patient safety concerns, knowing their concerns will be actively welcomed, listened to and acted upon.
- Healthcare organisations should regularly and independently assess their organisational culture and have programmes of action to ensure a just and learning culture is in place.

[5] Care Quality Commission, Opening the door to change: NHS safety culture and the need for transformation, December 2018. https://www.cqc.org.uk/sites/default/files/20181218_openingthedoor_summary.pdf

[6] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409.

[7] NHS England and NHS Improvement, The NHS Patient Safety Strategy: Safer culture, safe systems, safer patients, July 2019. https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf.

[8] House of Commons Debate, Paterson Inquiry, 4 February 2020. https://hansard.parliament.uk/Commons/2020-02-04/debates/560C88B9-4C75-483D-ABF2-12951326AE28/PatersonInquiry

Staff reporting concerns

- An open and learning culture clearly signposting staff on how to raise concerns and that these concerns are acted upon.

Harmed patients are supported

- Patients receive the support they need when things go wrong.
- 'Harmed patient care pathways' outline the provision of advice, guidance, practical and psychological support to patients and families.

Learning from complaints

- All private patients have the right to mandatory independent resolution of their complaint. Patient safety applies to all, irrespective of whether care is provided for in the NHS or independent sector.

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- Organisations develop systems and measurements to improve patient safety, collecting data on patient safety and sharing learning. We strongly support the recommendation made by the Inquiry that where a healthcare professional is suspended with a perceived risk to patient safety, these concerns should be communicated to other providers that they work for.

Leading and owning patient safety

- A new model for leadership and governance for patient safety that operates in both the NHS and independent sector. There should be high standards and behaviours set for our leaders and they should be supported by specialist patient safety experts in executive and non-executive board roles. Organisations need clear and published goals for patient safety with board focus and effectively oversight on reducing patient harm.
- The healthcare system operates as one coordinated system with patient safety as a core purpose.

If action isn't taken, then the Paterson Inquiry will become yet another report to unsafe care where sympathetic noises are made but no real learning and change occurs. If Government and leaders say that 'lessons have been learned' then they need to tell us what those lessons are, what actions they are taking, and publish updated reports on their progress and share them publicly. Without having these measures in place, how can the public and patients be assured that there won't be future reports of unsafe care? As the Inquiry Chair said, "it is wishful thinking that this could not happen again".