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# NHS accused of suppressing investigation reports on poor care

Health bosses are watering down auditors' recommendations for improvement

new


Shaun Lintern, Health Editor
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Health officials have tried to suppress the work of investigators reporting examples of poor NHS care, it can be revealed.

In a series of recent power grabs, NHS England has stopped investigators alerting the media to their national clinical audits, watering down key recommendations and limiting the way the reports are written, published and used.

Sir Jeremy Hunt, the former health secretary, Donna Ockenden, the leading midwife, and Dr Bill Kirkup, who chaired inquiries into maternity scandals, have criticised the increased control over the investigations, which are meant to be independent.

Sir Jeremy HuntADRIAN SHERRATT FOR THE TIMES

Each year the NHS funds more than 40 national clinical audits into areas as diverse as maternity care, stroke care, diabetes, cancer and dementia. The work, which costs more than £11 million a year, has resulted in significant improvements in care.

In 2016, the national audit on stroke care in England said 9,000 patients a year were missing out on mechanical clot retrieval procedures that can restore blood flow to the brain and prevent lasting disability. A year later NHS England vowed to expand the service.

Similarly, the national prostate cancer audit, published in September last year, highlighted the dramatically low levels of black men being diagnosed in England, despite having twice the risk of others. Since then the issue of screening for black men has been central to the debate on prostate cancer.


Bill KirkupYASMIN RAPLEY/PA

National clinical audits are meant to be independent of the NHS, analysing data and patient experience to highlight consistent poor performance and areas where changes are needed. The work is done under contract with NHS England by universities, medical royal colleges and charities.

Hunt said the revelations suggested NHS England was trying to protect its own reputation and act as "gatekeeper" to the truth about the state of care.

He said: "Their value depends on experts being free to publish evidence and recommendations without undue influence. NHS England should not be acting as a gatekeeper for independent findings or recommendations.

"The lesson from every major patient safety scandal is that failing to confront uncomfortable truths only allows unsafe care to persist. NHS England should be championing independent scrutiny and transparency — not creating the impression that reputational management is taking precedence over patient safety."

Documents obtained by The Sunday Times, dated last month, spell out restrictions on the way the investigations are done and require the teams behind them to discuss final reports with NHS England. The rules mandate the length of reports, the number of recommendations and ban the authors from alerting the media or making recommendations to local hospitals where they find problems.

Donna Ockenden JULIAN BENJAMIN FOR THE SUNDAY TIMES

Starting this year, auditors have also been told they cannot repeat recommendations even where there is clear evidence the NHS has failed to act on past warnings and the same problems are persisting.

NHS England sets the day of publication, often earmarked for "super-stats Thursday" when a slew of NHS data is regularly published, meaning the reports and their messages are at risk of being overlooked.

The rules also allow recommendations to be rewritten and limited to just five in number to ensure they are "more likely to be well received".

At the centre of the row is the national investigation into mother and baby deaths, carried out by the national perinatal epidemiology unit at the University of Oxford. Each year it produces the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries report, known as MBRRACE.

Professor Marian Knight, who leads the work, said the ability to drive improvements had been curtailed. She told The Sunday Times: “I would say I feel the restrictions placed on us about reports and reporting have limited our ability to make a difference, to get our messages through and to drive change.”

She said recommendations her team had wanted to make about improving the education and training of midwives had been watered down after intervention from NHS England.

Two inquiries into maternity scandals published last month highlighted the systemic cover-up of maternity problems and a reluctance to tackle failings in care. MBRRACE reports repeatedly flagged high neonatal and stillbirth death rates at Leeds Teaching Hospitals for many years. The trust is at the centre of its own maternity scandal and facing an inquiry by Ockenden. “The restrictions on messages not being directed at NHS trusts, given we’ve identified trust level problems, are unhelpful,” Knight said.

Restrictions had been increasing for several years, with this year’s changes including a ban on repeating previous recommendations even if there is evidence of problems persisting.



“The wording implies that it is our recommendations that are somehow at fault and not the failure to act on them,” Knight added. “If the rules we are supposed to work under restrict the ability to make a difference it does call into question the point of doing it at all.”

She was concerned that speaking out about the changes in rules would “come back on me in some form”, but she added: “Having seen what I’ve seen in the two latest reports, I just don’t feel that I can carry on without trying to make the work we do of the greatest value it can be.”

Concerns about the approach being taken by NHS England were echoed by several other members of clinical audit teams but they were not prepared to be named for fear of retaliation against their organisation.

Ockenden and Kirkup backed Knight and the concerns she was raising. Ockenden, who led the inquiry into poor maternity care at Shrewsbury and Telford and Nottingham University Hospitals, said she was surprised and concerned about the restrictions imposed on Knight's work.

She said it was "absolutely unacceptable", adding Knight's team "should be free to act without fear, without favour, and should be in a position where they absolutely report the facts as they find them."



Kirkup, who investigated the Morecambe Bay and East Kent maternity scandals and has also chaired inquiries into the actions of Jimmy Savile and NHS failings in Liverpool, said: "A big theme of all the investigations I have done is that the system needs to be open and transparent about these things and not try to bury bad news. We need to shine the light on tough issues, not push them under the carpet."

Kirkup resigned from the maternity review carried out by Baroness Valerie Amos, which reported this month, in a dispute over its conclusions about "normal birth" ideology being a risk to patients. He said this was another example of difficult topics being avoided.

"If recommendations are being watered down as has been suggested or restrictions put in place on independent pieces of work, I don't think that's right," he added. "The danger with this approach by NHS England is that it stops the system learning and improving."

An NHS England spokesman said it did not alter the underlying data or facts in national clinical audits and the authors had control over their analysis and conclusions.

They added: "Clinical audits are independent evidence-based reports to help the NHS improve services for patients and families and we work with auditors to ensure their recommendations are clear and can be implemented across the NHS to improve care."