EHMA 2024

Shaping and managing innovative health ecosystems

Understanding failures in patient safety in hospitals in England using Labour Process Theory (LPT)

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5 - 7 June 2024 - Bucharest, Romania

Politehnica University of Bucharest, Bucharest, Romania

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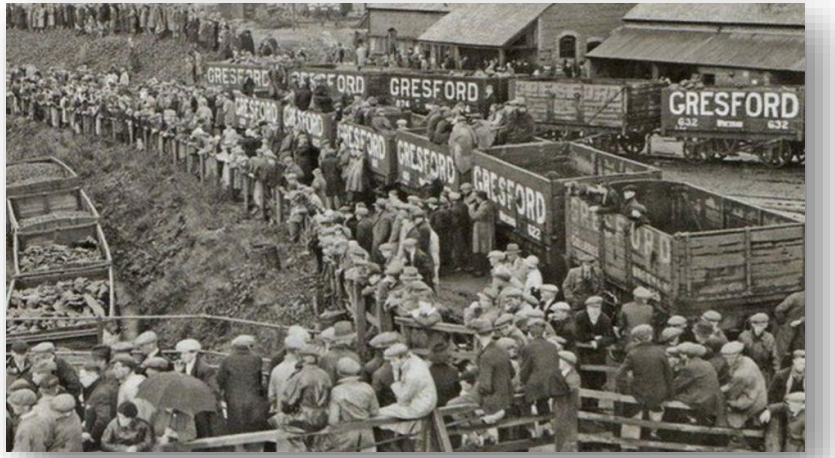
It had been one of the worst tragedies ever to befall British mining and was inevitably followed by a formal inquiry into what happened, with union and owners' representatives and expensive lawyers with well-modulated voices bullying people who had not had their advantages in life. It was chaired by the chief of mines, who at least knew about mines...

(Paxman, 2021:225)



Background

- History and culture in the UK of public inquires
- Purpose is to learn lessons and prevent situations (often involving loss of life) from happening again
- Type, scope and range varies – Gresford Mining Disaster (1934); Kings Cross Underground Fire (1988); Hillsborough Stadium Disaster (1989-90); Phoning Hacking (2011-12); Manchester Arena (2019-2023)
- Healthcare focused inquires – Covid 19 pandemic; Infected Blood; Mid-Staffordshire NHS Foundation Trust; Harold Shipman; Maternity Services

Maternity Services Failings - NHS England

Labour Process Theory & Maternity Services

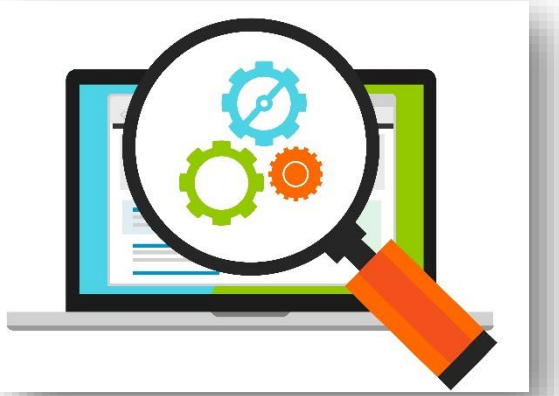
- A different theoretical lens for understanding why staff behave in a dispassionate, unkind and often selfish way towards patients and each other
- Established theoretical framework that illuminates the labour process of workers under capitalism
- Specific focus on maternity services – key priority for quality improvement in the UK

We make no criticism of staff for individual errors, which, for the most part, happen despite their best efforts and are found in all healthcare systems. Where individuals collude in concealing the truth of what has happened, however, their behaviour is inexcusable, as well as unprofessional. (Kirkup 2015:8)

A senior obstetrician told the Panel that the staff were fundamentally good people who were placed in an impossible position because of the pressures of the roles they were

Methodology

- Research Question: *What are the experiences of staff delivering care in organisations where maternity services have been shown to have failed?*
- Agreed that we would collect data from the three recent reviews of maternity: Morecambe Bay (2015); Shrewsbury & Telford (2022); East Kent (2022)
- The focus of our data collection would be guided by "staff experience of delivering care"
- Methodological approaches
  - Narrative analysis informed by labour process theory
  - Grounded theory



Initial Themes

- **Inter and Intra professional dynamics**
- **Inequitable treatment of members of different professional groups**
- **Fear of speaking out / repercussions**
- **Bullying**
- "Expansification":

…a woman who was 35 weeks pregnant and thought her waters had broken attended…The woman needed a speculum examination…the SHO hadn't been trained on how to do it. Although the consultant was called, they did not attend and the SHO sought advice from YouTube on how to do the procedure. (Kirkup 2022:86)

EHMA 2021

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Thank you for listening

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References

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