SYSTEM-WIDE NHS FAILURES

REDUCING FUTURE RISK

Bill Kirkup

SCOPE

(1) Major failures – what happened

(2) Themes: warnings and responses

(3) Preventing organisational failure

MAJOR INVESTIGATIONS 2010-

2010	Children's Heart Surgery Deaths, Oxford
2012	Hillsborough Independent Panel
2014	Jimmy Savile, Broadmoor Hospital and DH
2015	Morecambe Bay Maternity Services
2018	Liverpool Community Health Review
2018	Gosport Independent Panel

CHILDREN'S HEART SURGERY DEATHS

- Small unit under threat of closure
- Attempted rapid expansion
- Previous working 'idiosyncratic'
- New surgeon poorly supported
- Unexpected run of four deaths
- Trust unwilling to report or investigate
- Whistleblower contacted press

HILLSBOROUGH INDEPENDENT PANEL

- Crowd crush at football match 1989
- 96 men, women and children died
- Initial reaction blamed fans
- ‘Drunken, ticketless hooligans’ story
- Police, pathologists, coroner
- Initial inquests: pathology, 3:15 cutoff
- New inquests 2016
- Unlawful killing

JIMMY SAVILE, BROADMOOR AND DH

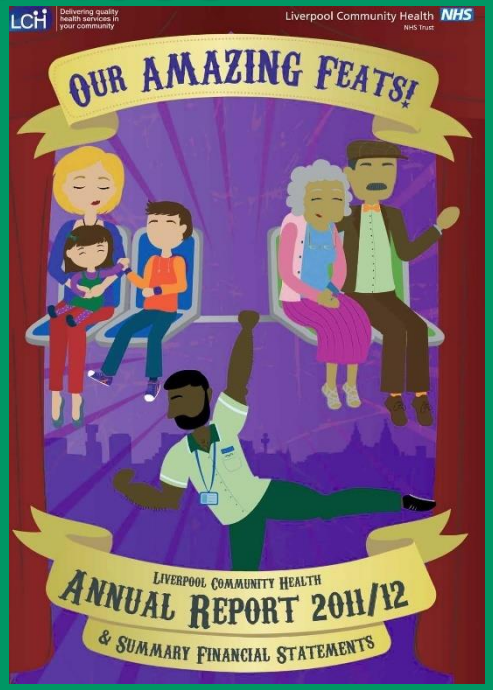
- DJ became part of high-secure unit
- Closed institutional culture
- Access – “the highest mark of trust”
- Head of Task Force running hospital
- Abuse of vulnerable patients
- Widespread rumours

MORECAMBE BAY MATERNITY

- Small, isolated clinically and on map
- Dysfunctional unit
  - poor practice, lack of teamworking
  - pursuit of normal childbirth
  - failure to investigate and learn
- Foundation Trust application
- Denial and cover-up
- Reassurance emphasised
- Tenacity and fortitude

LIVERPOOL COMMUNITY HEALTH

- New Trust, inexperienced leadership
- FT application, infeasible cost target
- Crude staff reductions, flawed QIAs
- Staff struggled to sustain services
- Poor morale, patient harm
- Bullying, suspensions (335)
- Incidents not investigated
- MP complaint - grievances
- Denial and cover up



GOSPORT INDEPENDENT PANEL

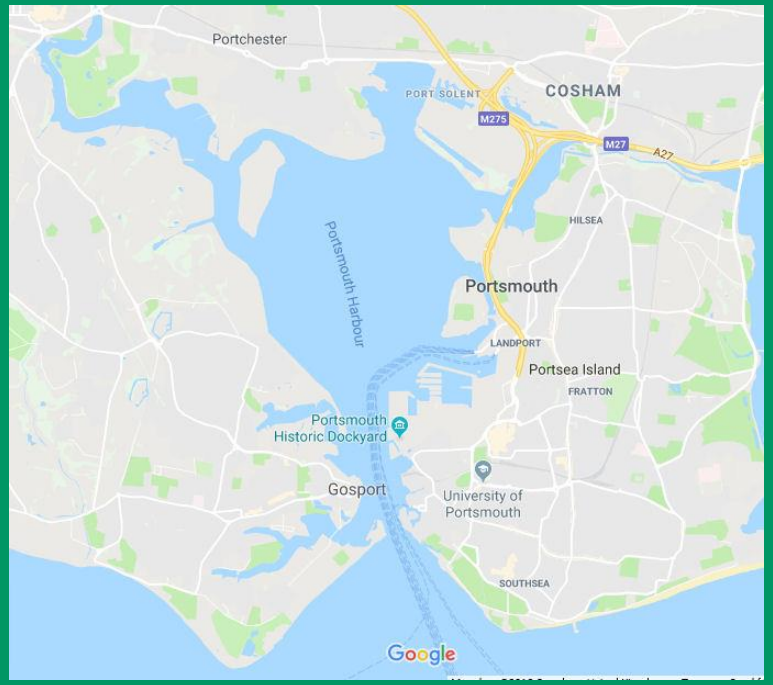
- Small, isolated clinically and on map
- Nurse concerns over opioid use 1990
- Practice increased 1991 – 1998
- Known to others but no investigation
- Complaint 1998, taken to police
- Multiple investigations 1998-2013
  - police, CHI, GMC, NMC, inquests, others
- 450+ deaths
- Cover up and dishonesty
- Tenacity and fortitude

Section Two:

THEMES: WARNINGS AND RESPONSES

CLINICAL ISOLATION

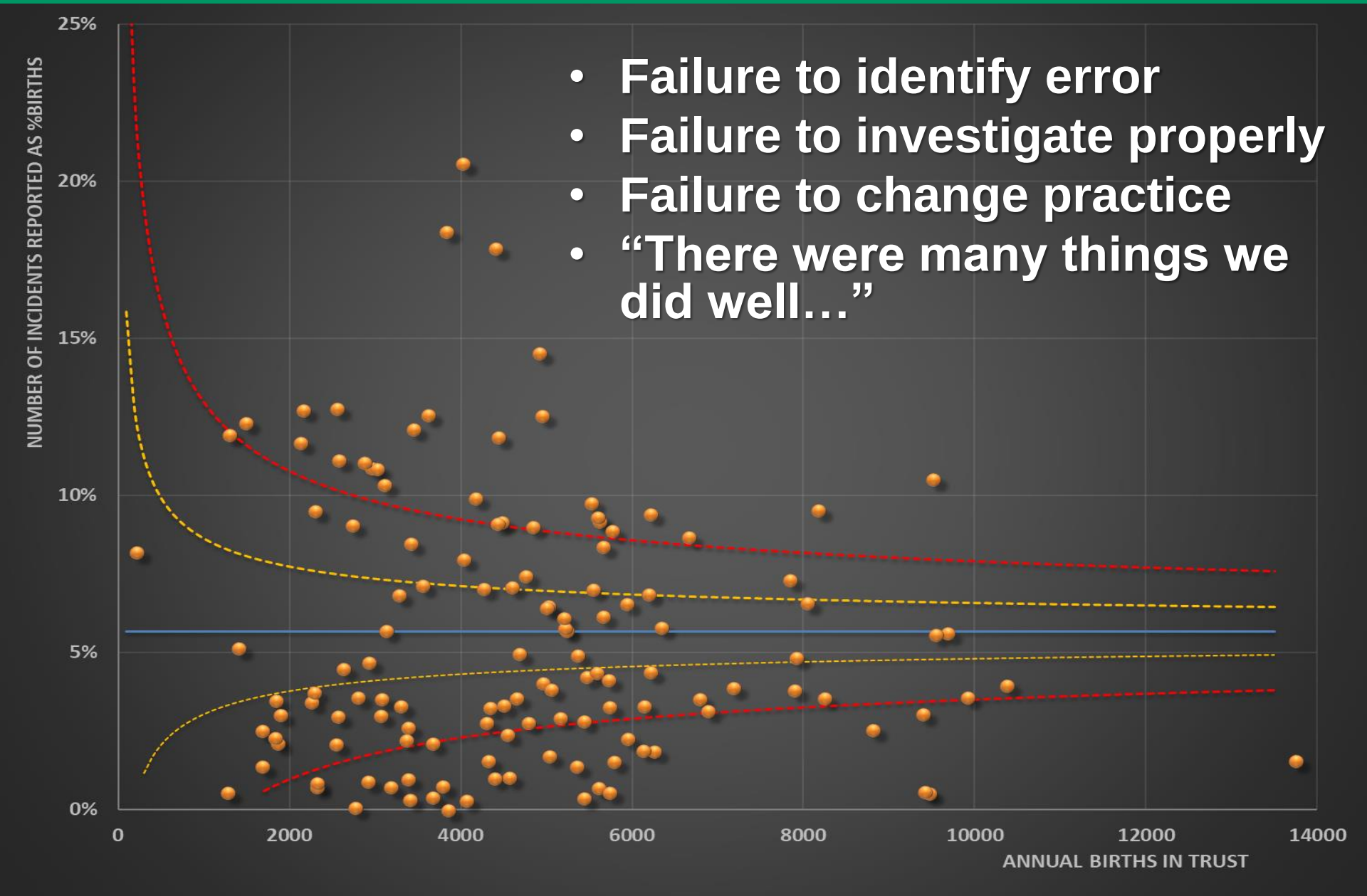
- Geographical, cultural, personal
- Standards drift, practice deviates
- Lack of external validation
- Self inflicted – refusal to engage
- Morecambe Bay, Gosport
- Broadmoor Hospital
- ‘Idiosyncratic’ practice, Oxford



DYSFUNCTIONAL TEAMS

- Breakdown of trust
- Professional rivalry
- Interpersonal conflict
- Poor multidisciplinary working
- Failure to accept responsibility
- Obstetricians and midwives could only agree on one thing…

FAILURE TO LEARN

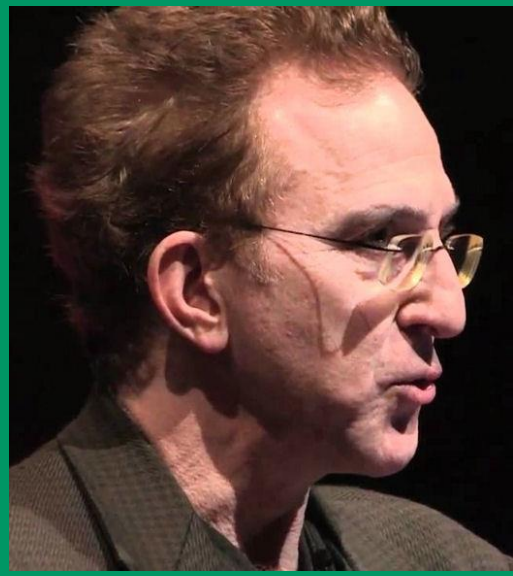


- Failure to identify error
- Failure to investigate properly
- Failure to change practice
- “There were many things we did well…”

FAILURE TO IDENTIFY ERROR

COGNITIVE DISSONANCE:

- nobody likes owning up to mistakes
- harder when people are harmed
- clinicians poorly trained to handle
- embarrassment and shame



FEAR OF BLAME:

- Trust response
- press and public
- professional regulators
- gross negligence manslaughter

Result: pressure to minimize or deny error

NORMALISATION

- That's how we do things here
- And the results are what happens when we do
- "Bad things happen in maternity – people just have to accept it"
- Little woolly hats for the stillborn babies

WARNINGS DISMISSED

- Complainants ‘chronicly dissatisfied’
- Bereaved families ‘need to find closure’
  - beware concept of ‘closure’
  - grief is a journey without a destination
- Whistleblowers ‘pursuing a grudge’
- One warning may not be significant but more need taking seriously
- “Everybody knew, but nobody said…”

“WE HAD OTHER PRIORITIES”

- Cost savings, reconfiguring, FT status
- Limited capacity, distraction
- But also rejection of bad news
- Unwanted reports hidden
- Bullying (“JFDI”)
- “The Trust was very good at telling us what we wanted to hear…”

CRISIS MANAGEMENT

- First response to breaking problem:
  - openness and honesty?
  - apology and investigation?
  - reputation management?
- Dismissive responses to enquiry
- Rebuttal and reassurance
- ‘Closing ranks’ will see us through
- But families don’t give up

SLIPPERY SLOPE STAGE ONE

EDGE OF THE PRECIPICE

Mindset	There is no problem here…
Actions	Challenge unwelcome findings Seek for and stress good news Direct focus to ‘the bigger picture’ Deflect complaints and requests
Effects	False reassurance, papering over cracks

SLIPPERY SLOPE STAGE TWO

GATHERING MOMENTUM

Mindset	**Limited problem, we can sort it out…**
Actions	**Put reputation management first** **Manipulate information to regulators** **Internal information 'need to know'** **Denial in response to enquiries**
Effects	**Concealment and suppression**

SLIPPERY SLOPE STAGE THREE

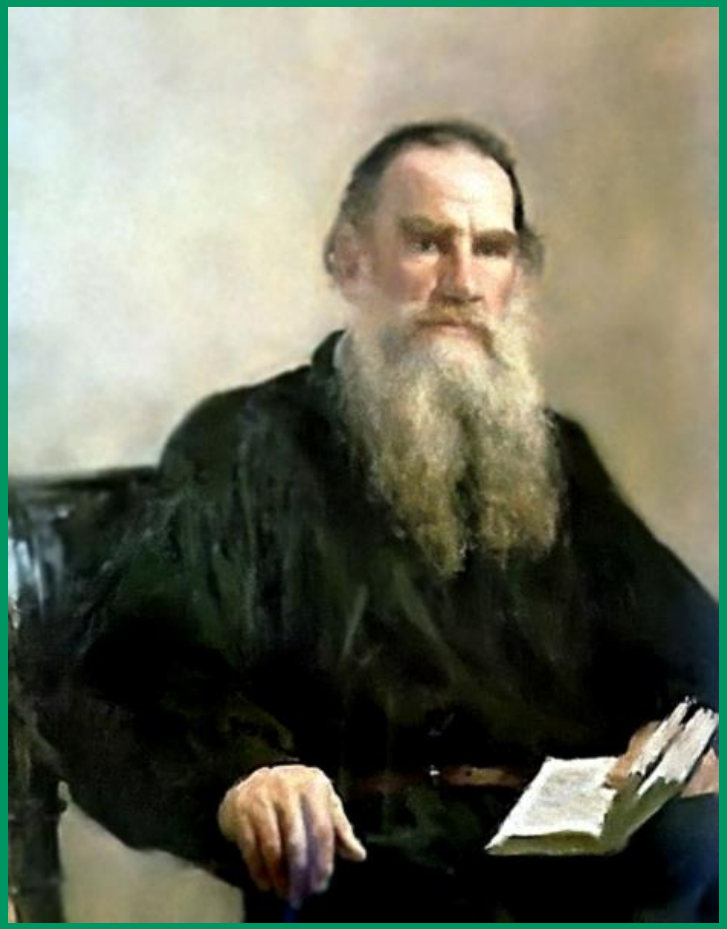
HEADING FOR THE BUFFERS

Mindset	**We are in too deep to go back…**
Actions	**Siege mentality, us against the world** **‘Justifiable’ deception and dishonesty** **Failure to recognise own limitations** **False information, cover up, collusion**
Effects	**End-stage organisational failure**

Section Three:

PREVENTING ORGANISATIONAL FAILURE

LEARNING FROM OTHERS



"All happy families are alike; each unhappy family is unhappy in its own way."

So we can learn more about families by writing about the unhappy ones...

...and more about health services by studying those with problems.

SITUATIONAL AWARENESS

- Knowing how failure can occur
- Knowing where the risks are
- Scanning for early warning
- Seeking assurance not reassurance
- Eliminating blind spots
  - patients, families, whistleblowers
- Investigating and learning

KEY POINTS

- “Listen to the patient, [they are] telling you the diagnosis” (Osler)
- Honesty, not reputation management
- Investigating and learning, not suppressing bad news
- Dismissiveness and denial lead to a slippery slope that ends badly
- “It could never happen here” is nothing more than a comfort blanket