SYSTEM-WIDE NHS FAILURES

REDUCING FUTURE RISK

Bill Kirkup
SCOPE

(1) Major failures – what happened

(2) Themes: warnings and responses

(3) Preventing organisational failure
<table>
<thead>
<tr>
<th>Year</th>
<th>Investigation / Panel</th>
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<tbody>
<tr>
<td>2010</td>
<td>Children’s Heart Surgery Deaths, Oxford</td>
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<td>2012</td>
<td>Hillsborough Independent Panel</td>
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<tr>
<td>2014</td>
<td>Jimmy Savile, Broadmoor Hospital and DH</td>
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<tr>
<td>2015</td>
<td>Morecambe Bay Maternity Services</td>
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<tr>
<td>2018</td>
<td>Liverpool Community Health Review</td>
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<tr>
<td>2018</td>
<td>Gosport Independent Panel</td>
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</tbody>
</table>
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 ‘chronically 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

<table>
<thead>
<tr>
<th>Mindset</th>
<th>There is no problem here...</th>
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</thead>
<tbody>
<tr>
<td>Actions</td>
<td>Challenge unwelcome findings</td>
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<tr>
<td></td>
<td>Seek for and stress good news</td>
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<tr>
<td></td>
<td>Direct focus to ‘the bigger picture’</td>
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<td></td>
<td>Deflect complaints and requests</td>
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<tr>
<td>Effects</td>
<td>False reassurance, papering over cracks</td>
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</tbody>
</table>
### SLIPPERY SLOPE STAGE TWO

#### GATHERING MOMENTUM

<table>
<thead>
<tr>
<th>Mindset</th>
<th>Limited problem, we can sort it out...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions</td>
<td>Put reputation management first</td>
</tr>
<tr>
<td></td>
<td>Manipulate information to regulators</td>
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<tr>
<td></td>
<td>Internal information ‘need to know’</td>
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<tr>
<td></td>
<td>Denial in response to enquiries</td>
</tr>
<tr>
<td>Effects</td>
<td>Concealment and suppression</td>
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</tbody>
</table>
# SLIPPERY SLOPE STAGE THREE

**HEADING FOR THE BUFFERS**

<table>
<thead>
<tr>
<th>Mindset</th>
<th>We are in too deep to go back...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions</td>
<td>Siege mentality, us against the world ‘Justifiable’ deception and dishonesty Failure to recognise own limitations False information, cover up, collusion</td>
</tr>
<tr>
<td>Effects</td>
<td>End-stage organisational failure</td>
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</table>

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