PETER PRIBILLA FOUNDATION

Leadership

Failure · Innovation

FAILING TO LEARN FROM FAILURE

by Torsten Oliver Salge and Sebastian Schäfer

Context

Mid Staffordshire NHS Foundation Trust is part of the English National Health Service (NHS). The NHS is a public health care system delivering primary and secondary care to English citizens that is free at the point of care. The trust itself consists of two hospitals located at Stafford and Cannock. Stafford Hospital is an acute care hospital founded in 1983 with approximately 345 beds. Cannock Hospital was founded in 1991, manages 115 beds and specializes in orthopedic and rehabilitation services. A total of around 3,000 employees are responsible for a population of 320,000 citizens in the greater Stafford area. In February 2008, the Trust's application for Foundation Trust status was granted, as a result of which it obtained greater organizational and financial autonomy as reflected in the right to retain profits and access capital markets.

Failure

Severe quality problems were detected at Stafford Hospital in 2007. More specifically, the Healthcare Commission was alerted to the fact that hospital standardized mortality ratios (HSMR) for the financial years from 2005/06 to 2007/08 ranged from 127 to 145. This indicates that the number of actual deaths in the hospital might have exceeded the number of statistically expected deaths given the patient mix treated, by as much as between 27% and 45%, yielding up to 1,200 "unexpected" deaths. Especially mortality rates for heart, blood vessel, nervous system, lung and infectious diseases were significantly higher than statistically expected. Next to high HSMRs, front-line employees and patients alike reported poor standards of nursing and emergency care. Consistent with this observation, Mid Staffordshire Trust found itself amidst the bottom quartile of hospitals in terms of quality of care in 2007.

Triggered by these warning signs, three formal inquiries were conducted between 2009 and 2012. They provided evidence of dramatic shortcomings in management as reflected in dreadful clinical hygiene levels, alarming violations of patient dignity and respect, inexcusable delays in clinical assessment, provision of medication and pain relief, poor recording of important bodily functions, ignored symptoms and requests for help as well as insufficient communication between staff and patients or their relatives. Moreover, the inquiries found substantial problems with the trust's information governance and data exchange with national systems.

Domain
Public ⊠
Private ☐

Non-profit ⊠
Commercial ☐

Business: Hospital Services

Start up (0-1yr) ☐
Growth (1-5 yrs) ☐
Mature (5yrs +) ⊠

Micro (Staff <10) ☐
SME (10 – 250 Staff) ☐
Large (250+) ⊠

Regional ⊠
National ⊠
Multinational ☐

Methods
Longitudinal ⊠
Cross-sectional ☐

Access ☐
Exemplar ⊠
Random ☐

Innovation
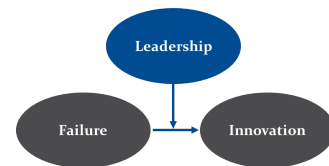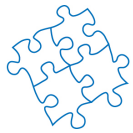Top Down ⊠
Bottom-up ☐

Product ☐
Process ☐
Organizational ⊠

Radical ☐
Incremental ☐

Repeated management failures and an excessive focus on boosting financial performance and meeting national standards figure particularly prominently among the likely root causes identified. In an attempt to achieve foundation trust status, Mid Staffordshire Hospitals' management team sought to realize cost savings of £10 million along with a £1 million surplus. This involved cutting 150 clinical posts as well as training expenditures, which resulted in understaffing in critical areas of care and subsequent problems in clinical leadership. Insufficient staffing levels triggered as series of clinical failings as illustrated by the fact that receptionists without medical training had to assess patients, that doctors had insufficient time for post-surgery supervision or that junior doctors had to run the hospital during after hours. Obsessed with meeting national targets such as reducing the maximum waiting time in the accident and emergency (A&E) department to four hours, managers had staff discard clinical protocols and move patients out of A&E without adequate assessment by qualified doctors.

Although initially benefiting from substantial bottom-up error reporting, management developed a visible reluctance to attend to – let alone react to – such vital signals. Unsurprisingly, employee voice behaviours were gradually replaced by persistent organizational silence. This issue was further amplified by inadequate error reporting and analysis systems, precluding management to notice and understand recurring problems in patient care. Finally, a suboptimal clinical layout, missing equipment and a general lack of space and cleanliness further corrupted the conditions at Stafford hospital. The scope of management failure and the dreadful human suffering it spurred led the British Prime Minister David Cameron to apologize in February 2013 in public for one of the worst hospital scandals in history today known as the "Mid Staffordshire Hospital Scandal".

Innovation and Transformation

The three commissions in charge of the inquiries developed far-reaching recommendations pertaining both to the organizational level (i.e. Mid Staffordshire Hospitals) and the broader level of the organizational field (i.e. NHS Hospital Trusts). The recent "Francis Report" published in February 2013 alone contained 290 such recommendations, many of which call for management and process innovations both locally and nationally.

At the organizational level, expert groups proposed sweeping changes including the need to develop novel incident and complaint reporting systems, to establish a clinical audit system fed by rich internal and external data on clinical processes and outcomes, to build a culture of openness and to shift the focus of

Failure

Caused externally ☐
Caused internally ☒

Step1 Invent ☐
Step2 Select ☐
Step3 Implement ☐
Step4 Capture ☐

Transformation

Internal to Organisation ☐
External to Organisation ☒
Delivered by Organisation ☐
Delivered by Others ☒

Role of Leadership

Strategic Recovery ☐
Employee-led Recovery ☐
Field-level Response ☒

New Leader Engaged ☒
Existing Leader ☒

Recovery Strategy Published ☐

Recovery Led by Operational Activity ☐

Strategy Announced ☐
Recovery Evolved ☒

Learning outcomes

- Learning from failure can occur at the level of both the individual organization and the organizational field
- Learning from failure requires effective leadership
- Failing to learn from failure threatens the legitimacy and survival of organizations
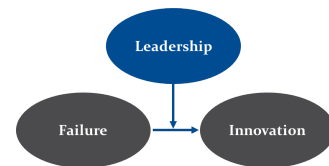
organizational attention from national and financial targets to patient well-being.

At the level of the organizational field, investigators called for a mandatory national incident reporting system, improved patient complaint management, stricter legal sanctions for clinical negligence, higher patient orientation and novel clinical alert systems highlighting unexpected performance shortfalls. Perhaps most importantly, the inquiry commissions recommended the rigorous collection and timely publication of reliable information on hospital mortality rates and other outcome indicators to inform patient choice and counteract the prevailing focus on financial instead of clinical performance. As Robert Francis concluded in his final report published in 2013:

> "People must always come before numbers. Individual patients and their treatment are what really matter. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS."

Leadership

Surprisingly, however, the trust failed to act adequately on almost all recommendations proposed by the three inquiry commissions. Managerial attention remained focused on financial and process rather than clinical outcome metrics, clinical audit and incident reporting systems continued to be inadequate and speaking-up remained discouraged and even sanctioned thereby cementing the prevailing "culture of fear" and fostering employee silence. Perhaps most astonishingly, senior management sought to attribute the alleged quality problems of its Trust to administrative coding errors and other measurement issues rather than to appalling clinical and managerial standards. Being reluctant to collect and share insightful outcome data, senior management precluded regulators and the general public from assessing the true scale of the scandal and the efficacy of possible counter-measures. Failing to learn from failure, the trust and its management saw its legitimacy gradually being withdrawn. This led to series of regulatory actions affecting not only the trust's autonomy, but also its license to operate. This involved the temporary closure of A&E, the replacement of senior management and the decision to put the trust under administration.

At the organizational field level, in contrast, far-reaching changes could be implemented including the broad dissemination of comparative mortality data via the NHS Choice website or the development of mandatory national incident reporting systems.
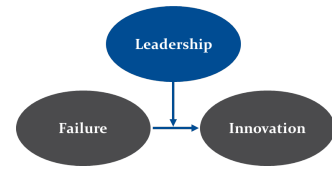
Data

This case study relies on data collected as part of the three formal inquiries published between 2009 and 2013. The first report published in 2009 was based on 309 interviews conducted by the investigation team in particular with staff members and patients of the trust. The second report published in 2010 drew upon oral evidence from 113 witnesses in person, while 164 witnesses were heard in person in preparation for the third report published in 2013.

Further Reading

Healthcare Commission (2009). *Investigation into Mid Staffordshire NHS Foundation Trust. London.*

Francis, R. (2010). *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 to March 2009 (Volumes I & II). London.*

Francis, Robert (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

(Volumes I, II & III). London.