SOMETHING IS ROTTEN IN THE STATE OF THE NHS

SOUTHERN HEALTH (NHS) FOUNDATION TRUST – A CASE STUDY IN NHS MANAGEMENT AND QUALITY IMPROVEMENT FAILURE
(Abridged Version)

Observations by John L Green, Former Public Governor, Customer and NHS Part Owner

1. Why, the public and some MPs are asking, have Southern Health (NHS) Foundation Trust (SHFT) Board Members not been dismissed, or at least censured as a result of the Mazars Report? **The answer is simply that the Government and the NHS fear a costly claim for unfair dismissal and the publicity involved, which will expose their deficiencies.**

2. **To understand why the SHFT Board has not been censured, organisations need to be seen as a human machine/system delivering a service (or making a product) and that the behaviours of the managers and staff and their ultimate individual and collective performance of the services they provide result from the design of that human machine/system.** Outside the workplace, people normally have substantial degree of freewill to decide how they wish to behave, but within organisations their behaviour is determined as a result of the power of conformity to the organisation's employment practices, social rules, systems of work and management culture. The power of conformity to control people's behaviour should not be underestimated, particularly when one's livelihood and career progression depends upon it.

3. **The Department of Health in England operates a highly centralised very hierarchical command and control (C&C) totalitarian management regime, which makes decisions and issues directives from the very highest level.** Under the present top down system of highly regulated management the people most responsible for failures in the NHS have therefore to be those who designed and operate the NHS organisational paradigm and retain much power of decision-making at the top. The regime is the antithesis of the management culture required to achieve world-class standards of quality and safety management.

4. **The first responsibility of the Department of Health/top NHS civil service regime is to report the performance of the organisation to the Secretary of State for Health.** So much so that I have concluded that the NHS civil service is an administrative industry within itself - comprising the collection of data, report writing, attending meetings and issuing directions – with its own common purpose. Indeed I sometimes wonder whether the provision of healthcare services occurs as a by-product to this administrative activity.

5. **The second responsibility of the regime is to not embarrass the Minister, which is achieved by distracting the attention of the public and media by offloading blame for failure down to the lowest front line level.**

6. **The third responsibility of the regime appears to be, in true 'Yes Minister' style, to protect its loyal members from harm** - as is the case of Katrina Percy, who won a chief executive of the year award only a few years ago. Also, by example, no senior manager was dismissed as a result of the Mid Staffordshire Inquiry for exactly the same reason. **Equally, those who are critical of the regime i.e. 'whistleblowers' (free speakers in a democratic consensus management culture) will either be isolated or removed and silenced,** as reflected by the use of gagging orders in the event of dismissal.

7. **The Department of Health, which reports to the Secretary of State for Health, is further complicated by the fact that service provider organisations (NHS provider trusts or private sector companies) are accountable to three Department organisations:**

- NHS England (NHSE), which directly or indirectly, through Clinical Commissioning Groups (CCGs), commission the services.
- NHS Improvement (NHSI) previously Monitor, which regulates governance/management performance and has the power to hire and fire NHS trust boards and councils of governors.
- The Care Quality Commission (CQC), which regulates healthcare quality and safety of the clinical and care services provided by service providers.

8. **None of the organisations appear to be entirely clear themselves as to where their respective responsibilities begin and end. This makes it difficult to identify the causes of failure and more importantly who is responsible for what and for rectifying failures.** Also, as healthcare quality and safety are inextricably linked with the effectiveness of the governance/management it is ridiculous that they are looked at separately by the two regulator organisations. It is all a seriously ill conceived highly dysfunctional, confusing and ineffective arrangement, which militates against a powerful single management line relationship bond from developing between the commissioner and the service provider, which is absolutely essential for effective quality and safety improvement.

9. **It is important to recognise that, because the NHS is so centrally directed, managed and regulated, the causes of front line healthcare quality and safety failure can occur in any part of the NHS** including its suppliers i.e. not just within the organisation providing the front line services. It could be due to failure by the commissioner (Government/NHS England and its CCGs). It could also be as a result of the manner in which the Department of Health regulators operate, which I believe is a major factor. The Report of the Expert Advisory Group (May 2016) into the setting up of the Healthcare Safety Investigation Branch (HSIB), to be modeled on the Air Accidents Investigation Branch (AAIB) specifically emphasises this point and thus the need for it to be totally independent of the NHS – as the AAIB is to the aircraft industry. The Report Concludes:

   'HSIB must be empowered to investigate safety incidents and their causes anywhere across the entire healthcare system, including NHS organisations, national bodies, local government and commercial providers ' …….. ' Safety issues and related incidents are often the result of complex local, organisational and system wide processes, with similar events recurring repeatedly in different places across the healthcare system. The purpose of safety investigation is to understand the patterns of causality that produce harm, and to make recommendations that can address those causes across the healthcare system in order to improve the safety of all patients. '

10. After examining the findings of the Mazars Report, December 2015, it would appear that there are numerous causes of quality and safety failure that resulted in the failure of the Trust to investigate unexpected deaths and most importantly take appropriate action to prevent further deaths, many of which result from failings in other parts of the NHS:

    I. **The Trust was not operating a quality and safety management system to a high enough standard for a safety critical industry, necessary to meet Health and Safety at Work Act 1974 and Health and Safety Regulations Act 1999 standards, as identified in the Mike Holder, CMIOSH, Report, February 2012.** The Holder Report made similar criticisms to the Mazars Report 4 years earlier. It listed 15 deficiencies, which included that 'Total Quality Management (TQM)/Safety Management Systems (SMS) standards', appropriate for a safety critical industry be introduced in the Trust. It also made specific recommendations in respect of ligature management in Trust establishments. However, Katrina Percy, CEO never placed the Report before the Trust Board for its consideration and it also appears did not implement its most important recommendations. This is presently the subject of an investigation by the Health and Safety Executive. **(Trust failure)**

II. **A top down command and control dominated totalitarian NHS management regime, which appears to add little value, if not negative overall value, to the provision of front-line health services. By design it creates a blame culture by focusing on the failure of individuals and thereby creates a climate of fear and retribution. This in turn promotes a behaviour in the workforce of covering up of failures (e.g. not reporting and investigating unexpected deaths), which militates against effective quality and safety improvement. (Government; Department of Health; NHSI & CQC failure).**

III. **NHSI (previously Monitor) and the CQC, along with the Trust, operate a quality and safety management method of regulation and inspection, which is well below world-class standards. It is clearly totally inadequate for the purposes of identifying the quality and safety management failures and most importantly taking swift action to prevent further unexpected deaths.** To prove the point, neither organisation picked up on the findings of Mazars during the four-year period of the study and this methodology, however hyped up and modified, continues to fail to prevent further unexpected deaths. **(NHSI & CQC failure)**

IV. **NHS England and the CCG did not specify clearly in their commissioning contracts who should carry out investigations of unexpected deaths where a number of health organisations were involved.** Nor did they specify procedures to be followed in relation to unexpected deaths i.e. investigation, and quality and safety management improvement standards, which should be at least to Health and Safety Executive Standards appropriate for a critical safety industry. **(NHS England/CCG failure)**

V. **Lack of resources to meet customer demand for services and pressures on the Trust by NHSI to achieve financial budget targets.** It is widely accepted that mental health and learning disability services were and still are substantially underfunded. **(Government; NHSI and NHS England/CCG failure)**

VI. **A demoralised workforce, with too little time available to cope with the demand for services, let alone investigate their failures** – as reflected by figures in the Trust of 8% staff vacancies; 18% turnover; 9-10% temporary employees; sickness absence 5-6%; 20% feel bullied etc. These figures, which are shocking by any standards, particularly for a safety critical care industry, are typical across the whole NHS and therefore are not just a Trust problem caused by Trust management failure. **(Government, NHSI & CQC failure)**

VII. **A serious lack of education and training in business and management skills and world-class standards of quality and safety management methodology**, **including clinical investigation methods**. These requirements should be clearly specified in service provider (NHS trust or private) commissioning contracts, as they would be by world class companies in their contracts with sub contractors. **(Trust; NHS England/CCG failure)**

VIII. **A lack of effective market research with regard to customer needs and demands. Also, a wholly ineffective customer feedback and complaints system** available to patients and carers throughout the NHS for them both to obtain a remedy for poor services and equally importantly influence the improvement of services. Timely high quality customer feedback as to patient experience and more importantly effectiveness of treatment and care is essential to the process of achieving continuous quality improvement to world-class standards. **(Government; NHS England/CCG & Trust failure)**

IX. **The introduction of marketisation, introduced in 2006, resulted in all trusts having to compete against each other and private companies to obtain contracts commissioned by either NHS England itself or its Clinical Commissioning Groups (CCGs). This has inevitably led to much focus by senior Trust managers on the need to win contracts.** Competition may provide more customer choice and help to bring down costs/prices but it does not ensure the development of more integrated services or high quality services - indeed excessive competition lowers quality. The car industry in the UK has always been highly competitive, but cost effective high quality car production was only achieved when Total Quality Management methods, involving all staff in the organisation, were introduced**. (All Governments failure)**

11. **Even after the death of Connor Sparrowhawk in July 2013 both the NHSI and CQC regulators continued to approve existing practices of inadequate regulation and inspection quality and safety management methods used by the Trust, in spite of continuing criticism from coroners** with regard to unexpected deaths. Also, neither commented on the inadequacy of resource levels, which I believe is also a significant factor. From my observation, the NHSI was more concerned as to whether the Trust was meeting its financial targets than achieving its purpose of meeting the needs of its customers. It appeared to me that they showed little concern, along with the CQC, as to whether the Trust had managed to lower its suicide rates.

12. **At the 28th June 2016 SHFT Board meeting approval was given to the 'Trust Quality Strategy 2016 – 2021'. The strategy is still substantially dependent upon outdated regulation and inspection methods (no doubt approved by NHS Improvement and the CQC), which is nothing like adequate to ensure the prevention of further unexpected deaths.** It would therefore appear that NHSI/the Interim Chair, CEO, Director of Nursing, Allied Health Professionals and Quality, and Director of Patient Safety (Chief Operating Officer) still, even now, have no real understanding of the methods and standards of quality and safety management required to meet Health and Safety Executive standards necessary for a safety critical industry, let alone satisfy the Health and Safety at Work Etc. Act 1974?

13. **In view of the above, requesting NHSI along with the CQC to investigate the findings of the independent Mazars Report, December 2015, was clearly totally inappropriate.** Both organisations, no doubt to their embarrassment, failed to pick up on the findings of the Mazars Report in the four year period 2011 – 2015; in particular the CQC, which carried out a mass inspection of the Trust in the Autumn of 2014 and which only raised issues of ligature management in April 2016 after being fully briefed by Mike Holder. Also, neither organisation has any serious expertise and experience in world-class quality management methods. It equated to asking an accused person to investigate his/her self and determine his/her own sentence. **A cover up was therefore certain to occur. Accordingly it was and is still never likely to bring about a credible result that the public could have confidence in.**

14. **The NHS organisational paradigm is a human machine/system delivering a service. If that human machine/system is not delivering a cost effective high quality service to meet customer need and satisfaction it must be redesigned** to create the right behaviours and performance levels required, or it will continue to repeat its failures day after day - like defective products flowing off a defective production line.

15. **What is required for the future is for the NHS to achieve:**

    World class standards of quality and safety management to provide healthcare services to satisfy the needs and demands of its customers and to meet Health and Safety at Works Etc. 1974 Act and Safety Regulations Act 1999 quality and safety standards appropriate for a safety critical industry.

Major reform in the way the NHS is organised and managed to enable the above to be achieved. This would involve:

- The substantial training of managers and staff at all levels in world class quality and safety management methods - as espoused and promoted by the Health Foundation (UK) and the Institute for Health Improvement (USA).

- An organisational paradigm shift away from totalitarian/command and control dominated management involving the devolution of the management of local NHS healthcare services to elected representatives of the communities it serves and the better integration of healthcare, social care and other health related services under one management umbrella.

- Giving much higher levels of autonomy to front line healthcare teams.
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