Title: Organisational Learning and the Double Bind: the case of the Mid Staffordshire NHS Foundation Trust

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Organisational Learning and the Double Bind: the case of the Mid Staffordshire NHS Foundation Trust

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Introduction

The question of how it is that organisations do, or do not, learn has engaged scholars ever since Cyert and March (1963) coined the term ‘organisational learning’. It also has considerable practical importance due to the frequency with which organisations are exhorted to learn from crises or scandals. Prominent recent examples in the UK concern crises associated with unsatisfactory patient care in the National Health Service (NHS).

A discourse of learning surrounds such crises. For example, Robert Francis QC, who led two Mid Staffordshire NHS Foundation Trust inquiries, emphasises ‘the need to learn from the two inquiries in Stafford’ (foreword to Thorlby et al., 2014:4). The implication of such rhetoric is that learning, often formalised through some form of inquiry, should enable interventions to be developed and implemented that will ensure that such failings do not reoccur. Despite this rhetoric, experience suggests that such failings do reoccur regularly (Walshe and Higgins, 2002), implying that the desired learning is seldom realised. It seems especially puzzling that organisations appear to fail to learn from such crises despite exhortations to do so, and despite their own efforts.

It scarcely seems necessary, given that the tragic consequences of such crises are well-documented, to emphasise the importance of improving our ability to understand what may be preventing such learning and, if possible to suggest remedies. The aim of this paper is to conceptualise these issues within the field of Organisational Learning (OL) in order to explore the possibility that reasons for such failure to learn are more complex than a lack of will, intention, or ability to implement solutions proposed by inquiry reports. We suggest that there is a need for new insight into barriers to OL in these situations, and we explore the potential for such insight to be provided by Bateson’s concept of the double bind (Bateson et al., 1956; Bateson, 2005). This concept is chosen purposely because it illuminates how attempts to achieve OL can fail despite people’s best efforts.

We apply Bateson’s concept to the longitudinal case of one UK NHS organisation, the Mid Staffordshire NHS Foundation Trust, which features what could be described as an ongoing crises concerning Staffordshire hospital in particular. Drawing on publically available secondary data, including inquiry reports and news items, we use Bateson’s concept of the double bind as an interpretive framework through which to illuminate the dynamics affecting OL. The proposition we explore is that the crisis at the Mid Staffordshire NHS Foundation Trust can be understood as creating a double bind situation; and that this offers a potential explanation for the prospect that the desired OL will not ensue.

The paper begins with a consideration of the concept of Bateson’s double bind and its relationship with OL. Next we provide a temporal overview of the Mid Staffordshire NHS Foundation Trust crisis, before applying the lens of the double bind. Our concluding discussion debates whether, and to what extent, the double bind concept offers useful insights into barriers to the kind of OL that is called for when such crises occur.
The concept of the double bind and organisational learning

Writers have conceptualised organisational learning as a dichotomy between types or orders of learning (Tosey et al., 2012). Although this dichotomy has been referred to using a variety of labels, such as single-loop and double-loop (Argyris and Schön, 1996); lower-level and higher-level (Fiol and Lyles, 1985); and adaptive and generative learning (Senge, 1990), a reasonable consensus has been established that they refer to comparable learning processes and outcomes (Tosey et al., 2012).

In its basic form, single-loop learning is action-oriented, routine, and incremental, occurring within existing frameworks, norms, policies and rules (Argyris, 1999), having been characterised as the response to the question, ‘are we doing things right?’ (Romme and Witteloostuijn, 1999: 452). However, where organisations are experiencing more profound problem situations a qualitatively distinct, secondary form of learning is necessary. Such double-loop learning aims to correct mismatches by modifying the frameworks, norms, policies and routines underlying day-to-day actions and routines (Cope, 2003). It therefore involves reframing problem situations and learning to see them in new ways, and has been characterised as the response to the question, ‘are we doing the right things?’ (Romme and Witteloostuijn, 1999: 452).

However, in both single and double loop learning there is an implication that learning is primarily conscious and planned. This suggests in turn that OL can be accomplished intentionally, given the requisite intelligence, skill and commitment. In our view, such a suggestion should be questioned. We seek to explore an alternative possibility, namely that conscious, planned learning is inadequate when faced with the complex problems represented by such crises; and furthermore, that attempts to resolve such problems through intentional planned learning can be counter-productive. In essence this is because the type of solution proposed and the nature of the problem are mismatched; the solution can make things worse, not better.

In order to attempt this we adopt Bateson’s concept of the double bind (Bateson et al., 1956; Bateson, 2005). Originally developed in the context of family systems, the double bind concept refers to a choice between complementary yet opposing or contradictory solutions (Lawley, 2000), referred to as a prototypical bind, compounded by an additional bind that not only prevents resolution of, but also prohibits escape from, the prototypical bind. For example, resolution of a prototypical bind expressed by the dilemma ‘damned if I do and damned if I don’t’, might be prevented by an additional bind, ‘if I reject damnation, I will suffer an even worse fate than damnation’. Hence, whilst a dilemma can usually be overcome by reconceptualising, within a double bind the dilemma is compounded by an injunction that prevents reconceptualising, and thus escape. In effect, Bateson’s concept implies that human communication generates an order of complexity that renders conscious, planned solutions ineffective. Double binds cannot be avoided or eliminated as actions taken from within a bind to escape it can simply reinforce it.

Bateson argued that double binds exist as patterns of thought and belief that are perceived as real by participants and have real effects, providing a context for their behaviours (Harries-Jones, 1995). Although often thought of as rare and necessarily pathological, following Bateson (1973) we regard double binds as common and endemic in human organisations; ‘part of the fabric of ordinary life’ (Bateson, 2005: 15).

A double bind consists of five components (Bateson et al., 1956), comprising those involved (component one), the nature of their relationship (component two) and associated communication - a primary injunction (component three) and a secondary
injunction (component four) - which together make up the prototypical bind. This is compounded by communication that denies that the bind exists; the pretence of not being in a bind then needs to be maintained in order to avoid punishment – which Harries-Jones (1995) refers to as denial of the existence of a falsified context.

A tertiary injunction with associated punishment that prevents escape from the prototypical bind provides the additional bind (component five). Bateson (Bateson et al., 1956; Bateson, 2005) argued that where the intensity of the significant relationship and the severity of punishments were high, the double bind was likely to be more harmful.

In summary the five components, which comprise the framework that we shall apply to our case, are:

1. Two or more persons or parties;
2. In a significant relationship involving a repeated, recurrent experience;
3. A primary injunction reinforced by punishment - if you do this you will be damned;
4. A secondary injunction conflicting with the primary injunction also reinforced by punishment - if you do not do this you will be damned;
5. A tertiary injunction with associated punishment that prevents escape from the bind - if you reject damnation you will suffer an even worse fate.

OL literature that makes explicit use of double bind theory is limited to date. Dopson and Neumann (1998) refer to the double bind in their study of British middle managers’ reactions to change, specifically when ‘being forced to choose between two equally undesirable alternatives’ (Dopson and Neumann, 1998:S66). Doern and Visser (2013) apply the concept to an analysis of barriers to entrepreneurship in Russia. People in organisations inevitably develop ways of construing and responding to double binds. How they do this has implications for OL. According to Visser (2007), the nature of the double bind is such that it prevents double-loop learning; the behavioural conditioning of individuals within their organisational contexts will impact upon their ability to respond to the double bind and, as a consequence, the ability of the organisation to learn (Visser, 2007).

The proposition we explore below is that the crisis at the Mid Staffordshire NHS Foundation Trust can be understood as creating a double bind situation; and that this offers a potential explanation for the prospect that the desired OL will not ensue.

Methodology

A double bind comprises communications taking place within a particular context, and can be inferred from observable behaviours and accounts. This paper relies on longitudinal, textual documentary secondary data (Saunders et al. 2012) from accounts in publically available sources in order to produce a case study of the Mid Staffordshire NHS Foundation Trust. These documents comprise principally data originally collected as part of the two associated inquiries and compiled subsequently within the inquiry reports (Francis 2010a, 2010b, 2013a, 2013b) and associated media reports. Such documents provided unobtrusive access to large amounts of data, the inquiry reports including first hand responses from the key actors in the process; and allowed changes to be tracked and insights developed (Bowen, 2009). However, while this level and breadth, of access would have been impossible to obtain using conventional primary data collection methods, these data have, invariably, been subject to some form of selection or summarising prior to publication (Saunders et al., 2012).
Our curiosity about the potential issues of OL in the Mid Staffordshire case was prompted by widespread media reports, especially by the rhetoric of the need to learn from mistakes, coupled with concern about the seriousness and apparently commonplace nature of such crises, along with prior interest in Bateson’s double bind concept (Langley et al., 2014).

We commenced a search for secondary data about the Mid Staffordshire case in 2013. This search was both retrospective and contemporaneous. As described in the following section, the Mid Staffordshire crisis unfolded over several years. For the purpose of bounding the data search, we decided to regard the first indication of poor performance at Stafford Hospital in a formal report, in 2002, by the Commission for Health Improvement (CHI) as the beginning of this longitudinal case study and our search for documentary evidence. The search continues up to and including the time of writing this paper; we anticipate that new documentary sources will continue to appear. The search yielded a wide range of publically available inquiry reports and other secondary accounts. Following Bowen (2009) sources were evaluated in terms of relevance, completeness and balance, alongside the each document's original purpose and intended audience. These sources include numerous documents found on the website of the Mid Staffordshire NHS Foundation Trust public inquiry, including the Francis report (Francis, 2013a) of the inquiry presented to parliament (comprising 1776 pages in three volumes and including verbatim transcripts of evidence), alongside numerous unsolicited news media reports in both national and trade press (for example, Lintern 2013).

These documentary sources were treated like field notes (Turner, 1983), analysis being based on categorising themes and patterns of language found in relation to the components of the double bind. The data were read and reviewed in order to yield two initial types of finding. First, we constructed a contextual timeline of events outlining the crisis as it unfolded, including the principal actors involved and actions taken. The timeline is presented below in the form of a narrative with an accompanying summary table (Table 1). Second, we applied the five components of Bateson’s double bind concept as an interpretive framework. Through this we produced an account of the possible structure of a double bind as it relates to this case.

**The case of Mid Staffordshire NHS Foundation Trust**

Within the UK NHS there have been an increasing number of public inquiries addressing failings in health care, relating in particular to unprofessional and unacceptable behaviour, poor treatment and unsafe practices. A consideration (Walshe and Higgins, 2002) of 59 NHS inquiries over the period 1974 – 2002 highlights four reoccurring themes. These they summarise as (1) isolation hindering peer review and constructive critical exchange, (2) inadequate leadership which lacks vision and is unwilling to tackle problems, (3) system and process failure and poor communication, and (4) disempowered staff and patients. The last of these, they argued, meant that problems were not picked up (Walshe and Higgins, 2002). Based on their analysis Walshe and Higgins noted many of the failings were organisational and cultural and would necessitate changes in attitudes, values, beliefs and behaviours which were difficult to prescribe in recommendations.

Eleven years after Walshe and Higgins’ (2002) analysis was published, similar issues were uncovered by the public inquiry into the apparently high mortality (Healthcare Commission, 2009: 3) at the Mid Staffordshire NHS Foundation Trust’s Stafford Hospital (Francis, 2013a). However, the publication of the Francis Report in 2013 was
by no means the first indication of poor performance at Stafford Hospital (see Table 1). In 2002 the Commission for Health Improvement (CHI) published a report outlining a lack of governance, poor culture and some staff under pressure, raising doubt about both hospital management and shortfalls in nurse staffing that were perceived to influence the ability to provide quality care. The report emphasised that urgent action was needed (CHI, 2002; cited in Francis, 2013).

The following year (2003) concerns were raised in a peer review report regarding the quality of care, a lack of staff and a lack of feedback from managers (Lintern, 2013). In 2004 the Hospital had received a zero star rating from the Healthcare Commission (2004), the regulatory body that succeeded CHI. This star rating indicated that the hospital had shown the poorest level of performance, by failing to achieve four of nine key targets. In particular the hospital underachieved on cancer treatment and financial management and significantly underachieved in relation to waiting times for both outpatients and elective admissions.

In 2005 a new Chief Executive, Martin Yeates, was appointed and the Hospital looked to apply for Foundation Trust (FT) status, whilst also announcing the loss of 150 posts (Lintern, 2013). At that time, FT status, which gave NHS Trusts a greater degree of autonomy from central government, was predicated primarily upon finance and not quality of patient care (Lintern, 2013). The loss of these posts, Yeates argued, would save £10 million (Lintern, 2013:2) and was necessary for the Hospital to be financially sustainable, and hence no longer underperforming against one of its key performance targets. The Hospital also instigated a ban on the use of agency staff, which were more expensive, and left 150 posts vacant, a third of which were clinical positions.

A 2006 peer review report emphasised the same concerns as in 2002, a subsequent 2007 external assessment (Dr Foster Intelligence, cited in Lintern, 2013) then highlighting that hospital mortality was 27 per cent above what would be expected. The Dr Foster guide (Dr Foster Intelligence, 2007) described the hospital as being ‘vulnerable’, with ‘insufficient senior medical cover in A&E’ (Accident and Emergency). The hospital maintained that the relatively high mortality rate was due to an administrative problem rather than the quality of clinical care. However, the report of the Healthcare Commission (2009:3) commented that ‘The response of the trust to our requests for information contained insufficient detail to support its claim that the alerts were due to problems with its recording of data, and not problems with the quality of care for patients’.

Over the next two years there were increasing local newspaper reports regarding poor care at the Hospital, and an action group ‘Cure the NHS’, established by people who had lost relatives or experienced poor care standards, was formed after a public meeting (Lintern, 2013). In 2008, at the same time as these concerns were being raised, the hospital was awarded FT status. Within a few months of being awarded FT status, the Healthcare Commission had launched an investigation into the high death rates at the Hospital. Writing some four years later, the Francis Inquiry (2013a:7) highlighted the role of patients and carers in bringing about this awareness;

In the end, the truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them. This group wanted to know why they and their loved ones had been failed so badly.

Reporting in 2009, the Healthcare Commission revealed that between 400 and 1,200 more people died than would have been expected between April 2005 and March
2008, highlighting ‘appalling care’ and neglect of patients. It was noted in the Hospital Trust’s subsequent review that: ‘A central theme of the failures at Mid Staffordshire hospital trust appears to be an over reliance on process measures, targets and striving for Foundation Trust status at the expense of an overarching focus on providing quality services for patients’ (Colin-Thomé, 2009:5)

In July 2009 the first independent inquiry was ordered, chaired by Robert Francis QC, the report being published in 2010 (Francis, 2010a,b). This report concluded that patients were routinely neglected, and that the culture was a bullying, focused on government targets and ignoring the needs of patients.

In June 2010 a second inquiry, again chaired by Francis, was announced to look at the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Trust. The (Francis) Report, published in 2013, contained 290 recommendations and stated that fundamental change was required. Francis (2013a:4) referred to ‘an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern’, arguing that such behaviour may have been fostered by governments’ performance culture, combining targets and blame, engendering a culture of fear of failure and reward for achievement of financial and measureable operational targets.

Within this culture, Francis (2013a:10) commented, ‘staff did not feel able to report concerns’; ‘the trust board shut itself off from what was happening and ignored its patients’; and a ‘culture of bullying prevented people from doing their jobs properly’. Within this, employees were continually exhorted to meet performance targets or be punished.

As summarised by the Inquiry Report (Francis, 2013a:5):

The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary. But it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this report shows that this cannot be assumed to be happening.

The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed. This does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it.

In summary, the 2013 Francis Inquiry emphasised that the current organisational culture of a fear of failure and a focus on financial measurable targets had to change. Whilst the report considered this could be implemented within the new system that had been created by new NHS reforms to deliver an acceptable level of care to each patient, Francis emphasised repeatedly the need to learn from the past.

On 27th February 2014, the Health Secretary Jeremy Hunt confirmed that the Mid Staffordshire NHS Foundation Trust would be dissolved, its two hospitals being taken over by the neighbouring NHS trusts (Cooper, 2014).
The case of the Mid Staffordshire NHS Foundation Trust through the lens of the double bind

We now examine these events through the lens of the five components of Bateson’s double bind.

For a double bind to exist, it must be possible to identify the persons or parties involved and a significant, enduring relationship between them. It is important to note that a double bind can exist between parties at various levels. In the NHS it would be possible, for example, to consider the relationship between government and the NHS; between the Mid Staffordshire Hospital Foundation Trust and Stafford Hospital; between the hospital’s management and its clinicians (doctors, nurses and other healthcare professionals); and between the clinicians and the hospital’s patients and their carers. In this case all these relationships are relevant, however for the purposes of this paper we concentrate on the relationship between Stafford Hospital’s management and its clinicians. These groups engage in repeated, recurrent interaction in order provide healthcare, including maternity, critical, outpatients and paediatric services alongside and accident and emergency services, for the surrounding geographical area (Mid Staffordshire NHS Trust, 2014).

It is important, nevertheless, to stress that this relationship cannot be taken as existing in isolation. As noted above, Francis (2013a:4) highlighted the importance of a context in which the government’s performance culture, combining targets and blame, engendering a culture of fear of failure and reward for achievement of financial and measureable operational targets. Stafford Hospital operated and continues to operate within the overall context of the UK publically funded NHS. This is a context characterised by debate about the relationship between budgets and changes in demand for healthcare. It is also a context in which a large number of inquiries into failings have highlighted common issues relating to hindering of peer review and lack of constructive critical exchange, inadequate leadership, system and process failure, and disempowered staff and patients (Walshe and Higgins, 2002).

The conditions for the third and fourth components of the double bind, the primary and secondary injunctions, arise for example through the need for the hospital to address the 2004 underachievement in financial performance, resulting in its zero star rating, alongside a requirement to be financially sound in order to achieve FT status, which led to a reduction in the number of employees. Then, in 2009, the hospital needing to address the high mortality rates, which were 27% above what would be expected.

The primary and secondary injunctions are created by exhorting the medical and nursing staff both to meet performance targets for productivity and efficiency, and to comply fully with policies and procedures relating to quality standards, accompanied by the threat of sanctions for failure or non-compliance.

Why would managers not acknowledge and perhaps remedy such a situation? An insight into this is offered by the co-founder of Dr Foster, the healthcare information organisation (Taylor, 2013):

> What happens when a hospital like Mid-Staffordshire finds it is struggling to deliver a high quality service with the resources available?

> As an NHS chief executive in that situation, you could simply overspend and breach your targets – and quite likely lose your job.
You could try to argue to re-organise services but you are likely to face considerable opposition from both clinicians and the public.

Or you can just cut costs, cross your fingers and hope that no-one notices if the standards of care deteriorate.

The frightening truth about the NHS is that the third of those options is the one that every incentive in the system is pushing you towards.

Because the risk that a poor quality service will get identified quickly, and the risk of that having consequences for your career, remain troublingly remote.

Under pressure to cope with these conflicting demands, staff may also find themselves faced with what appears to be an impossible dilemma. Either they must seek ways to cope with apparently unattainable targets - which is likely to impact on standards - or they must prioritise standards - which is likely to impair the meeting of targets. Either choice is likely to entail compromises or violations (Amalberti et al., 2006), and therefore holds the prospect of sanctions. Hence the position in which staff find themselves is of the form, ‘damned if you do, damned if you don’t’.

For example, Lintern (2013:3) quotes Dr Chris Turner, an emergency medicine trainee at Stafford A&E, as complaining of:

a bullying culture and harassment of staff to meet targets, which put patients at risk. With not enough staff, Dr Turner said the department had “no vision of what ‘good’ looked like”. He said: “There were not enough nurses; those who remained were demoralised. They had no senior nurse to unite and lead them. They were threatened on a near daily basis that they would lose their jobs if they did not get patients through the department within the four hour target.

The experience of patients in these circumstances can be gleaned from the evidence gathered from patients and their families or careers in Francis’s first inquiry (2010b). This covers the years 2005-9 and includes both positive and negative experiences. An example of the latter type is (Francis, 2010b:15):

The patient went to A&E at Stafford Hospital suffering from abdominal discomfort. A junior doctor insisted it was a urine infection but the patient was certain it was appendicitis. When the patient asked to see a specialist he was ignored and discharged. The following day the patient collapsed when his appendix burst.

The patient was admitted to hospital as a result of the burst appendix and had a successful operation. However, on Ward 6 he was rarely offered water and his catheter was frequently left to overflow. On one occasion he noticed that oxygen tubes were passed between patients without being cleaned and observed that no one used the available anti-bacterial gels.

The double bind involves the further dilemma of whether, and at what point, an individual member of staff speaks out about the situation. If they do speak out, they take a risk because there is evidence that they may be punished for doing so by managers and colleagues, who may perceive the whistle-blowing as disloyalty. Yet if they keep quiet they risk breaching (for example) their code of professional ethics. If found in future to have chosen not to speak out despite knowing that such problems exist, they could be blamed for not speaking out and punished. In short, actors face the
prospect of being punished if they do speak out, and punished if they do not. In effect this adds a further, `damned if they do and damned if they don’t’. Members of staff could, therefore, have concerns about the reasons for the higher than expected mortality rates, yet end up being punished whether or not they speak out about those concerns.

The tertiary injunction preventing escape from the prototypical bind therefore relates to the culture within the Hospital. The Francis Report (2013a) highlighted the institutional culture which focussed upon positive information and a performance culture combining targets and blame. This compounds and falsifies the context of the prototypical bind; in other words, the very existence of the dilemma faced by staff (i.e. about the perceived choice between targets and standards) is denied by management. It is this denial of the experience and perceived reality of the dilemma that, in Bateson’s original formulation of the double bind, gave rise to pathology. In other words, a person in this situation is forced to find a way to cope with being in an impossible dilemma and having the existence of that dilemma denied. From this perspective, one can argue that behaviours such as compromising on patient care and falsifying performance data represent what are perceived as the only possible ways to cope.

An additional irony – or tragedy – occurs if external solutions compound this bind. Thus it may be tempting (especially for politicians and the media) to construct such situations retrospectively as ones in which actors had clear knowledge of unsatisfactory practice and a simple rational choice to make about whether or not to speak out. Logically, therefore, imposing sanctions for the failure to speak out should ensure that unsatisfactory practice is exposed. However, it is more likely that actors experience the double bind as shifting ‘shades of grey’, seldom coalescing into a situation in which it is either definitely time to speak out, or definitely devoid of concerns about standards. Far from forcing a solution to the double bind, the introduction of additional sanctions is likely to exacerbate the double bind and encourage a search for possible coping behaviours.

Interventions designed as a response to the initial bind, especially if based on a linear, rational problem-solving approach, are therefore almost certainly inadequate for the purpose of resolving the paradoxical, recursive patterns of communication that are involved in a double bind. In consequence, such solutions can have the opposite effect to that intended; they are more likely to prevent OL than to enable it. Or, to nuance this slightly, the OL that is most likely to occur is in the form of innovations in coping behaviour.

While there is not space here to discuss what can be done to address double binds, our previous research on arts organisations facing failure (Langley et al., 2014) highlights interest in the different ways in which organisations respond to and manage double binds.

**Discussion and Conclusion**

In order to explore how the double bind concept offers a potential explanation of the dilemmas faced by people in organisations such as Stafford Hospital, we have applied this concept, to secondary data concerning the Mid Staffordshire NHS Foundation Trust. We acknowledge limitations of this approach, especially its interpretive nature. Invariably the analysis presented above needs to be refined and validated through further work.
However, our findings could have important implications for practice because similar dynamics, and similar failures to learn, have been noted elsewhere in the NHS. For example, prior to the Mid Staffordshire NHS Foundation Trust inquiry, the Bristol Royal Infirmary’s Kennedy Inquiry (2001), which also highlighted features that could be said to resemble the components of the double bind. The Bristol Royal Infirmary report highlighted the hierarchical relationship between doctors and other caring staff as a significant cultural weakness, nurses who raised concerns often being ignored (Kennedy, 2001). Analysis indicated that the behaviours of doctors and other caring staff were dictated by and justified within these cultural norms, in effect a ‘culture of entrapment’ (Weick and Sutcliffe, 2003:6). Non-compliance with the hierarchical culture, in which doctors instructions were to be carried out, was linked with some kind of cost to the individual (Lawrence et al., 2009; Scott, 2008).

This study has potential significance socially and economically, given that the situation faced by the Mid Staffordshire NHS Foundation Trust is important to many other types of organisations, occurring frequently in both public and private sectors.

As noted above, on 27th February 2014, the Health Secretary Jeremy Hunt confirmed that the Mid Staffordshire NHS Foundation Trust would be dissolved. The demise of an organisation can be one way for it to escape a double bind – although this does not guarantee that the double bind will not be replicated within the new organisational arrangements. Our continuing research is concerned with whether and how organisations can manage and respond to double binds in ways that avoid the tragic consequences seen in Mid-Staffordshire.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Source</th>
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<tbody>
<tr>
<td>2002</td>
<td>The Commission for Health Improvement report</td>
<td>Commission for Health Improvement clinical governance report (cited in Francis, 2013)</td>
</tr>
<tr>
<td>2003</td>
<td>Peer review report `raised serious concerns about the accident and emergency department at Stafford Hospital'</td>
<td>Lintern (2013:2)</td>
</tr>
<tr>
<td>2004</td>
<td>The Hospital received a zero star rating from the Commission for Health Improvement</td>
<td>Francis (2013a: 41)</td>
</tr>
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<td>2005</td>
<td>(September) New Chief Executive, Martin Yeates, appointed</td>
<td>Lintern (2013)</td>
</tr>
<tr>
<td>2006</td>
<td>Hospital looks to apply for 'foundation status'. Peer review report emphasises the same concerns as an earlier review in 2002</td>
<td>Lintern (2013)</td>
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<tr>
<td>2007</td>
<td>(April) External assessment highlighted that Hospital mortality was 27% above what would be expected. The trust maintained the problem was to do with how patient deaths were coded, although this was shown not to be the case.</td>
<td>Dr Foster Hospital Guide (2007), cited in Lintern (2013:3)</td>
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<td>2007</td>
<td>An action group, 'Cure the NHS' was formed after a public meeting</td>
<td>Lintern (2013:3)</td>
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<tr>
<td>2008</td>
<td>(February) The Hospital was awarded foundation status</td>
<td>Lintern (2013:4)</td>
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<td>2009</td>
<td>Healthcare Commission report `includes a figure for the expected number of deaths due to poor care of 400 to 1,200 between 2005 and 2008’. Trust Chief executive Martin Yeates resigns in May.</td>
<td>Lintern (2013:4)</td>
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<tr>
<td>2009</td>
<td>(July) The first independent inquiry was ordered, chaired by Robert Francis QC</td>
<td>Colin-Thomé (2009)</td>
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<td>2010</td>
<td>(February) First Francis report published</td>
<td>Lintern (2013:4)</td>
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<tr>
<td>2010</td>
<td>(June) A second inquiry is announced, again chaired by Robert Francis</td>
<td><a href="http://www.midstaffpublicinquiry.com/">http://www.midstaffpublicinquiry.com/</a></td>
</tr>
<tr>
<td>2014</td>
<td>(February) Health Secretary Jeremy Hunt backs calls to dissolve the trust that runs the scandal-hit Stafford Hospital.</td>
<td><a href="http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-26349205">http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-26349205</a></td>
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Table 1: The Mid Staffordshire NHS Foundation Trust crisis: a timeline (developed from Colin-Thomé, 2009:27-8; Lintern, 2013)
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