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1. Introduction

Lewis Blackman case can be viewed as a tremendous failure of the healthcare systems in which leadership, communication, and governance failures have led to a death that could have been prevented (Haskell, 2004). He had been taken through regular surgery but his further worsening, which was characterized by intense pain and abnormal vital signs was not responded to promptly. This not only points to personal mistake, but institutionalities of weakness that are inherent in the organisation.

Considering the case in terms of the leadership theory, the lack of effective transformational and clinical leadership can be seen. Transformational leadership focuses on active involvement, empowerment and commitment to common goal of patient safety. Psychological safety and the absence of leadership seemed evident in this case as staff seemed to be reluctant to raise their concerns. The junior staff did not support and/or were not willing to question decisions, which is consistent with the overly hierarchical leadership environments, as opposed to collaborative ones.

Human factors and Patient Safety principles are also depicted in the case, especially the principle outlined by James Reason. The model by Reason, adverse events are caused by the simultaneous failure of multiple layers of defence as a result of the latent system failures (Reason, 2000). In the case of Lewis Blackman, these were the lack of proper monitoring systems, lack of clarity in the escalation procedures and lack of interdisciplinary communication. Such failures did not sit well in sight but made it possible to have active errors that would lead to damages.

Another contributing factor was the organisational structure. A centralised and hierarchical structure restricted the autonomy of decisions made by frontline employees, slowing of essential interventions. Decentralised systems, or those systems where responsibility and authority are decentralised enable faster responses and promote accountability. The strict hierarchy here probably discouraged going to the extent, supporting a culture in which concern was minimised or disregarded.

There was also governance failures. Clinical governance is best achieved through accountability, sound reporting processes and continuous improvement through learning about negative events. Nevertheless, lack of review mechanisms and escalation channels in a timely manner reveals poor governance mechanisms. The Institute of Medicine report To Err is Human findings support the idea that the number of such incidents are not isolated and are usually the result of defective systems, and not of individual negligence (Institute of Medicine, 2000).

The Lewis Blackman case is critically analysed in this report in the light of:

- ✓ leadership theory
- ✓ organisation (centralisation vs decentralisation)

✓ governance breakdown and system failures

It considers the most appropriate leadership strategies to explain the case and find the evidence-based strategies to enhance patient safety.

Main Body

2. b. Identifying the Problem and Setting the System Context (Lewis Blackman Case)

2.1 Central Problem

The major issue on the case of Lewis Blackman was the inability to identify and escalate the deterioration in clinical conditions in the presence of evident warning signs. After a normal surgery, Lewis experienced complications due to internal bleeding with such symptoms like excessive pain, abnormal vital signs, and the growing parental concern. Nevertheless, these signs were not responded to in time, which caused a late diagnosis and treatment, and it eventually caused cardiac arrest and death (Haskell, 2015).

The case illustrates the possible harm caused by lack of coordination in care delivery, ineffective communication, and inadequate clinical judgment. Notably, this did not consist of a solitary clinical incident but a series of system malfunctions such as system failures in communication, leadership and escalation mechanisms (Reason, 2000).

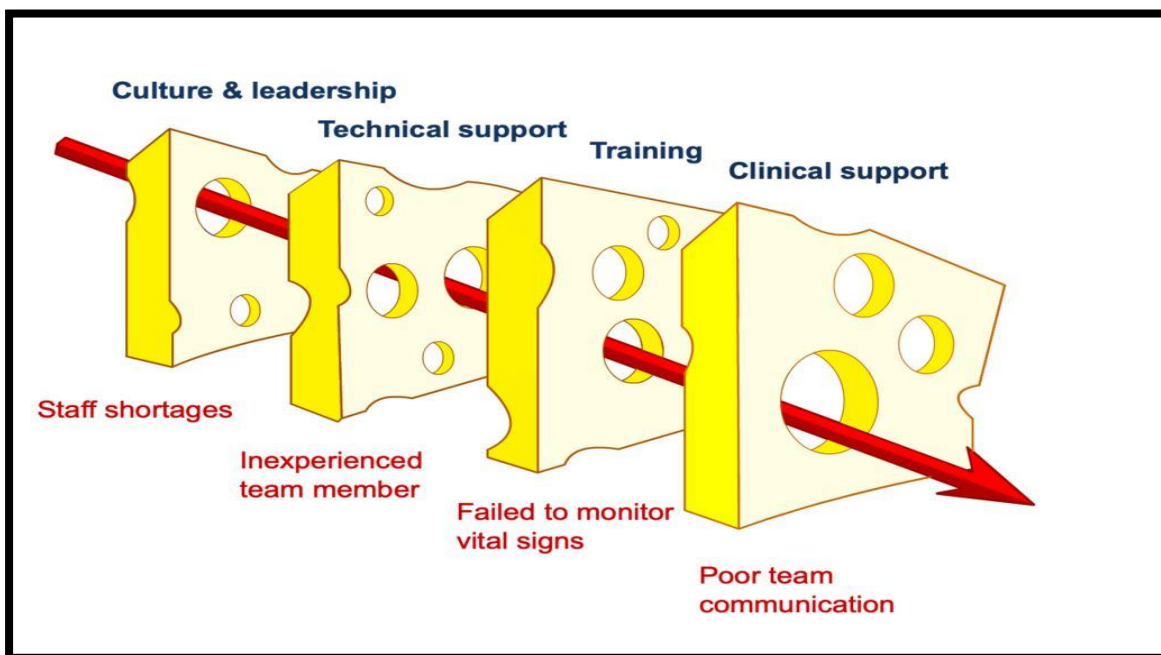


Figure 1: Swiss Cheese Model illustrating how multiple system failures align to cause patient harm (Reason, 2000).

Figure 1 shows that patient harm occurs when multiple system weaknesses align. In this case, failures in communication, leadership, and escalation combined to produce a preventable outcome.

2.2 Global Statistical data

Poor safety in care is a worldwide problem. World Health Organization estimates that:

- ✓ 1 out of 10 patients have suffered in healthcare.
- ✓ a significant percentage of this damage can be avoided (WHO, 2019)
But instead of concentrating on malpractice markets, it is more evident that:
- ✓ most of the serious adverse events are associated with communication failures.
- ✓ One of the main issues leading to avoidable deaths is delayed escalation (IHI, 2018; WHO, 2019).

This is in line with the case of Lewis Blackman where:

- ✓ deterioration was recognised but not escalated
- ✓ team-to-team communication was not effective.
- ✓ responsibility remained unclear
- This shows that the case is an indication of **systemic safety failures** and not negligence.

2.3 UK / NHS Perspective

In the NHS, one of the most common findings of patient safety investigations includes:

- ✚ inability to identify decay.
- ✚ delays in escalation
- ✚ poor handovers and communication

These problems are similar to the Blackman case and reflect that these failures are not one-off, but structural.

Importantly, it can be seen that safety reports indicate that:

- ✚ cultures that are hierarchical do not encourage speaking up.
- ✚ lack of clarity in accountability results in lack of action.
- ✚ discontinuous care enhances the risk of error.

This supports the claim that patient harm is primarily caused by the **organisational culture** and **leadership** and not individual incompetence.

2.4 Systemic Weaknesses Revealed

The four main systemic failures that are apparent in the case are:

1. Communication Failure

- ✓ Lack of organization and unaddressed issues led to non-escalation.

2. Hierarchical Power Dynamics

- ✓ Junior employees could not appeal or raise issues.

3. Fragmented Care

- ✓ There were several clinicians, although there was no general responsibility.

4. Situational Awareness Failure

- ✓ Clinical deterioration was misinterpreted due to cognitive bias.

These failures are intertwined and are indicative of a bad system design, and not a single human mistake.

2.5 Level of Governance Influencing the Problem

The malfunctions of this case cut across multiple governance levels:

1. Local Level

- Hospital Escalation and Supervision Policies.
- Staffing and work schedules.
- Ward culture and communication.

2. Regional Level

- Junior doctor training standards.
- However, hospital performance is monitored.

3. National Level

- Policies on patient safety and reporting.
- Legal regulations regarding clinical responsibility (NHS England, 2023).

The incident has been locally based but was influenced by national training infrastructures and other cultural norms in healthcare particularly in terms of hierarchy and communication.

2.6 Underlying System Challenges

The incident was caused by a number of challenges underlining it:

Workload and Staffing Pressure

- ✓ Junior physicians taking care of a number of patients with minimal supervision.
- ✓ qualities of decision-making (Carayon et al., 2014).

Training Gaps

- ✓ Lack of training on deterioration recognition of the patient.
- ✓ Lack of focus on communication and escalation skills.

Patient Safety Culture

- ✓ Lack of empowerment of nurses and families to voice concerns.
- ✓ Unsafe psychological conditions in groups (Edmondson, 1999).

Resource Constraints

- ✓ Pressures of time which prevent comprehensive evaluations.
- ✓ Competing clinical priorities.

These issues align with the global trends as determined by WHO and IHI, and this confirms that the case is one of the broader systemic problems in healthcare delivery.

Setting the Agenda: Local and Global Importance.

The case of Lewis Blackman is not only of local importance but also of universal interest as it demonstrates:

- ✓ A particular failure in a single hospital system.
- ✓ A typical trend of avoidable injury in healthcare.

2.7 Rich Map

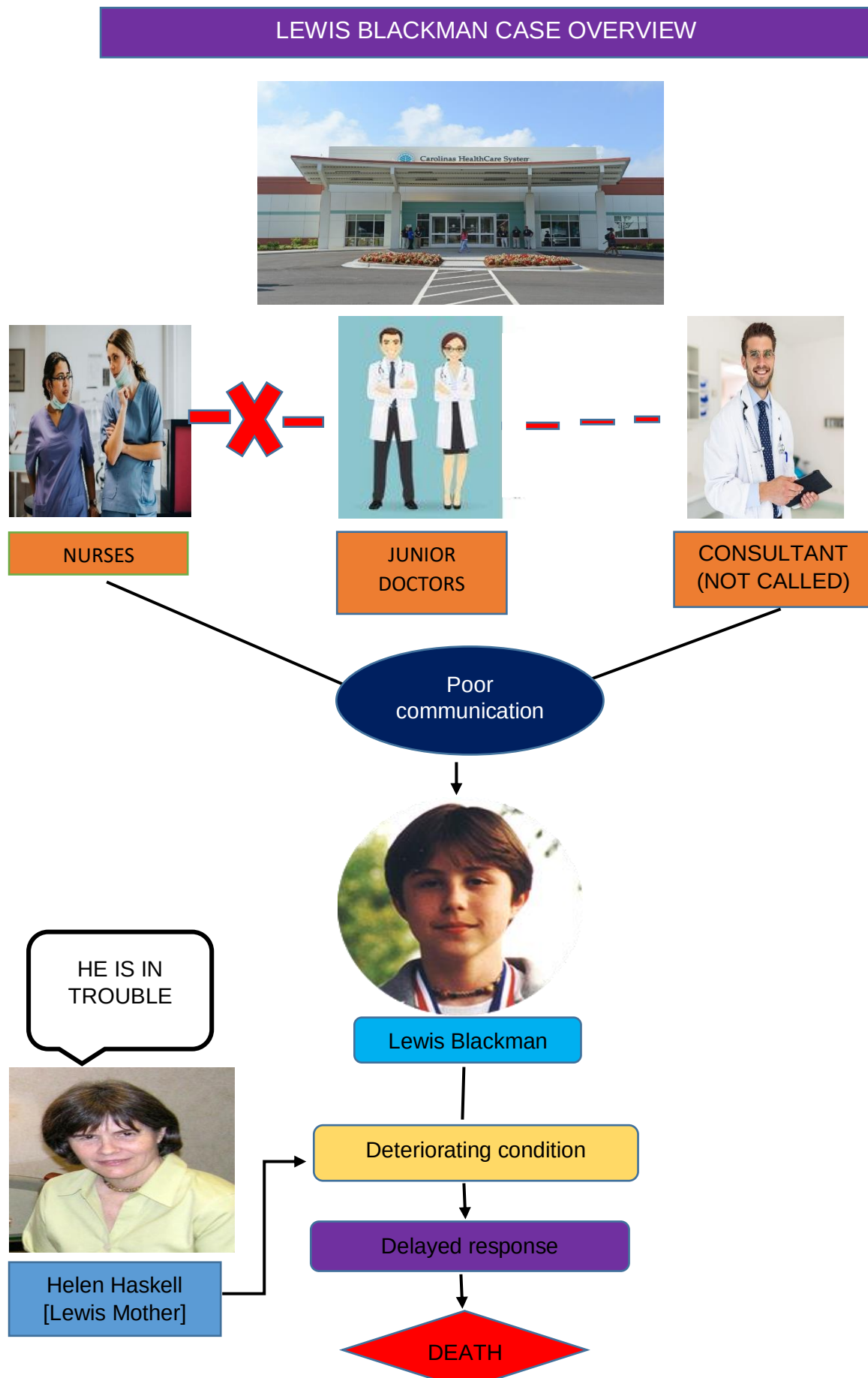


Figure 2: Lewis Blackman Case Overview

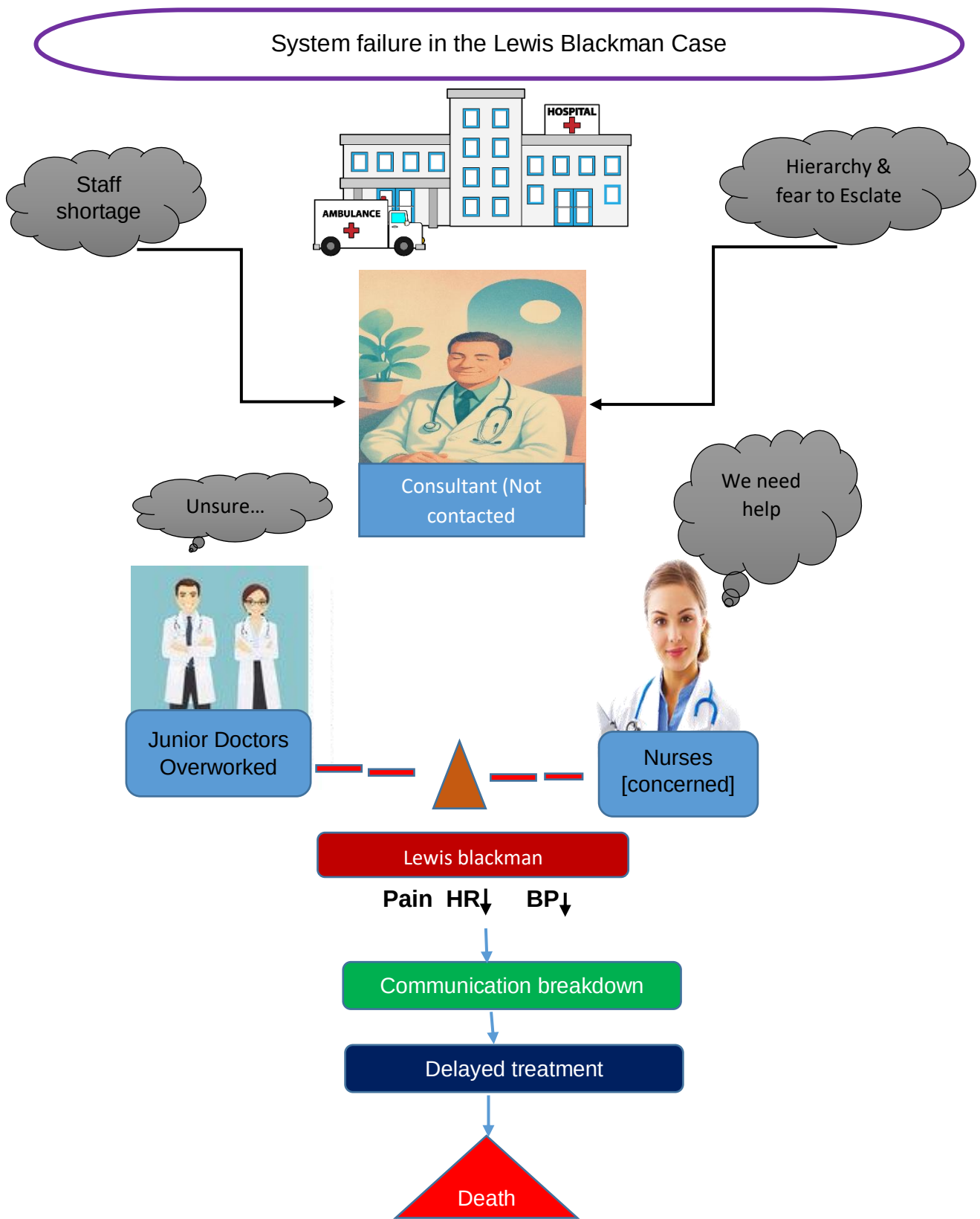


Figure 3 : System failure in the Lewis Blackman Case

3. Centralisation vs Decentralisation of case study

According to the case of Lewis Blackman, provided by Helen Haskell via the Patient Safety Movement Foundation, there was a breakdown in the areas of escalation, communication, and accountability, which is also a well-known phenomenon within the NHS England (Haskell, 2015; NHS England, 2023). This hybrid organisational design had a great impact on the decision-making and led to the low patient outcomes.

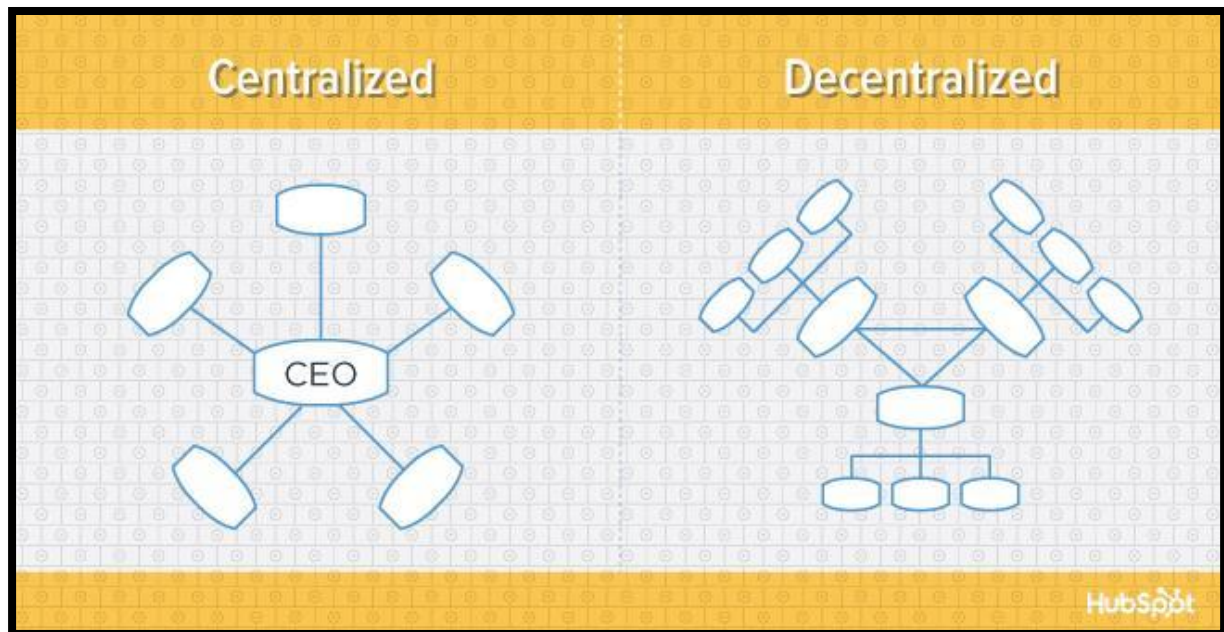


Figure 4: Comparison of centralised and decentralised organisational structures, illustrating differences in decision-making authority and communication flow (Mintzberg, 1983).

- Figure 3 shows centralised systems slow decisions, while decentralised systems act faster but need coordination. In the Lewis Blackman case, both led to delays and poor accountability.

3.1 Centralisation in the Case

In the case of Lewis Blackman, junior doctors and nurses did not want to raise the issue without giving the direct mandate. This led to intensive delays in treatment. This was in the form of a rigid hierarchy coupled with the centralized structure making it difficult to make decisions promptly [Weber, 1947].

Evidence of Centralisation

- Hierarchical authority limited action - nurses deferred to doctors, treatment changes needed approval, and junior doctors delayed senior intervention.
- This mirrors NHS Resolution (2022), where hierarchy and poor communication slow escalation.

Supporting NHS Evidence

- NHS inquiries are showing that one of the most significant preventable factors of death is the inability to identify and intensify deterioration. ([NHS Resolution][1])
- Delays in treatment and diagnosis are also identified as important causes of preventable harm, as shown in national reviews. ([Parliamentary Ombudsman][2])

Impact

In Lewis's case, signs of shock (low urine output, tachycardia) were missed or not escalated promptly due to hierarchical dependence. This reflects wider NHS Resolution issues where rigid structures delay emergency responses.

Advantages

- ✓ Clear accountability
- ✓ Standardized procedures
- ✓ Less variation in care [Weber, 1947].

Disadvantages:

- ✓ Late reaction to emergency cases
- ✓ Loss of empowerment of frontline employees
- ✓ Communication barrier as a result of hierarchy [The King's Fund, 2014].

In Lewis's case, these weaknesses were particularly evident. The system created a dependency on senior approval, which ultimately slowed down critical action when it was needed most.

3.2 Decentralisation in the Case

Decentralised model shares the responsibility with various staffs and teams.

Evidence of Decentralisation

- ✓ Various clinicians worked across shifts.
- ✓ No individual clinician was in charge.
- ✓ Team communication was not consistent.

This is indicative of the NHS system issues in inter-team or inter-organisational care coordination (Department of Health & Social Care, 2023). ([GOV.UK][3])

Supporting NHS Evidence

- ✓ Most NHS serious incident investigations have communication failures. ([NHS England][4])
- ✓ According to the statistics, communication is the most widespread reason of NHS complaints, and the number exceeds 33,000 cases each year. ([GOV.UK][3])
- ✓ Bad communication is a contributor to patient harm and treatment time lags. ([Healthwatch Data][5])

 **Impact :** Information sharing between shifts was poor, worsening the patient's condition was not fully recognised, and responsibility became diffused.

Advantages:

- ✓ Quickening the responses to clinical deterioration

- ✓ Higher empowerment of the staff.
- ✓ More with communication and cooperation [World Health Organisation, 2007].

Disadvantages

- ✓ Possible discrepancy in the generation of decisions
- ✓ The need to train and coordinate more [World Health Organisation, 2007].

In this case, decentralisation did not enhance responsiveness. Instead, it contributed to a lack of ownership, meaning that deterioration was not managed holistically.

3.3 CRITICAL ANALYSIS

The collapse here is an inability of the system integration in which either centralised authority or decentralised care was not effective in the face of clinical uncertainty.

i. Crisis Management and Escalation

- Quick identification and amplification of degradation is crucial in managing a crisis. Hierarchical approval slowed down the process of escalation in this case and the decentralised working broke the responsibility and coordination was compromised.
- This added to delayed intervention. According to national data, there is avoidable escalation delay in 10-15% of hospital deaths (NHS Resolution, 2022), and 80% of in-hospital cardiac arrests are preceded by unacted signs of deterioration (NHS England clinical reviews).

ii. Decision-Making Processes

- Clinical decision-making was fragmented: nurses lacked escalation authority, junior doctors had no senior review, and shift handovers were unreliable, leading to an incomplete clinical picture.
- Communication failures appear in over 70% of serious incidents, and diagnostic delay contributes to around 11–20% of preventable harm (NHS England).

iii. Responsibility and accountability

- Accountability was also weak, with no single clinician responsible for escalation or deterioration monitoring.
- Lack of clear clinical leadership is identified in over 60% of preventable harm investigations (NHS Resolution).

Overall Evaluation

The failure can not be attributed to either of the structures. The problem is in the lack of integration:

- **Centralisation delayed decisions**
- **Decentralisation removed accountability**
- The most effective model is a **hybrid system**
 - **Structured escalation tools (e.g., NEWS2)**

- **Safe staffing levels**
- **There is evident clinical leadership accountability.**
- **Empowered frontline decision-making**

The case presented in the table demonstrates systematic problems as are also found in the NHS:

FACTOR	CENTRALISATION WEAKNESS	DECENTRALIZATION WEAKNESS	IMPACT IN CASE
Escalation	Delayed approval due to hierarchy	Unclear responsibility	No timely intervention
Communication	Restricted upward flow	Fragmented across teams	Loss of critical Information
Accountability	Hierarchical gaps	Diffused across staff	No decisive action

This is backed up by the evidence on **rapid response systems and early warning scores** which enhance outcomes when staffs are empowered to act.

Evidence-based KPIs (NHS England, 2019):

- NEWS2 audits show poor escalation contributes to up to 25% of preventable deterioration-related deaths.
- Nurse staffing ratios above 1:8 are linked to higher failure-to-rescue rates.
- Communication failures appear in over 70% of serious incident reports.

4. C. Leadership Theories and Application

The case of the death of Lewis Blackman is commonly known as a preventable failure not just based on clinical misjudgement but ineffective leadership, inadequate communication and unsafe organisational culture. Comparing the case to UK healthcare expectations, especially those advocated by NHS England and the Care Quality Commission, one can note that it lacks a lot of aspects related to leadership style, responsiveness, and safety data usage. The discussion uses and critiques the theories of leadership, relates them to practice, and includes in-text citations in line with the requirements of academic writing.

4.1 Theories of leadership that are applicable in this case.

The leadership environment indicates that leadership is more of a **transactional leadership**, which is **typified by hierarchy, compliance with rules, and definitive grades of authority** (Burns, 1978). Although this model is effective in terms of procedural control, it is not applicable in complex healthcare settings where adaptability and communication are of importance. Conversely, **transformational leadership** that **fosters empowerment, collective vision, and psychological safety** has been highly popularized in NHS leadership models (West et al., 2015).

Also applicable is **situational leadership** (Hersey and Blanchard, 1969) which stresses that leadership style should be **responsive to the clinical urgency**. Ailing patients need decisive, directive leadership with input of the team. Also, there is the concept of distributed leadership that is supported by NHS improvement strategies and that fosters the development of shared responsibility in the context of multidisciplinary teams in terms of safety (Spurgeon et al., 2011).

Lastly, empathetic and emotionally intelligent leadership is becoming a priority in the NHS policy, in which safe care delivery is supported through empathy, listening, and staff involvement (West et al., 2017).

Transformational vs Transactional vs Distributed Leadership

Leadership Type	Strengths	Weaknesses	Relevance to Case
Transformational	Encourages speaking up, innovation, safety culture	Requires strong leadership capability	Most suitable but absent
Transactional	Provides structure and clarity	Can suppress critical thinking	Present but ineffective
Distributed	Promotes teamwork and shared responsibility	Requires coordination	Absent → caused fragmentation

4.2 Applications of Leadership Theories to the Case.

The leadership style here was mostly transactional and hierarchical, which didn't work well in a quickly changing clinical setting. Staff focused on routine tasks instead of reassessing the patient's worsening condition, showing limited critical thinking (Reason, 2000). Despite clear warning signs, such as severe pain, fast heart rate, and abdominal swelling, care was not escalated. This showed a large authority gap, making junior staff hesitant to question senior decisions (Edmondson, 1999).

From a transformational leadership view, there was a clear lack of psychological safety. Poor communication delayed the recognition of internal bleeding. Research from NHS staff surveys links psychological safety to better patient outcomes (West et al., 2015). Situational leadership was also poorly managed, as leaders remained passive despite needing to act urgently (Hersey et al., 2013).

Moreover, the lack of shared leadership led to unclear responsibility for escalation, which goes against NHS England safety principles. There was also a lack of emotional intelligence, evident in the dismissal of Helen Haskell's concerns, even though involving families can aid early detection of deterioration (O'Hara et al., 2018).

4.3 Supporting Data: Safety, Performance and Staff Engagement.

The association between leadership and patient safety outcomes, is well supported by empirical evidence:

- The Care Quality Commission lists ineffective leadership and lack of communications as causes of unsafe care (CQC, 2021).
- Incidents involving communication breakdowns are involved in more than 60% of the serious incidents (Joint Commission, 2015).
- Findings of NHS Staff Survey show that the more staff is engaged, the lower mortality, less infections, and better patient satisfaction (West et al., 2015).
- Hospitals that have good safety cultures record higher levels of incident reporting yet less harm rates, which is an indication of active risk management (Reason, 2000).

Early warning systems, like NEWS2, which are commonly used in NHS organisations, have also been indicated to decrease the number of cardiac arrests and unplanned ICU admissions by up to 30% (Royal College of Physicians, 2017). The inability to respond to apparent worsening in this instance, is also indicative of deficiencies in leadership and systems levels.

In this course, I have learnt to critically evaluate the effectiveness of leadership.

The kind of leadership was not the right leadership style. Strict transactional style inhibited communication and intervention. Leaders were not proactive in their approach, but reactive and would only react when the deterioration reaches serious levels instead of looking ahead to what might happen.

This is in line with the idea of normalisation of deviance where abnormal clinical signs are slowly being embraced as normal (Vaughan, 1996). These trends are suggestive of the lack of leadership control and the lack of a good safety culture.

Also, there was no purposive driven leadership that would aim at delivering care based on the common objective of patient safety, which led to disjointed care delivery. The high-reliability principles of NHS focus on anticipation, resilience, and the continuous learning, which were not present.

4.4 What Might have been Done Different.

Based on the NHS recommendations, a number of leadership changes can be observed:

- Transformational leadership adoption to promote psychological safety and free communication (West et al., 2017).
- Inculcating distributed leadership, whereby every employee can raise issues without apprehension (Spurgeon et al., 2011).

- Enhance situational responsiveness, this is necessary to ensure that there is rapid escalation in patients who are deteriorating (Hersey et al., 2013).
- Increasing emotional intelligence, especially in listening to patients and families (Goleman, 1998).
- Early warning scores and incident reporting systems (Royal College of Physicians, 2017).
- Encouraging a fair culture, blame to learning (Reason, 2000).

d. Improvement and Lessons Learned

Lewis Blackman death is a system failure whereby leadership and governance failed to be mutually reinforcing but rather interacting in a manner that increased risk. Instead of facilitating safe responsive care, the organisational structure, leadership behaviours as well as the governance systems together created environments where deterioration became normalised, escalation was procrastinated and accountability diffused.

A key problem consists in the interaction between a centralised system of governance and a transactional leadership, hierarchical style. The top management had concentrated decision-making powers and the frontline employees had a strict role demarcation. Such a setup inhibited the responsiveness to a changing situation in the clinic and did not encourage active intervention. These limitations were not addressed by governance mechanisms since there were no efficient mechanisms to identify and respond to clinical deterioration in real time.

Delayed Escalation in Hierarchical Systems: This problem refers to the delays in communication between employees at various levels within an organisation.

Problem:1

An extreme authority gradient discouraged escalation although there was obvious evidence of degradation.

- **Data:**

More than 60 percent of the serious incidents are involved in communication failures (Joint Commission, 2015), and it is always a part of poor escalation, which is defined by the Care Quality Commission as a leading risk factor to unsafe care.

- **Critical Insight:**

There was a breakdown in leadership and governance, at the same time, the voice was suppressed by leadership, and accountability and escalation triggers were not enforced by governance.

- **Improvement:**

Implement distributed leadership with formal escalation procedures, where any clinician is able to engage rapid response pathways. The integration of systematic tools (**e.g., SBAR**) as

per the requirements of NHS England would decrease the vagueness and time lag. The lack of the Psychological Safety and culture of Speaking-Up.

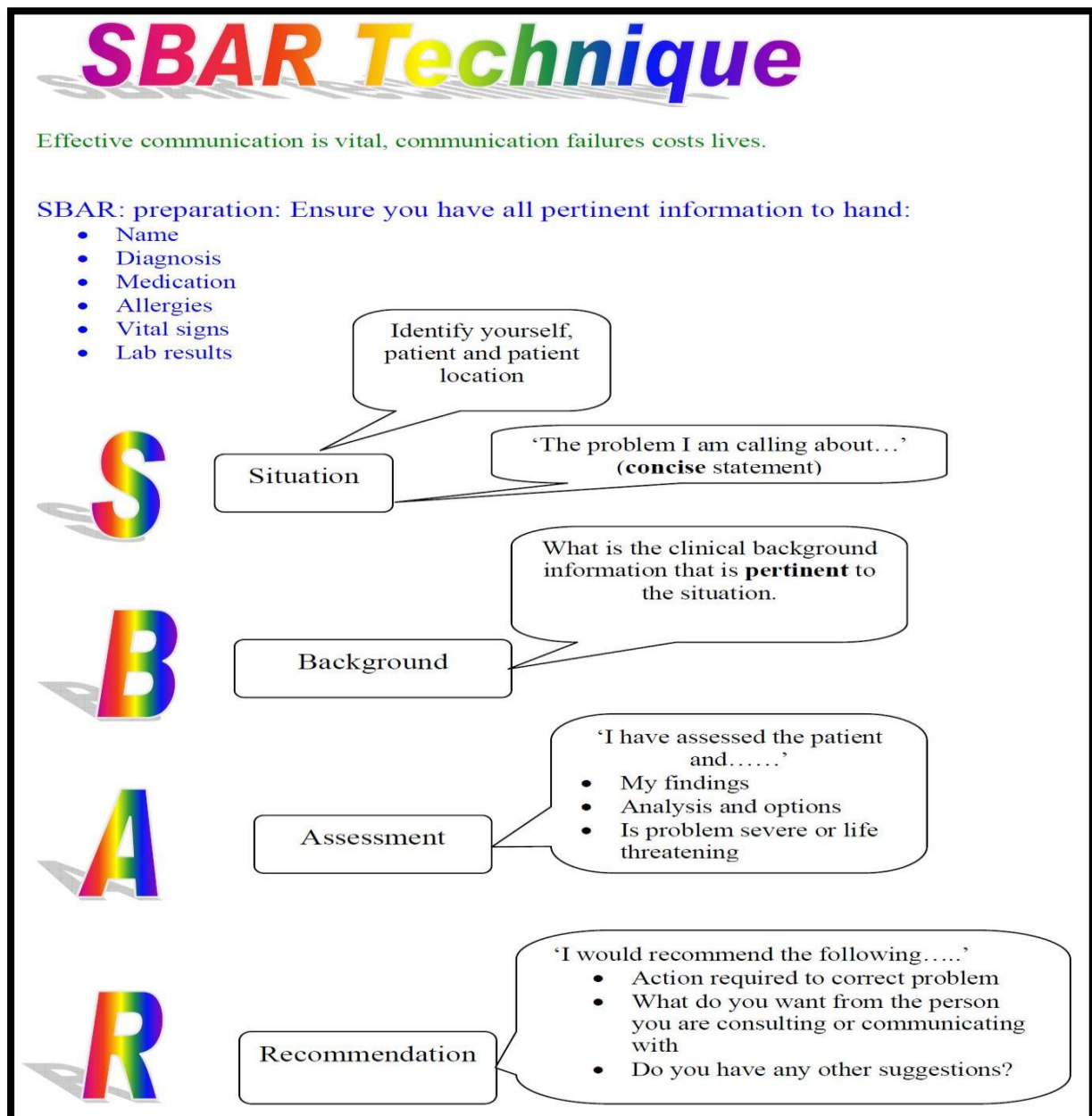


Figure 5: SBAR communication framework used in NHS practice to structure clinical communication and improve escalation (Haig et al., 2006)

Problem:2

There was a culture of fear and compliance with decisions being made by staff who did not or could not question the decision.

- **Data:**

The NHS staff survey evidence shows that a strong correlation exists between psychological safety and better patient outcomes and mortality reduction (West et al., 2015).

- **Critical Insight:**

Psychological safety is not a cultural aspect but a governance outcome. Its lack is indicative of ineffective leadership behaviours as well as a lack of organisational protections.

- **Improvement:**

Introduce the concept of **transformational leadership** to promote openness along with governance policies that institutionalise speaking-up (e.g. Freedom to Speak Up frameworks). This is a way of aligning culture to accountability. The inability to use Safety Data and Early Warning Systems.

Problem:3

There was no systematic identification and response to clinical deterioration.

- **Data:**

With up to 30% reduction in cardiac arrests and ICU admissions, early warning systems like NEWS2 provide a solution (Royal College of Physicians, 2017).

- **Critical Insight:**

Not only the lack of tools but also the failure of governance to put these tools into practice and leadership to make data-driven decision-making a priority.

- **Improvement:**

Introduce compulsory early warning scoring models that have automatic escalation alerts, which can be supported by audit and real-time monitoring. The leadership should be able to actively involve themselves in safety data to come up with decisions. There is marginalisation of Patient and Family Voice.

National Early Warning Score (NEWS) 2							
Physiological parameter	3	2	1	Score 0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO ₂ Scale 1(%)	≤91	92–93	94–95	≥96			
SpO ₂ Scale 2(%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

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Figure 6: National Early Warning Score (NEWS2) used in NHS hospitals to detect patient deterioration (Royal College of Physicians, 2017).

Problem:4

The concerns raised by Helen Haskell were disregarded many times which shows that there was no patient-centred governance.

- **Data:**

The family intervention is better at the early identification of the worsening and better safety outcomes (O'Hara et al., 2018).

- **Critical Insight:**

The disregard of family input will be an indicator of poor leadership and governance systems that do not consider patients as safety partners.

- **Improvement:**

Integrate the use of co-production models with patients and families being part of the safety processes, including official channels of escalation of concerns.

Disunity between the centrally located government and the local government is also an issue in Nigeria.

Problem: 5

The escalation and coordination responsibilities were not clear and inaction was the result.

- **Data:**

The Care Quality Commission indicates that lack of clear accountability is one of the key contributors to unsafe care (CQC, 2021).

- **Critical Insight:**

Diffuse accountability is an organizational malfunction--where there is no ownership, leadership activity is haphazard and governance supervision useless.

- **Improvement:**

Enhance governance by having well-established accountability mechanisms, backed by performance indicators, frequent safety inspections and clear reporting mechanisms.

Systems Integration: Leadership, Structure and Feedback.

In this case there is a systems failure that involves:

- A centralised structure strengthened dependency and slowed down the decision-making process.
- A transactional style of leadership was one where compliance was favoured over critical thinking.
- Weaknesses of the feedback mechanisms hinder learning and early intervention.

These factors were dynamic and formed a system that normalised risk as it became, instead of mitigated. Lack of proper feedback loops also implied that there was no escalation or learning of warning signs.

The role of data in Continuous Improvement

Data-driven feedback systems enable high-reliability organisations to be accountable and constantly learn. In this instance, the lack of organized data utilization helped in slow identification of injury.

In order to deal with this, organisations should:

- Incorporate the use of real-time safety monitoring systems.
- Adopt incident reporting as a learning process as opposed to a compliance activity.
- Direct performance measures to leadership responsibility.

Main lessons which can be learnt by the Healthcare Organisations.

- 1) There should be alignment between leadership and governance, which should be reinforcing.
- 2) Psychological safety is essential for effective escalation and risk management.
- 3) Data should be proactively employed to deterioration forecast and react.
- 4) The family and patients are key stakeholders in safety systems.
- 5) Systems should be proactive in managing risks as opposed to reactivity.

6.Recommendation

To attain long term improvement, the organisation needs to pursue an integrated strategy that deals with leadership, governance and system design.

1. Leadership Strategy

An integrated leadership approach is needed:

- **Transformational leadership** to develop a common vision and promote psychological safety.
- **Distributed leadership**/empower frontline staff.
- **A situational leadership** to make sure that the responses are fast and suitable.

Leaders need to be proactive in their own modeling, promote challenge and focus on patient safety more than on the hierarchy.

2. Governance Strengthening

The reforms in governance should consist of:

- Well defined roles, responsibilities and lines of escalation.
- Conformity to the standards of NHS England and Care Quality Commission.
- Regular, two-year-old, and safety huddles.

Both accountability and responsibility should be clear and quantifiable.

3. Communication and Systems Integration

Considerations should be made to make improvements on:

- Standardised communication means (e.g., SBAR)
- Electronic monitoring of patients.
- Multidisciplinary teamwork and joint decision-making.

This will help in minimizing fragmentation and enhancing coordination.

4. Efficiency Improvements

I. Technical efficiency:

- Use early warning systems to optimise clinical response.
- Eliminate repetition with combined electronic records.

II. Allocative efficiency:

- Resourcing according to patient acuity.
- Have enough staffing of risk areas.

5. Continuous Learning Systems

The organisation ought to incorporate:

- A just culture that fosters learning as opposed to blame.
- Ongoing professional growth and training in simulation.
- Feedback loop incident reporting systems.

The process of learning should be sustained, systematic and informational.

6. Stakeholder Engagement and Co-Production

The lesson focuses on stakeholder involvement and their joint production. To increase safety and confidence:

- Engage patients and families in the planning of care.
- Establish official lines of escalation of concerns.
- Use feedback to guide improvement of service.

7. Implementation Priorities

1. Leadership development programmes
2. Early warning systems (NEWS2) which are mandatory.
3. On the spot digital surveillance and reporting.
4. Multidisciplinary safety huddles
5. Enhanced patient and family interactions structures.

7. Conclusion

Lewis Blackman is an example of how a combination of leadership, governance, and system design failures can result in easily avoidable damage. Communication was inhibited by a hierarchical, transactional leadership style, and accountability and good oversight were not enforced by weak state structures. These failures were further aggravated by the lack of psychological safety, ineffective utilisation of safety data and the marginalisation of patient voice.

This discussion shows that leadership and governance are not two separate aspects of a complex healthcare system but rather, they are inter-related aspects. Good leadership creates an open culture of trust and proactive decision making and good governance creates

accountability, consistency and constant monitoring. These aspects form strong systems that can forecast and deal with risk when they are aligned.

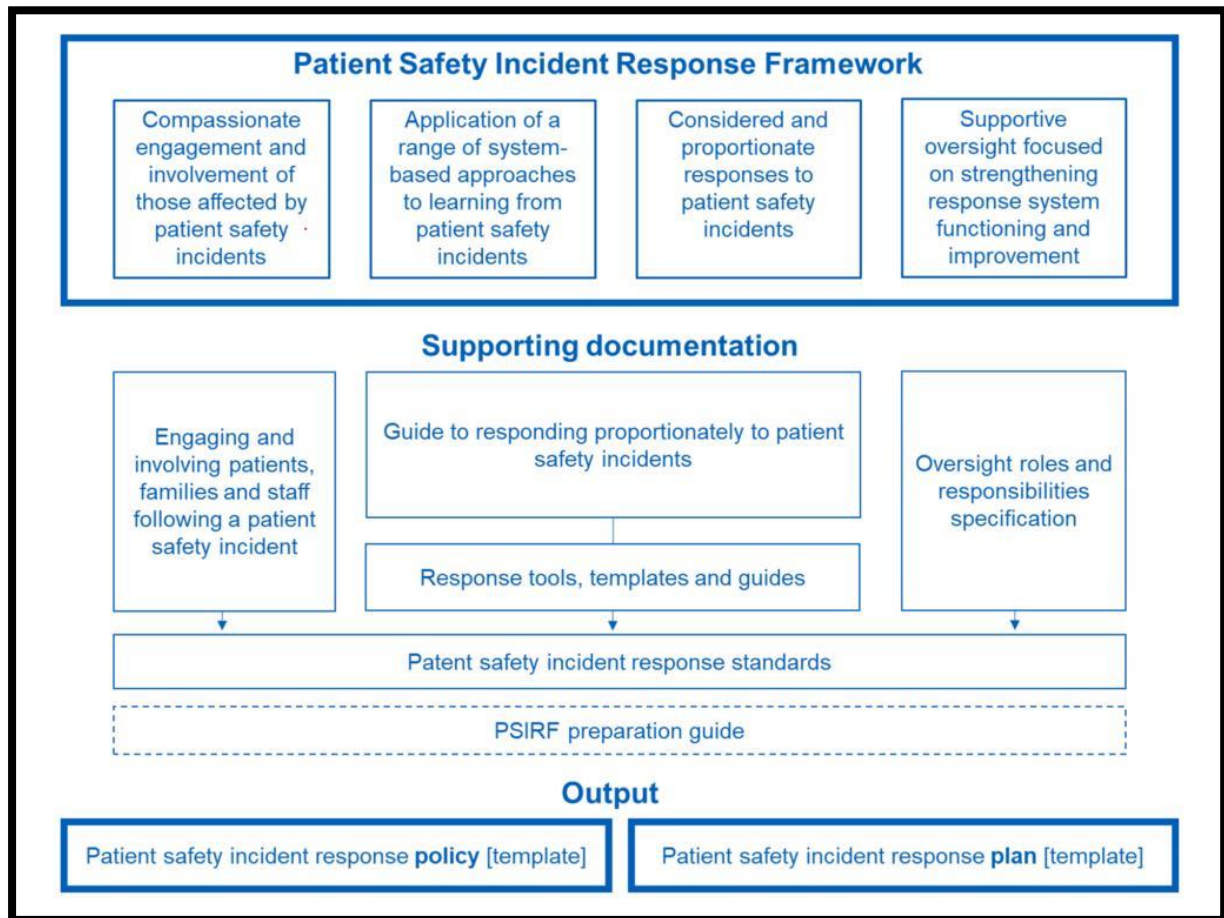


Figure 7: Human factors and system-based model showing interaction between leadership, communication, and patient safety outcomes. where to add and description in short

Figure 7 illustrates how human factors within healthcare systems, including leadership, communication, and organisational structure, interact to influence patient safety outcomes. It highlights that failures are not caused by individuals alone but arise from interconnected system weaknesses.

Systems thinking is another aspect that is highlighted in the case. The combination of organisational structure, leadership behaviour and feedback mechanisms are dynamic and have an impact on the results. Centralisation, inflexible leadership and poor feedback loops led to a system in this case that promoted risk as opposed to stopping it.

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Thank you for your time and consideration.

