Inform

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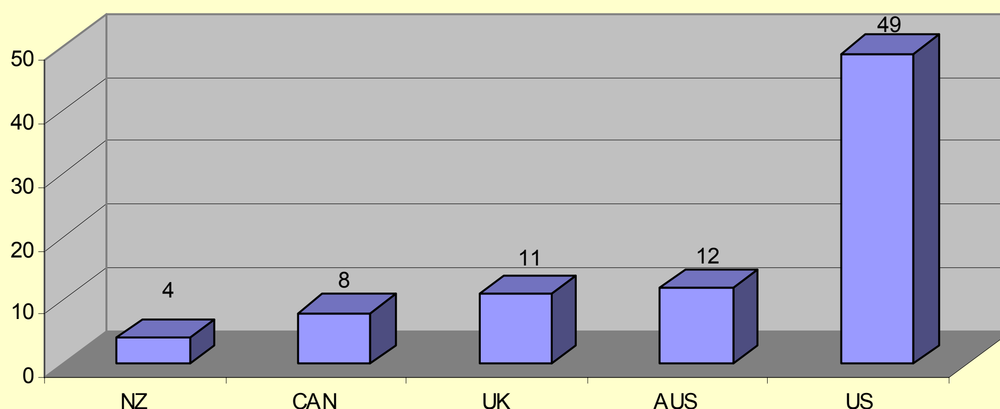
New Zealand hospital executives more satisfied than others with their health system.

The most recent Commonwealth Fund International Health Survey asked hospital executives in five countries – Australia, Canada, New Zealand, the United Kingdom and the United States – for their views on their nation's health care system, the level and quality of hospital resources and efforts to improve the quality of care. Findings show that hospital executives in New Zealand are more satisfied with their health care system than executives in other countries surveyed. The findings were reported in Health Affairs 23 (May June 2004) pp 119-35 and a summary is available at www.cmwf.org/usr_doc/data_us_745.pdf

The survey consisted of interviews with a sample of hospital chief operating officers or top administrators of the larger hospitals in each country

Staffing shortages, poor quality emergency room facilities and long waits for emergency department care were problems shared by all five countries. On a positive note, executives in all countries endorsed recognised strategies to improve quality of care, such as treatment guidelines, computerised ordering of drugs, and electronic medical records. Executives named information technology and electronic medical records as their top priorities for a one time capital investment to improve the quality of care.



Inadequate funding, staffing shortages and inadequate or outdated facilities were named as major problems facing hospitals in all countries. Other than the United States, executives in all other countries named inadequate, outdated and overcrowded facilities as one of the two biggest problems they face. That is linked to the finding that United States hospitals were in a far better financial state. New Zealand respondents were more concerned than English and Canadian respondents about losing patients to competitors – 4% to 7%. But only half as concerned as 16% of Australians were.

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Across all countries, respondents were critical of their hospital's emergency department. At most, a third of hospital executives rated their emergency departments as excellent, while about one fifth to one half rated them as only fair or poor (New Zealand 30%). Emergency Department waiting times of more than 2 hours were highest in the United Kingdom 58% and lowest in New Zealand 17%. New Zealand hospitals reported the fewest diversions to other hospitals because of a lack of emergency department or inpatient capacity. They also reported the least discharge delays due to limited post hospital care, suggesting better co-ordination among primary, emergency, and community based care providers.

Although virtually all hospitals in the five nations have some type of system for identifying and addressing medical errors, only one in four of the hospital executives in the US, UK and Australia were likely to respond that their system was effective. Even fewer in Canada and New Zealand reported this. Hospital executives in the US and UK were significantly more likely than their counterparts in the other countries to say that physicians in their hospital were very supportive of reporting and addressing medical errors.

Eighty percent of executives in all five countries endorsed the use of electronic medical records, computerised ordering of drugs, treatment guidelines for common conditions and comparisons of medical outcomes with other hospitals, rating them as at least somewhat effective in improving quality of care.

A majority of the executives approved of the public disclosure of quality data on hospital performance, the frequency of specific procedures and public satisfaction ratings. However, in a likely reflection of malpractice concerns, over 30% of US and Australian executives said that medical error rates, mortality rates for elective procedures, average waiting times for specific procedures and noscomial infection rates should not be reported to the public.

Hospital staffing concerns were named a top concern in all five countries. The impact of staffing shortages and facility constraints is evidenced in cancellation rates for scheduled surgeries and procedures. Surprisingly, New Zealand respondents expressed the lowest level of concern over staffing shortages.

Across all five countries, the majority of respondents named high start up costs as a major barrier to expanding the use of computer technology. Projected maintenance costs, insufficient technical staff and a lack of uniform industry standards also were seen as major barriers.

Quality of Hospital Resources

Percent rating as only fair or poor:	NZ	AUS	CAN	UK	US
Intensive care unit	10	9	13	11	5
Operating rooms or theatre	12	7	20	17	5
Diagnostic imaging equipment or other medical technology	22	13	19	18	4
Emergency room or department faculties	30	21	48	17	19

Two Biggest Problems Facing Hospitals

	NZ	AUS	CAN	UK	US
Inadequate Funding	57%	58%	62%	39 %	16%
Inadequate reimbursement	-	8	-	-	60
Staffing shortage	54	45	54	64	47
Inadequate/overcrowded/ outdated facilties	54	32	54	42	7
Indigent care/uninsured	-	-	-	-	17
Malpractice costs	-	6	-	-	11

These two tables suggest some conflicting perception issues

Hospital Staffing Shortages

Percent reporting serious shortages of:	NZ	AUS	CAN	UK	US
Nurses	11	23	30	22	31
Pharmacists	14	26	33	27	14
Specialists or consulting physicians	7	11	26	17	16

Management Speak

A magazine recently ran a "Dilbert Quotes" contest. They were looking for people to submit quotes from their real-life Dilbert-type managers. Here are the top five finalists:

1. As of tomorrow, employees will only be able to access the building using individual security cards. Pictures will be taken next Wednesday and employees will receive their cards in two weeks. (This was the winning quote from Fred Dales, Microsoft Corp. in Redmond, WA)

2. What I need is an exact list of specific unknown problems we might encounter. (Lykes Lines Shipping)

3. E-mail is not to be used to pass on information or data. It should be used only for company business. (Accounting Manager, Electric Boat Company

4. This project is so important, we can't let things that are more important interfere with it. (Advertising/Marketing manager, United Parcel Service)

5. Doing it right is no excuse for not meeting the schedule. (Plant Manager, Delco Corporation)

Dirty hospitals named and shamed on health service sick list

A list of England's dirtiest hospitals published by the Government this month showed that more than half had borderline standards of cleanliness, or worse.

The latest results from local inspections by "patient environment" teams found 118 NHS hospitals, just 10% of the total, had "excellent" standards of cleanliness. In a further 456 hospitals standards were "good". The largest group in the ratings, 583 hospitals (49 per cent), had only "acceptable" standards. In another 24, standards of cleanliness were "poor" and in three, all mental health wards or units, the standard of cleanliness was "unacceptable".
Lord Warner, the health minister, said that the proportion of hospitals with levels of cleanliness found to be only acceptable was "unfortunately large". He said: "We want to see a lot more in the good and excellent categories".
Hospitals in which standards were found to be excellent, ranged from small cottage hospitals such as Honiton Hospital in east Devon to major teaching hospitals such as Birmingham Heartlands Hospital.

Lord Warner said the level of MRSA infection acquired in hospitals had stopped its steep rise and was tailing off. Last year the "superbug", MRSA, accounted for 40 per cent of the staphylococcus aurius infections. This has been about the same proportion since 2000 when mandatory reporting of MRSA was introduced.

Defending the Government's record on MRSA, Lord Warner said: "The idea that no action has been taken is nonsense and I would like to emphasise that the growth in staphylococcus aurius and in resistance began taking off in about 1993."
Scientists say that there is no evidence that dirty hospitals cause MRSA but Lord Warner said the two were linked in the public mind. "This is the public perception. If a hospital is well cleaned it is likely that it has good infection control procedures."
Christine Beasley, the chief nursing officer, launched a "model" cleaning contract to set national standards and help senior nurses, matrons and administrators ensure the necessary levels of cleaning. This divides hospitals into four areas, from "very high risk" such as operating theatres and accident departments to "low risk" areas such as offices.
Previously hospitals were given "red, yellow, green" ratings. In 2002 no hospital was given the worst, "red" rating; 41.7 per cent rated yellow and 22 per cent green.

The Royal College of Nursing said: "Unless steps are taken to increase numbers of cleaning staff massively in the NHS, the RCN has serious doubts that the new guidance will have the necessary impact on reducing health care associated infections". Dave Prentis, the general secretary of Unison, the public service union, agreed. "There is no complicated formula," he said. "If you want cleaner hospitals, if you want to fight off superbugs, you must have more cleaners."

The worst offenders

Edale Unit - Manchester Royal Infirmary	Manchester Mental Health & Social Care Trust	Mental Health	Unacceptable
York House - Manchester Royal Infirmary	Manchester Mental Health & Social Care Trust	Mental Health	Unacceptable
Clifton & Abberley Ward	Worcestershire Mental Health Partnership NHS Trust	Mental Health	Unacceptable
Heanor Memorial Hospital	Amber Valley PCT	General Acute	Poor
St Martin's Hospital	Avon And Wiltshire Mental Health Partnership NHS Trust	Mental Health	Poor
Edgware Community Hospital (Barnet)	Barnet PCT	General Acute	Poor
St Ann's	Barnet, Enfield & Haringey Mental Health Trust	Mental Health	Poor
Lichfield Victoria Hospital	Burntwood Lichfield And Tamworth PCT	General Acute	Poor
Mile End (Main Site At Tower Hamlets PCT)	East London And The City Mental Health NHS Trust	Mental Health	Poor
Summerdale Court	East London And The City Mental Health NHS Trust	Mental Health	Poor
Mount Vernon Hospital	Hillingdon Hospital NHS Trust	General Acute	Poor
Peel Court - Rehabilitation & Continuing Care	Leeds Mental Health Teaching NHS Trust	Mental Health	Poor
Department Of Psychiatry (Pilgrim Hospital)	Lincolnshire Partnership NHS Trust	Mental Health	Poor
Hitchin Hospital	North Hertfordshire And Stevenage PCT	General Acute	Poor
Lea Castle	North Warwickshire PCT	General Acute	Poor
Arnold Lodge Regional Secure Unit	Nottinghamshire Healthcare NHS Trust	Mental Health	Poor
Ward B2 - Bassetlaw Hospital	Nottinghamshire Healthcare NHS Trust	Mental Health	Poor
Oxford Community Hospital	Oxford City PCT	General Acute	Poor
Radcliffe Infirmary	Oxford Radcliffe Hospital NHS Trust	General Acute	Poor
Duchess Of Kent House	Reading PCT	General Acute	Poor
Cane Hill	South London And Maudsley NHS Trust	Mental Health	Poor
Evesham Community Hospital	South Worcestershire PCT	General Acute	Poor
Malvern Community Hospital	South Worcestershire PCT	General Acute	Poor
Moorgreen Hospital	Southampton City PCT	Mental Health	Poor
Mile End Hospital	Tower Hamlets PCT	Mental Health	Poor
Lincoln County Hospital	United Lincolnshire Hospitals	General Acute	Poor
Perseverance House	Walsall PCT	Mental Health	Poor

Source: Department of Health

A Canterbury Tale

At the last meeting of the year we were delighted to have Stephen Boardman from Finnnamore Management Consultants in the UK talking about the Bristol heart scandal from an insider's perspective.

An appreciative group of around 25 were sumptuously feed and watered courtesy of Eurest (NZ) Ltd - special thanks to Ludovic Mahu and his team from Christchurch Hospital. As usual it was hard to tear people away from the networking to settle for the presentation but it was well worth while when we did

Stephen started with the iconic nature of the Bristol scandal quoting a very recent review of the Emergency department in Christchurch: "In the last decade our belief in the safety of our health systems has been shattered by Bristol, the King Edward and other hospital and system failures". He then focussed as much on what he did not know about the issues at the time as the issues themselves and pointed very clearly to the systemic structural issues which allowed the problems to exist without proper oversight. He described Bristol as led by a man who was a transformational leader with little interest in detailed systems who tolerated managers and despised administrators. The hospital was run on a very medical model with the surgeons who were failing in positions of authority. There was a very strong "club culture" in the organisation. The poor clinical outcomes from the heart unit were never discussed at a senior management level within the organisation.

The GMC hearings following the revelations by an anaesthetist whistleblower led to the formation of NICE (National Institute for Clinical Excellence) http://www.nice.org.uk/ and Commission for Healthcare Audit and Inspection (CHAI) www.chai.org.uk and more recently the National Patient Safety Agency (NPSA) http://81.144.177.110/

Now Bristol consistently scores as one of the top hospitals in the UK in paediatric and cardiac surgery outcomes but the iconic status lingers.

Stephen went on to discuss the findings from Kotter and Heskett, studying a larger sample of US firms and their long term economic performance. They identified successful companies as having strong and effective company cultures which were aligned with the company's business strategy; were responsive but maintained core values and met the needs of key stakeholders (customers, employees and owners). They conclude that corporate culture was 'more powerful than anything else', including strategy, structure, leadership, financial analysis or systems, in determining corporate success.

"The culture of the future must be a culture of safety and quality: a culture of openness and accountability, a culture of public service, a culture in which collaborative teamwork is prized and a culture of flexibility in which innovation can flourish in response to patient needs"

He left us with a scenario:

You are having lunch in the staff cafeteria and overhear two anaesthetists talking about a vascular surgeon's high mortality rates. This is not the first time you have heard these rumours. What would you do? What should you do?

At the conclusion of his presentation there was further discussion around the different contexts of clinical governance (UK vs. NZ).

Thanks to all of you for your support during the year with special thanks to Bruce White (chief logistical support organiser), Pauline Barnett and Ian Sherrin from the School of Medicine (speaker support), the Canterbury District Health Board (data projector, communications, and venue) and Eurest (NZ) Ltd (excellent provisions and venue). We look forward to next year's programme - as always we are on the look out for speakers and suggestions are welcome.

Merry Christmas to all

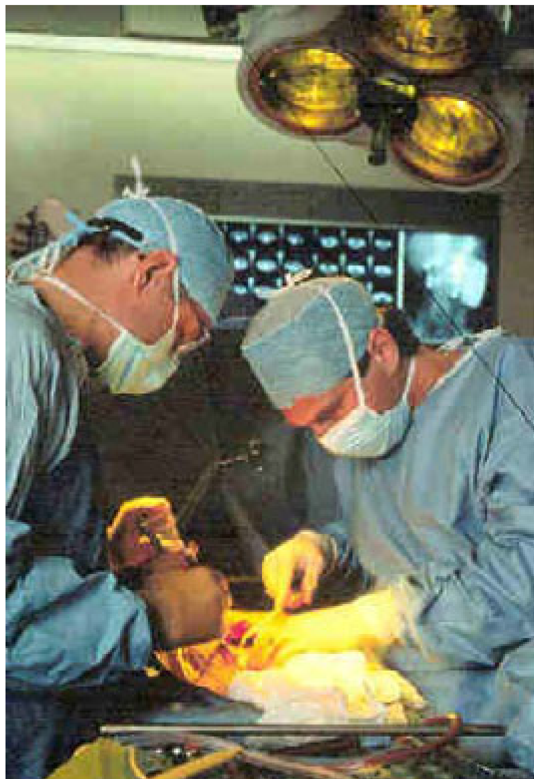
Michael Aitken FCHSE
Vice President
NZIHM/ACHSE

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz

NHS Revolution: Nurses to train as Surgeons

Ministers are planning a revolution in the NHS under which nurses will be trained to perform surgery to help reduce hospital waiting lists. John Reid, the Secretary of State for Health, is desperate to increase the surgical workforce to meet a government pledge that no one will wait longer than 18 weeks for treatment from GP referral by 2008.



Predictably, Doctors have accused ministers of misleading the public and "sacrificing patient safety" by drafting in nurses in the rush to get waiting lists down. Figures published this month show that despite a 35 per cent fall in hospital waiting lists in the past six years, there were still 857,200 people waiting for operations at the end of October, with 69,000 waiting more than six months.

Under the Government's plans, a wide range of operations, including hernia repair, vasectomies and arthroscopies (internal examination of joints), will be performed by surgical care practitioners - nurses, physiotherapists and operating department assistants - after two years of training. Between 4,000 and 5,000 will be appointed over the next decade, depending on demand. They can qualify with five GCSEs, the minimum required to become a nurse, and will provide support to consultant surgeons as well as operating alone. A consultation document to be published in the New Year proposes three grades of practitioner - basic, senior and advanced - who will be paid up to £35,000 a year.

The move has provoked anger among medical organisations. Paul Miller, the chairman of the British Medical Association's consultants committee, said: "Ministers seem to be cutting corners and sacrificing safety in order to increase the number of people operating to bring waiting lists down. The title [surgical care practitioner] is misleading and dishonest - these are non-medically qualified surgeons. The NHS takes the best part of 15 to 20 years to train a surgeon and patients have to know who is going to operate on them. We have considerable doubts about the adequacy of the training these practitioners are to be given."

Matthew Freudmann of the British Orthopaedic Trainees Association, representing junior surgeons, said: "It is preposterous in terms of public safety. The Government cannot do what they are proposing to do without lowering standards. It represents a fundamental change in the way we practise surgery in this country." He added: "[The practitioners] will operate without a consultant surgeon present, pretty much unsupervised. You can imagine the delight of hospital managers who will have a biddable group of people to take patients off the waiting list. The Government is trying to introduce this without a public consultation ... on the sneak."

The move comes as a new NHS pay system, Agenda for Change, is being introduced designed to encourage staff to work more flexibly. Supporters see it as a way of developing unused talent in the NHS workforce and accuse surgeons of protecting vested interests. But critics say the political pressure to cut waiting lists could force the NHS to compromise on training, threatening standards and endangering patients. Major reforms to surgical training for doctors, to be introduced by the Royal College of Surgeons in 2007, are already causing alarm about falling standards. They will see consultants appointed after six years of postgraduate training, half the current minimum of 12. Junior doctors are also working fewer hours, following a European Union directive, further reducing the availability of surgical manpower and time for training.

Hugh Phillips, president of the college, said the consultants of the future would have to be trained more intensively to ensure standards were maintained. "I am very concerned because I don't see any move from the Government to fund [the training] in an appropriate way." From 2010, there would be one junior surgeon in training for every five consultants, Mr Phillips, an orthopaedic surgeon, said. Consultants cannot operate without assistance from junior surgeons. "So who is going to support the other four consultants? It is in my view perfectly reasonable to skill other people in the team to do the work," he said. He dismissed as "scaremongering" the suggestion that the practitioners might carry out these procedures, alone and unsupervised.

Jill Biggins, who chairs the National Association of Assistants in Surgical Practice, said the plans to train nurses were aimed to fill a gap in the clinical service caused by the shortage of junior doctors. There are 400 practitioners working in the NHS carrying out procedures such as stripping the veins from the leg for coronary bypass surgery, but they have had no formalised training programme. "Within the next decade there could be 4,000 to 5,000 practitioners. We are not mini-doctors. This is a way of filling the gap," she said. A spokeswoman for the NHS Modernisation Agency said: "We are trying to give NHS staff more opportunities. This is about ensuring that people who have got the potential and the skills are being used effectively."

New Zealand Institute of Health Management
A Branch of the Australian College of Health Service Executives

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Inform Editor Bruce Parkes

HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

The Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) has released a new tool to help hospitals and health care systems evaluate employee attitudes about patient safety in their facilities or within specific units.

The survey on patient safety culture—which was released in partnership with Premier Inc., an alliance of not-for-profit hospitals and health care systems; the Department of Defence; and the American Hospital Association—is designed to allow hospitals and health care facilities to measure organizational conditions that can lead to adverse events and patient harm, officials said.

"Improving patient safety is not just a function of having the best research findings available," said AHRQ Director Dr. Carolyn M. Clancy. "There has to be an environment or culture that encourages health professionals to share information about patient safety problems and actions that can be taken to make care safer, and that also supports making any changes needed in how care is delivered."

According to AHRQ, assessments of patient safety culture typically include an evaluation of a variety of organizational factors that have an impact on patient safety, including: awareness about safety issues, evaluating specific patient safety interventions, tracking changes in patient safety over time, setting internal and external benchmarks, and fulfilling regulatory requirements or other directives.

The survey was pilot tested with over 1,400 hospital employees from 21 hospitals in the United States to ensure that the items were easily understood and relevant to patient safety in a hospital. The survey can be found online at www.ahrq.gov/qual/hospculture.

Seminar Programme

January 25th

Celebrate 2005

@ Sky City
5:00p.m.

Free from the Christmas rush, the Auckland Committee invite you to welcome in the New Year at a social function at Bar 3 (level 3, next to the sky bridge to the new convention centre) – Refreshments supplied. All members and prospective members are welcome to attend this informal gathering where we will discuss plans for the coming year and also host a brief AGM. We do hope you are free to attend. We promise, there will be no danger of being elected to the committee (if you would really like to join the committee contact Trisha Dunn at Gillies Hospital) Please RSVP for catering purposes to admin@nzihm.org.nz

Eurest supports our seminar programme

Thank You

The Auckland Branch Committee thank all of you. Our members, supporters and friends for your support during 2004. We have really enjoyed the constant flow of old and new faces at our seminars and social functions. Healthcare is one big family and we are encouraged, supported and learn from those whom we meet and share experiences across the sector. From acute care to residential care, community and primary; public to private and NGO.

At our Committee dinner we were discussing the diverse ways our organizations recognized the contribution of staff during the year. Whatever the material reward, we all agreed that our real reward was a personal satisfaction in knowing we had worked hard to make a contribution in our area of operation.

Healthcare is a 7x24 operation. We trust you all have some time for work respite and family pleasure. Rested and restored, please try and join us for our social event at Sky City in January.

Bruce Parkes