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THE BRISTOL INQUIRY: AT FIRST HAND

Our Eurest sponsored September seminar featured Hugh Ross, who has been the Chief Executive of the United Bristol Healthcare NHS Trust since October 1995. Bristol is one of the largest hospital and community service NHS Trusts, employing 7500 staff with 9 Hospitals and a turnover of some £200m per annum. Hugh's key role was to lead the Trust through the first published report on past performance in paediatric cardiac surgery, the subsequent General Medical Council investigation and the Bristol Royal Infirmary Public Inquiry. Hugh has since left his position at Bristol and is now taking up a project director roll within the NHS.

Hugh's presentation attracted our largest attendance this year, 80 people, from a wide range of clinical and managerial disciplines. The 40 minute presentation sparked 30 minutes of questions from the audience. For those unable to attend through other commitments, we present a summary of our notes from Hugh's address.

"Very briefly, what happened in Bristol was that over a prolonged period significant excess mortality and morbidity following paediatric cardiac surgery. Between 1991- 1995 as a result of the poor standards of surgery in Bristol it is estimated that there were between 30 and 35 excess deaths compared to comparable institutions in the UK. There are no estimates before this time. Some 40 claims for damages have been settled to date. There are some 200 claims in total and the eventual liability is estimated to be in the circa of £20 m. This, in a country with a relative primitive litigation system. The whole episode has in many ways been a watershed for the National Health Service and has led to many changes

The Public Inquiry, which followed a General Medical Council inquiry, was the first body that got to grips with what actually happened. During the GMC inquiry we witnessed on a nightly basis very distressing scenes of abuse even assault on doctors as they left the inquiry. Parents used shoeboxes as cardboard coffins and everyday we would have rows of these "coffins" lined up on the pavement outside the inquiry.

Professor Sir Ian Kennedy, the chairman of the Public Inquiry, is a well known academic lawyer with a long standing interest in medical/legal issues. Most of us thought he was an excellent choice to head the inquiry and he assembled a high powered team, another lawyer with an interest in children's issues, a senior nurse, and a professor of epidemiology. To his credit he widened the terms of reference and undertook to do nothing more than publish a critique of the National Health Service over those years. The inquiry was exhaustive and thorough with 577 witnesses, of whom 80 or 90 gave evidence in person over a 90 day period. I myself gave evidence on 3 occasions about what I had found when I came to the Trust.

There were 238 parents, 1800 medical records and 900,000 pages of documents. This put our medical records systems to very severe test, which they just about passed. The opportunity cost of providing all this information to the inquiry was enormous. There was no recompense to the Trust and people would argue that there should not be any recompense both for the actual costs and the huge opportunity costs.



Hugh Ross

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Catering Management
Specialists

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Professor Kennedy and the inquiry brought in teams of international experts to look at things that came up in the inquiry. Throughout the inquiry there were strong informal links between the Trust and the inquiry back up team. Although Professor Kennedy and the Inquiry panel properly kept their distance, the secretariat were in touch all the time so we were able to work with them and schedule key witnesses so as not to disrupt ongoing hospital service.

This was a court of inquiry, not court of law so no aggressive cross examination was allowed of witnesses, many of whom were very stressed and distressed. All questions came from panel, not from lawyers so both parents and staff were able to talk freely in a less intimidating atmosphere.

The inquiry attracted intense public interest and there were lawyers aplenty but they were only allowed to speak when invited to speak to make points of clarification. Therefore, the inquiry was not confrontational and both parents and staff were able to talk much more freely.

Before the inquiry, the chairman of Trust, who is a wise bird, said no action would be taken by the Trust against any member of staff for anything that came out in the inquiry. That sent an extremely important signal to staff that said, we know you did not come to work to do a bad job, we know you did your best and this inquiry is about going forward.

The issue of retained organs came up through a comment by the President of the Royal College of Pathologists who almost in passing mentioned that in all the major children's centres in the UK there was a policy of retaining organs from post mortems for teaching and research. To those of us who worked in teaching hospitals for many years this was no surprise but to the public and the media it came as an absolute bombshell. This was distressing for many parents and brought an explosion of anger. Fortunately, at Bristol the collection was of moderate size and had been gathered and used responsibly. Whereas another inquiry found the manner another collection at the Allderhay Hospital in Liverpool had been put together skated at the edge of acceptability and some criminal proceedings followed that inquiry. Our laws in the UK around retention are a really difficult issue.

Kennedy made two very important findings. First, he said that this is not a story about bad people. Everyone had come to work to do their best even though we could see with hindsight that their best was not good enough. Second, it was not about lack of data, Bristol was awash with data. It was about systemic failure - poor communication, teamwork, resources and equipment, planning and monitoring. These things are endemic in inquiries around the world. He identified a lack of insight by surgical team into their performance, which could not have come about in a culture of continuous quality improvement.

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One area where we fell down was in our support to families. Family support was provided by well meaning volunteers who are excellent people in their own right but had not received training in counselling. These volunteers found it difficult to deal with the families of the failures and withdrew their support, which lead the families becoming more and more marginalized and to comment that they felt they had been abandoned.

The issue of informed consent is an international issue and is one we are still trying to get to grips with in the UK and when my surgeons come to me and say that they are having trouble getting through their workload because the consultations are longer through the need to explain to patients the risks and benefits of certain procedures, then at least I know that at least we are getting into a debate on what true informed consent is. The Department of Health, as in so many things, rushed out new guidelines and consent forms and sadly as is the case in many things done in haste these things don't seem to be practical and we are already having big and they will have to be redrafted.

Kennedy thought issues around quality and safety and professional regulation could, as far as he was concerned, wait for another time and a couple of our Secretaries of State have said to the General Medical Council that this is their last chance for professional self regulation and I think the GMC is running very hard to try and catch up and develop a system of medical self regulation that is really accepted by the general public and the politicians.

The Inquiry made nearly 200 recommendations grouped into 7 categories.

- ✘ Respect and honesty
- ✘ A health service, which is well led
- ✘ Competent healthcare professionals
- ✘ The safety of care
- ✘ Care of an appropriate standard
- ✘ Public involvement through empowerment
- ✘ The care of children

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The government response started before Kennedy said what he had to say. For example, we saw the term 'clinical governance' back in 1997 when the new Labour government took over and produced some fundamental documents about the future work of the NHS. The response included the introduction of Commission for Health Audit and Inspection and a National Institute of Clinical Excellence (which has been completely hijacked by the drug rationing agenda).

The government accepted almost all the recommendations with one major exception. Kennedy said that managers should be regulated in the same way as other professions. The government said that they preferred that for managers there be a voluntary code of conduct

While Kennedy said that managers should be regulated in the same way as other professions, the government preferred a voluntary code of conduct

A National Clinical Assessment Authority has been introduced, which is meant to give support to medical directors and people like that to try and stop persistent problems before they end up on the steps of the General Medical Council or a newspaper. This is not a substitute for employers' responsibility and it only applies to doctors, which has been something of a bone of contention. In an attempt to gain from every critical incident report, the introduction of National Patient Safety Agency, so we can spot trends and early warnings much more successfully than we have done in the past. One of the things that exercises our Chief Medical Officer most is when the same mistake happens in some hospital every year. On a couple of occasions he himself has gone to meet the families to apologise for the NHS failing to learn the lessons.

Some of the things Kennedy recommended and which the government agreed in their formal response in February 2002 included:

A National Service Framework for children. Prior to this in the UK there had been no standards for paediatric cardiac surgery. There were none because nobody had written them down. We now have a number of national service frameworks. I think that the framework will lay down clear care pathways and targets for access to services

In the UK each professional group has been regulated in silos. Therefore, there was no effective open communication across the silos because they were all subject to different regulations and hierarchy. Kennedy recommended to the government the breaking down of those regulatory barriers and as is often the way the government responded by creating a new body, the Council for the Regulation of Healthcare Professionals. I expect they will be told to start merging the regulatory frameworks. I understand that in New Zealand you are ahead of us, as you are in a number of things and I will be interested to hear how that is perceived by the professionals.



Kennedy identified that, at the time, there were not a lot of inspectors, auditors and regulators wandering around the system. There wasn't enough then, there are probably too many now. One of my Chief Executive colleagues estimated that his organisation could be inspected by 37 different bodies, some of whom would need to give only a few weeks notice and you will know how difficult it is to prepare for these inspections.

Again, the government decided to set up a National Council for the Quality of Health Care. I haven't heard much about this and I suspect that there is an enormous turf war going on behind the scenes as some of these bodies fight for survival. As far as I am concerned it cannot happen soon enough for the hard pressed persons on the ground.

Kennedy said Bristol was awash with data and nobody did anything with it and that is true. We have the bizarre situation in England where because of management cuts and reorganisation a lot of the organisational memory and good work in comparing and looking out outliers has been lost. So now we are at the mercy of private companies who come along and collect the information from us, manipulate it and present it back to us for a large fee. Kennedy said that he thought that this was disgraceful. The government agreed and established the Office for Information on Healthcare Performance, which will gradually sweep up all the clinical indicators and all the other performance indicators that we use.

We have the bizarre situation where we are at the mercy of private companies who come along, collect information from us, manipulate it and present it back to us for a large fee.

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Kennedy noted at the time and subsequently we fail to have proper system for the appraisal and revalidation of Consultants and the appraisal for medical staff was lagging behind the other disciplines. We are only getting going with the appraisal agenda. I think that there is reasonable goodwill and understanding that this is necessary and the Colleges recognise that references from a couple of mates and certificates from a couple of CPE events is not good enough.

Kennedy was very critical of the NHS for not publishing clinical performance data. That is now being done but has to be approached with incredible sensitivity. In New York State when they did this, in a short space of time 10 – 15% of cardiac surgeons gave up cardiac surgery and now there is a problem of access to cardiac surgery. We had a recent Secretary of State who believed everybody could be above average so there needs to be a lot of education around this and snapshots can be very misleading.

Kennedy said that there had been a considerable vacuum of leadership all the way from the operating theatre to the Secretary of State and there had been a failure to make use of the wide range of talent available. The outcome of that is a planned NHS University, which will eventually accredit development and training for each of the 1 million staff in the National Health Service and will eventually accredit the undergraduate curricula at all other universities.

Vacuum of leadership

Kennedy was very critical of the stop go approach by central government to I.T. investment in the NHS. We went through the National direction phase then the government withdrew in confusion and said "here is some money go and do it yourself", whereas the Scots got it right and said there would be one system for everybody. The government is now going to put a lot of money into IT. The money will come from part of the planned increased spending on health by 2020 from 7 to 10% of GDP.

All this has taken place against a background of continuing organisational change. I used to think New Zealand changed their structures more regularly than we did but I think we are trying to catch up. Our last two or three years have been a whirl of change events and every layer in the hospitals have tried to change their structure in some way. There has been a lot of cultural change around clinical performance and I think that we are much better now but it is a very difficult area for managers and there are many views about what is truly managerial responsibility.

There was a background of continual organisational change.....

I think we are trying to catch up to New Zealand.....

A whole superstructure is going to be set up alongside the NHS, independent but part of it, to further the interests of patients and there will be an 8 to 10 person patient forum in every Hospital Trust, Ambulance Trust, Mental Health Trust and Public Care Trust who will have the right to select one of their members to sit on the Board of that Trust as an additional non executive Director. People are speculating now whether that appointed person would be expected to accept the full corporate responsibility a Director takes and interest themselves in activity across the full range of Board functions, or just confine themselves to patient advocacy matters. My own experience is that these people often have a passion or focus on one particular disease or issue and do not have the capability or interest in addressing the full range of issues confronting a Trust. The government will require each Trust to set up a network of Patient Advice and Liaison services and some Trusts have been operating these for some years.

We have a media driven government who, more than any government before, are very conscious of the power of the media. One or two of the national dailies have an anti NHS agenda and nearly every day point out the failures of the NHS and rarely the successes in the same terms. The government are very sensitive to what goes on in the media and the Secretary of State never fails to start talking with managers without saying "have you seen what's in the bloody Daily Mail today?" We are now required to manage the reputations of our organisations in a very public way and we are constantly being advised by senior civil servants on the "line to take" on any issue. Within that there is very strong personal pressure on health managers and their personal accountability is growing all the time wrapped up within a much wider corporate governance and risk management agenda.

We have a media driven government and are constantly being advised on "the line to take".

Notes by Bruce Parkes



Networking and catching up. An integral part of our branch seminars



New Zealand
Institute of Health
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A Branch of the
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Executives

For all inquiries re Branch activities or membership contact nzihm@xtra.co.nz or (09) 577 5477 Phone/Fax



Up coming Seminars

Both at Minter Ellison Offices, Level 24, BNZ Tower Building, 125 Queen St 5.30 for 6 p.m.

Light refreshments supplied

Non Members Welcome

Cost:
Members \$20
Non Members \$30

October 24th

Do governments actually have the capacity to reallocate health resources to meet policy goals?

Presented by Tim Tebensel
University of Auckland

November 20th

Challenges facing GPs and their ageing workforce

Presented by Tony Hanne GP and Senior Lecturer at Dept of General Practice, University of Auckland

Profile

Auckland Branch Treasurer Allan Johns has worked in the Health sector for thirty years. His eclectic career has included positions in Laboratories, Clinical Support, Planning and Development and latterly the ADHB Building Programme.

For the past four years Allan has been engrossed in the planning and now execution of the \$500m redevelopment of the Auckland District Health Board's Grafton and Greenlane sites.

Allan played a key role in the preparation and approval of the Business Case for the redevelopment, which was approved in 1999. To date a new Laboratory Building, and Carpark have been completed, a new Acute Mental Health facility is nearing completion and work is underway on the new Auckland City Hospital, and the Greenlane Clinical Centre. Allan's roles include Project Director of the Equipment and Technology Project, Project Director for the Migration of services to the new facilities, Assistant Programme Director and Probity Officer for the projects.

Allan has been Treasurer of the Auckland Branch of the NZIHM for six years and until recently served on National Council



Morality Tale

There was a health manager who found herself sitting next to a Lawyer on an airplane. The lawyer just kept bugging the health manager wanting her to play a game of intelligence. Finally, the lawyer offered her 10 to 1 odds, and said every time she could not answer one of his questions, she owed him \$5, but every time he could not answer hers, he'd give her \$50.00. The lawyer figured he could not lose, and the health manager reluctantly accepted.

The lawyer first asked, "What is the distance between the Earth and the nearest star?"

Without saying a word the health manager handed him \$5. then she asked, "What goes up a hill with 3 legs and comes back down the hill with 4 legs?"

Well, the lawyer looked puzzled. He took several hours, looking up everything he could on his laptop and even placing numerous air-to-ground phone calls trying to find the answer. Finally, angry and frustrated, he gave up and paid the health manager \$50.00

The health manager put the \$50 into her purse without comment, but the lawyer insisted, "What is the answer to your question?"

Without saying a word, she handed him \$5.

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 nzihm@xtra.co.nz