Hospital Governance: can Medicine, Ethics, the Law, Compassion and Wisdom find common ground?

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Conference Proceedings & Report

ADELAIDE HEALTH POLICY INITIATIVE

THE ADELAIDE HOSPITAL SOCIETY

TRINITY COLLEGE DUBLIN

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Preamble

The Adelaide Health Policy Initiative (AHPI) was established in 2009 by the Adelaide Hospital Society (AHS) in conjunction with the Department of Public Health & Primary Care, Trinity College Dublin. The AHPI has been instrumental in advocating for a fair and equitable health system through the development of a universal single-tier health service, which guarantees access to medical care based on need, not income. The AHPI is recognised as developing evidence-based policies that will help to implement progressive change within the Irish healthcare system. The AHS has made a policy decision to develop the AHPI as part of its strategic plan. The maxim of the AHPI is Observe, Comment, Contribute and to this end a meeting was convened to discuss aspects of the ongoing and forthcoming hospital reforms within Ireland.

Speakers

Dr Catherine Darker, Adelaide Assistant Professor in Health Services Research
Opening remarks

Dr Ambrose McLoughlin, Secretary General, Department of Health
An oversight of the proposed Governance structures for Hospital Groups and an update on progress.

(Shared Legislative session) Senator Ivana Bacik, Barrister-at-Law & Dr Adam McAuley, Law Lecturer, Dublin City University
The utility of legislation to help or hinder hospital governance in a compassionate, patient focused, healthcare system.

Dr Rhona Mahony, Master, National Maternity Hospital, Holles Street, Dublin
Clinical and operational challenges of a major hospital operating under the new governance structures of a hospital group.

Dr Dónal O'Mathúna, Senior Lecturer in Ethics, Dublin City University
The interface between ethics and the integrity of governance.

Professor Gabriel Scally, Director of the WHO Collaborating Centre for Healthy Urban Environments; formerly Director of Public Health at NHS South of England.
Lessons learned from UK enquiries into complexities of hospital governance, clinical negligence and patient care.

Dr Fergus O'Ferrall, Fellow of the Adelaide Hospital Society
Discussant

Professor Ian Graham, Chair of Adelaide Hospital Society
Closing remarks

Dr Simon Mills, Barrister-at-Law
Chair of meeting

Summary of key points and outstanding questions arising from the meeting:

- The meeting was substantially influenced by the report to the Minister for Health by Professor John Higgins 'The Establishment of Hospital Groups as a transition to Independent Hospital Trusts', referred to as the 'Higgins Report' and the AHPI's wish to foster an objective and authoritative opinion on this document.

- Appointments to Hospital Group Boards – In the Higgins report, it is suggested that the Minister appoints the Chair and the Chair submits the names of Board Members to the Minister. This is likely make the Board members in effect political appointees. It was the firm opinion of the meeting that this is not compatible with optimal governance. It was strongly recommended that a more independent system of selecting Board members be developed, taking cognisance of the skill mix required and the need for community involvement.

- Size of Boards – Prof Higgins recommends 6 to 9 members. The evidence that this will ensure an adequate skill mix is not clear. International opinion would support 12-14 members as being more appropriate for optimal governance.

- Role of Boards and individual appointees – What will be the role of individuals appointed to Boards and subsequently the role of the Board itself overall and in relation to governance of the Hospital Groups?

- Board Composition – The HIQA Tallaght report recommends a 'competency based Board'. Skills mixes should be represented. It would seem that there would be no to little clinician representation at Board level, despite this being proposed in the Madden Report 'Building a Culture of Patient Safety' (2008). Clinical staff should be represented at Board level. How will patients be represented at Board level? Training should be provided for all Board members, especially patient representatives. Ethnicity and gender balance at Board level should be considered. There is evidence from the UK that Community Health Councils were effective in providing an independent voice of patients but these were subsequently abolished.

- Communication to and from Boards – how will information be communicated to and from Boards? Analysis of the failures of the Board of Mid-Staffordshire Trust in the UK demonstrated that there was ineffective communication to the Board, which has been deemed a critical factor in the Inquiry into the failings of that Trust. Two-way communication mechanisms should be put into place. It is not clear from Prof Higgins how this will be achieved.

- There was a clear opinion that over-reliance on regulatory inspection, while attractive, is flawed in that it is essentially fire-fighting. The responsibility for maintaining standards must lie firmly with the Boards of the Hospital Groups, with HIQA strictly in reserve.

- Clinical audit is fundamentally important to improving quality of care and clinical outcomes, but require completion of the 'audit loop' to be effective. Increasingly, audits now appear to be done simply to satisfy inspections and in the UK regional audits have ceased. Develop the capacity of clinicians and managers to lead quality improvement through clinical audit. Ensure that clinical audit is an improvement tool rather than solely a quality assurance tool. The quality of national and local audits needs to be improved with a rigorous methodology. Service frameworks and quality assurance programmes work if properly applied.

- Public involvement in scrutiny is highly valuable.

- Autonomy of hospitals within Groups – It is not clear how much autonomy hospitals will have under the current Group structure.

- There is stark heterogeneity of hospitals within Groups especially in terms of the types of care delivered and financial backgrounds. How will this be addressed? Has there been sufficient engagement with current Boards and CEOs of Hospitals to seek their advice and input?

- Healthcare delivery at community and primary care levels needs to be strengthened and integrated with reforms at secondary care level.

- Numbers of Hospitals within Ireland – despite the transition of hospitals away from single silos to Groups Ireland will still have a large number of hospitals for the size of population. There appears no political will to reduce or rationalise the number of hospitals overall. It may be better to change the role or function of certain hospitals rather than closing them.

- There is a two-stage process within Prof Higgins recommendations. The first stage is Hospital Groups, and the second is the transformation of Groups to Hospital Trust status. Is the second stage necessary or can the reforms be realised within the first stage? Will patient outcomes be improved further by Trust status? What is the evidence of this internationally?

- Reform should be guided by data. The Health Information Bill is long overdue. HIQA seems to have lost its 'information' function. Good quality data and research are needed to match healthcare resources to normative population needs.

Conference Proceedings

The dilemma of diversity

Dr Catherine Darker, Adelaide Assistant Professor in Health Services Research

The Irish healthcare system is in a state of flux. The Programme for Government proposes radical reform of our health service offering a promised end to the two-tiered system with the introduction of Universal Health Insurance (UHI), and structural reforms such as the dissolution of the Board of the HSE and its replacement with seven new Directorates. A reconfiguration of secondary care services is also envisaged.

The catalyst for today's meeting was the publication in the summer of 2013 of a report to the Minister for Health, Chaired by Professor John Higgins, entitled 'The Establishment of Hospital Groups as a transition to Independent Hospital Trusts'. Prof Higgins' recommendations, will underpin the transition of our hospitals from single silos to Groups based on geographical configurations, which are expected to operate in administrative, managerial and clinical synchronicity. Over time these Groups will become independent, not-for-profit Trusts.

The current state of play is that Prof Higgins' recommendations have begun to be put into action. There are to be six Hospital Groups – each comprising a maternity hospital, a cancer care facility and an academic partner. We have had some announcements in the media about who will be the CEOs of particular Groups. Therefore the contribution from Dr Ambrose McLoughlin, Secretary General of the Department of Health, on progress to date is of prime importance.

Legislation – Is it reasonable to expect legislation to be able to cope with the complexities of the interaction between medicine, healthcare and the law? Senator Ivana Bacik and Dr Adam McAuley will give us their insights into the ability of legislation to help or hinder hospital governance, for a compassionate, patient-focused healthcare system.

Clinical & operational challenges – Dr Rhona Mahony, Master of the National Maternity Hospital, will be sharing her insights into the clinical and operational challenges of a major hospital operating under the new governance structure of a hospital group – coupled with the logistical nightmare of a site move!

Ethics – Defining governance is problematic and complex, for example, indirectly referencing moral and ethical issues such as 'how power is exercised', or calling for improvements in 'responsibility and accountability'. We know that each Hospital Group will have to compete for funding under the new 'Money Follows the Patient' financing model, which will incentivise hospitals for activity completed within a quarter. One of the implications of an ethics of care is recognition of the importance of seeing patients embedded within the wider community, as individuals with specific needs. Is there an inherent conflict that governing bodies face in attempting to align their duty to the public good with gaining a competitive edge? Dr Dónal O'Mathuna from DCU will be discussing the interface between ethics and the integrity of governance.

UK insights – Command and Control model of care – the best model? Professor Gabriel Scally, formerly Director of Public Health at NHS England and currently Director of the WHO Collaborating Centre for Healthy Urban Environments, will be sharing with us some of the lessons learnt from the UK health system where senior NHS managers and clinicians have been denouncing central government target setting, performance monitoring and interventions in the day to day running of services. What can be learnt from the failures of governance from Mid-Staffordshire Trust and Sir Bruce Keogh's recent report? What can we do to avoid repeating what our UK colleagues now perceive as mistakes?

The Adelaide Hospital Society participated in the merger of the Meath, Adelaide and National Children's' Hospital into a single entity at Tallaght – indeed, a hospital grouping. In so doing a Charter was developed over several years of discussion that respects above all the rights of minorities to full and equal access to health care. Tallaght Hospital has survived a HIQA inquiry into the governance of our hospital. While the Charter might need some revision to accommodate all minorities more explicitly as well as more recent concepts of governance, it may be considered as a template for the independent not-for-profit trust status that is coming down the line within the new Groupings.

An oversight of the proposed governance structures for Hospital Groups and an update on progress.

Dr Ambrose McLoughlin, Secretary General of the Department of Health

Dr McLoughlin said that it was a personal privilege for him to be Secretary General of the Department of Health, which is in effect the chief administrator role, with the Minister being the Chief Executive. He reiterated that the reform is based on the Higgins Report, designed to meet needs nationally so that existing hospitals can be accommodated into efficient and accountable Groups, each aligned with an academic institution.

Some crucial steps in the process have already been taken:

• the 6 hospital groupings and their academic partners have been identified,

• the three children's hospitals will form a seventh group, and will be aligned with all the academic units,

• development of the National Paediatric Hospital is well under way and siteworks at St James's Hospital are expected to begin in early 2015,

• the National Maternity Hospital at Holles Street is moving to more suitable premises at the St Vincent's University Hospital site

• Ms Eilish Hardiman has been appointed C.E.O. of the National Paediatric Hospital

The development of these hospital groupings is expected to advance the Universal Health Insurance agenda further. The Deans of the various academic units have endorsed the groupings and the move has been backed by all of the political parties. The aims of the reform are to improve management by eliminating duplication and thus cut costs; to provide robust governance; to clarify roles and to deal with the normative needs of the population. Competency based Boards will be paramount and the roles of Chair and CEO will not be combined.

The challenge for Government will be to achieve a Healthy Ireland and issues such as tobacco use and obesity need to be taken on board. The HIQA Tallaght Report will form the guideline for clinical, business, advocacy, IT and ethics aspects of the new groups.

Consultation and collaboration are important and will continue, but overall policy will be determined by the Department of Health. It was deemed to have been a mistake to let go of the reins in the past. Legislation will be passed by 2014.

A National Strategic Advisory Group, under the Chairmanship of Leo Kearns, will steer the hospital groups, along with a Governance Forum for the Chairs and Executives of the 7 Groups. Due diligence will be employed one year after Groups get underway, to ensure they are safe and efficient before moving to Trust status. In closing, Dr McLoughlin told delegates that the whole reform process had started as soon as the Programme for Government 2011 was published. He welcomed the proposed establishment of the Trinity Institute of Population Health at Tallaght, which he said was an important development. He remarked that we must bring a 'no blame' culture to our health service and concluded that with competency at the forefront, Ireland's system will improve.

The utility of legislation to help or hinder hospital governance in a compassionate, patient focused, healthcare system.

Senator Ivana Bacik, Seanad Eireann

Senator Bacik was pleased to be invited to speak to the conference by the Adelaide Hospital Society, which she said had a proud tradition of advocacy.

In her opening remarks she said that Government's plans for radical reform included disbandment of the HSE, itself a relatively recent body. Its demise, and that of co-location plans, were not regretted and it was good to see the Department of Health back in a lead role. Reform included a radical commitment to delivery of healthcare according to need not means, as stated in the Programme for Government 2011.

The Labour party had a long standing commitment to Universal Health Insurance and had maintained this ambition throughout the recession. The notion of free healthcare is seen by many as pure socialism. The path to UHI is a complex one and the end result will be achieved through legislation. There is a white paper in preparation, which will be ready by the end of the year.

Hospital governance plans are more advanced:

- hospital groups with shared management and board
- based on existing links
- non-statutory initially
- will be established as Trusts, if the groupings work

It is planned to introduce free GP fees on a phased basis

- the long-term-illness scheme has been abandoned as a model
- may be introduced by age cohort, possibly starting with children
- additional resources are to be provided
- legislation on the A list – ready by 2014

Political will is key to all reforms. The Catholic Church has had a great influence on health and social services in the past, with many hospitals based on the Catholic ethos. Church interference has typically resulted in matters such as the symphysiotomy debacle and the abandonment of Noel Browne's Mother and Child scheme. Delivery of maternity services is particularly difficult to legislate for. Religious iconography is still abundant in hospitals and perhaps a message could be taken from Prof John Counihan's report on primary schools – iconography should be pluralist.

The utility of legislation to help or hinder hospital governance in a compassionate, patient focused, healthcare system.

Dr Adam McAuley, Lecturer in Public and International Law, DCU

Health governance legislation has been traditionally exceptionally dry and focused on management and delivery. Patients must be central to all reform with all stakeholders represented. Quality, safety, value for money and patient driven are not always easy bedfellows. Politicians must address the issues and legislate, and there will need to be a change in mindset for all involved.

Dr McAuley offered the example of the Mental Health Act 1945, which was completely organisation focused. There has been a change in attitudes in the interim resulting in the 2001 Act encompassing the need to protect the rights and interests of mental health patients. This seismic shift ensured that the 2001 Act undergoes five yearly reviews with interim reports being fed into by clinicians and service users. This is essential in case we get things wrong. There is also a need to guard against the tendency to go to the opposite end of the spectrum when problems are identified.

Governance oversight is essential. HIQA, with only 170 employees is charged with trying to achieve quality assurance throughout the health service. Ethics in governance in Ireland has largely been driven by religious institutions. We should not lose sight of the right of patients to access treatment and we must respect people with different views and beliefs.

Legislation is a very crude instrument to achieve the common good. Buy-in and a change of mindset are essential.

Clinical and operational challenges of a major hospital operating under the new governance structures of a Hospital Group.

Dr Rhona Mahony, Master of the National Maternity Hospital

Dr Mahony remarked that arguably the health system in Ireland has grown up around the parish pump with no obvious national strategic vision in the past. Governments are generally too short lived to see through major reform. One of the major issues in the Hospital sector in Ireland is the number of acute hospitals in the state – 49 acute hospitals and 19 obstetric units for a relatively small population of 4 and a half million approximately. Rationalisation of our hospitals is very difficult to achieve in a country that has significant political representation at national level. With an extraordinary 166 TDS in the Dail, local issues at times seem to take precedence over a national agenda or national strategy. Proportional representation allows members of the same party fight it out at local elections. Efforts to rationalise hospital services by closures or remodelling are often met with deep suspicion and resistance in an effort to protect local community services. Such reform is not politically popular and the last decades in health have been characterised by cosmetic reform and local pockets of development which have not addressed key national challenges nor achieved rationalisation and improved efficiency. This is particularly true at management level and the negative effects of radically changing and poorly implemented health strategy is now very apparent on the frontline in Irish medicine which has seen relatively poor investment. Maternity services are a case in point – over many decades they have not received the appropriate attention and investment required with no coordinated national strategy. This legacy has translated into a variety of pressing challenges.

The History of the Dublin maternity Hospitals: The Rotunda Hospital was founded in 1745, to serve the needs of the poor of Dublin and the Coombe Lying-In hospital followed in 1826. During the Gaelic/Catholic revival of the 1890s, The National Maternity Hospital was founded in 1894. The Catholic Archbishop of Dublin is the titular head of the hospital, but has no role in the actual management.

NMH or Holles Street has currently 187 beds, about 700 staff and looks after approximately 9,000 deliveries each year, plus 1,500 Neonatal ICU admissions and 2,160 gynaecological procedures.

Dr Mahony spelled out many of the difficulties the hospital faces, the big challenge being money:

- Shortage of staff. Ireland has the lowest number of obstetricians in the OECD at 3/ 100,000 population or approximately 126 (Germany has 19/100,000).

- This is despite fertility rates at the upper end of European norms: approximately 17/1000 population compared with 8/1000 in Germany.

- The HSE allocation is reducing from a peak in 2008 to below 2006 levels in 2011

- Manpower is a big issue – getting and keeping staff – the work is hard and the hours long and an overstretched capacity brings increased clinical risk

- Adverse working environment created by fear of litigation and public exposure as a result of intense media scrutiny.

- Numerous regulating bodies for maternity hospitals – Institute of Obs & Gynae; Royal College of Obs & Gynae; HSE; HIQA; DoH. Plentiful regulation in an environment of meagre resource.

- Numerous clinical governance guidelines have been set down for hospital groups

- Healthcare is insatiable – costs may spiral

- NMH business model is of necessity 'an open door' model – patients cannot be turned away. We cannot have recourse to waiting lists and trolleys. We operate at constant peak levels with super peaks. Activity has gone up by around 30 to 40% over the last decade. Patient presentation is unpredictable. Labour cannot be scheduled.

- The proposed Universal Health Insurance may place a severe burden on the "coping classes" who will support the health system. This is a diminishing population.

- There will be tensions in outpatient work versus inpatient work with 'money follows the patient.' Needs to be carefully modelled so that complications are not rewarded financially e.g. recourse to caesarean section.

- The Mid-Staffordshire Trust problems were compounded by the money not being controlled by those at the medical coalface. The disconnect between the commissioning agents and the clinical requirements led to unsound financial planning.

- Infrastructure is a critical problem and in this regard NMH welcomes the Government's commitment to developing a new up-to-date facility.

Dr Mahony went on to outline the rationale for hospital reform:

- Large number and range of acute hospitals, operating in relative isolation

- Duplication and fragmentation of resources

- Difficulty in recruitment and retention of key clinical staff

- Non-compliance with EU directives

- Inequitable distribution of workload and resources

The vision for the future is that over time the Hospital Groups will become independent Trusts, integrated with the academic sector, to deliver:

- Higher quality services

- More consistent standards of care

- More consistent access to care

- Stronger leadership

- Greater integration between the healthcare agenda and the teaching, training, research and innovation agenda

The National Maternity Hospital will be associated with the Dublin East Group of hospitals, aligned with University College Dublin (UCD). The partner hospitals comprise:

- Mater Misericordiae University Hospital

- St Vincent's University Hospital Group

- Midland Regional Hospital Mullingar

- St Luke's General Hospital Kilkenny

- Wexford General Hospital

- Our Lady's Hospital Navan

- St Columcille's Hospital
- St Michael's Hospital Dun Laoghaire
- Cappagh National Orthopaedic Hospital
- Royal Victoria Eye and Ear Hospital

The proposed governance of the Dublin East Transitional Hospital Group was outlined:

- The Chair of the interim group board will be appointed by the Minister.
- The Chair will nominate the interim group board membership for ministerial appointment.
- The primary function of the board is to oversee the delivery of high quality, safe patient care to meet the needs of the population it is appointed to serve.
- The board will comprise the necessary skills, competencies and experience which will enable them to make a contribution to the performance of the hospital group. Membership must ensure demonstrable expertise including but not limited to at least the following domains: Clinical; Business; Social; Legal; Medical Academic; Patient Advocacy. (HIQA, 2012)

Dr Mahony posed the question – what of obstetric and neonatal representation?

- The management team (CEO, Clinical Director, Chief Nursing officer, Chief academic officer, Chief Finance Officer, Chief Operations Officer) will report to this board, which ideally should have a minimum of 6 and a maximum of 9 members. The role of the Chair and CEO will not be combined

Again Dr Mahony posed the question – What representation will maternity services have at Board level?

Dr Mahony warned that reform takes time, but politicians won't necessarily last the course. Elections occur too frequently to allow the time scale that permits true reform. In addition, one size does not necessarily fit all. With Obs and Gynae, the only guarantee is uncertainty.

Will the Group system do what it says on the tin and enhance patient care?

Dr Mahony reiterated the vision for the future. She expressed concern that some degree of autonomy must rest with the groups and at this stage, the allocation and methodology of funding remain unclear. The maternity services are unique and have unique challenges which will require protected investment.

Ethics and Integrity in hospital governance

Dr Dónal O'Mathúna, Senior Lecturer in Ethics, DCU

Dr O'Mathúna presented a table of the top 10 ethical challenges facing Canadians in health care. Top of the table was communications. He went on to remind delegates of recent issues in the Irish health care system, such as the Leas Cross scandal where deficiencies in care and institutional abuse were found; the finding of Mental Health Inspectors that there is widespread use of sedatives in psychiatric hospitals; and the report that premature babies were put at needless clinical risk when they had to be evacuated from the neonatal ICU in Holles Street, due to a delayed upgrade of the building.

He posed the question – what has governance to do with ethics? The Governance Act 2012: states 'redesign the system to put the needs of the patient front and centre'. The NHS definition of governance states 'Clinical governance is the way the NHS works to improve the quality of care patients receive and to maintain that high quality of care. It is about ensuring that patients get the right care at the right time from the right person and that it happens right first time.' But how do we achieve this challenging ideal?

The 2012 Act also states that

- Clinical governance is embedded within the overall corporate governance,
- Is the responsibility of each individual, and
- 'A culture of trust, openness, respect and caring is evident among managers, clinicians, staff and patients.'

Dr O'Mathúna asked how does anyone attempt to develop such characteristics as trust, respect, caring? He proposed some general principles, which required a bottom up growth of an atmosphere of dignity as laid out in the UN Universal Declaration of Human Rights (1948), 'All human beings are born free and equal in dignity and rights.' Human dignity – how to incorporate it in governance and bedside? Dignity is difficult to define but we are aware when it is absent. The Royal College of Nursing carried out a survey of 2,000 nurses in 2008, on promoting dignity. Most of the respondents thought they did a good job promoting dignity although some participants sometimes left work feeling distressed because they had given undignified care to a patient. The most significant thing to help peoples' awareness of issues around dignity, was to become a patient oneself or to have a family member become a patient. A simple illustration of treating people with dignity was the hospital receptionist who brought a bag of coins to work with her daily, so that she could provide change for people to use the coffee machine, which only accepted the exact money.

Dr O'Mathúna said that educators have much to contribute to equip students in the healthcare professions with an awareness of dignified treatment of their patients and colleagues. Although this is a challenge, a course in Literature and Ethics can be valuable in helping to maintain compassion:

- Literature helps bring ethics to life and brings life into ethics. A film or novel engages the heart, mind and soul with the ethical issues.
- Literature, then, and fiction in particular, can be more true to life, more rounded, three-dimensional and nuanced than the world of objective, impartial reasoning.

As an example of how literature helps in ethics, Dr O'Mathúna related the story of the lawyer who asked Jesus how he could earn himself a place in Heaven. He was told to love God and love his neighbour. The lawyer wanted a definition of neighbour. It was as if he wanted to know if having certain attributes makes someone deserving of human dignity. When dignity is viewed as earned, people can be excluded from being treated with compassion. Instead, if dignity is inherent it gives people the responsibility to act with dignity.

Returning to the lawyer' question, Jesus did not respond by telling him how to determine who was a neighbour to be treated with dignity. Instead, he recounted the story of the Good Samaritan who helped a Jew who had been set upon by bandits. He was left injured on the roadside by several passers-by until a Samaritan (his sworn enemy) came to his aid. Jesus then asked the lawyer "which was his neighbour?" The lawyer correctly identified the Samaritan as the neighbour, because he was the one who had treated the injured man with dignity.

So promoting dignity requires that we:
- acknowledge others as the valuable persons they are, equal to ourselves;
- see others as individual persons with potential;
- respect another's personal space;
- humble oneself to serve another.

Dr O'Mathúna said that leaders have a big part to play. They need to be willing to both confront and encourage. Success in the hospital reform will require good leadership and a certain humility.

Lessons learnt from UK inquiries into complexities of hospital governance, clinical negligence and patient care.

Professor Gabriel Scally, formerly Director of Public Health at NHS England and currently Director of the WHO Collaborating Centre for Healthy Urban Environments

Professor Scally showed media reports of various health service scandals over the years, commencing with a Sunday Times report from 1985 on an inquiry into the deaths of 19 patients from food poisoning (salmonella) at the Stanley Road Hospital in Wakefield. Another 300 staff and patients were taken ill. When they became ill, rather than more appropriate clinicians being called in to look after them, patients were treated by psychiatrists.

The inquiry into the Bristol heart babies scandal concluded that a third of children received less than adequate care. It was found that at the hospital, there was a club culture, with too much power concentrated in too few hands.

Prof Scally quoted from George Bernard Shaw's preface to The Doctor's Dilemma (1911), '…the medical profession, like other professions, consists of a small percentage of highly gifted persons at one end, and a small percentage of altogether disastrous duffers at the other.' He himself had personal experience of working with two doctors, one competent and one incompetent, when he was charged with ensuring that patients were streamed past the incompetent colleague.

More recent was the abuse of patients with severe learning difficulties at Winterbourne View care home near Bristol run by Castlebeck Care Ltd, opened in 2006. The abuse was revealed through a Panorama programme on BBC1.

In all, there were 6 reviews into Winterbourne View:

1. Police Investigation – 12 former staff members charged and all pleaded guilty.

2. Care Quality Commission – two pieces of work
   An internal review of their contacts with Winterbourne View
   A review of 150 services for people with a learning disability

3. NHS Review of Commissioning – led by NHS South West with NHS West Midlands and NHS South Central

4. South Gloucestershire Adult Safeguarding Board Serious Case Review – independent chair with reports from Council, NHS, Police, CQC, Castlebeck Care

5. PwC review of Castlebeck Care Ltd

6. Department of Health – review by officials with an external reference group.

Twelve staff members were found guilty and 6 were imprisoned. Mencap did a phenomenal job in highlighting neglect.

The Mid Staffordshire Trust 'should be dissolved' Robert Francis QC reported in his review of the NHS Trust which went into administration in April 2013 after it was found to be not clinically or financially sustainable. The public enquiry was triggered at Stafford Hospital after a higher than expected number of deaths at the Trust.

The executive summary of the report placed an emphasis on what is truly important in healthcare governance:

- Emphasis on and commitment to common values throughout the system by all within it;

- Readily accessible fundamental standards and means of compliance;

- No tolerance of non compliance and the rigorous policing of fundamental standards;

- Openness, transparency and candour in all the system's business;

- Strong leadership in nursing and other professional values;

- Strong support for leadership roles;

- A level playing field for accountability;

- Information accessible and useable by all, allowing effective comparison of performance by individuals, service and organisation.

As recently as the 1st October 2013, The Telegraph reported how Professor Sir Bruce Keogh, NHS Medical Director spelled out how the failings of the 14 worst hospital Trusts were responsible for 13,000 'excess deaths' since 2005.

Dr Donald Berwick, was a health policy expert who ran the Centers for Medicare and Medicaid Services for President Obama but whose position was not ratified because Republicans considered him to be too pro the NHS system. He carried out a review into patient safety for the UK government in which he recommended the following:

- Place the quality of patient care, especially patient safety, above all other aims.

- Engage, empower, and hear patients and carers at all times.

- Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.

- Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Community Health Councils (CHCs) were established in 1974 to provide a voice for patients and the public in the NHS. The Councils had resources and statutory powers and independence to express their views. They worked extremely well but were abolished in 2003 and replaced with a succession of other bodies, currently Healthwatch. However Healthwatch lacks the resources previously invested in the CHCs.

Professor Scally concluded with his personal views for future governance:

Personal view 1

- In a rush to sort out the worst don't forget the average – shift the mean.

- There is usually a political wish to create an elaborate inspectorial regime – it should be resisted.

- Appointing a member of staff is the most important decision you can make – credentialling, the process of assessing and validating the qualifications and record of a practitioner, should be paramount and hospitals fined if it is not adhered to.

- Never rely on regulators to sort out your problems – sort them out yourself. Rules and regulations should enable institutions to sort out clinical problems and send 'alerts' to other hospitals. Mr George Bernard Shaw, invited to contribute to a series of articles in a Manchester paper on the question 'Have we lost faith' said 'Certainly not; but we have transferred it from God to the General Medical Council.'

Personal view 2

- Clinical audit is fundamentally important, but audits are now being done simply to satisfy inspections and in the UK regional audits have ceased. Sir Bruce Keogh invited clinicians to comment on audits and extracted the following common themes;
Local resources limited, use those available wisely;
Develop the capacity of clinicians and managers to lead quality improvement through clinical audit;
Ensure that clinical audit is an improvement tool rather than solely a quality assurance tool;
The quality of national and local audits needs to be improved with a rigorous methodology.
- Service frameworks and quality assurance programmes work
- Public involvement in scrutiny is highly valuable

- The model of business style Boards is potentially seriously flawed. Non-executive board members with no experience see themselves as there simply to support the executives.
- A comprehensive approach is possible.

Discussant

Dr Fergus O'Ferrall, Fellow of the Adelaide Hospital Society

Dr O'Ferrall began by saying that it appeared that all were in favour of reform but want to get it right!

He set out his thoughts in 5 overarching key points:

1 Recognise the crisis in the health system in regard to caring

- The ideology of managerialism accounts for failures – failures in governance and management

- The Mid-Staffordshire situation should be taken as a stark warning

- As Dr Mahony asked, will the Trust system enhance patient care?

2 What if patient experiences guided us in respect of hospital governance, quality improvement and service delivery and organisational change?

- The Canadian Foundation for healthcare improvement provides evidence of some of the things that patients need from their health service.

- Transformational changes can be achieved by giving patients real power, using their wisdom and experience to help design care processes and systems that are truly patient-focused.

3 Challenge the prevailing ideology and 'group think' re governance based upon failed corporate governance models and managerialism.

- As Adam McAuley said, 'a change in mindset is required'

- We have grown into a culture of neo-liberalism – we must recognise the limits to markets and competition in healthcare.

- Articulate the reasons for having health services in the public realm:

- Social justice, equality

- integration of health services

- market disciplines, eg profit, seriously undermine professional ethics and the caring culture and result in poor quality of care and the worst health outcomes for patients.

- complex services required by every citizen require to be governed by public and patients – the key stakeholders

4 Restore confidence in public service provision based upon public and patient participation and nurturing of professional medical and nursing ethics and values.

- These values are set out in the Careful Nursing Philosophy and Professional Practice Model by Therese Meehan.

- There is an alternative to the centralised command and control proposals of Prof Higgins – susceptible to state failure, and market-led health services desired by neo-liberals – susceptible to market failure.

- We need to focus on developing decentralised non-market models for public health services – a properly organised, publicly funded and publicly provided universal health service with delivery patient focused, efficient and equitable responsive care.
- This must be consistent with competency based boards and with due diligence and accountability/oversight.

5 The erosion of the sources of the caring culture needs to be addressed.

- Ambrose McLoughlin asks 'are hospitals different from other agencies?'
- A key dimension to healthcare is the relevance of faith and spirituality.
- Holistic high quality patient care is at great risk when spiritual care is diminished.
- We must focus on nurturing the meaning and joy healthcare staff ought to find in their caring.
- There is a growing body of evidence that healing and holistic care have a vital spiritual dimension and role models are of vital importance.
- We need to be careful not to throw the baby out with the bathwater.

Closing remarks

Professor Ian Graham, Chair of the Adelaide Hospital Society closed the meeting by thanking all the speakers who had participated and the delegates, and said that a report of the meeting would issue. He has since added a few thoughts:

1. "The primary determinants of disease are mainly economic and social, and therefore the remedies must also be economic and social. Medicine and politics cannot and should not be kept apart" Geoffrey Rose in 'The strategy of preventive medicine'.

2. This implies medical engagement in the political process, not excessive political and central control.

3. Arising, there was widespread concern at the political nature of the appointment of Board members to the new Hospital Groupings, as well as the perpetuation of the central command-and-control model.

4. We seem to be a nation that is more comfortable with publishing reports and recommendations than with implementing them.

5. Two factors militate against effective health planning- a four-year political cycle with a wish to retain power at any price, and the power of veto of local politicians.

6. The primacy of the patient rather than the system was a consistent thread running through the meeting.

7. Data systems and meaningful audit are under-developed.

8. It does seem possible for ethics, good governance, facilitatory legislation and compassion to find common ground, but not if a particular single religious ethos is dominant.

9. The governance model for the new Hospital Groupings might be usefully informed by the inclusive principles of the Tallaght Charter.

Adelaide Health Policy Initiative: Principles for Hospital Governance and Trusts

1. Boards appointees should be independent and not constrained by political considerations which may or may not be compatible with their primary responsibility, which is to deliver optimal patient care.

2. Hospital Boards and clinical leaders should provide evidence that they are effectively driving quality improvement and patient safety across each and every service that they provide. They should demonstrate that they are conversant with the principles and techniques of quality improvement and should ensure that they have people with the specific expertise to know what data are required for this, how to scrutinise them and then use them to drive tangible improvements.

3. To this end, Boards should actively seek data that indicate a need for quality improvement and look critically at unsupported reassuring statements.

4. Boards should base staffing levels on documented and available criteria that provide assurance about the impact on quality of care and the patient experience while avoiding excess staffing and duplication of work.

5. Boards should define strategic aims with regard to patient care and safety, and should regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings. Minutes of Board meetings should be timed to determine the length of time the Board spends discussing patient safety and quality improvement. Minutes of Board meetings should be publicly available.

6. Boards and leadership bodies should employ structures and processes to engage regularly and fully with patients and carers and members of the local community served by the hospital, to understand their perspectives on and contributions to patient safety.

7. Patients and their carers should be represented throughout the governance structures within Groups and should be seen as an essential resource. Development and training will be needed for Non-Executive Directors and Community, Patient and Lay Governors to help them to contribute meaningfully bringing a powerful patient voice to Boards.

8. Clear and consistent communication to and from the Board is essential. Systems need to be put into place to communicate routinely and also for the escalation of urgent issues.

9. Hospital Governance should be informed by reliable, accurate and comprehensible data. This requires implementation of the national Health Information Strategy backed by legislation.

Observe, Comment, Contribute