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Branding/ Reputation

Umesh Prabhu
Former Medical Director, Wrightington, Wigan and Leigh NHS Foundation Trust & Bury Trust, UK
pupprabhu101@yahoo.com

@DrUmeshPrabhu

wwl.nhs.uk

Happy staff, safe patients

An Interview with Dr. Umesh Prabhu

Leading NHS medical director, Dr. Umesh Prabhu on what a hospital can do to improve patient safety – yesterday.

Patient safety is a critical area of focus for all healthcare institutions, requiring involvement from all levels, from the Board to individual staff members on the frontline, Dr Umesh Prabhu, the former Medical Director, Wrightington, Wigan and Lehigh National Health Service (NHS) Foundation Trust (2010-2017) and Bury NHS Trust (2001-2003) gives us his thoughts, and tells us how he helped to transform the Trust into one that reduced harm to patients by 90 percent just in 8 years.

Should patient safety be more of a priority in healthcare?

It was nearly 160 years ago, Florence Nightingale said: 'The very first requirement of a hospital is that it should do the sick no harm."

Anything which focuses on safety and quality will never go wrong. In Wigan, the Trust was like any other Trusts - focused on finance and target. Both are important, because it is public money and the Trust has statutory duty to spend public money wisely and to achieve the targets.

In 2007, the CEO, Andrew Foster, attended an Institute for Health Improvement (IHI) conference in the USA and he decided to make patient safety the top priority. There were some successes but, underneath there were some cultural challenges.

I joined the Trust in 2010, as the Medical Director and in 2011, the Trust staff feedback survey showed that the Trust was in the bottom 20 percent for staff happiness and that was the burning issue. The Trust decided to embark on staff engagement and a 'Listening into Action' programme. The Trust also decided to focus on culture of staff happiness, staff and patient engagement.

A leader's job is to create a culture of staff happiness so that staff can do a good job. Leaders must achieve both financial balance and targets by working with staff. The more we listen to and engage staff, the more they will be able to deliver good, safe and effective care to their patients.

When the Trust focuses on finance and targets, its puts staff under tremendous pressure. Whereas if the Trust listens to staff and creates a culture of staff happiness, then the Trust can work with the staff, understand their day-to-day pressures and pains and solve them through collaboration with personnel.

> "ONLY 20 PERCENT OF LEADERS ON A TYPICAL UK NATIONAL HEALTH SERVICE (NHS) BOARD ARE CLINICAL. THAT IS A MISTAKE"

When I joined the Trust, I realised that the Trust had many hard-working staff, but many were demoralised. Unhappy staff equals unhappy patients. The culture of any organisation is decided by few dominant individuals. It may be the Chief Executive, finance director or nurse or medical director and this is where the differences lies as to what is given the top priority in any Trust.

In 2011, the Trust started listening to its staff, appointed some very good medical, nursing leaders and managers and implemented good governance. They focused on staff and patient engagement, transformed the Trust and learnt lessons.

For patients to receive the safest and the best care, we must create a culture of staff happiness and we must care for our staff.

Good team working is essential for good patient care. Good teams are led by good leaders, who are kind, caring, compassionate but are also self-disciplined and those who work hard and lead from the front and lead by example. These are the role model consultants or nurses or physios or other staff in the team.

To transform our performance, I asked nurses, GPs, junior doctors, SAS doctors and consultants:
Who is the best consultant in the department?
Who is a nice human being?
Who is a good team player?
Whom do you want to see as a leader and why

I always ask why questions. Why is the most important question in our life. Why makes us think. Why do I want to be a medical director or a nurse director? Why do we think someone is the right person to do the job?

When I asked these questions, in each department, staff nominated only one to two names for leaders. This is because, in each department there are only one or two popular doctors and these are the leaders of that department or the division.

When I met these doctors in 2010, nearly 60 percent of them did not want to be leaders. This is the sad irony of our NHS. Most good doctors who have the ability to be leaders, do not want to be leaders and the reason is simple: we do not train, or encourage good doctors to be good leaders nor do we train or nurture them to be leaders.

The current training, we provide for any clinical staff to be leaders, is management training. If we provide management training for leaders, then all we do is produce more managers and not more leaders.

Managers manage the task whereas leaders inspire, motivate, help, support, guide staff to be at their best. NHS needs more and more leaders and not more and more managers. Of course, the NHS needs good managers to be good leaders and this can transform NHS.

Today, only 20 percent of leaders on a typical NHS Boards in an acute sector are clinical staff and the remaining 80 percent of Board members are 'non-clinical. They tend to focus on targets and finance and less on safety or quality.

When you started your medical career, did you think that patient safety would become such a huge part of your focus?

Absolutely not. I had no training in patient safety or quality. I was trained to be a doctor - a paediatrician - and the whole focus was on clinical care. There was no training in patient safety, quality, quality improvement, dealing with complaints, finances, or dealing with difficult colleagues or team working or even basic communication skills.

I had excellent training to be a paediatrician, but I had a very strong personality. Even as a child I had a very strong personality, because of my grandma who brought me up in a small village in India. She was a follower of Mahatma Gandhi, and she told me always be honest and always be sincere, see good in others and do good to others, only focus on you and keep on learning and one day you will be somebody. She also told me that whenever you do something right, don't be afraid of anybody. Courage is the most important quality for someone to succeed as a leader.

With that, I came to UK in 1992. I had finished my basic undergraduate training and Diploma in Child's Health in India. I passed my PLAB exam conducted by GMC and worked in Manchester, Leeds, Edinburgh and Oxford, obtained further training and passed all my exams. In 1992, I was appointed as the Consultant Paediatrician at Fairfield General hospital, Bury.

Within two months of becoming a consultant, I was asked to be the clinical lead for the Paediatric department and I headhunted consultants with my own values. With the help of my colleagues, we built an excellent department. We told the nurses that, in case of an emergency, they could call any one of us and we would be there. Over next 18 years or so, I was twice called at night even when I was not on-call and both occasions I was able to save the babies.

We realised good team working was essential for good patient care.

Where did your passion for patient safety start?

It was in 1992. Within a short period of being a consultant, I made a serious mistake and a six-week- old baby developed severe brain damage. I had seen the baby in the ward round and baby had a very faint mark on the penis. I was not sure whether it was a 'birth mark' or a faint bruising. As I was not sure, I asked junior doctor to arrange special X-ray called skeletal survey. This X-ray would indicate if there were any fractures, which would support the diagnosis of 'child abuse'.

Unfortunately, my junior doctor did not realise,

Dr. Prahbu at UK Care Quality Commission Board Meeting in London, 2015

> "LEADERSHIP IS ABOUT GIVING THE BEST CARE TO EACH PATIENT; TO PROVIDE THE BEST CARE, YOU NEED THE BEST TEAM"

there were two babies with the same name and same age. At the end of the ward round, he picked up the wrong case notes of another baby with same name and wrote the request form for this second baby. He gave the request form to the nurse who was not in my ward round and she did not realise she was taking the wrong baby for the X-ray.

She brought the x-ray and gave it to the sister who was in my ward round and sister thought it must be the X-ray of baby I had requested and hence filed it in the wrong baby's file. I saw the X-Ray and it was normal so sent the baby home without realising the baby did not have an X-ray. The stepfather was abusing the baby and within a day or two he stamped on the baby's skull and the baby was admitted with severe brain damage.

My colleagues from the neighbouring hospital where the baby was admitted rang me and she told me that the baby was severely brain damaged and had multiple rib fractures and some of them were old fractures. I was devastated and called a meeting to understand what went wrong. I realised five things had gone wrong so I put systems in place and thought that was the end of it.

Sadly, within six weeks another baby died due to doctors' and nurse's mistakes. I had not made any mistake, but I was in charge of the baby. This baby had severe Respiratory Distress Syndrome (RDS). Three things went wrong, and the baby died.

Both these tragedies affected me a lot and hence took keen interest in patient safety and it took over my whole life.

Being a doctor is a big responsibility and I wanted to understand why doctors make mistakes and harm patients. I wanted to understand how we can protect patients and protect doctors and the team.

When a patient suffers serious harm due to 'medical errors' it has huge impact on patients their families and the doctor and his/her families.

As doctors, we know that prevention is always better than cure. Each human being makes five to seven mistakes every day so, we cannot stop doctors, nurses or our staff from making mistakes. But we must make sure patients do not suffer because of the mistakes made by our staff.

My interest in patient safety led me to organisational culture, leadership, good governance, subconscious bias, institutional racism, culture of bullying, harassment, professional regulation, impact of poor team working and why doctors and nurses make mistakes and victimisation.

Please tell us how you have reduced harm to patients in Wigan by 90 percent?

At the outset itself, I would like to thank many wonderful staff of Wigan. It is their hard work and sincere commitment to patient safety and the quality that transformed the Trust. I also want to thank the Trust Board, the CEO Andrew Foster, the two Chairman, Wigan Council, Wigan CCG, Wigan GPs and Bridgewater and five Borough's Trust.

Success is when we all work together for a common purpose. CEO Andrew Foster's commitment to patient safety helped me a lot and the Trust Board appointed some amazing Non-Executive and Executive Directors who all contributed to the transformation of the Trust.

The Trust focused on staff and patient engagement, good values-based leaders and managers, patient safety champions, dementia champions and focused on good culture, good governance, good team working.

In 2010, I personally met many consultants

individually, SAS and junior doctors in small groups and GPs and nurses in small groups. We made some significant changes to the way the Board members interacted with staff. The Board members became visible, approachable and started meeting staff and all these changes were fully supported by the Trust Board members.

We started sending nice emails to our staff to create positive energy, thanking them and praising them for all their hard work and sincere efforts. The whole Board, including the CEO and the Chairman started telling staff 'don't do it if it is not safe to do so'. This empowered staff and managers. Staff spoke to someone senior if they were concerned about anything which was putting patient safety or quality of care at risk. Having many kind, caring and compassionate senior leaders and managers helped the Trust to transform the culture.

To a good leader, everyone matters and every voice counts. A good leader listens to each staff member and inspires, motivates, helps, supports and guides to get the best out of fellow human beings. Transformation needs transformational leaders with great vision, charisma, knowledge and skills.

What advice would you give both individual physicians and hospital departments facing a patient safety crisis?

I would say two things. Do not worry where you are today. It is important to know where you want to be tomorrow. Secondly, to get to know your organisation, you must talk to people who are on the frontline.

Work with your team, identify the challenges in the department. Ask staff, engage them and understand the challenges your team is facing. What are the main concerns, how do we improve patient safety? Start base line measurements, have a dashboard to each department, identify the nature of patient safety concerns, put measurements in place. Measure what matters to patients, engage patients and carers and engage staff and start improving things.

In Wigan, it was brilliant 'Listening into Action', staff and patient engagement, excellent governance and good working relationships with CCGs, Primary Care, Mental Health, GPs, CCGs, Community Trust and Mental Health and Wigan Council which really transformed the Trust. In Wigan, we also encouraged frontline staff to be patient safety champions.

A leader's and manager's job is to make staff members' jobs easy. As such, our staff work very hard and there is acute shortage of well-trained doctors, nurses and other staff. The NHS must transform itself and use the skills of other staff. The NHS must also invest in digital health, digital transformation. If there is a good IT department working with good doctors and nurses and if a

What role does patient safety play in a hospital's reputation?

The NHS is a very safe Institution. Each year, there are 360 million visits supported by 1.3 million staff. In 36 hours, approximately 1 million patients are seen by nearly 40, 000 GPs. The majority of these patients receive safe and the best care. However, each year 20,000 patients die, and 55,000 patients suffer for more than six months or are permanently disabled owing to 'medical errors'. Nearly 80 to 90 percent of these are preventable.

It is important that we, the NHS leaders, focus on preventing these human tragedies and make sure every patient gets the safest and the best care.

Success is when we all work together for a common purpose and our purpose is always our patients, the fellow human being irrespective of race, gender, ethnicity, disability or religion. It is they who must get the safest and the best. ■

KEY POINTS

- ✓ Focusing on patient safety and quality will always lead to better all round performance
- ✓ In any organisation, 2 or 3 individuals set the tone of the culture
- ✓ Only 20 percent NHS board leaders are clinical which leads to viewpoint and priority imbalance
- ✓ Good governance is essential for successful hospital operation
- ✓ Physicians need more leadership training
- ✓ Listening to frontline staff ideas for solutions reaps beneficial results
- ✓ Digital transformation could make healthcare cheaper
- ✓ Happy staff helps to support happy and safe patients