VERITA

INVESTIGATIONS – REVIEWS – INQUIRIES

Independent investigation into the care, treatment and management of Elizabeth Rourke

Addendum to the report

January 2010

Authors:
Ed Marsden
Derek Mechen
Lucy Scott-Moncrieff
Julian Woolfson

Verita is an independent consultancy which specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

Verita
53 Frith St
London W1D 4SN

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website www.verita.net

Contents

Appendices

1. Introduction

1.1 After our investigation started the Minister asked us to make clear that we were happy to hear from anyone with concerns about the hospital, even if those concerns did not fit squarely with our terms of reference. A number of people took us up on the offer. Others we interviewed about matters within our terms of reference also raised wider concerns.

1.2 We were not asked to investigate these concerns and have not done so. However, we were clear that these matters needed to be brought to the attention of those responsible for the hospital and HSSD and we therefore produce this addendum.

1.3 We had noticed some of the concerns interviewees raised during our investigation but we did not deal with them in detail in our main report because we wanted to ensure that it focused on Mrs Rourke's care and treatment and matters closely related to it. We do not know how widespread these concerns are or the extent to which those whose job it is to deal with them have identified them.

2. Matters to do with the health and social services department

Culture of the hospital

2.1 A number of interviewees told us about the culture of the hospital. Many spoke of having satisfying jobs but they also commented about the fear of speaking out and a tendency for others to mistake reasonable questioning for disloyalty.

2.2 Those external to the hospital felt that senior staff were unwilling to be open with them.

2.3 The publication *An organisation with a memory – report of an expert group on learning from adverse events chaired by England's Chief Medical Officer*[1] speaks about the need for an honest, open, no-blame reporting culture in healthcare if patients are to be safeguarded.

2.4 In its response *Building a safer NHS for patients* the Department of Health says "*creating the right culture is essential to successful reporting and learning from errors and adverse events*".

2.5 The hospital needs to be sure that all staff accept this culture and that it prevails in the hospital because it is in the best interests of patient safety.

2.6 Getting the culture right is also fundamental to the success of HSSD's New Directions and Sustainable Hospital strategies. Good leadership is central to the creation and maintenance of this culture.

[1] *An organisation with a memory* (published June 2000) examines the key factors at work in organisational failure and learning, a range of practical experience from other sectors and the present state of learning mechanisms in the NHS before drawing conclusions and making recommendations. *Building a safer NHS for patients* (published April 2001) sets out the Government's plans for promoting patient safety following the publication of *An organisation with a memory*.

Individuals rather than systems

2.7 Some interviewees spoke about a perception that when something went wrong, senior managers had a tendency to blame individuals rather than looking at the systems in which the mistakes occurred.

2.8 Governments and healthcare providers now commonly recognise that many patient safety incidents have their origins in weak systems. As Dr Lucian Leape says in *Building a safer NHS for patients*:

> *"Human beings make mistakes because the systems, tasks and processes they work in are poorly designed."*

2.9 We were told that the perceived tendency to blame individuals rather than systems is less marked than it was – particularly as a result of the efforts of the current director of nursing and governance – but that more had to be done if the current anxious culture was to be replaced by one of openness. Many interviewees saw this as a major challenge, not least because they would be reluctant to report poor practice if they felt that the consequences for the individual reported, or even for themselves, would be punitive rather than constructive. Furthermore, if people who make mistakes know that system failure is always looked at as a possible explanation they will have less need to be defensive and/or retaliatory and the prospects of a positive outcome will increase.

2.10 The effect of working on the island on people's sense of security must be taken into account. This applies particularly to working at the hospital. We rely here on what many interviewees told us.

2.11 Jersey General is the only one on the island and so the only option for someone who wants to work on the island and in a hospital. We are told, convincingly, that people are reluctant to raise issues on their own behalf or that of others because it is perceived to be personally and professionally risky. We have been given examples, not just in relation to hospital staff, of employers using this harsh reality to obtain compliance from employees. Such a tactic may be immediately effective in stifling challenge but if the aim of the

employer is to create an organisation with shared values, goals, and high standards of patient care and safety it is counter-productive.

2.12 The hospital has a whistle-blower's policy, for which it is to be applauded, but it is clear that whistle-blowing is only ever necessary when a culture of cover-up prevails and where it does, whistle-blowers are likely to doubt if such a policy will protect them. An organisation open and receptive to constructive criticism should find that it does not need to use its whistle-blower's policy.

Management of the hospital

2.13 Interviewees have provided many descriptions of the lack of common purpose between senior managers and senior clinical staff. Many people said there seemed to be little sense of a genuine shared view about the future of the hospital. This may partly be explained by the dual roles of senior management.

2.14 Much more than on the mainland, senior managers combine both a central policy-making function with a hospital operational one. They have to look two ways at once, discharging in their overall role some of the equivalent responsibilities of the Department of Health, a strategic health authority and an NHS trust board. This means that although the hospital is only of modest size, the managerial task is complex and makes unusual demands on senior staff.

2.15 First-class healthcare organisations must have a sense of shared purpose. Politicians, managers and senior clinical staff should ensure that such a shared sense of direction exists and is communicated to all those concerned with, and working in, the hospital.

2.16 Some interviewees said, and we could see for ourselves, that the hospital is isolated both geographically and organisationally, although it has strong clinical links with other hospitals. It is not part of a wider community of health organisations and does not easily benefit from developments in thinking and capacity elsewhere. We think it would be worth exploring whether a strong, formal 'twinning' arrangement with another healthcare provider could help – for example with staffing and the development of policies and procedures that

meet modern standards while also taking account of Jersey's unique character and circumstances.

2.17 Interviewees said, and we could see for ourselves, that the hospital had made progress on governance in the last three years. But we were also told that more needed to be done to achieve a uniformly good standard. Current good practice, which we know senior management at the hospital accepts, is that senior medical staff need to be part of these developments, which means they must be given the practical and organisational support to contribute.

2.18 Our impression is that the hospital has little routinely collected data by which it can monitor services and plan developments. This puts it at a disadvantage in identifying the need for change and monitoring the success of any remedial actions.

Structure

2.19 Interviewees told us that putting paediatrics into a separate department from obstetrics and gynaecology had created organisational barriers to best practice. Many trusts in the UK bring together obstetrics, gynaecology and paediatrics and ensure continuity between the disciplines. We suggest that the senior management team consider creating a women's and children's department to this end.

Clinical activity

2.20 A number of senior clinicians said there were financial incentives for general practitioners to refer patients to the hospital. These incentives may result in more referrals than is clinically necessary. The most recent figures we have show about 11,000 surgical operations are carried out each year. Our interviews with clinical staff also suggested that the number of non-invasive diagnostic interventions carried out in the hospital is proportionately higher than in mainland UK. There are a number of potential explanations for these figures – including that all the operations and diagnostic interventions are clinically appropriate.

2.21 Similarly a number of senior clinicians said that there are financial incentives for general practitioners to refer patients to the hospital. These incentives may result in more referrals than is clinically necessary.

2.22 These matters may be worth investigating further.

Consultant staffing

2.23 Consultants who work in the hospital are encouraged to do private work but there is a limited amount to go round on a small island. Competition for private work can generate unhelpful rivalry. A number of those who spoke to us believed that such rivalry existed, though some specialties appeared to manage private work so as to avoid it.

2.24 Similarly, senior medical staff face a conflict in assessing the need for further consultant appointments. More senior staff may help with a growing volume of public work but they would also compete for limited private work. This would have a direct impact on the earning power of existing senior doctors in a specialty. Some interviewees believed that such considerations might have affected recruitment decisions in some cases.

2.25 Many interviewees spoke about the committed, hard-working consultants in the hospital and the excellence of much of their clinical care. However, the ability and willingness of current consultants to work long hours in support of the status quo must not be allowed to conceal the difficulties ahead which are bound to lead to change.

2.26 A number of interviewees spoke about the impact of consultant retirements. About 40 per cent of consultants working in HSSD are likely to retire in the next 10 years. Retirements could have an impact on service provision and patient safety if they are not carefully managed. Replacing retiring consultant medical staff could have significant financial consequences for the States – not least because changes in medical education mean that recently trained consultants no longer have the broad range of skills of their predecessors.

2.27 This problem is not simply one of cost. Modern consultants are highly skilled in their sub-specialty and need enough work to maintain their skills. The hospital serves a relatively small population and it is not clear that it would be able to provide the volume of work necessary for such a consultant.

2.28 It would be a pity if the hospital were obliged gradually to reduce its services as a result of this growing mismatch between the size of the population and the needs of its doctors. One possible solution would be for the hospital to enter into job-sharing or department-sharing arrangements with another hospital so that consultants could maintain their skills through work on the mainland.

2.29 Appendix A shows the numbers of consultants employed in HSSD over the age of 55 as of 1 January 2010.

Consultant job planning

2.30 A number of interviewees said that consultants' job plans often did not reflect what they do. Apparently it is not uncommon for a consultant to have clinical duties that take up virtually all of his/her contracted time and then to have time-consuming teaching, managerial and administrative tasks as well. No one has complained to us about the extra work, which is effectively often unpaid, but interviewees told us that if consultants had too much to do and not enough time to do it, things would be missed, delayed or rushed. This is not helpful for good governance, nor does it seem likely that consultants will want to take on added tasks in the interests of good governance if they do not believe they will be given the time to be effective. Our interviewees said, and we agreed, that the engagement of senior clinical staff is essential if progress is to be made in developing the sense of shared purpose that is now needed. More consultants need to be employed if there are not enough to perform all the necessary clinical, supervisory, teaching, administrative and managerial tasks for the hospital to flourish.

Middle grade staffing

2.31 We had evidence from a number of interviewees about middle-grade doctors. These doctors and surgeons are the backbone of some specialties in the hospital, for example, medicine, surgery and obstetrics and gynaecology. Interviewees questioned whether the overall funded establishments of middle grades are sufficient in some specialties. Some interviewees were concerned about the long working hours and general lack of prospects for these doctors. We know that some are nearing retirement and that the hospital will be hard-pressed to replace them – particularly given the changes in medical education and the competition with UK hospitals for staff. Appendix B shows the position on middle grades in the hospital as of September 2009.

2.32 The ministerial and management team should make a decision about the future model of medical staffing – particularly in light of impending consultant and middle-grade retirements. They should also address any shortfalls in middle-grade staffing.

Nurse staffing

2.33 Interviewees told us that the hospital had recently completed a review of nurse staffing. We understand it looked at 35 inpatient areas and found that 65 full-time equivalent nursing staff were needed to ensure safe levels.

2.34 We were also told about long-standing difficulties filling nursing posts in theatres and the day surgery unit. These arise from changes to nurse education in the UK that mean that these specialist nurses are now in short supply.

2.35 Recruiting to current vacancies and newly created posts will be a major challenge. The introduction of the local nurse cadet scheme will help. On the basis of what we have been told, the States should review terms and conditions offered to nurses employed in the hospital so as to ensure that HSSD can compete with UK foundation trusts and other potential employers. Such a review needs to consider pay, living accommodation, training and career development opportunities and the employment and other opportunities of the partners of potential employees.

Recommendations

R28 The senior management team should implement the outcomes of the staffing review so as to ensure safe levels. *Urgent*

R29 Simultaneously, the chief officer should commission a review of the terms, conditions - including residency rules – and prospects offered to those who come to work in HSSD and consider their impact on the staffing of the hospital and on its ability to attract and retain good-quality staff. *Urgent*

Training

2.36 A number of interviewees told us that the hospital had a well established programme of mandatory training. However, we were informed that the recent nurse staffing review had highlighted that no training allowance was made within nursing establishments. This meant the take-up of training courses – including mandatory ones - had been low because of the difficulty wards had in releasing staff. This needs to be addressed.

2.37 All departments should identify general and specific training needs and produce an annual programme of lectures, seminars and practical demonstrations or courses. This programme should be discussed with senior managers and clinicians with a view to identifying actions that would allow all staff to fulfill these educational obligations. This can be done by holding the same programme several times a year or, if appropriate, by rescheduling or cancelling other activities in order to allow the clinical areas to release staff. Attendance should be compulsory and a register kept. It may be difficult at first but the risks of not providing and insisting on regular training can be significant.

External relationships

2.38 The hospital is a major institution on the island. Some of what it does is newsworthy. We were struck by the fact that the hospital does not have a designated press officer to handle routine enquiries from the media or to ensure that the hospital promotes a balanced view of its activities. We think this should be addressed.

2.39 The management team need to identify a single point of contact for police officers to use when there is a coronial or criminal investigation in the hospital. We make a recommendation in our report about the need for a local agreement.

Effect of Elizabeth Rourke's death on the hospital

2.40 We felt during our interviews that many people had been hurt by the events of the last three years. They were not necessarily those most closely involved in the events of 17 October. They included junior as well as senior staff, people still work at the hospital and people who have left.

2.41 The hurt comes from several sources: some feel unfairly criticised; others feel unappreciated for their efforts to do the right thing and others feel let down by people they trusted and admired. We have been told of broken friendships and strained relationships.

2.42 We believe that much of this hurt is based on misunderstanding, aggravated by the delay in establishing what happened and why. It seems rumour, supposition and distortion have had chance to thrive in the absence of reliable information and have damaged trust and goodwill.

2.43 There is still plenty of trust and goodwill between individuals, and certainly towards patients but the atmosphere in the hospital seems to have become less happy, relationships between some groups and individuals somewhat hostile. Some staff find it difficult to believe in the good intentions of others.

2.44 However, we also believe based on what we have been told that the situation is retrievable. Hospital staff from all backgrounds have told us of their hope that our report will form the basis for a renewal of the friendliness and respect that they recall from happier times. We believe there is enough goodwill and optimism to achieve this if everyone works together.

2.45 We asked most people we interviewed to identify three improvements that could be made in the hospital and to health services. People responded positively to this invitation and the list of their suggestions is in appendix C. We have organised their suggestions and ideas in the same categories as the recommendations in our main report.

3. Other points

Individuals with multiple roles/recognition of conflicts of interest

3.1 Jersey is a largely self-governing state: it has a complex and ancient system of government that requires the involvement and contribution of the people of Jersey from the parishes upwards. The States is a major employer on the island. When these facts are put together on an island with a permanent adult population of 54,000, it is inevitable that overlapping and interlocking personal, professional and political connections will frequently cause conflicting loyalties. A number of interviewees expressed concern that there was little shared understanding on the island of the issues involved or how to deal with the problem.

3.2 Conflict of interest can arise not just when an individual has a choice between a right and a wrong course of action and chooses the wrong course for personal advantage. It can also arise when an individual has two or more legitimate responsibilities towards others that are in conflict with each other. For instance, a charity trustee who is also a States employee may be invited to decide on a planning application in which the charity for which he volunteers has an interest, although he has no personal interest. His wish to support the charity is perfectly virtuous in itself, but clashes directly with his obligation not to take account of irrelevant matters in reaching his planning decision. His personal involvement with the charity is irrelevant as far as making the decision is concerned. It would be impossible for him to prove that a decision which benefited the charity had been made properly, so he should take no part in the decision-making, however honest his intentions.

3.3 Equally, conflict of interest does not become a problem only when someone is aware of it. It is perhaps more of a problem where the person is not aware of it and makes a well-intentioned decision in good faith without thinking through all their responsibilities. For instance, a manager with a responsibility to manage staff may have to deal with alleged inefficiency by a member of staff who she knows and likes. Her natural unwillingness to upset her friend may lead her to gloss over the inefficiency rather than deal with it effectively. She may be unaware that this treatment (or lack of it) of her friend has caused resentment with other members of staff, who feel that she has displayed favouritism: with the result that a kind impulse damages morale and efficiency, because the manager did not

recognise conflict between the interests of her friend and the interests of those employing her to manage effectively.

3.4 To identify a conflict of interest is not to criticise the conflicted person or to impugn their integrity. It is simply to point out a fact that needs to be dealt with to ensure that no criticism or allegation of impropriety can reasonably be made.

3.5 Interviewees thought these conflicts were not always recognised and acted upon in wider Jersey society and that similar problems existed in the hospital.

3.6 We suggest the States gets expert help in devising a protocol for identifying and dealing with conflicts of interest. This should take full account of the realities of Jersey's size and structure and should be publicly available so that people can see how publicly accountable decisions are made in accordance with good practice.

Suspensions and exclusions

3.7 Many people expressed concern about Mr Day's exclusion, the handling of events during his exclusion and the appropriateness of the policy under which he was excluded. We are aware that the States Employment Board is commissioning an independent review into these matters that will look at the suitability of the policy as well as its application in Mr Day's case, so we make no comment on this point.

The 'Jersey way'

3.8 A number of interviewees have referred to the 'Jersey way' when explaining why things are as they are. We asked people what they meant by this term and received a variety of answers.

3.9 One consistent element which accords with our observations is the preference for informal understanding and agreement over formal, documented policies and procedures. It was suggested that this informality made it easier for people to avoid responsibility when something went wrong. A more benign explanation would be that people were trusted to behave sensibly, without the need to have every 'i' dotted and 't' crossed. The 'Jersey way'

is certainly an alternative to the UK culture of micromanagement. Nonetheless, it has its disadvantages and dangers:

- The knowledge of experienced professionals is lost when they move on. It takes time for new people to reach their level.

- Achieving consistency from staff is hard if policies and procedures are not written, and it makes it more likely that people will believe they are acting in accordance with policy when they are not.

- Where written policies and procedures are not available for newcomers, either permanent appointments or locums, ignorance can lead to difficulties or even disaster.

- Lack of clear written policies and procedures blurs lines of responsibility, which can lead to problems not being identified because no one has responsibility for them.

- Lack of clear written procedures for dealing with problems may lead to issues being ignored because no one feels authorised to tackle them.

- Blurring of lines of responsibility and a lack of paperwork can lead to misunderstandings about the status of individual projects, which can lead to morale-sapping disputes when differing expectations emerge.

Conclusion

3.10 This addendum should not be read as a full or accurate description of Jersey General Hospital. People have spoken to us about their concerns and worries while acknowledging a great deal that is valuable and praiseworthy about the hospital and its staff. Our impression is that those who spoke to us did so constructively in the hope of improving a vital part of Jersey life.

3.11 The concerns raised with us cover different aspects of the work of the hospital but we believe that there is a unifying theme which can be expressed as the difficulty of a small, geographically isolated, largely independent state providing good healthcare for a population which expects the service to keep up with the ever-higher modern standards of treatment, care and management.

3.12 Traditionally, the clinical, managerial and administrative work has been done by men and women born in Jersey or by people who decide to move and settle there. This system has worked satisfactorily for many years, but the inexorable raising of expectations to meet modern standards may now be causing problems that are likely to get worse. For example:

- High-flying potential candidates for key senior posts may not contemplate applying to work in Jersey because of limited opportunities for career development if they stayed and too much upheaval for themselves or their families if they moved back to the mainland.

- Local candidates may not have the necessary expertise or wider experience to identify what should be done.

- Those making employment decisions may see familiarity with Jersey and its ways as a virtue in a candidate when in fact a fresh point of view may be needed.

- Anyone living on the island becomes a member of Jersey society and may find it difficult to stay sufficiently detached to ensure that necessary change takes place.

3.13 These are not difficulties that can be resolved by spending money because they arise from Jersey's physical, geographical, political and social character and culture, which make for something unique and to be cherished.

3.14 One possible way forward would be for Jersey to find ways for the hospital to work cooperatively with other health care organisations so that it preserves its independence but is able to benefit from the skill and expertise of people who enjoy working on the island while also wishing to maintain links with the mainland.

3.15 Such a solution would mean radical change for the hospital. Other solutions might also work, for instance slimming down the role of the hospital so that it mainly provides emergency, outpatient and non-elective services, with most elective work referred to hospitals on the mainland. Medical training, developments in treatment and the expectations of patients and their political representatives are all moving upwards. A hospital that does not move with them becomes increasingly out of date and unacceptable.

3.16 We believe that a public debate about what the people of Jersey want from their hospital and what they can get for the money they are willing and able to spend is a necessary step in deciding the hospital's future.

Appendix A

Consultants who will be over 55 after 1 January 2010

Radiology	3 out of 4
Pathology	2/4
Surgery	2/3
Accident & Emergency	1/3
Paediatrics	1/3
Obstetrics and gynaecology	2/3
Orthopaedics	2/3
Ear, Nose and Throat	2/2
Ophthalmology	2/2
Medicine	1/7
Anaesthetics	3/6
Psychiatry	1/3
Dermatology	1/1

Appendix B

Snapshot of consultant and middle grade medical staffing as at end of September 2009

Obstetrics and gynaecology

The department has funding for five middle grade doctors. Currently three of the posts are filled – one by a doctor who has been in post for less than a year. The remaining two posts are filled by locums.

The department has three consultants. One has been suspended since October 2006. His post has been filled by a locum. Owing to periods of illness, further locums have been required. The health and social services department have approved in principle the appointment of a fourth consultant and sixth middle grade.

Medicine

The department has funding for seven middle grade posts. Unusually, all these posts are currently filled although many of the doctors have been in post for less than a year. However the department has running on as many as five locums at any one time over the last few years.

General surgery

The department has funding for four middle grade posts. All four are filled by permanent appointees. However, one is excluded and another has been under investigation. Their posts are filled by locums.

Anaesthetics

The department has funding for ten middle grade posts. These posts are filled by permanent staff but one doctor is on limited duties and has been assessed by NCAS.

Orthopaedics

The department has funding for five middle grade posts. All are filled by permanent staff.

Paediatrics

The department has funding for five middle grade posts. Four are filled by permanent staff. One post is vacant and has been for eighteen months.

Psychiatry

The department has funding for six middle grade posts. Five are filled by permanent staff. One is filled by a part-time locum.

The department has funding for three consultant posts. Two of these posts have been filled by locums for the last eighteen months. One is now filled by a permanent appointment. The other is being held open for someone on a sabbatical.

Accident & Emergency

The department has funding for four middle grade posts. Three are filled by permanent staff. One post has been filled by locums for over a year.

Appendix C

During the course of our interviews we asked most people we saw to identify three improvements that could be made in the hospital. This list shows their responses categorised in the same way as our own recommendations.

Improvements	Recommendations
The management of the hospital	• Better management of medical staff • Invest in fabric of hospital • Robust processes and HR • Support to lead a directorate and implement clinical governance • Process and management of staff to be stronger • Strong leadership and strong decision making • A clinical director structure that has meaningful responsibilities and power and meaningful engagement with senior management • Stability; steadying the ship • Clear tight guidelines and processes for recruitment and induction of staff • Change of our attitudes; let's be honest about where we are and how much private practice we do • People to regain confidence in their management and feel they are working together
Maintaining and enhancing a patient	• More challenge – especially nurses to doctors – 'everyone has a voice' • Invest in people i.e. education and training • Development of policies • Doctors and nurses to have a de-brief • Improve on governance, need a divisional governance team; a directorate governance team • Dissemination of SUI investigations and the action planning of it afterwards • Need structures in place in order to assure things are being done properly and managing risks • A fairer system – things to be perceived in a balanced way in the public eye • Decent systems and structures – clinical governance • SUI processes – more communication, trust openness

safety culture	• Support to lead a directorate and implement clinical governance • Open up the lines of communication at all levels; nurses sitting on committees with doctors • Datix system needs to be more user-friendly • Medics to accept that nurses are in charge sometimes and are all working together at one level • Structured policy and procedure format • Sorting out some of the procedures • Sorting out some of the ambiguity so we all know what system and what structure we are working in • Management obsessed by number targets rather than safety and quality of medical care. This is a serious underlying problem, which is that we will get this operation done at any cost, and if something goes wrong it will be the doctor's fault. We should not be put in that position
Tackling staffing	• Minimise the use of locums • More front-line staff – more training to provide a better care service to patients • No external locums
The operation of the obstetrics and gynaecology department	• Improve the harmony between people in their department • Improve the practice in the unit; regular meetings with everyone: doctors, nurses • Restoring confidence
The use of locums	• No more locums. Use good quality permanent staff • A policy of reducing locum use to a minimum, or zero • An introduction, where the consultant leaving would say: "*by the way, this is Mr X. He's here for a week*". • Locums working in harness with consultants – to see them there for a couple of days and see the outgoing consultant seeing the locum's ability, observing what the locum is capable of doing

Day surgery unit and theatres	• A black box in theatres • Pre-operative management of patients – making sure that consent policies are right and that patients are consented by people who are going to carry out the treatment • Reduce the number of patients on the list • Have the right people with the right experience doing the right surgery • Clarity on theatre protocols • Standardising equipment • To see an area whereby the replacement is on the floor before the outgoing consultant • The WHO pre-operative checklist
Information	• Development of outcome measures • Clinical effectiveness • Infrastructure for collecting data and analysing – good clinical audit
Managing external relationships	• A fairer system - things to be perceived in a balanced way in the public eye • A press officer – positive PR. A press officer roaming around the wards • To know that there is someone accountable to somebody or somewhere where to go if I wanted to complain. I would want to know what the next stages are • A press officer or media training • Being open and upfront in telling it how it is - factual – these are some of the factors that led to this …
Others	The above outcome would be satisfaction for Bob Rourke in some way; whether saying to him, “the consultants would like to apologise”, something to say, “We’re really going to try to get our act together.”