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- News: Southall plans to sue GMC for delays and an unfair trial (*BMJ* 2012;344:e954)
- Observations: The GMC should be investigated over its Southall and Meadow hearings (*BMJ* 2011;343:d6708)
- Feature: Expert witnesses above the parapet (*BMJ* 2010;341:c3672)

David Southall: anatomy of a wrecked career

After 14 years in the rifle sights of the General Medical Council, the paediatrician David Southall has now had the final case against him dropped. **Clare Dyer** unpicks how he was failed by the regulatory system and what steps have been taken to make sure no other doctor has to go through such an ordeal

David Southall, a professor of paediatrics and child protection specialist with a world reputation, was hauled before the UK medical regulator not once but three times, accused of serious professional misconduct. The cases dragged on for years, bouncing back and forth between the courts and the regulator. Hearings ran out of time, were adjourned, and then resumed months later. In all, Southall spent 14 unrelenting years in the rifle sights of the General Medical Council before the final case against him was dropped.

Serious professional misconduct has been defined as conduct "which would be regarded as deplorable by fellow practitioners." Yet Southall has had the support of the Royal College of Paediatrics and Child Health and of colleagues on both sides of the Atlantic. In the UK, paediatricians who see what happened to one of the leaders of their profession are loath to put themselves in the firing line and the numbers willing to do child protection work have dropped. "There is something grossly wrong with the medical and legal system which allowed this to happen," wrote Jerold F Lucey, editor of *Pediatrics*, the journal of the American Academy of Pediatrics, of Southall's case and that of Roy Meadow, another professor of paediatrics struck off by the GMC and later reinstated by the court.[1]

What went wrong?

Southall's problems date back to the mid-1980s when, as a specialist in babies' breathing problems at the Royal Brompton in London, he couldn't fathom why some babies would stop breathing for no apparent reason. With the cooperation of police and social services, he set up a system of covert video surveillance, which proved that some parents were deliberately suffocating their children. He was hailed by the profession for his pioneering papers, but he became the target of a vitriolic and high profile campaign that lasted for two decades. His work as a leading expert on Munchausen syndrome by proxy (now called fabricated or induced illness) and a trial he

Timeline: Southall's ordeal

1993
Moves from Royal Brompton Hospital in London to North Staffordshire Hospital in Stoke on Trent

1997
Publishes paper in *Pediatrics* on covert video surveillance[16]

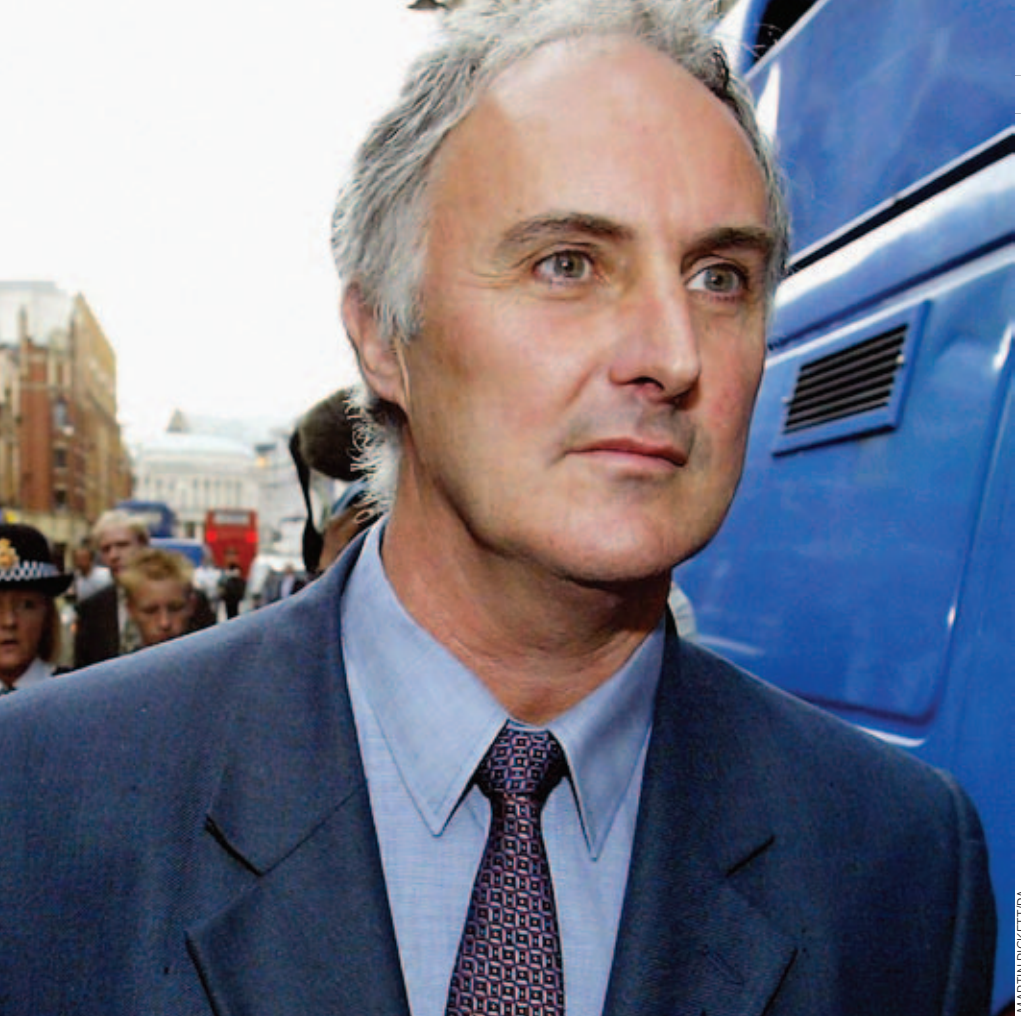
1998-2000
Griffiths inquiry into research on non-invasive ventilation (CNEP-continuous negative extrathoracic pressure) in neonatal respiratory failure calls for follow-up of children involved

1999-2001
Suspended by hospital trust while it carries out inquiries. Reinstated November 2001

2004
GMC finding of serious professional misconduct in Stephen Clark (above) case. Banned from child protection work in the UK for three years

2006
Long term follow-up of children involved in the CNEP trial shows no adverse outcomes

2007
GMC finds that he accused Mandy Morris of killing her son. Orders he be erased from the medical register and immediately suspended. He resigns from his job



MARTIN RICKETT/PA

Professor David Southall leaves the GMC in Manchester in 2004 after being found guilty of serious professional misconduct

and colleagues carried out in the 1990s on continuous negative extrathoracic pressure (CNEP) to help premature babies' breathing became the focus of multiple complaints by parents and lurid media coverage.

Southall was suspended by his employers in 1999 while his child protection and research work was investigated but ultimately cleared of any wrongdoing and reinstated in 2001. However, complaints against him continued to flood into the GMC. It banned him from doing child protection work in 2004, lifting the ban four years later. In a second case, it ordered him to be struck off the medical register—and imposed an interim suspension it had no power under its own rules to impose. He was reinstated to the register by the Court of Appeal, but too late to save his NHS career. In the third case, in which he faced charges with two colleagues, it took 11 years before the complainants' case was thrown out at half time as showing no case to answer.

Southall finally emerged from the shadow of the GMC in February 2012, when the regulator cancelled its last case against him. He has been free to practise without restrictions since the Appeal Court overturned his striking off in 2010. But along the way he lost his NHS job and his B merit award, leaving him with a reduced pension. He accuses the GMC of denying him a fair trial, wrecking his child protection work, and allowing itself, among other failings, to be swayed by an orchestrated campaign waged against him and other child protection doctors with the help of a credulous media.

In two of the three cases brought against him, the GMC's expert witness was Tim David, a paediatrician who had criticised his video surveillance work and who Southall says had a conflict of interest and should never have been instructed. In the third case, brought by parents who accused Southall and colleagues of experimenting without their consent in the CNEP trial, the GMC panel eventually ruled that the main "expert" for the GMC and the parents, Richard Nicholson, editor and owner of the *Bulletin of Medical Ethics*, had "a deep animosity towards Dr Southall" and lacked the objectivity and the expertise to be considered an expert at all. In 2010 the GMC's former president Graeme Catto acknowledged that it had made many mistakes in the way the CNEP case was handled.[2 3]

Penny Mellor, a mother of eight who took up the role of parents' advocate, spearheaded a campaign of complaints against Southall to the GMC, his employers, and the police on blogs and in the media. She filed 38 complaints about doctors with the GMC between 1999 and 2010, 76% of them about paediatricians.[4] Complaints also came from parents she advised, including Mandy Morris, a mother who claimed Southall had accused her of murder in a child abuse investigation, the case which led to his striking off. Mellor was jailed in 2002 for conspiracy to abduct a child whose sibling had been taken into care by social services. It was one of Southall's cases and he reported her to police. For him it was "a slap in the face" when she was appointed to a GMC working group set up to draft guidance

2008
High Court (right) overturns the suspension, which GMC concedes was outside its powers

GMC overturns the 2004 ban on child protection work. He is allowed to practise with no restrictions

GMC's case of research misconduct over CNEP is thrown out after his lawyers successfully submit there is no case to answer

2009
High Court throws out appeal against erasure in Mandy Morris case. Erasure takes effect

2010
Appeal Court allows appeal against erasure, sends case back to GMC. Court says any rehearing should be heard by a fresh panel but gives strong hint that rehearing would not be in public interest. He is free to practise again

2011
Original GMC panel in Morris case hears two further allegations which had been joined with that case and clears him of serious professional misconduct

2012
Investigation committee member Roger Green cancels Morris case, deciding evidence is not "sufficient for the case to progress" (letter below)

for doctors on child protection. She stepped down from the group after Southall threatened a High Court challenge to the decision to appoint her.[5]

In 1993 Southall had moved from the Royal Brompton with his team to take up a professorship at Keele University and to become a consultant paediatrician at North Staffordshire hospital in Stoke-on-Trent. His multicentre trial of CNEP to support the breathing of very premature babies was already going on there. Two babies born to Carl and Deborah Henshall, Sofie and Stacey, were randomised to the CNEP arm of the trial. One died and the other survived but was later diagnosed with cerebral palsy. The Henshalls insisted they had never given proper consent to participation in the trial. Mrs Henshall accused doctors of "murdering" Sofie and causing Stacey's brain damage. At first she denied having given consent at all. Then, after the trust's acting chief executive Keith Prowse produced her signed consent form, the accusation changed to forgery—found to be "entirely false" by another GMC panel that exonerated Prowse of misconduct after the Henshalls complained that he had breached their confidentiality.[6]

Clark case

Southall's first appearance before the GMC came in 2004 following a complaint by Stephen Clark, husband of the solicitor Sally Clark, who had been found guilty of murdering two of her baby sons but cleared on a second appeal in 2003. Mr Clark complained that Southall had reported him to police after watching a TV interview in 2000, while Mrs Clark was awaiting her appeal. Mr Clark described a bilateral nosebleed baby Christopher suffered at the age of 8 weeks, and his struggle to breathe, when he was alone with him in a hotel room after Mrs Clark had gone shopping. Ten days later Christopher was dead.

An authority on babies' breathing problems, Southall knew that bilateral nosebleeds in small babies are extremely rare and, once a small number of medical conditions are excluded, intentional suffocation is the leading cause. Virtually all the research shows that bleeding happens immediately after suffocation and he thought the jury might have convicted the wrong parent, leaving the Clarks' surviving baby at risk and without his mother.

A High Court judge, Mr Justice Collins, would later declare that "his theory that Mr Clark killed his sons was seriously flawed."[7] But the GMC panel accepted that Southall had a right to raise his concerns with the police child protection team, although it accused him of acting precipitately and inappropriately on the basis of limited information. Tim David, professor of paediatrics at Manchester University, was the expert witness for both the GMC and Mr Clark in the misconduct case. He was also a witness of fact because he was the joint expert for all the parties in the family court proceedings to decide whether the Clarks' third son, taken into care at birth, should be allowed back to live with his father. And he had been subpoenaed by Sally Clark's team to give evidence at her criminal trial.

Acknowledging the flaws in its systems, the GMC has set up a Medical Practitioners Tribunal Service, headed by a judge, which will take over the management of doctors' fitness to practise hearings

A strategy meeting that included the child's guardian, a social worker, and the child's solicitor agreed to ask the family court to release medical records to Southall but the application was never made. The family court judge made an order that Southall should put his points of concern to David and that the two should meet, along with the child's solicitor, who would take minutes. David, who was given leave by the judge "to discuss such issues with Professor Southall as he feels necessary arising out of the case," would then prepare an addendum to his lengthy report for the court. But David decided he would prefer to meet Southall alone. He told Mr Clark's solicitors in a letter that he would not give Southall any information and would only ask him questions.

The document read out at the GMC hearings showed that Southall headed his points of concern "report," used the normal sign-off line for a report to the court and said he was certain "beyond reasonable doubt" that Stephen Clark had killed Christopher and his brother Harry. But "David Southall wrote a report with lots of question marks in it," says Mary O'Rourke, who took over as Southall's lead counsel at the end of 2007. "He worded it unfortunately but it's quite clear when you read it in total that these were preliminary thoughts and he asked a lot of questions. The charges in my view were all out of order, because that report went only to Tim David. It didn't go to the court, and it never was going to the court."

No expert evidence was called for Southall at the GMC hearing, so David was the only expert the panel heard. Two leading paediatricians had written reports that were supportive of Southall and were intending to give evidence. One pulled out after featuring on the front page of a Sunday newspaper with quotes from Mellor saying she was aware of complaints about him to the GMC. The other's decision not to appear was never explained, says Southall. A third was asked to give evidence "but said it would place him at too much risk because of the campaign," he recalls.

The panel found Southall's actions "precipitate," "irresponsible," "misleading," and an abuse of his professional position and imposed a three year ban on child protection work. In 2007, by now embroiled in the Mandy Morris case, he agreed to a year's continuation of the ban pending a review hearing.

For the review in 2008, now represented by O'Rourke, he produced four paediatricians and an experienced local authority child protection lawyer, who gave evidence that his fitness to practise was not impaired and cast doubt on the original panel's findings. O'Rourke argued that David was "deeply embedded in the factual matrix" of the case and was not an independent expert, and that the first panel had made a number of incorrect assumptions, including treating Southall as an expert witness preparing a report for the court, when he was not. The review panel lifted the ban with immediate effect.

At the heart of many of Southall's problems with the GMC, suggests O'Rourke, is the fact that all three of his cases were "complainants' cases" under pre-2004 rules, which applied because the cases had started before the rules were changed. Under the old rules, the barrister representing the GMC also represented and took instructions from the complainant, who could choose the expert witnesses. At the same time judges were ruling that complainants had a legitimate expectation that, where there was a factual dispute, their complaints should go to a public hearing and not be disposed of behind closed doors.[8-10]

Slim evidence

In two of Southall's three cases, the GMC had tried to drop the case but met objections from a determined complainant. One was the Mandy Morris case, in which a "rogue" panel—O'Rourke's description—decided to strike him off the register in 2007 after accepting the mother's story that he had accused her of murder. Southall had been instructed by a local authority, which was considering applying to take a boy into care. His brother had hanged himself aged 10 and he was talking about taking his own life.

Southall interviewed Morris in the presence of a senior social worker, who took contemporaneous notes and denied that Southall made the accusation. He said he was simply outlining a range of scenarios, and the notes of a child psychiatrist who interviewed Morris said that she "felt" she was being accused of murder. But the panel decided the charge was proved even though the standard of proof at the time was "beyond reasonable doubt." The decision alarmed paediatricians, who concluded that they were not safe interviewing a parent even if another professional was present.

Again, no expert evidence was called on Southall's behalf, this time because his then counsel was against it. O'Rourke thinks Southall's former legal team may have been lulled into a false sense of security, knowing it was a case which the GMC had tried to cancel. She has "no doubt" that the decision to let it go to a full hearing after Morris objected to cancellation was influenced by the line of High Court cases at the time backing the right to a public hearing.

The order striking Southall off the register would not have taken effect immediately if he had appealed, but the panel decided to impose an interim suspension to stop him practising in the meantime. It had no power to do so in a case brought under the old rules, but nearly five months passed before the mistake was spotted and put right. When a High Court judge, Mr Justice Blake, upheld the panel's findings, the order removing Southall from the register took effect and he could no longer practise. But O'Rourke decided to go to the Court of Appeal. There, three senior judges held that the panel had given inadequate reasons, Blake "fell into error," and Southall should be reinstated.

Two other charges—that Southall had kept his own files in two cases without sufficient signposting to main hospital records and had written a letter about child protection concerns to an unnamed paediatrician at a child's local hospital—had been joined with the Morris allegations and the case had to go back to the panel for a decision on those. With expert evidence on Southall's behalf this time, the panel decided those actions fell short of serious professional misconduct.

The Court of Appeal had sent the Morris case back to the GMC with a strong hint that, 14 years after the event, it should not go to a fresh hearing. But it took a further year and nine months—during which the two minor charges were heard—before Roger Green, the member of the investigation committee who had originally refused to cancel the case, concluded in February 2012: "I do not believe that the evidence to unambiguously support the single factual allegation in dispute is sufficient for the case to progress."

No case to answer

Meanwhile, in 2008 the CNEP case had been thrown out by a panel at half time, after taking 11 years to get to a hearing. The Henshalls made their complaint in 1997 but the case failed to get to first base at the GMC because the screener decided not to refer it to the preliminary proceedings committee (PPC). Mrs Henshall then complained that the screener had failed to take account of a large amount of documentation. The screener agreed in 2002 to reconsider and in 2004 referred it to the PPC, which decided not to send it further, concluding it had no real prospect of success. But the Henshalls got legal aid to apply for judicial review. They lost in the High Court, but went on to the Court of Appeal, which in 2005 by a two to one majority sent the case back to the PPC for reconsideration.

The PPC referred the case for a hearing, which did not start until 2008. A series of independent investigations had found no fault with the CNEP trial,[11 12] and the panel, chaired by a chief crown prosecutor, accepted a submission by the doctors at the halfway point that there was no case to answer. But during the 11 years, wrote Neena Modi and Neil McIntosh, current and former vice presidents for science and research of the Royal College of Paediatrics and Child Health, "the lead investigators endured prolonged suspension, traumatised personal lives, multiple GMC hearings, loss of income, career destruction and repeated vilification in the press."[13]

Three professors of paediatrics have been struck off by the GMC, Southall notes, and all three have been reinstated by the courts—himself, Roy Meadow (an expert witness for the prosecution in the Sally Clark case), and John Walker-Smith (an author of the discredited *Lancet* paper that claimed a link between MMR and autism). The courts are starting to look more critically at the GMC: in two cases in March this year—those of Walker-Smith and a psychiatrist, Robin Lawrence—judges made devastating criticisms of the quality of the panels' decision making before quashing their findings.[14 15]

Acknowledging the flaws in its systems, the GMC has set up a Medical Practitioners Tribunal Service, headed by a judge, which will take over the management of doctors' fitness to practise hearings from this summer. Judge David Pearl will be responsible for appointing, training, appraising, and mentoring panel members. At the top of his list should be to make sure that nothing like the Southall saga ever happens again.

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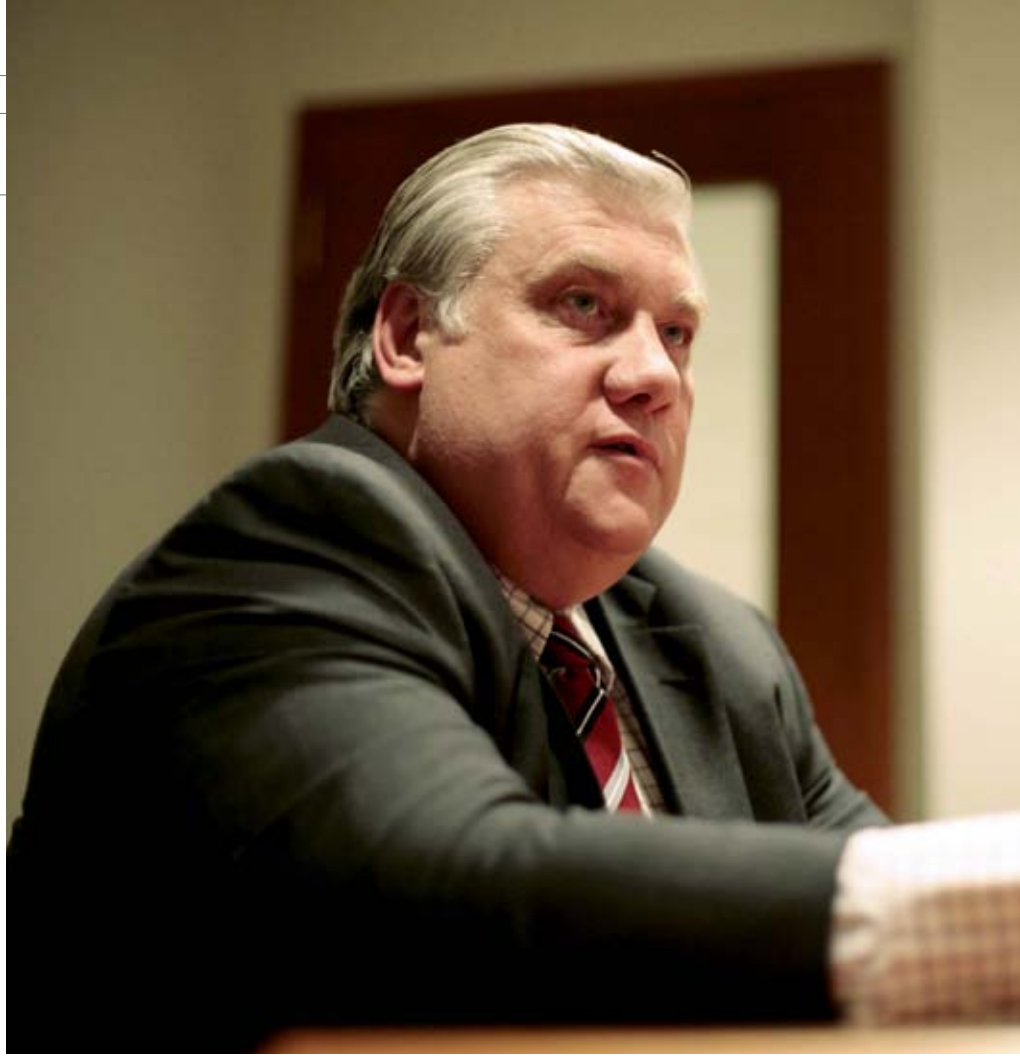
Kizer's permanent qualities

After Kenneth Kizer turned around the Veterans Health Administration it was credited with providing the best medical care in the US. **David Payne** met him in London recently and heard how he pulled off such a reform, and about his past job taking on the tobacco giants



In 1990 Kenneth Kizer clashed with the vice-president of the US Tobacco Institute, Brennan Dawson, on NBC's *Today* show after the state of California launched a multimillion dollar antismoking campaign.

The news clip includes a television advertisement in which industry executives cynically discuss the need to recruit 3000 new smokers each day to replace the 2000 Americans who quit and 1100 who die. A second advert shows a pregnant woman passive smoking.

Dawson warns Kizer, then director of health services for California, that America's tobacco farmers are a powerful lobbying group in Washington.

California's electorate, who had voted for 25 cents to be added to a pack of cigarettes to fund an antismoking campaign, had not sanctioned a $30m (£19m; €23m) attack on the industry by Kizer's department. "Mudslinging doesn't go well with voters," Dawson told him.

But Kizer responded: "The only thing that's being attacked here is the image. Tobacco use isn't sexy or glamorous. One thing that's unique about our campaign is we've built in a very rigorous evaluation mechanism."

Over the next 20 years adult smoking rates in California dropped by 41% to 13.3%.[1] Last year the rate fell to 11.9%.[2]

A 2010 paper in the journal *Tobacco Control* compared the change in smoking attributable cancer mortality rate (SACMR) in California with that in the rest of the US from 1979 to 2005 among adults aged 35 years or older.[3] The study assessed deaths attributable to smoking from lung cancer (smoking causes 85% of lung cancer cases) and nine other cancers, including the oesophagus, stomach, pancreas, larynx, and lip, oral cavity, or pharynx. It found that California's mortality started to fall in 1984, seven years earlier than the rest of the US, and declined by 25.7% between 1979 and 2005, compared with 8.9% for the rest of the US.

Kizer's leadership qualities: I try to cut through the clutter and get to the essence of the problem. I think everyone would agree I'm willing to take substantial risks

"People still are amazed that the government would put stuff out like that," says Kizer referring to the television adverts he ran as director of health services. "Everyone was convinced when those aired that I would be immediately fired by George Deukmejian, who was a conservative Republican governor."

Kizer kept his job, and the campaign's high profile at a time of unprecedented change in California (the HIV epidemic, the embryonic environment movement), combined with launching a five a day nutrition campaign and running the country's largest Medicaid programme, inevitably bought him to the attention of the federal government.

Federal challenge

In 1994 President Clinton appointed Kizer, a former US Navy diver who had specialised in emergency care after graduating in medicine and public health, to lead the beleaguered Veterans Health Administration, part of the Department of Veterans Affairs, the second largest US government department.

Established after the first world war to provide treatment for veterans with combat related injuries and now the largest provider of healthcare services in the US, it was seen as centralised, punitive, and bureaucratic, as too hospital and specialty based, and with little focus on disease prevention and monitoring quality.

Colleagues warned Kizer that the cabinet level post was a "career ender," with elected officials queuing up to ridicule the department on CNN each time its failures hit the headlines.

But he argued that six years of delivering large scale change in California's large economy was an ideal preparation for life in the federal capital. "If there is any place that has politics that are similar to Washington, DC, it's Sacramento."

Kizer's 80 page *Vision for Change* integrated

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David Payne meets Kenneth Kizer

care strategy contained bold plans for service configuration and devolving greater accountability to the heads of 22 new integrated service networks across the country. Typically these consisted of 8-9 hospitals, 25-30 community clinics, 5-7 long term care facilities, 10-15 counselling centres, and one or two residential care units for people with chronic mental health and substance misuse problems.

After he left in 1999, *BusinessWeek* said the Veterans Affairs system provided "the best medical care in the US." A later cover feature in *Fortune* magazine described "How the VA healed itself."

The Veterans Health Administration reduced bureaucracy but increased the number of caregivers

The media seized on the VA's technological reforms, particularly the extension of VistA (Veterans Health Information and Technology Architecture) and its computerised patient record system, across 172 hospitals in three years.

A patient barcode system helped to check dose timings and reduce prescription errors. Kizer also introduced a limited national formulary and tough price negotiations with drug companies.

An observational study published in the *New England Journal of Medicine* found that the VA outscored Medicare's fee for service programme for the quality of preventive, acute, and chronic care.[4]

But service configuration was a bitter pill to swallow. It meant the closure of 29 000 acute beds (55% of the total) and the opening of 300 community clinics staffed by general internists. Inpatient admissions reduced by more than 350 000.

This month Kizer told an international summit on integrated care in London: "We reduced staffing but the proportion of caregivers increased. You have to restructure your assets, but hospitals are major employers in every community and when you talk about cutting jobs it causes elected officials' sphincters to tighten because hospitals are part of a community's identity."

Kizer experienced this first hand after four years when he sought reconfirmation for his job. One senator demanded an assurance that the VA would never close a local hospital, an assurance he felt unable to provide. Another supported him privately but said he could not endorse him publicly.

Ultimately a law was passed that kept Kizer in post for a further year, but by then he decided to leave for personal reasons and was keen to set up and lead the National Quality Forum, which had been recommended by a presidential commission to set and endorse standards of care using a formal consensual process. He stayed for six years.

After heading so many organisations, how would he describe his leadership style? "I always have a hard time answering, but I think most people find I solicit input broadly.

"I expect people to be brutally honest and tell me why things won't work. And then I'll make the decision. I tend to be fairly aggressive, particularly as far as timelines and moving things forward.

"I try to cut through the clutter and get to the essence of the problem. I think everyone would agree I'm willing to take substantial risks. I try to avoid taking stupid or poorly informed risks, but I have no problem going way out on a limb."

Patient safety

At the VA Kizer also encouraged colleagues to report errors but was warned by his boss that going public on them was "political suicide."

Kizer adds: "He said you have to understand that if you move forward, you'll be the first casualty if things don't go well.

"We did report on our errors and collected 19 months' worth of data, which showed that there were about 3000 errors in the system and then 700 preventable deaths over that 19 month period. And we put it in a report and sent it to Congress.

"It was an unsolicited report; we didn't have to do it. To my amazement nothing happened."

Six months later he got a call from Robert Pear, Washington correspondent for the *New York Times*. Pear said he'd heard about the report, asked if it existed, and assumed he would have to submit a freedom of information request to get a copy.

"I told him to drop by that night and I'd give him a copy, but we needed to talk about it to put it into some context. So we talked for about two hours," says Kizer.

On Monday the newspaper led on the story with a typically hard hitting but factually accurate story written by Pear.

"The key point I wanted to make sure that Robert got was that as bad as this was, this is what was happening in hospitals every day, everywhere around the country. And the difference was that the VA was doing something about it.

"Instead of basically brushing it under the rug, we were overtly trying to do something about it. And a couple of days later there was a nice glowing editorial. It was a risky thing to do. It turned out OK. As a matter of fact I think it turned out better than OK."

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BMJ Group Improving Health Awards In association with MDDUS

Inspirational leaders

Kathy Oxtoby introduces the doctors shortlisted for the Clinical Leader of the Year award

Motivational and inspirational leaders can encourage clinical teams to achieve real service improvements. But to transform services they will face challenges, such as budgetary constraints and resistance to change.

The four finalists for the BMJ Group award for clinical leader have not only overcome obstacles to bring about change but can also show a measurable improvement in patient care.

Jon Cardy, West Suffolk NHS Foundation Trust

Before Jon Cardy became clinical director for accident and emergency services at West Suffolk NHS Foundation Trust in 2011, the department had failed year on year to meet national quality standards. But within a month of his taking on this post, his department achieved a dramatic improvement across a range of measures of quality performance, hitting and maintaining the number one position in the country on the four hour wait standard.

One of the challenges Cardy faced was that West Suffolk emergency department was designed to manage many fewer than half the number of patients that currently attend. He worked tirelessly on improving interdepartmental cooperation and enhancing patient flow by gaining hospital-wide support to improve the urgent care pathway.

Cardy stood "shoulder to shoulder" with his team to get the job done, "because I wouldn't expect anyone to do anything I wouldn't do myself," he says.

John C John, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry

John C John is a consultant anaesthetist at one of the largest elective orthopaedic hospitals in the UK, where up to 2800 joint replacements are carried out every year. John has led the introduction of a new approach to speed up the rehabilitation process for patients, which has significantly reduced the length of stay after surgery.

Traditional analgesia in joint replacement procedures has drawbacks for recovery: morphine can cause nausea and sedation, while nerve blocks cause muscle weakness, which delays patients' mobility until the first or second day after their procedure. John's vision was to replace anaesthetist led techniques with intra-articular local anaesthetic infiltration by surgeons.

Achieving this required a complete change in analgesic techniques and a cultural transformation within the trust. John overcame resistance to change by showing through his own practice how effective the new method was, highlighting to clinicians the quicker recovery and that some patients were able to go home within a day after having a joint replacement.

John ensured that clinicians were involved in the project from the start to avoid their feeling alienated and give them a sense of ownership. He describes his leadership style as "inspirational and enthusiastic." He says: "Being passionate about the project, and feeding back to colleagues how much patients love this programme has helped to inspire the team."

Pradeep Khanna, Aneurin Bevan Health Board

Managing chronic conditions and frailty in adults is a considerable challenge for health and social care. As clinical leader for the Gwent Frailty Programme, Pradeep Khanna has been instrumental in uniting local authorities, health boards, and voluntary organisations in the region to work together to benefit frail people in a holistic way.

Responding to Khanna's belief that the healthcare needs of many frail patients are best served in their own homes, rather than in secondary care, the Welsh Assembly Government has invested £6.9m (€8.6m; $11.3m) to support the Gwent Frailty Programme. Thanks to his drive, leadership skills, and influence, health and social care organisations in the Gwent area now work as one, with a single budget to improve patient outcomes and support care within communities. The programme has considerably reduced the time people spend in hospital, producing substantial savings and increased patient satisfaction.

Having a clear vision, seeing "the big picture," and being single minded are qualities that have helped Khanna to break down organisational barriers. "You have to be totally on the side of patients—and I'm passionate about looking after them," he says.

Duwarakan Satchithananda, University Hospital of North Staffordshire

In 2007, a Healthcare Commission report suggested that the University Hospital of North Staffordshire was one of the worst performing hospitals for heart failure in the country. Since becoming clinical lead for heart failure in 2008, Duwarakan Satchithananda has transformed the care of patients.

He has implemented two interventions for the management of symptomatic and worsening heart failure within an overall programme of change. The first intervention provides community based subcutaneous diuretics for relief of symptoms in the palliative care of patients with heart failure. The second offers what would have been standard inpatient care in heart failure—including intravenous diuretics—on an outpatient basis through an ambulatory heart failure unit.

These changes have led to better links with primary care and community teams caring for patients with heart failure and a strong relationship between palliative care and heart failure teams. Patients have welcomed the initiative, and in one year the scheme has reduced hospital admissions for palliative care patients by 350 bed days.

Satchithananda has also boosted staff morale by encouraging them to develop their skills and leading from the front by example. "Staff were feeling demoralised and their practices were old fashioned. I introduced a teaching regime that has changed the way they work and given them more confidence. I like to think I can inspire people to do better," he says.

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