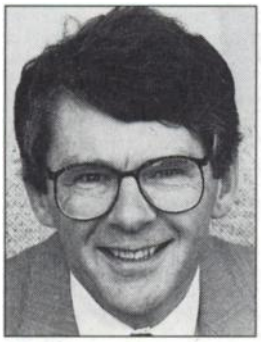
INTERVIEW

Peter Kennedy

In conversation with Alan Kerr



Dr Peter Kennedy, born 1941, was educated at St Bede's Grammar School, Bradford and at Leeds Medical School. He started Psychiatry in the Mental Hospitals of York, then went to Edinburgh as Research staff of the MRC Psychiatric Epidemiology Unit where he remained as Senior Lecturer from 1972–80. In 1980 he returned to York where as Consultant and General Manager he led the Mental Health Services through major developments of community services which led to the closure of Naburn, Clifton and Claypenny Hospitals. He was District General Manager of York Health Authority 1988–92 before leading the development of York Whole District Trust of which he is now Chief Executive. In 1994 he co-led the Mental Health Task Force London Project which followed the Clunis enquiry.

Where did the urge to enter medicine come from?

I have to be very honest about it. It was not a burning vocation in the beginning. It was very easy to gain entrance to medical school in those days. I consider myself extremely fortunate that an impulsive adolescent choice has led to a career that could not have been more interesting.

I entered medical school in the late fifties and at the time medicine was in the doldrums with university vice chancellors wondering if it ought to be farmed out to technical colleges because they did not regard it as having academic standing. The prestige of medicine was pretty low. I remember thinking they must have got it wrong. Fortunately by the time I graduated medicine was into a scientific boom with massive investment in research from the mid-sixties onwards.

You qualified at Leeds?

Yes.

What do you recall of your psychiatric training?

I got to know Arthur Bowen, then Medical Superintendent at Bootham Park and Naburn Hospitals, York. We were having our second child, a house job ended and like most junior doctors you are in this frightful situation of short-term employment requiring moves that are very difficult for a family. Arthur offered me an extremely nice flat over the front door of Naburn Psychiatric Hospital, including a free nappy supply from the hospital laundry. The institution presented so many clinical questions and possibilities that I became very interested. Within weeks I enlisted for the DPM course in Leeds and met Max Hamilton. That was an experience never to be forgotten.

Could you tell us about that?

Max had a statistical leaning that he was determined to drive into a field which had up to that time been entirely philosophical and humane. It grated a bit and I remember some people saying, "keep the chi-square out of psychiatry". So it was an environment that was quite controversial as well as stimulating. The training there was excellent in what now might be called the evidence-based approach. Max was extremely meticulous. When I later went back, to 'defend' as he put it my MD thesis, I had to defend some split infinitives as well as the implications of my data on parasuicides.

What took you up to Edinburgh?

I had been involved with a piece of research (on tardive dyskinesia) as a registrar with Howard Hershon which to our amazement was published. I will never forget the letter that came back from Eliot Slater (Editor of the *British Journal of Psychiatry*, 1961–72). It was the kind which every registrar ought to receive to encourage research effort and lift horizons. He said very positive things about the paper but made excellent suggestions to improve it. It is a lesson I have tried to apply in refereeing papers for years: to emphasize the positives; genuinely help to make the paper better; and always show appreciation of the effort.

So not having thought of myself in that way before I put in an application to the Medical Research Council (MRC) unit in epidemiological studies in Edinburgh. I went for an interview and was appointed. So from being a registrar in a peripheral mental hospital, suddenly to find

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myself at McMaudsley as they called it, one of the top teaching and research centres was quite a life event.

What do you recall of the time you spent in the MRC unit?

It was a mixed blessing at first coming from a very busy clinical job to have a conversation with the Director, Norman Kreitman, who said, "Take two or three months to find out what people do and think". I suddenly realised I had an office, an empty desk and nothing to do.

You were not clear what you were going to do?

No, I arrived in a unit which was developing fast with plenty of money because research into the social aspects of mental disorder was in its heyday. I was suddenly realising that I had time to think, but had to find my own structure, nobody was going to tell me. I was learning just what research is about. Norman's integrity in research was important to have experienced. He was not interested in promoting results or publishing for the sake of it. I remember giving a presentation to a large group of general practitioners (GPs) about a survey that he and I wanted to do. I was in danger of overselling it to get cooperation of GPs who I knew to be action oriented, seeking early practical results. Norman held me back and said, "If we are ever to reach the truth we have got to stick ruthlessly to the data and within their limitations". How right he was, now that we have all seen too many recycled papers, exaggerated claims, and heard of people 'massaging data'!

Later you studied the milieu of an admission ward and wrote about short-stay acute psychiatric help. What was that about?

Well at the time people were staying a fairly long time in hospital after an emergency admission and much of what went on in terms of therapy was actually done in limited segments of time. There was a lot of empty time. I was affected by a visit to Dingleton Hospital where Maxwell Jones had developed a complete therapeutic community which Professor Henry Walton was also fostering in Edinburgh. I was struck by this whole new approach, giving people more power to determine their own treatment needs, in more of a partnership than under the professional paternalism they were used to.

It could go two ways. Some seemed to revel in the therapy and became dependent on the institution but often it gave courage to move on more quickly. There was an argument at the time that short-stay meant losing patients that our medical students and registrars needed for training. How barmy that patients should accommodate trainees rather than vice versa. The short-stay unit was trying to identify what are the essential things that have to be done in hospital. How soon can one start restoring their social situation. The problem for me was that there was very little out there at the time. There were a handful of community nurses for a population of half a million and little else in the way of aftercare. The conclusions seem obvious now. Discharge planning needs to start immediately on admission and the whole care system has to be changed, not only the in-patient bit.

You became senior lecturer at Edinburgh. Did you have ambitions for a Chair?

I applied for a Chair or two – too young. They did me a favour by turning me down. I was 36 and to be appointed in those days was to be Head of Department immediately.

In fact, about that time I became very interested in the mental hospital scandals that had started in the sixties and were rolling on with depressing regularity through the seventies. It was a course which Bob Kendell (then Professor R. E. Kendell) was very keen on me teaching. The more I went into it I found that the seeds of failure were in most long-stay hospitals. The scandals were threatening the credibility of British psychiatry. I realised that as an academic I could have no influence. As a National Health Service consultant I might, but medical management was not invented in those days.

So that was all in your head when you returned to York?

Yes, besides the fact it was my home county and I wanted to be close to my elderly parents. It was quite a risk. Arthur Bowen had just retired. We used to talk about leadership and he reminded me that the place had run better when there was somebody in charge but the physician superintendent role had been chipped away over the years and now consensus ruled which often meant deferred decisions and no direction setting.

Is that what you meant by the risk?

The risk was not knowing whether I would have an opportunity to do anything or just be stifled by an administration that avoided difficult choices. But I met a health economist called Professor Alan Maynard at York University and we talked about a revolutionary idea. I'd never heard of it before.

What was that?

Opportunity costs. It is the now well-known principle that you never just ask how much

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something costs, you also ask what could we buy instead? We walked around Naburn, Bootham Park and Clifton Hospitals (mental hospitals in York at that time) and realised that corridors, buildings, orchards, gardeners, printing shops, laundries, wards had opportunity costs of huge sums of money that could, with imagination, be turned to better purpose. Over 95% of the mental health budget was being spent on a tiny minority of the mentally ill. Maynard organised a course for me and a few others to talk about the economics of health care. I then began to have some influence on the administration of the time talking about opportunities from closing Naburn, and transferring millions of pounds into new services. They seemed pleased to have a clinician interested in what existing services cost but the District Administrator saw change as a slow evolutionary, process forecasting that Naburn might close in 1997 and Clifton hospital after the turn of the century.

But to implement these ideas you decided to become a manager. Did you find it difficult to understand why other colleagues were not also enthusiastic about taking such a step?

I understand that most consultants want to be leaders, but many are nervous about being trapped into thinking about the cost of care rather than its quality. To my mind quality cannot be achieved without consideration of cost and opportunity costs. But attitudes are changing.

How did the local scene appear to you when you became Unit General Manager?

There were three very dilapidated mental hospitals with hundreds and hundreds of staff and only two or three community nurses to serve a population of 250 000. The only day centres were on mental hospital sites and were the most depressing places imaginable. Troops of people crowded in daily to do extremely boring things. When I realised that at 1985 prices it was £25.00 per day for a patient to go to these day centres I wondered what would be the effect of standing outside with a wad of fivers asking each "what would you rather do with £25.00 today?"

Unfortunately we psychiatrists rarely, if ever, met to discuss where the service was going and what it could be like. We met to simply try and resolve disputes about rotas and use of beds and junior staff.

How did you set about changing this?

We produced detailed information demonstrating that trends in falling occupancies at Naburn hospital meant that patients in 12 wards could be aggregated into eight. This could release £750 000 and that could buy two or three more consultants and a lot of commmunity nurses. Consultants and nurses began to take an interest. We were in business.

Of course first reactions were somewhat mixed. No one could quite believe in it because of recent history where savings made in the mental health services usually disappeared into a financial deficit in the acute hospital sector. With the District General Manager's help, I embarrassed the Health Authority about such looting of the so-called 'priority services' and they gave an undertaking that any savings made would be ploughed back into mental health. More than that, the authority recognised that to gain everyone's confidence, putting some money up front could inspire trust. So we got £150 000 or so and started to renovate wards at Bootham Park and Naburn. Even though we had set a closure date for Naburn we were not going to let it deteriorate while any patients and staff remained. Those renovations showed people how a good environment could be produced in an old hospital even in a tight financial situation. At a time when the Health Service was screaming for money we were manifestly spending it.

Within 18 months we had appointed two additional consultants and 26 more community psychiatric nurses. Then ideas began to flow about better day care. There was a tendency in those days to think of purpose built buildings first. It was turned upside down by asking actual groups of patients how they would like to spend their time, then renting properties or buying houses around the town that could be sold easily later. Their needs and interests were bound to change.

And you involved consultants?

You absolutely have to. In no time at all some consultants were out there ahead producing better plans for services than I had ever dreamed of. But there was always some tension about. There were resistances, no doubt about it, because closing wards to fund the community services required significant changes in clinical practice. There is a whole science about handling and resolving conflicts. I wish I had known then what I know now.

Perhaps you could tell me what you know now?

Before making any proposal for change it is well worth checking that everyone concerned acknowledges that there is a problem or that services could be much better. If that is denied, make sure there is direct exposure to the criticisms and dissatisfactions expressed by

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patients about the service. Then, when making a proposal to improve things do welcome dissent. Encourage dissenters to come up with a better proposal – they often do. Make sure everyone knows from the outset when the decision has to be made and by whom. When there are strong differences of opinion among consultants then there are often important ethical issues at stake like the interests of one set of patients versus another. No individual, particularly a chief executive, should claim authority to decide such questions. Their resolution should be referred to the Board which should hear all the arguments and decide giving explicit reasons for its decison. With decisions of lesser gravity it should be clear from the outset of the debate that greater weight will be given to those members of staff who will be most affected and who will be accountable for a good outcome.

It can be difficult to involve people in decision-making who are lone rangers. One has to insist that those who come late to meetings, leave early or do not attend at all must nevertheless be bound by the decision when it is made. *Post hoc* dissent by non participants is disrespectful to those who put time and effort into the debate or into developing proposals. One must always try to avoid battle language that assumes winners and losers, preferring the analogy of developing scientific theory where everyone's contribution might help to advance the theory. Of course managers like clinicians are trying to make the best decision on inadequate evidence. I reserve the right to change my mind and I try to be the first to admit it when I get things completely wrong. It is all part of an ethical approach to management that I learned from management consultant and former Maudsley psychiatrist Warren Kinston.

After many many major decisions the spend on mental health was the same at the end of our strategy as it had been at the beginning. We had double the number of consultants and lots more staff in the community with fewer beds in very much superior accommodation. There is now more energy among staff, some healthy anarchy, and ideas flow from all quarters. But of course that is all about input; it is the outcome for patients and the local community that is of paramount importance.

How controversial were the changes with GPs and the public?

We realised at the outset that whatever we did would be controversial and needed public debate to gain understanding of the long-term objectives and every step towards them. I became a regular newspaper feature. It is not something I ever expected in my career and at first I did not know how to live with it. But the more I think about it, senior professionals who are leading major changes have to be willing to stand up and be questioned. People might learn to trust an individual whereas they are unlikely to trust published plans from bureaucratic organisations. If they do not trust you you cannot lead changes in public services.

It must have had some uncomfortable moments?

Extremely. When we went out to consult on the closure of Naburn Hospital and then Clifton Hospital, there were noisy public meetings involving hundreds of people. The most articulate of course are the Trade Unions whose primary concern is about staff and their jobs. That makes it more difficult for members of the public to understand the detail about what will happen to patients. In reality every patient, relative and member of staff needs questions answering on how the changes will affect "me". In theory it would be much better if the plan could be launched gradually dealing with individual concerns first but that is impossible in a public service that keeps no secrets.

Were you able to reassure them that their jobs were secure?

We explained to staff that consulting them 3–4 years ahead of closure meant that they could take part in managing the change, re-train and take the new jobs in the new services. That programme of training plus our forecast of retirements and people moving jobs meant that we anticipated no compulsory redundancies. More than a thousand staff moved with the changes and there were only 20 compulsory redundancies. They were people who lived near Naburn and did not wish to work a few miles away.

You worked as Unit General Manager for Mental Health and then became District General Manager for York and are now Chief Executive, so you have been on both sides of the purchaser/provider split. What are your views on how it is working?

There is a need for decisions to be made on health priorities detached from the interests and enthusiasms of professionals providing treatment. But as yet most purchasers are too detached with too little knowledge of the realities of clinical practice. I know it can work because I have seen US Health Maintenance Organisations having a powerful and positive influence on obtaining appropriate and cost-effective services. But they employ medical directors who have had extensive clinical experience themselves.

There is plenty of evidence in mental health services that resources are poorly targeted on cost-effective treatments for those most in need. I think it is a pity that Health Authorities did not

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some years ago demand of providers that they produce effective systems for managing and monitoring patients with severe and chronic mental illness. Then psychiatrists would have developed their own local versions of the care programme approach (CPA) and supervision registers and we would not have had all the fuss about government imposed solutions.

You are also implying that the profession should have got its act together some years ago?

I think it should. We deserved what we got having dragged our feet so long that government had to act, and what they have given us is something that of course is not exactly right because it has not been grown at grass roots. But I think psychiatrists have to accept it and start modelling it to suit the needs of their local population.

You were asked last year to conduct an enquiry into psychiatric services in London?

Yes, it was prompted by the horrific death of Jonathan Zito killed by Christopher Clunis. The traditional apathy of the general public about mental health services had been stirred by self interest that "it could be me" who was murdered.

I was surprised to be asked. I had never worked in London. One could understand the scepticism of people there about anyone coming along to tell them what to do when they had been struggling in appallingly difficult situations with few beds and too many patients for so long. But government and Health Authorities wanted an action plan in three months! I gather I was a kind of acceptable broker to the Royal College of Psychiatrists and to the NHS Executive.

I accepted the job because the Chief Executive of the Health Service said he wanted to know the truth and would act upon it. Also I won the argument in the task force that our approach should be to see whether there was coherence and consensus among those in the London service about what was wrong and what to do. We should not presume to know better. I expected all sorts of ideological conflicts between the different professions, the purchasers and the providers but there were absolutely none. When we talked about the severely mentally ill, everybody knew who they were and had similar views. People with chronic psychosis were accumulating in large numbers in central London, having drifted there from all over the country. There appeared to be extra-ordinary numbers but no one had counted them.

The main recommendations were that in each Health Authority they should agree a simple definition of severe mental illness, then they should count them. Contracts should relate directly to the needs of these patients. We identified severe shortages of beds in some areas. Many patients did not need to be in these beds but we predicted that it would take 2–5 years to develop effective alternative services. There were some gross inefficiencies. In one area £1 million out of a £9 million budget was going out of London to private hospitals in the North of England to care for their patients. When asked, local professionals had lots of ideas about how to deal with these patients much better in the local area.

What has happened since?

There has been a follow-up report that shows an increase in the number of beds in London and in secure beds in particular. But it is slow, and it is not enough. At least mental health is now among the six planning priorities for the NHS and the new funding allocation formulae will favour central London non-acute services which means mental health. It is of course Mrs Jayne Zito and Christopher Clunis more than anyone else who have affected national consciousness and changed priorities. That is one of the peculiarities of politics because I understand that murders of total strangers by mentally ill persons remain rare and are not increasing. But do not for heaven sake let us waste this time of opportunity.

One of the biggest problems I encountered in London was psychiatric teams who were successful innovators of community care programmes but nobody had heard of them just a few miles away. There is a real problem about transfer of good practice. There need to be much better mechanisms for drawing attention to successful services and making sure that visiting and cross-training takes place. Dare I say it to an editor of a journal, I am not sure that journals will be the vehicle in the future by which people update their practice. I understand that to keep up to date in any speciality you need to read about 57 articles a day. I am a member of the Central Research and Development Committee for the NHS and from what I hear it will not be long before there are links perhaps through the Internet which will provide at the press of a button a synopsis of the results of current research on any service or treatment you are worrying about. That presupposes of course an appetite for the results of R & D and a mentality that welcomes constant change.

It seems that some young doctors are leaving medicine to go into other things. Any particular observations on this?

Doctors have been willing to carry enormous responsibility and stress, personal as well as physical and family stress, if they are appreciated for what they do. The great worry I have at the moment is that so many professionals do not feel appreciated. In my opinion it is due more to changes in society's expectations of professionals

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than anything else. Consumerism, accountability, the requirement for checks on competence and effectiveness are all chipping away at that sublime trust and status I enjoyed early in my career just because I was a doctor. I believe there is still no shortage of recruits to medical school but maybe people who choose to do medicine in the future will be different with different expectations. And their teachers will need to be different. Meanwhile there is a great deal to do to support each other in making sense of the new expectations, handling stress and making the transition.

You also have a close interest in the GMC Sick Doctors Scheme.

I am enormously positive about such efforts but of course they are only at the end of the road. They come into play when things have gone really wrong. What we seriously need to consider is sensitive career planning where every consultant has a mentor linked into the management system of the Hospital or Trust. Someone who can tell them sensitively what others are saying about their performance, help them develop their career aspirations, or make job changes to match talents and abilities to the work. I have found a personal appraisal system as a manager enormously supportive and my career development as a manager has depended greatly on a mentor. The relative autonomy of consultants may be limiting careers and leading to unnecessary stress. The worst cases are those consultants who have been talked about behind their backs for years. They only find out they have lost credibility when there is some kind of crisis or complaint. Then the only way out is early retirement. That need not happen. I would recommend to consultants in every Trust in the country to start thinking about how a supportive doctor-to-doctor mentoring system could be developed to their benefit.

Where do you stand in the controversy over local pay and performance related pay (PRP)?

The important issues have not been debated. Hardly anything has been said about the potential benefits to patients and staff from more flexibility over local terms and conditions. PRP is almost an irrelevance. The services in my Trust are improving because there is more interprofessional collaboration. PRP encourages internal competition and may promote the idea that people only work harder for more money. That would actually detract from the enormous drive I see around me from professionals motivated by the satisfaction of doing a good job, improving care for patients and seeing their services develop. But let me give you an example where the inflexibility of national terms and conditions could prevent a major benefit to my local community. York District General Hospital is running at very high occupancy so that to increase the volume of service we either need to build large extensions or use weekend and bank holiday capacity. The capital and running costs of new buildings are enormous, meaning that far fewer patients will be treated for the increased investment than if we put it all into 6 or 7 working days instead of closing down the hospital from Friday to Monday except for emergencies. But you cannot begin to discuss the benefits obtainable for patients without open mindness on the part of the staff about terms and conditions. I am not at all suggesting gaining benefits to patients by working staff harder or paying them less. High productivity and excellent service will only be achieved through a highly motivated, well paid workforce, intimately involved in the running of their organisation.

I guess I am back to my theme that if the NHS is to flourish we must have the flexibility for constant innovation.

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