By Dr Tan Wu Meng

SMA News Interviews Mr Malcolm Stamp, Chief Executive of Cambridge University Hospitals NHS Foundation Trust

Photo credit: SingHealth

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INTRODUCTION

Malcolm Stamp, CBE, is Chief Executive of Addenbrooke's Hospital, the flagship hospital in the Cambridge University Hospitals NHS Foundation Trust. It is named after John Addenbrooke (1680-1719), who was the first Englishman to bequeath his private wealth to fund a voluntary hospital. The hospital opened in 1766 and has been at its current site in south Cambridge since 1961. With an annual income of over £360 million (close to S$1 billion) and around 1,100 beds, Addenbrooke is one of the biggest employers in Cambridgeshire, employing over 6,500 staff who provide a range of clinical and non-clinical services. The hospital is a national and regional centre for cancer services, liver transplants, organ transplantation, neurosciences and genetics. It is also a leading international centre for biomedical research and medical education, sharing its site with the University of Cambridge Clinical School, the UK Medical Research Council, the Wellcome Trust, Glaxo SmithKline, Wolfson Centre and the British Heart Foundation.

Mr Stamp has over 32 years' experience in the UK's National Health Service, including Chief Executive posts at a number of hospitals. He currently holds a number of UK national positions, including the Advisory Committee on Clinical Excellence Awards. He is also an elected

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member of the Association of UK Teaching Hospitals and the national Foundation Trust Network. From 1 July 2006, Mr Stamp will be taking up a new position as Chief Executive of a large health board in New Zealand.

Mr Stamp was recently in Singapore at the invitation of SingHealth; both very kindly agreed to *SMA News* Editorial Board Member Dr Tan Wu Meng interviewing Mr Stamp.

TWM: Good morning, Mr Stamp and thank you very much for coming to Singapore. Coming from the UK, what are your impressions of Singapore healthcare?

MALCOLM STAMP: Well, I think in terms of the facilities that I have seen here in Singapore General Hospital, you have got some excellent facilities. The people I have met have been great, they have been very friendly, very warm. And a lot of the issues you are facing are very similar to anywhere else in the developed world – issues such as an ageing population, limited resources, new technologies, new drugs. I do not think that there is very much difference between the challenges that we are all looking at. And of course, we do not know about the new diseases that are waiting to be described to us.

Healthcare in the developed world is a very similar issue wherever you go. And I think that from what I have seen in SingHealth and the Singapore General Hospital, you have got some superb people ready for the challenges.

TWM: What do you think of healthcare targets? Can we ever have a well-chosen target that accurately reflects performance on the ground?

MALCOLM STAMP: Yes, I do. I am a great believer in targets. And I guess that for the government, like the English government, who at the present time has radically increased health expenditure, it is only right that you want the return on that. And I think one of the ways that you ensure improvement in some things is to use the targeted approach. Now, whether targets are a solution to all the things I mentioned earlier on, well, of course they are not. But they are a good indicator of performance on the ground, and they are a good measure for governments to say "we have improved something" or "we haven't improved something". I do think some targets do not necessarily represent the best measure. I think some targets can be wasteful of resources, or alternatively – being positive about it – can reduce the resource usage. But overall, I think the target approach is a good approach.

TWM: With clinical governance and audit, figures are often easily available – or at least easily collated – for doctors' performance, for example, the complication rates of surgery. Do you think there is a role for publicly available league tables where doctors are ranked, either by clinical outcome or by number of cases managed in a given time period?

MALCOLM STAMP: This is a more difficult area. What we have to recognise, is the ability to measure the complexity in pathology in individual cases. And if we master that, then I see no problem in having publicly available success rates for Consultants – because it will be weighted according to what I have just said.

The problem with a lot of those measures at the moment is they do not do that. So you could get quite easily misrepresented in statistics and lead positions, because – for example – for a particular cardiac surgeon in a particular year, the cohort of patients that he or she is operating on will be of an age and complexity, such that colleagues elsewhere in the country would not touch them.

Photo credit: SingHealth

So I think that you have got to have some balance to put some weight into those sort of things. But as a general principle, I think it is absolutely appropriate that such things are made publicly available, albeit with the caveats that I have said.

TWM: One recent phenomenon in the UK was the scaling back of Junior Doctors' working hours. That is an interesting issue that's been talked about both in the UK and the USA. For the benefit of our

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Singaporean readers, can you elaborate on why this has started happening in the UK?

MALCOLM STAMP: Well, it was basically the European Working Time Directive, which is exactly what it says. Essentially it is a set of working hours reductions determined by the European Parliament. Now, I have mixed views about that. I grew up in the Health service for the past 32 and a half years. I was never a fan of Junior Doctors working the hours they did – I thought it was unfair and in many cases I thought it was not in the interest of patient care or the individual's experience or ability to work. So I am a fan of reducing the hours. However, the extent to which they have been reduced and the time frame in which they have been reduced – that is a different issue. Because I think we have to be ready for those reductions and that means having different skilled workers available, given that the number of Junior Doctors has not increased. And it stands to reason that there are going to be some fairly significant gaps among rotas across England.

So yes, I understand where the Working Time Directive comes from. However I have been concerned about the pace at which working hours have been reduced. We met those *[European]* targets in Cambridge but I am still concerned about them.

On a positive side, it has encouraged us to look at the Junior Doctor role and duties which perhaps could have been done by other people. So we have been able to look at pathways of care and processes within hospitals and generate new roles, such as the physicians' assistant, surgeons' assistant and the like. So there have been some positives to come out of that, where we have introduced new workers into the equation.

Going back to negatives, as we try to shorten working hours and shorten the period of training – you still need certain skills when you come out of that period of training. And I question whether it will be a challenge to expose trainees to all that is necessary to be a Consultant.

TWM: Having visited Singapore, you will have heard a lot about international accreditation processes such as JCI by the Joint Commission International. What role do you see for processes such as hospital JCI Accreditation by the Joint Commission International? Is it being taken up in the UK?

MALCOLM STAMP: I think one of the problems we have in healthcare is that we lack the equivalent to what you see in, to some extent, Law and Accountancy: where basically you get Accountancy international rules, and Legal international rules. They might vary in terms of locality or content, but generally speaking, a lot of the basic principles are held across the globe – especially in the developed world.

JCI is not something that is done in the United Kingdom. That is not because there is something wrong with it, but because we have the European Quality Framework. And in England, we have the Healthcare Commission which is another set of, if you like, inspectorate- and accreditation-type functions. We also have around a hundred or something of others who do similar things in the UK too.

I am not completely a fan of the English bit, but I like the European Quality Framework and I like a lot of what is in the JCI. What I think we need to do in developed countries is perhaps make our mind open, find something common that we can all put in a package, something that we can then relate to. That is going to make benchmarking, working together, joint ventures (and so on) between developed countries a lot more easy in the field of healthcare. I think that internationally, it is something that we should strive to aim for. But nothing is wrong with the JCI.

TWM: The next question might just be a little bit controversial, but do you see any limitations of international frameworks?

MALCOLM STAMP. I think that we face similar problems, as I have said, in the developed world. One of those challenges is that we are all going to have to work within a national cash limit, however it is configured. And in recognising that what we have got to do is have the energy and determination to drive out costs, that helps us balance the equation. That presents all the challenges, especially with the new technologies, new drugs and so on that are coming about. You also have to balance that with public expectations which are rising. We have more educated people now than ever before; education is global and knowledge through the web is available to everybody. It is quite interesting going to oncology clinics these days and seeing people with laptops just checking what the latest American drug is for a certain disease. Whether it is approved or not in your country is irrelevant; they *[the patients and relatives]* just expect that their disease gets the best treatment for them. So all those pressures are there for all of us, but so is the pressure of being transparent

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and honest about where we believe waste is and being able to do something about it, and being able to demonstrate that we are improving our performance, and so on.

Now there will be always be the case for additional resources, whether in Singapore, whether in Cambridge, England, America, Germany, France, or wherever. But there will also always be the need to identify where we are being wasteful of resources, or how we can reconfigure things, or how mergers and acquisitions could deal with pathways of care, and so on. I am a great believer that it *[healthcare]* is the best service in the world to be involved in so we have got to do our best to get it right.

TWM: While on the topic of competing priorities, in private sector healthcare there is often pressure to generate profits and be as financially efficient as possible. On the other hand, in the public sector there is often an integral social welfare priority. Do you think it is possible to reconcile the two within the same institution? Or should we keep those in separate organisations?

MALCOLM STAMP: I think the two can coexist in the same organisation. One of the things that we have done in England is launch the Foundation Trust and my organisation is one of those. And one of the ideas underpinning the Foundation Trust is basically to go on to another level in terms of performance. One of the things we worked very hard at was to get out of the cycle of just having to balance the book to zero year-on-year, because that is a bit silly, by any measure of financial management in the world. So what Foundation Trusts have is the flexibility to overspend and to have the flexibility to make a surplus. And this year I have made a surplus of £3.5 million.

I think that one of the things that we need to do is get more of that principle in because the notions of bloc contracts and balancing to zero really are not an intelligent way to look at the health resource issue. And I think there is a need for mental energy to stimulate the balance sheet that is more like the private sector. So you do see a connection between surplus and capital investments and the ability to raise money, change things and so on and so forth. I think it is a very healthy one rather than sort of like the cap-in-hand mentality that I have got to balance, so I have got to invest in this, you know, all the short term-ism. So you can start taking a medium and longer-term view. I think there is a lot to learn from both sectors.

I think coming back to the question about the social welfare programme and the ethics and morality and the moral issues arising with money; I am afraid they are directly linked, they do not separate. Each individual makes decisions about what we can or cannot afford, in our everyday lives and I do not think health will ever be any different to that.

TWM: Do you think there is a role for means testing in healthcare systems?

MALCOLM STAMP: I guess this is very difficult, but looking at the demographics of the developed world, it is going to come in somewhere. To some extent, we do it already – not so much means testing on your personal income, but what we do is prioritisation, so things like breast enlargement, breast reduction, tattoo removal and things like that are not readily automatically available *[that is, subsidised]* on the National Health Service. But in certain circumstances, you can get it done on NHS; and that is usually when there are genuine psychological issues justifying the procedure. So there are some exclusions, if you like, from what is available.

When it comes to means testing, I get into some very deep philosophical problems. Because I worry endlessly by looking at systems where people pay or where people pay quite significant insurance like in the United States, so on and so forth. When you are looking at the uninsured there, the deal that you are getting is not very good and I worry about that in terms of the overall population, the elderly, the child, and – of course this is a bit trite – the small child from a poor farm.

And philosophically, I cannot get my head round excluding them. I just cannot do that as a person. So I struggle with the notion of means testing. As an economic device, sure, I can see, but I would like it limited to certain diagnostic groups or health-related groups. I like it limited to a very good measure of middle and upper class so that people who have perhaps got it *[the economic means]* can actually contribute but it has got to be done with an absolute safety net for those groups that I have mentioned. And you can see even with total insurance, questions arise. HIV sufferers - will they get excluded? TB? Somebody with COPD - just left out in the winter. So I struggle with it; you need a very good ethical framework. But I have every faith in Singapore in that being done and I have every

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faith in England in that being done too. But to do means testing globally when you see some of these effects of it?

I remember years ago working in a hospital in a country that had insurance-based healthcare and the hospital pharmacy was shut in November. Yet there was a big queue outside for prescriptions from the Consultants. This happened because there were no drugs and that was the state of the hospital and that was it. And I just cannot accept that.

TWM: Do you see a role for formal management training of clinicians about to assume positions of administrative responsibility? And if so, how has Addenbrookes's and the NHS addressed this issue?

MALCOLM STAMP: I think it is essential when I have a structure which has Clinical Directors (that is, clinicians sitting as directors, or directors of clinical services). And I have a Medical Director on my board as an Executive Director. My Clinical Directors are all Consultants or Professors, whatever. And they have all gone through formal training. We have a designated self-designed course that we run. We do that now to aspiring consultants who may well want to be a Clinical Director in the future and we also do it to Senior Registrars as well, who might take a management role wherever they go. That has been enormously successful.

We do sell it now to other hospitals and it is a very successful course; from the feedback from the people who do it, it is superb. It is an absolute must. We live in a very complex world now and we are a part of Europe, which entails lots of complex legislation and all sorts of things, not only the Working Time Directive but human relations policies and so on. So there needs to be a balance I think. And the majority of my Clinical Directors enjoy their role enormously actually. It is all very positive.

TWM: In many professions, including Medicine, respect is sometimes linked with seniority and experience. Coming from the perspective of not having been through formal medical training, did you face any challenges moving into a managerial role initially?

MALCOLM STAMP: No, not really. I recall that when I joined the Health Service in 1974, the Consultants were quite different animals then. They were quite, sort of, odd. In the context that I come from, Imperial Chemical Industries (ICI), I did not quite understand how you got the free roaming resource guzzlers that did not appear to be all that accountable in terms of resource utilisation.

So there were often concerns there for me personally. But I also worked very closely with them so I helped with number crunching on research projects, just basically helping my own learning of the health service. Given that I had no intention of being in the health service for more than a couple of years, the idea at the time was to go back to ICI.

I also did a number of other things. I worked in the kitchens, laundry, pharmacy. I also worked in the mortuary, even helped with PMs (post mortems) with the pathologists, so on and so forth. I did not actually do the procedures, but I got to understand the hospital side in a lot of detail very quickly, which is something that was not expected of me, but something I did personally. And I guess that I carried that on, really. A lot of people say things about consultants, so on and so forth, but I have never really found them to be the problem that all the people describe them as, wherever I have been. I always find it a great disappointment that they are somehow described to be in a different camp or from a different side, because they get gas bills and diarrhoea the same as I do, and they are human beings and I think that is often overlooked. And I think in the main, they are excellent human beings. I have enjoyed working with them immensely. I have never really had that sort of difficulty *[which others describe]*. I mean colleagues have; I never quite get to the bottom of why, I have never understood it.

But I guess that I always gave them the opportunity and the space and the time to speak their mind and express their views and I just do the same. And I have enjoyed immensely working with them, and I have never seen a camp divide, ever. And I think that most consultants who I worked with would say the same.

TWM: I assume you have heard about the phenomenon of outsourcing that is affecting diagnostic radiology and other specialties as well. What are your thoughts on outsourcing?

MALCOLM STAMP: Well, I think it has to be for a reason. I do not think you should have outsourcing just so you can get a badge to say you outsource. But I think you have to put into context what it really is about. In England, around about the mid-1980s, 1984, 1985, we went through a programme of outsourcing called competitive tendering. So we outsourced

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portering, catering, all those sorts of support facilities. And that remains the case today in 2006, so there have been 20-odd years of outsourcing in certain areas.

One of the newer challenges is outsourcing other things like elective care to the private sector (at national tariff rates) and diagnostic radiology. And both of those things are to do essentially with the access targets, the cancer targets that are being set for the health service to deliver. In the context of the phenomenal additional financial resource being given to the UK health service these few years, it is a huge investment and I think it is perfectly reasonable for the government to expect a return on that. I mean, if you are my banker and I say I am going to give interest and you say you will give me 2%, you are not going to get my money, are you? And I think that the government has got every right to expect the same deal.

So for diagnostic radiology, we all do have concerns and opinions about how they have got to be able to demonstrate the right quality framework. They have got to be able to demonstrate the right patient processes, the right responsible reading of films, and so on. Assuming all that is going to be done, then I think that it is probably a good wake-up call to say these are the things that need to be addressed within the institutions, and that the monopoly position of the NHS cannot be relied upon. And I think that is probably healthier for institutions like mine to say we've got a wake-up call here, we have got to look at how we deliver care to patients, look at how efficient we are, look at our costs, so on and so forth.

In the UK, the outsourcing issue also arises from some very ambitious access targets that have been set in England. I am not saying they are impressive worldwide - because they are not - but they are impressive from where we started. You may have to outsource some of the diagnostic input to reduce the backlog, because you might well set a cancer target at 32 days but then you find that after you have seen the cancer specialists, getting the MRI scan is another 32 weeks so you are going to struggle with your 32 days' deadline.

So the bottleneck has been described as around diagnostics. Therefore to get to the 18-week target by 2008, then you could take the view that once we get there, we might be in equilibrium; so we need some temporary non-recurrent diagnostic support. To do that, bring in the independent sector because it is quicker, in the sense that these people can get it done, a lot quicker than what hospitals could do. And I guess it is philosophical whether you believe that state of equilibrium will come about.

I do not necessarily see anything wrong because all these contracts are set by the department of Health, given that the contract with that supplier has got to tick the box of all those quality controls then I think it is probably a good thing to get to the targeted equilibrium.

TWM: What about outsourcing diagnostic radiology to outside the country? Presumably the current model you talked about involves outsourcing within the country itself?

MALCOLM STAMP: Well, no, the actual scan of patients was done within the country itself while the reading was done all over the place.

TWM: So in the UK the reading was done outside the country as well?

MALCOLM STAMP: Yes. Well, you have got to satisfy that quality framework. I personally have not outsourced *[diagnostic radiology at Addenbrooke's]* but clearly you got to start thinking about, well, if we have peaks and troughs – and we have always struggled with those – then maybe we can, with the right quality provider, get something done about that.

One of the interesting things is things like medical secretarial services: we do struggle to recruit those, we do have peaks and troughs, we do know a lot of medical secretaries are females, they get pregnant and we get big gaps in services. So some wonderful services that are accredited by the American College, we have in the Philippines or in India, where there are basically doctors, medically qualified people doing the typing. Maybe that is something we should be looking at in a lot more detail. The world is a funny small place, now, isn't it? Even I got here. *[laughs]*

TWM: How did you go into hospital management and why the career choice?

MALCOLM STAMP: Oh, that is a good one actually. I started off life as an Engineering apprentice. All I ever wanted to do was build bridges, furnaces and big machines that bellow lots of smoke. That is all I ever wanted to do. And I qualified as an Engineer. But halfway through my apprenticeship, England was going through a terrible time in Engineering, with lots of strikes and competitiveness worldwide; with damage in the English system, or England was damaging its own position because of the way

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it was economically disestablished. So a lot of engineering companies began to disappear and I came from Manchester where Engineering was a very big employer so, for example, you can lose your job one day and just walk 50 yards and get employed again. There were that many jobs – tens of thousands of jobs in Engineering all in one town. Today there are none. So I think probably I made the right choice in sort of looking at what was going on, thinking, probably Engineering is not the future. Maybe I think engineers are in short supply, or rather, good engineers are in short supply, so I think it is sad that I have to say that but I think on personal note, I have probably made the right choice.

So I got a job with ICI Manmade Fibres. This was the bit of ICI that did have trade unions, competition and all the rest of it. It encouraged me to finish my Engineering exams, which I did with them. I was a Management Trainee and I spent five years with them, which was extremely enjoyable. And I did very well with them too. What they encouraged me to do was to look at the public sector for two years because I was doing very well with organisational structures and in what was getting the best out of organisations. The processes around organisational structures interest me.

And at that time in England, you have got to remember that the public sectors in those days was local government, health, water, gas, electric, all these things. And I was very interested in the effect of bureaucracy, which I could see within the ICI Corporation, but I could not see in terms of the ICI Manmade Fibers division, which is a very dynamic, fluid cut-throat organisation, which was a great environment to work in. So my mentor suggested that I try one of the public sector organisations, which I did. I applied for a hospital job as an assistant's assistant's assistant's assistant something-or-other at a local hospital near to where I lived. I was a single guy then so I could actually walk to work because of this hospital. I thought it was okay. I took a phenomenal reduction in salary – I hasten to add – but I went into the health service and 32 and a half years later, I am still there. Absolutely adore it.

I think it is the most exhilarating, enjoyable field to be in and I think I came into it in just the right time with just enough background in other industries – just enough. I think I could have had too much later on. I think if I had been in a senior position in ICI – if I had joined *[healthcare]* in my late thirties or something – I do not think I could have survived in the health service. But I had enough questions, enough inquiry left in me, unadulterated by profit and all the rest of it, just to be able to start making my own sense of something. It was a huge culture shock – even coming at that young age, huge – but I absolutely adored it. I think the people are fantastic. We have bad ones, some bad apples, but you are bound to. I employ thousands and thousands of people – nearly 7,000 individuals. To say everybody is good and great is a bit dicey, I reckon, but what I can say with every confidence is that the vast majority are absolutely fantastic.

TWM: Well, apart from work, which you clearly enjoy, what other interests do you have?

MALCOLM STAMP: Going back to work. *[laughs]* I have a number, really. I like fishing. I like swimming - do a lot of swimming. I love football. I am a Manchester United fanatic – it is my religion. *[laughs]* It is also the best city in the world – Manchester. So, and that is where I am from, but like everybody else, I read, I garden, I walk and so on and so forth. But to say that I do all of those things as a cultural hobby would not be true.

TWM: And just one last question on the topic of books. Are there any books which you particularly recommend to our readers?

MALCOLM STAMP: I guess one book that I very much enjoy was the *Six Sigma* book by Jack Welch, former GE Chief Executive. I read that a few years ago when I was in Cuba and I found it wonderful reading about this man taking GE to great heights while watching the Communist regime in Cuba. It was quite interesting reading the book and then going for a walk around Havana. It was a little bit of difference! I enjoyed that probably because of where I was.

One of the best biographies I have read (because I do a lot of that) is about the guy who used to rule Grenada TV in Manchester – that was a good book, a good read as well. But I tend to read non-fiction. I tend to think you are wasting your time in doing fiction so Shakespeare has never done it for me. But I am sure once you modernise him enough I will get into it.

TWM: Thank you very much, Mr Stamp. It has been a pleasure interviewing you and I hope you enjoy your stay in Singapore.

MALCOLM STAMP: Well, the people have been fantastic so I am sure I will. And your food is great. ■