

Leadership in the spotlight

Christine Blanshard[©]

Correspondence to

Dr Christine Blanshard, Chief Executives Department, Salisbury NHS Foundation Trust, Salisbury SP2 8BJ, UK; christine.blanshard@nhs.net

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When I was appointed as Medical Director of Salisbury District Hospital in 2011, I felt fairly confident that I could manage the role. Salisbury was known as a relatively small quiet hospital where nothing much happened and my main worry was that I would get a bit bored after moving down from London.

But in March 2018, I was caught up in events that have made news headlines around the world and a lasting impact on myself, the hospital and its staff and the city.

On Sunday 4 March, just as the hospital was getting back to normal after 3 days of heavy snow, two people were brought into the emergency department having been found 'collapsed' in the city centre, just a few minutes away by ambulance. They were identified as Sergei and Yulia Skripal, and after resuscitation were transferred to intensive care for further treatment. When they did not respond to treatment as expected, some inspired clinical detective work identified that they were suffering from poisoning with an organophosphate type agent, later identified as Novichok. Nick Bailey, a police officer who had attended the scene and searched the Skripal's home, was also admitted with symptoms of poisoning, and over the next few days we saw and assessed another 50 people connected with the incident.

This became the longest-running major incident in the National Health Service (NHS), lasting 72 days and brought an unprecedented level of scrutiny to the city and the hospital. The hospital is the main employer in the city and most of our 4500 staff lives in the city and surrounding villages. Every day they came to work with their local streets cordoned off and police and military in full CBRN (chemical, biological, radiation and nuclear) personal protective equipment (PPE) decontaminating sites and removing vehicles. Nick Bailey's police car, which had been left on our ambulance ramp, was wrapped up and taken away on a military low loader by a team in 'space suits' in full view of the intensive care team who were treating the patients while wearing standard NHS PPE—gloves, gown, apron and splash mask.

During the whole of the incident, we were working in largely uncharted territory—from the first hours when we did not know what the diagnosis was, through the days when we did not know the source of the toxin and hence the risk from blood and body fluids, through the complex political landscape and the involvement of a huge number of external agencies: three police forces, the military, Defence Sciences Technology Laboratory (DSTL), environment agency, public health England, the council, commissioners, NHS England and NHS Improvement. In these circumstances we

had to keep focused on our three main priorities: saving the lives of the patients, protecting our staff and continuing to provide hospital services for our population with as little disruption as possible. We did not close the emergency department or the intensive care unit; we did not cancel any elective surgery or outpatient appointments and we continued to deliver the same quality of care as always to our other 450 inpatients.

In order to do this, we were reliant on the help of a small panel of carefully selected international experts in the field who provided clinical advice via a daily conference call as well as advice on protecting our staff and cleaning the environment. We were never too proud to ask for help while being clear that responsibility for the clinical care of the patients rested with the intensive care consultant and accountability for managerial decisions with the hospital executive team.

When in doubt, I found it helpful to go back to basic ethical principles—patient safety, autonomy, confidentiality and best interests. These guided our response to such diverse requests as the Organisation for the Prohibition of Chemical Weapons wanting to take blood samples from the unconscious patients, the police wishing to set up recording devices in their rooms and distinguished officials wanting to visit.

At the time of the incident, our press office comprised of one person. We accepted an offer of help with communications from NHS Improvement and tried to strike a balance between releasing enough truthful information to keep the press happy while protecting patient confidentiality. We did not attempt to respond to the conspiracy theories and general misinformation abounding on the news and in social media, but did have to brief our staff regularly to maintain their trust and confidence. Generally speaking, the UK media behaved very professionally and we were happy to cooperate with them by providing a place on site but away from the main entrance of the hospital to do their pieces to camera, sharing out our briefings to the different broadcasters and offering some carefully controlled interviews with staff once the patients were discharged.

Dealing with very sick patients in the midst of a diplomatic and political storm was particularly testing. Sharing information on a need-to-know basis with appropriate safeguards in place was challenging as different agencies had different views about both patient confidentiality and the confidentiality of the criminal investigation. As the Trust's Caldicott guardian (responsible for safeguarding or sharing confidential patient information), I was able to control what information about the patients was released within an appropriate legal and ethical



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framework, and I also had to deal firmly with some unauthorised access.

Sadly, the successful treatment of the Skripals and DS Bailey was not the end of the story. The day after we completed the multiagency debrief, a further two people were brought in to the hospital with Novichok poisoning, one of whom did not survive, and on 16 September, a third major incident was declared when an individual alleged that her partner had been poisoned by the Russians in a city centre restaurant.

Reflecting on those 6 months, I have thought a lot about what went well. Three of our four inpatients survived poisoning with an extremely toxic agent thanks to prompt high-quality resuscitation and excellent intensive care following first principles. We had ample supplies of relatively specific treatments—atropine, hyoscine and pralidoxime—thanks to being the receiving hospital for scientists working with nerve agents at the DSTL nearby. Some of our senior intensive care consultants had experience of treating farmers with organophosphate poisoning. We had and point-of care testing for cholinesterase levels supplied by our close neighbours (and new best friends) at Porton Down to guide treatment and reassure emergency department attenders. Only 10 min down the road, Porton was able to turn around our diagnostic tests very quickly and take away contaminated material for safe disposal. We have an organisational culture characterised by resilience, courage and creativity, and our values of being patient centred, professional and responsive are well embedded throughout the trust. Our relationships with the local community—always strong—have been further enhanced by working together. The hospital and its staff have been viewed positively in the media and given many plaudits by senior NHS staff and politicians. We have become international experts on the diagnosis and management of nerve agent poisoning and our clinical staff have felt a great sense of pride in being able to share what we have learnt. We have demonstrated that excellent first response and critical care is not confined to large teaching hospitals, and since the incident our emergency department and critical care service has been rated as ‘good’ and ‘outstanding’, respectively, by the Care Quality Commission.

In contrast to the military and aid agencies who thoroughly rehearse for crisis situations, we had never practised what to do. However, we had recently completed an Emergency Preparedness, Resilience and Response training exercise so our policies and procedures were up to date, our loggists well rehearsed and

we knew where the ‘gold command’ tabard (which indicates to staff who is in strategic command during the major incident) was kept! Our clinical teams were well established and used to working together and we had a full complement of executives and senior managers with no vacancies in key posts. The experience of dealing with previous incidents, particularly being snowed in, translated into a real sense of cohesiveness, confidence and resilience.

From a personal perspective, I have learnt the importance of drawing on the skills of as wide and diverse a range of people as possible. I have had to stand firm to basic principles of putting the patient at the centre of all decisions. I recognise that the executive team cannot do everything and that prioritising a major incident and day-to-day operational management of the hospital inevitably results in slippage of longer term strategic planning. We should have communicated this better to the board and our regulators.

There has been a lasting impact on the front line staff treating the patients, and I wish we had done more to ‘cold debrief’ them; this has been mitigated by the involvement of our clinical psychology team. The support staff—radiology and laboratories—felt less well supported and underappreciated in the first incident, so we made a particular effort to communicate with them in the second and included them in the clinical debriefings we held after the events. At a senior level, we worry that some of the decisions we made at the time will be picked over by history and found to be wanting.

Some of the things we learnt will I hope stand us in good stead in the future—the importance of being ‘seen in action’ while utilising the strengths of the team; recognising and responding to high emotions, stress and burnout; not being afraid to seek help and being aware of how people perceive your leadership style, behaviour and actions.

We hope that our lovely city will soon recover from the impact on tourism and local businesses and we have been delighted it has been voted as Britain’s best place to live.

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