

**An evaluative commentary on health services
management at Bristol: setting key evidence in a wider
normative context**

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Introduction

1. This commentary on health services management at the Bristol and Weston Health Authority (BWhA) and the United Bristol Healthcare NHS Trust (UBHT) between 1984 and 1995 has been commissioned by the Bristol Royal Infirmary Inquiry to inform the Inquiry's understanding of top-level health services management at the Bristol Royal Infirmary (BRI) and the UBHT. The authors were asked to locate key evidence to the Inquiry within a wider normative context, assessing the nature and merits of the management arrangements set in place at Bristol and how they compare against contemporary policy and professional guidance, accepted standards of good management practice, and the arrangements adopted by similar trusts elsewhere in England. A further request made of the authors was to use the evidence as a springboard for expert commentary on critical variables in, or determinants of, effective acute health services management.
2. This commentary has been produced by Judith Smith and Chris Ham. Judith Smith is a Fellow at the Health Services Management Centre at the University of Birmingham where she has been involved in health services research and development for over five years. She is currently leading two major Department of Health evaluation studies related to the development of NHS organisations, having previously carried out numerous research projects in the areas of new primary care organisations, the development of commissioning, and the reconfiguration of acute services. Prior to being appointed to HSMC, Judith worked as a senior manager in NHS trusts, having successfully completed the NHS General Management Training Scheme. Chris Ham is Professor of Health Policy and Management at the Health Services Management Centre at the University of Birmingham and he has been the Director of the Centre since 1993. He is recognized both nationally and internationally as an expert in health

policy and management, having served as an adviser to governments in a number of countries and to agencies such as the World Bank and the World Health Organization. Within the UK, Chris has experience dating from 1975 of work on the management of the NHS, and he has served in an advisory capacity with numerous health authorities and NHS trusts (including briefly in the mid 1980s with the Bristol and Weston District Health Authority). Professor Ham is acting as an expert to the Inquiry on matters of health services management.

3. This commentary is based on evidence already in the public domain, and draws on papers presented to the Inquiry, including witness statements and transcripts of oral evidence, supporting documents, and a briefing paper on NHS policy changes and their impact on professional and managerial organisation and culture prepared by the Inquiry. We have reviewed papers relating to health services management at the BWhA and UBHT selected and assembled by the Inquiry's legal team. These papers have been analysed in the context of developments in health services management in the NHS as a whole, drawing both on published material and the experience of the authors. In view of the fact that the research evidence on health services management is variable both in its quantity and quality, the experience we bring to bear (as a former manager in the case of JS and as a researcher and adviser who has worked extensively with NHS bodies in the case of CH) has been particularly important in enabling us to compare developments in Bristol with those occurring elsewhere.
4. The evidence related to management arrangements can be analysed with reference to two time periods. The first period (1984-1990) relates to the time during which general management was introduced in to the NHS, and the second (1990-1995) relates to the implementation of the *Working for Patients* reforms, including the establishment of NHS trusts and the move to a system of clinical directorates for the internal organisation of hospital services.

Health services management at Bristol – 1984-1990

5. Until the 1980s, the NHS was run on a model of ‘consensus management’ with multidisciplinary teams of administrators, doctors and nurses forming the central management team of a hospital or health district. The Griffiths Report of 1983 was critical of consensus management and diagnosed the lack of a clearly defined general management function as a key weakness in the NHS. The Griffiths Report proposed the immediate introduction of a general management structure at all levels in the NHS (regional, district and unit). In parallel, Griffiths argued that doctors should be more closely involved in management. The government of the day accepted these recommendations and consensus management was superseded by general management, beginning in 1984. At the same time, a number of management budgeting demonstration projects were launched to involve doctors in management. In 1986 the resource management initiative took over from management budgeting as more concerted efforts were made to ensure that doctors throughout the NHS took responsibility for the management of resources and services.

6. In Bristol, the response to the Griffiths Report was to appoint a district general manager (in February 1985) to lead the work of BWhA and he was supported by an executive group comprising two unit general managers (see para 7), the district medical officer, district treasurer, and personnel and training manager. The executive group formed the core of what became known as the district management group [WIT 0108 0041] whose members also included a university representative, a general practitioner and the chairman of the hospital medical committee. The decision to appoint a doctor (Dr Roylance) as district general manager was unusual as only 15 of the 188 DGMs in England in 1986 came from a medical background (Ham, 1999). Even more unusual was the decision to appoint a doctor from a clinical background to this post. Most of the clinicians who became general managers were appointed at the unit level rather than to district posts; and the doctors who were appointed as DGMs tended to come from public health backgrounds or related posts. This is acknowledged by Dr. Roylance in his evidence (Day 24, pages 40-41). The other point to emphasise is that Dr Roylance had worked for most of his career in Bristol,

and, in his own words, “...when I became District General Manager I had been the only person who had actually set foot in every part of the then district twice. I really had very intimate knowledge of the district at the time, how it had got there, what the past history was, what the aspirations of people were” (Day 24, page 43).

7. Within the Authority, two main units of general management were established: the Central Unit comprising six sub-units (of which the BRI was a sub-unit) and the South Unit comprising five sub-units. Each unit had a unit general manager, and each sub-unit had a general manager. The unit general managers reported directly to the district general manager who was in effect (if not name) the chief executive officer responsible for the performance of the district health authority and its units of management. The district health authority approved a management structure for the health authority and its units in May 1985. A copy of the structure is attached at **appendix one**.

8. In the 1980s, units of NHS management were typically smaller than those adopted in Bristol, the usual pattern being a unit of management for each hospital or service area (e.g. community health services, mental health services). In Bristol, a structure of two main units and eleven sub-units was preferred to a structure of say five units (e.g. acute services, community services, mental health services, learning disability services, maternity services) which would have been an approach more typical of NHS districts at the time (Shaw, 1983). The tension between having a few large units or a greater number of smaller units of management is acknowledged in BWhA’s 1985 paper setting out the rationale for general management arrangements [WIT 0038 0063]. BWhA apparently preferred to have a smaller general management core (the district general manager and two unit general managers [UGMs]) and a greater number of devolved sub-units of management. In the 1985 BWhA paper, the district general manager (DGM) notes: “Units that are too numerous would pose problems in the span of control of the District General Manager and would not each justify top level managers” [WIT 0038 0063]. The decision by BWhA to have just two very large units of management was therefore somewhat unusual, and placed a high

degree of responsibility on the two UGMs. On the other hand, it served the purpose of retaining and adapting at sub-unit level arrangements that were felt to have worked reasonably well before the introduction of general management.

9. Within these management arrangements, regular communication and co-ordination between the DGM, his colleague senior officers, and the UGMs would have been a vital requirement. In evidence presented to the Inquiry by Graham Nix [WIT 0106 0011], the district treasurer, it is clear that there was a regular meeting of the DGM, UGMs, treasurer, personnel officer and others. Such a forum would be regarded as appropriate and essential for a DGM and UGMs in this period. It is not however possible to detect from the evidence the ways in which the sub-unit managers reported to the DGM on a regular basis. One can only assume that this was deemed to be via the two UGMs, hence placing a span of responsibility and control upon them that equated to (or exceeded) the span of control of DGMs in other areas of the NHS.

10. In summary, the available evidence regarding health services management at Bristol over the period 1984-1990 suggests that units of management were larger than in many districts at the time. It was also unusual for a district health authority to have appointed a doctor as its district general manager, especially a doctor from a clinical background. Arrangements for senior management meetings, performance review of units, advice to managers, and the involvement of professional groups appear to be in line with those of comparable organisations of the time, taking into account the limited evidence on these issues available in the Inquiry papers.

Health services management at Bristol – 1990-1995

11. In 1988, the Prime Minister set up a review of the NHS, prompted by widespread perceptions of a financial crisis in the NHS. The review resulted in the 1989 White Paper, *Working for Patients*, within which the main focus of reform lay in the creation of a competitive environment through the separation of purchaser and

provider responsibilities and the establishment of self-governing NHS trusts and GP fundholders (Inquiry Secretariat, 2000). UBHT was established in 1991 as a first wave NHS trust, one of 57 such organisations seen as ‘flagships’ in the NHS. These first wave trusts were exhorted by government ministers and the NHS Management Executive (NHSME) to act in an independent and entrepreneurial manner, in line with the overall spirit of the 1990 NHS reforms. This exhortation to independence was one of the factors which sparked opposition to the reforms from the medical profession which feared erosion of national terms and conditions of service, and a ‘takeover’ of clinical freedom and autonomy by politicians and managers. It is not therefore surprising to note from the evidence that UBHT was formed in the face of some opposition from the hospital’s consultant body. The prevailing NHS policy environment of a desire for hospitals to be ‘self-governing’, independent, competitive and managerially focused is an important backcloth to subsequent analysis within this paper.

12. The management structure of the Bristol Provider Unit (the precursor or ‘shadow arrangements’ of UBHT) was formulated as set out in the DGM’s letter to the regional general manager (RGM) of 31 August 1990 [WIT 0038 0069-0071]. The management arrangements put in place for the shadow trust, and subsequently the NHS trust, built on those that had gone before, and there was continuity of personnel between the pre- and post-trust structures. The main change implemented during this period was the further development of a clinical directorate approach as part of the changes to management arrangements that stemmed from the introduction of management budgeting and resource management across the NHS as a whole (see para 5). The organisational chart for the unit in 1990 is set out at **appendix two**. The overall management arrangements were in accordance with NHSME guidance, although UBHT was considerably bigger and more complex, in terms of the size of its budget and the range of its services, than many NHS trusts.

13. Once the unit gained NHS trust status in April 1991, the newly appointed trust board assumed responsibility for UBHT. The board comprised a chairman appointed by the

Secretary of State, five non-executive directors and five executive directors. The previous district general manager of BWhA was appointed as chief executive of UBHT, the other executive directors comprising the finance director, medical director, personnel director, and director of operations/chief nursing adviser. The board took an approach of delegating authority as far as possible, confirming the clinical directorates as the core units of management in the trust [WIT 0086 0006]. For this purpose, the trust was divided into thirteen clinical directorates, the clinical director of each directorate was a medical consultant, and this role was seen as that of a 'non-executive chairman of the directorate' [WIT 0086 0006]. Each clinical director had a general manager working with him or her. The trust board sought to delegate to directorates the authority they needed to manage their services, wishing to avoid becoming bogged down in operational detail and hence having time to focus on major issues [WIT 0086 0006]. When a new trust chairman was appointed in 1994, he was struck by the highly devolved approach to clinical directorates at UBHT and the 'light' nature of the central management team [WIT 0102 0003]. This point was also made by another witness [WIT 0079 0007].

14. The clinical directors met regularly as a group with the medical director and chief executive in the clinical policy group (later renamed the management board). The general managers in the clinical directorates, who were accountable directly to the chief executive, met regularly with the director of operations/chief nursing adviser in the executive management group [WIT 0079 0036]. The trust's executive directors met in the executive directors group (also referred to in evidence as the group of executive directors) on a weekly basis. The trust's management arrangements therefore involved some degree of separation between the handling of clinical issues (on which the medically qualified chief executive took a lead with the medical director and the clinical directors) and general management issues, although the chief executive also attended some of the meetings between the general managers in the directorates and the director of operations/chief nursing adviser. As we discuss below, it seems that one of the reasons for this separation was to shield clinicians from what were perceived as unnecessary administrative burdens (in passing, it should be noted

that keeping track of the way in which management arrangements within the Trust evolved and the changing names of the main management groups has not been easy because of the general reluctance to write things down and antipathy to what was perceived as a bureaucratic approach – see below. Even those closely involved in UBHT (see for example WIT 0106 0021) were sometimes unclear when changes occurred).

15. The chief executive of UBHT was seen by his colleagues as a strong leader in the organisation, his power deriving from his formal position, a long history of working in the area, a combination of clinical and managerial experience, and personal qualities. As Hugh Ross, who was appointed as successor to Dr Roylance in 1995, states in his evidence, *“I think there is no doubt that Dr Roylance is a very dominant figure in the organisation, and it would be hard for me to think, thinking about other Chief Executives I have known over the years, hard to think of a more dominant Chief Executive in any other Trust that I have known. His very long service in Bristol, his considerable experience, the fact that he led the district and then the Trust through a very difficult period and established one of the very biggest of the first-wave Trusts meant that really he was quite unquestioned as the sort of leader and central figure of the organisation”* (Day 19, page 56). The power of Dr Roylance was underlined by the evidence of the chairman appointed in 1994 who identified the need to make changes to the trust’s management arrangements but felt constrained in so doing until after Dr Roylance’s retirement. Other evidence, for example from Graham Nix, indicates that the chief executive spent most of his time on strategic issues and avoided becoming involved in operational matters.

16. Among the executive directors, the deputy chief executive role of UBHT was split between two individuals, the finance director (general management issues) and the medical director (clinical issues). In addition, the director of operations, who was also the chief nursing adviser, acted on behalf of the chief executive in dealing with general managers in the clinical directorates. This division of responsibilities was relatively unusual among NHS trusts and it carried the risk of lack of clarity when the

chief executive was absent. This point is mentioned in the evidence of the incoming chief executive who shortly after his appointment in 1995 took a decision to have a single deputy role 'ready and able to deal with anything', a role that was taken on by the finance director [WIT 0128 0004].

Impact on management arrangements of the move to trust status

17. The move to NHS trust status, along with the introduction of clinical directorates, was a major change across the NHS as a whole but the shift to self governing status in Bristol was facilitated by considerable continuity among senior managers. Nevertheless, the change took place against a background of ongoing debate and controversy within the NHS concerning the merits of the policy of stimulating competition through an 'internal market'. There were also local considerations that had a bearing on developments in Bristol. UBHT was sited in the parliamentary constituency of the then secretary of state for health, and one witness suggests that this placed particular pressure on the trust to succeed in its application to be amongst the first wave of NHS trusts [WIT 0079 0011]. This witness also states that the move to trust status was an 'enormous distraction for the senior management of Bristol and Weston Health Authority' [WIT 0079 0010]. It is well documented in NHS organisational literature that mergers and wide-scale organisational change affect not only the morale and performance of individuals, but also the overall morale and progress of the organisation in the short to medium term. First wave NHS trusts were under pressure to become established by April 1991 and to demonstrate 'early wins', these organisations being seen as one of the main centre-pieces of the NHS reforms of the early 1990s. From the Inquiry evidence, it appears that whilst the move to trust status was time-consuming for some senior managers, it is not possible to say whether the management of UBHT was more distracted by the process of moving to trust status than other NHS organisations of the time.

Overall size, structure and organisation of UBHT

Choice of the directorate model

18. We have commented already that UBHT was among the largest NHS trusts in the country in 1991, as indeed it continues to be in 2000 (the finance director states that it was the seventh largest trust in England, WIT 0106 0022). The decision to base the hospital's management arrangements on the 'clinical directorate' approach was very much in line with the prevailing thinking of the day about appropriate ways of managing health care organisations (Griffiths, 1983; Department of Health and Social Security, 1986; British Medical Association, 1990; Disken et al., 1990). The principle behind the clinical directorate model is that these 'semi-autonomous units', based on a medical specialty or group of specialties, enable full budgetary responsibility and clinical decision making to be combined in a single entity (Inquiry Secretariat, 2000). In the early 1980s, the directorate model, originally drawn from the Johns Hopkins Hospital in the USA, had been taken up by Guy's Hospital in London, and this 'Guy's model' was then seen as the approach to which other flagship NHS trusts should aspire (Packwood, Keen and Buxton, 1991). The model was believed to offer the most appropriate way of building on the principles of the Griffiths report in relation to devolution and accountability, and to offer a way of properly engaging medical and other professional staff in the management of NHS trusts. The directorate model gradually evolved within the NHS over the late 1980s and early 1990s, and the fact that Bristol approached the introduction of directorates in an evolutionary manner is consistent with the experience of other NHS hospitals.

Number of directorates

19. Government guidance on resource management, general management and the introduction of NHS trusts did not specify the size of clinical directorates to be adopted by NHS units or trusts. The size and format of clinical directorates was left as a matter for local choice and determination, and UBHT elected to have thirteen directorates. The decision to have thirteen clinical directorates at UBHT is questioned by some witnesses in their evidence to the Inquiry [e.g. WIT 0079 0007,

WIT 0102 0009]. In the early 1990s, some large NHS trusts elected to have as many as sixteen clinical directorates (Disken et al., 1990), the rationale for this being to maximise the involvement of senior medical staff in the management of the trust. In these cases, directorates were usually grouped into collectives of directorates sharing a general manager and other administrative functions. The more usual number of directorates, however, was between six and ten, the reason being that most organisations felt they could not afford the management costs associated with a greater number of directorates, along with concerns about co-ordination and control. The choice of thirteen directorates for UBHT is not therefore particularly striking or unusual, given that the organisation was relatively large. It does however raise questions about the degree to which the performance of directorates was monitored and managed by the executive directors group, and about the overall strategic management and co-ordination of trust policy and practice.

Lines of accountability

20. Clinical directorates in Bristol evolved over time, with the arrangement being planned and implemented in advance of NHS trust status, yet refined in the light of experience [Day 24, pages 46-48]. The Inquiry evidence suggests that lines of accountability between the directorates and central management were viewed differently by different witnesses. Some witnesses state that the general managers were accountable to the clinical directors in all respects [Day 23, page 7, WIT 0103 0021, Day 26, page 55], others note that the general managers reported to the director of operations [WIT 0128 0003, WIT 0089 0032] and another states that they reported directly to the chief executive [WIT 0086 0006]. Dr. Roylance's evidence indicates that in his view there was a change from the original intention that general managers should be jointly accountable with the clinical directors to him to an arrangement in which the general managers became accountable to the clinical directors who in turn were accountable to him (Day 24 pages 57-60). The timing of this change varied between directorates. Arrangements in other NHS trusts at this time included general managers being accountable to clinical directors in some organisations and to the chief executive or his/her deputy in others. UBHT was therefore not unusual in how these issues were

handled, notwithstanding a degree of ambiguity in the perception of management arrangements among witnesses.

Highly devolved management arrangements

21. The relationship between a trust board and its clinical directorates involves all the tensions and opportunities inherent in the relationship between a board and devolved business units within any large organisation. In establishing clinical directorates at the time of moving to trust status in 1991, the preference in Bristol was for a devolved management arrangement with a lean central management function [WIT 0108 0006, WIT 0108 0008, WIT 0079 0035]. The thirteen clinical directorates are described by two witnesses as having been ‘semi-detached’ from the trust board [WIT 0079 0007; Day 19, page 22] and by another as lacking support from the central trust management team [WIT 0089 0025]. A further witness comments on the difficulty presented to the trust in seeking to co-ordinate and manage thirteen devolved units [WIT 0102 0009]. It is of note that in 1995 the incoming chief executive comments that “*there were not sufficient mechanisms and information systems in place for me to assure myself that all of the directorates were operating in a proper manner*” [Day 19, page 23].

22. The picture gained is of an organisation where the central management team sought to devolve the day-to-day operational management of the trust as far as possible [WIT 0086 0006; Day 19, page 21; WIT 0089 0032]. With the exception of the finance function, there appear to have been limited processes in place for monitoring the activity of directorates, managing their performance, or providing support to managers dealing with operational issues [WIT 0089 0004, WIT 0102 0009, WIT 0079 0007, Day 19, page 21]. The director of operations did take on a key role on behalf of the chief executive in working alongside directorate general managers but the evidence suggests that the way in which this role was performed was not always viewed positively. Given that UBHT was relatively unusual in having so many general managers from carer backgrounds (9 out of 13), this suggests that senior general management support for the directorates may have been inadequate. A related

point is that it took time for the clinical directors and general managers to grow into their role, with evidence suggesting that it was not until the mid 1990s that some of the directorates started to function as intended. This was not unusual in relation to developments elsewhere in the NHS but in the case of UBHT where the drive to devolve was particularly strong it appears that the 'centre' of the organisation may have relinquished control too quickly, or alternatively failed to provide adequate support to the staff (clinicians and managers) taking on devolved responsibility.

23. The separation of central and directorate management functions in UBHT is illustrated by the trust's business planning process in the early 1990s. The business plan for 1991 [WIT 0079 0018-0152] appears as an amalgam of thirteen separate directorate plans, and has little in the way of central trust aims and objectives. The only two areas of central targets for directorates are the management of budgets and management development, and the only detailed section relates to financial performance. The business plan for 1992-93 to 1996-97, although containing a more coherent set of directorate plans and trust objectives, states the trust's commitment to a devolved and flexible approach: "*The Trust places a high value on releasing staff from bureaucracy to meet objectives in their own way; it manages by values rather than through objectives*" [WIT 0079 0158]. This focus on values rather than objectives again underlines the prevailing professional, as opposed to managerial, culture in the trust. Related to this approach of managing by values rather than objectives is the Inquiry evidence which points to a culture in the trust that was anti-paper and task-based [WIT 0089 0004, Day 25, pages 129-130].

24. From the evidence available, the trust appears to have been run on relatively informal lines, with a focus on devolution of responsibility for operational issues to directorate level, and limited formal reporting and communication between the executive directors group and the directorates. This relative informality can be seen in the apparent lack of individual objective-setting for general managers [WIT 0089 0004, WIT 0089 0009, WIT 0079 0007, WIT 0079 0158, Day 27, pages 19-20], the lack of central aims and objectives for directorates in the 1991 trust business plan [WIT 0079

0038-0039], and the limited mention in evidence of regular and structured performance review of directorates, described by the chief executive as being a meeting of the chief executive, director of finance, director of personnel and director of operation ‘once or twice a year’ [WIT 0108 0008]. In a trust of the size of UBHT, one would have expected to find a formal system of comprehensive performance review of directorates, linked to business plan objectives. The agenda for regular formal meetings between the executive team and the directorate team would include directorate objectives and progress, financial performance, activity performance, quality developments and indicators, and priorities for the coming year. The evidence of the incoming chief executive confirms that UBHT was out of line with practice elsewhere in the NHS in adopting such an informal approach.

25. This informal approach is at odds with some of the other NHS management priorities and developments of the time. For example, in the late 1980s, individual performance review (IPR) was introduced into the NHS as a means of underpinning the Griffiths principles of personal accountability for performance. There is no real sense from the Inquiry evidence of regular and structured review of general managers’ or clinical directors’ performance by the chief executive or other senior managers. Indeed, there is a feeling of ambiguity in relation to the accountability of these two groups to the centre, and a sense that they were ‘left to get on with it’ and to report ‘solutions rather than problems’ (WIT 0089 0032, WIT 0079 0158, Day 33, page 33, Day 19 page 21]. When problems did arise, it appears that directorates were expected to take action and were not encouraged to seek support up the line. Again, this reinforces the observation above that the centre let go too quickly and failed to offer adequate support to the directorates.

Focus on financial management performance

26. The strong focus by the trust on financial performance is remarked upon by the incoming trust chairman in 1994 [WIT 0102 0009]. This highlighting of financial performance as the main performance indicator, as witnessed by the content of the trust business plans and the evidence of witnesses, has to be set in the wider NHS

policy context of the early 1990s. In the early 1990s, financial performance was perceived by most NHS chief executives as being their primary performance objective, not least because of the statutory duty to balance budgets. Although the monitoring of waiting lists and waiting times, and the tracking of Patient's Charter indicators were part of the performance review process of NHS trusts, the overriding requirement was for trusts to meet their financial targets. It was not until the second half of the 1990s and the introduction of clinical governance to the NHS that NHS chief executives were subject to a statutory requirement to assure the quality of care in their organisation. Given that UBHT was a flagship first wave trust, the focus by the chief executive on financial performance was to be expected in the prevailing policy environment.

Resource flows and the devolution of budgetary responsibilities

27. As noted above, targets set for directorates, and the business planning process in the trust, were largely financial in nature. Directorates are reported by witnesses to have been clearly and regularly monitored on their financial performance, but the incoming chairman in 1994 felt an early management priority was to improve other aspects of central monitoring and control [WIT 0102 0009], a priority that was also underlined by the incoming chief executive in 1995 [WIT 0128 0005]. From our assessment of the Inquiry evidence, arrangements for budgetary management in the trust appear to have been sound, and as one would expect for an NHS organisation of the size and complexity of UBHT. The trust involved clinical directorates in negotiations and meetings with purchasers, something that did not always happen in the early days of trust status elsewhere. The importance of strong financial performance in the trust is alluded to in the evidence [WIT 0079 0007], Dr. Roylance emphasising that this had been a priority since his appointment as DGM in 1985.

Extent and involvement and impact of clinical involvement in hospital and trust management

28. One feature of the trust's management arrangements which is of particular note is the fact that clinical directors were not involved in regular weekly meetings of the trust's executive directors, nor in the regular meetings held between the director of operations and the general managers. The clinical directors met on a monthly basis with the chief executive and medical director in the clinical policy board/management board. The involvement of the clinical directors in the mainstream management of the trust appears to have been dependent on the role of the chief executive as go-between and lynchpin between the directorates and the central management. The lack of a single executive management team involving the clinical directors raises questions about the ability of the trust to develop as a coherent and corporate trust management body. This point is emphasised both by the chairman appointed in 1994 and the chief executive who took up post in 1995.

29. A further aspect of the degree of clinical involvement on the management of the trust that is of note is the apparently limited role of the medical director in UBHT prior to 1995. The medical director role was assigned two sessions of time per week, an allocation which was changed to four sessions, and then subsequently to seven sessions by the chief executive who succeeded Dr Roylance [WIT 0128 0004]. It should however be noted that the fact that the chief executive was himself a doctor was viewed by the medical director and the chief executive as being a reason for the relatively limited, and advisory as opposed to executive, role of the medical director [WIT 0108 0009]. Indeed, the medical director reports that the chief executive dealt directly with doctors and had an 'open door' policy with his medical colleagues [WIT 0120 0019-20]. This underlines the powerful position of the chief executive within UBHT, particularly in relation to clinical issues.

30. It is noted in the evidence that the trust had a belief that it involved doctors in management to a greater extent than many other trusts [WIT 0106 0040]. The trust clearly moved to the clinical directorate model of management at an early stage, and

involved doctors in the negotiation of contracts for services [WIT 0106 0024]. It appears however from the lack of involvement of doctors in general management meetings and executive level discussions in the trust that clinical directors were mainly involved in directorate level, rather than trust level, leadership and management. Equally important is the evidence that the chief executive sought to protect and shield the directorates from certain issues in order to enable them to concentrate on clinical and patient issues. This is stated explicitly in the Business Plan for 1992/3 to 1996/7 which notes, “*The role of Executive Directors is one of support, professional advice and strategic development. They relieve Directorates of the constraints of administrative bureaucracy by collating and disseminating budgetary and workload information...Clinical Directorate staff are being released to provide the highest attainable standards of care*” [WIT 0079 0159]. Other evidence confirms this.

The role of the trust board

31. The evidence notes that the trust board was the body ultimately responsible for the performance of the organisation. A similar role was performed by the BWhA in the period before the trust was established. The trust board comprised a group of executive and non-executive directors appointed to oversee the provision of services on behalf of the Secretary of State for Health. From the evidence available, it appears that the board focused mainly on high level issues and was not drawn in to the detail of service delivery. Peter Durie, chairman of the Health Authority from 1986 to 1990 and of UBHT from 1991 to 1994, stressed that ‘*it was not my function to take over from the full time executive or to provide parallel management*’. He personally committed three days a week as chairman and this time was spent in meetings and walking around the hospitals and services for which the trust was responsible. He would meet the chief executive on a regular basis and he supported the delegation of authority to clinical directorates because “*it ensured that the Trust Board did not get bogged down in detail. The Board could concentrate on major issues*”. **Appendix three** lists the issues that required trust board approval and issues of which the board

had to be informed. It would appear that the trust board, including its non-executive directors, performed a relatively passive role during this period.

32. Peter Durie's successor, Robert McKinlay, stated that he reviewed the work of the board on his appointment in 1994 and acted to strengthen the management structure by forming board committees chaired by non-executives to 'take on a more inquisitive role'. At the same time, he echoed his predecessor's view that the board *'are not there to run the trust on a day-to-day basis; that is the task of the Executive team'*. The changes which he introduced were intended to strengthen co-ordination and monitoring from the centre given his perception that existing arrangements were not adequate. One of the board committees set up at this time focused on patient care, the aim being that over time this would examine clinical performance, while recognising the sensitivities among clinicians in this area. However, during Mr McKinlay's period in the chair, it was not the practice for reports on medical audit to be reported to the board or its committees. Given the prevailing view in the trust (see below) that responsibility for quality and standards rested with clinicians, this was not surprising, although the effect was to constrain the ability of the board and its non-executive directors in particular to fulfil the responsibilities they had been given. While systematic evidence on the way in which other trust boards fulfilled their functions is lacking, our view is that the UBHT board was less involved in monitoring performance than was often the case elsewhere and little encouragement was given to the non-executives to be pro-active in relation to clinical issues. Indeed, such encouragement would have been at odds with the chief executive's view that the quality of care was an issue for clinicians and clinicians alone to address. Mr. McKinlay explained this by reference to the concern of the chief executive to retain the confidence of medical staff and to avoid the trust board being seen as threatening in any way (Day 76 pages 20-21).

Culture of the trust

33. We highlighted earlier the prevailing NHS culture of the early 1990s as being one of entrepreneurialism, independence, competition, and freedom from unnecessary bureaucracy. Our examination of the Inquiry evidence suggests that UBHT embraced this culture with enthusiasm and energy.

Informal 'club' culture

34. The overall trust culture is variously described by witnesses who worked as managers within the trust as being dominated by the personality of the chief executive [WIT 0079 0013, WIT 0089 0104], based on 'fear and blame' and working against those who challenged the chief executive [WIT 0089 0025, WIT 0079 0014], failing to support managers [WIT 0089 0025, WIT 0089 0032, WIT 0089 0060], and being a 'club' to which you either belonged or not [WIT 0079 0014]. From the perspective of these witnesses, the trust was not an organisation in which it was easy to challenge the status quo or 'rock the boat'. The chief executive of the trust describes the culture as being 'task-orientated' as opposed to role-based, with a desire to avoid becoming stultified by paper and procedures [Day 25, pages 129-130]. In this he was influenced not only by his personal experience and background but also by the writings of management theorists such as Charles Handy whose work (which is widely read and respected) casts a long shadow over the testimony.

The primacy of doctors

35. A further aspect of the culture of UBHT which is highlighted by a number of witnesses is the underlying belief in the primacy of the clinician/patient relationship and the 'specialness' that this conferred upon doctors [WIT 0079 0015, WIT 0086 0021, WIT 0102 0009, WIT 0106 0040]. Related to this was the view clearly expressed by Dr. Roylance [WIT 0108 0018, WIT 0089 0034-35, WIT 0079 0013, WIT 0106 0038] that doctors were and should be responsible for setting and maintaining standards. As he commented in relation to consultants, "...one has to adopt a leadership style and one has to free up their abilities and recognise their

culture. Any suggestion that the Health Service can be improved by attempting to reduce consultants to the role of subordinate officers who are controlled by somebody who has no idea of the work they are doing, is wholly unreasonable and not something I ever attempted” (Day 25, pages 168-9). The fact that the chief executive of the trust was a doctor is regarded by some witnesses as being significant in relation to this focus on the primacy of the medical profession [e.g. WIT 0079 0013] and the apparent reluctance to question clinical decisions. Having a chief executive who was a doctor who had worked for almost all his career in Bristol is remarked upon by another witness as being unusual [Day 19, page 9]. Although clinical governance did not enter the NHS vocabulary until 1997, from *Working for Patients* onwards there was an expectation that managers as well as clinicians should take an interest in the quality of care provided and there was increased questioning of the view that quality was the sole preserve of the health professions. In this context, the chief executive’s position appears not to reflect the development of thinking and practice in the NHS as a whole, although the extent of change should not be exaggerated. As we noted earlier, one of the consequences was that the trust board, as the body ultimately responsible for the performance of the organisation, was not encouraged to take an interest in clinical standards and quality.

Overall management response to the expression of concerns

36. The culture of the trust, as described above, was felt by some witnesses not to encourage the open expression of concerns, or ‘whistle-blowing’ [WIT 0079 0014, 0079 0017, WIT 0089 0032, WIT 0102 0016]. It should however be noted that in the late 1980s and early 1990s, the NHS generally did not encourage whistle-blowers. A national requirement for NHS organisations to have policies on whistle-blowing came later, in the wake of well-publicised cases such as that of Graham Pink who raised concerns about nursing standards in an NHS trust. At UBHT, the relative lack of formal management processes and performance review referred to elsewhere in this paper, would however have been likely to make it more difficult for individuals to make known their concerns to senior management. Allied to this, the executive directors group’s distance from operational matters could also have made it

problematic for those wishing to raise concerns about aspects of the trust's day-to-day activity. The Inquiry evidence on this issue is however equivocal – whereas some witnesses state that the culture mitigated against whistle-blowing, others express confidence that robust mechanisms for raising concerns were in place [WIT 0086 0019-0020, WIT 0103 0044, WIT 0108 0029- 0030]. It should also be recognised that the chief executive's style of being accessible and walking about the trust, a style that appears to have been emulated by the director of operations, meant that he is likely to have been more available to staff than the chief executives of other trusts whose preferred to deal with strategic issues in the headquarters of the organisation.

Conclusions

37. Our analysis has shown that there were many similarities between developments in NHS management as a whole during this period and what happened in Bristol. In this conclusion, we highlight the main conclusions and points of contrast, bringing together the core themes from our review.

38. Starting at the top of the organisation, Bristol was unusual in having a doctor with a clinical background as its DGM and chief executive. Also unusual was the length of time Dr Roylance had worked in the district and the depth of knowledge this provided of its hospitals and other services. All of the evidence suggests that Dr Roylance was the dominant figure in both the health authority and the trust. His views on the NHS and its management exerted a powerful influence on the arrangements adopted in Bristol throughout this period. It appears that there were few checks and balances in these arrangements. More than in most other health authorities and trusts, the chief executive was the driving force behind the organisation and the evidence indicates that his position was accepted by his senior management colleagues, the board of the health authority and trust, and clinicians.

39. Like the chief executive, senior managers in Bristol were also distinguished by the length of time that most had spent working in the district. The corollary was limited exposure to management arrangements and practices elsewhere in the NHS. Given that the introduction of general management following the Griffiths report resulted in an increase in the turnover of senior staff, this degree of continuity was unusual. The establishment of trusts in 1991 was used as an opportunity in many areas to appoint new people to senior posts but in Bristol the existing management team was slotted in to the new roles that were created. This brought benefits in terms of continuity and the avoidance of some of the disruption that characterised change in some other parts of the NHS at this time. The potential disadvantage was to create a culture of insularity and acceptance of established ways of doing things.
40. The division of responsibilities among senior managers in the trust was unusual in that the deputy chief executive role was split between the finance director on management issues and the medical director on clinical issues. The responsibility given to the director of operations/chief nursing adviser by the chief executive meant that de facto she acted as a third deputy to the chief executive. A further consequence of this was that the operational aspects of the director of operations/chief nursing adviser role were significant and to some degree took time away from the role of chief nursing adviser. The medical director acted in an advisory rather than executive capacity and in comparison with other trusts the time allocated to this role was limited. This reflected the close involvement of the chief executive in relating to clinical directors - again underlining the central role he played within the organisation.
41. In common with other trusts, UBHT placed a great deal of emphasis on clinical directorates as a way of involving doctors and other clinicians in management. However, this was taken further than in many other trusts in two respects. First, the approach adopted was one of maximum delegation to directorates from an early stage in their evolution. And second, the central management of the trust was kept light to give the directorates as much scope as possible to take on their new responsibilities.

The evidence suggests that arrangements for setting objectives for the directorates and managing their performance were relatively underdeveloped, except in relation to finance and budgeting where the trust prided itself on consistently good performance. It also appears that relatively little senior general management support was provided to the directorates, other than through the director of operations/chief nursing adviser, and as a consequence they developed at variable rates. There was some ambiguity too in accountability arrangements between the directorates and the central management of the trust, even accepting that these arrangements changed in the light of experience.

42. The capacity for producing a corporate strategy for the trust appears to have been under developed in relation to practice elsewhere in the NHS. In so far as work was done on strategy, it was based on the plans of clinical directorates in a manner that was consistent with the policy of devolution. Indeed, given the light nature of central management, it is difficult to see how the trust could have done more during this period to look ahead at key trends and developments and work through the implications for services in Bristol. Only with the appointment of a new chief executive in 1995 was this rectified with the establishment of the post of director of development, a post that brought UBHT more closely into line with practices elsewhere.

43. Under the leadership of Dr Roylance, the health authority and the trust favoured an approach that was relatively informal and did not value writing things down unless there was good reason to do so. It is difficult to assess how far other trusts adopted a similar approach but our impression is that the antipathy to paperwork and formal procedures was more strongly expressed in Bristol than in many other places. The emphasis instead was on an oral culture and on flexibility in management arrangements. As a consequence, implementation of changes in NHS management practices during this period, such as performance review of managers and of directorates, appears to have been patchy.

44. The board of the health authority and the trust focused on relatively high level strategic issues and deliberately avoided involvement in operational matters. The non-executive directors of the board were not encouraged to take an interest in clinical standards and quality and medical audit reports were not discussed by the board. To a large extent the way in which the board functioned reflected the culture in the trust with its emphasis on clinicians alone having responsibility for clinical issues, including patient care and quality. Only towards the end of the period under review, with the appointment of a new chairman, did this begin to change. Although other trust boards only slowly extended their interest into the area of clinical standards and quality - issues that remain sensitive within the medical profession - the culture in Bristol appears to have been particularly unsupportive of board level engagement with these issues.
45. The strong impression to emerge from the evidence is the concern on the part of the chief executive to develop an organisation in which clinicians were given as much freedom as possible to focus on the delivery of care to patients unencumbered by involvement in management and bureaucratic restrictions. This was achieved through the central management of the organisation protecting and shielding directorates from external pressures. Clinical directors related mainly to the medical director and the chief executive and were not as involved in policy and management issues as was the case in many other trusts. Indeed, throughout the organisation the handling of clinical and management issues seems to have been kept separate, with general managers in the directorates taking responsibility for operational issues (including finance) on behalf of clinicians. The absence of a management group bringing together clinical directors, general managers and the central management team was consistent with the way in which the organisation was managed.
46. In summary, it appears from our review of the evidence that the culture of the trust was not only strongly dominated by the personality of the chief executive, it was also fundamentally pro-professional and anti-bureaucratic. What is more, basic management practices such as structured objective setting, integrated clinical and

general executive management team meetings, and co-ordinated centrally led business planning appear to have been eschewed in favour of 'letting the directorates have their head'. UBHT was apparently run on highly devolved lines, with an emphasis on directorates managing their own affairs and sorting out their own problems. Processes for managing the performance of directorates, as noted in this section and in earlier paragraphs, were largely informal, with the exception of financial performance. The executive directors group does not seem to have been involved in the full range of operational matters in the trust, justifying this in terms of a focus on values and professional freedom, and a desire to avoid what was seen as unnecessary bureaucracy and management by objectives. This devolved approach, combined with concerns about the ambiguity of accountability arrangements between directorates and the trust board, point to a picture of a trust lacking in rigorous performance management and co-ordination processes. Above all, at no time were issues of clinical standards and quality seen as a legitimate focus for involvement by non-medical managers and trust board members, the strongly held view of the chief executive being that only clinicians themselves should be concerned with these issues. This view appears not to have been questioned or challenged until the very end of the period under review. At a time when the notion of untrammelled clinical freedom was increasingly seen as anachronistic, and when the introduction of general management, resource management and clinical audit were changing the nature of accountability arrangements in the NHS, practices in Bristol and mechanisms to ensure effective monitoring of performance appeared to lag behind developments elsewhere.

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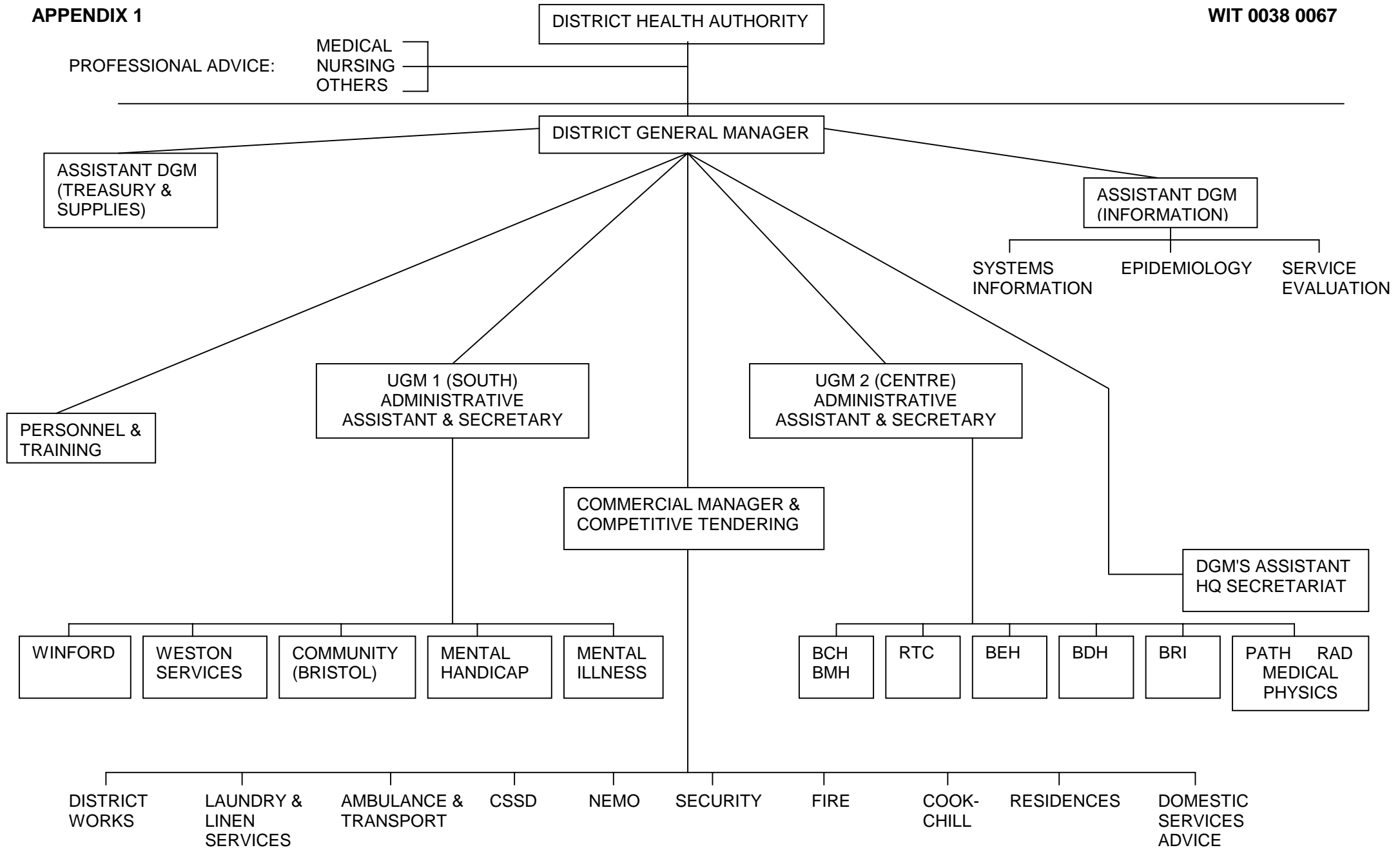
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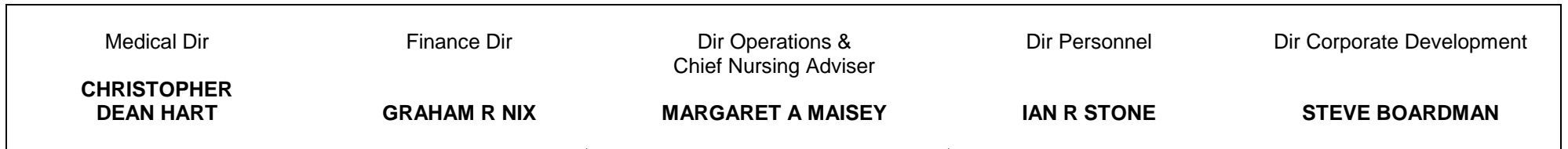
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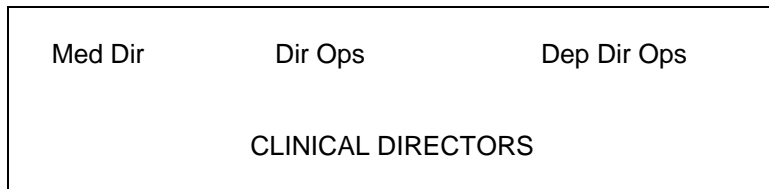
BRISTOL PROVIDER UNIT

PROVIDER BOARD

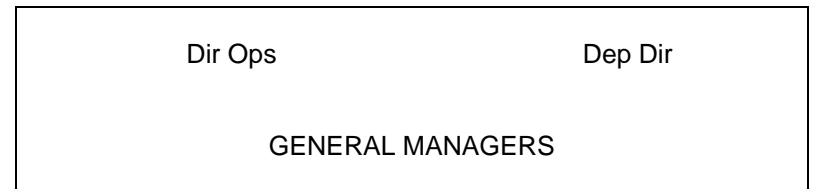
**DISTRICT GENERAL MANAGER
DR JOHN ROYLANCE**



POLICY BOARD



MANAGEMENT GROUP



STANDING ORDERS APPENDIX B

UNITED BRISTOL HEALTHCARE NHS TRUST

Issues Requiring Trust Board Approval

- 1) Strategic Plan
 - Research and Development Plans
 - Teaching and links with University
- 2) Business Plan
- 3) Budget
- 4) Business Cases for Capital Investment of £100k or more
- 5) Capital Programme
- 6) Employment Strategies
- 7) Major organisational change
- 8) Losses and Compensation Reports
- 9) Major Service Changes
- 10) Insurance Programme
- 11) Banking Arrangements
- 12) Standing Financial Instructions
- 13) Standing Orders
- 14) Appointment of External Auditors
- 15) Acceptance of Accounts
- 16) Creation and Terms of Reference of Trust Board Committees and Working Parties

STANDING ORDERS APPENDIX D

UNITED BRISTOL HEALTHCARE NHS TRUST

Issues of Which the Trust Board must be informed

- 1) Reports from Standing Advisory Groups
- 2) Income and Expenditure and Cash Flow monitoring
- 3) Medical Negligence Reports
- 4) Audit Committee Reports including Annual Audit Report and Audit Programme
- 5) Appointment of Clinical Directors, Senior Managers and Consultants
- 6) Major Contract Changes
- 7) Reports from Trust Board Committees and Working Parties
- 8) Recommendations from Grievance and Disciplinary Appeal Committees when decision is not unanimous
- 9) Outcome of Mental Health Guardian Reviews on behalf of the Non-Executive Directors of patients detained under the Mental Health Act 1983
- 10) Major PR Issues
- 11) Health and Safety – major issues
- 12) Major operational matters