Chapter 4 – National Accountabilities and Roles

The National Framework: responsibilities for healthcare

1 The period covered by the Inquiry's Terms of Reference is from 1984 to 1995. The background to that period, in terms of the NHS, has been set out in Chapter 2. Most of that information is common knowledge. However, the way in which the system actually worked may not be familiar, except to those intimately involved with it. Accordingly, the Inquiry sought evidence as to this. In particular, it was concerned to know who *in practice* exercised authority, and who *in practice* accepted responsibility for the parts of the service relevant to the Terms of Reference.

2 The evidence started with a broad overview of the health service, across the nation. It focused progressively on the specific circumstances of Bristol. However, it is always necessary to remember the broader context within which that particular evidence was set, and it is thus with a review of that evidence that this section begins.

3 Across the period, a number of divisions in function and responsibility at national level must be distinguished. First, different Departments of State had responsibility for different aspects of healthcare. At the outset of the period the government department within whose ambit hospitals came was the DHSS. In July 1988 the DHSS was split into two departments: the DoH and the DSS. The DoH was then concerned with care in hospitals, primary care and community health services.

4 Within the NHS itself, a consequence of the Griffiths Report[1] was a separation of 'policy' from 'management'. The Report had:

> '… recommended not only the introduction of general management in the NHS, but also the reform and strengthening of the Department's[2] internal organisation and mechanisms for discharging its responsibilities in respect of the NHS. Although the reform was intended to improve the Department's performance across the board, there was to be a particular emphasis on policy implementation and performance management in respect of the NHS.'[3]

This split between policy and management is sometimes expressed as a division between strategy and operations.

1 HOME 0003 0001; the Griffiths Report
2 At that time, the DHSS
3 WIT 0040 0001 Sir Graham Hart

5 The Griffiths Report also said:

> '2. The NHS … still lacks a real continuous evaluation of its performance against criteria such as those set out above [concern with levels of service, quality of the product …] …
>
> '3. It therefore cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake. In proposing the NHS in 1944, the Government declared that:
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> "– the real need is to bring the country's full resources to bear upon reducing ill health and promoting good health in all its citizens;" …
>
> '7. … Real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels.'[4]

6 Policy issues were the responsibility of a policy directorate, the Health and Social Services Policy Group, within the Department (DHSS/DoH).[5] Following Griffiths' recommendation, the Health Service Supervisory Board was established:

> '… to determine the purpose, objectives and direction for the health service, approve the overall budget and resource allocations, take strategic decisions and receive reports on performance and other evaluations from within the health service'.[6]

The Health Service Supervisory Board 'advised on the strategic direction of the NHS'.[7]

7 The NHS Management Board was established at the beginning of 1985[8] and 'had responsibility for the Department's management functions with respect to Health Authorities, particularly finance and performance review'.[9] The NHS Management Board reported to the Health Service Supervisory Board.[10]

8 In May 1989 the NHS Management Board was remodelled to form the NHS Management Executive (NHSME). In the same month, the Health Service Supervisory Board, which had not met for almost a year, was reshaped into the NHS Policy Board chaired by the Secretary of State.[11] The NHSME and NHS Policy Board were parallel bodies: the NHS Policy Board dealt with policy formulation; NHSME with management and policy implementation.

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4 HOME 0003 0012 and HOME 0003 0014; the Griffiths Report
5 WIT 0040 0003 Sir Graham Hart
6 Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust
7 WIT 0335 0004 Sir Alan Langlands
8 WIT 0040 0001 Sir Graham Hart. Sir Graham said the Management Board was set up in '1984/85', T52 p. 21
9 WIT 0335 0003 Sir Alan Langlands
10 Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust
11 Edwards, B. '*The National Health Service 1946–1994: A Manager's Tale*', (1995), Nuffield Provincial Hospitals Trust

9 The separation of lines of report was, it appears,

> '… founded on the assumption, on the belief, indeed, that the Chief Executive role could only be effectively carried out if the Chief Executive was himself an accounting officer in his own right'.[12]

10 A further distinction in function between the Chairman of the NHS Management Board (subsequently Chief Executive of the NHSME) on the one hand and the Chief Medical Officer for England on the other needs to be borne in mind. The Chief Medical Officer (CMO) acted as an advisor to the government but was also concerned with clinical health issues, whereas the Management Board and NHSME were concerned with NHS management issues.

11 The split between *policy* and *management* was, in the view of Sir Graham Hart, Director of Operations at the NHS Management Board 1985–1989 and Permanent Secretary, DoH 1992–1997, based upon two beliefs.[13] The first arose from the fact that the Management Board, following Griffiths, was a very new organisation. It had so great a task in terms of getting the Griffiths Report implemented that it was considered wise to keep work such as policy and strategy separate, to ease the load. The second belief was that it would be beneficial to separate policy from management and the implementation of policy, because doing so would clarify the respective issues. This theoretical clarity was, however, clouded by the fact that the Management Board and NHSME nonetheless had responsibility for policy on issues which were essentially those of management:

> '… for example, in relation to personnel practice in the NHS, in relation to finance, how the NHS should be financed, how much money it should have, how that should be distributed …'[14]

12 The division between policy and management was ended in 1995, following the Banks Report in the previous year.[15] Responsibility for all NHS policy matters was transferred to the NHS Executive. (The NHSME consequently dropped the word 'Management' from its title.) Sir Graham endorsed the view of Mrs Banks saying:

> '… that it would be better to include the policy for the NHS and about the NHS in the Executive'.[16]

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12 T52 p. 91–2 Sir Graham Hart
13 T52 p. 8 Sir Graham Hart
14 T52 p. 9 Sir Graham Hart
15 WIT 0040 0006 Sir Graham Hart
16 T52 p. 10 Sir Graham Hart, Director of Operations at the NHS Management Board 1985–1989 and Permanent Secretary, DoH 1992–1997

13 Sir Graham Hart told the Inquiry that he agreed with this view. He thought that a split between responsibility for management and for policy had not been the best organisation. He said:

> '… I always felt it was important for the Executive to be closely involved in … responsibility for the whole range of NHS policies, which is the position that we achieved in 1995…'[17]

Lines of reporting

14 The Health Service Supervisory Board was chaired by the Secretary of State. The NHS Management Board reported to the Secretary of State through its Chairman. Its successor, the NHSME, reported to the Secretary of State through its Chief Executive. The wider DoH reported to the Secretary of State through the Permanent Secretary.

The CMO and the NHS Executive

15 The Chief Executive of the NHSME was a manager, not a clinician. The CMO and his staff were mostly clinicians. Medical staff with the DoH reported to the CMO more widely during the earlier period of the Inquiry than during the later period. Following the Banks Report, medical staff of the DoH, apart from a half dozen or so secretariat staff, reported either to the Permanent Secretary or to the Chief Executive of the NHS and '… the Chief Medical Officer therefore had no direct reporting medical staff'.[18]

16 Despite the difference of background between the CMO and his staff on the one hand, and the Chairman/Chief Executive on the other, the evidence was that there was no inherent priority of view on any issue between them. Sir Christopher France, Permanent Secretary, DoH 1988–1992,[19] emphasised that:

> '… the decision-making process … always relied on weighing the merits of the various arguments, whatever their source, and not on recourse to some set of rules which purported to indicate which should prevail. Such "rules" simply did not exist.'[20]

17 Although the NHS is a national health service, the posts of Chief Executive and CMO, as described, were appointments in respect of England alone. Each of England, Scotland, Wales and Northern Ireland had its own NHS Chief Executive, and its own CMO. Each reported to the relevant Permanent Secretary (e.g. at the Welsh Office and Scottish Office, which were responsible for the health services in those countries).[21] There was no formal structure or committee dealing with matters of interest or importance common to each of the four constituent parts of the UK. However, there was an informal meeting once or twice a year between the Chief Executives and the

17 T52 p. 11 Sir Graham Hart
18 T66 p. 4–5 Professor Sir Kenneth Calman, former CMO
19 WIT 0055 0001 Sir Christopher France
20 WIT 0055 0002 Sir Christopher France
21 T52 p. 93–7 Sir Graham Hart

relevant Permanent Secretaries, and there was contact at more junior levels on an 'as required' basis between the DHSS/DoH and the Welsh and Scottish Offices. [22] According to Professor Sir Kenneth Calman, the CMOs for England, Scotland, Wales and Northern Ireland also met at two-monthly intervals between 1989 and 1998.[23]

18 Because of the close geographical proximity of Wales to Bristol, the consequent ease with which patients from South Wales could be transported to Bristol, and evidence that the development of cardiac surgical services for infants had an influence on the Bristol unit, the Inquiry also studied the relevant structure of health services in Wales.

19 Healthcare delivery in Wales was not[24] under the auspices of the DoH.[25] Instead, NHS provision in Wales is one of the responsibilities of the Welsh Office, both administratively and financially.

20 Mr Peter Gregory, Director of the NHS in Wales from March 1994 to 1999, stated in his written statement:

> 'The Department of Health was, throughout the period 1984–95, the "lead" UK Health Department, although the Secretary of State for Wales had the responsibility of providing a health service for the people of Wales.'[26]

21 In oral evidence, he said:

> 'The NHS legislation places upon the Secretary of State for Wales the duty of providing health services in Wales. That is not a duty which falls on the Secretary of State for Health.
>
> 'The Secretary of State for Wales has, therefore, the statutory powers to provide health services. As a consequence, the Secretary of State takes decisions about health services in Wales which are relevant to the circumstances of Wales. The Secretary of State is, of course, a member of the United Kingdom cabinet and that imposes its own political restrictions which are not unimportant in terms of developing policies ...'[27]

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22 T52 p. 93–7 Sir Graham Hart
23 T66 p. 75–6 Professor Sir Kenneth Calman
24 And was not at any point during the Terms of Reference
25 The Departments of Health and Social Security were separated on 26 July 1988 (see evidence of Sir Christopher France, Permanent Secretary to the DHSS until 26 July 1988 after which time he became Permanent Secretary to the DoH, WIT 0055 0001)
26 WIT 0058 0001 Mr Gregory
27 T10 p. 72–3 Mr Gregory

The role of the CMO (Wales)

22 Professor Gareth Crompton, CMO for Wales between 1 January 1978 and 31 August 1989, stated in his written statement to the Inquiry:

> 'My role, as CMO Wales, was to be the chief adviser on medical matters arising from and pertaining to the statutory functions of the Secretary of State for Wales. I was, also, the head of the Health Professionals Group.'[28]

The role of the Welsh Medical Committee

23 There was at the relevant time a Welsh Medical Committee which:

> '… is a statutory Advisory Committee to the Secretary of State for Wales. It has a formal function enshrined in the NHS legislation for advice on medical matters to the Secretary of State. … It has been in existence for many years and is the central focus for medical advice to the Department and the Secretary of State [for Wales].'[29]

Links between the Welsh Office and the DoH

24 Mr Gregory explained the links, both formal and informal, between the Welsh Office and the DoH in these terms:

> 'Given the greater resources of the Department of Health, and the need for consistency across England and Wales, or the whole UK, which the medical, nursing and other professions' governing bodies made desirable, the Welsh Office has always sought close informal and formal relationships with the Department of Health.' [30]

25 Mr Gregory said in his statement that liaison between the departments was provided by:

> 'a. Meetings of the 4 UK Chief Medical Officers (CMO) usually quarterly.
>
> 'b. Observer status at the National Specialised Commissioning Advisory Group (NSCAG) and before that its predecessor the Supra Regional [Services] Advisory Group (SRAG) [SRSAG].
>
> 'c. CMO attendance as observer at meetings of the General Medical Council (GMC).
>
> 'd. CMO attendance at meetings of the Joint Consultants' Committee (JCC).

28 WIT 0070 0001 Professor Crompton
29 T10 p. 6 Mr Gregory
30 WIT 0058 0001 Mr Gregory. See also comment by Sir Alan Langlands in Chapter 7 paras 239–240 concerning the responsibility of the DoH for supra regional services

'e. Observer status on the Joint Planning Advisory Group (JPAG) and following its demise, on the Advisory Group for Medical Education, Training and Staffing (AGMETS).'[31]

26 The nursing links which Mr Gregory identified as existing were:

'a. Meetings of the 4 UK Chief Nursing Officers (CNOs) quarterly.

'b. CNO [Wales] has observer status on the Standing Nursing and Midwifery Advisory Committee (SNMAC). This was, and still is, a Committee to advise the Secretaries of State responsible for the health services in Wales and England on nursing and nursing related issues.'[32]

27 Mr Gregory gave written evidence that the administrative links that existed were:

'a. regular meetings of Health Department Accounting Officers (Permanent Secretaries and heads of the NHS in each country).

'b. informal meetings of the 3 or 4 Health Departments to discuss issues of mutual interest in respect of specialised services.'[33]

28 Mr Gregory also gave evidence of the less formal links that existed between departments:

'On all sides, there has been regular contact with colleagues in the Department of Health face to face, and by letter and telephone. Ad hoc meetings were arranged where it was thought necessary.'[34]

The influence of DoH policy on the Welsh Office

29 Mr Gregory told the Inquiry that:

'... the Department [Welsh Office] … would not have, I believe, regarded itself as completely fettered in its discretion ...'[35]

30 Mr Gregory added:

'The Department's [Welsh Office's] position … would … have been very significantly influenced by the Supra Regional Advisory Group's conclusions ...'[36]

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31 WIT 0058 0001 Mr Gregory
32 WIT 0058 0002 Mr Gregory
33 WIT 0058 0002 Mr Gregory
34 WIT 0058 0002 Mr Gregory
35 T10 p. 73 Mr Gregory
36 T10 p. 73 Mr Gregory

31 In short, the evidence to the Inquiry was to the effect that, although the Welsh Office, in theory, had discretion to decide its own health policy for the people of Wales, this discretion was, in reality, influenced by the policy being pursued by the DoH in England. The influence of the DoH's policy on the Welsh Office was particularly strong in those specialisms that were part of the group of services which fell under the auspices of the DoH's Supra Regional Services Advisory Group (SRSAG).

32 Before focusing on evidence as to the respective responsibilities which the DoH and NHS took for the clinical care of any individual patient, one further matter should be mentioned. In 1992–1993 the NHSME relocated from London to Leeds. Although Sir Graham Hart told the Inquiry that this placed a strain on communications at least for a while, there was no clear evidence before the Inquiry that it adversely affected decision-making.

Perceptions of responsibility

33 It was suggested to Sir Graham that it was the view of the DoH that the responsibility for the individual patient lay ultimately with the doctor. He responded:

> 'I think the truth is that there is a shared responsibility but a lot of people, organisations and people are involved in this. It is the Secretary of State's responsibility, with his Department, for example, to make sure that enough money is provided so that the Health Service can be run properly. That is his responsibility. It is the responsibility of every consultant or every consultant in the NHS to practise according to good standards of professional conduct and competence. It is the responsibility of the Trust or the Health Authority or whatever that employs that doctor to make sure that he is a suitably qualified person; that he or she has the necessary resources in order to carry out the work that he or she has to do; and at least to supervise in some way or other the quality of what is done.
>
> 'So I think it would be very simplistic, if I may say so, to suggest that there is one person or one organisation which is wholly responsible and has an undivided and total responsibility for this. But I think one can explain properly, and I hope I have done so but I may have failed to do so, pretty well precisely where the boundaries of responsibility are and how they fit together.
>
> 'One has to use words like — I do think, just again to say it, the primary responsibility, when you or I or any of us puts ourselves in the hands of a doctor or the Health Service, the primary responsibility for what takes place lies with the individual doctor. But it is a responsibility which inevitably he shares with his employer, if he is working in a hospital. And the Health Authority or the Trust itself obviously has also to share some of the responsibility higher up the line, because higher up the line also has a part to play. But the centre of gravity, so to speak, has to be at the level of the individual patients. It cannot be satisfactorily discharged from someone sitting in Westminster or Whitehall. We are talking about, you know, millions of events per year of an intensely personal kind involving individuals

which they passionately care about, and it is quite wrong, really, I think, in any sense, to overplay the central responsibility. I hope, I sincerely hope, that is a realistic description and a proper description of how things are and how they should be, rather than simply seeking to step aside from responsibilities.'[37]

34 Sir Alan Langlands, Chief Executive of the NHS Executive 1994 to 2000, gave evidence to similar effect:

'Q. … the Inquiry has heard two opinions about the responsibility or otherwise of the Department of Health, and by that I mean the Supra Regional Services Advisory Group and the Ministers to which it reported, for the quality of the paediatric cardiac services. One is that because it was the Department of Health which as it were provided the money, and which also had direct contractual relationships between the unit and itself, so that this service stood outside the normal purchaser/provider territory, it was the Department that was responsible for ensuring or monitoring and assessing the quality of the service that was being provided.

'The alternative view that has been expressed by officials within the Department of Health is that it was the health authorities – this is "health authorities" unspecified – that retained that role as part and parcel of their public health functions and that the funding mechanism that was represented by the Supra Regional Services Advisory Group did not alter that basic public health responsibility. Can you comment on that conflict of views?

'A. I do not think I am willing to choose either/or. I think I fall back on my point. What I want to avoid at all costs is any notion that somehow no-one is responsible, because I do not believe that to be the case, but I believe that the clinicians directly involved in provision of that service have some responsibility. Health authorities and the Trust which was the home to that service have some responsibilities, as we discussed earlier this morning, and the Department of Health clearly had some responsibilities, not just in relation to resource allocation in my view, back to this point about systemic failure, but to ensure that there was a system in place that ensured that these services were being properly provided. I think that the crucial thing would be to be absolutely sure in each of these cases that the roles and responsibilities, the distinctive roles and responsibilities of each of these players, was adequately defined.' [38]

35 In relation to supra regional services, Sir Graham Hart was later to say that the roles were not, in his view, adequately defined.[39]

36 The Inquiry was told that the DoH, under the direction of the Secretary of State, had responsibility for: (i) policy rather than operations[40] (thus the provision and the

37 T52 p. 107–8 Sir Graham Hart
38 T65 p. 61–2 Sir Alan Langlands in the context of questions about responsibility for supra regional services
39 WIT 0040 0001 Sir Graham Hart
40 WIT 0335 0008 Sir Alan Langlands

distribution of resources in the form of money, capital development and to an extent the workforce, and the determination of policy for and about the NHS was undoubtedly a responsibility that the department accepted);[41] (ii) 'more problematically'[42] for ensuring the implementation of policy and a high standard of performance by the NHS. ('Performance' is to an extent an ambiguous word, the meaning of which has changed over time: it may have to be understood as referring to finance, rather than clinical outcome. Sir Alan Langlands emphasised the requirement upon the NHS Executive to 'manage the performance of the NHS – including securing and allocating NHS resources …'[43] and told the Inquiry that, in 1999, finance and performance were linked in one post within the NHS Executive HQ;[44] Dr Peter Doyle, Senior Medical Officer, DoH, told the Inquiry that when the Performance Management Directorate was set up at the DoH, the performance with which it was concerned was 'primarily' to be understood in the financial sense.[45])

37 This range of responsibilities was reflected in the formal accountability of local administration. After 1991, local administration was increasingly carried out by trusts. Sir Alan told the Inquiry:

> '… all Chief Executives of NHS Trusts and Health Authorities have, since 1995, been designated as "accountable officers". This will be extended to Chief Executives of Primary Care Trusts. This means that they are answerable to Parliament through me for the efficient and proper use of the resources in their charge. In case of serious management failure they would be expected to accompany me to answer personally before the Parliamentary Public Accounts Committee'.[46]

The legal accountabilities of a trust to the Secretary of State (and hence those matters over which the DoH would have immediate control) were predominantly concerned with financial performance and management.[47]

38 Further, following the introduction of hospital trusts, the NHSME set up regional 'outposts' to monitor the financial performance of trusts.[48] The function of these was described as:

> '… very much based on the financial arrangements of the trust; they were there — not I think exclusively, but certainly one of their main functions was to monitor the financial health, to handle capital allocation, that kind of thing.'[49]

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41 WIT 0040 0001 Sir Graham Hart
42 WIT 0040 0001 Sir Graham Hart
43 WIT 0335 0008 Sir Alan Langlands
44 NHS Executive HQ, as at September 1999; the post holder had responsibility for 'monitoring and analysis of NHS performance'
45 T67 p. 50 Dr Doyle. It should be noted that the Performance Assessment Framework introduced in 1999 now has responsibilities which specifically include assessment of 'health outcomes of NHS care'
46 WIT 0335 0009 – 0010 Sir Alan Langlands
47 HOME 0002 0202; *'Managing the New NHS'*
48 T52 p. 85–6 Sir Graham Hart
49 T52 p. 86 Sir Graham Hart

39 In reviewing the evidence as to the extent to which (and the sense in which) the DoH and the NHSME accepted responsibility for the care of patients, a distinction has to be made between non-clinical and clinical care. To the extent that the DoH and the NHSME were concerned with 'quality', it was defined until recently by reference to non-clinical care: the Patient's Charter, when introduced in October 1991, focused on non-clinical standards. The purchaser-provider contracts tended to focus on cost, volume and other non-clinical measures.[50]

40 When looking, on the other hand, at responsibility for the quality of clinical care, the DoH (including the NHSME) appeared to some observers to regard itself as having very little responsibility. According to Dr Phillip Hammond, a local GP and journalist:

> '… the DoH seems to show little appetite to have a "controlling mind" and appears unable to act to protect patients without the full agreement of the relevant professional bodies who are, by their nature, self-protective'.[51]

41 The evidence given on behalf of the DoH was, indeed, that it adopted a 'hands-off' approach so far as individual clinical care was concerned (this approach was said to be changing during the period with which the Inquiry is concerned).[52] Thus, Sir Alan Langlands said, in relation to the early 1990s, when asked about interventions by the Department in response to a trust's apparent failure to provide a proper quality of care (at least in relation to failure to meet numerical targets in respect of finance or waiting lists):

> '… mixed messages emerged from the Department of Health. On the one hand there was a clear signal that we should, from a regional perspective, have a definite hands-off approach in relation to trusts. On the other hand, we would be expected from a regional level to pick up the pieces if something was going wrong. So that was a time of rather confused accountabilities in that regard.' [53]

42 A number of reasons for such a hands-off approach were advanced by those from the DoH who gave evidence. First was clinical freedom. Sir Graham Hart recalled:

> '... if you go back to my early days, so to speak, of involvement in all this, which would be in the 1960s, and even roll it forward to the early 1980s, really, there was a feeling around – this can be oversimplified – that clinical freedom meant that the centre – Ministers, in effect – should keep out of anything to do with the practice of medicine …'.[54]

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50 T65 p. 51 Sir Alan Langlands
51 WIT 0283 0043 Dr Hammond
52 T65 p. 13 Sir Alan Langlands
53 T65 p. 13 Sir Alan Langlands
54 T52 p. 33 Sir Graham Hart

43 He also observed:

> 'There was a deeply-rooted reserve on the part of the Department – shared by the professions – about Departmental involvement in clinical performance. This was in general seen as the preserve of clinicians, individually and to some extent collectively.'[55]

44 This view was echoed by clinicians themselves, with an emphasis on individual rather than collective responsibility. Indeed, the latter was discounted. For instance, Professor Leo Strunin, President of the Royal College of Anaesthetists (RCA), told the Inquiry that:

> '… it was fairly common back ten years when people thought, "Well, as long as I am doing a good job it is not actually my problem what is occurring around me"'.[56]

45 Such a view was emphatically expressed by Dr John Roylance, Chief Executive of the UBHT 1991–1995, from the perspective even of local management:

> 'Q. Can we have your statement, WIT 108, page 20. I am going to ask you in a moment about the paragraph beginning: "In respect of senior medical staff ... ." Did you regard medical staff as professionals?
>
> 'A. Yes.
>
> 'Q. In effect, once appointed, was it part of the consequence of clinical freedom that they were self-teaching and self-correcting?
>
> 'A. Yes.
>
> 'Q. Did you take the view, therefore, that it was not for managers to interfere?
>
> 'A. I recognised that it was impossible for managers to interfere.
>
> 'Q. So essentially, the clinician at the bedside made the decision which he or she thought was in the best interests of the patient?
>
> 'A. Yes.
>
> 'Q. And management felt that it could not, and should not, interfere?
>
> 'A. And does not, in any part of the Health Service.'[57]

55 WIT 0040 0002 Sir Graham Hart
56 T14 p. 4–5 Professor Strunin
57 T24 p.14–15 Dr Roylance

46 A second reason for not accepting responsibility for individual clinical outcomes was that national responsibility for local activity would be impracticable. A third was that there was no effective power in central management to intervene. A fourth was that in any event the responsibility for the individual patient's care lay elsewhere, principally with the hospital doctor (or at least the consultant).

47 The first of these reasons has already been outlined. Part of it was a view as to the proper role of central government in creating (in respect of services such as paediatric cardiac surgical services) the '… right kind of environment in which the tendency would be towards limitation and specialisation' as opposed to '... putting down an absolutely rigid framework within which there was no room for movement at all.'[58] Part of it was a view (held by the profession itself), that the DoH should not get 'involved with anything to do with the clinical treatment of patients'[59] since this was the proper preserve of the individual clinician.

48 The second reason, the impracticability of taking responsibility at national level for local operations, was described as follows by Sir Alan Langlands:

> '… it is impossible, and certainly undesirable, for the NHS Executive to monitor the treatment of individual patients or patient groups';[60]

and by Sir Graham Hart:

> 'It is simply impracticable for the Secretary of State to be in any detailed sense responsible for what goes on every day in every hospital ... it is quite impractical, and I think wrong, for the Secretary of State or the Department on his behalf to try to superintend or supervise or be involved in routinely what is going on in each and every hospital, health centre and so on. It is just not practicable.'[61]

49 The third reason, the lack of powers, was expressed in the following terms in relation to hospitals *before* trust status was introduced:

> '… if the Secretary of State had tried to, as it were, put on his hobnailed boots and go down to a particular place and say, "Stop doing that". You could have done it, but it might not have been very wise and I think you would have had to have had some very good specific reasons, not just general reasons.'[62]

58 T52 p. 25–6 Sir Graham Hart
59 T52 p. 36 Sir Graham Hart
60 WIT 0335 0002 Sir Alan Langlands
61 T52 p. 3–4 Sir Graham Hart
62 T52 p. 24 Sir Graham Hart

50 Sir Alan Langlands said (in respect of the time *after* trust status was introduced) that the Secretary of State for Health could not tell trusts what to do:

> 'The NHS (Management) Executive was to manage the NHS primarily through Health Authorities. NHS Trusts were given greater freedom to manage more of their own affairs. They were accountable to the NHS Executive for meeting their financial targets and to Health Authorities through the contracting process for the volume and quality of services they provided. The Secretary of State had no power to direct NHS Trusts in respect of the services they provided.'[63]
>
> 'Q. … the members of the Trust Board, and in particular the Chairman, were appointed, were they not, by the Secretary of State?
>
> 'A. That is correct, and the Secretary of State, while having no powers to direct Trusts in the way at that time that he would direct health authorities, and that would be the contrast I would make, did, however, have powers to remove the Trust Chairman or the Trust Chairperson and members of the Trust Board.
>
> 'Q. On specified grounds?
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> 'A. On specified grounds.
>
> 'Q. Were those grounds linked to the financial performance of the Trust or were they more widely framed?
>
> 'A. I could not remember offhand what the legislation says, but certainly the interpretation on the rare occasions when this in my experience happened was drawn more widely than just financial failure.
>
> 'Q. More widely so as to encompass what factors?
>
> 'A. In my experience of this, to encompass factors like the breakdown of the relationship between the non-executive group, the managers and sometimes the clinical staff in the hospital. In other words, where relationships became dysfunctional to the point at which they impeded the proper work of the Board.'[64]

51 The DoH's apparent position, therefore, was that the best that could be done from the centre was to exercise persuasion to influence local units. Thus Sir Graham Hart said:

> 'I think it is very questionable what, as it were legal powers the Secretary of State would actually have had to stop a unit from carrying out … procedures';[65]

63 WIT 0335 0004 – 0005 Sir Alan Langlands
64 T65 p. 7–8 Sir Alan Langlands
65 T52 p. 21–2 Sir Graham Hart

and Sir Alan Langlands noted that:

> 'The Secretary of State, in legislation, had no power to direct Trusts [which may have been in difficulty because of the quality of service they were providing], but would seek to influence these Trusts and would use the team that supported him or her, the management team, to exert that influence. So whilst there was no direct power, there was very strong central influence where things were going wrong … .'[66]

52 One means of persuasion was the use of CMO's letters issued to publicise good practice.[67] However, there was no mechanism to monitor compliance with the advice and guidance in relation to clinical issues which was seen to be the prime concern of others, such as the Royal Colleges. Thus former CMO, Professor Sir Kenneth Calman said:

> 'The Department of Health from time to time issues guidance on management, but not generally in relation to clinical practice unless based on professional views from outside the Department.'[68]

53 The perceived lack of power, the need for persuasion rather than coercion, and the view as to the proper role of central Government, were reflected in a reluctance to become involved in controversy:

> '... if Ministers might be tempted to tread down that path of involvement and intervention, then they could be pretty sure that there would be a tremendous row about it with the profession, and that is something which you certainly do not want to do without forethought';[69]

> '… a Minister would always think twice or three times about, as it were, entering into a controversy with a particular unit or series of units by saying, "I want you to stop doing this", unless, as I say, there was some really good evidence';[70]

and (with specific reference to the de-designation of a particular unit as a supra regional centre):

> '… if [the Minister's] only ground for doing it was, "We have this general policy which is in favour of these procedures being done in a few centres and that is why we have supra regional services and you are not one of the chosen few, so to speak, so I want you to stop for that reason", I think that would be [a] very difficult argument to carry off in a situation of public controversy.'[71]

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66 T65 p. 11 Sir Alan Langlands
67 T66 p. 18 Professor Sir Kenneth Calman
68 WIT 0336 0003 Professor Sir Kenneth Calman
69 T52 p. 37 Sir Graham Hart
70 T52 p. 22 Sir Graham Hart
71 T52 p. 22 Sir Graham Hart

54 The fourth reason, that the responsibility for the quality of clinical care lay elsewhere, was stated by witnesses who gave evidence on behalf of the DoH. Sir Graham Hart said that the mainstay of quality was in the hands of healthcare professionals themselves and the trusts who selected and employed them:

> 'A. … the mainstay of quality, as I have tried to say throughout, the main safeguard as far as patients and the public are concerned, should lie in the qualifications and the professional conduct and whatever of the people who are chosen very carefully to carry out this work — the consultants.
>
> 'Q. The doctors?
>
> 'A. The doctors, and the other professional staff who work with them. And in the hands of the people who employ them, the trusts and so on and so forth. That is the main safeguard.'[72]

55 Doctors themselves did not easily acknowledge this notion of collective responsibility, even that of clinical teams:

> '... [the concept in] most doctors' minds [was that] … of accountability primarily to the patient and peers.'[73]

56 Sir Graham Hart thought that:

> 'It must be the case that the primary responsibility for clinical practice, wherever it is, lies with the doctors actually carrying it out. They do not get a very good airing on this, but actually that is the foundation of this whole system.'[74]

57 Professor Sir Kenneth Calman's view was that the immediate treating clinician would 'probably' have responsibility for the delivery of care, adding:

> 'I say that because it would be the consultant who would have the overall responsibility, rather than the doctor in training themselves.'[75]

58 Sir Graham echoed Sir Kenneth's view as to the role of the consultant, but expanded on the context:

> 'It is the personal responsibility of the consultant to carry out their work conscientiously and competently, and on the people who employ them, which in this case is the Trust or before that the Health Authority. So of course they have a primary responsibility.'[76]

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72 T52 p. 103–4 Sir Graham Hart
73 WIT 0051 0003 Sir Donald Irvine
74 T52 p. 101 Sir Graham Hart
75 T66 p. 20 Professor Sir Kenneth Calman
76 T52 p. 101–2 Sir Graham Hart

59 A clinician taking responsibility for his own practice may not secure good clinical care for an individual where he may lack the insight, skills, knowledge or perspective to appreciate what constitutes proper care in the context, even though his complete integrity is in no doubt. The Inquiry sought evidence, therefore, as to the level at which (and by whom, apart from the individual clinician) responsibilities for the competence of a clinician were discharged.

60 Sir Alan Langlands thought that guarantees of good clinical performance (at least between 1989 and 1999) derived from:

> '… the practice of individual clinicians and clinicians working in teams. The commitment of these individuals and teams to agree the standards of practice that they are trying to achieve, to audit and compare progress against these … .'[77]

61 Above the clinical team, Sir Kenneth regarded responsibility as lying with the employing trust[78] and then the Regional Director of Public Health or the GMC:

> 'A. If you are working in a team or a group of individuals, if there is a competence issue, then that might be picked up and be dealt with at that level, for example. Beyond that, it would be the Trust through the Medical Director or in pre-1989 terms, Medical Superintendent. Beyond that, it would be the governing body or Trust Board, and beyond that, to the Regional Director of Public Health.
>
> 'Q. And beyond the Regional Director of Public Health?
>
> 'A. It would depend on the issue, but if this was an issue of competence, it would go to the General Medical Council.' [79]

62 Both Sir Alan and Sir Kenneth explained further the role and responsibilities of the Regional Director of Public Health. Sir Alan said:

> 'Within the NHS Executive we have alerted staff to the procedures they should follow if they are approached with informal reports of poor clinical performance. In all cases the information should be passed to the Regional Director of Public Health who takes responsibility for ensuring that adequate investigation and follow-up actions are taken.'[80]

77 T65 p. 56 Sir Alan Langlands
78 The composition of the Trust Board is outlined in Chapter 8
79 T66 p. 21 Professor Sir Kenneth Calman
80 WIT 0335 0017 Sir Alan Langlands

63 Sir Kenneth told the Inquiry:

> 'Q. Is it the case that the Director of Public Health at the Regional Health Authority would be regarded within the Department of Health as being part of the Department of Health, albeit at a lower level than the central level?
>
> 'A. Yes, and in fact over the period of time as part of this Inquiry, it would be seen very much as part of it, and indeed, nowadays the regional office is part of the enquiry.
>
> 'Q. So it is a false distinction to talk of the Department of Health and then the Director of Public Health; the distinction would be between central and regional aspects of the Department; is that accurate?
>
> 'A. That is a very neat way of producing it. I saw Dr Scally [Regional Director of Public Health] as very much part of us, if you like.
>
> 'Q. Does the same apply to the Regional Medical Officer?
>
> 'A. Exactly the same. I mean, some of the relationships, going back a little bit further, are slightly different, but in general, that would be the same principle, yes.'[81]

64 Central responsibility for individual clinical outcomes was therefore not accepted, for the four broad reasons identified in evidence and examined in paras 42–63 above. Acceptance of responsibility for the provision of services of a particular type was also limited.

65 As to the provision of services, the view from the centre was that:

> 'By 1984 this responsibility [for providing hospital services] fell for the most part on about 200 District Health Authorities [DHAs], which were accountable to 14 Regional Health Authorities (RHAs) which in turn were accountable to the Secretary of State.'[82]

66 Sir Graham told the Inquiry:

> 'A. Back in the 1980s Districts were, as you know, responsible for the management of the individual hospitals, yes.
>
> 'Q. And the District responsible to the Region?
>
> 'A. Correct.

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81 T66 p. 91–2 Professor Sir Kenneth Calman

82 WIT 0040 0001 Sir Graham Hart. The statutory responsibilities of the RHAs and DHAs are dealt with in Chapter 5

'Q. And the Region to the centre?

'A. Correct.'[83]

67 Central power was, however, diluted by the structure. Sir Graham Hart told the Inquiry:

'… there are a whole series, many hundreds of statutory bodies set up by Parliament, who are responsible for running the services locally, and who have a responsibility to decide what goes on in those hospitals. That is bound, and very properly, to dilute the power which lies at the centre.'[84]

68 In addition to issues of responsibility and influence, there were practical difficulties that hindered the development of methods for the measurement and assessment of the quality of clinical performance. Sir Graham told the Inquiry:

'Q. … [quoting the Griffiths Report] "Surprisingly, however, it [the NHS] still lacks a real continuous evaluation of its performance against criteria such as those set out above … . Rarely are precise management objectives set. There is little measurement of health output. Clinical evaluation of particular practices is by no means common and economic [evaluation] of those practices extremely rare." Leaving aside the economic evaluation and leaving aside the question of output, the number of operations done, clinical evaluation of particular practices is by no means common. In this paragraph as a whole, what Griffiths appears to be observing and, the implication is, complaining about, is that the NHS had no proper measurement of the quality of the care it was providing in general terms. First of all, from your own perspective, was he probably right about that, at the time?

'A. Yes. I mean, I would say, I think, what he was saying was that there was no system, if you like. Some of these things happened, but they did not happen in an organised and systematic way. I think that is true. He was spot-on, there.[85]

'The 1983 report to the Secretary of State by the late Sir Roy Griffiths recommended not only the introduction of general management in the NHS, but also the reform and strengthening of the Department's internal organisation and mechanisms for discharging its responsibilities in respect of the NHS. … there was to be a particular emphasis on policy implementation and performance management in respect of the NHS. This was an area of activity in which the Department had already begun to recognise the need for improvement. …[86]

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83 T52 p. 73–4 Sir Graham Hart
84 T52 p. 27 Sir Graham Hart
85 T52 p. 35–6 Sir Graham Hart
86 WIT 0040 0001 Sir Graham Hart

'Although much data on clinical outcomes and performances was available [in the 1980s], it was not used systematically, except in limited contexts, and then by professional organisations. National systems such as the Confidential Enquiry into Maternal Deaths were very much the exception.[87]

'As I have said I think later on in the statement, the Department's responsibilities – functions, at any rate – tend to be very much of a kind of strategic and general kind related to policy, to the provision and distribution of resources, and at a high level, I suppose, the implementation of policy and performance, although, as I say in my statement, I think these are rather more problematical areas and ones where, over the years, I think probably the position has changed somewhat.'[88]

The Performance Management Directorate

69 A Directorate within the DoH dealt specifically with 'performance management'. The potential significance of this for the Inquiry arises from a letter of 21 July 1994, in which Dr Doyle wrote to Professor Gianni Angelini, Professor of Cardiac Surgery, University of Bristol, as follows:

'It has recently been brought to my attention that there are concerns about the mortality rates for paediatric, especially neonatal and infant, cardiac surgery performed at the BRI. … If there is a problem and, for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate, who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal enquiry would follow.'[89]

70 Counsel to the Inquiry asked Dr Doyle:

'Q. So the performance [that the Performance Management Directorate addresses] is to be understood in the sense of keeping to financial targets, is it?

'A. Primarily financial, but there are also other elements, other guidances that have gone out to Trusts, so if there is a clear failure of Trust management in any issue, then the performance directorate would certainly want to be involved because in whatever area of Trust management there is a clear breakdown, this then becomes the responsibility of the Trust Board, the Chairman, the Chief Executive, to deliver on those bits of guidance that have gone out to the Trusts. So they would certainly want to know about clear evidence that a Trust had failed in its duties. If a Trust failed to resolve a situation like this, that is a failure of Trust management.

87 WIT 0040 0002 Sir Graham Hart
88 T52 p. 4 Sir Graham Hart
89 UBHT 0052 0287; letter from Dr Doyle to Professor Angelini, 21 July 1994

'Q. So performance management, largely financial but also other management aspects. What would they do? What could they do?

'A. I think that would depend on the circumstances. Clearly the Secretary of State has the right to set up any form of investigation or enquiry.

'Q. That is the Secretary of State. What about the Performance Management Directorate?

'A. The Performance Management Directorate is an arm of the formal mechanisms for managing the NHS.

'Q. What could they do to alert the Secretary of State that you could not?

'A. If they had become aware of the problems, presumably they would have alerted other colleagues in the Department to the problem.

'Q. Why could you not do that?

'A. At this stage ...

'Q. Not why did you not, but why could you not?

'A. I could have done.

'Q. So the Performance Management Directorate is a directorate which exists for the purposes you have mentioned. It had no more power – I think is what you are implying – than you did to act, the acting in circumstances where there is a failure of management control consisting of notifying other people who may be able to apply such pressure as they have at their disposal?

'A. Their formal job within the responsibility of the Department was to look at the management of Trusts. Mine were very difficult responsibilities, to look at policy development in cardiac services. So they did have a formal requirement to look at the performance of Trusts.

'Q. What was it about the problem as you understood it to be that made you think there may be a failure of management?

'A. If the Trust failed to tackle a clear issue for which there was a clear mechanism for dealing with it and allowed that problem to go unresolved, that, in my book, is a failure of Trust management.'[90]

[90] T67 p. 52–4 Dr Doyle

71 Dr Jane Ashwell, Senior Medical Officer, was asked about the role of the Performance Management Directorate:

> 'Q. You will have seen … the letter from Dr Doyle to Professor Angelini we looked at earlier, if I can look at it again. It is UBHT 0052 0287, the last paragraph on that page: "If there is a problem and for any reason, you are not able to reassure me that it has been resolved, the circumstances are such that I would be obliged to seek the help of colleagues in the Performance Management Directorate, who would doubtless raise the matter formally with the Trust. It is highly likely that some sort of formal inquiry would follow." You heard Dr Doyle explain what that directorate was and why it might have been an appropriate body to intervene. Do you agree with the evidence he gave about that?
>
> 'A. I do not think it was my opinion at the time that the Performance Management Directorate actually dealt with clinical practice. It would be much more concerned with financial management, corporate governance, those kinds of issues. That was my opinion.'[91]

The Clinical Outcomes Group

72 On 13 December 1993 Dr Ashwell wrote to Dr Stephen Bolsin, consultant anaesthetist, 'The CMO's committee … should address these sorts of issues [poor clinical performance]'. Dr Ashwell told the Inquiry:

> '… I think it was probably something to do with the Clinical Outcomes Group. That is the only thing I have actually managed to work out and that was a committee I was not on but I knew a little of, to do with looking at the development of medical audit, the sorts of issues I am referring to are dealing with outcome, audits and outcome … .'[92]

Changes since the period of the Inquiry's Terms of Reference

73 A number of changes in approach and view since 1995 were highlighted in evidence. Sir Graham Hart told the Inquiry:

> 'I think these days there is a greater interest at the centre in policy implementation and performance of the NHS than there was originally. That is an area where I think attitudes have changed somewhat, practice has changed somewhat, over the years.'[93]

91 T67 p. 183–4 Dr Ashwell
92 T67 p. 183 Dr Ashwell
93 T52 p. 4 Sir Graham Hart

74 As a result of the Bristol experience and other factors, the DoH[94] and government ministers are now more willing to intervene generally. Sir Alan Langlands thought that:

> '… current Ministers have no hesitation about intervening in areas where they feel, rightly in my view, responsible and where they feel they have to act. … So I think attitudes have been changing over time, and I think that really the point I want to get across here is a sort of evolutionary point: that through all of this, the relationship between the government medical profession and the public has been changing … issues of public accountability and self-regulation have to be in keeping with the current public mood. They cannot somehow be rooted in the past or in sort of romantic notions of clinical freedom in a bygone age. We are living in a different world.'[95]

75 Examples of where the willingness of the DoH to use its influence has changed UK clinical practice are heart transplants and the Kasai procedure for biliary atresia. Following a departmental press release, No 1999/0268 of 30 April 1999, Counsel to the Inquiry was able to tell the Inquiry that:

> 'We have heard what has recently happened with the Kasai procedure for biliary atresia, where we are given to understand that the Department has secured as a result of representations made to it that no more than three centres in England should conduct this particular form of procedure, the idea being, as we understand it, that otherwise the numbers of such operations would not be sufficient to ensure that any one team of clinicians had the sufficient expertise, quite apart from the necessary facilities.'[96]

76 Current interest in the supervision of poorly performing doctors by the DoH or its representatives is exemplified by an internal minute of 9 December 1996 from Dr Graham Winyard, Deputy CMO 1993–1998, to all Branch Heads and above in the NHS Executive, which advised staff who became aware of allegations about poorly performing doctors that they should report the matter to the appropriate Regional Director of Public Health.[97] The note adds, however, that:

> 'Simply notifying the Department of Health does not absolve people from taking local action within their own organisation, and they should be reminded of this.'[98]

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94 T65 p. 79 Sir Alan Langlands
95 T65 p. 105 Sir Alan Langlands
96 T66 p. 28 Counsel to the Inquiry
97 WIT 0335 0043 Sir Alan Langlands. The note 'Handling Reports of Service Problems Post Bristol' is at WIT 0335 0193
98 WIT 0335 0193 Sir Alan Langlands

77 The introduction of new surgical techniques has, since 1996, been managed under the Safety and Efficacy Register of New Interventional Procedures (SERNIP). Professor Sir Kenneth Calman explained the operation of SERNIP:

> 'The principal safeguard [for ensuring that the introduction of new surgical techniques is managed safely] – beyond the work of local ethics committees – is the Safety and Efficacy Register of New Interventional Procedures (SERNIP). This voluntary system, which is independent of the Department of Health, was set up under the auspices of the Academy of Medical Royal Colleges in 1996 and continues to receive funding from the Department of Health.
>
> 'SERNIP is staffed by a part-time clinical director and a full-time administrator, and is supported by an Advisory Committee whose membership includes 11 representatives of the Medical Royal Colleges, and representatives from the Standing Group on Health Technology, the Medical Research Council and the Medical Devices Agency. The Department of Health has observer status on the Committee.
>
> 'A clinician when considering introducing an innovative procedure into his/her clinical practice is encouraged to contact the SERNIP office; alternatively, the enquiry may come from a Trust or commissioner. If the procedure in question is already on the register, the SERNIP office notifies which of four categories it has been assigned to. If it is not on the register, they arrange for an assessment of the intervention by a professional advisory committee, based on the published literature, to assign a category.
>
> 'In their current form the four categories are:
>
> - 'Safety and efficacy established: procedure may be used
> - 'Efficacy established. Further evaluation required to confirm safety: procedure can be used as part of a surveillance programme registered with SERNIP
> - 'Safety and efficacy not proven: should be used only as part of a primary research programme, using appropriate methodology and registered with SERNIP
> - 'Safety and/or efficacy shown to be unsatisfactory, should not be used.
>
> 'The Committee's advice is then notified to the clinician who raised the original enquiry. A summary of SERNIP's recommendations is also circulated to health authorities. SERNIP has so far categorised over 100 operations and procedures.
>
> 'If a surgical intervention involves the use of a *medical device*, the device is subject to statutory regulation under the terms of the two European Directives (a third directive covering in-vitro diagnostics will come into force in June 2000).

Essentially, these provide safeguards about the safety and performance of the device, in particular that any risks associated with use of the device are acceptable when weighed against the benefits to patients. The Directives also establish procedures for post-market surveillance and reporting of adverse events. The competent authority in the UK for overseeing the application of the Directives is the Medical Devices Agency (MDA). …

'The Department of Health and the Academy of Medical Royal Colleges are currently reviewing SERNIP. In particular they are considering the steps needed to ensure the participation of clinicians across all relevant specialties; detailed aspects of the process, including the possible need for a formal "appeals" procedure; and relations to the MDA and the National Institute for Clinical Excellence [NICE].'[99]

78 SERNIP was set up following problems with the introduction of laparoscopic surgery. The May 1994 report *'Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice'* of the Senate of The Royal Surgical Colleges of Great Britain and Ireland stated:

'New techniques and procedures that are developed after an individual's training has been completed will be dealt with by the continuing professional education programme (see Section 3). …

'3. Continuing Professional Education

'The profession believes that new techniques should be dealt with in the following manner:

'a. New techniques must be detected, through literature, communication and conference reviews, when they are first made public.

'b. If a technique is considered by the profession to be sufficiently novel as to require special training and assessment before being introduced into general clinical practice, its initial use should be controlled and limited to a number of specified centres for clinical trial. The Colleges are now devising the mechanisms for achieving such control. …

'The problem for surgeons will be the definition of what is sufficiently new and different from existing practice to demand such control. Most technical developments are simply minor improvements on an existing technique.'[100]

99 WIT 0336 0021 – 0023 Professor Sir Kenneth Calman

100 WIT 0048 0143 – 0145; *'Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice*'

79 Sir Barry Jackson, President of the Royal College of Surgeons, told the Inquiry:

> 'If you look in (b) [WIT 0048 0144] it says "the Colleges are now devising the mechanisms for achieving such control". They did this by setting up the Safety and Efficacy Register, New Interventional Procedures, SERNIP for short, which was developed in the 12 months after this document was published. It was actually formalised at the beginning of 1996, and widely publicised amongst purchasers, Trusts, clinicians, specialty associations and such like, whereby new techniques should be referred to this new body, SERNIP, for careful assessment as to whether or not this was a technique that could be recommended to Trusts and purchasers for widespread implementation, or whether it needed further refinement, proper controlled trial assessment, or whether it was found wanting. This body, SERNIP, has now been working for three years and has, by common consent, been reasonably – I say "reasonably" rather than "wholly" – successful in its aims and objectives. Only "reasonably", because it has not always had everything referred to it for assessment. It is a voluntary system of referral, and there have been one or two things that have just not been referred to it, but by and large, it has worked, I think, terribly well and its funding, which is Department of Health funding, has been extended for a further one year pending discussions with the new body, the National Institute of Clinical Excellence, and how it might interrelate with that new special authority, NICE.
>
> 'Q. So the mechanism set up in 1996 was SERNIP?
>
> 'A. Yes.
>
> 'Q. Prior to SERNIP, would it be the case that the identification of a new technique which raised ethical issues or issues of training would be reliant upon the surgeons concerned and that they might, if they needed advice, be reliant on local ethics committees or research committees to discuss the problems raised by new techniques?
>
> 'A. You would be right in that, yes.'[101]

80 SERNIP categorised procedures into four; however, Mr Julian Dussek, President of the Society of Cardiothoracic Surgeons, wrote:

> 'It [SERNIP] incorporates a method of identifying and registering new international procedures whose safety and efficacy have not been established and advising on how they may be evaluated in a controlled way. … Unfortunately, admirable as the system is, it does not deal with the actual problem of a surgeon learning a new operative technique.'[102]

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101 T28 p. 104–6 Sir Barry Jackson

102 SCS 0003 0002; Dussek, J. *'Avoiding the Learning Curve'* (13 September 1998)

81 The expert evidence on the issue of innovation in surgery is set out in Chapter 19.

82 In so far as the change in approach described by Sir Graham Hart relates to a greater willingness to be prescriptive about what services may be provided, Professor Sir Kenneth Calman explained that the DoH can prevent, on ethical grounds, a new technique from being introduced: '… government at that level has a fairly strong veto on the kind of things that can and cannot be done'. [103] He cited the example of xenotransplantation.

National regulatory and professional bodies

83 There is a multiplicity of regulatory, professional and specialist bodies and associations in medicine, nursing and the other healthcare professions. They may set, monitor and enforce standards and support practitioners. This overlap of bodies and of both functions and the responsibilities for these functions is addressed in the following paragraphs.

84 The evidence was that the proliferation of such bodies led to a degree of lack of co-ordination so far as regulation was concerned. Sir Donald Irvine, President of the GMC, told the Inquiry:

> 'Q. … if one were to look at the system of regulation as a system involving the GMC, the employer, that is the National Health Service or the Trust as may be the case, and the other regulatory bodies such as the Ombudsman, the court system and so on, would you describe the period from 1984 to 1995, at any rate, as one in which the system was co-ordinated in any way between those regulatory bodies?
>
> 'A. Co-ordinated up to a point, but I have expressed my opinion about this in public before. I do not believe the system was as well co-ordinated as it might have been, or should be.'[104]

Professional regulation – medicine: the GMC

85 The GMC is concerned with the practice of medicine; the United Kingdom Central Council (UKCC) with nursing. Both have a statutory basis. The Inquiry received evidence as to the GMC's statutory powers and duties from Mr Finlay Scott, Chief Executive and Registrar of the GMC, who also detailed the statutory rules relating to

[103] T66 p. 69 Professor Sir Kenneth Calman
[104] T48 p. 20–1 Sir Donald Irvine

the GMC's procedures in respect of the conduct, health and performance of doctors.[105]

86 Sir Donald Irvine gave details of the GMC's statutory responsibilities, committee structure, and disciplinary procedure.[106] Mr Scott told the Inquiry:

> 'The GMC licenses doctors to practise medicine in the United Kingdom and has four main functions:
>
> 'a. Keeping up-to-date registers of qualified doctors.
>
> 'b. Fostering good medical practice.
>
> 'c. Promoting high standards of medical education.
>
> 'd. Dealing firmly and fairly with doctors whose fitness to practise is in doubt on grounds of conduct, health or performance.'[107]

87 Only since 1997 has the GMC had its specific power to deal with doctors whose fitness to practise is in doubt on the ground of performance.[108]

The approach of the GMC

88 Sir Donald took the view that the primary responsibility for the quality of clinical care rested with individual clinicians:

> 'I am saying, in this paragraph,[109] how vital it is to recognise that for the patient the quality of the consultation and all that flows from that in terms of diagnosis and treatment is immensely dependent on the integrity and the ability of the doctor to try and get things right. Most decisions in medicine – not just general practice – are still taken in relative privacy. It is that recognition of that very fundamental fact that leads us, or has led us in the GMC, to place such an emphasis on the culture. You cannot supervise the millions and millions and millions of independent individual decisions that are made about, "Is it this treatment rather than that?", "Is it this pill?", "Do I do this now or at another time?", et cetera. So the whole system I am putting here has to be geared to trying to make sure that doctors get it right first time as often as possible, and conduct themselves in a way that patients find helpful and which they expect.'[110]

105 WIT 0062 0002, 0016, 0018, 0020, 0021, 0022 Mr Scott. Mr Scott also includes a table of statutory amendments to the 1988 Procedure Rules: WIT 0062 0620
106 For details of the GMC's processing of complaints and the disciplinary mechanisms, see T48 p. 110–21 Sir Donald Irvine
107 WIT 0062 0001 – 0002 Mr Scott
108 The General Medical Council (Professional Performance) Rules Order of Council 1997 (SI 1997 No 1529) came into force on 1 July 1997
109 WIT 0051 0014 Sir Donald Irvine
110 T48 p. 61–2 Sir Donald Irvine

89 A principle underpinning the statutory functions of the GMC is that of self-regulation by doctors of doctors. Sir Donald supported the concept:

> '… while I fully acknowledge that there is a demonstrable need for improvement, self-regulation does work. It is for the critics of self-regulation to convince – in sufficient detail, and on the basis of evidence not assertion – that an alternative would be more effective in protecting the public interest.'[111]

90 Earlier, he had written:

> 'Professional self-regulation is one element in the complicated relationship between the medical profession and society. For example, doctors working for the NHS are also accountable as employees and contractors. In a web of complex regulatory arrangements some tension is not only inevitable but healthy.'[112]

91 An important issue for the Inquiry is how the GMC conducted itself during the period of the Inquiry's Terms of Reference and of the respective responsibilities assumed by (and of) others, such as the Royal Colleges, the British Medical Association (BMA), and the employers of individual clinicians.

92 Throughout much of the period, according to Sir Donald, there had been

> '… growing public concern about the way the General Medical Council (GMC) and the Royal Colleges have operated professional self-regulation. To many, these institutions have reflected more general attitudes in the profession and have appeared unduly protective of doctors rather than patients. They have been accused of being inward-looking, self-interested, unaccountable, ineffective, and increasingly at odds with public interest.'[113]

93 During the period, the GMC has tried, Sir Donald said, to make itself more patient-centred. There has been a trend, since at least 1984, towards increased lay representation on the GMC and its committees.[114] However, throughout the period under review the general culture was said to be one centred on practitioners rather than on patients. Sir Donald wrote that one outstanding problem was that:

> 'The culture within medicine and medical regulation was predominantly doctor- rather than patient-oriented.'[115]

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111 WIT 0051 0005 Sir Donald Irvine

112 WIT 0051 0067 Sir Donald Irvine; 'The Performance of Doctors. I: Professionalism and Self-regulation in a Changing World', '*BMJ',* 1997; 314:1540–2.

113 WIT 0051 0061 Sir Donald Irvine, '*Lancet',* 1999; 353:1174–7

114 See WIT 0062 0003 Mr Scott for membership of GMC; WIT 0062 0007 – 0008 for membership of the Standards Committee; WIT 0062 0010 for membership of the Education Committee; WIT 0062 0016 for membership of the Preliminary Proceedings Committee (PPC); WIT 0062 0018 for membership of the Professional Conduct Committee (PCC); and WIT 0062 0021 for membership of the Health Committee. Since 1984 the proportion of lay representation in all these memberships has increased with each change in composition (with the exception of the PPC, in which lay membership was reduced in 1996)

115 WIT 0051 0006 Sir Donald Irvine

94 Within this culture, the GMC's approach was to set standards by giving generic advice and stating principles, and to supervise the conduct of doctors in response to complaints.

95 So far as the former is concerned, it was the evidence of Mr Scott that:

> 'The Committee on Standards of Professional Conduct and on Medical Ethics (the Standards Committee) formulates generic advice on standards of professional conduct and on medical ethics. The Standards Committee defines the principles which underlie good professional practice; applies them to new situations as the circumstances of medical practice change; and where necessary, recommends revised guidance to the Council.'[116]

96 It does not, therefore, lay down specific clinical guidelines for the treatment of particular conditions. It expects such guidelines to be set by the Royal Colleges.

97 Moreover, there are also other areas of clinical practice that the GMC avoided: it gave limited guidance on consent and other areas that it regarded as the responsibility of the courts:

> 'Throughout the 1980s and early 1990s the Council saw a clear distinction between areas governed by law – both common law and legislation – and questions of conduct and ethics. The GMC gave no guidance on matters which it believed were covered principally by law and would be dealt with in the courts. This is still the policy, but not every subject falls neatly into one category or the other.' [117]

98 Nevertheless, the GMC dealt (and deals) with some cases involving 'consent' through its professional disciplinary procedures:

> '… the Standards Committee has from time to time thought about whether guidance could be appropriately given, but the difficulties of disentangling the professional and the legal matters seemed at the time to be too difficult to handle, but that did not stop the Professional Conduct Committee considering individual complaints in individual cases.'[118]

99 The main mechanism available to the GMC with which to supervise doctors, to ensure fitness to practise, is and was its disciplinary procedures. These may result in a doctor's name being removed from the register. This does not in theory prevent a doctor from practising medicine as such, but has much the same practical effect, since he may not represent himself as a registered medical practitioner.

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116 WIT 0062 0007 Mr Scott
117 WIT 0051 0076 Sir Donald Irvine
118 T48 p. 122 Sir Donald Irvine

100 In the period covered by the Inquiry's Terms of Reference, a doctor could have his name removed from the register if found guilty, beyond a reasonable doubt, of 'serious professional misconduct', upon a complaint to the GMC.

101 The 'serious professional misconduct' standard is practitioner-centred; according to Sir Donald it may not accord with the patient's experience:

> '… from a patient's point of view, there is a greater difficulty. Most patients do not start asking themselves with a complaint "Is this likely to be serious professional misconduct or not?", they want to know what to do and where to go and have the thing taken forward.'[119]

102 Four features of this regime were explored more fully in evidence: the impact of the word 'serious' as qualifying 'professional misconduct'; the burden of proof; the focus on his conduct rather than poor performance; and the fact that any system operating by complaint may be reactive rather than proactive.

103 There is no statutory definition of serious professional misconduct. However, the Privy Council in a case on appeal from the General Dental Council in 1987 (*Doughty v GDC*)[120] gave the following definition (subsequently confirmed in 1995 as applying equally to doctors in *McCandless v GMC*):[121]

> 'Conduct connected with his profession in which (the dentist) concerned has fallen short, by omission or commission, of the standards of conduct expected among (dentists) and that such falling short as is established should be serious.'[122]

'Serious'

104 The use of the adjective 'serious' was accepted as too restrictive by Sir Donald.[123]

105 The impact of its use was explored in relation to a proposal for the future that contemplated replacing 'serious professional misconduct' with 'seriously deficient in performance'[124] or a 'recognisable deficiency of performance'.[125]. The latter would require two matters to be distinguished according to Sir Donald: (i) the degree of deviation from good clinical practice and the degree of culpability in such falling short; and (ii) the evidential standard of proof required. He said:

> 'I was trying to disentangle the two elements here: what is serious deficiency from the standard of proof, the evidence that might be required to get to that point.' [126]

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119 T48 p. 22 Sir Donald Irvine
120 [1988] AC 164; [1987] 3 WLR 769; [1987] 3 All ER 843 (PC)
121 [1996] 7 Med LR 379 (PC)
122 WIT 0062 0015 Mr Scott
123 T48 p. 22 Sir Donald Irvine
124 WIT 0051 0007 Sir Donald Irvine; T48 p. 74–5 Sir Donald Irvine
125 T48 p. 75 Sir Donald Irvine
126 T48 p. 76 Sir Donald Irvine

Burden of proof

106 Throughout the relevant period, the GMC not only had to be satisfied that the professional misconduct was 'serious' but also that it had been established as such, beyond reasonable doubt.

107 The standard of proof is the same as that applied by the UKCC in respect of nurses. Concern was expressed by one witness, a nurse, that in both the GMC and UKCC, the criminal standard of proof, persisting only because of the serious consequences to a practitioner of being struck off, might lead to a feeling that doctors had the significant benefit of the doubt in a situation where patients' safety was involved, and that protection of the public needed to be seen as more central to regulatory proceedings.[127]

Misconduct rather than poor performance

108 'Professional misconduct' has resulted in the GMC's disciplinary procedures and guidance traditionally being employed in relation to a few narrow areas, such as sexual relations with patients and advertising (maintaining the probity and reputation of doctors). There have been changes in emphasis over the relevant period, which may reflect changes in the perceived role of the GMC. (Such changes over the period are demonstrated in particular by the change in emphasis from a greater focus on 'disparagement' of a colleague to a recognition of the greater importance of the duty to notify others if a colleague's conduct is open to question. This change will be explored later in this chapter, once the evidence as to the analogous position of the UKCC in respect of discipline and standards has been reviewed.)

109 A consequence of the GMC's authority being limited to 'serious professional misconduct' which had to be proved beyond reasonable doubt, was that it left the public exposed, as this exchange between Leading Counsel to the Inquiry and Sir Donald revealed:

> 'Q. So misconduct aside, the poor performer has never, between 1984 and 1995, been erased from the register on the grounds of poor performance alone?
>
> 'A. A number of doctors have been erased from the register where their performance has been so unsatisfactory as to constitute serious professional misconduct in the GMC's eyes. But of course you touch on a fundamental weakness in the fitness to practise procedures, which we recognised in that period and set about a strengthening of the procedures by having the Medical Performance Act. It gave us the power to look at a doctor's pattern of practice over a period of time, but the basic fact of the matter is that we became aware that where a doctor's practice was manifestly unsatisfactory, it was nevertheless very difficult to bring a charge of serious professional misconduct and make it stick. This left the public exposed.'[128]

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127 T33 p. 149–50 Ms Lavin and WIT 0052 0193; '*The Regulation of Nurses, Midwives and Health Visitors*', overview

128 T48 p. 12–13 Sir Donald Irvine

Reactive rather than proactive

110 Sir Donald told the Inquiry that the GMC had been reactive rather than proactive:

> 'Q. … the points which I think you would accept in respect of the way in which the GMC had a place in the regulatory framework from 1984 to 1995 are these: that first it was punitive rather than preventative; you have already accepted that?
>
> 'A. Yes.
>
> 'Q. Secondly, it was – it may be the same thing – reactive rather than proactive?
>
> 'A. Yes.'[129]

111 However, Sir Donald later qualified his statement:

> 'I should add, by the way, just in relation to the fitness to practise arrangements, you asked me if I agreed with you this morning that they were essentially punitive, and I said yes, and I do not actually agree with that. There is a punitive element to them, but of course they are primarily about maintaining the public interest and the safety of patients. I am sure you know that from the various matters that have been published. I would not like to leave you with that wrong impression.'[130]

112 Sir Donald stated that an outstanding problem was that:

> 'The GMC's fitness to practise procedures were complaints-driven; they were not designed for prevention.'[131]

113 Sir Donald told the Inquiry: '… you simply cannot get at a preventative strategy if one relies on a complaints-driven system alone'[132] and that:

> '… my view is the more general one that I have put to you earlier – it is a personal one – that there is something inherently unsatisfactory in the way we are dependent on complaints for raising questions about poor practice.'[133]

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129 T48 p. 33–4 Sir Donald Irvine
130 T48 p. 81 Sir Donald Irvine
131 WIT 0051 0006 Sir Donald Irvine
132 T48 p. 24 Sir Donald Irvine
133 T48 p. 116 Sir Donald Irvine

114 The GMC's complaints-driven system was not even working as efficiently as its inherent limitations allowed, as Sir Donald said:

> 'Q. Do you think that [the considerable time-lag expected between complaint to the GMC and resolution] has operated over the last 20 years as a fetter upon people making complaints to the GMC?
>
> 'A. It has certainly been one of the factors which has deterred people.'[134]

115 However, the GMC, according to Sir Donald, has recognised the need for change and sees revalidation as the way forward. One of the trends since 1984 that Sir Donald Irvine identified is 'a move from reactive to proactive regulation':[135]

> 'This seems to us to be the only sensible way of addressing the inherent weakness of any complaints-driven system, whether it is the GMC's or whether it is the NHS's arrangements, and that is actually of having a systematic on-going demonstration of fitness to practise.'[136]

Specific positive standards of professional conduct

116 As part of the trend from reactive to proactive, the GMC has changed the form of its standards from negative prohibitions to positive requirements.

117 The '*Blue Book*'[137] set, for the first time, positive standards that a doctor was required to adhere to:

> 'We have to go to the change in guidance in the 1985 Blue Book, page 10, and the reference there to "explicit clinical standards". That represented the first development of an explicit statement of expectation from a doctor, and as I referred to in an earlier response to you, that finds its way now into the current guidance. But it was more than that; it formed the basis against which charges of serious professional misconduct were framed and accounts for the substantial rise in the proportion of clinical cases which appeared before the Professional Conduct Committee'.[138]

118 Since 1995 the GMC has replaced the '*Blue Book*' with the package '*Duties of a Doctor*'[139] (consisting of *'Good Medical Practice'* and other booklets)[140] and '*Maintaining Good Medical Practice*'.[141]

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134 T48 p. 113 Sir Donald Irvine
135 WIT 0051 0002 Sir Donald Irvine
136 T48 p. 78–9 Sir Donald Irvine
137 The editions of the *'Blue Book'* current during the period of the Inquiry's Terms of Reference are at: WIT 0062 0127 (August 1983), WIT 0062 0145 (April 1985), WIT 0062 0165 (April 1987), WIT 0062 0183 (March 1989), WIT 0062 0201 (June 1990), WIT 0062 0220 (February 1991), WIT 0062 0239 (May 1992) and WIT 0062 0283 (December 1993)
138 T48 p. 69–70 Sir Donald Irvine
139 WIT 0062 0008 Mr Scott. '*Duties of a Doctor*' is at WIT 0062 0305
140 WIT 0062 0009 Mr Scott. WIT 0051 0007 Sir Donald Irvine. '*Good Medical Practice*' is at WIT 0062 0309 (October 1995 edition) and WIT 0062 0374 (July 1998 edition)
141 WIT 0062 0009 Mr Scott. '*Maintaining Good Medical Practice*' is at WIT 0062 0398

Implicit to explicit standards

119 A parallel to the move from negatively to positively expressed standards has been the trend since 1984 for 'a move from implicit to explicit professional and clinical standards'.[142]

120 Sir Donald told the Inquiry:

> 'Q. So far as the "thou wilt" part of it was concerned, standards tended to be unspoken rather than prescribed by the GMC, or for that matter by the Royal Colleges?
>
> 'A. That was the position in medicine as a whole, both in this country and elsewhere. Much of medicine, until the late 1980s, was based on implicit standards, the movement to explicit standards is relatively recent.'[143]

Content of standards regulated by the GMC

121 The change in form of standards from negative to positive also reflected a change in the content of the standards. Sir Donald identifies a principal philosophic change in the GMC's policies in 1984–1995 as not only:

> 'Adopting a role in fostering standards of good practice by defining the qualities and attributes of a good doctor rather than defining what would amount to serious professional misconduct'[144]

but also, parallel to that:

> 'a … move towards regulating doctors' standards of practice and performance rather than a narrow concentration upon doctors' conduct and probity'.[145]

122 Annex D of Sir Donald's statement *'The Development of GMC Policy on Professional Standards'* explains the expansion and change in nature of the standards with which the GMC concerned itself. Poor performance had been peripheral to its concerns:

> 'In the early 1980s the guidance in [the *"Blue Book"*] made clear … that the Council was not "ordinarily concerned with errors in diagnosis or treatment"'.[146]

123 The shift from a concentration on misconduct to include concerns with poor performance involved a shift in focus from isolated events to patterns of conduct:

> '… there was the separate category where you knew there was a pattern of repeated poor practice, but none of it at any point, any of those incidents, sufficient

142 WIT 0051 0002 Sir Donald Irvine
143 T48 p. 34 Sir Donald Irvine
144 WIT 0051 0007 Sir Donald Irvine
145 WIT 0051 0002 Sir Donald Irvine
146 WIT 0051 0074 Sir Donald Irvine

that you could bring the conduct procedures to bear. That was the genesis of the performance procedures, to alter the evidential basis upon which one looked at a doctor's practice away from a single incident to a pattern of practice over time.'[147]

124 The new emphasis on performance required standards that were measurable, but an outstanding problem was that 'Measurable clinical standards were few and far between…'.[148]

125 More recently, developments have included the introduction of the GMC's performance procedures by the Medical (Professional Performance) Act 1995, from 1 July 1997,[149] and the establishment of the GMC's Fitness to Practise Policy Committee in 1997.[150]

Response to criticism: constraints imposed by statute

126 The response to criticism of the GMC for supposed inaction and its slowness to reform is that the GMC has been constrained by statute:

'The relevant legislation both imposes duties upon, and extends powers to, the GMC. As a corollary, the GMC cannot act beyond those duties and powers.'[151]

127 Sir Donald observed:

'I think that some of the criticisms stem from a misunderstanding or lack of understanding or appreciation of precisely what the functions of the GMC are, and the framework within which it works, what it can and cannot do. … That framework, then, we have to strictly adhere to. It gives us powers to act decisively in some areas, but it places considerable constraints particularly at the operational level where the Council's responsibilities do not run.'[152]

128 However, the approach of the UKCC may be contrasted with that of the GMC. It has adopted a more flexible and proactive approach to addressing day-to-day issues in trusts. Ms Mandie Lavin, Director of Professional Conduct, UKCC, told the Inquiry:

'I can think of many occasions where I have been directed to write to Directors of Nursing, most recently I think to a Chief Executive who wrote back to me and expressed his concern that the UKCC should have such a degree of interest in the day-to-day activities within his Trust. I assured him we were interested.'[153]

147 T48 p. 73 Sir Donald Irvine
148 WIT 0051 0006 Sir Donald Irvine
149 WIT 0062 0014 Mr Scott. The relevant statutory instrument (The General Medical Council (Professional Performance) Rules Order of Council 1997, SI 1997 No 1529) is at WIT 0062 0684 Mr Scott
150 WIT 0062 0013 Mr Scott
151 WIT 0051 0001 Sir Donald Irvine
152 T48 p. 10 Sir Donald Irvine
153 T33 p. 155 Ms Lavin

129 Sir Donald, however, told the Inquiry:

> 'You [the Trust] are the people who are employing the doctor, we [the GMC] are not, and it is not part of our statutory duty to do that monitoring.'[154]

130 He stressed:

> 'What I am saying is that, we have to operate within our framework. … Our framework did not include the management of doctors at work. The relevant framework is giving advice on standards of practice and promulgating those standards, seeking to inform the culture of practice, particularly through the education system and that part which we are specifically responsible for, and acting on the basis of complaint when things appear to have gone wrong.' [155]

131 Its statutory powers appear to have inhibited the GMC from initiating investigations itself:

> 'Its statutory position, of course, is as you describe: the GMC activates or acts on the basis of a complaint. It has not scanned the media, et cetera … that has not been part of the practice.'[156],[157]

132 Further, Sir Donald indicated that the GMC's previous response to its statutory framework had been more restrictive than it had to be:

> '… within the statutory framework that I have described, we have been undergoing a considerable change of outlook ourselves which began, again, in the early 1990s, and that was effectively to see how far within the framework, the statutory framework as it was, we could be as effective as possible.'[158]

133 Some of the GMC's reticence went beyond that required by statute:

> 'Q. … There would have been nothing, would there, in the statute to have stopped the GMC, had it wished to do so, having an individual who would write to the author of a media report saying, "You have said various critical things; do you wish to make a complaint?" Obviously you cannot act unless he does?
>
> 'A. That is absolutely true: there would have been nothing to stop that. The starting point for the Council is, was there a complaint? That is what the policy was and that is how it was operated.'[159]

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154 T48 p. 84 Sir Donald Irvine
155 T48 p. 28–9 Sir Donald Irvine
156 T48 p. 115 Sir Donald Irvine
157 T48 p. 132. Despite saying this, Sir Donald Irvine later said 'that the [General Medical] Council does in fact scan the press and pursues matters at the material time. However, it did not scan *"Private Eye"* as a matter of fact.'
158 T48 p. 31 Sir Donald Irvine
159 T48 p. 115–16 Sir Donald Irvine

134 The following exchange between Leading Counsel to the Inquiry and Sir Donald emphasises the point:

> 'Q. I want to ask you about a suggestion from her [Marilyn Rosenthal's] observation that the GMC was resisting enlargement of its own disciplinary responsibilities and would prefer to let the other mechanisms, that is the NHS authorities and the courts, deal particularly with medical malpractice and maloccurrence. As an historical [1987] snapshot, is it right or wrong?
>
> 'A. I think it was probably an accurate historical snapshot … I think then that the translation from, as it were, one approach to a different approach took time.'[160]

135 Moreover, the view that the statutory framework in this area imposed a fetter on the activity of the GMC in this area may be contrasted with another area, in which the GMC interpreted its statutory powers more broadly:

> 'Q. … The GMC inspects, does it, medical schools and those institutions where doctors are trained?
>
> 'A. The definition of the Act is rather narrower than that. I do not have the right words in front of me, but the essence is the inspection of the final qualifying examinations. That is interpreted as generously as the Act actually allows, as an enquiry as to the sufficiency of what has gone before that leads to that final examination. But it is not a formal power of accreditation.'[161]

136 Moreover, since the end of the period with which the Inquiry is concerned, the GMC has requested increases in its disciplinary powers:

> 'Orders for interim suspension or interim conditions may be made for up to six months but are renewable for up to three months at a time (until 1996, this power was limited to a single period of three months but, *at our request*, the power was increased).'[162]

137 Sir Donald circulated widely an explanation of the effects of The Medical Act 1983 (Amendment) Order 2000:

> 'Both Houses of Parliament have now approved the legislation *we sought,* to widen our powers. The Privy Council approved our new rules on 12 July 2000. The effects will be:

160 T48 p. 71–2 Sir Donald Irvine
161 T48 p. 105 Sir Donald Irvine
162 WIT 0051 0134 Sir Donald Irvine; *'Supplementary Evidence from the General Medical Council'* (emphasis added)

'To provide us with greater powers of interim suspension, and interim conditions on registration, exercised by a new Interim Orders Committee, on which there will be very strong lay representation.'[163]

Professional regulation – nursing: the UKCC

The statutory basis

138 The UKCC's role is broadly analogous to that of the GMC.[164] Ms Lavin gave evidence to the Inquiry about the legal foundations of the UKCC and its relationship to the National Boards:[165]

'1. The UKCC, together with the four National Boards (in England, Scotland, Wales and Northern Ireland), regulates the education and practice of nurses, midwives and health visitors. The 1997 Act is a consolidation of the 1979 Act which established these bodies, and the 1992 Act which reformed their powers and composition.

'2. The role of these statutory bodies is to define standards for the education, clinical practice, and professional conduct of nurses, midwives and health visitors; and to monitor the implementation and effectiveness of these standards. Broadly, the UKCC is responsible for standard setting and conduct procedures, including maintaining the register of professionals deemed fit to practice. The National Boards are responsible, within their respective countries, for oversight of the implementation of education standards and other related functions. The 1979 Act brought together all the statutory bodies concerned with regulating the professions at both pre- and post-registration levels and rationalised the regulatory structures across the UK.

'3. A review of the organisation and functioning of the five statutory bodies in 1989 led to the 1992 Act and changes in legislation – the UKCC became the directly elected body and the National Boards became smaller, executive bodies appointed by the respective Secretaries of State (and, for Northern Ireland, the Head of the Department of Health and Social Services for Northern Ireland). All professional conduct functions were transferred to the Central Council.

'4. Nurses have been regulated under statutory professional self-regulation since 1919; and midwives since 1902. Until 1979, health visitors were regulated through their nursing qualification, with other arrangements made under a separate body for their education and training as health visitors.'[166]

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163 WIT 0051 0145; letter from Sir Donald Irvine, GMC President, to 'chief executives, NHS Executive in England, Wales, Scotland and Northern Ireland; regional chairs and directors, NHS; chairs of CHCs; local health councils and directors of public health authorities; health boards; health and social services boards; chief executives and medical directors of NHS trust and independent hospitals', dated 13 July 2000 (emphasis added) Sir Donald Irvine

164 T33 p. 136 Ms Lavin

165 The National Boards for England, Scotland, Wales and Northern Ireland

166 WIT 0052 0001 – 0002 Ms Lavin

139 Ms Lavin[167] referred the Inquiry to the statutory provisions governing the professional conduct of nurses, midwives and health visitors: the Nurses, Midwives and Health Visitors Act 1997, the Nurses, Midwives and Health Visitors Rules Approval Order 1983,[168] the Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993[169] and the Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998.[170]

140 Ms Lavin explained the functions of the National Boards:

> 'The functions of the Boards are to:
>
> - 'approve institutions to provide courses of training
> - 'ensure that courses of training meet Central Council requirements as to their kind, content and standard
> - 'hold or arrange for others to hold such examinations as are necessary to satisfy requirements for registration or additional qualifications
> - 'collaborate with Council in promotion of improved training methods and
> - 'provide advice and guidance to Local Supervising Authorities for midwives.
>
> 'In addition the Boards are to carry out any other functions prescribed by the relevant Secretary of State.
>
> 'In addition to their primary function of the implementation and monitoring of Council standards for education, all the National Boards have additional functions. These are specified in the statutory instruments through which they were established in each country; any may differ from country to country. These functions include careers information, research into training methods, provision of courses of training and further training for nurse, midwifery and health visitor teachers and provision of a central applications system (Scotland). The constitution of the National Boards is prescribed in the [1997] Act and elaborated in statutory instruments.'[171]

141 The four UK Health Departments commissioned J M Consulting Ltd to:

> '… review the legislation which regulates the education and practice of nurses, midwives and health visitors and the five statutory bodies which operate it'.[172]

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167 WIT 0052 0016, 0278 Ms Lavin
168 SI 1983 No 873
169 SI 1993 No 893
170 SI 1998 No 1103
171 WIT 0052 0004 – 0005 Ms Lavin
172 WIT 0052 0188 Ms Lavin

142 J M Consulting Ltd is an independent, Bristol-based, company that specialises in conducting public sector reviews on commission from national agencies, particularly in the higher education and health sectors.

143 The review was announced in Parliament in July 1997.[173] At its conclusion, J M Consulting Ltd produced '*The Regulation of Nurses, Midwives and Health Visitors*'[174] which sets out the history and background to the Nurses, Midwives and Health Visitors Act 1997.[175]

144 One matter to emerge from the review was that the relationship between the UKCC and the National Boards could be improved[176] and indeed, the Government has accepted proposals to replace the UKCC and National Boards with a Nursing and Midwifery Council.[177]

Relative roles and responsibilities of the UKCC and the Royal College of Nursing

145 Although the UKCC's role is broadly analogous to that of the GMC, the relationship between the Royal College of Nursing (RCN) and the UKCC is different in nature from the relationship between the GMC, BMA and the Royal Colleges. The table of comparisons below helps to explain the respective roles of the RCN and the UKCC.

Table 1: Respective roles and responsibilities of the UKCC and the RCN

	RCN	UKCC
Founded	1916	'Nurses have been regulated under statutory professional self-regulation since 1919; and midwives since 1902. Until 1979, health visitors were regulated through their nursing qualification, with other arrangements made under a separate body for their education and training as health visitors.'[1] UKCC was established by the Nurses, Midwives and Health Visitors Act 1979
Constitution	Royal Charter granted 1928 It is a voluntary association It is a trade union – nurses may also belong to Unison, or another trade union which is open to membership from health professionals	Statutory: Nurses, Midwives and Health Visitors Acts 1997, Nurses, Midwives and Health Visitors Rules Approval Order 1983,[2] Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993,[3] Nurses, Midwives and Health Visitors (Professional Conduct) (Amendment) Rules 1998 Approval Order 1998[4]
Charitable status	Registered charity	
Headquarters	London	London

173 WIT 0052 0216 Ms Lavin
174 WIT 0052 0183 Ms Lavin; *'The Regulation of Nurses, Midwives and Health Visitors – Report on a Review of the Nurses, Midwives and Health Visitors Act 1997'*
175 WIT 0052 0218 Ms Lavin
176 T33 p. 141 Ms Lavin
177 T33 p. 152 Ms Lavin; WIT 0052 0322; *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations HSC 1999/030'*, p. 6 (dated 9 February 1999)

Table 1: Respective roles and responsibilities of the UKCC and the RCN (continued)

	RCN	UKCC
Responsible to whom?	'The College is accountable to Her Majesty the Queen in Privy Council'[5]	'The UKCC is an autonomous body … accountable to the public for their safety through Parliament (the Secretary of State), and accountable to registrants for the proper discharge of its functions on their behalf'[6]
Responsible for	Nurses	Nurses, midwives and health visitors
Aims	'To promote the science and art of nursing and the better education and training of nurses and their efficiency in the profession of nursing'[7] and other aims	'To establish and improve standards of training and professional conduct',[8] 'standard setting and conduct procedures, including maintaining the register of professionals deemed fit to practice'[9]
Number of members	318,000	634,229[10]
Sources of funding	Membership subscriptions, gifts[11]	'UKCC is … funded principally by registrants'[12]
Basic membership		
Higher membership	No higher categories of membership	UKCC's register has 15 parts
Fellowship	No higher categories of membership	
Is membership a requirement for employment?	No	Yes. Registration is compulsory for nurses, midwives and health visitors who want to practice[13]
Training post approval	No	Approval of institutions to provide courses of training; the quality of such courses is the responsibility of the National Boards[14]
Standard setting	'The RCN is a leading player in the development of nursing practice and standards of care.'[15] 'The RCN offers its members a wide range of services including: development of nursing practice and standards of care';[16] 'the Dynamic Quality Improvement Programme has focused on development work, including … developing specialist guidelines and standards';[17] 'an initial programme of work to develop national standards for particular speciality areas was undertaken in the late 1980s and early 1990s. This resulted in the production of standards for a whole range of specialist subjects'[18]	See aims above
Current President	Christine Watson (General Secretary: Christine Hancock)[19]	Alison Norman
Discipline of members	'The RCN can remove members from membership, although this power has never been used'[20]	As the professional regulatory body, it has sanctions for misconduct and ill health

Table 1: Respective roles and responsibilities of the UKCC and the RCN (continued)

	RCN	UKCC
Continuing Professional Development (CPD)/ Continuing Medical Education (CME)	'The RCN offers its members a wide range of services including: … education and professional development activities.' RCN has a continuing education points (CEP) system [21]	Compulsory post-registration education and practice (PREP).[22] 'CPD is a requirement for all nurses and midwives and evidence of appropriate activity will be a condition of renewed registration'[23]
Historic links to other colleges	'The RCN has a good track record in working with other organisations in order to improve health care'[24]	

1. WIT 0052 0002 Ms Lavin
2. SI 1983 No 873
3. SI 1993 No 893
4. SI 1998 No 1103
5. WIT 0042 0003 Miss Hancock
6. WIT 0052 0007 Ms Lavin
7. WIT 0042 0004 Miss Hancock
8. Nurses, Midwives and Health Visitors Act 1997, section 2(1)
9. WIT 0052 0001 Ms Lavin
10. UKCC 0001 0001 total number of registrants 1998/1999
11. WIT 0042 0004 Miss Hancock
12. WIT 0052 0007 Ms Lavin
13. Nurses, Midwives and Health Visitors Act 1997, section 13
14. WIT 0052 0004; WIT 0052 0223 Ms Lavin; T33 p. 136–8 Ms Lavin
15. WIT 0042 0003 Miss Hancock
16. WIT 0042 0003 Miss Hancock
17. WIT 0042 0005 Miss Hancock
18. WIT 0042 0005 Miss Hancock
19. Until May 2001
20. WIT 0042 0003 Miss Hancock
21. T34 p. 124–5 Mrs Jenkins; WIT 0042 0003 Miss Hancock
22. See *'PREP and You'*, UKCC, October 1997; WIT 0052 0089
23. WIT 0052 0203 *'The Regulation of Nurses, Midwives and Health Visitors; Report on a Review of the Nurses, Midwives and Health Visitors Act 1997'*
24. WIT 0042 0025 Miss Hancock

Fitness to practise: nurses

146 The statutory definition of 'misconduct' for nurses: 'conduct unworthy of a registered nurse…'[178] is broadly similar to the GMC's 'serious professional misconduct', and has been described as vague and unhelpful.[179] A charge of 'misconduct' cannot be brought simply by citing a breach of a provision of the *'Code of Professional Conduct'*, although the *'The Regulation of Nurses, Midwives and Health Visitors'* proposes such a change.

178 WIT 0052 0055; Nurses, Midwives and Health Visitors (Professional Conduct) Rules 1993 Approval Order 1993, Rule 1(2)(k)
179 WIT 0052 0205, 0249 Ms Lavin; *'The Regulation of Nurses, Midwives and Health Visitors'*

147 Charges of misconduct against nurses, as with doctors, must be proved beyond a reasonable doubt. However, when the UKCC does not pursue a case to a hearing because the evidence is not strong enough to meet this threshold, or it is dropped for another reason, there is other action that the UKCC can take. The UKCC has a practice of writing to practitioners:

> '… indicating areas where they might want to reflect on practice, for instance, in relation to the administration of medicines or in relation to guidance on records and record-keeping'.[180]

Limits of disciplinary powers

148 The statutory powers of the UKCC, like those of the GMC, appear to be restricted.[181] It has no power, for instance, to impose a life ban on nurses (i.e. removal from the Register with no right to reapply for registration).[182] J M Consulting Ltd in its review did not support the introduction of this power.[183] The GMC similarly does not currently have the power to impose a life ban but has requested the Government for such a power. The Government has indicated its willingness to enact the necessary legislation.

Alternative sanctions and interventions

149 The Government supports the proposal to give the UKCC's successor Council the power to impose sanctions other than removal from the Register, for instance the power to remove the registered marks of a nurse's higher level qualifications or specialism without going so far as to remove the nurse's basic registration.[184]

150 Although the UKCC is complaints-oriented,[185] and thus reactive like the GMC, it has been more punitive in its approach than the GMC. Differential treatment of Doctors and nurses is reflected in the different rates of their being removed from the Register.

151 The UKCC advised the Inquiry of the number of nurses, midwives and health visitors registered with the UKCC and the number removed by the Professional Conduct Committee (PCC), for 1995/96–1999/2000. The following table sets out the figures:[186]

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180 T33 p. 155 Ms Lavin

181 WIT 0052 0190; *'The Regulation of Nurses, Midwives and Health Visitors'*, overview para 12(g); WIT 0052 0251 Ms Lavin

182 WIT 0052 0015 Ms Lavin

183 WIT 0052 0251; *'The Regulation of Nurses, Midwives and Health Visitors'*

184 WIT 0052 0326 'The new register will include marks against registrant's [*sic*] entries to indicate enrolled nurse status, specialisms (within nursing) and higher level qualifications. A further level of public protection can be afforded by making it possible for these marks to be removed (for example, on the grounds of unfitness to practise or failure to meet periodic re-registration conditions) without the practitioner being removed from the register.' *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations HSC 1999/030'*

185 WIT 0052 0009 Ms Lavin

186 UKCC 0001 0001; letter from Rebecca Blease to Peter Whitehurst, 15 September 2000

Table 2: Number of nurses, midwives and health visitors registered with the UKCC and the number removed by the Professional Conduct Committee (PCC)

	1999/2000	1998/99	1997/98	1996/97	1995/96
Total registrants	634,529	634,229	637,449	648,240	645,001
Removed by PCC	96	93	84	96	73
Number of registrants for each one removed	6,610	6,820	7,589	6,753	8,836

152 The reporting period for each year covers 1 April to 31 March. In addition, the UKCC's Health Committee removed and suspended a number of registrants on health grounds.

153 By comparison, there are about 100,000 doctors practising in the UK[187] but only a few are erased from the medical register each year, as is indicated by the figures in the next two paragraphs.

154 The GMC provided the Inquiry with statistics for each year of the period of the Inquiry's Terms of Reference relating to the progress of complaints to various stages of the GMC disciplinary procedures. The number of cases referred to the PCC were:[188]

Table 3: The number of cases referred to the PCC

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
No of cases	52	42	49	53	33	35	51	31	35	59	83	117

155 The number of erasures (with immediate suspension) relating to clinical performance (in the sense of disregard of professional responsibilities and irresponsible prescribing only) were:[189]

Table 4: The number of erasures from the UKCC Register

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
No of cases	5	6(2)	4(2)	3(1)	2(1)	5(1R)	3(1R) (1)	4(2)	1(1R) (1)	13 (1R) (11)	6(1R) (2)	6(3)

156 The UKCC feels it is currently constrained as regards the flexibility of its response to those facing disciplinary action by its limited repertoire of responses:

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187 T48 p. 18 Sir Donald Irvine. 'Of the total doctors on the Medical Register, the ball-park would be around 180,000. But of those, around 100,000 practise in the National Health Service. Many of our registrants are overseas or retired. The operating figure for this country is effectively 100,000.'

188 WIT 0051 0136 Mr Hamilton. 'Figures have been taken from [GMC] Annual Reports for 1984–1994 and from the Report to Council of the work of the PPC in 1995.'

189 WIT 0051 0137 Mr Hamilton. 'Figures taken from [GMC] Annual Reports 1984–1995. Figures in brackets and marked (R) denote the number of cases which were resumed from an earlier hearing in a previous year. Figures in brackets and not marked (R) are the number of cases in which an order for the immediate suspension of the doctor's registration was also made.'

'The difficulty we have at the moment is, we have nothing in between no action and a caution,[190] which remains on the register for five years. That is a pretty big gap in terms of flexibility of response to cases.'[191]

Issues common to regulation of doctors and nurses (and others)

Disparagement and the duty to inform others if a colleague's conduct is in question

157 The change in emphasis since 1984 from a prohibition on disparagement of a colleague to a duty to inform others can be traced through evidence given to the Inquiry of GMC publications and of clinicians' attitudes over time. The change was felt necessary,[192] was made in response to particular cases[193] and reflected changes in attitudes.

Clinicians' traditional attitudes

158 Professor Leo Strunin, President of the RCA, told the Inquiry:

'Q. You are emphasising there, I think, two things: firstly, the development of a team or corporate identity and, secondly, more self-consciousness about professional standards and the need to keep abreast of those. Is that fair comment?

'A. I think that is true. I do not think it is true in anaesthesia, although anaesthetists are better in some respects. They work in departments with some other specialties because of the nature of the work we do, but I think *it was fairly common back ten years when people thought, "Well, as long as I am doing a good job it is not actually my problem what is occurring around me"*, whereas now that has changed and people believe there is a corporate structure and they are responsible for everybody. That is obviously in line with what the General Medical Council now recommends to doctors, that we are not only responsible for our own activities but for those of others around us.'[194]

159 Sir Donald Irvine told the Inquiry:

'A. The notion that clinicians and team members might have some collective responsibility, an explicit notion, I think was not in the mind then [1984].

'Q. So responsibility for one's fellows, if one's fellow was guilty, if I can use that word, of shoddy practice, was not necessarily something which a clinician saw himself as having any duty in 1984 to report upon?

'A. I think that was a very common attitude.'[195]

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190 T33 p. 156 Ms Lavin. '… a caution can only be given by the Preliminary Proceedings Committee in circumstances where a practitioner admits the facts of a case and admits misconduct. It is to deal with one-off deviances…'
191 T33 p. 156 Ms Lavin
192 T48 p. 98 Sir Donald Irvine
193 Principally, the cases of Dr Frempong (see para 164), Dr Dunn (see para 173)
194 T14 p. 4–5 Professor Strunin (emphasis added)
195 T48 p. 89 Sir Donald Irvine

Movement in attitudes and published guidance

160 Sir Donald traced the series of amendments in consecutive editions of the '*Blue Book*'[196] which indicate the trend away from disparagement towards a duty to inform others.

161 The August 1983 '*Blue Book*' stated:

> **'Depreciation of other doctors** …
>
> 'The Council also regards as capable of amounting to serious professional misconduct:
>
> '(i) the depreciation by a doctor of the professional skill, knowledge, qualifications or services of another doctor or doctors …'[197]

162 The April 1985 *'Blue Book'* included an identically worded section. Although this advice in the *'Blue Book'* was unqualified, Sir Donald felt that disparagement required a malicious motive:

> 'Q. If one honestly reported poor practice but was wrong, that would be disparagement, would it not?
>
> 'A. I am not sure that that would be disparagement; I mean, it comes back to the motive behind it. Disparagement was about reporting with malice.'[198]

163 The GMC's guidance on disparagement was perceived to discourage doctors from expressing legitimate concerns. Dr Ernest Armstrong, Secretary of the BMA, said:

> 'Q. So one consequence … of the doctor whistle-blowing the colleague would be that it might be said that he was actually acting in breach of his own contract?
>
> 'A. Not in breach of his own contract, but certainly in breach of his own codes of professional conduct as set out by the GMC.
>
> 'Q. And those are those codes of conduct to be expected explicitly under his contract?
>
> 'A. Correct.

196 The editions of the *'Blue Book'* current during the Inquiry's period are at: WIT 0062 0127 (August 1983), WIT 0062 0145 (April 1985), WIT 0062 0165 (April 1987), WIT 0062 0183 (March 1989), WIT 0062 0201 (June 1990), WIT 0062 0220 (February 1991), WIT 0062 0239 (May 1992) and WIT 0062 0283 (December 1993)
197 WIT 0062 0136 Mr Scott
198 T48 p. 90 Sir Donald Irvine

'Q. Because they are the only standards there are under his contract?

'A. That is correct.'[199]

'Q. So one had the rather Alice in Wonderland, topsy-turvy position that the doctor who might very well be incompetent in particular areas could not be dealt with for that in any realistic way, other than through the Regional Medical Officer as you have described, the informal mechanisms, whereas another doctor complaining about him would, at least until the early 1990s, until the culture began to change, himself be transgressing in a clear and objective way the standards to be expected of him?

'A. That, sadly, is a very neat encapsulation of the doctor's dilemma.'[200]

164 In March 1984 Dr Frempong's case before the Professional Conduct Committee (PCC) raised the question why doctors had not reported a colleague whom they knew to be a danger to patients. Some doctors said they did not do so because they feared falling foul of the GMC's guidance on disparagement. In response, the Council made clear in its next Annual Report that:

'… there may be circumstances in which it would be the responsibility of doctors to report to the Council evidence which may raise a question of serious professional misconduct'.[201]

165 Thus it was that Sir Donald could say there was a policy change between April 1985 and April 1987 that:

'… came about because of an increasing awareness inside the Council that reporting poor practice — that there was a problem here that had to be addressed, and it was articulated by both lay and medical members who took this matter very seriously, but it was also illustrated by the case of Dr [Frempong] in March 1984, and I think it was Esther Rantzen who made a film about this particular situation in which, in this case, there were clearly circumstances in which colleagues had known about the doctor's quite wrong practice and had done nothing about it, so that created the debate which led to this change of policy.'[202]

199 T20 p. 30 Dr Armstrong
200 T20 p. 34–5 Dr Armstrong
201 WIT 0051 0075 Sir Donald Irvine
202 T48 p. 91–2 Sir Donald Irvine

166 As a result, the April 1987 '*Blue Book*' incorporated the first explicit duty to inform others about a colleague who was apparently guilty of serious professional misconduct or experiencing serious ill health.[203] Sir Donald said:

> 'This change was highlighted in the Annual Report (1987) which went to all doctors on the Medical Register.'[204]
>
> '"Disparagement of professional colleagues
>
> '"65. It is improper for a doctor to disparage, whether directly or by implication, the professional skill, knowledge, qualifications or services of any other doctor, irrespective of whether this may result in his own professional advantage, and such disparagement may raise a question of serious professional misconduct.
>
> '"66. It is however entirely proper for a doctor, having carefully considered the advice and treatment offered to a patient by a colleague, in good faith to express a different opinion and to advise and assist the patient to seek an alternative source of medical care. The doctor must however always be able to justify such action as being in the patient's best medical interests.
>
> '"67. Furthermore, a doctor has a duty, where the circumstances so warrant, to inform an appropriate body about a professional colleague whose behaviour may have raised a question of serious professional misconduct, or whose fitness to practise may be seriously impaired by reason of a physical or mental condition. Similarly, a doctor may also comment on the professional performance of a colleague in respect of whom he acts as a referee."'[205]

167 The June 1990 '*Blue Book*' included an identically worded section.[206]

168 The April 1987 and June 1990 editions of the '*Blue Book*' contained no guidance on the meaning of the qualifying phrase 'where the circumstances so warrant'[207] which was open to individual interpretation by individual doctors.[208] Sir Donald said: '… we [the GMC] also acknowledged the difficulty inherent for the doctor in that guidance, because it then changed'.[209]

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203 T48 p. 93 Sir Donald Irvine
204 WIT 0051 0075 Sir Donald Irvine
205 WIT 0062 0175 Mr Scott
206 WIT 0062 0210 – 0211 Mr Scott
207 T48 p. 93 Sir Donald Irvine
208 T48 p. 94 Sir Donald Irvine
209 T48 p. 95 Sir Donald Irvine

169 Coupled with the series of 'clarifications' and 'refinements' of the duty to inform, the GMC tried to publicise the duty as widely as possible within the medical profession:[210]

> 'In 1990, the Council – in public session – considered whether to remove the guidance on disparagement from the *"Blue Book"* altogether, but concluded that it was not right to do so. However, it was agreed that the focus of the guidance should be on reporting colleagues, with questions of disparagement – defined as "gratuitous and unsustainable comment" – being raised as a subsidiary matter. All doctors were told of the importance of this in the 1990 Annual Report.'[211]

170 The February 1991 '*Blue Book*' stated:

> 'Comment about professional colleagues
>
> '62. Doctors are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a doctor is asked to give a reference about a colleague. It may also occur in a less direct and explicit way when a patient seeks a second opinion, specialist advice or an alternative form of treatment. Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered and can be justified, that it is offered in good faith and that it is intended to promote the best interests of patients.
>
> '63. Further, it is any doctor's duty, where the circumstances so warrant, to inform an appropriate person or body about a colleague whose professional conduct or fitness to practice may be called in question or whose professional performance appears to be in some way deficient. Arrangements exist to deal with such problems, and they must be used in order to ensure that high standards of medical practice are maintained.
>
> '64. However, gratuitous and unsustainable comment which, whether directly or by implication, sets out to undermine trust in a professional colleague's knowledge or skills is unethical.'[212]

171 For the first time 'honest comment' was explicitly acceptable in relation to doctors called upon to express a view (para 62),[213] but the duty to inform was still qualified by the phrase 'where the circumstances so warrant' (para 63), so that the difficulties of its interpretation remained.[214] The words 'arrangements exist to deal with such problems', it was said, '… referred to the local arrangements such as the informal procedures which local medical committees operated in general practice, or the "three wise men" procedures in hospitals.'[215]

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210 T48 p. 98–9 Sir Donald Irvine
211 WIT 0051 0075 Sir Donald Irvine
212 WIT 0062 0230 Mr Scott
213 T48 p. 96 Sir Donald Irvine
214 T48 p. 96–7 Sir Donald Irvine
215 T48 p. 96 Sir Donald Irvine

172 Identically worded sections were included in the *'Blue Book'* editions of May 1992[216] and December 1992.[217]

The Dunn case and *'Good Medical Practice'*[218]

173 The first edition of *'Good Medical Practice'*, published in October 1995,[219] contained the first unqualified statement of a duty to inform others about a colleague.[220] It arose from the case of Dr Dunn, a clinical director who had known of a locum consultant's deficient practice and had done nothing about it.[221]

> '8. The Dunn case in March 1994 marked a further step in making clear the GMC's policy on the importance of reporting poor practice. The case against Dr Dunn arose from that of Dr B S Irani, an anaesthetist who was erased following a PCC [Professional Conduct Committee] hearing in July 1993. The case involved a patient left with permanent brain damage after anaesthesia. Dr Dunn was Chairman of his hospital anaesthetics division during the time that Dr Irani was employed there as a locum consultant. Serious concerns had been expressed to him about Dr Irani's competence and conduct, but he failed to take appropriate action.
>
> '9. Dr Dunn was found guilty of serious professional misconduct. In its determination, the PCC drew on the draft guidance being prepared for *"Good Medical Practice"* in stating:
>
> '"Doctors who have reason to believe that a colleague's conduct or professional performance pose a danger to patients must act to ensure patient safety. … This Committee has already drawn attention to the existence of appropriate procedures for response to the reports of evident, and dangerous, incompetence. Doctors have a duty to activate these procedures promptly, where such cases arise. At all times patient safety must take precedence over all other concerns, including understandable reticence to bring a colleague's career into question."[222]
>
> '10. The Dunn case was well publicised by the GMC because of the central importance of patient safety. The GMC took the unusual step of issuing a press release giving details of the case to all national and medical press editors on 18 March 1994. Furthermore, the Annual Report for 1994 alerted all registered doctors to the forthcoming publication of "*Good Medical Practice*" and reminded them of their duty to protect patients from colleagues whose health or professional conduct poses a danger. "The Dunn case" was highlighted in the same report and

216 WIT 0062 0250 Mr Scott
217 WIT 0062 0294 Mr Scott
218 *'Good Medical Practice'* is at WIT 0062 0309 Mr Scott (October 1995 edition) and WIT 0062 0374 Mr Scott (July 1998 edition)
219 WIT 0062 0309 Mr Scott
220 T48 p. 97–8 Sir Donald Irvine
221 T48 p. 97–8 Sir Donald Irvine
222 GMC Annual Report 1994, p. 20

part of the judgement was reprinted, repeating once again that patient safety must take precedence over all other concerns.

'11. While developing *Good Medical Practice*, as well as strengthening the guidance on the duty to protect patients, the GMC also reviewed the need for guidance on disparagement. The GMC concluded that such guidance should be retained, but its scope should be restricted to cases where patients were affected – "You must not make patients doubt a colleague's knowledge or skills …" – and not apply to cases which concerned only the reputation of a colleague or the profession. It was agreed that this guidance should appear in the booklet separately from the guidance on reporting colleagues whose fitness to practise is in doubt, in order that the advice on disparagement should not be seen as qualifying the duty to report dangerous colleagues.'[223]

174 The Dunn case and the change in emphasis are reflected in the wording of *'Good Medical Practice'*.

175 In October 1995 the GMC issued the package of guidance '*Duties of a Doctor'*.[224] '*Duties of a Doctor'* concerns 'The duties of a doctor registered with the General Medical Council'. It states 'In particular as a doctor you must…', followed by a list of 14 particular duties, including the duty to 'act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice'.[225] The list is repeated on the inside front cover of the leaflets in the pack, '*Good Medical Practice'*,[226] '*Confidentiality'*,[227] '*HIV and AIDS: The Ethical Considerations'*[228] and *'Advertising'*.[229]

176 *'Good Medical Practice'* (October 1995 edition) states:

'Maintaining trust

'Professional relationships with patients

'11. Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:[230]

'… respect the right of patients to a second opinion. …'[231]

223 WIT 0051 0075 – 0076 Sir Donald Irvine
224 WIT 0062 0305 Mr Scott
225 WIT 0062 0307 Mr Scott
226 WIT 0062 0310 Mr Scott
227 WIT 0062 0343 Mr Scott
228 WIT 0062 0360 Mr Scott
229 WIT 0062 0328 Mr Scott
230 WIT 0062 0314 Mr Scott
231 WIT 0062 0315 Mr Scott

It adds:

'Your duty to protect all patients

'18. You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them,[232]

'19. Before taking action, you should do your best to find out the facts. Then, if necessary, you must tell someone from the employing authority or from a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague. The safety of patients must come first at all times.'[233]

And continues:

'Working with colleagues…

'24. You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them.'

And again:

'Working in teams …

'27. If you disagree with your team's decision, you may be able to persuade other team members to change their minds. If not, and you believe that the decision would harm the patient, tell someone who can take action. As a last resort, take action yourself to protect the patient's safety or health.'[234]

177 Although outside the time frame of the Terms of Reference of the Inquiry, it should be noted that the July 1998 edition of '*Good Medical Practice'* contained amendments making explicit a doctor's duty to inform on colleagues who were not doctors and to give more advice on whom doctors should approach with concerns. In the following extracts additions to the October 1995 edition are in **bold**, deletions in ~~strikethrough~~.

'Your duty to protect all patients

'23. You must protect patients when you believe that a **doctor's or other colleague's** health, conduct, or performance is a threat to them.

'24. Before taking action, you should do your best to find out the facts. Then, if necessary, you must **follow your employer's procedures or** tell ~~someone~~ **an appropriate person** from the employing authority, **such as the director of public**

232 WIT 0062 0316 Mr Scott
233 WIT 0062 0317 Mr Scott
234 WIT 0062 0318 Mr Scott

> **health, medical director, nursing director or chief executive, or an officer of your local medical committee**, or ~~from~~ a regulatory body. Your comments about colleagues must be honest. If you are not sure what to do, ask an experienced colleague **or contact the GMC for advice**. The safety of patients must come first at all times.'[235]

178 Since the Bristol case has been widely publicised there have been many other publications (including '*Maintaining Good Medical Practice*'[236]) that have explained the doctor's duty to inform others about colleagues, the appropriate channels for expressing concern and mechanisms for rectifying problems.

179 The changes in guidance on informing others about colleagues should be understood in the context of the shift in regulatory emphasis from conduct to performance, as explained above: there is not only greater encouragement of doctors to inform others, but also a change in the nature of that about which they should be concerned.

Disparagement and the duty to inform others if a colleague's conduct is in question – (nurses)

180 The evidence emphasised that a nurse has always been required to be the 'patients' advocate'. It was accepted that this might bring a nurse into conflict with another health professional.

181 The UKCC's '*Code of Professional Conduct*' of 1992[237] stated:

> 'As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must …
>
> '11 report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;
>
> '12 report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;
>
> '13 report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice and care.'[238]

235 WIT 0062 0384 Mr Scott
236 WIT 0062 0398 Mr Scott; '*Maintaining Good Medical Practice*'
237 3rd edition, June 1992
238 WIT 0052 0142 Ms Lavin

182 Although the 1996 guidance gives 'inadequate resources to maintain standards of care',[239] amongst the examples of situations in which it is required that a nurse should report, the obligation on nurses to report applied and applies regardless of whether the substandard circumstances involve another nurse.[240] Thus, further examples include colleagues suffering ill health,[241] and colleagues' 'inappropriate behaviour'[242] (which has overtones of misconduct and abuse of patients). There is no specific mention of colleagues underperforming, but there is an obligation to report 'circumstances in the environment which could jeopardise standards of practice'.[243]

Changes since 1995

183 The Inquiry was told that since 1995 nurses have become more likely to express their concerns. It may be inferred, therefore, that the position in the period with which the Inquiry is concerned was less propitious for them to do so. Ms Lavin said:

> 'I think we are getting better at it. I think people are far more likely to express concerns and be the patients' advocates in circumstances where they have worries about individual practitioners across the board, not just doctors.'[244]

> 'Q. You talked about the changing situation of nurses now being perhaps more willing to challenge or complain about or comment on the conduct of doctors than they were in the past. Is that a change that has taken place since or during the period that the Inquiry is concerned with?
>
> 'A. Yes, I would say so.
>
> 'Q. So in the mid-1980s, the culture would be other than that that you have described as being the one that is developing now?
>
> 'A. I qualified as a nurse in 1987 and at that time I think the change was starting to happen.' [245]

184 Ms Lavin explained the possible reasons for nurses being more likely now to express concerns:

> 'A. I think there have been a number of reasons for it. I think that many people would say the changes in nursing education have resulted in practitioners who

239 WIT 0052 0341 Ms Lavin; 'Employers have a duty to provide the resources needed for patient and client care, but the numerous requests to the UKCC for advice on this subject indicate that the environment in which care is provided is not always adequate. You may find yourself unable to provide good care because of a lack of adequate resources'. WIT 0052 0341 – 0342 Ms Lavin; 'This [advice] will help to make sure that those who manage resources and staff have all the information they need to provide an adequate and appropriate standard of care. You must not be deterred from reporting your concerns, even if you believe that resources are not available … this [communication] may require senior managers to justify their actions if inadequate resources are seen to affect the situation.'

240 T33 p. 109–10 Ms Lavin

241 WIT 0052 0142 Ms Lavin

242 WIT 0052 0341 Ms Lavin; 'You may also have concerns over inappropriate behaviour by a colleague and feel it necessary to make your concerns known.'

243 WIT 0052 0342 Ms Lavin

244 T33 p. 111 Ms Lavin

245 T33 p. 113 Ms Lavin

perhaps have got better skills in terms of expressing concerns and feeling able to do so. I am not sure I entirely concur with that view.

'Q. May it be that now that nursing is more of a university-orientated, educational environment than it was before, that nurses are taken more seriously by doctors than they were before?

'A. Again, I am not sure about that. I certainly have been in a position as a fairly junior nurse in challenging a doctor about not telling a patient the truth, and in latter years, as a Hospital Manager holding a nursing registration, tackling a consultant about not telling a patient the truth and in fact suggesting I was going to go and tell the patient the true state of affairs myself if he was not willing to do so. I think much depends on the individuals and the dynamics and the relationships between people in the organisation as to how seriously and how credible nursing is viewed.[246]

'I think that there are some areas of nursing where nurses still see themselves in a very subordinate role to doctors, but again, I think that is changing. Nurses are extending the boundaries of their competence and knowledge; they are taking on many tasks that I think traditionally might have been associated certainly with a junior doctor's role.'[247]

Duty to inform – whistleblowing: healthcare staff in general

185 There was concern, following the introduction of trusts, that healthcare staff, in some trusts, might be in breach of their contract of employment if they were to speak out about issues relating to healthcare in the trust. It was thought that this might be a breach of the duty of confidentiality an employee owes to an employer in respect of information that might be commercially sensitive. Sir Alan Langlands noted that:

'… the rights and responsibilities of all NHS staff when raising concern about health care issues were set out in guidance to the NHS in 1993.[248] It is the NHS Executive's policy that there should not be confidentiality clauses in contracts.'[249]

Recent developments

186 The Public Interest Disclosure Act (PIDA) 1998 [250] inserts additional sections into the Employment Rights Act (ERA) 1996.

187 In effect, they provide that any provision in a contract which purports to preclude a worker from making a 'protected disclosure' is void; that an employee may not lawfully be subjected to any detriment by any act or deliberate failure to act by his employer, done to him because he has made a 'protected disclosure', nor may he be

246 T33 p. 113–14 Ms Lavin
247 T33 p. 111 Ms Lavin
248 Guidance to staff on relations with the public and media; EL(93)51 GMC 0006 0017
249 WIT 0335 0016 Sir Alan Langlands
250 Enacted 2 July 1998

dismissed, or selected for redundancy on that basis. If detriment, dismissal, or unfair selection for redundancy is proved, the employee is entitled to compensation, in respect of which there is no limit.

188 All depends upon the meaning of 'protected disclosure'. Under the Act, it is a 'qualifying disclosure' [251] meaning:

> '… any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following —
>
> '(a) that a criminal offence has been committed, is being committed or is likely to be committed,
>
> '(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
>
> '(c) that a miscarriage of justice has occurred, is occurring or is likely to occur,
>
> '(d) that the health or safety of any individual has been, is being or is likely to be endangered,
>
> '(e) that the environment has been, is being or is likely to be damaged, or
>
> '(f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.'

189 To be protected, a qualifying disclosure must not only be of information in one of those categories, but also must be made:

> '… in good faith —
>
> '(a) to his employer, or
>
> '(b) where the worker reasonably believes that the relevant failure relates solely or mainly to –
>
> '(i) the conduct of a person other than his employer, or
>
> '(ii) any other matter for which a person other than his employer has legal responsibility, to that other person.'

190 Thus, the disclosure is protected only if it is made to the employer, or to someone in an analogous position — or (perhaps oddly) to the person whose failing is criticised.

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[251] Section 42A, ERA 1996; defined in Section 43B

191 However, it is also a 'protected disclosure' if made to a legal advisor in the course of obtaining legal advice,[252] to a Minister of the Crown,[253] to any person prescribed in an Order made by the Secretary of State for the purposes of the section [254] and otherwise (by Section 43G) if:

> '(a) the worker makes the disclosure in good faith,
>
> '(b) he reasonably believes that the information disclosed, and any allegation contained[255] in it, are substantially true,
>
> '(c) he does not make the disclosure for the purposes of personal gain,
>
> '(d) any of the conditions in sub-section (2) is met, and
>
> '(e) in all the circumstances of the case, it is reasonable for him to make the disclosure.'

192 By sub-section (2), the conditions referred to in sub-section (1)(d) are:

> '(a) that, at the time he makes the disclosure the worker *reasonably believes* [256] that he will be subjected to a detriment by his employer if he makes a disclosure to his employer …
>
> '(b) that, in a case where no person is prescribed for the purposes of Section 43F in relation to the relevant failure the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer, or
>
> '(c) that the worker has previously made a disclosure of substantially the same information —
>
> '(i) to his employer, or
>
> '(ii) in accordance with Section 43F.'

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252 Section 43D ERA
253 In the case of the NHS: see Section 43E ERA
254 HSE, for example: as at September 1999 no specific person had been proscribed in respect of the NHS (Section 43F ERA)
255 See Section 43G ERA
256 (Emphasis added)

193 In determining whether it is reasonable for the worker to make the disclosure, regard is to be had in particular to: [257]

> '(a) the identity of the person to whom the disclosure is made,
>
> '(b) the seriousness of the relevant failure,
>
> '(c) whether the relevant failure is continuing or is likely to occur in the future,
>
> '(d) whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person,
>
> '(e) in a case falling within sub-section (2)(c)(i) or (ii), any action which the employer or the person to whom the previous disclosure in accordance with Section 43F was made has taken or might reasonably be expected to have taken as a result of the previous disclosure, and
>
> '(f) in a case falling within sub-section (2)(c)(i), whether in making the disclosure to the employer the worker complied with any procedure whose use by him was authorised by the employer.'

194 It follows that, under the PIDA, disclosure must be made in the first place to the employer, or to a Minister of State or to a prescribed official. It may not be made to any other person, and still retain the quality of a 'protected disclosure', unless the conditions in Section 43G are met. They speak for themselves, but it needs to be emphasised that the provision that the disclosure should be made 'in good faith' means (as the requirement of good faith always does in a statute) 'in the absence of bad faith'. Thus where a worker has mixed motives for making a disclosure (personal pique, pursuance of a political objective, or mischief-making) the disclosure may not qualify. Mixed motives may be very easy to attribute to any potential whistleblower, and would prevent protection under this section.

195 Moreover, the belief must be 'reasonable'. That implies an objective standard in addition to the subjective belief as to the truth of the information. Applying this analysis of the recent developments in the law to the events in Bristol, it is not clear whether any disclosures would have been protected even under the newly enacted law.

Healthcare professionals in management

196 Doctor-managers remain subject to the GMC's jurisdiction, even while acting in a managerial or administrative capacity. The view of the GMC in this regard was upheld by the Privy Council in *Roylance v General Medical Council.*[258]

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257 Section 43G(3) ERA

258 1999 *'Lloyd's Law Reports'* 139–52, PC

197 Nurse-managers similarly remain bound by their professional code of conduct:

> 'They [managers] are absolutely bound by the code whilst they maintain their [UKCC] professional registration.'[259]

And, similarly:

> '… we [UKCC] see cases where we have managers who also hold nursing registration who are reported to us for failing to act on concerns that have been made known to them.'[260]

198 The Privy Council rejected the view of Dr Roylance, which is, perhaps, exemplified by the following exchange:

> 'Q. Did you, being a doctor, have any responsibility, as you saw it, for the best interests of the patient?
>
> 'A. I had a responsibility, but I had no ability to determine what was in the best interests of the patient.'[261]

Team-based standards

199 One trend in professional standards has been the move from standards based on individual responsibility to team-based standards. According to Sir Donald Irvine, as has been seen:

> 'The concept of collective responsibility in clinical teams did not sit easily with such individualism' which '… flowed from, and was reinforced by … the concept – in most doctors' minds – of accountability primarily to the patient and peers.'[262]

200 Sir Donald identified 'The move towards more clinical teamwork and the concept of collective as well as personal responsibility'[263] as a trend since 1984. By contrast, the recent[264] report *'The Regulation of Nurses, Midwives and Health Visitors'*[265] suggests that collective responsibility was the norm, but is being built upon:

> 'Nursing is going through a period of significant change and professional development. Changes in nursing roles and practice include … nurses becoming individually accountable for their practice'.[266]

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259 T33 p. 108 Ms Lavin
260 T33 p. 111–12 Ms Lavin
261 T89 p. 62–3 Dr Roylance
262 WIT 0051 0003 Sir Donald Irvine
263 WIT 0051 0002 Sir Donald Irvine
264 WIT 0052 0275 Ms Lavin; the exact date of the report is uncertain but it is after January 1998
265 WIT 0052 0183 Ms Lavin; conducted by J M Consulting Ltd for the UK Health Departments
266 WIT 0052 0220 Ms Lavin

201 However, Ms Lavin qualified that statement:

> 'Individual accountability has always been there. I think nurses are becoming more aware of what it means in practice … .'[267]

202 The GMC essentially regulates individual doctors (it maintains a register of individuals) not clinical teams (such as units). It nonetheless now promulgates standards for teams, but:

> '… [responsibility for] the implementation of this [guidance for collective responsibility] is not with us, it is with employers and this is where the overlap with institutions comes.'[268]

203 In addition, clinical teams are often multidisciplinary and responsibility is shared with managers (who might not belong to one of the healthcare professions):

> '… the regulating bodies, be it for nursing, for medicine, have their prescribed responsibilities for the fitness to practise of the individual practitioner. But managers have always had a duty of care, responsible managers have always seen themselves as having a duty of care for those who come to their hospital or their practice for a service.'[269]

Nursing – National Boards for Nursing, Midwifery and Health Visiting: statutory basis and functions

204 There are National Boards for Nursing, Midwifery and Health Visiting in each of the four countries of the United Kingdom.[270] Their constitution and functions are set out in the Nurses, Midwives and Health Visitors Act 1997, sections 5 and 6.[271] Mr Anthony Smith, the English National Board (ENB) Chief Executive, set out ENB's aims, structure and funding in his witness statement.[272]

205 In 1993 the ENB was streamlined to become a purely professional quality assurance organisation, without a role in administering the management of training courses.[273] The ENB has been concerned with matters such as the standards of training courses,[274] and the quality of student nurse clinical experience,[275] but not directly with standards of nursing care itself.

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267 T33 p. 135 Ms Lavin
268 T48 p. 134 Sir Donald Irvine
269 T48 p. 136 Sir Donald Irvine
270 English National Board for Nursing, Midwifery and Health Visiting (ENB), National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), Welsh National Board for Nursing, Midwifery and Health Visiting (WNB), National Board for Nursing, Midwifery and Health Visiting for Northern Ireland (NBNI)
271 WIT 0052 0025 – 0027 Ms Lavin
272 WIT 0063 0001 – 0006 Mr Smith
273 T9 p. 52–3, 136 Mrs Le Var and Mrs Marr
274 T9 p. 97–8 Mrs Le Var and Mrs Marr; WIT 0063 0010, 0738 Mr Smith. Such as the requirement in children's wards that student nurses be supervised by Registered Sick Children's Nurse at all times: 1988 ENB Circular 1988/53/RMHLV
275 Mr Smith devotes much of the main part of his witness statement to describing courses, both pre-registration (WIT 0063 0009 – 0016) and post-registration (WIT 0063 0009 – 0022). Mrs Le Var and Mrs Marr address ENB's scrutiny of course quality at T9 p. 89 and T9 p. 93–6

206 The main sanction available to National Boards was the de-recognition of wards or units for training purposes if they did not have sufficient appropriate staff to supervise nurses in training.[276] This is similar to the Royal Colleges' only sanction of de-recognition of medical training posts. The emphasis was on ensuring the quality of training rather than clinical quality itself.

207 The implicit assumption in the focus of the ENB on training is that training will lead to better care. So far as paediatric services are concerned, however, the theory that 'attaining levels of qualifications of children's nurses actually makes a difference to the outcomes in terms of care' is based on only anecdotal evidence.[277]

208 Although the National Boards set standards for training, they do not regard themselves as responsible for compliance with them. Professor Jarman asked Mrs Le Var:

> 'Q. … my general impression is that the ENB is in favour of units where children are nursed, the nurses having children-training. … who actually is responsible for getting what you consider to be a better situation? Whose ultimate responsibility is it? Is it the ENB or the Department of Health, the RCN, or is it nobody? I just want you to give me your general impressions.
>
> 'A. It is a Health Service responsibility, so the Board does not have the power to have that responsibility; the Board can influence and the Board can certainly have responsibility in relation to the areas which are approved for training, but that is where it stops. The general availability of children's nurses is determined by the NHS Executive …
>
> 'Q. So although it is your opinion that it should be a high proportion, it is not actually your responsibility; it is the Health Service, I think you said. You mean who, the NHS Executive or the Department of Health?
>
> 'A. The broad Department of Health, and then specifically within the Department of Health and the NHS Executive …'[278]

209 Although the UKCC, unlike the GMC, is a registered charity,[279] the National Boards are funded by the respective Departments of Health.[280]

210 The Royal Colleges' role in medical education has similarities to the role of the National Boards in nursing education. [281] It is, however, not precisely analogous,

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276 T9 p. 66 Mrs Le Var and Mrs Marr
277 T9 p. 126 Mrs Le Var and Mrs Marr
278 T9 p. 131–3 Mrs Le Var
279 T33 p. 138 Ms Lavin
280 WIT 0052 0007, T33 p. 138–9 Ms Lavin. '*The Regulation of Nurses, Midwives and Health Visitors*', para 2.42 (WIT 0052 0225). The proportion of ENB's funding derived from government grant has changed over the years. It has been 98% (1984 onwards), 83% (after the 1992/93 financial year); 70% (for the 1994/95 financial year); and 77% (since 1995) (WIT 0063 0003 – 0006). See Mrs Le Var's explanation of the figures at T9 p. 137
281 T33 p. 136–8 Ms Lavin

in that the Royal Colleges have a role to play particularly in the attainment of post-registration qualifications, whereas the National Boards focus upon the attainment of an 'entry' qualification.

Royal Colleges

211 There are Royal Colleges for each of the principal hospital-based clinical specialties. They are established by Royal Charter (e.g. the Royal College of Surgeons of England (RCSE) was established in 1800; and the Royal College of Physicians of London[282] (RCP) in 1518).

212 The objectives of each vary, but have a broad similarity in encouraging education and knowledge ('science') in their respective fields. Royal Colleges typically have charitable status. The Inquiry took evidence from the RCSE, the RCP, the RCA, the Royal College of Paediatrics and Child Health (RCPCH) and other Royal Colleges. The first table of comparisons (Table 5) below sets out comparisons between four Royal Colleges of hospital-based clinical specialties in respect of such matters as constitution, membership, fellowship, discipline and funding.

213 There are also Royal Colleges relating to non-hospital-based medical specialties, such as the Royal College of General Practitioners (RCGP). In the second table of comparisons (Table 6), the RCGP is contrasted with the British Paediatric Cardiac Association (BPCA), one of very many other, ad hoc, associations of healthcare specialists. The other specialist associations that have given evidence to the Inquiry include: the British Cardiac Society (BCS), the Paediatric Intensive Care Society (PICS), the Intensive Care Society (ICS), the Society of Cardiothoracic Surgeons of Great Britain and Ireland (SCS), the Association of Paediatric Anaesthetists of Great Britain and Ireland (APA) and the Society for Cardiological Science and Technology. The details of the RCGP in the second table of comparisons (Table 6) may also be compared with those of the four hospital-based specialties in the first table of comparisons.

214 There are also Royal Colleges for healthcare professionals other than doctors, such as the Royal College of Nursing of the United Kingdom (RCN) and the Royal College of Midwives (RCM). In practice, the RCN has functions like that of a trade union, in addition to having a Royal Charter. Miss Christine Hancock, General Secretary, RCN, told the Inquiry:

> 'The RCN is a professional union, responsible for addressing its members' employment and welfare needs, as well as the realisation of their professional goals. In addition, unlike most other accredited trades unions within the health service, it is governed by its Royal Charter to promote the science and art of nursing.'[283]

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282 There are other Royal Colleges of Physicians, including the Royal College of Physicians of Edinburgh and the Royal College of Physicians of Glasgow

283 WIT 0042 0004 Miss Hancock

215 The third table of comparisons (Table 7) sets out the similarities and differences between the RCN and the RCM.

Table 5: First table of comparisons

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Founded	1800	1518	1992	23 August 1996
Constitution	Royal Charter granted 1800	Royal Charter granted 1518, endorsed by statute 1523. RCP's role and responsibilities altered over time, notably due to the founding of the GMC and the Medical Acts of 1858, 1860, 1886 and 1960	Faculty of Anaesthetists established within RCSE 1948, became College of Anaesthetists in 1988. Royal Charter granted and become Independent Royal College 1992	RCPCH was formerly the British Paediatric Association (BPA) with no statutory authority or duties. Royal Charter granted 17 October 1996
Charitable status	Yes	Yes	Yes	Yes
Headquarters	London	London	London	London
Responsible to whom?	Independent	Responsible to the Privy Council	Independent	Independent
Responsible for	Surgical specialties	Medical specialties, general internal medicine	Anaesthesia	Full range of general and specialist paediatricians (but not paediatric cardiologists)
Aims	Art and science of surgery	To set the standards and to influence the quality of medical practice in hospitals[1]	Education, training, research and promotion of anaesthesia	Art and science of paediatrics, raising standards, education of practitioners and public
Number of members	Fellows and members: 6,000 (UK) and 2,000 (overseas)	9,000 fellows worldwide and 7,000 active collegiate members	10,728 fellows, 962 members and 1,965 trainees	Just over 5,000
Sources of funding	Courses (16%), investments (16%), membership subscriptions (15%), rents, charges and sales (11%), examinations (9%), grants (9%), legacies (8%), residential and conference (8%), donations (8%)	Membership subscriptions, examination fees, DoH grants in aid, investments, room hire	Fellows' subscriptions (45%), examination fees (21%), course fees (13%), DoH grants (6%), investment income (6%), other income (9%)[2]	Members' subscriptions, annual meeting, research unit, profits from archives, trading subsidiary, sales of publications, donations, surveillance unit, training grants[3]

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Basic membership	LRCS (primary qualifying diploma)	Membership is obtained through passing an examination (MRCP(UK)) and payment of a diploma fee	Membership (paying College subscriptions and participating in College activities) voluntary	Ordinary members have passed College membership examination – MRCPCH (parts 1 and 2). Junior members have commenced training but not passed exam. Administers Diploma in Child Health (DCH)
Higher membership	MRCS (postgraduate diploma – basic surgical training)	Associate membership; MRCP(UK) qualification[4]	Fellowship: FRCA (following traditional surgical model)	Associate members are paediatricians in non-consultant career grade posts and medical practitioners from other specialties with an interest in child health
Fellowship	FRCS (intercollegiate examination toward end of specialist training)	FRCP	See above	Fellows are selected by Council from members on Specialist Register
Is membership a requirement for employment?	No, but widely looked for	Membership and Fellowship are not compulsory for employment in relevant posts, though generally recognised	Membership has no legal relationship to the continued practice of the specialty	
Training post approval	Role in the Joint Committee on Higher Surgical Training and the Specialist Advisory Committees	Approves senior house officer (SHO) posts and rotations for training. Central to the Joint Committee on Higher Medical Training's approval and supervision of training posts and programmes	Programmes of inspection of hospital posts for approval of training of anaesthetists: 'a powerful tool … through the ultimate sanction of removal of training posts'.[5] Provides an Advisory Appointments Committee assessor on consultant and non-consultant career grade appointment committees	Higher Specialist Training: monitors trainees, publishes syllabus and recommends Certificates of Completion of Specialist Training. General Professional Training: inspecting and approving SHO posts. Advising committees appointing consultant paediatricians

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Standard-setting	Has published many documents, including *'The Surgeon's Duty of Care'*. No statutory powers	Ad hoc reports and guidelines are recommendations as to good practice. Some statutory powers: providing representatives on advisory appointment committees; also delegated powers with respect to specialist training from specialist training authority	Sets educational and training standards for entrants and good practice and conduct for continuing members	
Current President[6]	Sir Barry Jackson	Prof Sir George Alberti	Dr Peter Hutton (Professor Cedric Prys-Roberts was President from June 1994 for 3 years)	Prof David Hall
Discipline of members	'The College's disciplinary powers over members are limited. … It cannot … of itself, initiate disciplinary action against individuals in relation to their standards of professional practice'[7]	If member 'has been guilty of any great crime or public immorality, or has acted in any respect in a dishonourable or unprofessional manner.'[8] Participation in Joint Cardiology Committee 'intermediate procedure' review	Grounds for termination of membership include fraudulent application for membership, criminal conviction, GMC erasure, bankruptcy (not yet used). The Joint Liaison Committee responds to requests for help in dealing with the poor performance of anaesthetists and with system failures	'The College has the ability (rarely exercised) to expel a member for misconduct.'[9] Scope for expansion with CME and reaccreditation. 'The College sets professional standards: the GMC enforces them'[10]
Continuing Professional Development/ Continuing Medical Education (CME)	Involved in Senate of Surgery publications promoting CME	Co-ordinates and monitors for consultant and non-consultant career grade physicians	Likely in future to be a requirement of membership. Wants statutory role in CME linked to revalidation	

Table 5: First table of comparisons (continued)

	College			
	RCSE	**RCP**	**RCA**	**RCPCH**
Historic links to other colleges	RCSE keeps pre-1992 archives of RCA	Historic links with many other Colleges. Before formation of RCPCH, paediatricians were represented on own board within RCP. RCP retained responsibility for paediatric cardiology. Joint CME programme with the Royal Colleges of Physicians of Edinburgh and Glasgow	RCSE keeps pre-1992 archives of RCA. Mutual recognition of Fellowship of College of Anaesthetists and Royal College of Surgeons in Ireland	RCP retained responsibility for paediatric cardiology

1. WIT 0032 0001 Professor Sir George Alberti. The College has, since the period covered by the Inquiry, developed a new statement of purpose – see further WIT 0032 0002
2. WIT 0065 0117; RCA annual report 1997/98 Professor Strunin
3. WIT 0036 0151; annual report 1997/98 Professor Baum
4. WIT 0032 0003 – 0004 Professor Sir George Alberti
5. WIT 0065 0007 Professor Strunin
6. As at January 2001
7. WIT 0048 0003 Sir Barry Jackson
8. WIT 0032 0017 Professor Sir George Alberti; chapter 34, bye-law 168 'Of Penalties'
9. WIT 0036 0009 Professor Baum
10. WIT 0036 0010 Professor Baum

Table 6: Second table of comparisons

	College	
	RCGP	**BPCA**
Founded	1952	1991
Constitution	1952 (unincorporated association), 'Royal' prefix 1967, Royal Charter granted 1972	1991. Non-statutory body[1]
Charitable status	Yes	A non-profit-making organisation
Headquarters	London	No headquarters building
Responsible to whom?	Independent	Independent, but affiliated to the British Cardiac Society
Responsible for	General practitioners	Paediatric cardiologists and paediatric cardiac surgeons

Table 6: Second table of comparisons (continued)

	College	
	RCGP	**BPCA**
Aims	'To encourage, foster and maintain the highest possible standards in general medical practice'[2]	'To promote the study and care of infants and children with heart diseases … to promote and distribute study data pertaining to these problems and their prevention; to help those engaged in this work … to promote communication and co-operation between these workers.'[3]
Number of members	18,400	270
Sources of funding	Annual membership fees, examination fees, sale of publications, grants for specific research and particular projects and activities	Members' subscriptions
Basic membership	MRCGP	–
Higher membership	–	No higher membership
Fellowship	FRCGP	No fellowship
Is membership a requirement for employment?	'Membership of the College is voluntary.'[4] 'The College in 1994 stated that all new principals in general practice should normally possess the MRCGP.'[5]	No
Training post approval	'The College plays no direct role in the regulation of entry to the profession nor continued membership of it. The Competent Authority which regulates entry to general practice is the Joint Committee on Postgraduate Training for General Practice (JCPTGP)'[6]	'The Association plays a major role in training but the statutory control of this rests with the Specialist Advisory Committee (SAC) of Paediatric Cardiology of the Joint Committee on Higher Medical Training of the Medical Royal Colleges and of the SAC in Cardiothoracic Surgery of the Joint Committee on Higher Surgical Training of the Royal Colleges of Surgery.'[7]
Standard-setting	'In 1993 the Royal College of General Practitioners, in conjunction with the British Paediatric Association, produced guidelines on the paediatric component of vocational training for general practice'[8]	'It has attempted to advance professional standards and good inter-disciplinary practice.'[9]
Current President[10]	Dame Lesley Southgate	Dr Michael Godman
Discipline of members	'The College has limited regulatory control over its members in the sense of their right to practise. The College's disciplinary powers are generally confined to striking them from the list of members if they fail to renew their subscriptions or when they are struck off the Medical Register by the General Medical Council (GMC)'[11]	'The British Paediatric Cardiac Association at present is not a regulatory body…'[12]

Table 6: Second table of comparisons (continued)

	College	
	RCGP	**BPCA**
Continuing Professional Development/Continuing Medical Education (CME)	Introduction of Accreditation of Professional Development (APD) planned	The BPCA appoints a Council Member to regulate and assess programmes of Continuing Medical Education in Paediatric Cardiology. This responsibility has been devolved to the Association from the Royal Colleges[13]
Historic links to other colleges	None	Affiliated to the British Cardiac Society, and thereby to other similarly affiliated associations[14]

1. WIT 0047 0014
2. WIT 0059 0020 Royal Warrant
3. WIT 0047 0014 Dr Godman
4. WIT 0059 0003 Dr Reith
5. WIT 0059 0006 Dr Reith
6. WIT 0059 0003 Dr Reith
7. WIT 0047 0004 Dr Godman
8. WIT 0059 0005 Dr Reith
9. WIT 0047 0003 Dr Godman
10. As at January 2001
11. WIT 0059 0005 Dr Reith
12. WIT 0047 0004 Dr Godman
13. WIT 0047 0003 Dr Godman
14. WIT 0066 0002 Dr Howard Swanton

Table 7: Third table of comparisons

	College	
	RCN	**Royal College of Midwives[1]**
Founded	1916	1881: Midwives Institute founded under the patronage of Queen Victoria 1889: Incorporated under the Companies Acts 1942: Name changed to The College of Midwives 1947: Name changed to The Royal College of Midwives 1971: The Royal College of Midwives was included on the Special Register of trade unions established under the Industrial Relations Act 1971
Constitution	Royal Charter granted 1928	The last modifications to the Memorandum and Articles of Association were made on 20 April 1999
Charitable status	Yes	The College does not have charitable status. A sister college (The Royal College of Midwives Trust) is registered as a charity
Headquarters	London	London

Table 7: Third table of comparisons (continued)

	College	
	RCN	**Royal College of Midwives[1]**
Responsible to whom?	'The College is accountable to Her Majesty the Queen in Privy Council'[2]	Independent
Responsible for	Nurses	Midwives
Aims	'To promote the science and art of nursing and the better education and training of nurses and their efficiency in the profession of nursing'[3] and other aims	'To promote and advance the art and science of midwifery, to promote the effectiveness of and protect the interests of midwives'[4]
Number of members	318,000	Approximately 35,000
Sources of funding	Membership subscriptions, gifts[5]	Membership subscriptions: 95% Net income from courses: 2% Dividends and interest: 2% Other: 1%
Basic membership	Full membership is open to all nurses on any part of the UKCC Register. In addition there are Newly Qualified, Joint, Career Break and Associate memberships, depending on circumstances	Full membership and Overseas membership are available to practising midwives. Associate, Retired and Honorary memberships are available for those no longer practising, depending on eligibility
Higher membership	No higher categories of membership	No higher categories of membership
Fellowship	No higher categories of membership	No higher categories of membership
Is membership a requirement for employment?	No	Membership is not required or even recommended for practice as a midwife
Training post approval	No	The College does not inspect or approve midwifery training posts
Standard-setting	'The RCN is a leading player in the development of nursing practice and standards of care.'[6] 'The RCN offers its members a wide range of services including: development of nursing practice and standards of care'.[7] 'The Dynamic Quality Improvement Programme has focused on developing work, including … developing specialist guidelines and standards.'[8] 'An initial programme of work to develop national standards for particular specialty areas was undertaken during the late 1980s and early 1990s. This resulted in the production of standards for a whole range of specialist subjects'[9]	The College plays only an advisory role to its members and the five statutory bodies (the UKCC and the four National Boards)
Current President	Mrs Roswyn Hakesley-Brown (General Secretary: Christine Hancock)[10]	Dame Lorna Muirhead (General Secretary: Karlene Davis)[11]

Table 7: Third table of comparisons (continued)

	College	
	RCN	**Royal College of Midwives[1]**
Discipline of members	'The RCN can remove members from membership, although this power has never been used'[12]	The College regulates the conduct of its members only in relation to the Code of Conduct for Council members as directors of the company and trustees of a charity
Continuing Professional Development/Continuing Medical Education	'The RCN offers its members a wide range of services including: education and professional development activities'[13]	The RCM currently runs courses, study days, workshops and conferences
Historic links to other colleges	'The RCN has a good track record in working with other organisations in order to improve health care.'[14]	Links with other Royal Colleges are informal and depend upon mutual co-operation

1. Information in WIT 0576 0001; letter from Louise Silverton, Deputy General Secretary, Royal College of Midwives to Inquiry, dated 6 October 2000
2. WIT 0042 0003 Miss Hancock
3. WIT 0042 0004 Miss Hancock
4. WIT 0576 0016; Memorandum of Association of The Royal College of Midwives
5. WIT 0042 0004 Miss Hancock
6. WIT 0042 0003 Miss Hancock
7. WIT 0042 0003 Miss Hancock
8. WIT 0042 0005 Miss Hancock
9. WIT 0042 0005 Miss Hancock
10. As at January 2001
11. As at January 2001
12. WIT 0042 0003 Miss Hancock
13. WIT 0042 0003 Miss Hancock
14. WIT 0042 0025 Miss Hancock

216 As 'independent' bodies, the Royal Colleges are not accountable to anyone other than their own members for achieving their respective objectives, save to the extent that some are responsible to the Privy Council (see Tables above). Much evidence was received as to the role of the Royal Colleges in the maintenance of standards, both in relation to clinical practice and to professional education.

Educational and training standards

217 The GMC has the statutory function of promoting high standards of medical education, but traditionally, the Royal Colleges and specialist associations have set standards for higher and specialist training:

> 'Responsibility for the form and specific content of training programmes, and for overseeing the assessment of trainees, rests with the appropriate training body – usually a Royal College, Faculty or joint higher training committee.' [284]

218 Over the period 1984–1995, the Colleges (including the RCSE) awarded Certificates of Accreditation to those who satisfactorily completed specialist training, as a mark of a fully trained surgeon ready for a consultant appointment and independent practice.

284 WIT 0062 0012 Mr Scott

This certificate was not a mandatory requirement for appointment.[285] However, such accreditation gradually became more generally recognised and was more likely to be required by consultant appointment committees.[286]

> 'The College [RCSE] … ensures that the required standards of training are provided by regular inspection and approval of training posts and recognition of individual consultant surgeons as trainers. It can act, and has done so, to de-recognise a training programme or trainer where it considers the required standards of provision or supervision not being met. These arrangements have been in place for many years, applied during the period 1984–95, and continue to operate.'[287]

219 A Regional Medical Postgraduate Dean is appointed by a university; there is, for example, one appointed by the University of Bristol. Postgraduate Deans were mentioned infrequently in evidence to the Inquiry about standards and quality of care, despite the extensive machinery for postgraduate training in every region. Sir Barry Jackson told the Inquiry about the role of the Postgraduate Dean in dealing with recognition of trainers and training posts in relation to surgery:

> 'The Postgraduate Dean is responsible for ensuring that the educational function of a higher surgical training post is actually carried out, the educational side.'[288]

220 Professor David Baum, the then President of the RCPCH, told the Inquiry that part of the career progress of a paediatrician is:

> '… higher training … in which there is … an annual appraisal with the Regional Adviser of the College and the Postgraduate Dean'.[289]

221 Whilst a College could point out an institution's deficiencies, de-recognition as a training institution was the only sanction it could apply to it:

> '… no Royal College or comparable professional body had statutory powers to impose professional and quality standards on hospitals or individual consultants.'[290]

> 'If at the end of that inspection and the interviews that take place, the committee is dissatisfied with any aspect of the training, what would normally happen – and I stress "normally" – would be that they would make it clear in a written statement to the Trust concerned that there were deficiencies and that they would not approve that post for training for the next quinquennium, but they would wish to reinspect,

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285 WIT 0048 0003 Sir Barry Jackson. Sir Barry Jackson's statement continues, however, 'With the introduction of the European Specialist Medical Qualifications Order (1995), it became mandatory from 1 January 1997 for an individual seeking appointment as a consultant to be entered on the new Specialist Register of the General Medical Council'

286 T28 p. 3–5 Sir Barry Jackson

287 WIT 0048 0004 Sir Barry Jackson

288 T28 p. 24 Sir Barry Jackson

289 T18 p. 55 Professor Baum

290 WIT 0047 0027 – 0028 Royal College of Surgeons

reassess the situation within a given period of time, usually 6 months, sometimes a year, after the perceived deficiencies have been corrected and they would then go back and see the post again to check that the deficiencies that they have noted have been rectified. In almost every case – not all, but in almost every case – those deficiencies are rapidly corrected by the hospital concerned, by the trainers concerned, because they do not wish to lose training status. Occasionally, it turns out that those corrections have not been put into place, in which case, in the case of the SAC, they would recommend to the JCST, the Joint Committee, that training, the recognition be removed and in the case of the Hospital Recognition Committee, they would recommend to their parent committee in the College, the Training Board, that recognition should be removed. Very rarely, a committee may come across such a situation which would merit instant de-recognition.'[291]

Educational and training standards – with particular reference to surgery

222 Higher surgical training is controlled and administered by the Joint Committee on Higher Surgical Training (JCHST). It is 'joint' in the sense that it represents not only the four surgical Royal Colleges in the United Kingdom and Ireland, but also the relevant specialist associations and the university professors of surgery.

223 So far as basic medical and surgical training is concerned,[292] the Hospital Recognition Committees (HRCs) discharge the functions of the Royal Colleges.

224 The JCHST's '*A Manual of Higher Surgical Training in the United Kingdom and Ireland*' sets out the scheme of higher surgical training:

> 'The Scheme of Higher Surgical Training is controlled and administered by the JCHST representing the four surgical Royal Colleges in Great Britain and Ireland, the relevant Specialist Associations and the University Professors of Surgery. The JCHST is the advisory body to the surgical Royal Colleges with regard to Higher Surgical Training and award of the Certificate of Completion of Specialist Training, supported for the day to day management of the scheme by the Specialist Advisory Committees (SACs). The JCHST and the SACs are administered by a secretariat at the Royal College of Surgeons of England.'[293]

225 Sir Barry Jackson described the respective roles of the JCHST, SAC and HRC:

> 'A. The Hospital Recognition Committee is run solely by the Royal College of Surgeons, but part of its complement would include invited members representing a range of specialties. It is responsible for monitoring similar to the Joint Committee on higher surgical training, the training and the posts for what is known now as basic surgical training. That is the training that all trainees receive in the generality of surgery, sometimes called "common trunk training", before embarking on a

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291 T28 p. 10–11 Sir Barry Jackson

292 'The Hospital Recognition Committee was strictly under the aegis of the Royal College of Surgeons in England looking at training in England and Wales alone.' Sir Barry Jackson T17 p. 57, but other Royal Colleges (including the Royal College of General Practitioners) have an HRC

293 JCHST, '*A Manual of Higher Surgical Training in the United Kingdom and Ireland*', p. 1 (May 1996); WIT 0048 0038 Mr Jackson

specialist training in one of the nine recognised surgical specialties such as orthopaedic surgery, cardiothoracic surgery and such like. It has a very similar role at basic surgical training level as the JCHST you have referred to has at higher surgical training level, and it is responsible also for ensuring that the training the basic surgical trainee obtains is suitable and appropriate for them to be eligible to sit an examination in the generality of surgery, which used to be called the FRCS [Fellowship of the Royal College of Surgeons] and is now called the MRCS [Membership of the Royal College of Surgeons].

'Q. So if one were looking at the accreditation of teaching posts and teaching positions within Bristol, one would be looking firstly at the role of the Hospital Recognition Committee for basic surgical training, and then at the specialist level, looking within the field of cardiothoracic surgery, it would be the specialist advisory committee with particular responsibility for that field which would be responsible for the appropriate accreditation?

'A. That is absolutely correct, yes.'[294]

226 The main means by which the Royal Colleges regulate medical education is through the SAC's inspection of training posts. Sir Barry Jackson described the system in relation to cardiothoracic surgery thus:

'Cardiothoracic surgery is a relatively small specialty and therefore the SAC itself acts as the training committee and interviews all higher surgical trainees at least once during the course of their training. The SAC also arranges regular inspections, normally every 5 years, or more frequently where necessary, of programmes and posts where training is carried out. At all such inspections trainees have confidential interviews with the visitors at which time they can comment on the quality of the training post and their trainers. All trainees are subject to annual assessment by their trainers and all trainees are required to complete training post assessment forms so that the relevant training committee and the SAC gets feedback from the trainees.'[295]

227 The reporting process further explains the relationship between the bodies:

'… the report of each SAC inspection would be reported to the parent Specialist Advisory Committee in full session, which in turn would report to the Joint Committee on higher surgical training … .'[296]

294 T28 p. 7–8 Sir Barry Jackson
295 WIT 0048 0012 Sir Barry Jackson
296 T28 p. 15 Sir Barry Jackson

228 A limitation on Royal Colleges' inspections (SAC and HRC) is simply that they were not designed to monitor the clinical quality as such of the training clinician or institution:

> 'Q. Would you say that the inspections are mainly designed to make sure that trainees have adequate clinical experience and supervision, or would you say they were designed to examine the quality of the care in the hospital?
>
> 'A. The former.'[297]

229 To a question about the regard paid by SAC visitors to the quality of surgery performed by a consultant involved in training, Sir Terence English, past President of the RCSE, said:

> 'A. It was not a requirement as such. It was perhaps something — well, it certainly did not receive as much attention as the quality of the training which the individual was receiving.
>
> 'Q. Quality of training was the whole purpose of the visit?
>
> 'A. Correct.
>
> 'Q. So inevitably, quality of outcome would not, could not, receive as much consideration as that, but I think what you are telling me – I want to be sure I am right about it – is that whether formally or informally, it was the expectation of all concerned that those visiting the unit would ask about quality of outcome, or quality of surgery?
>
> 'A. I think the reality of it was that generally, throughout surgery, it was not regarded – it was not common to enquire specifically about mortality at SAC visits. I am not sure about that, but as a generalisation, I think that is true.'[298]

230 The quality and effectiveness of visits at Bristol in respect of cardiothoracic surgery were evidenced by what was said about two visits within a week of each other, the first on behalf of the SAC by Mr David Hamilton and Mr Julian Dussek (8 July 1994) and the second on behalf of the HRC (therefore dealing with more junior doctors in training) by Miss Leela Kapila and Mr P May (13 July 1994). The detailed evidence is set out later, to the effect that obvious features of the layout and facilities were mis-stated in the former report, which also bore such similarity to the report five years earlier, to bear the inference that the text had merely been copied, without there being any fresh consideration of its contents. Such was the difference between the factual circumstances recorded in the two reports, that the co-ordinating of information between them was called into question.

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297 T28 p. 140 Sir Barry Jackson
298 T17 p. 27 Sir Terence English

231 Sir Terence told the Inquiry about the difficulty of co-ordinating training visits:

> 'Q. And so far as giving a complete picture of the service, not only the more important, as you describe it, senior trainees, but also the less important junior trainees, who in the Royal College would, as it were, look at or be likely to look at the 2 reports, put them side by side and say, "Well, we have a problem here which has to be sorted", or something to that effect?
>
> 'A. That, to my knowledge, did not happen. The SAC, as I explained earlier, was very much an intercollegiate committee. The Hospital Recognition Committee was strictly under the aegis of the Royal College of Surgeons in England looking at training in England and Wales alone. And the whole question of which units should be recognised for training, which should be warned if they were falling down in their training, was dealt with very separately. That may be an error, but that is the way it was. I think it would have been difficult to try and co-ordinate the two. Having said that, if there was a problem in a particular unit that was brought to the attention of the College, then I would hope that both reports would be looked at critically.
>
> 'Q. What I think you are telling me – please confirm if it is the case – is that any cross-referencing between the reports would occur by accident rather than design, except if there were a particular query about a particular unit?
>
> 'A. In essence, I think that is correct.'[299]

232 The lack of co-ordination in visits from Royal Colleges was recognised by Professor Strunin as a drawback of the system:

> 'This is one of the criticisms of the College visits, of course: there is no co-ordination. I have to say now, if we encounter serious anaesthetic problems, our visitors are instructed to ask the Medical Director whether they have had a visit from any other College recently, because often there are problems in other specialties. The Medical Director does not always wish to tell us that, of course, which is a problem. There is no co-ordination at the moment. That is about to change as well, because it is obvious that visit after visit is unsatisfactory, and there are moves to see whether these can be brought together… .'[300]

Educational training standards – proposals for change

233 Sir Barry Jackson emphasised that 'the [Royal] Colleges and the specialist associations are reconsidering all aspects of inspection, [and] training processes'.[301]

234 Amongst ideas being considered is that there should greater co-ordination between HRC and SAC visits and between visits of different SACs, or that visits should be

299 T17 p. 57–8 Sir Terence English
300 T14 p. 132–3 Professor Strunin
301 T28 p. 60 Sir Barry Jackson

broader in what they look for and to whom they speak. Professor Strunin was questioned on this:

> 'Q. … do you think some formal method of co-ordination could be helpful and practical?
>
> 'A. I think it would be helpful. The practicalities of it are not quite as straightforward as might be. There is also of course the role of post-graduate dean, and some of the things we look at in visits we are going to devolve to the post-graduate deans. Our college, and I suspect others will do the same, would wish to reserve the right to visit anyway, because of course the post-graduate deans may also find themselves compromised on occasional issues and we would wish to come as an outside body and look at that specifically.'[302]

The Colleges' role and responsibility for setting and monitoring standards of care

235 There were differing views as to which organisation it was that laid down standards relating to the outcome of care in the period of the Inquiry's Terms of Reference. Professor Sir Kenneth Calman said that it was the medical profession as a whole, rather than the DoH or any particular Royal College:

> 'Q. In terms of laying down standards [relating to the outcome of care], who would do it? The Royal Colleges? The Department of Health? Would it depend on the area?
>
> 'A. It would generally be the profession, and I say that rather than the Royal Colleges, because there may be a number of areas which do not neatly fall into a particular Royal College.'[303]

236 In the specific context of supra regional services Dr Norman Halliday, the Medical Secretary of the SRSAG, by contrast, took the view that he was reliant upon the Royal Colleges for such matters, to the exclusion of a role for the SRSAG.

237 Professor Gareth Crompton (former CMO, Wales), speaking of cardiac services, said that:

> 'Welsh policy was heavily reliant on the best available authoritative advice, notably from … Joint Cardiac Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England.' [304]

302 T14 p. 132–3 Professor Strunin
303 T66 p. 17 Professor Sir Kenneth Calman
304 WIT 0070 0001 Professor Crompton

238 Dr Roylance relied heavily on the Royal Colleges to maintain clinical standards:

> 'A. … The whole purpose of a Royal College of Radiologists is to oversee standards in radiology, and they do that in a whole variety of ways. If they are not maintaining standards in radiology, I do not know what they are doing.
>
> 'Q. So you depended a lot on them?
>
> 'A. The expertise in whether the clinical work was up to standard lay within the profession and the profession was concentrated and represented and overseen by the Royal College.'[305]

239 Dr Roylance stated:

> 'I also considered that the Royal Colleges had an overall responsibility for the maintenance of standards and that if concerns about such issues were made known to them and a solution could not be found through their own good offices, they would notify me that appropriate management action was required.'[306]

240 Dr Roylance thus indicated a belief that maintenance of clinical standards was primarily the Royal Colleges' responsibility rather than that of local management. For their part, the Royal Colleges regarded problems with local services as the responsibility of local management:

> 'Q. What would you conceptually regard as being the role of management in such a situation as I started off by positing, when there are some concerns being expressed about the performance or outcomes of a particular service within a hospital?
>
> 'A. Conceptually, I think if management was aware of that it would be up to management to discuss that with the clinicians concerned to try and resolve the matter, quite clearly.'[307]

241 Management faced difficulty in knowing what precisely to expect of doctors clinically, as the evidence of Sir Donald Irvine suggests:

> 'Q. So was it one of the problems in bringing the bad doctor to book that the non-medical management did not necessarily know what to expect of a good doctor?
>
> 'A. Yes.'[308]

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305 T26 p. 4–5 Dr Roylance
306 WIT 0108 0020 Dr Roylance
307 T28 p. 129–30 Sir Barry Jackson
308 T48 p. 83 Sir Donald Irvine

242 Sir Barry Jackson told the Inquiry that part of RCSE's role in more recent years had been the preparation and dissemination of clinical guidelines for the surgical management of certain conditions.[309] However:

> '… in the production of clinical guidelines, the College has no statutory power to ensure that these are followed by individual surgeons but these are again published on the assumption that they will be adopted by surgeons. The College's powers in this area and in other areas of professional regulation of consultant and other career-grade surgeons may be extended with the introduction of re-validation as a basis of continuing registration to practice, but this concept is still at an early stage of development.'[310]

243 This was echoed in respect of the RCP by its President, Professor Sir George Alberti:

> '… I would also hope that we can ensure that all consultants in the country, in all specialties, continued to maintain and improve their standards, their practice and their knowledge, throughout their working career, which, in most professions, was a tacit assumption but without any obligation in the past.'[311]

244 Sir George agreed that the RCP had in the past been reactive rather than proactive:

> 'A. I think now we would be much more interventionist on the grounds of safety, particularly, and quality.
>
> 'Q. What you are telling me is that in those particular years, at any rate, the Royal College of Physicians would hesitate to interfere or influence the exercise of clinical freedom upon the grounds that it perceived generally that the public interest lay in an opposite direction?
>
> 'A. I think that, first of all, if we were not informed that there were problems, we would not have any ability to interfere, other than informally.
>
> 'Q. So it would be reactive rather than proactive?
>
> 'A. Correct.'[312]

245 Sir Barry Jackson told the Inquiry that:

> 'The College's [RCSE's] disciplinary power over members are limited. …
> It cannot … , of itself, initiate disciplinary action against individuals in relation to their standards of professional practice. The College will not remove the status of fellow or member from individual members unless they have been found guilty of

309 WIT 0048 0004 – 0005 Sir Barry Jackson
310 WIT 0048 0005 Sir Barry Jackson
311 T9 p. 3 Professor Sir George Alberti
312 T9 p. 41–2 Professor Sir George Alberti

serious professional misconduct by the GMC, have been convicted of a significant criminal offence or fail to pay their subscriptions to the College.'[313]

246 Professor Strunin discussed the relative roles of the GMC, Royal Colleges and trusts:

'Q. The question I was asking was the balance of responsibility or involvement between, firstly, the General Medical Council; secondly, the Hospital Trust; and, thirdly, the Royal College of Anaesthetists or other Colleges in, as it were, regulating, to use that word in its loosest sense, the competence and performance of individual practitioners?

'A. I understand the question. The reality is this. If you take the General Medical Council first, they have the ultimate sanction in that they control the register, but they have no power to go and visit anywhere, they have to wait for a complaint, and under the law that operates it has to be a serious complaint. Up to 1st July 1997 they could only look at specific cases. They can now look at patterns of performance, but, nevertheless, they are, I think, at the end of the line, because it would take a while before something comes to them. The College, again, for an individual practitioner, would have to wait for a report, although we could pick up problems in a department when we do a training visit. But, as I indicated, that is for training specifically, it is presumably training, and not to look at the clinical service per se. The Trust is the right place. That is where the work is carried out; that is where it should be done, and they have mechanisms to deal with that. They can prevent a practitioner from practising, they can suspend a practitioner, they can report him to the General Medical Council if they wish, they can go down the procedures laid down by the Department of Health for suspension, and so forth. And I would say, as the prime group who look at quality clinical practice day by day, that has to be locally within the hospital, and as far as an anaesthetic department is concerned, that is a prime responsibility of the Clinical Director.

'Q. So you are saying that the Trust represents what you might call the "front line" of quality, or scrutiny of the quality, of clinical practice?

'A. I think they have to, because there is no means of anybody externally knowing about that until there is a serious problem. We are based in London. It is unlikely we will know what is going on anywhere else in the land until somebody tells us about it, whereas that is an absolute responsibility. Now, with the clinical governance, of course, it starts with the Chief Executive, but it has always been, in my view, an absolute responsibility of the Clinical Director of the service to make sure it is properly delivered and, if there are problems, to address them.

'Q. You describe the GMC as representing what you might call the "end of the line" in terms of acting upon complaints. It is right, I think, that your statutes require you to follow the judgment of the GMC in striking off any practitioner, or removing

313 WIT 0048 0003 Sir Barry Jackson

from membership any practitioner, who has failed to meet proper professional standards. If we look at page 7 of your statement[314] where, at paragraph 5.1 you summarise the position, it follows that you do not have power, as I understand it, under your ordinances, to discipline for clinical incompetence without the prior decision of the GMC; is that right?

'A. That is correct.

'Q. The corollary of that seems to be that in fact you have never actually had to exert that power; is that right?

'A. That is also correct.'[315]

247 The only formal sanction over consultants who do not follow clinical guidelines is to remove the trainer status of those who are college trainers. Sir Barry Jackson told the Inquiry:

'… we had no statutory way in which we could maintain standards at consultant level at that time, or even now we have no statutory method of doing it, other than by removing trainer status.'[316]

Sir Barry Jackson's evidence included this exchange:

'A. … any College guideline that comes out, such as the one you have on the screen at the present moment,[317] is a recommendation by the College to its fellows and others, but it is not mandatory upon our fellows and others to follow those guidelines or those recommendations.

'Q. No, we understand from your evidence that the College may set standards, but it has very limited powers, indeed, in terms of enforcement?

'A. Sadly, that is true.'[318]

314 WIT 0065 0007 Professor Strunin
315 T14 p. 13–15 Professor Strunin
316 T28 p. 141 Sir Barry Jackson
317 RCSE 0001 0009; *'How Doctors Explain Risks To Patients'*
318 T28 p. 120–1 Sir Barry Jackson

248 The Royal Colleges had no power to enforce compliance with its standards for those already in post other than the indirect one of the threat of de-recognition of training posts.[319] This does not, of course, affect surgeons who have finished training, namely consultants: 'The Royal College of Surgeons of England has no formal or statutory role in identifying or enforcing retraining obligations for consultant surgeons.'[320]
The greatest sanction that a Royal College can apply to an individual consultant is limited and indirect: if the consultant is a trainer or examiner for a College, the College can withdraw that recognition.[321]

249 If the Royal Colleges' powers over its members are limited, their ability to persuade their members to adopt new practices is also limited. Dr Kieran Walsh, Senior Research Fellow, University of Birmingham, indicated (at least in relation to the introduction of audit) that professionals at the grass roots were less than enthusiastic about following the lead of Royal Colleges:

> 'I would distinguish though, between the reaction of the professional bodies, the Royal Colleges and others and the great and the good, and the profession on the ground. I think your paper cites a study that suggested that on the ground the profession was perhaps less enamoured, less convinced, than professional bodies and organisations. That is reflected in some of the papers recruited from individual clinicians, saying "Whilst we sign up to the aims of this, we are not sure it is really going to work and deliver improvement" or whatever.'[322]

250 It is not possible for the DoH or professional bodies to implement a policy without consensus agreement, as Professor Sir Kenneth Calman agreed:

> 'Q. You need a very firm consensus view to carry a whole profession with a particular policy?
>
> 'A. Yes.'[323]

251 Sir Donald Irvine stated that an outstanding problem was that: 'The Royal Colleges had no power to impose on individual members the professional standards they developed and were refining: they could only require an entrance examination.'[324]

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319 Although Sir Donald Irvine and Professor Liam Donaldson state: 'In Britain, the accreditation of training schemes for doctors in hospital, general practice or public health medicine has led to the setting of standards and their enforcement by the Royal Colleges.' Irvine D, Donaldson L. 'Quality and Standards in Health Care'. *'Proceedings of the Royal Society of Edinburgh'* (1993); 101 B: 1–30 at p. 22; WIT 0051 0051 Sir Donald Irvine

320 WIT 0048 0012 – 0013 Sir Barry Jackson

321 WIT 0048 0013 Sir Barry Jackson: 'Since 1996 the Colleges have been implementing a structured system of continuing medical education in which all practising surgeons were expected to participate as a professional obligation. The Senate has more recently expressed the view that it is mandatory for all practising surgeons to participate but the only sanction the Colleges currently have against individuals who fail to participate would be to withdraw recognition as a trainer or examiner for the College. It should be recognised that not all surgeons are necessarily trainers or examiners'

322 T62 p. 18 Dr Walsh

323 T66 p. 35 Professor Sir Kenneth Calman

324 WIT 0051 0006 Sir Donald Irvine

252 Dr Halliday's view appears to be that the Royal Colleges assist upholding standards, but are not responsible for the upholding of those standards:

> '… we are very fortunate in the way that our Royal Colleges assist us, because they are not formally part of the National Health Service. They have no responsibility for the provision of services. Their role is educational and the training of doctors. Yet despite that, they are only too happy to contribute their time, and sometimes money, to look at the things we want them to address. So I think we are very lucky in that sense.'[325]

253 Dr Halliday's description suggested that the Royal Colleges worked by exerting peer pressure on a colleague who was not adhering to the promulgated standard.

254 Sir Alan Langlands confirmed that the Royal Colleges had provided assistance to SRSAG:

> 'Both groups [SRSAG and NSCAG] have regularly sought advice from the Medical Royal Colleges and other professional bodies on such matters as the services to be designated and the best units to provide these services.' [326]

Relationship between the Royal Colleges and the GMC

255 Sir Donald stated that an outstanding problem was that:

> 'Co-ordination between the various professional bodies with regulating functions was limited and accountability often unclear.'[327]

256 A principal change of philosophy in the GMC's policies during the period 1984–1995, he said, was that of 'regarding poor or unsafe clinical performance as within the GMC's scope rather than as the sole responsibility of others'.[328] This did not, however, imply that the GMC would review Royal Colleges' training reports. The reason for declining to do so is given in the following exchange:

> 'Q. Did the GMC have any function in reviewing the reports by Royal Colleges for the purposes of their accreditation of their specialist training?
>
> 'A. No, it is not empowered to do so under the Act.'[329]

257 It should be noted that a College such as the Royal College of Paediatrics and Child Health (RCPCH) now takes a firm line on the enforcement of standards. Professor Baum, Former President, RCPCH, said it would 'hold our College Fellows responsible, if knowingly they were not alerting us to a failing in standards'. [330]

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325 T13 p. 121 Dr Halliday
326 WIT 0335 0020 Sir Alan Langlands
327 WIT 0051 0006 Sir Alan Langlands
328 WIT 0051 0007 Sir Donald Irvine
329 T48 p. 110 Sir Donald Irvine
330 T18 p. 64 Professor Baum

However, reference may be made to the tables of comparisons for the limited extent to which any disciplinary power has been exercised by the College (or, indeed, any of the Colleges).

258 The primary approach is thus working with a colleague to remedy a problem . If this is not possible, RCPCH's sanction is to report the clinician to the GMC:

> '… if it was outwith that kind of corrective programme, then we would openly say "This is a matter we must refer to the General Medical Council".'[331]

Proposed reforms of the Colleges

259 The Royal Colleges would wish to have similar powers to maintain the standards of performance of consultant as they currently have for doctors in training:

> '… I would wish very much indeed that the Medical Royal Colleges could be given statutory powers to maintain standards at consultant level, just as they now have statutory powers of maintaining standards for trainees in ensuring that any consultant appointed is appropriately qualified and trained and competent to carry out the responsibility of a consultant. That statutory responsibility has only been given to them in the last two years through the medium of the specialist training authority and the College's participation in the specialist training authority. I would like to see that extended to consultant level, and I think that that would strengthen medicine throughout this country enormously. And I hope very much it happens.'[332]

260 Similarly, Professor Sir George Alberti told the Inquiry:

> '… it is evident that continuing lifelong education is essential for all consultants, and that this should be assessed at regular intervals'.[333]

Specialist associations

261 Specialist associations are groups of healthcare professionals. They have no power over their members. They set standards but cannot enforce any of them.

262 Sir Barry Jackson told the Inquiry about the origin of specialist associations and their relationship to the Royal Colleges:

> 'Q. Can I just ask you a little bit more about the specialist associations and their relationship with the Royal College of Surgeons? Generally, can I ask, how would specialist associations come into being in the first instance? Would that be anything

331 T18 p. 65 Professor Baum
332 T28 p. 141–2 Sir Barry Jackson
333 T9 p. 47 Professor Sir George Alberti

to do with the initiative of the Royal College, or would that be purely a professionally led evolution?

'A. The latter; it would be professionally led. The College would have no part in the gestation of a specialist association.

'Q. We have seen, for instance, that some have a very long history; that from a statement provided to the Inquiry by the President of the Society of Cardiothoracic Surgeons, that Society, for instance, was established in 1933, would that be typical, too, of some other specialist associations?

'A. The specialty association representing general surgery antedates that quite considerably. That was founded in 1917, I believe.

'Q. So there is no formal relationship between the Royal College of Surgeons and specialist associations?

'A. No formal relationship, although informally there are very close links indeed, to the extent that on the Council of the College of Surgeons, we have invited representatives from each of the nine specialist associations representing the nine SAC specialties and within the college buildings, we have the offices of each of the specialist associations.

'Q. Do you have any formal supervisory or monitoring role within the work of the specialist associations?

'A. No.'[334]

263 Dr Michael Godman, President of the BPCA, a specialist association, told the Inquiry:

'The British Paediatric Association at present is not a regulatory body but … it attempts to publicise its work as widely as possible … The Association plays a major role in training but the statutory control of this rests with the Specialty Advisory Committee of Paediatric Cardiology of the Joint Committee on Higher Medical Training of the Medical Royal Colleges and of the SAC in Cardiothoracic Surgery of the Joint Committee on Higher Surgical Training of the Royal Colleges of Surgery.'[335]

334 T28 p. 11–13 Sir Barry Jackson
335 WIT 0047 0004 Dr Godman

Trade unions of healthcare professionals

264 The principal trade unions are the BMA, for doctors, and the RCN and Unison, for nurses. Unison covers other healthcare workers and other public sector workers: its nursing membership in teaching hospitals such as the BRI tends to be low. There are also a number of other professional associations that are entitled to qualify as trade unions under the ERA 1996.

British Medical Association (BMA)

265 The BMA sees itself as more than a trade union: 'The BMA is a professional body and a trade union …'.[336] Membership is voluntary and some 80% of practising doctors are members:[337]

> 'The principal objective for which the BMA was established in 1832 was "to promote the medical and allied sciences and to maintain the honour and interest of the medical profession". This remains its principal aim and abiding concern.'[338]

BMA – role

266 The professional aspect of the BMA is exemplified by the BMA's Medical Ethics Committee (MEC) which '… publishes ethical guidance on a very wide range of subjects and its secretariat advises individual doctors'.[339] It does not, however, set educational or training standards as such.[340]

267 The trade union aspect was referred to by Dr Ernest Armstrong, Secretary of the BMA. It has 'heavy involvement in negotiations and consultation concerning virtually all aspects of doctors' professional working lives, including in particular their contractual arrangements'.[341]

BMA – responsibilities

268 The BMA has no authority to require anyone to do anything:

> 'The BMA plays no role in regulating entry to or regulation of membership of the medical profession. It has a limited [virtually non-existent] disciplinary power over its members …'[342]

336 WIT 0037 0005 Dr Armstrong
337 WIT 0037 0004 Dr Armstrong
338 WIT 0037 0004 Dr Armstrong
339 WIT 0037 0005 Dr Armstrong
340 WIT 0037 0005 Dr Armstrong
341 WIT 0037 0005 Dr Armstrong
342 WIT 0037 0004 Dr Armstrong

269 Nonetheless, it voluntarily accepts a responsibility for patients' safety, and rejects the notion that it is an entirely self-serving body of doctors:

> '… notwithstanding our duty to stand by a member in terms of the rights and privileges that he has under his membership … we must be aware that if, in the course of our work, we find or unearth a problem which gives rise to a serious concern about patient safety, then we do not have the option of doing nothing; … doctors, including myself, have to have regard to our own duty to protect patients at all times.'[343]

270 Dr Armstrong expressed the views of the BMA on many issues in healthcare, such as doctors' pay and conditions, the NHS reforms of 1991, the NHS internal market, employment contracts for hospital consultants, revalidation, and disparagement/whistleblowing.

271 There are also medical defence organisations such as the Medical Defence Union (MDU) and the Medical Protection Society (MPS) that represent members, in particular where they may be exposed to liability or discipline in respect of their practice, but they have no powers to regulate their members.

Employment contracts

272 There is a distinction to be drawn between an employee (employed under a contract of service) and an independent contractor (employed under a contract for services).[344]

273 Employment has, as a distinguishing feature, control over the employee by the employer.[345] Although this should not be overstated – e.g. an airline pilot is employed, but his employer may not know how to fly – it gives rise to a power to direct where, when, in what circumstances, and, in particular, what an employee should do, subject only to any contractual agreement between employer and employee to the contrary.

Medical contracts – terms

274 The National Health Service Act 1946 set up the NHS. It provided that:[346]

> 'All officers employed for the purposes of any hospital providing hospital and specialist services, other than a teaching hospital, shall be officers of the Regional Hospital Board for the area in which the hospital is situated … and the remuneration and conditions of service of all such officers shall, subject to regulations, be determined by the Regional Hospital Board …'

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343 T20 p. 39–40 Dr Armstrong

344 For example, the chauffeur, employed by a company, is an employee, employed under a contract of service; the taxi driver, hailed for a one-off journey, is an independent contractor

345 See Cooke, J, in *Market Investigations Limited v Minister of Social Security* [1969] 2 Q. B. 173 p. 184–5

346 Section 14(1) National Health Service Act 1946

275 The effect of this provision was considered by the courts in the case of *Barber v Manchester Regional Hospital Board* [1958] 1 WLR.

276 The judgment treated the plaintiff as an employee, subject to the terms and conditions which had been promulgated by the Minister of Health. In doing so, the court had held that someone in the position of Mr Barber, though a consultant, and in that sense an officer of the Hospital Board, was, in law, an employee.

277 In later cases, hospital consultants working in the public sector have also been held to be employees.[347]

278 Any consultant to whom the Barber principle might have applied, prior to the creation of NHS Trusts under the National Health Service and Community Care Act 1990, would have had his contract of employment transferred automatically from the Health Authority to the new Trust.[348]

279 Thus, with effect in Bristol from April 1991, and with effect in other parts of the country depending upon the date that the relevant trust came into being, consultants ceased to be employees of the regional health authority, and became employees of the relevant NHS trust. As such, they were no longer under the (theoretical) control of the Region, possibly seen as distant from the unit where they worked, but were from then on under the more direct control of the employing unit.

Junior hospital doctors

280 Junior doctors, either career grade or in training, will in general also be employees. For instance in *Johnstone v Bloomsbury Health Authority* [1992] QB 333 a senior house officer (SHO) was regarded as engaged under a contract of employment (in 1988/89, when the events which gave rise to his claim arose).

Nurses

281 A nurse will also usually be an employee. Thus in *R v East Berkshire Health Authority ex parte Walsh* [1985] QB 152 a senior nursing officer was regarded as an employee; and similarly a charge nurse[349] and a nurse[350] have been treated as employees of, respectively, the district health authority and the NHS trust.

282 However, it is open to a hospital authority to contract for services to be provided by an individual health professional. It is thus, theoretically, possible for a consultant (e.g. a locum) to be an independent contractor, rather than employee; and nurses are frequently engaged through a nursing 'bank' (agency). In *Clarke v Oxfordshire Health*

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347 *Bliss v South-East Thames Regional Health Authority* [1987] ICR 700, CA ; *Porter* [1993] IRLR 486, QBD; and *Mishriki* (EAT, Morison J, 10 May 1999)

348 Section 6, National Health Service and Community Care Act 1990, in relation to 'any person who, immediately before an NHS Trust's operational date – (a) is employed by a health authority to work solely at, or for the purposes of, a hospital … which is to become the responsibility of the Trust …' and Section 6(3): '… the contract of employment … shall have effect from the operational date as if originally made between him and the NHS Trust'

349 *Paul v East Surrey District Health Authority* [1995] IRLR 305

350 *Gale v Northern General Hospital NHS Trust* [1994] IRLR 292, CA

Authority [1998] IRLR 125 it was held that a staff nurse who was offered and accepted employment, where it was available, at any of the Health Authority's hospitals and was paid hourly on the applicable scale, but who received no payment during periods when she was not supplying her services and had no contractual entitlement to sick pay or holiday pay, and whose contract stipulated that she had no entitlement to guaranteed or continuous work, was not an employee of the Health Authority, at least at times between engagements. There was no 'overriding' or 'umbrella' contract of employment to which her work for the Health Authority and its hospitals was subject. However, this is short of saying that each time she actually worked as a nurse she was *not* an employee – and, of course, each and every time she worked her work was regulated by a contract. In *Mensah v West Middlesex University Hospital* [351] the Court of Appeal accepted a similar analysis in the case of a midwife who worked as a bank nurse.

Professions Allied to Medicine

283 Similar considerations apply to Professions Allied to Medicine (PAMs); those working in these professions are likely, particularly if engaged full-time, to be employees. If employed sporadically, under a succession of contracts of short duration, they are likely to be employees whilst performing the contract, but not otherwise. They *can* theoretically be independent contractors, though most are likely to be treated as employees by any court or tribunal. The tendency, generally, of the law is to treat anyone who could be an employee as being an employee.[352]

Chief executives, hospital managers and administrators

284 These are almost all likely to be employees.

General practitioners

285 By contrast, GPs are rarely employees. They are, in general, the equivalent of sole traders, or partners in an enterprise, who provide their services to their patients. The fact that their remuneration comes from central funding does not essentially alter their status as independent contractors. That this is so is recognised in statute. When the PIDA 1998 came into force on 2 July 1999, the ERA 1996 was amended to provide that for the purposes of provisions protecting employees against victimisation and adverse treatment because they had 'blown the whistle', the definition of 'worker' for the purposes of the Act would be taken to include a person who:

> '… works or worked as a person providing general medical services, general dental services, general ophthalmic services or pharmaceutical services in accordance with arrangements made –

351 22 October 1998, CA, unreported

352 *'Harvey on Industrial Relations and Employment Law'*, para 51; Butterworths

'(i) by a Health Authority under Section 29, 35, 38 or 41 of the National Health Service Act 1977…'[353]

Terms of employment

286 Some of the terms and conditions of employment of health care professionals are standard terms, decided in national collective bargaining agreements such as those derived from the Whitley Councils.[354] For many years pay and other terms and conditions of employment were determined centrally for the whole of the NHS by the Whitley Councils and Review Bodies that has evolved over many years. Each occupational group tended to have a separate system of negotiation and consequently there was a multiplicity of different terms and conditions. Collective negotiation over several decades resulted in a large number of different allowances and special payments including complex rules on such things as annual sick leave and acting-up.

Once the trusts were in place there was a widespread move away from centrally agreed negotiated terms. Many Trusts have negotiated local recognition agreements with the principal trade unions and have devised their own terms and conditions. Key features were a reduction in the multiplicity of bargaining groups and the elimination or reduction of special allowances combined with an obligation on the employees to work more flexibly. Added impetus to these developments has been given by the 1995 national pay awards, where some national increases have been limited in order to give scope for local pay awards.

287 Mr Graham Nix, Finance Director, UBHT, told the Inquiry about the UBHT's use of Whitley terms regarding pay:

'Q. … "Staffing flexibility. The changed status will allow the Trust to reward excellence and ensure that it retains staff" [WIT 0106 0017]. What was the mechanism for that anticipated to be, when you drew up this document with your colleagues?

'A. Centrally, Trusts were told that you could change the way you pay staff. Prior to this you had to stick to Whitley Council payments, terms and conditions of service, and under trust status you could move away from that and pay people locally. In reality, UBHT are stuck to Whitley all the way through, but other trusts did use other mechanisms.

353 Section 29 of the NHS Act 1977 provides that the Family Practitioner Committee should arrange with medical practitioners to provide personal medical services for all persons in the locality wishing those services, and for the making of regulations providing for payment at predetermined rates for the provision of those services; Section 35 does the same for dentists, Sections 38 and 41 for ophthalmic practitioners and pharmacists

354 DOH 0015 0471; Whitley Councils for the Health Services (Great Britain) Main Constitution (revised 1 January 1984)

'Q. The plan at this stage [1990], obviously, for those drawing up this document [UBH/T's application for trust status], of which you were one, was to reward excellence, presumably in financial terms. Was there a corollary of that, of an intention, at least a willingness, to penalise the opposite of excellence, where that was found?

'A. No, absolutely not. This was really saying that, as Trust status, you had this flexibility to achieve this end. In reality, we have not used it the way other trusts have done, because we felt that Whitley Council terms and conditions have been created over many years of experience, and we should stick with that.'[355]

288 Mr Hugh Ross, Chief Executive, UBHT from 1995 to date, told the Inquiry about UBHT's use of Whitley terms regarding internal complaints:

'Q. So far as the formalised structures [to deal with internal complaints] are concerned, do you know whether they existed in individual contracts of employment prior to your becoming a Chief Executive?

'A. Yes. Those policies would have been standard in NHS Trusts.'[356]

289 Leading Counsel to the Inquiry raised with Dr Roylance the issue of the UBHT's use of Whitley provisions in non-health disciplinary cases. [357] The health circular put to Dr Roylance states:

'The recommended procedure (above) [the "three wise men" procedure] is intended to deal with cases where disability (including addiction to drugs or alcohol) is suspected in a member of medical or dental staff which might, if not remedied, lead to harm or danger to patients. It is not intended to replace or detract from the procedures set out in HM(61)112 and Section XXXIV of the General Whitley Council Conditions of Service. However, it may be appropriate to use the procedure recommended above in cases where it is possible that disciplinary action could arise but where there is reason to suspect disability.'[358]

355 T22 p. 171–2 Mr Nix
356 T19 p. 76 Mr Ross
357 T25 p. 8–9 Dr Roylance
358 UBHT 0061 0268; *'Prevention of Harm to Patients Resulting from Physical or Mental Disability of Hospital or Community Medical or Dental Staff',* para 15 (July 1982), HC (82) 13

Summary of respective roles of bodies concerned with standards and their implementation

290 This section attempts to summarise the shared and divided responsibilities for setting and implementing standards borne by the various bodies described above.

291 A distinction has to be made between general and specialist standards and between setting and implementing standards once set.

292 Dr Graham Winyard said that prior to the publication in 1989 of *'Working for Patients':*

> 'General standards were set by the GMC and the Medical Royal Colleges, through general and specialist examinations, the inspection of training posts and involvement in consultant appointment committees. However the prime responsibility for a doctor's ongoing standard of professional practice lay with that individual and was seen very much as a matter for him or her. General peer pressure was undoubtedly important in maintaining overall standards but could prove much less effective when an individual was, for whatever reason, resistant to criticism.'[359]

293 Of the period of concern to the Inquiry, Sir Donald Irvine and Professor Liam Donaldson, CMO for England and Wales, referred to Black's *'Quality Assurance of Medical Care'*, which comments:

> 'In the 1990s, developing standards of good care is increasingly likely to fall to national expert groups such as the medical Royal Colleges, partly because they are most likely to have the resources necessary to assemble the scientific, clinical and medical ethical expertise needed to construct guidelines which are competent and widely acceptable, and partly because of the sheer complexity, time and expense involved in achieving such guidelines. The implementation of standards, on the other hand, may be a more local matter in the form of protocols which can be attained within specified but manageable deadlines by practitioners operating under widely differing circumstances.'[360]

294 In practice, responsibility for setting general and specific standards was divided, as was their implementation.

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359 WIT 0331 0002 Dr Winyard

360 Cited by Irvine D and Donaldson L. 'Quality and Standards in Health Care'. *'Proceedings of the Royal Society of Edinburgh'* (1993); 101 B: 1-30 at p. 16 (WIT 0051 0045). The full Black 1990 reference is: Black N. 1990. 'Quality assurance of medical care'. '*Journal of Public Health Medicine'*, 12, 97–104 (cited at WIT 0051 0055)

295 The GMC advised and advises on generic professional standards. It did not and does not set clinical standards for particular specialties (such as paediatric cardiac surgery).[361] Such specific standards were and are set primarily by the Royal Colleges. The GMC's view was that:

> 'The Royal Colleges and specialist associations were primarily responsible for detailed, condition-specific clinical standards … The GMC offered no specific advice on audit during the 1980s and early 1990s.'[362]

This view was mirrored by that of the RCSE, which had published guidance on child surgery but '… has not published any guidance specifically referring to the competence or conduct of paediatric cardiac surgeons'.[363]

296 Furthermore, the GMC only enforced or implemented the standards it established. It has no jurisdiction to enforce the specialist standards laid down by the Royal Colleges.

297 The DoH meanwhile looks to the Royal Colleges and the GMC together to maintain standards. Dr Halliday told the Inquiry:

> 'The Secretary of State is not responsible for the way medicine is practised. He has no duty to Parliament for that. The responsibility of how clinical medicine is practised is a matter for the General Medical Council. The Secretary of State is obviously concerned about the way that service is provided and he looks to the Colleges and to the GMC to ensure that that is the situation.'[364]

298 The crux of the split between setting standards and implementing them is that the bodies that set specialist standards (the Royal College) have no direct power to enforce them, and the body (GMC) charged with enforcing general standards is unable to enforce specialist standards, not least because they cannot assess compliance with them. Leading Counsel to the Inquiry asked Sir Donald Irvine:

> 'So far as standards then were concerned during 1984 to 1995, standards of good practice, we have heard from the evidence given to us by the Royal Colleges that they would promulgate the standards in their own particular specialisms. Much of the evidence that we have heard suggests that there was a vacuum when it came to the enforcement of those standards. Is that how you would have seen the years 1984 to 1995, or not?

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361 WIT 0062 0026 Mr Scott

362 WIT 0051 0009 Sir Donald Irvine

363 WIT 0048 0013 Sir Barry Jackson. However, 'In 1995 the SAC in Cardiothoracic Surgery approved a programme for advanced training for those wishing to specialise in paediatric cardiac surgery …' (WIT 0048 0011). The document is: *'Suggested Paediatric Cardiac Surgical Training Programmes'* (WIT 0048 0018). *'Training for Paediatric Cardiac Surgery'* (J Stark's document presented to the SAC 1995) (WIT 0048 0016) and *'Training Curriculum in Paediatric Cardiothoracic Surgery'* (WIT 0048 0021) are '… the specific curriculum document for training in paediatric cardiac surgery that is used at Birmingham and Great Ormond Street to follow through the training of individuals on the rotation between these [two] hospitals' (WIT 0048 0011)

364 T13 p. 80 Dr Halliday

'A. The enforcement by the Royal Colleges, do you mean?

'Q. Enforcement generally.

'A. In general terms, yes.' [365]

299 Sir Donald was subsequently asked:

'Q. So in terms of standards throughout the period we are looking at, the Royal Colleges would set the standards of performance generally speaking for doctors and their specialties, would they?

'A. Yes. They would indicate in their various ways what standards would be expected for their individual specialties.

'Q. But there was no sanction from the GMC for a failure to meet those performance standards until 1997, I think?

'A. Until ... ?

'Q. 1997, was it? The change was brought in in 1995, but that was the first year for "seriously deficient professional performance"?

'A. I am sorry, yes.

'Q. So the only sanction for the failure to meet a Royal College standard would either be up to the Royal Colleges themselves or to the local employer?

'A. Yes.' [366]

300 The evidence of the GMC was that it set professional, but not clinical, standards; that it adopted but did not enforce clinical standards, and that it expected employers (with the assistance of the Royal Colleges) to enforce those clinical standards.

301 The evidence of the Royal Colleges was that they lacked any means to enforce clinical standards, and relied upon the GMC to ensure professionalism.

302 The evidence of the DoH was that it relied on both the Royal Colleges and the GMC to set standards and to enforce them, but declined any direct responsibility itself for doing so. Responsibility for clinical treatment was that of the individual clinician (or, at least, consultant). The role of the DoH was, in part, to set the framework within which standards might be set and implemented, but its focus was split until 1995 as between management and policy, and its emphasis was on financial rather than clinical performance.

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365 T48 p. 26–7 Sir Donald Irvine
366 T48 p. 108–9 Sir Donald Irvine

303 The individual doctor was required to satisfy the GMC of basic medical competence, and the Royal Colleges of specialist competence, but only at the outset of a career, as a one-off qualification.

304 This last point has been addressed by Continuing Medical Education (CME)/ Continuing Professional Development (CPD), to the evidence on which we now turn.

Continuing professional development (CPD)

305 'CPD' is an equivalent term to 'CME', used in various professions and replacing CME as the predominant term used.

306 The development and acceptance of 'CPD' was stimulated by problems in the introduction of minimal access (or 'keyhole') surgery. As Sir Barry Jackson said:

> '… discussions and debate had been taking place about these general issues relating to audit, to CME, in the 1980s, but were stimulated and perhaps minds focused quite sharply by the introduction of minimal access surgery in the 1990s in this country, 1991, I think.[367]
>
> '… the introduction of minimal access surgery played a part in focusing the mind quite acutely. This was "keyhole surgery" by want of another name, because as is well known, when keyhole surgery in the field of gallbladder surgery was introduced in this country in the early 1990s, there was unfortunately a spate of complications resulting from the introduction of that particular technique which focused the mind very acutely.'[368]
>
> 'There was a recognition, and there had been over some years before, that these matters of audit, continuing medical education, ensuring that individual practitioners participated, was an area that needed more formal adoption than had previously been the case.'[369]

307 CPD includes training for new techniques such as minimal access surgery, but is broader. It includes keeping up to date with improvements to existing techniques,[370] and requires post-qualification training.[371]

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367 T28 p. 75 Sir Barry Jackson
368 T28 p. 30 Sir Barry Jackson
369 T28 p. 76 Sir Barry Jackson
370 WIT 0048 0145 Sir Barry Jackson; 'Most technical developments are simply minor improvements on an existing technique.'
371 The relationship of CPD to the 'learning curve' is dealt with in Chapter 14

308 In addition to what was described to the Inquiry as the 'furore'[372] over minimal access surgery, medical litigation added to the pressure for making CME and training, generally, more rigorous:

> 'I think one of the factors might have been the increasing rate of medical litigation, of alleged under-performance by medical practitioners. Certainly, it is a fact that the number of cases brought to the solicitors have increased almost exponentially over the last 15 years, and I think it became clear that the proportion of these cases where there was alleged under-performance, there might have been some justification for the allegations that were made; certainly not all, but some.'[373]

CPD as a professional obligation

309 During the period of the Inquiry's Terms of Reference, there was very little enforcement of CPD. It was left to the individual as a moral obligation, as Sir Barry Jackson explained:

> '… the question of continuing medical education or continuing professional development, during the period of our terms of reference again, I think it is accurate to say there were no formal obligations placed upon a Fellow of The Royal College of Surgeons or a Member of the Royal College of Surgeons to take part in such an exercise?
>
> 'A. That is correct.
>
> 'Q. So what would the nature of the obligation to keep oneself up to date as a matter of professional competence be?
>
> 'A. It was a moral obligation. That is the short answer.
>
> 'Q. A moral obligation possibly backed up by the Code of Practice of the GMC?
>
> 'A. The answer is yes, although I have to say that I cannot remember the dates when successive GMC documents were published, but certainly, the GMC did not figure high in the minds of most surgeons throughout the time in question, the Inquiry time.
>
> 'Q. So the prime concern would be the individual moral or ethical responsibility?
>
> 'A. Yes.

372 'This document [WIT 0048 0140], came out to some extent in response to the furore over the complications arising from the introduction of minimal access surgery', Sir Barry Jackson T28 p. 75–6

373 T28 p. 79 Sir Barry Jackson

'Q. Would contracts of employment or job descriptions of consultants be likely to have contained during this period any requirements to engage in continuing medical education?

'A. I think it most unlikely, but I cannot state authoritatively that that was the case, particularly towards the end of the terms of your Inquiry. Certainly, in the 1980s, that would not have been in job descriptions; it may have started creeping in in the early to mid-1990s.[374]

'Q. I appreciate it is difficult for you to answer because no doubt the practices would have varied locally from Trust to Trust, at least to some extent, but is it fair to conclude from the earlier part of your answer that even if they did, the real pressure that would be felt by consultants is likely to be the moral and ethical one, rather than whatever the job description might have said on the subject?

'A. Yes.'[375]

310 Similarly, in relation to new procedures, it was left to the individual doctor to decide what training he felt he needed to do before embarking on the procedure:

'Q. … what would be the expectations as to the practical steps that had to be taken before a person could be confident or reasonably confident that actually they would not be harming their patient if they embarked on something relatively new?

'A. There was nothing laid down about this. It was not formalised. It was up to an individual surgeon to take what steps they considered necessary to enable them to carry out that operation with a clear conscience.'[376]

311 The Inquiry has received little evidence on what proportion of hospital doctors actually felt obliged to undertake CPD and what proportion of doctors actually did undertake CPD as recommended. Such information is available for general practice, through data on Post Graduation Education Allowance payments, but otherwise it may be impossible to find out, as no one monitored compliance with what recommendations there were:

'Q. … what assessment would the College make of the extent to which consultants were already participating in CME prior to the introduction of a formal accreditation programme?

'A. None, formally.

374 The standard form of contract for a hospital consultant contained a clause relating to study leave, which both authorised and encouraged it
375 T28 p. 72–3 Sir Barry Jackson
376 T28 p. 112 Sir Barry Jackson

'Q. Nobody was formally engaged in it in so far as nobody was required to formally notify their engagement in it, but to what extent did the College believe it was all chugging along nicely with everybody doing what was expected of them, or to what extent did they regard there might be a problem in this field?

'A. I do not think the College as such took a formal position in the early 1990s that continuing medical education had to be carried out by all their fellows.[377]

'Q. … prior to the early 1990s there was very limited awareness of the extent to which consultants were keeping themselves up to date?

'A. Yes. I think the answer to that is probably yes; there was a limited awareness. I mean, it was, as I said before, a moral obligation that consultants did keep themselves up to date and did continue to practice appropriately … .'[378]

312 Further, there was no systematic assessment of trainers providing CPD:

'Q. … Did I understand you previously to say that there was no systematic assessment of the trainer?

'A. I do not think I said it in those terms, but your derivation, the implication of what I said was exactly as you suggest.' [379]

GMC

313 The GMC has now become more involved in periodic review of clinicians' performance than it used to be.[380]

Royal Colleges

314 The Royal Colleges have been active in promoting CPD, with publications including: *'Quality Assurance: The Role of Training, Certification, Audit and Continuing Professional Education in the Maintenance of the Highest Possible Standards of Surgical Practice'* (The Senate of Surgery of Great Britain and Ireland, London, 1994)[381] and *'Handbook on Continuing Medical Education for Surgeons'* (The Senate of Surgery of Great Britain and Ireland, London, 1995).[382]

377 T28 p. 77–8 Sir Barry Jackson
378 T28 p. 80 Sir Barry Jackson
379 T28 p. 70 Sir Barry Jackson
380 T52 p. 45 Sir Graham Hart
381 Listed in 'Further Reading' section RCSE 0001 0137
382 Listed in 'Further Reading' section RCSE 0001 0137

315 The RCSE recommends the explicit incorporation of standards (such as training and CPD) into contracts of employment:

> 'Q. Do I take it from that that the College would in fact support the inclusion in terms of contracts of employment, contractual terms which required consultants to maintain CPD, CME, according to terms of the Royal Colleges' schemes?
>
> 'A. The College would support that 100 per cent.'[383]

Revalidation

316 CPD may be related to revalidation. The aim of revalidation is the maintenance of doctors' fitness to practise. The mechanism envisaged is continued entitlement to registration. The Inquiry has received evidence giving some indication of the standards sought to be upheld and the procedures involved:

> 'Hitherto, doctors have remained registered without any continuing assessment of their fitness to practise. In February 1999, the Council [GMC] decided that all doctors must be able to demonstrate on a regular basis that they are keeping themselves up to date and remain fit to practise in their chosen field.
>
> 'Revalidation of fitness to practise will be linked with registration.'[384]

317 Sir Donald told the Inquiry:

> '… we have taken the decision to change the basis of registration so that doctors in future have to be able to demonstrate on an ongoing basis their fitness to practise …'[385]
>
> 'For all established doctors, the principles of '*Good Medical Practice*' – interpreted for each specialty by the Colleges – will provide the template against which doctors' continuing registration will be regularly revalidated in future.'[386]

318 And again:

> 'The GMC's fitness to practise procedures, especially the performance procedures, will be used to underpin revalidation when it is introduced. They will be the instrument through which the GMC will assess the performance of doctors who fail to meet the criteria for revalidation, and through which it will decide whether to act on a doctor's registration.'[387]

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383 T28 p. 83 Sir Barry Jackson
384 WIT 0062 0006 – 0007 Mr Scott
385 T48 p. 78 Sir Donald Irvine
386 WIT 0051 0010 Sir Donald Irvine
387 WIT 0051 0013 Sir Donald Irvine

319 The revalidation is 'revalidation of registration'.[388] It could apply both to basic and other registrations, such as higher level nursing registrations.[389]

320 The principle of revalidation (or re-accreditation) is widely supported by general practitioners:

> 'In 1992 the General Practitioners' Committee of the BMA ran a very large opinion survey … to which 25,000 GPs replied. … One of the questions was: did doctors believe that re-accreditation, regular re-accreditation, would improve standards of care. Two-thirds said yes.'[390]

Mechanics of revalidation

321 The mechanics of revalidation are still being discussed. The GMC's view was given to the Inquiry by Sir Donald:

> '… many of these problems that have arisen in the United States and elsewhere arise because of a reliance or seeking to rely on the assessment itself, and, you know, the questions arise as to what the appeal would be against, et cetera. The difference with the proposals that we have in mind – this is already adopted as policy – is that against the screen, effectively, which is what revalidation will be, if questions about performance, fitness to practise arise, then they will be investigated further and in all the appropriate detail within the GMC's fitness to practise procedures, almost certainly the performance framework. In that, it will bring the questions into an established statutory framework in which patients and doctors have their respective rights and all is settled and all agreed. So there is no need at that earlier stage to be concerned, be revalidated or not. It is not at that point that the decision would be taken. It would be taken by the GMC within that statutory framework. That is settled.'[391]

388 WIT 0051 0014 Sir Donald Irvine
389 WIT 0052 0326 Ms Lavin; *'Review of the Nurses, Midwives and Health Visitors Act 1997 – Government Response to the Recommendations'*, p. 10, HSC 1999/030
390 T20 p. 35–6 Dr Armstrong
391 T48 p. 142 Sir Donald Irvine

Chapter 5 – Regional, District and Trust Management

Scope of this chapter

1 This chapter aims to give a factual description of the history of both the regional and district health authorities and their management structures throughout the period in question, and of how their respective rights and obligations were distributed and changed or were transferred over time.

2 Although the account is given of the evidence as to the position nationally, it focuses on the regional and district framework most relevant to Bristol, in particular that relating to paediatric cardiac services (PCS).

Brief chronology of the main events

1 April 1974	South Western Regional Health Authority (SWRHA) established
	Avon Area Health Authority (Teaching) established
	Bristol Health District (Teaching) established
	Weston Health District established
1 April 1982	Bristol & Weston District Health Authority (B&WDHA) established
1 February 1985	B&WDHA appointed its first District General Manager, replacing the District Administrator
1 April 1991	United Bristol Healthcare NHS Trust (UBHT) and Weston Area NHS Trust became operational
1 October 1991	Bristol & District Health Authority (B&DHA) established
1 April 1992	Frenchay Healthcare Trust operational
	Southmead Healthcare Trust operational
	NHS Executive regional outposts established
1 April 1994	Boundaries of SWRHA enlarged and name changed to South & West Regional Health Authority (S&WRHA)
1 October 1994	Avon Health Commission established
1 April 1996	NHS Executive South & West established

(S&WRHA abolished)

Avon Health Authority (Avon HA) established

Statutory framework

Introduction

3 The relevant statutes governing the matters described in this chapter are:

- National Health Service Act 1946 (the 1946 Act)
- National Health Service Reorganisation Act 1973 (the 1973 Act)
- National Health Service Act 1977 (the 1977 Act)
- Health Service Act 1980 (the 1980 Act)
- National Health Service Community Care Act 1990 (the 1990 Act)
- Medical (Professional Performances) Act 1995 (the 1995 Act).

4 The 1973 Act revised the structure of the NHS and introduced regional and area levels of management in England (but not Wales)[1] by providing for the establishment of regional health authorities (RHAs), area health authorities (AHAs) and area health authorities (teaching).

5 Under the 1977 Act 'It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement –

'(a) in the physical and mental health of people in those countries, and

'(b) in the prevention, diagnosis and treatment of illness, and for this purpose to provide or secure the effective provision of services in accordance with this Act.'[2]

6 The 1977 Act confers a wide discretion on the Secretary of State, in deciding what services ought reasonably to be provided. It provides that, 'It is the Secretary of State's

1 Sections 5 and 5(1) (b), 1973 Act
2 Section 1(1), 1977 Act

duty to provide throughout England and Wales, to such an extent as he considers it necessary to meet all reasonable requirements –

'(a) hospital accommodation;

'(b) other accommodation for the purpose of any service provided under this Act;

'(c) medical, dental, nursing and ambulance services;

'(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;

'(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

'(f) such other services as are required for the diagnosis and treatment of illness.'[3]

Establishment of regional and district health authorities

7 The 1977 Act required the Secretary of State to establish health authorities for the regions.[4]

8 Fourteen RHAs were set up under the 1973 Act.[5] In 1993 the decision was taken to abolish all 14 RHAs and to replace them with 8 regional offices of the NHS Executive, performing fewer functions than the authorities they replaced. It was recognised in 1993 that, given the many responsibilities of RHAs, it would take some time to bring this change into effect. Thus, in 1994, as a step towards eventual abolition, the number of RHAs was reduced to 8, and the regional offices of the NHS Executive were set up to run in parallel. The change was fully implemented in April 1996 when the RHAs ceased to exist.[6]

9 The 1980 Act[7] gave the Secretary of State power to establish district health authorities (DHAs) in place of AHAs. On 1 April 1982 AHAs ceased to exist and 192 new DHAs took their place.[8] DHAs became the main operational authorities.

10 By the Health Authorities Act 1995, RHAs and DHAs were abolished with effect from 1 April 1996, and the Secretary of State was under a duty to establish 'health authorities'. These new health authorities were created from the merger of the old DHAs and family health service authorities (FHSAs).

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3 Section 3(1) (a)–(f), 1977 Act
4 Section 8, 1977 Act
5 Regional health authorities established by the NHS (Determination of Regions) Order 1981, SI 1981/1836: Northern, Yorkshire, Trent, East Anglia, North East Thames, South East Thames, North West Thames, South West Thames, Wessex, Oxford, South Western, West Midlands, Mersey, and North Western
6 The eight regional offices are: Eastern, London, North West, Northern & Yorkshire, South East, South & West, Trent and West Midlands
7 Section 1, 1980 Act
8 DHAs established by the NHS (Determination) Order 1981, SI 1981/1837, Reg. 3

The regional health authority

11 The region was established in 1973.[9] 'Regional Authority as respects its region … shall exercise on behalf of the Secretary of State his functions relating to the health service under the enactments … [set out in Schedule 1 of these regulations]'.[10] The relevant duties delegated to the RHA included those under Section 3(1) (a)–(f) of the 1977 Act.

12 The 1977 Act provided that the Secretary of State may direct an RHA to '... exercise on his behalf such of his functions relating to the health service as are specified in the directions'.[11] The RHA could in turn direct DHAs within its region to exercise those functions.[12]

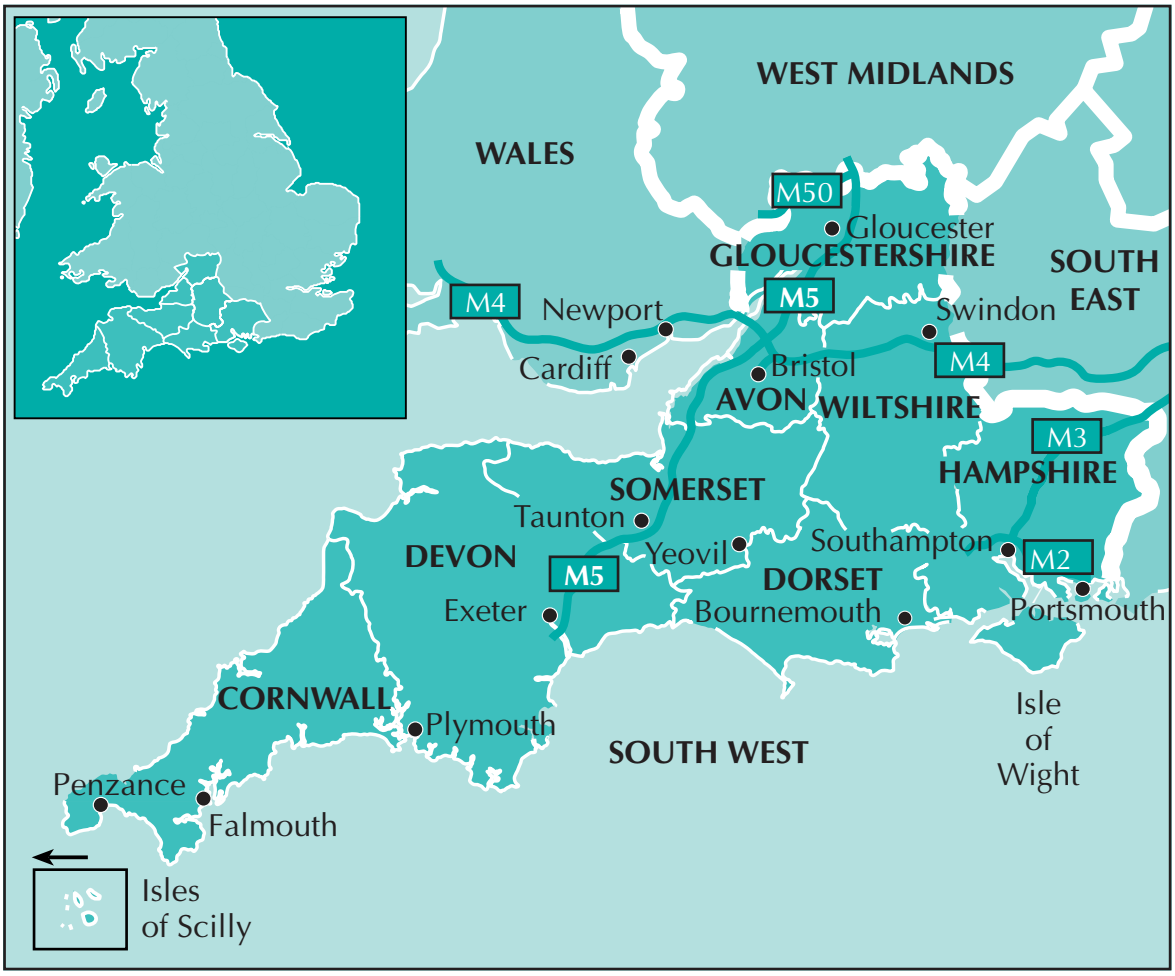
13 Statutory Instrument (SI) No 1989/51 delegated functions to the RHAs (including all of those under Section 3 of the 1977 Act) and obliged the RHA in turn to delegate certain matters to its DHAs.

14 The DHA had to act in accordance with limitations or directions set by the Secretary of State or the RHA (provided that these latter directions, from the RHA, were not in conflict with those from the Secretary of State).[13]

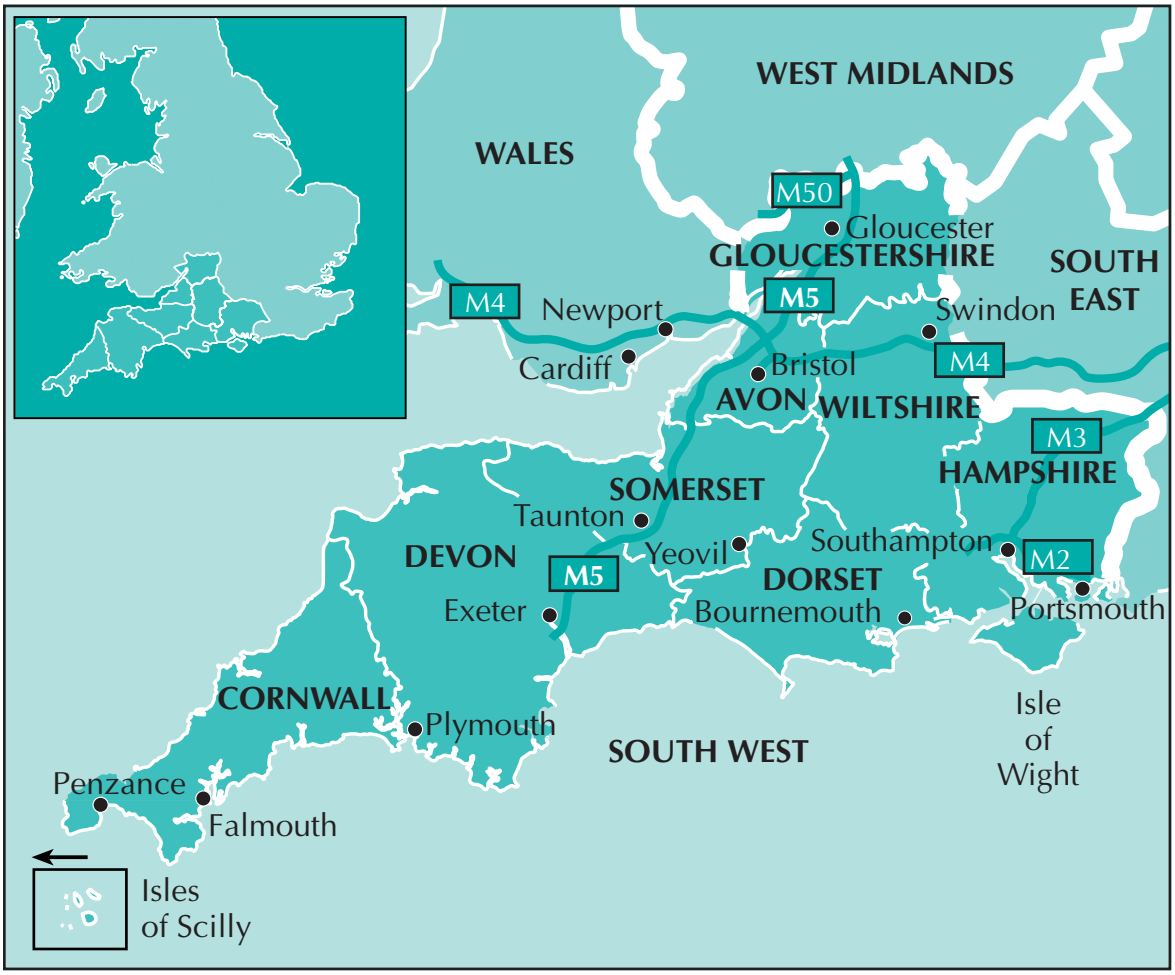
15 The sequence of maps below show the extent of the RHA from 1981–1996 and the boundaries of the Avon Health Authority created in 1996

9 NHS (Determination of Regions) Order 1973
10 Regulations consolidating the NHS Functions (Directions to Authorities and Administration Arrangements) Regulations 1982, SI 1989/51 regulation 3
11 Section 13(1), 1977 Act
12 Section 14(1), 1977 Act
13 Regulation 6

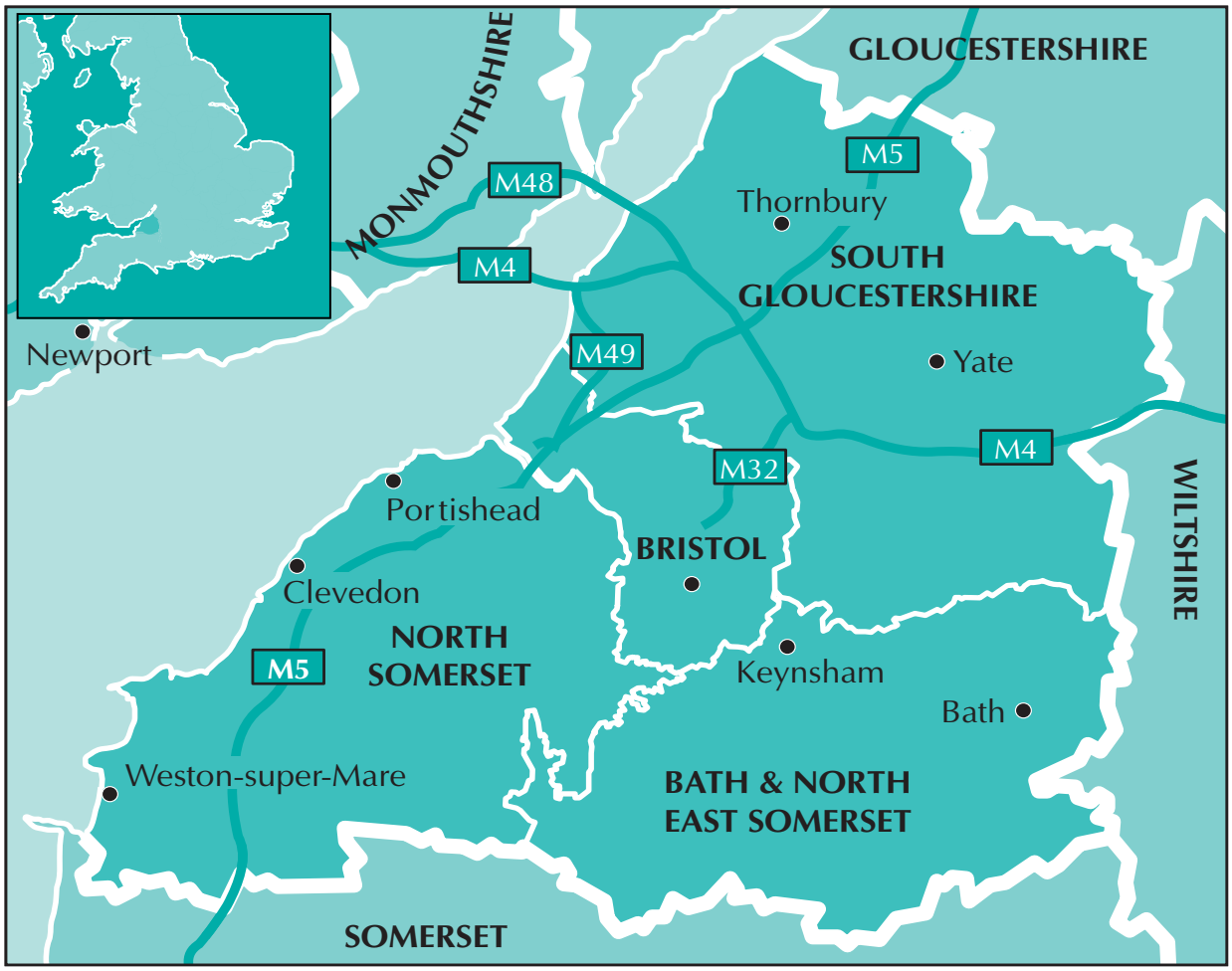
South Western Regional Health Authority 1981 – 31/03/1994



South & West Regional Health Authority – 01/04/1994 – 31/03/1996



Avon Health Authority 01/04/1996



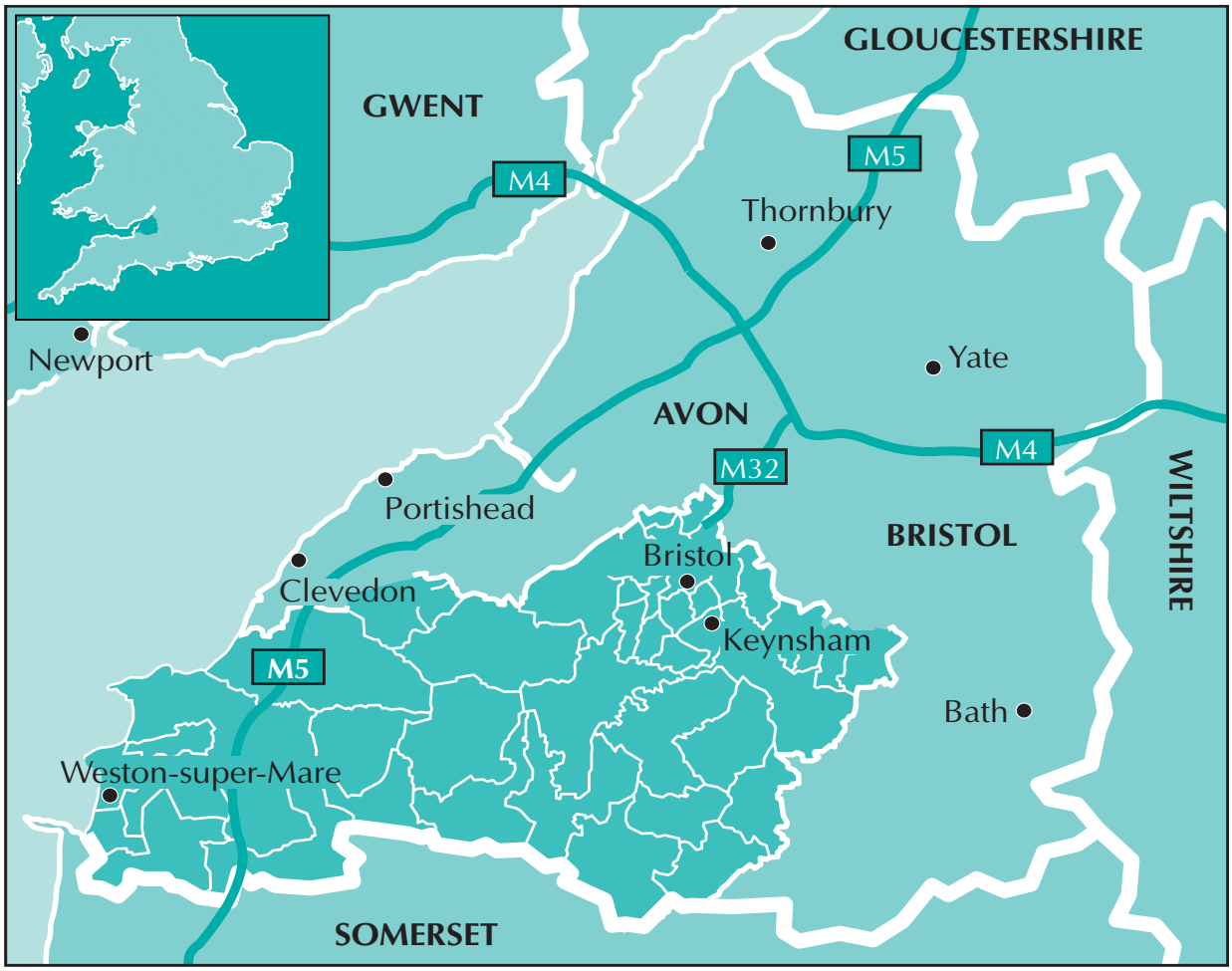
The district health authority

16 The district was established by the NHS (Determination of Districts) Order 1981.[14] The districts were largely constituted out of the old AHAs, and took over most of their staff. In Bristol, the constitution of the district was varied in 1991 by SI 1991/2039, which created the B&DHA.

17 The Secretary of State allocated funds to DHAs and could direct how these funds were to be applied.[15]

18 The following sequence of maps below show the extend of the DHA over time.

Bristol & Weston District Health Authority – 02/04/1982 – 30/09/1991



14 SI 1981/1837
15 Section 97, 1977 Act

Bristol & District Health Authority – 01/10/1991 – 31/03/1996

NHS trusts

19 The legal framework for NHS trusts was established by the 1990 Act, which empowered the Secretary of State by order to establish bodies 'to assume responsibility … for the ownership or management of hospitals … or to provide and manage hospitals'.[16]

20 Each trust is a body corporate with a chairman appointed by the Secretary of State, and with executive and non-executive directors (the latter were not to be employed by the trust). However, NHS trusts are independent and the trust is not a servant or agent of the Crown or the Department of Health (DoH).[17]

21 There is nothing in the 1990 Act to spell out the duties of directors on the trust's board. The Secretary of State was, however, empowered to make Regulations to regulate the

16 Section 5, 1990 Act
17 Section 5(8) and Schedule 2 paras 16(1) and 18, 1990 Act

appointment and tenure of chairmen and directors of NHS trusts.[18] These set the maximum number of directors at 11. Two were to be appointed by the RHA. All others were appointed by the Secretary of State. The tenure was not to exceed four years, but reappointment was allowed. The Regulations set out circumstances in which disqualification would occur (e.g. bankruptcy, sentence of imprisonment, loss of independence as a result of trade union office or membership of a health service body).

22 The executive directors of the trust had to include the chief officer, the finance officer, a medical practitioner and a registered nurse or midwife. A committee, composed of the chairman and non-executive directors of the trust, appointed the chief officer. Once appointed, the chief officer joined that committee in order to appoint the other executive directors of the trust.

23 The Regulations made provision for standing orders to govern proceedings of the trust (Regulation 19), and for the exclusion of directors from business in which they had a pecuniary interest (Regulation 20). The Regulations are 'procedural' in nature only. They give no guidance as to the duties or responsibilities of the directors, whether executive or non-executive.

24 The orders given by the Secretary of State in respect of each trust were meant to specify the functions of the trust.[19] The trust is required to carry out 'effectively, efficiently and economically'[20] those functions that have been conferred on it by this framework.[21] It has a duty to comply with guidance or directions from the Secretary of State (e.g. in circulars). An annual report has to be submitted to the Secretary of State, in a form determined by him; the Secretary of State also has the power to require trusts to submit further information.

25 The trust is also obliged to ensure that revenue covers outgoings and that it meets any financial objectives set from time to time by the Secretary of State.[22] NHS trust hospitals are funded from the revenue generated by contracting with NHS purchasers and others.

26 The trust has the power to do anything necessary in discharging its functions.[23] Under the 1990 Act Section 3, the RHA and DHA could enter into an NHS contract as a purchaser; under Schedule 2 para 10 a trust may enter contract as a provider.

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18 Section 5(7). See also the NHS Trusts (Membership and Procedure) Regulations 1990, SI 1990/2160

19 Schedule 2, part 1, para 1

20 The Audit Commission has defined those terms, in relation to its own work, in its 1990 code of Audit Practice for Local Authorities and the NHS in England and Wales. 'Economy' relates to the terms on which resources are acquired; an economical organisation acquires them at the lowest cost. 'Efficiency' is concerned with the services provided in relation to the costs of provision; an efficient organisation produces either the maximum services for a fixed level of output or a fixed level of quality of service for the minimum output. 'Effectiveness' is a measure of how well a service achieves its goals. The statutory framework and any relevant guidance or directives set the goals

21 Schedule 2, part 1, para 6(1)

22 Section 10(2)

23 Schedule 2 para 16(1), 1990 Act

27 The UBHT was formally established by the 'The United Bristol Healthcare National Health Service Trust (Establishment) Order'[24] which came into force on 21 December 1990. The Trust was established for the purpose specified in Section 5(1)(a) of the 1990 Act. The Trust's functions were to 'own and manage hospital accommodation and services' at various premises. It was to have a chairman, five executive directors and five non-executive directors. The operational date for the start of the Trust was 1 April 1991. Various transitional provisions were made to allow it to get up and running at that date.[25]

Management structures throughout the period in question

28 The management structures of the relevant health authorities changed significantly over the period covered by the Inquiry.

The South Western Regional Health Authority (SWRHA)

29 The 1973 Act established the SWRHA, which came into operation from 1 April 1974.

30 At that time, within the SWRHA were Avon Area Health Authority (Teaching) and a number of health districts. The Avon Area Health Authority (Teaching) included about 800,000 people in the Bristol and surrounding areas. The BRI and the BRHSC were both contained within the Bristol Health District (Teaching) which served a population of about 360,000 people, mostly within the Bristol area.[26]

31 Miss Catherine Hawkins, SWRHA Regional General Manager (RGM) from August 1984 to December 1992, explained the history of the SWRHA:

> ' … the South West region had been there since 1974. In fact, longer than that: in 1948 there had been a regional authority. What had changed was that in 1984 general management was introduced at regional and district levels. So, there had always been a regional authority dealing with programmes and strategic planning and financial allocation but it changed in 1984 when general management was introduced, and it changed again in 1991.'[27]

32 The SWRHA was one of 14 different RHAs in England, and within its boundaries were 11 separate DHAs. Among those 11 districts were Bristol and Weston, Southmead and Frenchay, which between them covered 880,000 population in the greater Bristol

24 SI 1990/2450
25 Under para 6(2)(d) of Schedule 2 of the 1990 Act
26 Southmead, Frenchay and Weston Hospitals were separate districts within Avon Health Authority (Teaching)
27 T56 p. 18 Miss Hawkins

area.[28] The SWRHA itself spanned a far larger area, including Gloucestershire, Avon, Somerset, Devon, Cornwall and the Isles of Scilly.[29]

33 The RGM split the responsibilities within the SWRHA into five main areas (amongst others). These were, in general terms:

- Community Medicine (latterly called Public Health Medicine);
- Capital Planning;
- Service Planning;
- Finance; and
- Human Resources.[30]

34 Although the structure and organisation of the SWRHA changed over the period from 1984 to 1995, these main areas were always present in one form or another. For example, the Capital Planning and Service Planning departments merged and de-merged from time to time.[31]

35 The Regional Treasurer of the SWRHA was responsible for all of the Region's financial matters, including resource allocation to the districts, monitoring the financial position of the districts and providing financial advice to the Regional Health Authority Board.[32]

36 Dr Marianne Pitman was the Regional Specialist in Community Medicine. This title later changed to Consultant in Public Health Medicine, but the main functions of the position remained the same. The number of consultants in public health medicine varied between one and three at the most, and they had secretarial and administrative support. Dr Pitman's line manager and head of the department was the Regional Medical Officer (RMO)/Regional Director of Public Health (RDPH),[33] to whom she was managerially and professionally responsible. The RMO/RDPH created the work programme for the year that was agreed with the regional team officers, who were the executive directors of the SWRHA.[34]

37 The consultant(s) in public health medicine liaised with the RMO, as well as the public health departments located within the DHAs. Direct contact with the trusts,

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28 T56 p. 18 Miss Hawkins
29 T56 p. 19 Miss Hawkins. The Isles of Scilly were added in 1981
30 WIT 0317 0002 Dr Pitman
31 WIT 0317 0003 Dr Pitman
32 WIT 0119 0001 Mr Wilson
33 T58 p. 5 Dr Pitman. Office held by Dr Martin RF Reynolds, then Dr Marie J Freeman, then Dr A Mason; the title of RMO changed to RDPH at about the time community medicine became public health medicine, in about the middle of the period of the Inquiry's Terms of Reference
34 WIT 0317 0003 Dr Pitman

once these were set up, was mostly through individual clinicians and associated managers.

38 The consultant(s) supported the Regional Hospital Medical Advisory Committee[35] (RHMAC) and later the Regional Primary Care Medical Advisory Committee (RPCMAC). The RMO attended each meeting. Dr Pitman attended when required. She also attended as an observer as many appropriate RHMAC sub-committee meetings as possible. This was not on a regular basis though, because the various different sub-committees were at times over 30 in number. Initially the RHMAC was made up of the chairmen of these sub-committees. Latterly, it was comprised of trust medical representatives with sub-committee chairmen attending as required or on request of the Chair.[36]

39 Dr Pitman's work with the RMO, as a result of attendance at these sub-committee meetings, was to provide support as required and to act as an additional conduit of information between the RMO and the sub-committee. However, not all matters would be channelled in this way. Any consultant could ask for an interview with the RMO if they had confidential issues which they wanted to discuss or impart instead of choosing to follow the route of raising the matter in committee or first with a consultant in public health medicine.[37]

40 However, it was Dr Alistair Mason's[38] experience as RMO that:

> 'It was very rare for consultants, whom I did not know, to come out of the blue with a particular problem concerning themselves or colleagues. Members of the medical advisory committees did on a number of occasions bring forward concerns about their colleagues.'[39]

41 The consultants in public health medicine were also involved in cross-RHA departmental strategic planning for service and capital developments.[40]

42 The role of consultant in public health medicine also involved Dr Pitman in the initiation procedures for setting up the supra regional service (SRS) of neonatal and infant cardiac surgery (NICS) in January 1984 and the discussions regarding its effect following its inauguration.[41]

Managerial relationships with the Department of Health

43 One of the main functions of the RHA was its role in strategic planning. According to Miss Hawkins, the RHA formed a view of which services should or should not be developed, taking into account national priorities passed down from the DoH/

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35 The RHMAC is dealt with further below, see paras 61–74
36 WIT 0317 0003 Dr Pitman
37 WIT 0317 0004 Dr Pitman
38 Dr Alistair Mason, RMO/RDPH from April 1988 to June 1994
39 WIT 0399 0044 Dr Mason
40 WIT 0317 0004 Dr Pitman
41 WIT 0317 0004 – 0005 Dr Pitman

Department of Health and Social Security (DHSS) and the views expressed from the districts.[42]

44 The DoH/DHSS made their views and priorities known by issuing circulars and directives to the regions, and also through the medium of annual reviews which took place between the DoH and the Region. These reviews were between the Minister and the Chairman of the RHA. The Vice-Chairman would also normally attend, together with the RGM and the appropriate members of the RGM's team. As Miss Hawkins explained, the Minister would lead the departmental team, supported by civil servants as necessary.[43]

45 The purpose of the meetings was to review different aspects of healthcare according to the particular interests a particular Minister may have had:

> ' … but there was always a thread running through it [the meeting] about financial viability and how we had performed against national targets, whether we were achieving our overall strategic plan and whether there were any specific items of interest or concern on either side. It was a very open type of meeting where you could argue back, but then you would be given set targets or tasks to go away and achieve.'[44]

46 At the DHSS review in April 1984 SWRHA was told that it was not getting the best for patient care because it was not demanding more value for money from its districts.[45]

47 The need for the Region to change its management style filtered down to the districts promptly, with it being noted in a meeting between the Region and the B&WDHA[46] that it was the opinion of the DHSS that Regional strategy needed specific plans for achieving its objectives with the districts, rather than a mere statement of good intentions.

48 Miss Hawkins was the Chief Nursing Officer at the time of the review and had just joined the Region. She said:

> ' … we were told [by the DHSS] that the Region was so laid back that it could fall off the chair … and that is when we were told to stop being friends with the districts, in quotes, and to get to grips with them and to start making them perform well, because Region was not doing that.'[47]

49 General management was shortly to be introduced into the Region. Interviews were held in July and Miss Hawkins was appointed RGM in August 1984. The management style was changed in accordance with the Department's wishes, and services for

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42 T56 p. 22–3 Miss Hawkins
43 T56 p. 23 Miss Hawkins
44 T56 p. 25 Miss Hawkins
45 T56 p. 29–31 Miss Hawkins
46 UBHT 0102 0433; notes of a meeting between SWRHA and B&WDHA on 11 June 1984
47 T56 p. 29 Miss Hawkins

patients generally improved (especially in mental illness and mental handicap services).[48]

Managerial relationships with the district health authorities

50 There was regular and ongoing contact between the SWRHA and the district general managers (DGMs) of all the DHAs, including the B&WDHA. Either the DGM or one of the DHA's representatives would attend meetings with the Region's Finance Officer, Planning Officer and medical officers. In addition, there would be informal contact between the DGM and the RGM, if and when requested by either party on a less regular ad hoc basis.[49]

51 The Region held annual reviews with each of the 11 DHAs within its area. This again was a chairman-to-chairman review. Each of the chief executives attended with the relevant team officers, depending on what subject was being discussed at the time. Normally the Vice-Chairman of the RHA also attended the meeting, otherwise a non-executive from the RHA who had a particular oversight of a district was present.[50]

52 A team of assistant RGMs, who had responsibility to the RGM for the individual districts, assisted the RGM. A certain amount of feedback from the DHAs would also come to the RGM on an informal basis through these assistant RGMs following meetings with the DGMs and other officers of the individual DHAs. The size of the area covered by the RHA and the number of individual departments and specialties maintained within all the hospitals in this area determined the degree of their individual scrutiny by the RGM.

53 Miss Hawkins explained in oral evidence:

> ' … [the feedback from districts] would have been done on an informal network, because I did have AGMs [assistant RGMs] who were responsible for individual Districts, and that would have been done when they actually sat with them to see what should be coming up as agenda items at our reviews. I mean, cardiac surgery was a very small part, as I have tried to explain, of the total acute and other services in the Region, so it was not high on my agenda every single time I sat down with a DGM.'[51]

54 The function that the RHA could perform was limited by the authority and control it had over the districts. Miss Hawkins in her oral evidence was asked whether her role as RGM gave her the direct supervision of the 11 districts underneath the SWRHA. She replied:

> 'It was a very difficult system because the Regional Health Authority had monitoring and a degree of control, in italics, of its Districts without the actual

48 T56 p. 31 Miss Hawkins
49 T56 p. 21 Miss Hawkins
50 T56 p. 23–4 Miss Hawkins
51 T56 p. 68 Miss Hawkins

authority to affect them directly, because each District had its own Chairman and non-Executive Board who actually managed the Districts.

'So it was a situation where you had accountability and responsibility without true authority.'[52]

55 Continuing on the issue of the control the Region had over the DHAs, Miss Hawkins was asked whether these reviews were *of* the district or *with* the district:

'It was a situation where, when I came into office in 1984, we were tasked by the then Minister to take control of our Districts who were perceived not to be performing as well as could be expected and that Region needed to get a grip on things.

'… I was a very strong executive and although we did not have direct control of Districts, they did feel accountable to us. That was partly style and partly the fact that I had a good team at Regional level who were in a position where they could challenge and naturally take things forward with their counterparts at District level.'[53]

56 Dr Pitman explained the position of the RGM within the RHA as follows:

'The RGM was the … head of the officers of the RHA, but there was also a Health Authority with a Chair. The regional team of officers were the executive officers and the lay members, who may have been drawn from clinical specialties as well as from other groups, where the non-executive directors intersect. Together they form the Health Authority.

'The Regional General Manager had a number of departments with the equivalent of directors at the head of them. One of them was community medicine or public health medicine, which also included pharmacy and dental advice, and the Regional Scientific Officer, who administered the scientific equipment budget for the Region, and that was things like linear accelerators, radiotherapy, and the larger pieces of investigational equipment, some of the catheterisation equipment.'[54]

57 In addition to the departments of Community Medicine (latterly called Public Health Medicine), Capital Planning, Service Planning, Finance and Human Resources, was the Works Department, which was linked to Capital Planning. The Service Planning Department and the Finance Department were also closely affiliated.[55]

58 With respect to the Public Health Department, the RMO delegated his function by allocating responsibilities to cover different areas, depending on how many people

52 T56 p. 22 Miss Hawkins
53 T56 p. 24 Miss Hawkins
54 T58 p. 6 Dr Pitman
55 T58 p. 7 Dr Pitman

he had in the department, to the public health consultants and also to the other professional staff. Any one particular person would not be involved with a particular area all the time, but would do some of the routine work and due to their general involvement would be the first person to be called upon if something needed to be done. It was a question of delegation by the RMO.[56]

59 The number of areas any one individual had to keep a watch on varied from year to year, depending on what the priorities were and how many other consultants there were in the department. Dr Pitman was the only consultant in the department for 'substantial periods of time', at other times there were as many as three. Between them they looked after approximately 25 different specialties, not all of which would be active at the same time. Sometimes, four or five specialties would be involved in respect of the same medical discipline, such as was the case with cardiac surgery.[57]

60 The role of the RGM was mainly strategic, concerned with financial allocation and overseeing general performance, rather than the specifics of any one particular individual service, such as cardiac surgery.[58] In order to put this strategy-forming function into effect, the RHA used a committee structure.

The Regional Hospital Medical Advisory Committee (RHMAC)

61 The role of the RHMAC was to support the RHA in its strategic function. Its function was primarily reactive, responding to specific enquiries from the RHA for expert specialist knowledge. This specialist knowledge would come from the RHMAC's sub-committees, which would be commissioned to advise on a specific matter. This advice was then included in the RHMAC's reports and recommendations submitted back to the Region.

62 Prior to 1984, SWRHA had an RHMAC that dealt with a mixture of both primary and secondary services. This committee was then split, so that the secondary (hospital) services were separated from community services, allowing GPs to become more involved in the actual development of primary care. The remaining secondary hospital services side of the committee became the new RHMAC,[59] which became a key link between the RHA and the profession.[60]

56 T58 p. 7–8 Dr Pitman
57 T58 p. 8 Dr Pitman
58 T56 p. 47 Miss Hawkins
59 T56 p. 52 Miss Hawkins
60 T58 p. 8–9 Dr Pitman

63 Miss Hawkins explained:

> 'We revamped the Regional Medical Advisory Committee so that it had representatives from every District serving on it, as well as the Regional Medical Officer, and I was a member, at that time, for the decision-making meetings.
>
> 'Each time we [the Regional Health Authority] needed to look at acute or other services, then the subject was given to the Regional Hospital Medical Advisory Committee who would form a sub-committee for the specialty under review, and they would put together a strategic outline of the services that were under review. They would take it back to the main committee, who would take it to their Districts and when they signed up, it would form the strategic statement for the Region. So all Districts and all the specialty people had been involved in developing the service strategy.'[61]

64 From 1984 onwards, the RHMAC was made up of the chairmen of the various specialties' sub-committees. The membership of the RHMAC was selected from across all the districts within the RHA. The consultants' committee of each district (and later NHS trust) nominated two individuals. The chairman of the RHMAC and the RMO/RDPH then chose the committee from these nominations to ensure there was an equitable spread of specialties represented.[62] Typically there were 20 or so consultants chosen to make up the committee. Mr David McCoy noted that there was no specific consultant for cardiac surgery on the RHMAC while he was chairman.[63] From 1991 the DHAs were purchasing authorities which did not employ clinical consultants so were not represented on the RHMAC, but there was always a district public health physician in attendance who could give a DHA perspective.[64]

65 At the time of the purchaser-provider split, the constitution of the committee changed to trust-nominated medical representatives together with sub-committee chairmen attending as required or on request of the Chair. In addition, a primary care representative was also added.[65]

66 Therefore, the RHMAC membership was mainly provider-based after the split, with a minimal role being played by the DHAs. A representative from the consultants in public health medicine also sat on the RHMAC. Although accountable to the RMO in any event, this assisted the structure and communication by making the Department of Public Health in effect like another sub-committee.

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61 T56 p. 51 Miss Hawkins
62 WIT 0399 0044 Dr Mason
63 WIT 0436 0001; Mr McCoy was chairman of the RHMAC from 1990 to March 1994
64 WIT 0399 0044 Dr Mason
65 T58 p. 9 Dr Pitman

67 The RHMAC produced a number of advisory statements, each of which would take a couple of months to develop. They would be worked on gradually over a number of weeks.[66] Dr Mason, in oral evidence, said:

> 'A major problem in drawing up the RHMAC strategic statements about services was the poor quality of the data about clinical activity. The data collected at regional level once fed back to clinicians had little credibility. Total numbers of discharges and deaths for a speciality in a hospital were reasonably accurate but: … analysis was only by speciality and not individual consultant …'[67]

68 The Cardiac Services Medical Advisory Sub-committee produced a document, *'Cardiac Services within the South West Regional Health Authority – A Strategy for 1988/98'*.[68] This was a document produced by taking advice from, amongst other sources, the RHMAC's sub-committee on cardiac surgery and cardiology. The purpose of the document was to advise the RHMAC and the RMO, and through them the RGM, as to the direction in which they felt, clinically, the Region should be moving.[69]

69 The sub-committee meetings were composed of clinicians from the relevant departments. The cardiac sub-committee meetings, for example, included cardiac surgeons, cardiologists and radiologists. It was concerned with heart disease of all types. In addition, there was the paediatric sub-committee which considered matters specific to children.

70 The cardiac service sub-committee was supported by Dr Pitman. The RHMAC strategic statement on cardiac services was published in November 1989.

71 The Chairman and the RMO/RDPH instigated all the work of the RHMAC, and the Committee responded to any requests for specific advice from the RHA or RGM.[70] The RHMAC meetings were held monthly. The discussions held were to review and advise on papers provided by the RMO/RDPH and reports provided by the sub-committees.[71] The RMO/RDPH subsequently presented the minutes of the meetings to the RHA meetings.

72 The RHMAC was purely advisory and had no executive or budgetary authority. The aim was to advise and review the present hospital situation in the Region and to advise on future new hospital developments, e.g. new buildings or departments, appointment of consultants or other hospital medical staff.[72] The advice given was generalised in nature, based on facts and figures provided by the RHA, e.g. length of

66 T58 p. 10 Dr Pitman
67 WIT 0399 0003 Dr Mason
68 UBHT 0156 0255; *'Cardiac Services within the South West Regional Health Authority – A Strategy for 1988/98'*, 29 September 1988
69 T58 p. 60 Dr Pitman
70 WIT 0399 0044 Dr Mason
71 WIT 0436 0001 Mr McCoy
72 WIT 0436 0001 – 0002 Mr McCoy

waiting lists, patient throughput, and shortages in staff and facilities. The Committee had no special knowledge of the quality of the service given.[73]

73 In order to advise the RHA in its strategic planning role, the RHMAC produced 29 strategic statements about clinical specialties or services, which were published in five documents between November 1989 and July 1991. Each sub-committee produced a report to the RHMAC, supported by one of the Regional public health specialists. The RHMAC then discussed the report and prepared a summary in a standard form. This was then sent back to the sub-committee for its approval prior to being submitted to the SWRHA.[74]

74 None of the individual RHMAC statements were formally endorsed by the SWRHA at the time they were presented until December 1992, when the Regional Strategic Framework, which incorporated edited versions of the statements, was formally adopted.[75]

Other channels of communication within the Regional Health Authority

75 Miss Hawkins explained that the Regional Team Officer meetings were attended by the senior management team: the RGM, the Finance Director, the Medical Officer, the Human Resources Director, the Capital Planner and the Service Planner.[76]

76 The channels of communication within the RHA were described by Dr Pitman as follows:

> 'The RMO would have met regularly with the other heads of department and Catherine Hawkins, and would have relayed back information from those meetings which was relevant in his or her eyes to individuals within the department. There was not, as far as I remember, a regular meeting within the Public Health Department of everybody involved, but there would have been 1 to 1 meetings or 1 to 2 or 3 meetings at fairly regular intervals around specific topics.
>
> 'Across the Regional Health Authority there were groups called the Capital Planning Group which would look at capital investment, and the Service Planning Group, and some of the letters which you have involve some of those managers who were involved in organising those and they would have asked relevant people within public health to come for specific items or to come for the whole meeting, depending on what was being discussed.
>
> 'So there was quite a lot of horizontal communication, but most of the vertical communication, practically all of it, was through the head of department at my level.'[77]

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73 WIT 0436 0002 Mr McCoy
74 WIT 0399 0002 Dr Mason
75 WIT 0399 0002 Dr Mason
76 T56 p. 78 Miss Hawkins
77 T58 p. 88–9 Dr Pitman

77 Miss Hawkins described the RMO as having had oversight of the Avon districts as part of the duties assigned to them.[78] She further explained:

> 'The situation was, as RGM in a very big Region and a very large budget in the billions, there was no way that I could have a dialogue with DGMs or important officers on every single occasion. There was also in my mind the fact that every now and again one would have to be quite rigorous with the DGMs in order to achieve the change of style and that could be more than confrontational in the early stages and was something to try and be avoided and to come in as the reinforcer and not the enforcer.
>
> 'So I set up a system where I had four major officers at Regional level: the Finance Officer, the Human Resources Officer, the DMO and the Capital Planner. So each one of those was assigned basic responsibilities overseeing certain Districts. The RMO was assigned the Avon Districts: Frenchay, Southmead, Bristol & Weston, because Southmead and the BRI were teaching hospitals and there was a lot of University liaison and medical teaching.
>
> 'So that the RMO could be the first point of contact by a DGM who would say, "We would like to do X", or "We do not want to do Y", "What will the RHA make of it?", "What will Catherine do?", or "We have a problem up there, come back and let me know and we can get together with Catherine and the team and try and sort something out".
>
> 'So, they were the first point of contact and had the first oversight of the District: anything of importance, they were supposed to come and keep me informed, not for me to dabble in it unless they needed that assistance, but to deal with things; to prepare a District for the review, give us feedback for the departmental reviews. So the RMO had oversight of Avon.'[79]

78 So the RMO would have more direct information and would have that information sooner, before it had been filtered through to the RGM. That was, unless the matter was so serious that a DGM brought it straight to the RGM.[80] Dr Mason said that the number of consultants and the distances to be travelled in the South West made keeping in close touch difficult.[81]

79 The post of RMO/RDPH was accountable to the RGM. The major role of the RMO at Regional level was in planning matters.[82] The core responsibilities of the post were:

- ensuring that the RHA obtained the best medical advice, particularly its strategic planning role;

78 WIT 0091 0001 Miss Hawkins
79 T56 p. 118–19 Miss Hawkins
80 T56 p. 119 Miss Hawkins
81 WIT 0399 0044 Dr Mason
82 WIT 0399 0044 Dr Mason

- ensuring the effective functioning of the district public health departments and reporting annually on the state of the public health in the Region; and
- implementing the procedures for clinical complaints against hospital doctors.[83]

80 In addition, the RMO/RDPH was also made responsible for the development of medical/clinical audit (1989–1993), the development of clinical computing and information (1988–1993), and for liaison with the Bristol districts (1988–1991).[84]

81 The RMO/RDPH had three formal mechanisms for obtaining medical views and opinions:

- He was the secretary of the RHMAC, which met monthly. It had over 20 specialist sub-committees that met periodically.
- He was also secretary of the RPCMAC, which also met monthly.
- He was also the Chairman of the Directors of Public Health Forum.[85]

82 The RMO/RDPH and these advisory committees were responsible for advising the RHMAC on what they considered should happen, and then it was the function of general management and later performance management to be responsible for ensuring that policy was carried out and the targets were achieved.[86]

83 In addition, informal medical advice came through general networking with doctors throughout the Region,[87] attending scientific meetings of particular specialty groups and visiting hospitals, particularly in respect of implementation of proposals concerning junior doctors' hours and quality of care initiatives.[88]

84 Until the trusts were set up in April 1991, the RMO was responsible to the RGM for liaison with the three Bristol health districts. This involved, where possible, a quarterly contact with the DGMs and assistance to the RGM in preparation of the annual review of the districts' performance.[89]

85 Dr Mason noted that this approach worked well with Frenchay and Southmead, but he was not able to meet Dr John Roylance,[90] District General Manager of the B&WDHA from 1985, as often as he would have liked.[91] He explained that Dr Roylance preferred to deal with general managers rather than medical advisors.

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83 WIT 0399 0001 Dr Mason
84 WIT 0399 0001 Dr Mason
85 WIT 0399 0001 Dr Mason
86 WIT 0399 0043 Dr Mason
87 WIT 0399 0001 Dr Mason
88 WIT 0399 0043 Dr Mason
89 WIT 0399 0003 Dr Mason
90 Dr Roylance was appointed DGM of B&WDHA from 1 February 1985 and held the office until 31 March 1991. On 1 April 1991 he became Chief Executive of UBHT, until his retirement on 21 October 1995
91 WIT 0399 0003 Dr Mason

If he had any major issue he would discuss it with the RGM direct. Dr Mason said that he did not press for meetings, knowing that Dr Roylance was reluctant and that Dr Roylance communicated regularly with Miss Hawkins.[92]

86 Miss Hawkins had frequent informal meetings with Dr Roylance. This was facilitated by the proximity of the two organisations:

> ' … he and I met informally on several occasions …. The Region was in Kings Square House. The BRI was literally 100 yards away.'[93]

87 The powers that the RHA had previously exercised also changed in other ways once trust status was conferred on the UBHT:

> ' … the control of trusts went directly to the Department, so Region was not involved. Region continued to oversee the non-trust units and the Department had a section which managed or had direct contact with trust status units.'[94]

88 Dr Pitman noted:

> 'In the early 1990s the role of the Regional Health Authority in the trusts was diminishing with the setting up of Department of Health Regional Outposts for the performance management of trusts directly responsible to the Department of Health.'[95]

89 The SWRHA merged with part of the old Wessex Region in 1994, almost doubling the population it covered to six million. This was now the S&WRHA. The employees from both regional authorities were 'slotted in' with each other.[96]

90 From 1 April 1996 the S&WRHA was abolished, and the South and West Regional Office of the NHS Executive was created.[97]

91 The role of the regional office of the NHS Executive (NHSE) was different from that of the old RHA. It was staffed by civil servants who were ultimately responsible, via a number of tiers of management, to the Secretary of State.[98]

92 The setting up of regional outposts of the NHSME was announced in January 1992, and they became active from 1 April 1992.[99] Their function was to performance-manage the trusts, being separate from the health authorities and directly responsible to the Secretary of State. The regional outposts were established 'in order to carry out

92 WIT 0399 0046 Dr Mason
93 T56 p. 94 Miss Hawkins
94 T56 p. 12 Miss Hawkins
95 WIT 0317 0004 Dr Pitman
96 T58 p. 14 Dr Pitman
97 T58 p. 14–15 Dr Pitman
98 T58 p. 15–16 Dr Pitman
99 Edwards B. *'The National Health Service 1946–1994: A Manager's Tale'* (1995), Nuffield Provincial Hospitals Trust

financial monitoring and to undertake appraisal of strategic capital investment on behalf of the NHS Management Executive to whom the NHS Trusts reported'. Also, according to Roger Hoyle[100], it was to 'co-ordinate with Regional Health Authorities and the Management Executive proposals for capital investment by Trusts through the use of commercial-type investment appraisal.' The liaison between the regional outposts and the RHA was seen as having a fairly low profile as far as Dr Pitman (and others) was concerned, because they contained no medical advisory staff. Their boundaries were not the same as the Region, but the regional outpost that the SWRHA dealt with was the one based in Bristol.[101] The regional outposts were abolished in 1996 and their performance-monitoring function was absorbed into the NHSME regional offices.

The Bristol & Weston District Health Authority (B&WDHA)

93 In 1982 the B&WDHA consisted of 22 hospitals, 12 health centres and eight clinics, divided up for management purposes into seven units. The BRI was included in the Central Unit and the BRHSC was included in the Children's and Obstetric Unit. The other units were the South Unit, Weston Unit, Winford Orthopaedic Hospital, Mental Illness Services and the Mental Handicap Service.[102]

94 The management structure of the B&WDHA that had existed prior to 1984 continued in place until the introduction of general management during 1985. There was a separate managerial hierarchy for each individual group of staff, so the professional, technical and administrative staff all had their own management trees.[103]

95 The consultants, on the other hand, were all viewed as equals and 'occupied what can best be described as a managerial plateau'.[104] Each consultant was a member of the Hospital Medical Committee (HMC). The HMC was supported by its Steering Committee, which was a smaller elected medical executive committee, and was also supported by the specialist divisions. The Steering Committee would act as a general steering group reporting to the HMC as a whole, and the specialist divisions comprised the medical advisory function reporting to the HMC.[105]

96 Each of the units within the B&WDHA contained its own management group made up of a unit administrator, a doctor and a nurse. These groups were accountable to the District Management Team, which included in its membership the District Administrator, the District Finance Officer, the Chief Nursing Officer, the District Medical Officer, the Chairman of the HMC, a general practitioner and a representative from the University of Bristol. Each unit management group managed by consensus, wherein decisions could only be made with the agreement of all members of the

100 WIT 0497 0001; Roger Hoyle was the Executive Director of the Regional Outpost of the NHS Management Executive responsible for monitoring NHS trusts in the former South Western and Wessex Regional Health Authority areas, from 1 April 1990 to June 1994
101 T58 p. 16 Dr Pitman
102 HAA 0130 0019 – 0021; draft consultative district operational and forward programmes 1983–1985 *'Your future health care – our concern'*, produced by the B&WDHA in July 1982
103 This includes the nursing management and the professions allied to medicine, e.g. pharmacists and physiotherapists
104 WIT 0108 0004 Dr Roylance
105 WIT 0108 0004 Dr Roylance

group. This gave each member of the group the ability to exercise an individual veto over any decision. Of the District Management Team, the District Administrator[106] managed all the District's administrative staff and services, the Finance Officer managed all the finance staff, and the Chief Nurse managed all the nurses, but the consultant member (the Chairman of the HMC) and the general practitioner member acted in a representative capacity only, expressing the opinions of their colleagues.[107]

97 When required, professional advice was received by the District Management Team, in particular by the Chairman of the HMC, and the District Medical Officer (DMO).[108] For example, Dr Stephen Jordan and Dr Hyam Joffe, consultant paediatric cardiologists, gave professional advice on cardiological services, and Mr James Wisheart, consultant cardiac surgeon, advised on surgical services at the BRI and BRHSC.

98 The first major change at district level occurred following the publication of a DHSS Health Circular[109] in 1984, which required health authorities to appoint a general manager. This was in response to the Griffiths Report,[110] which had been published the previous year and recommended changes in the management structures of the NHS.

99 In January 1985 B&WDHA complied with this requirement with the appointment of a DGM,[111] and required him to produce a management structure for the DHA by 30 April 1985,[112] to be approved by the B&WDHA and subsequently submitted to the SWRHA. According to Dr Ian Baker, Consultant in Public Health Medicine, this proposal[113] put the DGM as 'directly and visibly responsible'[114] for the management of the district, being directly accountable to the DHA. He was the overall budget holder and was responsible for the development of policies within the DHA and for monitoring their implementation.

100 Dr Roylance was appointed as the first DGM of the B&WDHA (a post he was to retain until he became Chief Executive of the UBHT in 1991). He explained his main responsibilities on being appointed as follows:

> 'So in 1985, being appointed the first District General Manager, I had two primary responsibilities; there were others, but the two primary responsibilities were to introduce the general management function, by which I mean getting rid of functional management, nurses being managed by nurses, physiotherapists by physiotherapists, administrators by administrators. It could be said at that time

106 Mr V C Harral held this post until it disappeared under general management, when he became Acting General Manager of the South Unit until he retired in March 1986
107 WIT 0108 0004 Dr Roylance
108 WIT 0074 0010 Dr Baker
109 HAA 0164 0004; DHSS Health Circular HC (84) 13
110 Griffiths R. *'NHS Management Inquiry. Report to the Secretary of State for Social Services'* (1983), London: DHSS
111 HAA 0126 0075 – 0084; minutes of the meeting of B&WDHA on 21 January 1985
112 HAA 0126 0084; minutes of the meeting of B&WDHA on 21 January 1985
113 WIT 0074 0424 – 0428 Dr Baker
114 WIT 0074 0425 Dr Baker

when I took up the District General Management role there were about nine different health services in the District coming together only at District level.

'In introducing the general management function, it was expressly required to delegate operational management decisions as near to the bedside as possible.'[115]

101 He explained further what general management was intended to address:

'Until this form of management was introduced, the exercise of clinical freedom, I regret to say, was entirely independent of resources and that management, up until that point, had to use quite crude measures to try and prevent the major overspending of a service, things like closing operating theatres, closing wards, so it was not possible to overspend, because there was a complete separation of the exercise of clinical freedom from the responsibility of staying within budget.'[116]

102 After the introduction of general management and the replacement of the old consensus management system, the hospital and community services were restructured. The structure of the B&WDHA changed in that the seven different units that had existed before were now rationalised into two: the Central Unit and the South Unit. The Central Unit comprised six sub units and the South Unit five sub units. The BRI Sub Unit and the Children's and Maternity Sub Unit were both contained within the former.[117]

103 All the professional, technical and administrative staff were amalgamated into this unit system, with their pre-existing hierarchies remaining only as advisory structures for the general managers. The consultant staff retained their advisory structure and their clinical independence.[118]

104 Due to problems of size and the wide area that they covered, each of the two units had a unit general manager who was directly accountable to the DGM.[119] They assisted the DGM in co-ordinating, planning and monitoring the performance of the sub units. Each of the 11 sub units also had their own general managers.[120]

105 In addition to these there were also the following officers, all of whom were directly accountable to the DGM:[121] two assistant district general managers (ADGMs), who were managerially accountable to the DGM but had direct access to the B&WDHA on matters of their respective professional responsibilities; and an ADGM (Information), who carried on the service planning role of the previous post of DMO

115 T24 p. 9 Dr Roylance
116 T24 p. 24 Dr Roylance
117 WIT 0108 0004 – 0005 Dr Roylance
118 WIT 0108 0005 Dr Roylance
119 The Unit General Manager for the Central Unit was initially Mr John Watson, who was followed in the position by Mrs Margaret Maisey
120 Mrs Marion Stoneham was Sub-Unit General Manager responsible for the BRHSC and the Bristol Maternity Hospital; Miss Janet Gerrish and then Ms Deborah Evans were General Managers with responsibility for the BRI
121 WIT 0038 0058 – 0067 Ms Charlwood

under the pre-existing management structure.[122] This ADGM was accountable via the DGM to the Policy, Planning and Resource Committee for strategic and operational planning.

106 Strategic planning from 1984 addressed the DHSS's guidance contained in the document *'Care in Action',*[123] which set out Government priorities in service planning.[124] The ADGM (Information) developed plans for the priorities adopted by the SWRHA from such Government proposals and submitted them via the DGM to the Policy Planning and Resource Committee.[125] This ADGM's role continued with strategic planning, although Dr Roylance's proposals under general management saw the initial planning process taking place at the sub unit level, with plans then being reviewed, discussed and integrated into a full District Plan.[126]

107 In addition, the role of the ADGM (Information) was that of a director of information, covering such matters as epidemiology, patient-care statistics, systems information and the District computing service, as well as assessing the desires and perceptions of the public.

108 The other of these ADGMs was the District Treasurer, who was responsible for the District Finance Department and the Divisional Supplies Service. He provided professional financial advice to the DGM and to the B&WDHA.

109 There was also a Personnel and Training Manager who reported to the DGM and was responsible for all matters relating to human resources. The Commercial Manager would deal with all the competitive tendering requirements.

110 In addition to the management structure there were four advisory committees which gave professional advice on their particular areas of expertise to the general managers at both unit and district level. These committees were the HMC, the District GP Committee, the Nursing Committee, and the Professional and Technical Staff Committee.

111 The majority of professional advice at district level was channelled through the Chair of the HMC. He was advised by Chairs of the clinical divisions. There was a division for paediatric services and one for surgical services.[127] It was through this structure of clinical divisions that the medical staff had direct involvement in the management of services.

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122 Dr Baker was the DMO at the B&WDHA, and continued as the ADGM (Information) when the post was created in July 1985 until October 1991

123 DHSS. *'Care in Action – A Handbook of Policies and Priorities for the Health and Personal Social Service in England'* (1981), London: HMSO; WIT 0074 0081 – 0140

124 WIT 0074 0004 Dr Baker

125 WIT 0074 0004 Dr Baker

126 WIT 0074 0010 Dr Baker

127 WIT 0074 0010, 0424 Dr Baker

112 There were also two free-standing committees that reported directly to the DHA. They had no executive functions, but discussed and developed policies independently to be presented to the DHA meetings. These were the Finance Committee and the Policy, Planning and Resource Committee.

113 Two further committees were added in 1985: the Performance Assessment Committee[128] and the Research and Education Committee. In 1986 the Finance Committee was expanded to become the Finance, Property and Computing Committee.

114 The basic structure of the DHA otherwise remained unchanged until the start of the transitional period to the separation of the purchaser and provider functions in mid-1989, and the creation of the B&DHA in October 1991.

Transition of the Bristol & Weston District Health Authority (B&WDHA) into the Bristol & District Health Authority (B&DHA)

115 In 1989 the Government White Paper *'Working for Patients'* was published.[129] This proposed the creation of an internal market in the NHS through the separation of purchaser and provider responsibilities. It recommended the establishment of self-governing NHS trusts and GP fundholders, with funding being allocated to the purchasers (DHAs and fundholders) rather than to the providers. The philosophy behind these changes was that the internal market would arise due to funding following the patient, rather than being granted as a fixed budget from the health authority. In addition, management arrangements were altered at local level, re-organising health authorities along business lines.

116 Dr Baker explained:

> 'In 1990 the SWRHA issued Planning and Review Principles for 1991 onwards[130] and guidelines[131] to accompany the separation of the purchaser and provider functions within the NHS. This change meant that B&WHA was required to plan for the needs of its own population and commission services to meet these needs within its own resource allocation.'[132]

117 From mid-1989 the DGM and the Board of the B&WDHA produced and reviewed the proposals for the changes in the management structure. Two new committees were set up and remained in existence between 1989 and 1991, the Purchaser Committee and the Bristol Provider Committee, which dealt with the planning of both halves of the split. The proposals for the split were submitted to the RGM of the SWRHA at the end of August 1990.[133] The relevant legislation took effect on 1 April 1991, at which point

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128 For details of the functions of the Performance Assessment Committee, see Chapter 18
129 Department of Health. '*Working for Patients*' (1989) (Cm 555)
130 HAA 0066 0003; minutes of the SWRHA RGM/General Managers meeting on 7 March 1990
131 WIT 0074 0385 Dr Baker
132 WIT 0074 0005 Dr Baker
133 HAA 0047 0020 – 0022; letter from Dr Roylance to Miss Hawkins dated 31 August 1990

the UBHT officially came into existence. The new Chief Executive of the UBHT[134] had been appointed in December 1990 in anticipation of the changes that were to take place. The B&WDHA continued in existence until 1 October 1991, when it officially became the B&DHA. However, by this time all its pre-existing provider functions had been delegated to the UBHT and it was left with its residual purchaser-based roles and responsibilities.

118 In 1990 the executive managers were also divided into those in the District purchaser unit and those in the provider unit. The post of District Medical Officer/Assistant District General Manager (Information) became the Director of Public Health Medicine,[135] and was linked to the purchaser unit. The main responsibilities became those of strategic planning and advice for the commissioning of services for, amongst others, cardiac services.[136]

119 The purchaser unit also had a Director of Health Development and Appraisals, as well as a Director of Finance and a Director of Quality and Monitoring.[137] The Director of Finance, Mr Anthony Parr, initially led the purchaser unit. Mr Parr left the District in early 1991, when the Director of Public Health Medicine became Acting District General Manager until October 1991, and the District was merged with the other DHA to form the B&DHA.[138]

120 The management structure in the DHA from April 1991 no longer had a need for the units and sub units that had existed previously. The DGM[139] now had six main officers reporting to him. Two of these centred on finance, one being the District Treasurer and the other being the Director of Contracting. In addition, there was the Consultant in Public Health Medicine,[140] the Consultant in Communicable Disease Control, the Policy and Planning Analyst and the Senior Planning Officer.

121 The B&DHA also retained a committee advisory structure and had a number of committees that advised on matters within their own particular areas of expertise. These were the Health Policy Committee, the Health Information Committee, the Finance and Contracting Committee, and the External Relations and Personnel Committee.

122 The B&DHA came to an end when it formally merged with the Avon FHSA on 1 April 1996, to become the Avon Health Authority (Avon HA). This was a result of legislation[141] to effect the merger of all the DHAs and FHSAs. The same legislation also abolished the SWRHA. In its place was created the South and West Regional Office of the NHSE.

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134 Dr Roylance
135 Dr Baker continued in this post throughout the period of the Inquiry's Terms of Reference
136 WIT 0074 0005 Dr Baker
137 The titles of offices changed as the purchaser unit evolved – HAA 0047 0020; cf. HAA 0144 0027
138 WIT 0074 0011 Dr Baker
139 Dr Baker was Acting DGM until 1 October 1991
140 Dr Baker's permanent role
141 The Health Authorities Act 1995

123 In effect, the Avon HA inherited the planning, purchasing and commissioning role of the B&DHA (which in turn had formerly been enjoyed by the B&WDHA) and the Avon FHSA. The South and West Regional Office of the NHSE inherited some of the functions and responsibilities of the SWRHA. The provider functions that had devolved to the trusts in April 1991 remained vested in the UBHT.

124 From its creation in October 1991 the B&DHA continued with a strategic planning function and set up a planning group, 'the Strategic Cell', to develop a framework which was responsive to national and regional requirements, and assessments of local needs and local service responses. Dr Baker led this group and it was within this framework that the purchasing function of commissioning and contracting for individual services took place.[142] Dr Baker told the Inquiry:

> 'I used a planning and advisory network of clinicians, GPs, Clinical and Associate Directors, General Managers and others in NHS Trusts, Local Authorities, and the University with which I worked ... A similar network covered my support function to the commissioning managers of the Health Authority in developing specifications and, negotiating annually, service contracts.'[143]

Provider functions taken on by the UBHT

125 The transition to the purchaser-provider split involved two years of preparation before the establishment of trust status, and in this time there were a number of further management changes. Twelve clinical directorates were created, each managed by a clinical director, who was a consultant, and a general manager. Dr Roylance explained that the larger directorates were further split into associate directorates, with associate clinical directors and associate general managers.[144] He told the Inquiry:

> 'The aim was for the Clinical Director to be "in charge of" the doctors and for the General Manager to be responsible for everyone else, and to ensure that the necessary administration and support services were in place for the directorate to run efficiently. In the discussions which took place before this change it was agreed that the most appropriate way forward would be to view the Clinical Director and General Manager as being in a managerial "bubble", jointly sharing the managerial responsibilities; thus, neither was directly responsible to or for the other. These two were assisted in their management roles by the chief nurse of the unit, a directorate personnel officer and a senior member of the Finance Department.
>
> 'The only other level in the management was that at operational level with ward sisters or their equivalents taking full responsibility for wards or their Units.'[145]

142 WIT 0074 0005 Dr Baker
143 WIT 0074 0005 Dr Baker
144 WIT 0108 0006 Dr Roylance
145 WIT 0108 0006 – 0007 Dr Roylance

126 Dr Roylance explained the transition period further in his oral evidence:

> ' … before we had completed the introduction of General Management, it was decided to add to it the purchaser/provider split, and by 1989 we were beginning to introduce shadow contracts or work agreements, service agreements, and we were endeavouring to flex the management in a way that responded to that new requirement. It was also a way of endeavouring for the first time to bring the consultant body within the general management function, so it was partly the continued evolution of General Management, I think it is fair to say precipitated by the new thinking of purchaser/provider split.'[146]

127 It was the responsibility of the DGM in 1991 to divide the District into a continuing DHA purchasing authority, and into trust provider units for the Bristol and Weston parts of the District.[147]

128 Originally, it was the intention that the general manager would support and be directly accountable to the clinical director,[148] but this view changed and they were both enclosed in what Dr Roylance described as a 'managerial bubble',[149] running the directorate in a joint capacity.

129 Eventually it was clear that their roles were that the clinical director took the final responsibility for policy within the directorate and the general manager took responsibility for effectively implementing management policy. So the 'managerial bubble' evolved with the clinical director reporting to the DGM pre-trust status, and the chief executive afterwards, and the general manager of the directorate reporting to the clinical director. This happened over a broad period of time, according to Dr Roylance, some time between 1990 and the time he retired in 1995, with each directorate evolving at a different rate.[150]

130 The new management arrangements were such that clinical directors led the services and held the budgets. The clinical directors negotiated, signed and implemented contracts for services from the purchaser authorities, and were responsible for turning these contracts into the policies and programmes for their directorate. The general managers supported the clinical directors in the implementation of these programmes, and were accountable to, and supported by, the Central Unit's Director of Operations.[151] The general managers provided the whole of the management function in implementing these contracts and managing the budgets. After the introduction of trust status, the general managers and clinical directors were accountable individually to the chief executive and, ultimately, to the Trust Board.[152]

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146 T24 p. 45 Dr Roylance
147 WIT 0108 0005 Dr Roylance
148 HAA 0047 0021; letter from Dr Roylance to Miss Hawkins dated 31 August 1990
149 The 'managerial bubble' is discussed in detail in Chapter 8
150 T24 p. 57 Dr Roylance
151 Mrs Margaret Maisey
152 WIT 0170 0004 Ms Orchard

131 Dr Roylance explained that initially the Director of Operations met on a monthly basis with the general managers to give them managerial support in the evolution of their roles.[153] The clinical directors reported to monthly meetings of what became the UBHT's Management Board, which after a few months became chaired by the Chief Executive[154] of the Trust.[155]

132 Dr Baker explained that, in the Central Unit, the Clinical Director for Children's Services was Dr Joffe and the Clinical Director for Surgery was Mr Roger Baird, whose directorate contained the Associate Directorate of Cardiothoracic Surgery headed by Mr Wisheart.[156]

133 This arrangement continued after the changes of 1991 and the purchaser-provider split, and the above people continued in their posts.

134 The changes led to an alteration in the management role of the medical staff. From 1985 onwards, medical staff had been involved in the management of services through the clinical divisions structure. From 1990 medical staff who became clinical directors or associate clinical directors were in a position to negotiate changes in services through planning or contracting. General managers working alongside clinical directors and associate clinical directors had a supportive role and had influence in particular on non-medical staff within services.[157] Dr Baker told the Inquiry:

> 'This system of management was conceived to give doctors lead responsibilities with back-up from those with general management experience and skills. This system was reflected at all levels in the District (and later UBHT). The system was headed by a District General Manager and later UBHT Chief Executive John Roylance, who was himself a doctor.'[158]

135 The clinical directorate structure adopted before the formal purchaser-provider split continued in place within the UBHT, with each directorate being led by its own clinical director. Some of the larger directorates contained a number of smaller associate directorates, each with their own associate director. The Directorate of Surgery[159] contained the Associate Directorate of Cardiothoracic Surgery,[160] covering both adult and paediatric cardiac surgery at the BRI and the BRHSC.

136 The system of clinical divisions was retained after the purchaser-provider split, although not all of the specialty groups retained them in full or in some cases at all,

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153 T24 p. 59–60 Dr Roylance
154 Dr Roylance became the first Chief Executive of the UBHT, officially from 1 April 1991
155 T24 p. 61 Dr Roylance
156 WIT 0074 0010 Dr Baker
157 WIT 0074 0011 Dr Baker
158 WIT 0074 0011 Dr Baker
159 Mr Baird was Clinical Director for Surgery until November 1993, when Mr Patrick Smith succeeded him. See UBHT 0081 0131
160 Mr Wisheart was Associate Clinical Director for Cardiac Surgery until 1992, and was succeeded in this post by Mr Dhasmana, who held it until 1995

and their functions were altered. The clinical directorates were made responsible for organising the services which the specialty provided and for the contract-making process, but, as Dr Trevor Thomas, consultant anaesthetist, explained:

> '… it was perceived that that was only part of the activity and responsibility of specialty groups, and that there was a continuing need for, if I may call it a professional network which addressed problems of education, interfacing with Royal Colleges, and the like.
>
> 'So, for some time, and indeed, in some instances there is still a divisional system within some specialties. Some specialties, I know, felt that that was inappropriate and did away with their divisional structure very early on…'[161]

137 Thus, Dr Thomas told the Inquiry that the divisional structure continued in existence in certain specialties after the purchaser-provider split and was still in place in 1995.[162]

Targets

138 Targets, typically financial or clinical, were set for the services by the RHAs and imposed on the hospitals through the DHAs. The B&WDHA was subject to targets set by the SWRHA and was constrained by the policies of the RHA in what it could or could not do.

139 Dr Pitman explained that the Region held the budget for any significant development of a major Region-wide service, and the District would not embark on such a development without specific support from the Region. There would have to be discussions with the Regional Finance Officer on cost and expected levels of service.[163] She said:

> 'It would have been a regional team of officers, the Regional Finance Officer and probably the RMO and others who were involved, like the Service Planning Officer, who decided at what level they should be encouraging the District, and Districts at that time were encouraging their units to hit those targets or guidelines.'[164]

140 If the targets set for operations were not met, the Region was involved further. It addressed the matter in reviews to discuss ways in which the targets were to be met in future.

141 Policy flowed down from the DHSS to Region to District to the hospitals that provided the service. For example, in 1984 there was a view at Ministerial level that it would benefit patients to be treated locally and not travel across regional boundaries, and

161 T62 p. 75–6 Dr Thomas
162 T62 p. 76 Dr Thomas
163 T58 p. 29 Dr Pitman
164 T58 p. 30 Dr Pitman

also that a greater case throughput led to more experience which in turn led to greater expertise and therefore better outcomes. It was at the April 1984 meeting between the SWRHA and the DoH, that a desire to increase the cardiac surgery caseload, for both adult and paediatric cases, to 600 per annum at the BRI was expressed on behalf of the Minister.[165]

The relationship between district health authorities and the UBH and UBHT

142 Prior to the separation of the purchaser and provider functions in the period up to 1991, the B&WDHA imposed obligations by way of resource allocation mechanisms, planning processes and contracts of employment. In the two years prior to the creation of trusts, the necessary changes to systems and structures that were being implemented in shadow form included the development of contracts as part of an ongoing process. These were not legally binding contracts, but took the form of service agreements which were created and refined 'so that by the time the Trust was created there was considerable experience and expertise in the development of continuation budgets'.[166] The changes in management had also been introduced in advance, 'so that when the Trust was created there was a very smooth transition with no immediate impact on the provision of healthcare'.[167]

143 In areas other than those funded as a supra regional service, the obligations between any of the DHA purchaser units (such as the B&DHA) and the NHS trust provider units (such as the UBHT) after the purchaser-provider split were imposed by the contract system of service provision. According to Pamela Charlwood, Chief Executive of Avon HA from October 1994[168] and Regional General Manager of SWRHA from 1993 to 1994, in initially drafting these contracts, the B&WDHA took advice from three main sources:[169]

- The DoH issued a paper in 1990 which gave initial advice on formulating service specifications, which included reference to quality requirements.
- The NHS Management Executive (NHSME) issued a paper, *'Contracts for Health Services: Operating Contracts',* in February 1990.[170]
- The SWRHA set up a Service Contracts Working Party, which presented to the DHAs a report on service contracts, and which mentioned the need to assess outcomes of treatment.[171]

165 UBHT 0102 0434; minutes of meeting April 1984 and T56 p. 32 Miss Hawkins
166 WIT 0108 0016 Dr Roylance
167 WIT 0108 0016 Dr Roylance
168 Then Avon Health Commission – the shadow form of Avon HA
169 WIT 0038 0027 Ms Charlwood
170 Executive Letter EL(90)MB24 *'Contracts for Health Services: Operating Contracts'*
171 HAA 0037 0021; report of the service contracts working party of the South Western Regional Public Health Medicine Sub-Committee dated 4 January 1989

The SWRHA also produced draft contracts for use by the districts.

144 In preparing these contracts, which included those to be used for the provision of cardiac surgical services, B&WDHA received input from its Purchaser Committee, which later divided to create the specialised Contracts, Quality and Monitoring Sub-Committee.

145 The B&WDHA produced the form of contract for cardiac surgery,[172] for use as the service agreement between the purchaser authority and the provider department.[173] This contract included quality criteria and targets in terms of referral rates for different classes of patient and for different procedures, and aimed to provide feedback to the District. It provided for systems of quality assurance to be put in place to 'include elements of quality control, identification of service deficiencies, and mechanisms for correcting and reviewing problems'.[174] Specific sections dealt with the process of medical audit, to include audit of outcome, the medical process and the management process. Separate sections detailed nursing audit and audit of support services, together with monitoring provisions and obligations to report back to the DHA.[175]

146 The contract provided that:

> '15.1 The audit will include audit of outcome, the medical process and the management process. In addition to the statements in this document, the Cardiac Surgery Unit will set up an audit group to meet regularly and to provide the Bristol & Weston Health Authority with sufficient information for it to ensure that adequate audit is taking place.
>
> '15.2 The audit of outcome will include measures of 30 day mortality, one year mortality and one year symptomatic state. Symptom relief assessments to be agreed with the referring cardiologists.
>
> '15.3 The audit of process will include days spent in intensive care, days on a ventilator, units of blood and oxygen used.
>
> '15.4 Audit information will be made available to the Director of Public Health Medicine as the Purchaser's representative. ...'[176]

147 The responsibility for the purchaser-provider contracts passed to the B&DHA in 1991, specifically to the Director of Contracting[177] and the Finance and Contracting Committee. Further service specifications were produced as was a quality/monitoring manual.

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172 For application to cardiac services other than those designated as supra regional, i.e. for adults and children over 1 year of age
173 HAA 0011 0245 – 0252; service agreement dated 14 March 1991
174 HAA 0011 0248; service agreement dated 14 March 1991
175 For details of the audit provisions of these contracts, see Chapter 18
176 HAA 0011 0249; service agreement dated 14 March 1991
177 Ms Deborah Evans was Associate Director, latterly Director, of Contracting for B&WDHA from April 1991, and Director of Contracting for B&DHA from October 1991

148 The reviewing and updating of contracting requirements was an ongoing process during the life of the B&DHA. This included feedback to the Finance and Contracting Committee from the provider units and purchaser-driven reviews of services, which in turn fed back into B&DHA's future purchasing intentions.[178]

149 In January 1992 UBHT and B&DHA had a contract-negotiating meeting to assess contract requirements against performance.[179] A paper was tabled, listing topics for outcomes to be monitored and reported in 1993/94.

150 From May 1992 a report on contract monitoring was given to each board meeting of the B&DHA, where actual activity levels provided would be measured against the contracted activity levels purchased. Any shortfalls would then be reviewed with the SWRHA and addressed with the provider units.[180]

151 The situation by 1995 is summarised by Ms Charlwood:

> '... By 1995 the NHS Management Executive had moved from a policy which required contracts to be monitored for activity, to an approach which required contracts to be monitored for outcomes. In May 1995 the NHSME commended *"Clinical Involvement in Contracting, A Handbook of Good Practice"*.[181] This included checklists, one item of which asked purchasers whether contracting had been informed by clinical audit, and whether that could be demonstrated. It also included a reminder[182] ... that EL(94)20 on clinical audit in 1994/95 and beyond outlined a number of approaches to developing contracts for audit, "but whatever approach is taken it is clear that clinicians have the leading role in developing audit proposals and ensuring that the outcomes of clinical audit are used to inform future contracts". Providers[183] ... should "ensure that there is a shift from the activity and financial focus of existing contracting so that the contracting process is increasingly informed by the clinical audit process; covering issues around good practice, clinical effectiveness and quality of service delivery". Authorities needed to demonstrate that clinical audit had informed the contracting process.'[184]

Staffing and contracts of employment

152 The Personnel/Human Resources Department of B&WDHA[185] was responsible for producing and reviewing job descriptions and the criteria for appointments, as well as for training regimes and patterns of deployment.[186]

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178 WIT 0038 0029 Ms Charlwood
179 WIT 0038 0029 Ms Charlwood; HAA 0003 0021
180 WIT 0038 0029 Ms Charlwood
181 See HAA 0163 0155; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*
182 See HAA 0163 0166; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*
183 See HAA 0163 0171; *'Clinical Involvement in Contracting, A Handbook of Good Practice'*
184 WIT 0038 0030 Ms Charlwood
185 Mr Ian Stone was District Personnel Manager 1982–1985, then District Manpower Manager 1986–1991; from 1 April 1991 he became Director of Personnel at UBHT
186 WIT 0074 0012 Dr Baker

153 Increases in staffing took place in response to the planning requirements of the SWRHA/B&WDHA Project Team and on the basis of advice from the existing medical staff of the District. For the DHA, advice on medical staffing for planning purposes came from the DMO, Dr Baker.

154 Clinicians would raise the need to replace an outgoing consultant or for the appointment of additional staff via the clinical groups and advisory committees. A job description would then be prepared with advice from the relevant Royal College, incorporating contractual requirements as laid down by the DoH. They would then be submitted to the DHA, which would approve the appointments through its Annual Programme processes.[187] The standard of a candidate would be ascertained by examining their qualifications, then a shortlist would be produced of those who were to be interviewed. Formal appointments advisory committees, which included clinical representatives and representation by the relevant Royal College, conducted the interviews.

155 Control of the number of medical staff posts overall was exercised by the DHSS/DoH via the RHAs. Approval for new and replacement posts had to be sought from the regional manpower committees.[188]

156 The Regional Manpower Committee was an advisory committee of the SWRHA. The RMO advised the Regional Manpower Committee on national and regional medical manpower planning requirements. The Committee had to pre-approve any appointments, bearing in mind DHSS/DoH manpower planning requirements, before forwarding the prospective appointment to the Central Committee of the DHSS for its approval.[189]

157 Criteria and procedures for appointments of consultants were laid down by HC(82)10[190] and HC(90)19.[191] These Health Circulars advised on the composition and procedures of the Advisory Appointments Committee, which made recommendations to the DHAs for the appointment of consultant staff. Dr Baker explained that the DHA could accept or reject these recommendations, but they were usually accepted.[192]

158 As B&WDHA was a teaching district, it recruited consultant medical staff and held their contracts of employment. In non-teaching districts, the SWRHA held the contracts of employment. The role of the DHA therefore embraced ensuring competent staff were recruited and that there was sufficient provision within the contract of employment to maintain the standard of service, for example by training and study leave requirements.

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187 WIT 0038 0025 Ms Charlwood
188 WIT 0074 0012 Dr Baker; T36 p. 42; T30 p. 47–9
189 WIT 0074 0013 Dr Baker
190 HAA 0164 0375 – 0384; Health Circular HC(82)10
191 HAA 0164 0385 – 0387; Health Circular HC(90)19
192 WIT 0074 0012 Dr Baker

159 With regard to who held the contracts of the consultants at the hospitals, Miss Hawkins explained that the RHA would not be able to suspend a consultant directly:

> 'We held the contracts for all consultants except those in the Teaching Authority. They [the Teaching Authority] held theirs, so that was why we would have to have had the dialogue with the Chairman, the Vice-Chairman, even the DHA itself with the RHA to tell them of the problems, to involve them and to get them to suspend operations.'[193]

160 Senior registrars were employed by the SWRHA. Responsibility for their appointment lay with the Regional Committee in Specialist Training (RCST), which applied the criteria and procedures set out in HC(82)10.[194] The RCST was also an advisory committee of the SWRHA, reporting through, and accountable to, the RMO and his staff. The Medical Post-Graduate Dean was appointed to the RCST jointly by the SWRHA and the University, in order to take account of the national and regional policy for medical education and training. Dr Baker explained that the RCST was supported by a number of specialty sub-committees; for example, the Sub-Committee for Medical Specialties covered training in cardiology and the Sub-Committee for Surgery covered training in cardiac surgery.[195]

161 Dr Baker explained that responsibility for the appointment of registrars lay with the DHA between 1984 and April 1989. Thereafter it was transferred to the SWRHA and the RCST, following advice from the DoH.[196] Senior house officer (SHO) posts were subject to a nationally-imposed ceiling and their numbers were regulated by the RCST. This ceiling was lifted by 1995, and SHO posts became the responsibility of the Regional Task Force on Junior Doctors' Hours, chaired by the RMO and advised by the Post-Graduate Dean.[197]

162 The Advisory Appointments Committee assessed the experience of consultants at the time of appointment. Once they were appointed, their training was self-regulating. They were entitled to 30 days' study leave over a three-year period, with expenses paid from a budget held by the DHA. In addition, sabbatical leave could be taken. This was unpaid, although grants were available from various awarding bodies and other sources.[198]

163 Although as a teaching authority the DHA drew up and held the contracts for the consultants, it did not scrutinise the continuing training or study of the consultants employed. Ms Charlwood told the Inquiry:

> 'A standard form of consultant's contract allowed study leave. Job programmes identified time for research and audit, when the latter became an expectation.

193 T56 p. 120 Miss Hawkins
194 HAA 0164 0375 – 0384; Health Circular HC(82)10
195 WIT 0074 0013 Dr Baker
196 HAA 0164 0393; Executive Letter EL(89)P88
197 WIT 0074 0014 Dr Baker
198 WIT 0074 0014 Dr Baker

The [District] Health Authority supported professional self-regulation and development through funding and overall regulation of study and professional leave allocations. Since training and retraining was an individual professional responsibility guided by professional bodies, no Health Authority system supervised training/study or the resulting competencies of individuals.

'After recruitment, the maintaining and monitoring of standards and competence at B&WDHA level was by exception only, in terms of reports of inappropriate professional conduct. The work performance of consultants was largely self-regulated, with oversight by Directors of Clinical Divisions and operational managers. Infrequently, problems, usually about untoward behaviour or attendance, were referred to the District Medical Officer and/or the clinical representatives on the Health Authority.'[199]

[199] WIT 0038 0025 Ms Charlwood

Chapter 6 – Funding and Resources

Introduction

1 The Inquiry received evidence on the way in which paediatric cardiac services were funded in Bristol.

2 The first section of this chapter describes the policies and systems relating to the distribution of funds for healthcare which were in place nationally and regionally, during the period 1984–1995.

3 The second section sets out the way in which monies were distributed and managed within the Bristol hospitals.

4 The third section deals with the funding of paediatric cardiac surgical services in Bristol. It deals first with the contracting process for the over-1s (from 1991 onwards), and then the allocation of funds as a supra regional service for the under-1s, from 1984–1994.

5 The final section of this chapter draws together material received by the Inquiry that showed the impact of resources on clinicians, patients, or parents during the years 1984–1995.

Funding at a national level

6 The account in this section draws, in particular, on a paper commissioned by the Inquiry from Mr Gwyn Bevan[1] entitled, *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol',*[2] the Budget Books of the Bristol and Weston District Health Authority (B&WDHA) 1984–1991, the Budget Books of the United Bristol Hospitals NHS Trust (UBHT) 1991–1995, and statements and documents provided to the Inquiry by Mr Graham Nix, Director of Finance and Deputy Chief Executive of UBHT.

1 Reader in Policy Analysis, Department of Operational Research, London School of Economics
2 INQ 0047 0001; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

The allocation of resources to the Regional Health Authority

The Resource Allocation Working Party (RAWP)

7 From 1977, the allocation of resources to health authorities for hospital and community health services has been based upon methods recommended by the 1976 '*Report of the Resource Allocation Working Party'* (RAWP). The report introduced:

- setting health authority *targets* for revenue based upon the relative estimated needs of their populations;
- setting health authority *targets* for capital, based on the estimated relative needs of their populations, and estimates of the value of capital stock;
- setting the *pace of change* in reconciling health authority allocations to targets, subject to ceilings and floors on gains and losses;
- estimating the *service increment for teaching* (SIFT[3]) rates per student for undergraduates studying medicine and dentistry;
- making extra allowances for higher costs of employment in areas such as London (London Weighting).[4]

The overriding principle of RAWP was to provide an equitable pattern of resource allocation that would lead to equality of access to healthcare throughout the country.[5]

The distribution of healthcare funds to the regional health authorities

8 Revenue allocations to health authorities began with funds that were 'top-sliced' from the general budget, and earmarked for particular projects or costs. The most important of these, for the purposes of the Inquiry, were the funds for supra regional services (from the 1984/85 financial year) and the SIFT funds, for costs associated with the training of undergraduates in medicine and dentistry. The remaining sums formed the main allocation available for health authorities. The RAWP methodology was then used to calculate the allocations of sums by way of revenue and capital to each of the regional authorities.

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3 Later, service increment for teaching and research

4 Various changes were made to the RAWP methodology over the period of the Inquiry's Terms of Reference. These are summarised by Mr Bevan at INQ 0047 0012 – 0013; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

5 UBHT 0339 0058; B&WHA Budget 1984/85 – Distribution by Formula to Regions

'Top-sliced' funding

9 Further details of the allocation of 'top-sliced' funds in respect of the costs of training clinical undergraduate students, and the difficulties in estimating the true size of such costs, can be found in the paper from Mr Bevan.[6] The purpose of top-slicing funding for certain specialised, supra regional services was to protect and develop such services by funding agreed volumes at agreed costs.[7] Such protected funding was introduced for neonatal and infant cardiac surgery (NICS) for the first time in the financial year 1985/86,[8] and removed with effect from the financial year 1994/95, after this service was 'de-designated'. From the 1994/95 financial year, the funding of NICS changed, with costs being apportioned between regions on the basis of past usage measured by inpatient days.[9]

10 Mr Bevan wrote:

> 'This policy of funding supra-regional services at actual costs developed outside national policies on resource allocation and was justified by objectives other than seeking an equitable distribution of resources. For Neonatal and Infant Cardiac Surgery, these are indicated by a paper prepared by the Department, which explained the advantages of concentration in a few centres to achieve high standards of diagnosis and treatment: as established centres had lower than average mortality.'[10]

Revenue allocation

11 Mr Bevan wrote:

> 'For each RHA the Department derived *target* allocations for revenue: its estimated fair share of the total for England. This was based upon its *catchment* population: the numbers and estimated relative needs of its resident population, with adjustments for cross-boundary flows. … [11]
>
> 'The Department's policy was, over time, to move each RHA's main revenue allocation towards its target, at a manageable pace of change (to avoid extra resources being squandered, and disruption to services from having to make reductions too quickly). "Ceilings" and "floors" were set on rates of change in allocations to each RHA dependent on the growth monies available each year. RHAs were ranked according to how their actual allocations compared with their

6 INQ 0047 0029 – 0030; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

7 See the recommendations of the SRSAG October 1983; WIT 0482 0345 – 0362 Dr Moore

8 NICS having been designated as a supra regional service during 1984/85

9 INQ 0047 0024; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

10 INQ 0047 0031. Criticisms of the system, from the perspective of the policy aim of achieving equitable rates of access and use, are to be found at INQ 0047 0035; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

11 Further details of the process whereby targets were derived, and the changes or adjustments made over the period of the Inquiry's Terms of Reference can be found at INQ 0047 0024 – 0027; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (emphasis in original). See Annex B

targets. There was an important distinction between "above-target" RHAs and "below-target" RHAs (with revenue spend higher and lower than their targets). The Department's policy was broadly one of "levelling up": to direct growth money at "below-target" RHAs, which meant that "above-target" RHAs received little or no growth money. For a "below-target" RHA, the greater the distance of its allocation from its target, the greater would be the share of "growth" money allocated to that RHA.

'The introduction of the "internal market" from 1991 changed the structure of the capitation formulae for revenue allocations so that these applied to *resident* (not *catchment*) populations …'[12]

12 Between 1978 and 1985 the South Western RHA (SWRHA) was consistently below 'target' and therefore received slightly more growth money than the national average.[13] The allocations to the SWRHA are discussed further at para 16.

13 Throughout the period of the Inquiry's Terms of Reference, resource allocation was subject to financial constraints. One such constraint was the need to fund 'real' growth from 'efficiency savings'. Such 'efficiency savings', announced by the Secretary of State in December 1982, were set at 0.5% of actual allocations. In 1984/85, this approach was replaced by a requirement to submit to the Department of Health a programme of 'cost improvements' of 2% of the allocation. Health authorities were allowed to retain any savings which were generated, unlike the previous reductions for 'efficiency savings' that had been redistributed nationally and regionally using the RAWP equalisation principles.[14]

Capital allocations and capital charges

14 SWRHA's capital allocations varied from between 6% and 8% of the total capital allocations for all RHAs, and from between 6% to 8% of its main revenue allocation.[15]

15 The methodology of capital allocation by the DoH to the regions is discussed by Mr Bevan at paragraphs 56–61 of his paper.[16] Between 1983/84 and 1990/91, capital was allocated on the basis of three criteria: the population target share; a capital stock equalisation element; and 'ceilings' and 'floors' on rates of change. The aim was to achieve an equitable distribution of capital throughout the regions.[17] The methods available to the NHS to assess the need for capital were, however, inadequate or

12 INQ 0047 0015; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (emphasis in original). See Annex B

13 UBHT 0339 0058; after taking into account the further growth monies of 1.6% (£8.8million) which were provided for 1984/85, the South Western Region remained 4.4% below target

14 UBHT 0339 0043

15 INQ 0047 0050; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

16 INQ 0047 0027 – 0029; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

17 INQ 0047 0033; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*

crude.[18] After 1990/91 and with the introduction of the 'internal market', a system of capital charging was introduced: this is discussed further at para 54 below.

The pattern of funding in England

16 Mr Bevan advised the Inquiry:

> 'To estimate changes over time, it is essential to remove the effect of inflation and estimate expenditure in "real" terms (i.e. constant prices). There are two price indices that are used to do this: one is based on changes in pay and prices in the general economy (the GDP deflator), the other on pay and prices of staff and consumables in the NHS (the HCHS[19] deflator). There is a general tendency for pay to increase faster than general inflation, and most of HCHS expenditure is on pay.
>
> 'Figure 1 shows changes in the allocations of HCHS resources for England in "real" terms over the period 1982 to 1995. The sources of these data are official publications by the Department.[20] Thus Figure 1 shows that, using the GDP deflator, there were increases in NHS expenditure each year over this period, and in contrast, using the HCHS deflator, shows that expenditure to have been at a standstill between 1984 and 1988. After the publication of '*Working for Patients*'[21] in 1989, Figure 1 shows substantial increases in 'real' terms in the total HCHS allocated to the NHS. Hence the resource position was transformed in terms of spend on the NHS.[22,23]

18 INQ 0047 0044 – 0045 (paragraphs 103–5)

19 Hospital and Community Health Services

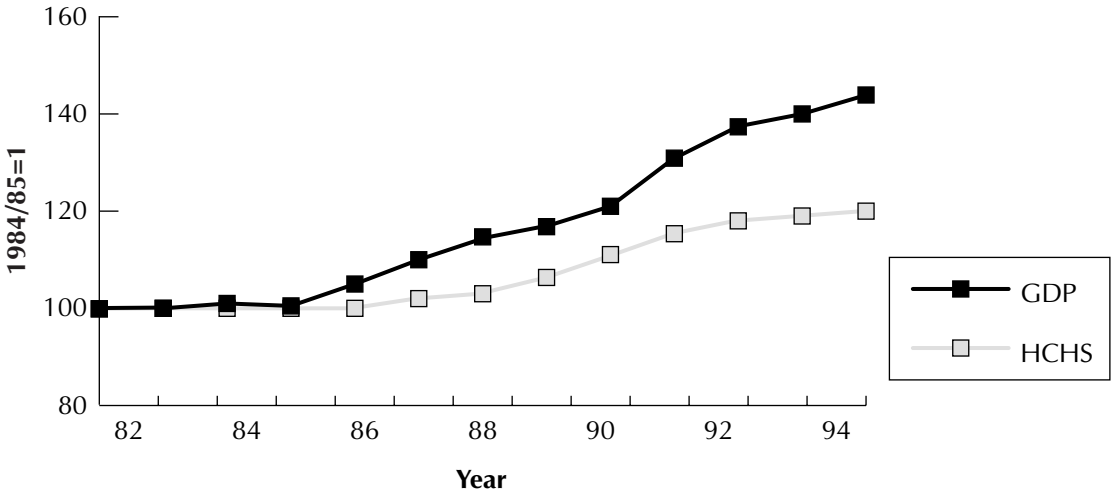
20 The footnote by Mr Bevan continues: 'Source: Technical Appendix, Table 1, columns 1 and 2. These data give a good indication of the changing resources available for HCHS in England as they are largely unaffected by the change in the funding of RHAs (from catchment to resident populations) and largely exclude capital charges introduced following the NHS reforms.' INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

21 *'Working for Patients',* January 1989, Department of Health

22 The footnote by Mr Bevan continues: 'But these extra resources were also required to help launch the NHS internal market with its various transaction costs: for example, of contracting, invoicing, price determination.' INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

23 INQ 0047 0046; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

Figure 1: Real spend HCHS England



NB Figures 1 and 3 on pages 234 and 235 are reproduced from *'National & Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. Figure 2 is not referred to in this chapter

Allocations to the South Western Regional Health Authority

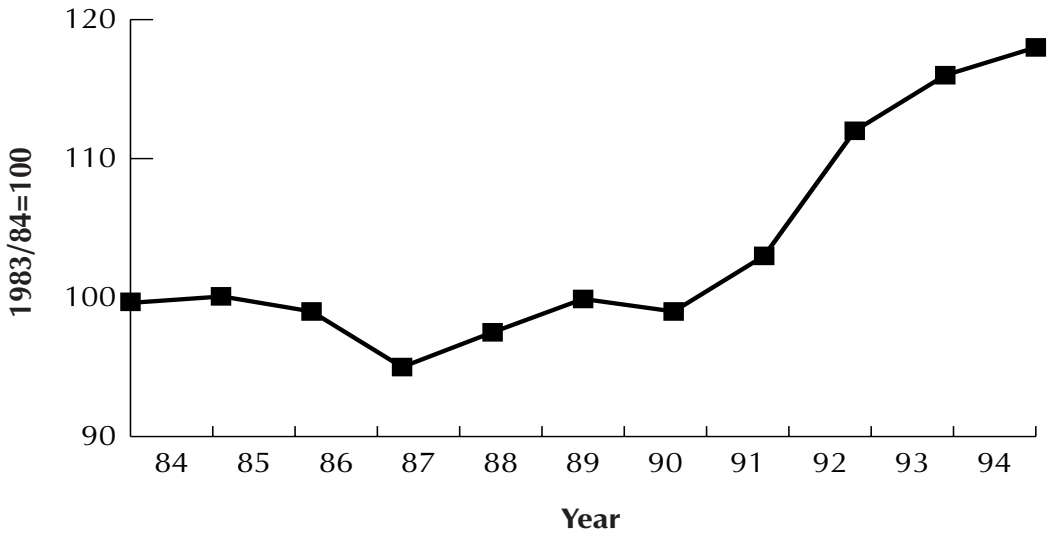
17 The South Western RHA was an RHA that was 'below-target'. Between 1979/80 and 1988/89, the Region moved from having an allocation that was about 96% of its target to one of about 98.5% of its target. Whilst there are complications in measuring its position in 1990/91,[24] thereafter the Region remained just a little below 100% of its target allocation. Mr Bevan wrote:

> 'Although South Western RHA benefited in terms of higher-than-average revenue allocations, before 1988–89, this was within a stringent regime of little or no "real" growth in the total. Figure 3 shows a bleak picture for 1984–85 to 1988–89 of limited growth in its main allocation followed by reductions so that, in "real" terms, the allocation for 1988-89 was marginally lower than for 1984–85. After that there was "real" growth each year.'[25]

24 INQ 0047 0047 – 0049 and table at INQ 0047 0050; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

25 INQ 0047 0049; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Figure 3: Changes in SWRHA's revenue allocation



NB Figures 1 and 3 on pages 234 and 235 are reproduced from *'National & Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. Figure 2 is not referred to in this chapter

The distribution of funds by the Region to district health authorities

18 Bill Healing[26] explained in his written evidence to the Inquiry the process of allocation from the RHA to the district health authorities (DHAs) in general terms. He explained that:

> 'The basis of funding to District Health Authorities is calculated as follows:-
>
> 'a) recurring Allocation from the previous year;
>
> 'b) +/- any technical adjustments to reflect changes in responsibility;
>
> 'c) + inflation (as determined by the Government);
>
> 'd) + growth (depending on whether an Authority is over/under-funded compared to a national formula);
>
> 'e) + any special or non-recurring allocations.'[27]

The supra regional and regional services: 1984–1990

19 The 'top-slicing' of funding for neonatal and infant cardiac services, from 1985/86 onwards, imposed an obligation on the RHA to pass the centrally earmarked sums to the DHA. The sums allotted by the Supra Regional Services Advisory Group (SRSAG) to neonatal and infant cardiac services in Bristol are set out in the Table 7, at para 83.

26 Finance Director, Avon Health Authority, formerly Finance Director of the B&WDHA
27 WIT 0092 0004 Mr Healing

20 In addition, the Region identified a number of regional specialties. These included cardiac surgery. Regional policy, in 1984/85, was to fund initial developments in such specialties for three years on a non-recurrent basis. After that they were to be financed by the districts, in proportion to the use made of the services by the population of each district. However, in practice there was continuing pressure to expand cardiac services at the BRI, since the level of provision of cardiac services was significantly below both national targets and provision in many other regions. As a result, Mr Bevan suggested that in practice '… regional protection of cardiac services at the BRI was not limited to the three years as stated as the regional policy.'[28] Further details of regional funding for expansion for cardiac services are to be found at Table 1, para 28 below.

21 The income derived from carrying out neonatal and infant cardiac surgery might be said to have formed a small part of the District's income. Mr Bevan wrote:

> 'The funding of supra-regional services accounted for 0.2% of total revenue funding of Bristol and Weston DHA in 1984–85. The introduction of funding for Neonatal and Infant Cardiac surgery in 1985–86 increased this to 1.2%, and thus presumably, offset the fall in funding in "real" terms for that year by about 1%. After 1985–86 supra-regional services accounted for 0.5%–0.8% of total revenue funding of the DHA (until 1990–91).'[29]

However, Mr Bevan nevertheless makes the point that adjustments to the RAWP allocations in respect of supra regional services were important for the District, since

> 'The funding of supra-regional services accounted for between 1.1% and 1.8% of revenue spending on acute services in Bristol.'[30]

22 Full details of the amount of NICS funding received by the Bristol hospitals from 1984–1995, and the processes by which those sums were allocated, are set out in a later section of this chapter.

23 As regards the allocation of SIFT funding to the DHA, as a teaching hospital, the BRI received a large share. Mr Bevan wrote:

> 'Bristol's teaching hospitals received nearly 70% of SIFT allocated to the RHA, and the BRI nearly 50%. SIFT accounted for about 8% of the total revenue budget of the DHA.'[31]

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28 INQ 0047 0053; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

29 INQ 0047 0060; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B. After 1990/91, the sums in respect of NICS were paid directly to the UBHT by the DoH, as the purchaser, until 1994/95, when 'de-designation'meant that districts, and subsequently areas, assumed responsibility for the purchasing of these services

30 INQ 0047 0069; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

31 INQ 0047 0069; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

Revenue allocations

24 The revenue allocations by the SWRHA to the B&WDHA were determined each year according to the SWRHA's own version of the Department's RAWP formula. The SWRHA's approach was designed to make the national model sensitive to local pressures.[32] The formula was subject to change from year to year.[33] In essence, the RHA used the national formula to distribute funds to the districts within its boundaries.[34] Mr Bevan commented:

> 'What comes across as the driving force of the RHA is a commitment to achieving equity between DHAs.'[35]

25 The allocations took into account the previous year's baseline figure, the predicted rates of inflation in pay and prices, a share of any growth funds received from the DoH and an adjustment for efficiency improvement.[36]

26 The formula also took into account the complexities arising from the flow of patients across district boundaries. Notional financial allowances were made for patients from one district who were treated in another. Equally, notional charges were made for a district's patients who were treated elsewhere.[37] These adjustments affected the distance financially between the B&WDHA and the RAWP target, as defined by the SWRHA.

27 In 1988 the SWRHA developed new policies to remove these cross-boundary adjustments; the policies anticipated the changes made in 1991/92 with the introduction of the 'internal market'. Under the new system, adjustments to cross-boundary flows within targets would be replaced by planning agreements, with payments being made directly by the purchasing districts to the supplying districts. The policy was introduced on a pilot basis in 1989/90. From 1990/91 (the year before the 'internal market' was introduced), payments were made by purchasing districts to supplying districts for the estimated actual costs of treating cross-boundary flow.[38]

28 The B&WDHA's funding was 8.8% above the target set by the Region as part of the sub-Regional resource allocation formula in the financial year beginning 1984/85. This meant that in that year it was better funded than other health authorities within the South Western Region, to the extent of £5.3 million.[39] As a result, the B&WDHA received a proportionally smaller share of growth monies in subsequent years, as can

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32 UBHT 0266 0075; NHS Resource Allocation – South Western Region Issues
33 UBHT 0266 0290; SWRHA, Regional Resource Allocation Working Party
34 INQ 0047 0054; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B
35 INQ 0047 0057; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B. This commitment was reflected, for instance, in the proximity of the DHAs within the SWRHA to their target allocations, by 1983/84; all were relatively close to their targets, compared to those in many other regions
36 UBHT 0339 0058; B&WDHA Budget
37 UBHT 0266 0073; SWRHA RAWP
38 INQ 0047 0054; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B
39 UBHT 0339 0059; B&WDHA Budget 1984/85. See also INQ 0047 0059

be seen from Table 1 below.[40] In his paper, Mr Bevan set out the changes in total revenue funding received by the District between 1983/84 and 1989/90.[41] He commented that:

> 'This shows a grim position for the DHA, wholly consistent with its being an over-target district in a RHA receiving no "real" growth.'[42]

Further, during the 1980s, the NHS's planning system required DHAs to consider 'priority' services: services which required particular development. These included the care for the elderly, mental illness and psychogeriatrics. Mr Bevan observed:

> 'These developments took place within the constrained budget of the DHA and hence imply that acute services would have been subject to even greater financial pressure than the DHA.'[43]

40 The table has been produced by the Inquiry from information contained in B&WDHA's Budget Books

41 INQ 0047 0061; Figure 4. *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

42 INQ 0047 0059; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

43 INQ 0047 0062; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'.* See Annex B

Table 1: Financial growth allocations 1984/85 to 1990/91 (all sums represent cash value at the relevant time)

Year	Increase in funding, year on year (growth money) South Western RHA		Increase in funding, year on year (growth money) Bristol & Weston DHA		Growth in funding for cardiac care (adults and children) Excluding supra regional funding[1]	
	Percentage	Cash (£)	Percentage	Cash (£)	Revenue (£)	Capital (£)
1984/85	Not available	Not available	Not available	Not available	383,000	Not available
1985/86	1.8	10,300,000	0.5	423,000	Not available	Not available
1986/87	1.2	7,100,000[2]	0.25	184,000	308,500[3]	Not available
1987/88	1.1	7,200,000	0.4	372,000	345,000	1,417,000[4]
1988/89	1.27	9,151,000	1.0	1,032,000	75,000[5] 960,000[6] 59,000[4]	Not available
1989/90	2.5	Not available	2.7	2,587,500	1,664,500[5] 57,000[7]	Not available
1990/91	3.3	Not available	1.0	1,109,000	1,785,000[5] 95,000[8]	Not available

1. Figures shown are in respect of B&WDHA
2. The RHA retained £1.4 million for regional developments: Budget Book 1986/87
3. RHA three-year revenue funding to expand cardiac surgery
4. Development of cardiac catheterisation at BRHSC
5. Contributions from other health authorities towards the cost of running cardiac surgery
6. Increase in cardiac surgery – regional specialty development funded by the RHA
7. Expansion of cardiac surgery and catheterisation
8. Development of cardiac services

29 Attempts were made to expand cardiac services. As can be seen from the Budget Book, in 1984 the RHA allocated £383,000 to the B&WDHA for the expansion of adult cardiac surgery by 100 cases to 375, with effect from April 1984. This money was held in reserve by the SWRHA and allocated to the appropriate budgets as the costs were incurred.[44] Further details of the sum allocated to fund growth in this field are to be found in the last column of Table 1, above. Mr Bevan noted that:

> 'Regional Allocations 1986–87… shows significant funding of cardiac surgery from regional reserves from 1986–87 to 1988-90 (to 490 cases) and for an increase from 480 cases to 600/700 from 1986–87 to 1990–91. Financial Allocations and Policies (1988 edition) shows significant funding for an increase to 675 cases from 1988–89 to 1990–91:

44 UBHT 0339 0045; B&WDHA Budget 1984/85

Year	86/87	87/88	88/89	89/90	90/91
	£'00s	£'00s	£'00s	£'00s	£'00s
Regional Allocations 1986–87					
To 480 cases	715	272	178	415	
480 to 600	750	750	750	750	
480 to 700	900	900	900	900	
Financial Allocations and Policies (1988 edition)					
To 675 cases			1,135	1,168	1,149

He continued:

> 'Funding over three calendar years may naturally span four financial years. There may also be slippage so that funding indicated in, for example, 1986–87 might not take place that year. Nevertheless, these figures suggest that regional protection of cardiac services at the BRI was not limited to the three years as stated as the regional policy.'[45]

30 The attempts to expand cardiac services continued after the NHS reforms of 1991, through contracts placed by purchasers.[46]

Private funding

31 Mr Nix was asked by Counsel to the Inquiry about a letter to Mr John Watson[47] dated 2 December 1987, in which Mr Keen[48] protested about the fact that the income received from private patients undergoing cardiac surgery (who paid £330 per day for accommodation) was not credited to the cardiac surgery budget.[49] Mr Nix explained that this was because:

> '… the unit itself had funding to provide this level of service, and it was financed in part overall for the Trust from private patient income. So, if you like, they have a spending budget and we also had an income budget. The income budget for the Health Authority came … from the Regional Health Authority plus the money coming on the private patient route. I should say, we did not do an awful lot of private patient work, so this is not part of any private major funding stream.'[50]

45 INQ 0047 0053; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B
46 Further details of this continued policy are set out at para 70
47 Unit General Manager, BRI
48 Consultant cardiac surgeon, BRI
49 UBHT 0295 0063; letter from Mr Keen to Mr Watson dated 2 December 1987
50 T22 p. 117 Mr Nix

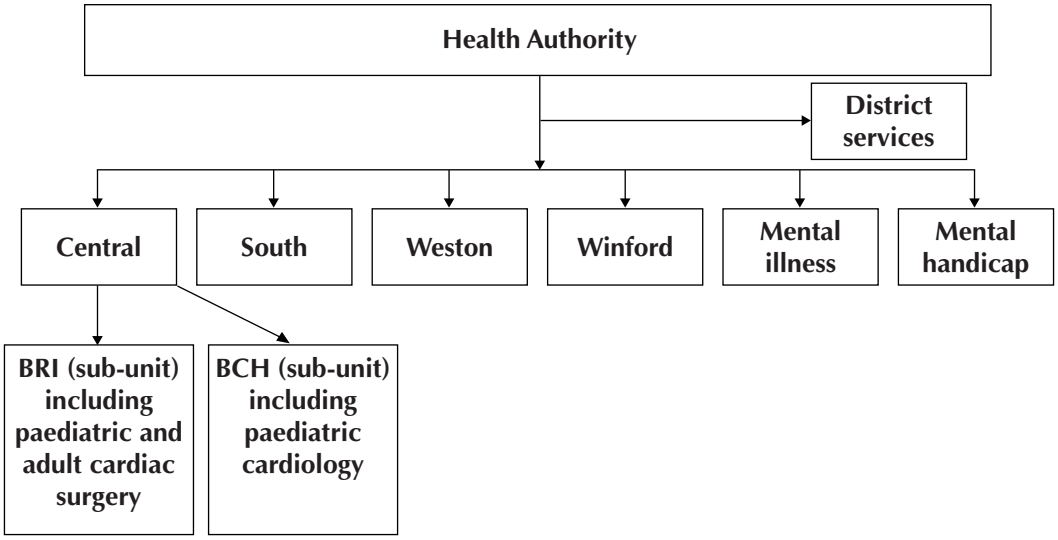
Management of funding by the District prior to 1991

32 From the beginning of the period of the Inquiry's Terms of Reference, the general manager of a district health authority was accountable for the financial performance of the district.[51] Dr John Roylance became District General Manager of B&WDHA in 1985 and retained this position until April 1991, when he became Chief Executive of the UBHT. General managers were encouraged to delegate budgetary control. All health authorities, including B&WDHA, were able to determine for themselves to what level budgets should be delegated and what flexibility individual budget-holders were to be given.[52]

33 Until the formation of the UBHT, the acute services of the B&WDHA were managed through two units: the Central Unit and the South Unit. Mr John Watson was the Unit General Manager of the Central Unit, which included the BRI and the BRHSC. Mrs Margaret Maisey was the General Manager of the South Unit.[53]

34 The structure of the management units within the District is summarised in Figure 1:

Figure 1: The structure of the Bristol & Weston Health District Authority and its units, 1984–1991



51 UBHT 0099 0087; DHSS Health Circular *'Financial Directions for Health Authorities in England'* HC(84)20: effective from the date of the General Manager's appointment

52 See, again, the Circular HC(84)20, UBHT 0099 0089: 'Each General Manager should be able to delegate responsibility for a budget or part of a budget to an individual officer who should be responsible for the activities provided for within that budget and/or the supply of information to the Treasurer to assist budget making and monitoring'

53 WIT 0106 0012 Mr Nix

35 Both the Central Unit and the South Unit had designated financial managers, supported by a qualified accountant and a financial team.[54]

36 The B&WDHA's budget statement for 1984/85 stated that it was a prime aim of the recent restructuring of the NHS[55] that decision-making be devolved to the operational level. An essential feature of this delegation was the devolving of budgets from district level to units, for which the responsible unit managers (administrator, nurse and doctor) would be accountable. Acting together, they should be able to manage services in the unit within service and budgetary objectives agreed with the district management team.[56]

37 The 1984/85 budget statement continued:

> 'Responsibility for managing budgets on a day to day basis rests with the budget holder. This will be an individual responsibility for District managed services but within units will be both an individual responsibility of each budget manager with a collective responsibility placed on the Unit Management Group …'
>
> 'The further delegation of budgets for 1984/85 is entirely consistent with the devolution of decision making and accountability to unit level. However, the Chief Nursing Officer, District Works Officer and other officers with District-wide responsibilities have a legitimate wider interest over the respective total budgets for their service and are to be consulted when annual budgets are determined.'[57]

38 The senior finance officers from the District Health Authority's finance department, as Unit finance officers, had a general responsibility for providing financial advice to the Unit Management Group. This included assisting in the compilation of annual budgets and reporting regularly to the Unit Management Group on budgetary performance, together with consideration of the financial implications of changes in the pattern of service being provided, the pursuit of efficiencies and the implementation of cost improvement programmes.[58]

39 Mr Nix stated that, although the principal financial accountability to the District Health Authority was through Mr Watson and Mrs Maisey, the actual day-to-day responsibility for financial management was at ward or department level.[59]

40 The Regional policy in respect of capital allocations is discussed by Mr Bevan in his paper, *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'* (see Annex B). The methods used followed national methods of capital allocation.[60] In 1984/85, 85% of capital

54 WIT 0106 0185 Mr Nix
55 The Budget referred to changes which took place in 1982
56 UBHT 0339 0061; B&WDHA Budget
57 UBHT 0339 0062; B&WDHA Budget
58 UBHT 0339 0062; B&WDHA Budget
59 WIT 0106 0181 Mr Nix
60 INQ 0047 0055

resources were allocated by the Regional Health Authority to the districts within the Region on the basis of projected populations, weighted by the use of services according to age and gender, and by morbidity. The remaining 15% was distributed in relation to the replacement value of the existing capital stock, weighted according to the age of the asset. This situation was recognised as being inequitable and it was planned to phase it out over the ensuing seven years.[61]

41 According to the B&WDHA Budget Books, the following capital allocations were made by the authority (see Table 2):

Table 2: Capital allocations, B&WDHA 1983/84–1990/91
(actual cash figures as shown in the Health Authority's Budget Books)

Year	Allocation £'000	Transfer from revenue included in capital allocation £'000
1983/84	2,173	627
1984/85	4,032	1,216
1985/86	4,160	2,433
1986/87	5,012	1,866
1987/88	4,205	412
1988/89	2,949	140
1989/90	4,068	468
1990/91	3,903	1,025

42 In 1989/90, 25% of the RHA's capital allocation was earmarked for the districts' capital programmes. This 25% allocation was allocated to DHAs in proportion to their revenue allocations.[62]

43 Mr Nix stated that in the case of B&WDHA, decisions as to which proposed plans for capital expenditure should be supported were taken by committees. The Policy Planning and Resources Committee (PPRC) considered business plans, strategic plans and service developments. The Finance, Property and Computing Committee (FPCC) considered the capital programme and investment (and monitored the financial position of the health authority).[63]

61 UBHT 0339 0180; B&WDHA Budget
62 UBHT 0339 0848; B&WHDA Budget
63 WIT 0106 0011 Mr Nix

UBHT's funding after 1991

44 After the introduction of the purchaser-provider split in 1991, the UBHT negotiated contracts[64] with its purchasers on an annual basis.

45 Mr Nix stated that he, as Director of Finance, and representatives from the individual clinical directorates were involved. He stated that the aim was to make certain that the various directorates had 'ownership' of what was required by the contract and also to ensure that the directorates could achieve what the purchasers were seeking.[65] Ms Deborah Evans[66] confirmed this process. She stated in her written evidence to the Inquiry:

> 'In the period October to December each year most of the contracting discussions would happen at the level of a clinical directorate or sub-directorate and a contract manager from the Health Authority, often with a manager from the central UBHT contracting support team sitting in. Between January and March each year discussions would also take place at Executive Director level between the Health Authority and each Trust to discuss the overall balance of additional funding between specialities and Trusts and to address any so far unresolved delivery issues at specialty level.'[67]

46 Mr Nix explained that the UBHT was required to negotiate with around 500 different purchasers, ranging in size from the Avon Health Authority (AHA)[68] involving a contract in the region of £100m, to a local GP fundholder, where the amount involved could be £50.[69] The major purchasers however, during the period from 1991 to the end of the period of the Inquiry's Term of Reference, were the district health authorities rather than GP fundholders.

47 Table 3 below sets out the UBHT's income revenue as a trust from 1991–1995, and the income of the Directorate of Surgery. It also shows the income, where it has been possible to identify it separately, of paediatric cardiac surgery and paediatric cardiology.

64 Although the term 'contract' was used, these were in fact service agreements with no legal force
65 WIT 0106 0024 Mr Nix
66 Executive Director of Avon Health Authority, formerly Director of Contracting of Bristol and District HA
67 WIT 0159 0013 Ms Evans
68 Established with effect from 1 April 1996, following the merger of the former District Heath Authority and Family Health Services Authority
69 WIT 0106 0024 Mr Nix

Table 3: UBHT income revenue 1991–1995
(All sums shown are as shown in the UBHT budget statements at the cash value of the relevant year)

Year	Gross income (£)	Directorate of Surgery (including audit & paediatric cardiac surgery) (£)	Adult and paediatric cardiac surgery (£)	Directorate of Children's Services (including paediatric cardiology) (£)
1991/92	128,010,000 [UBHT 0339 0007]	11,298,000 [UBHT 0338 0012]	Not specified	8,283,000 [UBHT 0338 0012]
1992/93	133,854,000 [UBHT 0338 0024]	18,113,610 [UBHT 0338 0122]	3,832,190 [UBHT 0338 0117]	11,424,040 [UBHT 0338 0051]
1993/94	138,371,000 [UBHT 0338 0155]	20,513,400 [UBHT 0338 0262]	4,758,600 [UBHT 0338 0257]	11,914,280 [UBHT 0338 0190] (paediatric cardiology specified as £366,140)
1994/95	141,775,000 [UBHT 0338 0350]	22,520,000 [UBHT 0338 0376]	Not specified	13,669 [UBHT 0338 0365]

48 In the early 1990s, block contracts[70] for a fixed sum were the principal form of contract. Such contracts provided security of income to trusts. However, Mr Nix stated that they carried the risk that the numbers of patients would outstrip those that had been assumed when the agreement had been negotiated.[71]

49 Ms Evans stated:

> 'Bristol and Weston Health Authority (and subsequently Bristol and District Health Authority) used "sophisticated block contracts"as its main type of contract. These were arrangements within which the purchasing Health Authority paid a fixed contract sum for access to a defined range of services or facilities. Indicative patient activity targets were included with some identification of case mix. This type of contract was the most common form in use across the NHS, particularly in the acute sector.'[72]

50 Ms Evans explained that, initially, the emphasis was on a 'steady state' that protected the newly established providers:

> 'The national contract pricing requirements … had the effect that if a Health Authority wished to switch a number of cases away from one hospital and buy them at another one, it would be difficult to realise enough cash to buy the equivalent service elsewhere. It was theoretically possible to require Trusts to release the relevant semi-fixed and fixed costs although this would take two or three years to achieve. There were also national regulations about "periods of notice" required if Health Authorities wished to reduce the value of their

70 Block contracts operated on the basis that the provider agreed to provide a specified service (e.g. accident and emergency services) to a purchaser. They may be compared to 'cost and volume' contracts (a specific number of patient episodes at a specified price) and 'cost per case' (the cost of one specific patient or patient episode of care)
71 WIT 0106 0175 Mr Nix
72 WIT 0159 0012 Ms Evans

"contracts" with a Trust by a significant sum. These values were not always precisely stated at national level, but it was local practice to give 12–18 months' notice for sums over £100,000.

'The difficulty in switching tranches of work from one hospital to another, or from hospital to primary care settings, had the effect of focusing attention either on remodelling services within an NHS Trust or on ways of developing services using the marginal annual increase in funding to the NHS.'[73]

51 Mr Baird stated in his written evidence to the Inquiry:

'There was a lot of over-simplification initially. For example, every operation had an average sum of money attached to it, and the system of accounting did not take the complexity of the procedure into account. We dealt with Finished Consultant Episodes (FCE's) rather than patient admissions, discharges and deaths which we had had before 1991. Dealing in FCE's had the effect on hospital activity of counting a patient twice if, for example, the patient was admitted to hospital under a physician and later transferred to a surgeon. The contract money for operations was *not* given to surgery to share out to cover the support services, eg anaesthesia. The clinical support services such as anaesthesia, pathology, radiology, etc were funded by central top-slicing, as were the Finance Department, the IT Department, general works and buildings maintenance, hotel services and so on.

'Consultants continued to compete for funding for their areas of work, although the routes to gain funding were different — there were still winners and losers. Winners included complex, low volume work such as cardiac surgery and bone marrow transplants which received investment to aid their development. Losers tended to be the high volume, low cost work which was locked tightly in contracts. Long waiting lists have already been a powerful lever for growth money.'[74]

52 Mr Nix stated that within the UBHT there was no system of cross-charging between services, as this was considered to be costly to administer. Clinical support services were allocated a share of income based on an agreed formula that was reviewed annually.[75]

Capital funding after 1991

53 From 1 April 1991 the NHS introduced a system of charging for the use of capital assets owned by self-financing trusts. Such assets were transferred into the ownership of trusts on their establishment. Interest on the value of the assets was payable to the DoH.[76] In turn, a capital charge was included in the charges made by providers to purchasers. This charge was intended to cover interest payments, depreciation and

73 WIT 0159 0011 Ms Evans
74 WIT 0075 0009 Mr Baird (emphasis in original)
75 WIT 0106 0188 Mr Nix
76 UBHT 0338 0013; UBHT Budget. See also HOME 0003 0084; *'Working for Patients: Capital Charges: Working Paper No 5'* (DoH, 1989) and HOME 0003 0028; *'Working for Patients: Self-Governing Hospital Trust: Working Paper 1'* (DoH, 1989)

the repayment of loans. In 1991/92, the aim of launching the NHS 'internal market' in a 'steady state' meant that capital charges were:

> '… introduced so as to have no impact: charges were estimated by providers and allocated by purchasers according to existing use.'[77]

Previously, capital to fund the replacement or development of equipment or buildings had been sought from either the major capital programme (managed by the RHA) or from the DHA's own capital programme. The UBHT's Budget statement commented:

> 'Capital was always seen as "free" and the more that could be obtained and used the better'.[78]

54 Trusts were required to determine the need for capital against a five-year rolling programme of capital investment.[79] The capital programme for trusts was controlled by the DoH through the setting of an External Financing Limit (EFL).[80] The UBHT's capital programme and EFL is shown at Table 4 below.

Table 4: United Bristol Healthcare NHS Trust capital programme (cash value at the year indicated)

Year	Capital £'000	External Financing Limit £'000
1991/92	8,993	–1,161
1992/93	8,048	2,622
1993/94	7,304	–670
1994/95	10,761	2,486

The budget-setting process after 1991

55 Mr Nix stated that all the executive directors of the Trust Board were fully involved in discussions with the various directorates and the purchasers.[81] At the end of the process, the Trust Board approved all budgets. Mr Nix stated in his written evidence to the Inquiry that there was extensive opportunity for individual directorates and clinicians to influence the outcome of this budget-setting process.[82] The UBHT, he went on, encouraged clinical directors and other clinicians to be fully involved in the

77 INQ 0047 0028; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B, and see further INQ 0047 0027 – 0029; *'National and Regional Resource Allocation Frameworks and Funding Availability for Acute Sector Health Services at Bristol'*. See Annex B

78 UBHT 0338 0013; UBHT Budget

79 UBHT 0338 0013; UBHT Budget

80 An EFL was, in effect, a cash limit on the net external financing of an NHS trust. NHS trusts had a financial duty to meet (or come within agreed limits of) the EFL. The EFL was calculated as the difference between agreed capital spending and internally generated resources. A positive EFL meant that the NHS trust could have access to public dividend capital to help finance capital expenditure. A negative EFL meant that the NHS trust had sufficient internal resources. The EFL was set after taking into account: 'The projected capital charges for the year; the interest chargeable on the opening balances; … the estimated depreciation charges [for the financial year in question]; an estimated … capital dividend set to 'claw back' the difference between the interest funded through prices and the actual interest payable for the [previous financial year]; minor expected variations in working capital; [and] the centrally approved capital programme.' UBHT 0338 0139; UBHT Budget

81 WIT 0106 0181 Mr Nix

82 WIT 0106 0181 Mr Nix

discussions with purchasers and in the preparation of papers. There were regular reports to the senior managers, the hospital medical committee, and meetings of the clinical directors, as well as to the Trust Board.[83]

The delegation of budgetary control after 1991

56 The UBHT drew up its own Standing Financial Instructions (SFI).[84] Mr Nix stated in his written evidence to the Inquiry that overall responsibility for finance lay with the Chief Executive and the Trust Board. Clinical directors were accountable to the Chief Executive for the directorates' performance, including financial performance. In this regard, they had the assistance of general managers.[85]

57 Paediatric cardiac surgical services were delivered through two different directorates. Paediatric cardiac surgery formed part of the Surgical Directorate, with Mr Roger Baird as the Clinical Director. Mr Wisheart was Associate Clinical Director of Cardiac Surgery; Mr Dhasmana later succeeded him.[86] Paediatric cardiology was separately managed, as it formed part of the Children's Services Directorate.[87]

58 From 1 April 1995 cardiac surgery was removed from the Directorate of Surgery by the creation of a Directorate of Cardiac Services. This included the disciplines of both surgery and adult cardiology.[88] In October 1995 paediatric cardiac surgery and paediatric cardiology were brought together within the Children's Services Directorate, when paediatric cardiac surgery was relocated to the Children's Hospital.

59 Mr Nix explained that the aim of appointing associate directors was not only to ensure that clinicians were involved in the management of the services they provided, but also to place the responsibility for achieving the patient service contracts and the financial targets on those who were delivering the service.[89]

60 He explained further that:

> 'Budgetary control was delegated to the Associate Directorates and then within them to the wards, theatres, perfusionists, cardiology, etc. All budgets were reviewed annually and mainly rolled forward at the same level as for previous years, with an increase for inflation and for any developments agreed with purchaser Health Authorities or GP fundholders'.[90]

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83 WIT 0106 0181 Mr Nix
84 UBHT 0023 0297; UBHT Standing Financial Instructions
85 WIT 0106 0182 Mr Nix. Further details of the directorate structure and of hospital management structures, are to be found in Chapter 8
86 UBHT 0338 0114; UBHT Budget
87 UBHT 0338 0044; UBHT Budget
88 WIT 0106 0023 Mr Nix
89 WIT 0106 0023 Mr Nix
90 WIT 0106 0034 – 0035 Mr Nix

61 The report of the Director of Finance dated March 1992 set out rules for virement[91] and budget guidelines for clinical directors.[92] The arrangements gave complete discretion to the clinical directors to transfer between revenue budget headings during the year, to use funds for minor capital schemes, and to carry forward underspending.[93]

62 When implementing any budget changes during the financial year, clinical directors and their managers were required to take account of the advice of their financial manager and those other officers who possessed a relevant professional interest.[94]

63 Any proposal to reduce the level of service to patients had first to be approved by the Chief Executive.

64 As with the District Health Authority, senior finance staff acted as financial managers in respect of each directorate. They were responsible for providing advice on financial management to directorates. This included establishing principles for the compilation of annual budgets, regularly advising on budgetary performance and service agreements, ensuring the proper appraisal of all proposals for changes in service, and encouraging the search for efficiencies, cost improvements and initiatives for income generation.[95]

65 Within the UBHT, financial management was on three levels:

- senior financial managers, providing strategic financial advice to clinical directors;
- a qualified accountant, working with the clinical director and general manager on a day to day basis;
- a team at operational level, supporting the budget managers.

66 Mr Nix explained that budget managers received monthly expenditure reports, with detailed transaction reports and summaries provided at directorate level for the Trust. The expenditure reports included an analysis of income against planned expenditure and data on actual workload against the plan as analysed by the purchaser. The purpose in supplying the data to the directorates was to assist them in meeting the targets set by the purchasers and the financial targets set by the Trust.[96]

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91 This is the ability to move money between designated budgets or budget sub-heads, e.g. to be able to spend money designated for capital expenditure on revenue costs
92 UBHT 0338 0027; Report of the Director of Finance 1992/93
93 UBHT 0338 0027; Report of the Director of Finance 1992/93
94 UBHT 0338 0034; Budget 1992/93: 'Budget Flexibility and Guidelines for all Budget Managers'
95 UBHT 0338 0033; Budget Management
96 WIT 0106 0036 Mr Nix

Funding for Paediatric Cardiac Services (PCS)

67 Funding for paediatric cardiac services (PCS), from April 1991 onwards, came from two separate sources. The first was for children over 1. It came from the general contracts or service agreements placed by local purchasers. The second source of funding was for children under 1 and it came from the DoH under supra regional arrangements.[97]

Contracts for cardiac services

68 The Inquiry received evidence from former staff of the B&DHA concerning the commissioning arrangements that they, as local purchasers, had made for cardiac services to children over 1 year old. Ms Deborah Evans stated:

> 'Bristol and Weston Health Authority had no involvement in the process of negotiating service agreements or of setting or monitoring quality standards for supra-regional services. One effect of designation as a supra-regional service on the Health Authority was that it did not have these responsibilities for services so designated.'[98]

69 The number of children requiring cardiac services for whom each district had responsibility was small. Pamela Charlwood[99] stated in her written statement to the Inquiry:

> '…B&DHA had been acting as a lead purchaser since 1991/92[100] for the adult cardiac services offered to all District Health Authorities in the South West Region. This required sharing service specifications, aspects of negotiations and monitoring data. Because of the small number of cases (twenty per annum) each of which was complex, paediatric cardiac services for children over one year old were commissioned through a block volume contract with no detailed specification.'[101]

97 See Chapter 7
98 WIT 0159 0009 Ms Evans
99 Chief Executive, Avon Health Authority from 1994, previously RGM SWRHA 1993/94
100 But see the evidence of Ms Evans, to the effect the B&DHA co-ordinated a contracting process for one year only; thereafter it had no 'lead role'. WIT 0159 0018
101 WIT 0038 0036 Ms Charlwood

70 The contract for the provision of health services for 1992/93 between the UBHT and the Bristol & District HA, for example, was a 'block contract'. It dealt with prices in Schedule (1)(a).[102] This listed the various departments providing services. They included 'cardiac surgery – BRI' and 'cardiac surgery – BCH'. Columns then represented the 'price' (cost per case) and 'volume' (the number of cases) and the total of these multiplied together, in respect of inpatients and outpatients. Cardiac surgery was a relatively high-cost discipline: the inpatient cost per case at the BRI was £6,977.94 (266 cases).[103] Children who were to receive treatment at the BRI were not separately identified.

71 This agreement operated in tandem with a parallel 'cost and volume contract.'[104] By this latter agreement, the DHA indicated a willingness to pay for additional cases above the indicative level agreed in the block contract, up to a specified ceiling. The relevant areas in which such an agreement was made included adult cardiac surgery: additional Coronary Artery Bypass Grafts (CABG) were provided for in a scheme aimed in part at clearing the waiting list for this procedure.[105]

72 These agreements reflected attempts to expand the capacity of the adult cardiac and cardiological services, and to cut waiting lists through the medium of contracts placed by purchasers. The Inquiry received from the Avon HA, for instance, details of the investment made by the B&DHA in cardiac services from 1992 onwards, set out in Tables 5 and 6 below:

Table 5: Additional recurring investment made by B&DHA in cardiology and cardiac surgical services, 1992/93 to 1995/96

Year	Investment
1992/93	£150,000
1993/94	£500,000
1994/95	£500,000
1995/96	£300,000
Total	£1,450,000

Note: All the above investment was in adult cardiology and cardiac surgery at UBHT.[106]

102 HAA 0156 0008; Schedule (1)(a)
103 The corresponding figure for the BRHSC, where no open-heart surgery was performed, was £4,604.99 per cases; some 20 cases were planned for, all of which, necessarily, involved children
104 HAA 0156 0012; Schedule (1)(b) 'cost and volume contract'
105 See Chapter 3 for an explanation of this term
106 WIT 0159 0054 Ms Evans

Table 6: Waiting list initiatives – care of adults purchased by B&DHA from UBHT in cardiology and cardiac surgery, 1993/94 to 1995/96

Year	Number and type of treatment	Price
1993/94	30 Coronary Artery Bypass Grafts (CABGs)	Included in block contract
1993/94	46 CABGs 8 angioplasties	£48,676
1993/94 & 1994/95	55 cases, approximately: 30% valve replacements 70% CABGs	£350,000
1994/95 (Project 44)	30 catheterisations 6 angioplasties 15 CABGs 2 valve replacements	£127,000
1994/95 (Project 47)	3 pacemaker insertions 6 angioplasties 57 catheterisations (mix of inpatients and day cases) 2 valuloplasties	£51,386
1995/96	340 cases (mix of inpatients and day cases cardiology and cardiac surgery)	£220,000

Note 1: A waiting list initiative was defined as an agreement for additional work, above that specified in the annual service agreement aimed at reducing inpatient, day case or outpatient waiting times.

Note 2: Within a specified case mix and price, monitoring would be against individual named patient returns.[107]

73 Ms Evans added:

> 'The national drive to reduce waiting times and the decision to invest in additional treatment were two highly significant influences on Bristol and District Health Authority's assessment of its need for adult cardiological and cardiac services. However there was an important clinical factor which made the picture more complex. This was the growth in emergency treatments for cardiology and cardiac surgery over the period.
>
> '… between 1989/90 and 1995/96, the emergency workload in adult cardiac surgery almost tripled (from 48 cases to 140 cases) and for adult cardiac surgery the workload almost doubled (from 224 cases to 523 cases) …
>
> 'The effect of this combination of factors was that at certain times, particularly from 1993/94 onwards, it appeared that the UBHT (and by report other NHS Trusts) were having difficulty in meeting the combined demand from Health Authorities.'[108]

[107] WIT 0159 0055 Ms Evans
[108] WIT 0159 0017 Ms Evans

74 She said further:

> 'The amount of additional investment which the Health Authority made in adult cardiac services was invariably a matter of contention during contract negotiations as clinicians put forward a strong professional view that more investment was needed and the Health Authority gave assurances that adult cardiac services was its top priority for the limited additional funds available.'[109]

75 The extent to which cardiac services benefited was contested. Mr Baird stated:

> 'However, funding for cardiac surgery was "ring-fenced", and the size of its ITU [a.k.a. ICU, or Intensive Care Unit] was protected. My perception is that cardiac surgery revenues benefited from the purchaser/provider split. But, when plans were being formulated involving major capital investment to move paediatric cardiac surgery to BRHSC [Bristol Royal Hospital for Sick Children], the purchasing Health Authority's policy was to minimise growth of high-tech expensive acute care, because it was plain that the service could be provided with the facilities already available. Instead, more care in the community by district nurses was favoured. This had an impact on the funding of cardiac surgery through pressure on contracts which reflected purchasers' reluctance to fund the demand in full.'[110]

76 He continued:

> '… as I have already explained, my feeling was that the cardiac surgical service fared well from the purchaser/provider split, because of additional contracts throughout the South West and South Wales rather than central funding. At the end of each year, any underspend on cardiac surgery was welcomed by the other Associate Directorates to offset their overspends, i.e. work carried out without funding recovered under existing contracts. In terms of developing cardiac surgery, it will have fared better as an independent Directorate, then having an opportunity to utilise its own financial gain.'[111]

77 Avon Health Authority commented on Mr Baird's view:

> 'Major capital investment was a matter that lay between UBHT and the Regional Health Authority, SWRHA; this did not concern the District Health Authority. As appears from Appendices 8 and 9 to the statement of Deborah Evans, the DHA was spending substantial amounts on cardiac services, consistently with the high priority it gave to favouring the funding of that service along with renal services, another very acute speciality. The DHA had a range of strategies which embraced both acute services and community-based care. It is an over-simplification to say that the DHA's "policy was to minimise the growth of high-tech expensive acute

109 WIT 0159 0026 Ms Evans
110 WIT 0075 0010 Mr Baird
111 WIT 0075 0013 Mr Baird. See further WIT 0075 0022 (Mr Dhasmana, commenting on Mr Baird's views)

care"; one consideration for a Purchaser is the extent to which "high-tech expensive acute care" best meets the community's needs.'[112]

78 Mr Wisheart commented on the statement of Mr Baird:

'Para 42

'1. Ring fencing of Cardiac Surgical Funds.

- 'The term "ring-fenced" was appropriately used only in relation to the Supra-Regional scheme funding for the under ones.
- 'I believe that the other income generated by cardiac surgery was not "ring-fenced".
- 'Both before and after 1990 funds came to the hospital for cardiac surgery. My understanding was that as long as the volume of work was delivered any residual, marginal sums of money could be used at the discretion of the hospital.
- 'Mr Baird acknowledges this in Para 52.'[113]

79 Mr Wisheart agreed that 'surplus' funds from cardiac surgery were used to offset the financial overspends of other associate directorships within the Directorate:

- 'What Mr Baird describes here is essentially correct.
- 'The irony is that when cardiac surgery was transferred from the Directorate of Surgery to the Directorate of Cardiac Service it then bailed out an overspent Sub-Directorate of Cardiology.'[114]

Supra regional funding for the under-1s

80 Throughout the period 1 April 1984 to 31 March 1994, funding for the service for children aged under 1 year came from a fund managed centrally by the DoH: the Supra Regional Services Fund. With effect from 1 April 1994, supra regional funding ceased.[115]

112 WIT 0075 0021 Avon Health Authority
113 WIT 0075 0025 Mr Wisheart. Paragraph 52 of Mr Baird's statement is set out at para 76 above
114 WIT 0075 0026 Mr Wisheart
115 See Chapter 7

81 The financial effect of a service being designated as supra regional was that the money already being spent on that service by each of the designated supra regional centres was identified and 'protected' within the RHA's allocation for the following year. 'This meant that the region is obliged to make that amount of money available to the appropriate district for expenditure on the designated service.'[116]

82 When allocations were made for second and subsequent years, the total allocation for the previous year was increased in line with inflation and was again 'protected' within the RHA's allocation.

83 The allocations made were as follows in Table 7:

Table 7: Supra regional services paediatric cardiac surgery allocations – Bristol (cash value at the year indicated)

Financial year	Allocation (£) (cash value as at the year allocated)
1984/85	705,000[1]
1985/86	784,000
1986/87	341,000
1987/88	492,000
1988/89	573,000
1989/90	602,000
1990/91	689,000
1991/92	1,818,000[2]
1992/93	2,019,000
1993/94	2,048,000

1. An estimated figure provided by the BRI
2. UBHT 0277 0276; capital charging was included. A description of capital charging is at para 15

84 In determining the initial allocations to be 'protected' when the service was first designated, the Supra Regional Services Advisory Group (SRSAG) was dependent on financial data provided by the relevant regional treasurers. However, from 1985 onward, it moved towards an allocation system in which requests for additional funds were compared with workload costings. RHAs were allocated the amount they requested, or the costed workload, whichever amount was the lesser.[117]

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116 UBHT 0278 0611. The sum was also discounted when assessing the region's distance from its RAWP target. In addition to 'protecting' the amount of money already being spent, the SRSAG was also authorised to recommend that an additional sum ('new money') be pre-empted from the NHS allocation to enable the service to be expanded. This sum would be added to the RHA's allocation to be made available to the district for expenditure on the service. Such 'additional' sums were normally made on a recurring basis and were also discounted when assessing the RHA's distance from its RAWP target

117 This system included NICS from the financial year 1986/87: UBHT 0278 0611 – 0612

85 The SRSAG initiated a study of the services provided in each unit and the cost involved, so that recommendations might be made at a later date as to the level of expenditure to be protected during 1984/85 and funding levels for 1985/86.[118]

86 In his written evidence to the Inquiry, Mr Angilley[119] stated that the actual and forecast financial workload data sent in by the SRS centres was the basis for the following years' SRS (supra regional services) funding.[120]

87 Using activity data supplied by Mr Wisheart, Dr Joffe and Dr Jordan ('with slight amendments for details supplied by the nursing staff in both the Children's Hospitals and the Bristol Royal Infirmary')[121] the costs in Bristol for the years 1983/84 and 1984/85 were calculated.[122]

88 The protected funding level for 1985/86 was notified to the SWRHA in January 1985.[123] The allocation for Bristol was £784,000: the fifth highest allocation of the nine centres in the UK.

89 In December 1984 the first meeting of representatives from each of the nine centres designated to provide NICS discussed the definition of the protected service and the system for collecting information about expenditure and workload.[124] The representatives were invited to report on the current situation within each unit and the problems that they were encountering. The representatives from Bristol were Dr Joffe and Mr Wisheart. They reported that:

> 'The children's hospital dealt with Supra-Regional specialities of various kinds. The surgical work was carried out at the Bristol Royal Infirmary which treated only adults. Additional staff were needed since there was only one fully dedicated paediatric cardiac surgeon and there was a shortage of nursing staff. A large amount of "soft" money had been used for the purchase of equipment; on the surgical side: the RHA was embarking on an extensive programme of expansion, and plans for the development of paediatric surgery lay within the development of cardiac surgery generally, which has obvious nursing and manpower implications.'[125]

90 Further information to assist regional general managers in the funding of SRS was supplied by the Department in its paper RGM(85)9.[126]

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118 In April 1984 the DoH wrote to the Regional Administrator at the SWRHA requesting up-to-date information on activity and costs for the purposes of this study. The SWRHA Regional Administrator in turn wrote to the relevant local administrators to obtain the relevant information: UBHT 0278 0593

119 Administrative Secretary to the SRSAG 1987–1992

120 WIT 0034 0002 – 0003 Mr Angilley

121 UBHT 0278 0573; letter from Mr Hucklesbury to Mr McCelland dated 25 May 1984

122 UBHT 0278 0573; letter from Mr Hucklesbury to Mr McCelland dated 25 May 1984

123 UBHT 0278 0564 – 0566; letter from Mr Hurst dated 28 January 1985

124 ES 0002 0006; meeting on 5 December 1984

125 ES 0002 0009; minutes of meeting of representatives of the designated supra regional centres, 5 December 1984

126 UBHT 0278 0609; RGM (85)9

91 In March 1985 the SWRHA wrote to Dr Roylance (then the District General Manager of B&WDHA) seeking information on workload and expenditure to be used in calculating the allocation for 1986/87.[127] In August, Dr Ian Baker (then District Medical Officer, B&WDHA) supplied completed schedules showing the statistical and expenditure data for NICS.[128] Dr Baker indicated that an expansion of the workload for NICS was planned in 1986/87 and an increase in expenditure of £87,000 which was partly due to the development of the new catheterisation laboratory.[129]

92 In September 1985 Mr Antony Hurst (then Administrative Secretary to the SRSAG) wrote to Miss Catherine Hawkins[130] indicating that the SRSAG had given some preliminary thought to the recommendations it might make to ministers on allocations for 1986/87.

93 On 17 October 1985 Dr Martin Reynolds (Chief Medical Advisor/Assistant General Manager, SWRHA) responded to Mr Hurst objecting to the proposed methodology for the allocation of funds for 1986/87.[131]

94 On 1 November Mr Hurst replied indicating that he had put Dr Reynold's objections to the SRSAG at their meeting on 23 October, along with similar objections, which were received from the West Midlands:

> 'The Advisory Group considered these objections carefully, and looked in some detail at its proposal methodology and at the implications for the individual centres. It fully appreciated that the methodology was somewhat rough and ready, but decided that it was the best that could be devised in the circumstances …'[132]

95 Dr Reynolds had asked Mr Hurst to supply details of the calculations used by the SRSAG. On 11 December 1985 Mr Hurst replied drawing attention to a document sent, in confidence, to regional general managers in late November.[133]

96 When the financial allocations for 1986/87 were announced in January 1986,[134] it was also announced that ministers had decided that capital funding should be brought within the arrangements for supra regional funding from 1 April 1987. Regional health authorities seeking capital allocations for 1987/88 were to submit any application by 15 June 1986.[135]

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127 UBHT 0278 0519; letter dated 11 March 1985
128 UBHT 0278 0509; letter from Dr Baker to Mr Churchill at SWRHA dated 5 August 1985
129 Figure shown at UBHT 0278 0507 – 0508; Schedules
130 UBHT 0278 0504; letter dated 26 September 1985
131 UBHT 0278 0497; letter from Dr Reynolds to Mr Hurst dated 17 October 1985
132 UBHT 0278 0500; letter from Mr Hurst to Dr Reynolds dated 1 November 198
133 UBHT 0278 0493; letter from Mr Hurst to Dr Reynolds dated 11 December 1985
134 UBHT 0278 0474; letter from Mr Hurst to General Managers dated 16 January 1986; and UBHT 0278 0492; 'Supra Regional Services, 1986–87'
135 UBHT 0278 0474 – 0483; letter from Mr Hurst to General Managers dated 16 January 1986; and UBHT 0278 0492; 'Supra Regional Services, 1986–87'

97 As with revenue funding, the sums to be allocated to supra regional services for capital funding had to be found from within the total resources available nationally for allocation to health authorities. Proposals for capital funding for supra regional services were to be referred to the SRSAG. Regions were advised by the DHSS about schemes that might be approved for funding:

> '1. New development, or expansion, of a unit to enable a greater quantity of service to be provided, will be funded through a central pre-emption on health authority capital. Such schemes will be subject to Advisory Group scrutiny of the level of increased service planned.
>
> '2. Replacement and/or upgrading of existing capital stock without any increase in the number of patients treated and developments which mainly consist of replacement or upgrading, will be funded in part by the host region, pro-rata to the use made of the unit by its own residents (averaged over the preceding three years) and the remainder by central pre-emption on health authority capital.'[136]

98 The protected revenue funds for Bristol for 1986/87 were £326,000. In addition, £15,000 'additional central pre-emption' was added, making a total of £341,000. 'Pre-emption' meant that this sum of money was anticipated as being available from the following year's financial allocations. Bristol's allocation of funds was the lowest of the nine centres, the next lowest being Newcastle with a total allocation of £693,000. The reason for the reduction in the amount allocated was directly related to the return made by Bristol to the SRSAG.[137] Fewer patients (137) had received inpatient treatment in 1984/85 than had been anticipated (247).[138]

99 In February 1987,[139] the Secretary of State announced his decision for the 1987/88 funding. He stated that the 'protected funding level' for Bristol was to be £357,000, and that the 'additional central pre-emption' was £135,000. This made a total of £492,000. The 'additional central pre-emption' was significantly larger than any granted to the other centres. The overall allocation to Bristol was such that, of all centres, it ranked second lowest, the lowest being Harefield.[140]

100 The announcement also indicated that: 'The Advisory Group envisaged that there would be little need for expansion in the total service'.[141]

101 1987/88 was the first year in which the SRSAG considered applications for capital allocations. Two centres carrying out NICS applied for capital funding. They were Liverpool (which applied for £89,000) and Bristol (which bid for £265,000).[142]

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136 UBHT 0278 0483 'Supra Regional Services, 1986–87'
137 UBHT 0278 0477 'Supra Regional Services, 1986–87'
138 UBHT 0278 0543 – 0556
139 UBHT 0278 0410 DHSS press release
140 UBHT 0278 0416; Harefield Hospital was thereafter to plan and perform its work in conjunction with the Brompton Hospital
141 UBHT 0278 0417 DHSS press release
142 For further details see Chapter 7

102 The SRSAG gave priority in capital allocation: '… to those Supra Regional Services and those Supra Regional Centres where an expansion of workload is envisaged during 1987/88 and beyond.'[143]

103 On 13 November 1987, the DHSS wrote to Catherine Hawkins indicating that the application for capital funding for extending the areas for wards and for operating theatres in the BRI had not been recommended for funding.[144]

104 Mr Nix wrote in a memorandum of 3 December 1987 to Mr Boardman:

> 'The bid to the DHSS was a combined effort between myself and the Regional Treasurer in an attempt to obtain funding to offset the capital injected by the Regional Health Authority into the developments at the BRI and the Childrens Hospital for cardiac services. The fact that we have not received any funding does not effect [*sic*] this District, it just means that the RHA has had to foot the full capital bill.'[145]

105 The total supra regional allocation of funds to Bristol for NICS for 1988/89 was £573,000, including an additional central pre-emption of £59,000.[146]

106 The SRSAG asked the SWRHA to provide a short report on the funding allocated to NICS in Bristol. On 19 August 1988, Catherine Hawkins wrote to Dr Roylance asking him to provide a brief account of the benefits obtained from the expenditure of supra regional funding and confirmation that increases in workload proposed for 1988/89 would be achieved as a result of the allocation of the funds.[147]

107 The funding allocation for 1989/90 was announced in December 1988. Bristol was allocated a total of £602,000.[148]

108 The allocation for 1990/91, announced on 3 January 1990, gave Bristol a total of £689,000.

109 The NHS reforms planned to take effect in April 1991 meant that the SRSAG would act as the 'purchaser' of the services for NICS from that date.[149] The process of contracting is set out later in this chapter.

110 In 1992, Bristol made a second bid for SRS capital funding, this time in the amount of £300,000. The money was to enable them to locate all paediatric cardiac surgical services on one site.[150] The projected total cost was £550,000. The proposal was that

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143 UBHT 0278 0421 DHSS press release
144 UBHT 0278 0279; letter from S Hiller, DHSS, to Miss Hawkins dated 13 November 1987
145 UBHT 0278 0258; letter from Mr Nix to Mr Boardman dated 3 December 1987
146 UBHT 0062 0430; letter from Mrs Clark to Dr Freeman dated 24 March 1988
147 UBHT 0278 0177; letter from Miss Hawkins to Dr Roylance dated 19 August 1988
148 UBHT 0278 0154 – 0156 DoH press release dated 29 December 1988
149 UBHT 0064 0090 – 0091 *'Supra Regional Services 1991–92'*
150 DOH 0002 0141; SRS(92)12

the remainder of the cost would be met by the UBHT. A paper, dated April 1992, prepared by the Secretariat of the SRSAG stated:

> 'The proposal submitted was only a draft outline requiring further discussion and planning. Until a firm proposal and a justified business case is received members are invited to defer this request.'[151]

111 Mr Nix told the Inquiry that he had not been aware that this bid had been submitted to the SRSAG until it was drawn to his attention by the Inquiry.[152] The bid appears to have been submitted by Dr Joffe.[153] Mr Nix went on to say that he had written a paper, setting out what work would be necessary to make a submission, dated 9 June 1992.[154] Thereafter, an 'outline submission' or 'interim statement' had been submitted about two weeks later in a document sent under cover of a 'with compliments' slip from Dr Joffe. The bid, Mr Nix went on, was clearly 'not extensive in its content'.[155]

The process of contracting

112 With the introduction of the internal market in the NHS in April 1991, the SRSAG became a 'purchaser'. It indicated that its role would be: '… to advise Ministers on the units with which contracts should be placed…'.[156] At its meeting in July 1990 it was noted that the National Health Service Management Executive (NHSME) was to provide arrangements for monitoring contracts.[157]

113 On 13 December 1990, a discussion took place about the draft contract with Bristol for the year 1991/92.[158] The discussion was between Mr Cameron,[159] Mr Nix, Mr Wisheart, Dr Joffe, Mr Barrington and three Department of Health representatives. The contract, which was in draft,[160] provided that the Unit: '… will ensure that the quality of the service is clinically and socially satisfactory, and will seek constantly to improve it.' It was to monitor regularly: '… all relevant aspects of the service, and make the results available to the purchaser.'[161] The Unit was to provide an Annual Report, dealing with matters such as 'quality of service' and 'statistics' as well as information on waiting lists and copies of the standards on quality agreed with the major purchaser(s). There was also an obligation to supply to the Department of Health a copy of the relevant part of the return to the UK Cardiac Surgical Register (UKCSR).[162]

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151 DOH 0002 0148; SRS(92)12
152 T23 p. 34 Mr Nix
153 JDW 0003 0142
154 This date is after the decision had been made to defer a request for funding pending a 'firm proposal and a justified [business] case'. T23 p. 35 Mr Nix
155 T23 p. 35 Mr Nix
156 UBHT 0064 0091; January 1991
157 DOH 0002 0194; minutes of meeting on 26 July 1990
158 UBHT 0277 0254; draft contract
159 Mr Ewan Cameron, Assistant Treasurer, Senior Assistant Director of Finance
160 The final version of the contract is at DOH 0004 0001, signed at DOH 0004 0009; the version signed incorporated the points discussed above
161 DOH 0004 0004; contract
162 DOH 0004 0007; contract. For the Register, see Chapter 19

114 In October 1991, the DoH commissioned a study by a management consultancy of the cost of the SRS.[163] By this time, removal of the NICS service from the supra regional system, or 'de-designation', was under discussion by the SRSAG.[164] De-designation took place with effect from 31 March 1994 and raised complex financial issues.[165] The funding previously made available directly from the DoH for neonatal and infant paediatric cardiac surgical services was instead apportioned by it amongst the regions, on the basis of past usage. Regional general managers promised to ensure a period of 'steady-state' for such services in the year following their removal from the supra regional arrangements.[166] Mr Nix gave evidence that at the time he was concerned about the proposed method to be used for the distribution of funds to the local purchasers. But he stated that, in the event, the possibility of losing funding through the reorganisation of funding arrangements did not materialise.[167]

115 As regards the effect which the de-designation of Bristol *alone* (without the de-designation of the other centres) would have had on the Bristol Unit, Dr Roylance stated in his written evidence to the Inquiry:

> 'Although I did not know it at the time, I now understand that the possibility of the unilateral de-designation of Bristol was being considered by the Supra-Regional Services Advisory Committee. It is right to point out that the unilateral withdrawal of centrally allocated funds for neonatal and infant paediatric cardiac surgery would have had no significant impact on the institution as a whole. The reduction in funding would have been addressed in negotiations for contracts for the successive year, presumably allowing an immediate increase of adult cardiac surgery within the resources at the BRI.'[168]

The effect of the cessation of supra regional funding

116 Following de-designation and the cessation of SRS funding on 31 March 1994, the SRSAG funds were reallocated to the various purchasing health authorities. Mr Nix stated that decisions about purchasing then rested with individual health authorities.[169] The UBHT entered into contracts directly with each of the health authorities, just as it did for other services provided by the Trust.

117 Mr Nix stated that 'in simple terms', when a child was referred from outside the area of the Avon HA, the health authority in whose area the child lived would be sent an invoice for the cost of the treatment.[170] The cost of treatment for those patients who

163 UBHT 0064 0182 – 0183; UBHT 0277 0141
164 This topic is addressed, in detail, in Chapter 7
165 UBHT 0064 0292 – 0316: UBHT 0277 0006 – 0007
166 DOH 0002 0249; detailed figures are at DOH 0002 0253
167 WIT 0106 0033 Mr Nix. See Chapter 7
168 WIT 0108 0017 Dr Roylance
169 WIT 0106 0032 Mr Nix
170 WIT 0106 0009 Mr Nix

lived within the Avon HA's boundaries was included in the block contract between the Avon HA and the UBHT.[171]

118 Deborah Evans stated:

> 'For the years 1994/95 and 1995/96, neo-natal and infant cardiology and cardiac surgery was no longer a designated supra-regional service. The terms under which services became de-designated were that health authorities received a sum of money relating to their usage of the service and were required to purchase an equivalent level of service in Year 1 (1994/95). In other words, they had to spend the same amount of money with the same NHS Trust for the same volume and type of service.'[172]

119 Miss Lesley Salmon stated:

> 'Following de-designation the Unit had to be more concerned about the number of referrals and where referrals were coming from in order to maintain income levels to sustain the service. In effect, the health authorities were responsible for purchasing the services they wanted and had to make sure they had enough money to continue the service. Financing of the service after de-designation was less certain, and the business side of paediatric cardiac surgery had to be more actively managed. The ongoing daily management issues that had to be actively managed all of the time were trying to get the right number of cases through, for the right health authority, for the right cost. … Every case counts because contracts are agreed at a cost per case. This was a high risk area financially for the Trust.
>
> 'After de-designation it became clear that the amount of money that the Trust had been getting for the under 1 contract was quite generous. I was aware that there was an issue about recovering enough money from purchasers to continue to fund the service after de-designation. This was a financial issue I was not involved in negotiating.
>
> '… There was some concern amongst clinicians that contracts might take precedence over clinical need, but this was not a problem in practice as urgent cases still took priority.'[173]

120 Dr Ian Baker stated in his written evidence to the Inquiry:

> 'De-designation placed the planning and commissioning of cardiac services for the neonates and infants with individual Health Authorities with little by way of specific guidance. The volume of service required by any one Health Authority was small although the range of defects presenting and the range of treatment required

171 WIT 0106 0009. The agreement between the Bristol and Weston Health District Authority for 1994/95 is at HAA 0156 0383. The agreement between the UBHT and Avon Health Authority for 1995/96 is at HAA 0161 0001
172 WIT 0159 0015 Ms Evans
173 WIT 0109 0003 Miss Salmon

could be large in any one year. Determining the range of care required and a level of investment for acceptable outcomes became difficult …

'There appeared to be no handover advice from the DoH or their clinical advisors.'[174]

The financial management of the budget for Paediatric Cardiac Surgical Services, 1984–1990

121 As set out earlier paediatric cardiac surgical services during the period 1984/91 were part of two separate management sub-units within the B&WDHA. The seven budget books, which cover this period, provided to the Inquiry by Mr Nix, do not separately identify the financial allocations made to the various services provided in the sub units. It is not possible to identify how the funding associated with NICS (from the SRS) was distributed to the different components of the paediatric cardiac surgical service. The funding is not separately identified as income coming into the Central Unit, nor is it separately identified in the narrative that precedes the financial allocations. Rather, the SRS funding was added to the general sum of the District's funding.

122 Within the Central Unit's budget, the only specific reference to cardiac surgical services is to cardiac perfusion. This is in the 1985/1986 Budget Book, which shows three entries:

Cardiac perfusion	Approved budget [£]	Revised budget [£]
Prof & Technical	57,030	67,990
Travel	1,360	1,360
Other	50	50[1]

1. UBHT 0339 0243

Resources

123 The word 'resources' is used in this section to mean not only financial and material resources, but also to the availability of human resources. It refers to staffing, qualifications and the workload imposed on staff.

The relation between funding and clinical services

124 Dr Roylance commented:

'… I am not aware of any positive incentives in relation to the services offered that were created by the methods of funding paediatric cardiac surgery. Indeed,

[174] WIT 0074 0030 Dr Baker

throughout my time first as District General Manager and then as Chief Executive, I was constantly seeking to persuade all clinicians that issues of funding of services mattered. The tendency during that period was for all those in the National Health Service to regard any purported or proposed financial restrictions on clinical activity as unacceptable, if not frankly immoral. This was the "culture change" referred to in the notes of the meeting of the Executive Directors Group held on 8 May 1991,[175] on which I have been asked to comment.

'As far as I am aware, throughout the relevant period, children referred to Bristol for care were accepted and treated solely on the basis of their clinical need, and were referred elsewhere if that was considered to be in their best interests.'[176]

125 Dr Roylance continued:

'Throughout the period under review I, as District General Manager and then as Chief Executive, was repeatedly urged to effect an improvement in each and every service that we provided. I cannot now recall any specialty or department which did not press for improvements, usually requiring substantial sums of additional capital and revenue expenditure.

'The demands for improved facilities, etc. were very often expressed in exaggerated and emotive terms. I do not say this intending to be pejorative: people working in the health service have always been characterised by the strongest desire to do the very best possible for their patients and it is a source of very real frustration and distress to carers that what may technically be possible is often practically not available. Lack of funding for the maintenance, development or improvement of a service has always been one of the most frustrating problems within the National Health Service.

'I was committed to obtaining the maximum possible level of funding for the services we provided, and I believe that there was a strong culture within the Trust of creativity in the identification and securing of additional sources of income, led by Graham Nix as Finance Director. However, I have never seen overspending as an acceptable solution to the problem of under-funding: it was my responsibility to ensure that the District Health Authority and then the Trust provided the best possible care within the resources available. Indeed, during the selection process that led to my appointment, I was required to give a presentation on how, within a 5 year timescale, I would bring the Health Authority within budget. When I was appointed, the Appointments Committee made clear that this was my primary responsibility.

'Once the budget had been set, therefore, I could not allow it to be exceeded. However, I know that elsewhere in the NHS overspending sometimes occurred and I am sure that the fact that from the year after I took up the post of DGM we

175 UBHT 0240 0742; notes of the meeting of the Executive Directors Group, 8 May 1991
176 WIT 0108 0003 Dr Roylance

remained consistently within budget was sometimes a source of additional frustration to those clinicians that saw other Authorities and Trusts "getting away with it", although I believe that we had done much to change the culture within the Trust, as I set out in my statement on Issue B.

'It is against this background that requests were repeatedly made over a number of years for improvements in the provision of paediatric cardiac surgery. Unfortunately, this fact alone did not distinguish this service from any other. One of the tasks of a District General Manager was to balance the competing needs of all the services within the District, and with the introduction of contracting it became harder to find "spare" money for ad hoc projects. Cross-funding was not permitted, so that savings made in other areas of the Trust could not be used for paediatric cardiac surgery: the funding for the improvements had to come from cardiac surgery itself.'[177]

126 Dr Roylance went on:

'I had been aware for some time that paediatric cardiac surgery was not achieving its full potential. The experts in the field were all agreed that UBHT needed to appoint a dedicated surgeon for the paediatric work and move the surgery to the Children's Hospital. The necessary management action had therefore been identified and work was being done to achieve both of those aims. In the financial climate of the time, where budgetary constraints were many and cross-funding of services was expressly prohibited, it had proved extremely difficult to identify the necessary funding.'[178]

127 Mr Baird commented, in his written evidence to the Inquiry, on the change to trust status:

'Dr Roylance had to push us into functioning as a Trust in the first wave. Initially there were the advantages of flexibility and leading the way. Trust status was achieved against opposition from many doctors in Bristol. However, the subsequent development of the NHS has proved that his decision to make us a first-wave Trust was a wise one.

'The theme was that money followed the patient thereby bringing business values to the NHS. There was resistance to this: staff simply wanted money to develop their services, as had been the traditional way of working.'[179]

177 WIT 0108 0118 – 0119 Dr Roylance
178 WIT 0108 0127 Dr Roylance
179 WIT 0075 0008 Mr Baird

Cardiac surgery and cardiological services at the BRI

128 Dr Johnson (Chairman of the Division of Anaesthesia), wrote to Mr Wisheart, Mr Keen and Mr Dhasmana, in June 1988:

> 'I am afraid that the Summer months are going to be a little problematic regarding experienced staffing of the Cardiac Unit. The most difficult months will be July and August when we will not have Steve Bolsin and there will be considerable consultant leave being taken. Donald [Dr Donald Short, consultant anaesthetist UBH/T] will provide you with full details, but I would ask you to be patient with us and go carefully on workload until September, when I hope that our anaesthetic service will match your every requirement (or almost so).'[180]

129 Dr Russell Rees, consultant cardiologist (adults), set out his views about the resources available for cardiological services in a letter to Mrs Margaret Maisey dated 3 June 1991:

> 'Thank you for asking me to list the main problems with cardiology following our meeting with the Chairman.
>
> 'We are faced with difficulties which have gradually built up over the years as district and regional demands for cardiological services have rapidly increased outstripping local resources and regional funding. The problems are inter-related and are listed below.'

As regards beds, he stated: 'There is a severe shortage [of beds]… '. As regards staffing, he wrote: 'At present we are just about coping, but serious problems will appear if we successfully contract for more work and our bed state improves … This lack of junior support for our senior registrars was severely criticised by the review body of the Royal College of Physicians at their last review, when withdrawal of recognition was threatened if things were not improved.'As regards emergency services, he wrote: 'As a result of delays, this aspect of our work is rapidly increasing. Many patients wait much longer than desirable in peripheral hospitals before transfer. Their management when they arrive disrupts planned work both by ourselves and surgeons. There are always appreciable delays before these patients can be transferred from our [cardiology] beds to the cardiac surgical unit, and seriously ill patients can wait three to four weeks. If we were to increase our throughput substantially, it would have serious implications for the surgical unit.'[181]

130 Surveys of cardiological staffing levels conducted on behalf of the British Cardiac Society (BCS) and others, indicated the national situation at various times. In 1988:

> '… there were less than six cardiologists per million population. The United Kingdom, with Ireland, has fewer cardiologists than all other European countries

[180] UBHT 0162 0084; letter from Dr Johnson dated 13 June 1988
[181] UBHT 0038 0280 – 0281; letter from Dr Rees to Mrs Maisey dated 3 June 1991

with reliable figures. The ratio for Europe as a whole is approximately 45 per million population; the recommended figure for the United States of America is 60 per million. The distribution of cardiologists in England and Wales is still very uneven. Seven million people – nearly 15% of the population – have no immediate access to special expertise in cardiology…

'The total number of cardiologists within the regions shows wide disparities that do not appropriately reflect the differences in population. For example the South Western region has one cardiologist for every 246,500, whereas North West Thames has one cardiologist for every 140,500.'[182]

131 In 1992, the position as regards paediatric cardiologists was stated to be as follows:

'The present staffing levels for paediatric cardiology in the United Kingdom are perilously low, and not comparable to those in most developed countries. Their training depends on eight senior registrar posts with two others agreed but not yet implemented.'[183]

132 In Bristol, there were problems in recruiting a paediatric cardiologist during the 1980s. Dr Martin was eventually appointed on a proleptic basis.[184]

133 The paediatric cardiology service in Bristol was provided by consultants only; there were no junior staff training to be paediatric cardiologists, who would have been capable of relieving their consultant colleagues of some of their workload.

The status of paediatric cardiac surgical services in Bristol

134 Dr Joffe told the Inquiry that he considered that paediatric cardiac surgery and paediatric cardiology were given a lower priority than adult cardiac services. Developments in the children's services were, he said, achieved: '… on the back of adult developments…'.[185] He commented, in evidence in the following exchange:

'Q. In comparison with the adult service it was the orphan service, was it?

'A. Yes, it was the stepchild, it always has been …'[186]

182 BCS 0001 0018 – 0020; Chamberlain D, Bailey L, Sowton E, Ballantyne D, MacBoyle D, Oliver M. *'Staffing in Cardiology in the United Kingdom 1988 Fifth Biennial Survey'*. From the Sussex Centre for Medical Research, University of Sussex, Brighton, in collaboration with the Cardiology Committee, Royal College of Physicians of London and the British Cardiac Society

183 BCS 0001 0096; Chamberlain D, Parker J, Balcon R, Webb-Peploe M, Cobbe S, Boyle D, Tynan M, Hunter S, Reval K. *'Eighth Survey of Staffing in Cardiology in the United Kingdom 1992'*

184 Appointment of a consultant on a proleptic basis is where the appointment is made in anticipation of further training taking place in the consultant grade

185 T90 p. 32 Dr Joffe

186 T90 p. 33 Dr Joffe

Resources for neonatal work

135 Paediatric cardiac surgical services in Bristol were part of a larger range of neonatal[187] services. In 1986, a document from the B&WDHA, entitled *'Strategy for Neonatal Care 1986–1994'*, stated:

> 'Professional representation has indicated a desire to increase the quality of services generally and to maintain or improve access to services in Bristol Maternity and Children's Hospitals for obstetric and neonatal referrals from within and outside the South Western Region. A key request was an increase in nursing levels to manage the desired workload without undue stress on those concerned … The strategy has been accepted as one which takes into account a Regional commitment, "to provide adequate facilities for the intensive care of infants (in consultation with neighbouring authorities if necessary)", and a pragmatic assessment of the opportunities for implementation throughout the decade. The adequacy of facilities for intensive care contributed by this District will be determined on a year to year basis in the light of developments in other Districts and agreement on the best balance of all aspects of obstetric, neonatal and children's care within the District's Children's and Maternity Unit.
>
> 'Members of the Authority's Policy, Planning and Resource Committee and District Managers acknowledge that in interpreting the policy of the Authority and accepting the resource assumption for planning that there will be a shortfall of attainment for future care of neonates. Members are not unaware of the extra strain which will be placed upon staff in the exercise of their professional judgment and in their relationship with the parents. If the District's resource allocation increases in the future and the policies of the Authority change, the opportunity to respond to future demand … will be taken.'[188]

136 Mr Nix commented on this document in the following exchange:

> 'Q. I appreciate that is not essentially concerned with neonatal cardiac surgery, but what it is, so it would seem … suggesting is that there was a shortfall of attainment, and going to be a shortfall in attainment in the care of neonates [in] the following years, and "shortfall in attainment" means essentially a lack of provision, which comes back in the end to staffing and money; is that right?
>
> 'A. Yes, what was technically going to be achieved for neonates was going to be expanded and is still expanding even now and there are strains on the service.'[189]

187 That is, children of under 1 month old
188 UBHT 0238 0236, dated 1 May 1986. This strategy was adapted as policy: UBHT 0076 0058
189 T22 p. 88 Mr Nix

Strains on resources more generally

137 The Inquiry received evidence of many other examples of strains on resources. After an inspection visit to the BRI and BRHSC in 1992: '… because of major alterations in the organisation of medical services at these hospitals' the Regional Advisors of the Royal College of Physicians (RCP) reported that there was:

> '… a happy, hardworking, cohesive hospital team.'[190]

The RCP Regional Advisors also identified:

> '… major problems due to the great increase in workload in emergency medicine without commensurate increase in resources. When a full complement of staff is present, the system is just able to cope, but if anyone is on leave those remaining can be stretched to the limit and the level of cover is inadequate to ensure proper training. It seems probable that, at times, the quality of patient care may fall below safe levels. In my [Professor Alberti's] discussions with Managers, it was clear that they are aware of these difficulties …'[191]

138 Dr Roylance told the Inquiry:

> 'When we were at District … we had a finite sum of money, which everybody, including me, agreed was woefully inadequate, and we had what people have described as an "infinite demand". … And this I tried to say is a fundamental challenge to the health service. You do not resolve it by pretending it was not there or wishing it was not there, you have to address it. I believe one of the major steps which helped in addressing that issue was to separate the very difficult task of deciding what was necessary from the challenge of delivering what was decided …'[192]

139 Dr Roylance went on:

> 'If you strategically plan a new unit like the Children's Hospital and then do not get contracts for it, I think somebody ought to have the situation discussed with them. I mean what I am saying here is that the cardiac disease was a major cause of death and demand in the regional services is high and so on, and this is an issue that we are not meeting the demand for cardiac services and we were not committed to developing the service. Of course the Trust is and was committed to developing the service, but only as far as the purchasers were committed to buying that service.'[193]

190 WIT 0032 0259 Professor Sir George Alberti
191 WIT 0032 0259 Professor Sir George Alberti
192 T25 p. 153–4 Dr Roylance
193 T24 p. 156 Dr Roylance

Beds

140 As regards shortages of beds, a visit to the Bristol hospitals in October 1986 by the General Professional Training Team of the Royal College of Physicians reported that:

> 'The number of beds in the Bristol Royal Infirmary in Medicine is just about adequate to enable training of the present Junior Staff level, and further reductions in bed numbers might impair the training programme. Junior Staff were genuinely concerned that they spend too much time attempting to find beds.'[194]

141 As regards delays in admitting paediatric patients, the minutes of meetings of the Division of Children's Services[195] commented on shortages of beds in the Children's Hospital throughout 1987:

> *'April*. Restriction of admissions … Dr Hinde reported that the bed situation in the Children's Hospital had eased somewhat over the past month, although this was a normal trend for the time of year. Notwithstanding this, the ITU had been closed to admissions between 17th–20th March, and the whole Hospital had been closed on 24th March. In addition, a total of 7 transfers to Southmead had had to take place during April (to date) because of lack of available cubicles for children needing isolation. It was noted with concern that the BCH was still not functioning fully as a District General Hospital for Children.
>
> 'It was further noted that the only long-term solution to the problem was to open one of the closed wards, but that this would require funding for additional nursing staff. Miss Stoneham advised Division that the deficiencies in the service being provided by the Hospital were regularly pointed out to the District Health Authority.'[196]
>
> *'May.* Restriction on admissions … Dr Hinde reported that, during the past month, it had not been necessary to refuse any admissions. This was considered, however, to be the normal seasonal pattern, and Division still endorsed the need for action to be taken to avoid a repetition of the severe bed problems that had been experienced during the Winter months.'[197]
>
> *'July.* Closure of hospital to admissions. Dr Hinde wished to draw the Division's attention to the situation which had once again arisen recently, when there had been no paediatric beds available in Bristol for emergency admissions. On that occasion it had been necessary to discharge sick children from BCH against informed medial opinion.

194 WIT 0032 0255 Professor Sir George Alberti
195 Of the Bristol and Weston District Health Authority
196 UBHT 0211 0085; minutes of meeting held on 21 April 1987 (month emphasised in original)
197 UBHT 0211 0078; minutes of meeting held on 19 May 1987 (month emphasised in original)

> 'The Chairman acknowledged receipt of Dr Hinde's letter on this issue, and undertook to respond when he had had an opportunity to consider it more fully, and to bring the concern of Division about patient safety once again to the attention of the Health Authority.'

The minute noted that savings of £26,000 had to be identified out of the medical staffing budget over the next ten years.[198]

142 In January 1991, the minutes of the meeting of the Division of Surgery recorded:

> 'Because of the lack of funds, the ITU would remain at its present size of 7 beds when the ceiling replacement and refurbishment were undertaken.'[199]

143 In relation to paediatric cardiac surgery at the BRI, Mrs Fiona Thomas[200] stated in her written evidence to the Inquiry:

> 'Some surgeons complained at times if there was a shortage of beds for adult cases as children were staying in ITU and blocking beds.'[201]

She stated that, at this time, the adult service was being expanded, but that beds in the ITU were often occupied by children. This only enabled a certain number of adult patients to be operated upon on any given day.[202]

144 Fiona Thomas explained, in the following exchange:

> 'Q. So it could be the case, could it not, that there would be adults ready, willing and able to have their operations, but no available space in intensive care to house them after the operation?
>
> 'A Yes. It is the same situation as there is today, yes: lack of beds, basically, in the intensive care unit. Patients are not well enough to move through as we would have necessarily planned, yes.
>
> 'Q. So there is always a demand for particularly adults to have surgery, and one of the bottlenecks is to be found in intensive care?
>
> 'A. Yes.

198 UBHT 0211 0049; minutes of meeting held on 21 July 1987 (month emphasised in original)
199 UBHT 0200 0046; minutes of meeting held on 9 January 1991
200 Clinical Nurse Manager, BRI
201 WIT 0114 0029 Fiona Thomas
202 WIT 0114 0029 Fiona Thomas

'Q. But that bottleneck would be more marked, more profound in the days when there were children in the intensive care because they would be there for longer?

'A. Yes, and you could have three or four beds blocked for a longer period of time because they were not moving through, yes.

'Q. So that led to some tension, did it?

'A. Yes, it did, yes.'[203]

145 Kay Armstrong[204] told the Inquiry that it was a regular occurrence to be told at the start of a day that an operation would have to be cancelled because of the lack of an intensive care bed, or a shortage of trained nurses in the ICU or the operating theatres.[205]

146 Dr Piers Rowlandson, a referring consultant paediatrician from Swindon, stated in his written evidence to the Inquiry that delays due to shortages of beds were not peculiar to Bristol. He explained that children with heart problems were referred from Swindon to either Bristol or Oxford. He stated that, initially, Oxford had not appointed a dedicated paediatric cardiac surgeon, but that even:

'… when Oxford had appointed a paediatric cardiac surgeon the choice was still Bristol for many patients because of lack of beds in Oxford. Bristol too often had a problem finding a bed. The whole service seemed chronically under resourced.'[206]

Nursing staff and sessions for cardiac surgery

147 In December 1985, the Acting General Manager of the Children and Obstetrics Sub-Unit, Geraldine Martin, wrote to clinicians and the managers at local health authorities. She noted the 'particularly acute' staffing difficulties at the Special Care Baby Unit at the Bristol Maternity Hospital. Patients who normally resided outside Avon would no longer be admitted. She continued:

'With regard to the Bristol Children's Hospital, acute staffing difficulties also persist here and by taking the above action additional pressures will be placed on ITU. Referrals to the ITU will however continue as at present but acceptance of referrals will have to be subject to the availability of nursing staff. Before any referrals are formally accepted by any member of the medical staff the current and expected workload on the Unit and within the Hospital as a whole should be checked by the Registrars on duty or On Take Consultant with the Senior Nurse in charge so as to ensure that appropriate care can be given to that referral. If neonatal surgical patients have to be refused then the referring Clinician should be advised to seek equivalent paediatric surgical expertise in either Southampton, Oxford,

203 T32 p. 48 Fiona Thomas
204 Cardiac Sister, BRI, 1984–1995
205 T59 p. 12–13 Mrs Armstrong
206 REF 0001 0036; letter from Dr Rowlandson dated 31 August 1999

Birmingham, or London, and Miss Noblett, Consultant Paediatric Surgeon, has already alerted these centres to this situation.

'This restriction on bookings to S.C.B.U.[207] will be operative with effect from 1st January 1986 and will continue until such time as the staffing situation improves on the Unit, and further notification will be made at that time.'[208]

148 On 27 January 1987, Mr Dhasmana wrote to the Chairman of Children's Services, Dr Martin Mott, and the Chairman of the Division of Anaesthesia, Dr Robert Johnson, suggesting that an additional operating session for cardiac surgery at the BRHSC be held on a Monday morning, as the theatre time and space were available. Mr Dhasmana stated that Mr Wisheart supported him in this.[209]

149 On 24 March 1987, Dr Mott wrote to Mr Dhasmana, saying that this could not be accommodated: '… the nursing staff required to support the extra session are not available, and you will be well aware of the fact that our nursing allocation is already used to the full.'[210]

150 The matter was raised again by Mr Dhasmana in January 1989 in a letter to Dr Roylance:

'I am now requesting, through your office, reconsideration of my earlier proposal. There is a space available and if this session could be funded it would provide me one morning session every week. This would help to cut down the Waiting List on my routine cases, and reduce some of the emergency work which I do outside the normal routine hours. I am enclosing a copy of my previous letter for your perusal.'[211]

151 No progress having been made, Mr Dhasmana continued to work outside routine hours. He again raised the matter at a meeting of the Division of Children's Services[212] on 20 February 1990.[213] The minutes recorded:

'Mr Dhasmana raised the need for an additional cardiac surgery operating session at BCH. At present a proportion of cardiac surgery was undertaken out of hours because of the lack of scheduled sessions, both inconvenient and costly. … Miss Stoneham agreed to look into this.'

152 During his oral evidence, Mr Dhasmana confirmed that, in his letter of 17 November 1988 to Dr Alastair Mason, Regional Medical Officer, he had stated that there

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207 Special Care Baby Unit at Bristol Maternity Hospital
208 UBHT 0238 0411; letter from Ms Martin dated 30 December 1985
209 JPD 0001 0001 – 0002; letter from Mr Dhasmana to Dr Mott dated 27 January 1987
210 UBHT 0212 0083; letter from Dr Mott to Mr Dhasmana dated 24 March 1987
211 JPD 0001 0007; letter from Mr Dhasmana to Dr Roylance dated 20 January 1989
212 Of the Bristol and Weston District Health Authority
213 UBHT 0208 0091; minutes of meeting held on 20 February 1990

was a: '… lack of resources and it was a constant struggle for time, for theatre space, and also for medical and nursing manpower to look after my cases.'[214]

153 In January 1988 the minutes of a meeting of the Division of Children's Services recorded:

> 'Nurse staffing …
>
> 'As discussed at the previous meeting of Division, a working group has been convened to discuss possible solutions to the problems caused by the acute shortage of nursing staff. As a result, it had been agreed to close Ward 31 for a period of one month, in order that the situation could ease somewhat, and to allow an intensive programme of training in paediatric nursing for RGNs to take place. Miss Perrett said that it was planned to reopen Ward 31 over the weekend of 23rd/24th January, and, although the temporary closure *had* partially eased the nursing situation, the previous difficulties would return once the ward re-opened. Although cover had been maintained on the ITU, this had only been done with difficulty, and on some occasions, the Unit had relied on bank staff for cover. However it had been possible to send a number of nurses on an intensive two week training course designed to give them a greater understanding of paediatric nursing, and this had been extremely well received by the participants.'[215]

154 Michelle Cummings, mother of Charlotte, told the Inquiry of her experience in the ICU at the BRI in 1988:

> 'I do know, when Charlotte was in intensive care, that she had a student nurse looking after her. I think there was a question, being that it was the BRI, it was not the Children's Hospital, it was a mixed intensive care, whether there were actually enough paediatric trained nurses, and I spoke to many of the nurses about this, and it was something they themselves were extremely concerned about. I know they were extremely concerned over the resources that were available to them at that time. So, yes, there were definitely students there, and at times, instead of having a 1-to-1, it was a 1-to-2, so one nurse would be looking after two …'[216]

155 In the following exchange, Belinda House, mother of Ryan, told the Inquiry of her experience in 1989, when a transfer from Southmead Hospital to the BRHSC had to be arranged:

> 'Q. So were arrangements made to make that transfer?
>
> 'A. Well, that was very traumatic. Mr [*sic*] Joffe told us we had to be at the Children's [Hospital]. The doctor again got on the phone, because he had to arrange for theatre space, at a convenient theatre at the Children's. He spent an

214 UBHT 0174 0013 Mr Dhasmana
215 UBHT 0211 0108; minutes of meeting held on 19 January 1988 (emphasis in original)
216 T3 p. 142 Michelle Cummings

awful lot of time doing that, which was very distressing for him. He then found the theatre space and could not find the nurses to staff the theatre. That went on for a very long time, until Julian and I actually suggested, could we pay agency nurses, because we were so desperate, because we knew this procedure had to happen within so many hours.

'Q. Can I stop you there. You say he was having difficulty finding theatre space. That is theatre space at the Children's Hospital?

'A. At the Children's Hospital.

'Q. You then went on to say there was difficulty finding nursing staff?

'A. Yes.

'Q. Was that in relation to nursing staff at the Children's Hospital, or in relation to nursing staff to manage the transfer?

'A. That was both. That was nurses to look after Ryan in the theatre, and also, Ryan needed quite a senior nurse to go with him in the ambulance with the incubator and they also needed a senior nurse left on the SCBU at Southmead Special Care Baby Unit.

'Q. Were they able to find nurses?

'A. Yes, finally they found the nurses …'[217]

156 In her written statement to the Inquiry, Belinda House stated:

'It also then appeared that there was no ambulance available in the whole area with the equipment needed for such a Transfer. It was a horrific situation for everyone concerned, until eventually a suitable ambulance was located. This was the beginning of our education to the fact that the NHS, at the time, was desperately underfunded, so much so that Ryan's life was put at risk.'[218]

157 In a letter dated 7 February 1990, Drs Monk, Masey and Bolsin (consultant anaesthetists) wrote to Margaret Peacock.[219] They stated that on 26 January 1990, the cardiac anaesthetists on duty had agreed to do one extra cardiac case in order to enable surgeons to reduce waiting lists. Pressure had then been caused by the admission of a patient with a major cardiovascular problem, on an emergency basis; extra staff were not available. They protested that in future they would not allow more than two cardiac cases to be anaesthetised unless they were given categorical

217 T6 p. 62 Belinda House
218 WIT 0025 0003 Belinda House
219 General Manager (Inpatient Services), BRI

assurances that emergency staff would be available to help with life-threatening emergency cases.[220]

158 Ms Alison Whiting[221] replied on 22 February 1990. She set out the nursing levels and workload, and said that no guarantee could be given that similar emergencies would not take place in future.[222]

159 By a letter dated 12 July 1990, Dr Bolsin recorded his view that, in view of his 'experience in this department', it was unreasonable to start major cardiac cases after 3pm, other than in exceptional circumstances. He would not do so in future, and stated that he would instruct his juniors similarly.[223]

Equipment

160 Mr Wisheart, in his written evidence to the Inquiry, described the availability of equipment:

> 'A post-cardiac surgery ICU requires a substantial amount of expensive equipment. This equipment also tends to become increasingly developed and sophisticated with the passage of time. The cost of such equipment was a challenge and often a problem. The sources of money to purchase equipment were as follows:
>
> 'REGIONAL CAPITAL:
>
> - 'At a time of significant or major development such as 1987–88 when the Ward was totally refurbished, we obtained replacement of a substantial amount of our capital equipment.
>
> 'DISTRICT/TRUST MAJOR MEDICAL EQUIPMENT BUDGET:
>
> - 'For the renewal of equipment from year to year we had to compete with other demands for equipment within the Trust. It was common for the total cost of requested equipment to exceed the total of money available by a considerable factor.
>
> 'DEPARTMENTAL DISCRETIONARY FUNDS:
>
> - 'Patients and families who were treated in the Unit often gave donations, sometimes significant ones and it was possible to purchase equipment using this money.

220 UBHT 0118 0001; letter to Ms Peacock dated 7 February 1990
221 ITU/Theatre Service Manager, BRI
222 UBHT 0118 0005; letter from Ms Whiting to Ms Peacock dated 22 February 1990
223 UBHT 0118 0007; letter from Dr Bolsin dated 12 July 1990

'EMERGENCY RESPONSE:

- 'If there was a totally unexpected breakdown in the function of vitally important equipment then the Trust kept a reserve fund which could be used to enable the work to continue.

'CHARITABLE ORGANISATIONS:

- 'Sometimes equipment was donated by charitable groups.

'While there were times when we felt that we were well equipped and had the resources to replace equipment as we wished, there were certainly other times when we felt we were unable to replace old equipment when this should have been done. This was another reflection of what appeared to be reality, namely that the resource available to us fell far short of the demands that were placed upon us.

'When we became a sub-directorate in 1991, Ms Lesley Salmon and I began to compile a list of our equipment, its age, expected life and cost, as a first step in the development of a programme of regular replacement.

'To the best of my knowledge, we never undertook surgery when there was not functioning and safe equipment available to meet the needs of the patient who was being cared for. As an example, if there was no suitable ventilator available for the patient, then the operation would have to be postponed.'[224]

161 Dr Joffe stated:

'We struggled to acquire suitable echocardiography equipment during the early 1980s, and it was only though the financial support of charitable organisations that we were able to purchase a 2D echocardiography machine in about 1984, and a second in about 1989. The situation improved after Trust status, when we acquired our third machine, in lieu of the outmoded first apparatus. We were always short of cardiac technological staff and, throughout 1984 to 1995 we shared technicians with the adult cardiac catheterisation service at the BRI. It was only in this way that we could ensure that, for emergency catheterisation after hours, there would be someone on call who was familiar with the BCH equipment. The paediatric cardiologists performed all echocardiography procedures themselves until the late 1980s, when we were able to appoint our first echocardiographic technician with financial help from the Paediatric Oncology Department for whom we provided a regular service. In the early 1980s, the paediatric cardiologists reported on all angiograms as part of the cardiac catheterisation reports. This was taken over by Dr Wilde in the mid 1980s, and his overall advice and assistance was most welcome. By the early 1990s, he became overwhelmed by the demands of adult

[224] WIT 0120 0216 – 0217 Mr Wisheart

cardiology and was no longer able to participate in the angiographic procedures himself, but still reported on the angiograms.'[225]

162 Dr Geoffrey Burton, consultant anaesthetist,[226] stated:

'… some centres (e.g. Great Ormond Street) had much more equipment sourced from generous charity monies, whereas we had to work on a much more restricted budget and had relatively little money sourced from charities …

'In Bristol, we were only paid for three sessions to cover a day of cardiac surgery — frequently this did not even cover the time spent in the operating theatre, let alone continuing care for several days in the Intensive Care Unit. We were working on a very "tight" budget and it was not unusual for me to work for over 80 hours in the week and be paid for only 37½ of them.'[227]

163 As regards equipment, Mr Wisheart stated:

'The equipment in operating theatres is fairly well standardised and is very similar from one hospital to another. This includes the basic operating theatre equipment such as tables, lights, diathermy, anaesthetic equipment such as ventilators, the surgeon's equipment such as instruments and the perfusionists equipment, the bypass machinery. The patient's life is dependent upon many items of equipment working reliably and effectively; therefore they must be well maintained.

'The main variability is that equipment and instruments are constantly evolving. Any given surgeon or institution will buy the newer equipment either sooner or later; there are often financial issues involved. However, these changes tend to be incremental rather than truly decisive in nature.'[228]

164 Mrs Rachel Ferris stated:

'Lack of capital investment was clearly reflected in the state of the equipment that was available in the Directorate. Much of this seemed to be reaching the end of its life span, with frequent need for maintenance and repairs. There was no rolling replacement programme for capital equipment. This seemed to be a particularly acute problem because cardiac services is such a high tech area of work, with some very complex and expensive equipment in use. (For example, to equip a new catheter laboratory might cost in the region of £1 million, which would be a substantial proportion of the Trust's capital budget for the year.) Work had been undertaken to devise a rolling programme for replacing equipment in a planned way, to try to ensure that the equipment did not let us down in providing a high

225 WIT 0097 0306 Dr Joffe
226 Dr Burton was appointed as lecturer, Department of Anaesthesia in the University of Bristol, in 1959. His clinical practice covered both the BRI and the BCH until the summer of 1991
227 WIT 0555 0004 – 0005 Dr Burton
228 WIT 0120 0172 Mr Wisheart

level of service to patients, and I wanted to build upon and give greater emphasis to this. I was not very familiar with much of the equipment and was assisted by Dr Pryn and Fiona Thomas.'[229]

165 Dr Pryn stated that when he arrived at the UBHT, he took an active interest in the nature and state of the equipment that was available to him:

'Despite relatively old equipment, this was sufficient for full compliance with the standards proposed by the Royal College of Anaesthetists (Guidance for Purchasers 1994) and Association of Anaesthetists Recommendations for Standards of Monitoring during Anaesthesia and Recovery 1994. The one area of monitoring that was not available was capnography.[230] There were no capnographs present in the cardiac theatre suite when I joined BRI in 1993. It was felt that this was acceptable, although not ideal, as (i) fixed volume ventilators with expired volume monitoring were used in theatre and (ii) the blood gas analyser was readily available in the theatre itself. New theatre monitors, with the capability of capnography, were purchased in 1995, and around the same time capnography became available in the anaesthetic room as well. …

'When I arrived at the BRI I found that much of the equipment, both in theatre and in the intensive care unit was old, and there were no mechanisms for replacement. I assumed responsibility for the co-ordination of equipment purchase. Document UBHT 0084 0101 is the list of "minor" equipment which I identified as being required. There was, in addition to this list, a list of major equipment. By way of example the syringe pumps in use in theatres had a number of problems. The replacement product which I recommended was purchased.'[231]

166 Mrs Ferris stated:

'… I would say that it is not quite right that "there were no mechanisms for replacement".

'There was a clearly defined mechanism for the replacement of major medical equipment. This involved undertaking a bidding process and completing an application form by 30 September each year for items of capital equipment over the value of £15,000. These bids were meant to be prioritised within the Directorate and then considered by the Trust's major medical equipment committee. A decision would be made about these bids by December of the same year or January of the following year.

229 WIT 0089 0013 Rachel Ferris
230 Capnography is the measurement of exhaled carbon dioxide values
231 WIT 0341 0021 – 0022 Dr Pryn

> 'The main problem as I saw it, was that despite this clear mechanism, the Trust had insufficient capital to meet the demands made upon the major medical equipment committee. In particular the decision to build the new Children's Hospital had led to a situation whereby £1.5 million of capital per annum had to be put aside for the Children's Hospital. As a consequence, the major medical equipment committee only had around £1.5 million per annum to spend on large capital items. As I said in my statement, the cost of capital for Cardiothoracic Services was very high, and it was clear to me that it was not possible to meet a rolling programme of the replacement of capital equipment through the major medical equipment committee.'

167 She added:

> 'As far as minor medical equipment was concerned there were mechanisms for bidding for equipment, but these were inconsistent.'[232]

168 As regards the absence of capnography monitoring equipment, Dr Pryn told the Inquiry:

> 'There must have been other institutions that did not have capnography throughout, but in an area like cardiac surgery, where it is extremely technical, you would have expected the state-of-the-art monitoring, and clearly this was not state-of-the-art.'[233]

169 He responded in the following exchange:

> 'Q. Is that a fair summary of your impression of the equipment in Bristol, that it was adequate but it would not be state-of-the-art?
>
> 'A. Yes. Fair.'[234]

170 Dr Pryn referred to:

> '… an ongoing battle and "battle"is the right word, because you are competing with other departments in the hospital for very limited funds, and some of the wording on this document[235] is specifically coloured to paint the picture — a more dramatic picture than perhaps was necessary, just so we could have our voice heard. It is a battle to get money.'[236]

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232 WIT 0341 0100 Rachel Ferris
233 T72 p. 77 Dr Pryn
234 T72 p. 78 Dr Pryn
235 The list of minor equipment which Dr Pryn prepared
236 T72 p. 83 Dr Pryn

171 Dr Pryn told the Inquiry that the cardiac surgical unit at the BRI when he was appointed as an intensivist in August 1993:

> '… was a unit that was often run minute by minute by relatively inexperienced doctors, with their senior cover not being that available, and it was a unit run by trainees who were not used to general intensive care issues, were quite familiar with managing the cardiovascular system, but were relatively poor at integrating that with the other systems, for instance, the respiratory system. … Their background was not in general intensive care.'

He told the Inquiry that he felt that more input was required from staff with a general intensive care background, and that senior cover needed to be more available. It was an awareness of this, he said, that had fuelled his own appointment and that of Dr Ian Davies.[237]

172 The Inquiry's Expert, Dr Michael Scallan, consultant anaesthetist, Royal Brompton Hospital, commented on the points made by Dr Pryn in the following exchange:

> 'The shopping list we see here is the sort of shopping list that you see in many hospitals. There is a constant need to upgrade equipment, to replace equipment. A lot of the equipment that we use these days does not have a life really of more than ten years, and you have to think of moving forward to the next generation of equipment.
>
> 'So what we see here is a very fair shopping list.
>
> 'Q. If we had gone into other NHS units across the UK performing paediatric cardiac surgery at about this time, are we likely to have seen similar issues about the replacement of machines of this nature?
>
> 'A. Yes. I think that is a fair comment, yes.
>
> 'Q. So there is nothing here that strikes you as being out of the ordinary in terms of the needs of this particular unit?
>
> 'A. I think the section on the equipment in the theatres and in intensive care does suggest that that equipment should have been replaced a little earlier. I think that was the middle 90s. What was in existence does appear to have been rather old equipment and quite correctly the need to upgrade it — the case for the need to upgrade it was made in this list.'[238]

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237 T72 p. 20 Dr Pryn
238 T72 p. 82–3 Dr Scallan

173 When Dr Scallan referred to equipment being unavailable at his hospital, the Chairman of the Inquiry explored the point in the following exchange:

> 'Q. (The Chairman) You say that you encountered some of the same difficulties. Would that persuade you to say that therefore one can say that whatever was provided at your institution or at Bristol was adequate and appropriate, or does it persuade one to say that against a different standard, a slightly more absolute standard, neither were up to snuff?
>
> 'A. (Dr Scallan) To answer that question in a slightly indirect way, I think the standards are evolving all the time and as new equipment becomes available and becomes used, so it creeps into what is considered basic monitoring, or basic standards. So in an ideal world, you could say that both institutions were short of the ideal standard.'[239]

174 In January 1992, the first of the 'recommenced' audit meetings of paediatric cardiology and cardiac surgery reviewed the audit topic 'closure of the patent ductus by a transvenous insertion of the Rashkind device' in 24 cases. Conclusions were reached upon the most appropriate procedure. The note of the meeting read, under the heading 'Action Taken/Clinical Changes Instituted', 'Unable to implement due to lack of finance… Cost £1783 + VAT more than for cardiac catheter.'[240]

175 Dr Roylance was asked by Counsel to the Inquiry to comment on this note in the following exchange:

> 'Q. On the face of it, this is a document which — I may have to ask those more closely connected with the delivery of the cardiac service about it, but this is a document which might suggest that a lack of finance was preventing the delivery of optimal care.
>
> 'A. Yes.
>
> 'Q. Have I misunderstood or not?
>
> 'A. No, I mean, I believe you have not misunderstood.'[241]

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239 T72 p. 98 Dr Scallan
240 UBHT 0061 0156; minutes of meeting on 22 January 1992. See Chapter 18
241 T24 p. 142 Dr Roylance

Disruptions in service

176 The Inquiry was shown a letter from Mr Paul Walker, consultant physician and cardiologist (adults), to Ms Linda Williamson of the B&DHA, dated 27 October 1993.[242] The letter concerned cardiac catheterisation services for adult patients from Southmead Hospital. It had been prompted by the case of such a patient who had decided to tell his story to the *'Bristol Evening Post'*. The letter commented on the need to avoid 'sudden crisis directives' from the UBHT concerning matters such as the cancellation of all non-emergency and all non-long-term-waiter patients who were not on the long-term waiting list.

177 Mr Roger Baird[243] commented on this letter in the following exchange:

> 'Q. Is it the fact that whether the decision is right or wrong, a shortage of money has led to a lack of treatment?
>
> 'A. Yes. There were always pressures on the cardiac catheterisation budget. There were always more people that could be investigated than there was the money to do it and they tried to increase the number that were done year on year, but there were often problems like this and we would always try to resolve them.'[244]

Increasing the number of anaesthetists and surgeons

178 Efforts made by the surgeons at the BRI to obtain additional operating sessions were affected in 1987 by the need to appoint a further consultant anaesthetist. Mr Gerald Keen, consultant cardiothoracic surgeon, wrote to Dr Robert Johnson[245] in November 1987:

> 'I believe that my anxieties concerning the consultant anaesthetist cover from July 1988 onwards stems from a chronic shortage of consultant availability in cardiac surgery. We have been dogged by this for many years, and it seems to me that this situation will not really improve following the commencement of our expanded service. There are two causes of this problem.
>
> 'In the first instance we are barely covered by consultant anaesthetist sessions and this is highlighted on Wednesday when the consultant anaesthetist is legally obliged to work a morning session only. To anybody with the faintest understanding of cardiac surgery and cardiac anaesthesia, it is clearly wrong that cardiac surgical patients should be attended by the anaesthetist in charge for the first half of a case only, and that the completion of the operation and perhaps the management of important immediate complications, should have no official consultant anaesthetist cover. The second cause and to an extent associated

242 WIT 0159 0086 Ms Evans
243 Consultant general surgeon, BRI
244 T29 p. 118 Mr Baird
245 Consultant anaesthetist and Chairman of the Division of Anaesthesia at the BRI

with the first problem, is the very heavy commitment of the consultant cardiac anaesthetists to other legitimate duties.

'Although we are completely covered for cardiac surgery on paper (excepting for Wednesday afternoon), these prolonged and often simultaneous absences of consultant anaesthetists gives us poor and often inadequate cover. Unhappily in my view the acquisition of another consultant anaesthetist will not really improve the situation, bearing in mind the proposed expansion of the service, for the new anaesthetist will undertake four sessions only in the operating theatre. At the same time, other consultant anaesthetists who are heavily overworked will quite understandably see the arrival of the new anaesthetist as an opportunity to reduce their own commitment to their contractual obligation. I did of course, set out most of these points in my recent letter to you, but your response, although helpful, gives me no indication that the service provided by your colleagues will be adequate in the future.

'As you know, James [Wisheart], Janardan [Dhasmana] and I have set out tentative proposals concerning our own work programme for the expanded service, but this can only happen with appropriate consultant cover. For the time being I do not propose to send any of this correspondence to the Regional Health Authority, but they may at some time in the future, need to be made aware of the under-provision of support for a service which they are now heavily financing.'[246]

179 As regards the need for cardiac surgeons, in October 1988 Mr Keen wrote to Dr Alastair Mason[247] at the SWRHA:

'With the further development and extension of cardiac surgical facilities in the South West region, certain consequences have been accepted by the Regional Health Authority. We have increased the nursing staff considerably and at the same time appointed two further consultant anaesthetists to support this development.

'When Mr J P Dhasmana was appointed in 1985, his appointment was partly proleptic to enable a further increase in work to take place, and as you know in 1986, we undertook a total of more than six hundred open and closed cardiac operations on adults and children. It was agreed at that time that this unit would eventually undertake a considerable number of those patients in the south west requiring cardiac surgery, and to achieve this, the need to appoint, a fourth cardiac surgeon at some time was appreciated. It was generally understood that once we had achieved a level of about seven hundred open heart operations per annum (in addition to about one hundred closed operations per annum), a total of eight hundred operations, the appointment of a fourth surgeon would become mandatory.

246 UBHT 0138 0018; letter from Mr Keen to Dr Johnson dated 23 November 1987
247 Regional Medical Officer, SWRHA

'This topic was raised at the meeting of the South West Regional Cardiology Committee, held at Taunton on 6 October and after full discussion, it was agreed that the time to appoint this surgeon had now arrived. We are now operating on planned fifteen operations per week (apart from emergencies); that is approximately seven hundred and twenty five patients per annum. Whereas at the present time we are able to achieve this, it is only with the greatest difficulty, for the three surgeons in post, are working very hard and my two colleagues who also do paediatric cardiac surgery at the Children's Hospital, Mr J D Wisheart and Mr J P Dhasmana, are working all hours, day and night, and their weekends are rarely free.

'This really cannot continue, for even should these numbers be achieved during normal working periods, there is no way that this volume of work will be sustained during the summer, that is from the middle of May until the end of September, when one or other of the cardiac surgeons is away and at the same time, junior staff need to have their holidays staggered.

'It is anticipated that in the absence of a fourth surgeon, the volume of work undertaken will decrease to perhaps two thirds of its present level during that period, with consequent under-usage of our expensive, well equipped and well staffed cardiac surgical unit.

'With this in mind, it was recommended by the Committee that steps are taken to consider the appointment of a fourth cardiac surgeon, whose work would be primarily in adults, that the successful applicant would be in post by the late spring of 1989.

'Financial support for this fourth surgical appointment has been agreed in all planning documents for this expansion, prior to 1987, but as far as we can tell, any mention of this fourth appointment has not appeared on recent documents. I am sure that this discrepancy will come to light when you have had an opportunity to study the background of this request and I look forward to meeting you, together with my colleagues in the near future.'[248]

180 Mr Dhasmana wrote to Dr Mason in November 1988:

'I am writing to you to express my views on the above subject especially in reference to Mr Keen's earlier letter dated 11th October and your recent meeting with Mr Wisheart and Mr Keen on 11th November. …

'You are well aware that ours is a moderate sized Cardiac Surgical Unit which deals with both paediatric and adult cardiac surgery averaging about 520 cases per year over the past two years. During this period my own clinical work-load was not fully stretched due to lack of resources and it was a constant struggle for time, for theatre

[248] UBHT 0174 0011 – 0012; letter from Mr Keen to Dr Mason dated 11 October 1988

space and also for medical and nursing manpower to look after my cases. It is only since the recent improvement in the staffing level and an extension in the cardiac surgical unit that I am able to achieve the target for which I was appointed three years ago. We are now hoping to achieve a target of around 700 cases a year in the extended Cardiac Unit.

'This figure I feel is just right for the present level of medical staff of three consultants, two senior registrars, one registrar and four SHO's. An almost similar figure was recommended by the Joint Cardiology Committee of Royal Colleges for the organisation of a Cardiac Surgical Unit (Brit Heart J 1980; 43:211-219). There are a number of units in this country which are managing an even higher number of operations per year with three consultants and supporting staff. Even units like Guy's and the Brompton Hospitals which deal with adult and paediatric cardiac surgery have been managing about 800–1000 operations a year with a similar number of consultant staff. The Brompton has only recently appointed a fourth surgeon. It appears that the secret lies in providing and increasing the support service rather than appointing a fourth surgeon alone in order to increase the number of operations. The fourth consultant would need theatre space and ITU beds. At the present time we are allocated 4–5 operations per consultant per week which in my mind is just right for a cardiac surgeon to maintain a high standard in the technical skill and the post-operative management. The above Joint Committee further emphasises "Facilities should be available for each surgeon and his team to perform four to six open heart operations a week with additional time for emergencies" in their recommendations for surgical staffing (page 214).

'I personally feel that the consultant appointment should not be made to cover leave and holidays of other colleagues. Locum appointment of a registrar or consultant during that period should see the work continued unabated. The present resources are utilised to the maximum by the three of us. In my mind there is no spare facility to accommodate the fourth person unless some of us agree to cut down on their own work.

'I agree that there is a threshold beyond which a fourth surgeon would be needed and we are approaching that figure when 700–750 open heart operations are performed a year. We should then combine this demand with further expansion of the unit here at BRI or the transfer of paediatric services to the Children's Hospital which would certainly make the way for a fourth cardiac surgeon to cover mainly the adult side. It would also be feasible to appoint a further surgeon if we have agreed in principle to establish a transplantation unit with increased resources.'[249]

[249] UBHT 0174 0013; letter from Mr Dhasmana to Dr Mason dated 16 November 1988

181 On 5 July 1989, Mr Keen, Mr Wisheart and Mr Dhasmana wrote a proposal for the appointment of a fourth cardiac surgeon addressed to the planning authorities:

> 'STATEMENT OF NEED
>
> 'Cardiac surgical services in Bristol have developed in a step-by-step fashion during the last decade, increasing the number of open heart operations performed annually from 253 in 1980 to a predicted 675–700 in 1989. During this time, the numbers of surgical staff responsible for the work have increased as follows:- Consultants from 2 to 3, Registrars/Senior Registrars from 2 to 3, Senior House Officers from 3 to 4. During the planning processes, the initial target for the 1988 development was 600 cases, and it was agreed that three surgeons would be sufficient; in the light of experience and in the presence of a large outstanding demand in the region, this number was revised to 675; it was recognised that an additional surgeon would probably be needed, and this was formally accepted at a meeting at the SWRHA on 11.11.88 when the Region undertook to fund this appointment and a secretary.
>
> 'While the three surgeons have managed to sustain this heavy workload over the winter months of 1988/1989, it is not a load which could be carried indefinitely. In particular, it would almost certainly be impossible to maintain the volume of work during the holiday season, simply due to lack of sufficient surgical hands. Further, the high level of throughput has been made possible, partly by the presence throughout these winter months of three exceptionally experienced and competent registrars. We cannot expect to have junior staff of such experience and reliability as a general rule in the future. The exceptionally heavy load borne by consultant staff over the winter months has undoubtedly contributed to unsociable hours of working for the whole team, medical, technical and nursing, and this would be better avoided.
>
> 'The proposal is that four surgeons would undertake precisely the work done by the three at present in post, and the timetable of the proposed fourth surgeon is enclosed. Further development in cardiac surgical services will only take place after discussion with all parties involved and will not result directly from the proposed appointment.'[250]

[250] UBHT 0174 0001; proposal dated 5 July 1989

182 The proposal[251] to appoint a fourth consultant cardiac surgeon was accepted and in 1989[252] Mr Jonathan Hutter was appointed to this position. When Mr Keen retired in 1990,[253] rather than being replaced directly with the appointment of another cardiac surgeon, the funding for his post was used ultimately to finance the position taken up by Professor Angelini in 1992. Dr Roylance explained:

> '… the plan when Mr Keen was retiring, is that we would appoint a Heart Foundation – I think it was the British Heart Foundation – funded Professor and we would use the resources, the salary of Mr Keen to appoint a supporting senior lecturer.
>
> 'It was an arrangement with the university we commonly pursued, and that is the university would pay for a Professor and we would pay for a consultant senior lecturer which was, the university felt, a minimum requirement for an academic unit. As a result of that deal, if you like, the university would have a whole time equivalent of one consultant for their academic purposes and the Trust would have a whole time equivalent for NHS work by each of us paying for an individual and having half their services shared.'[254]

[251] UBHT 0143 0084 and UBHT 0143 0085; letter from Mrs Willis, B&WDHA to Dr Johnson dated 15 May 1989 with attached job description
[252] WIT 0096 0002 Mr Hutter
[253] WIT 0080 0145 Mr Keen
[254] T88 p. 74–5 Dr Roylance