

4. On appointment I was asked to set up a system whereby clinical information needed for medical audit of services within the Directorate of Surgery could be recorded. The system used by the Directorate of Surgery was the MDI system which was already in place in the South West Region. Part of my role was to train clinicians, including junior doctors, in the use of the system and identifying the importance of accurate data recording. During the course of my interview I gained the impression that, aside from an interest in and familiarity within information technology, it was important that the post holder would be able to work confidently with all clinicians, from House Officers to Consultants.
5. As Audit Assistant within the Directorate of Surgery the specialities I supported were general surgery, urology, orthopaedics, and Accident & Emergency. I undertook a specialised audit for Accident & Emergency. I understood that they submitted their data to the National Audit Registry. Paediatric services had their own audit assistant at the Bristol Children's Hospital. I did not know the input clerk of cardiac services. As well as preparing data for monthly audit meetings for the Directorate, my duties included instructing the house officers on rotation into the use of the MDI system used for audit purposes. I worked with Mr Roger Baird and Professor Farndon, who took on the role of audit co-ordinator for the Directorate of Surgery.
6. Examples of the types of information that were entered onto the MDI system for the Directorate of Surgery were the bloods used; drugs given; procedures undertaken; the reason for death, (if it occurred and when); the length of stay in hospital, (pre and post operatively); if a catheter was inserted and for how long. Each piece of information enabled a picture to be formed as to how effective certain surgical procedures were. I understood that the medical staff aimed to audit themselves through checking how effective their surgical procedures were, to identify the best outcomes, and which procedures led to this. It was my understanding that this audit did not take place in isolation but through the medical staff using up-to-date locally, nationally and internationally published literature, which identified how other medical staff improved/modified their own procedures. The introduction of audit and the production of data was to enable the Directorate of Surgery to continue to measure the quality of its work, monitor the outcomes, and ensure that the service maintained its already high quality.
7. My work included planning and implementing audit projects. Medical staff in the Directorate of Surgery would identify an audit subject and, if the data was not already captured, I would liaise with the Information Technology Department to ensure that that specific data was captured.
8. I have been asked to comment on various documents, by the Inquiry and, in doing so, explain the type of meetings which I attended within the Trust and the Region.

Annex 1 to my statement**UBHT 00270124, Minutes of Meeting of UBHT Audit Co-Ordinators and Assistants**

9. Monthly meetings were held between Audit Co-Ordinators and Assistants throughout UBHT. I always tried to attend meetings unless I was away on annual leave or unable to leave my work. I do not think that I missed many. They were well attended by both the Audit Co-Ordinators and Audit Assistant representatives of the various Directorates, for example from Surgery, from the Eye Hospital and Medicine and sometimes from the Children's Hospital. I believe the meetings were minuted, although I never took the minutes. I note that the medical staff responsible for various specialities, acting as Audit Co-ordinators, described their own work in this meeting. I cannot now recall if meetings had been held in which medical staff had been formally involved prior to this meeting on 13th November 1992. I do not have any comments on the specific content of this meeting.
10. In addition to the monthly meetings Audit Assistants often met with others doing the same sort of work, throughout the region in a group called SWANNS (South West Audit Assistants Network Services). Meetings took place once every 3 months. As many Audit Assistants from UBHT as possible would go to every meeting. The objective of these regional meetings of Audit Assistants was to obtain clear agreement, on a regional basis, on how the government guidelines on audit should be implemented. It was also an effective forum for pooling ideas. Representatives from Trusts in other areas in the region or elsewhere came to speak to the Group. All data collected and discussed at these meetings was anonymised, so patient confidentiality was maintained. The purpose of the meetings was to discuss systems and statistics, not individual cases.
11. It was my experience that co-ordination and participation in the process of audit within the Trust between medical staff and Audit Assistants was excellent. It was my experience that all medical staff were keen to see that the implementation of effective audit systems worked well. My opinion is supported by documents in **Annex 2** (UBHT0028 0243 and UBHT0028 0250), correspondence in 1993 between Dr T Thomas, Chairman of the UBHT Medical Audit Committee and Janet Prior, Medical Audit Assistant. I recollect that Janet Prior carried out the same type of work as I did and at the same level.
12. I believe the correspondence arose because Audit Assistants were concerned that they had no representatives on the Committee through formal channels, and no knowledge of what decisions the Trust Medical Audit Committee were making on the implementation of audit, which we thought was needed. The response to this concern, contained in the letter of 28th July 1993