

16. When I joined in 1988, as far as I was aware there was no link between the perfusionists and the University of Bristol. After Professor Angelini joined (from about 1992), perfusionists started to assist in research projects at the University, at his instigation. Mr R. Downes (now the Chief Perfusionist) worked in theatre with Professor Angelini and had some informal contact with him. I believe there was no formal contact for research purposes until 1994 when Mr Downes became Chief Perfusionist.

**j. key managers and clinicians: identities, powers and functions, collaboration between disciplines;**

17. I can only really comment to the extent that Mr Caddy was my line-manager and that he initially formally reported to Mr Wisheart. With the introduction of the Trust, he started to report to Lesley Salmon who was Associate General Manager of the Associate Directorate of Cardiac Surgery, but maintained more contact with Mr Wisheart than with Lesley Salmon.

18. As far as I can recall, Mona Herborn was in charge of the nursing staff in cardiac theatres. The perfusionists were responsible clinically to the anaesthetists and surgeons. The nurses were regarded as a separate discipline.

19. I have no real comment, because I have no knowledge, on the extent of collaboration between the nurses and clinicians. The nursing staff appeared to work well with the cardiac surgeons, but in my view they had limited power in the overall running of the operating list. There was sometimes conflict over the length of the time some operations took and the consequence it had, of keeping staff working late. If the first operation took much longer than expected, a decision had to be made whether to cancel the second, which caused conflict between nursing staff and the cardiac surgeons.

20. The working relationship between the perfusionists, surgeons and anaesthetists was similar to what I has been used to at Guy's. There is and has to be a cohesion between all three with good communication. My impression was that there was, and still is, good inter-professional communication. The nursing staff (scrub team) does not really have a great deal of input with the duties of the perfusionist and anaesthetist, but is more concerned with assisting the surgeon. Having said this there was, and still is, good communication between the scrub nurse and perfusionist concerning the types of cannulae, connections, and other perfusion related equipment, which might be needed.

**k. nature and scope of "outreach" clinics and other services offered by the paediatric cardiac team to local hospitals;**

21. I have no knowledge of this. I had no input, as a perfusionist, to such clinics.

**Issue B2: The implications and effect of designation, and de-designation, as a supra-regional centre upon the financing, organisation, management and delivery of paediatric cardiac services at Bristol**

**Issue B3: The effect of the creation of the UBHT in April 1991 on the financing, organisation, management and delivery of paediatric cardiac services at the BRI.**

**Issue B4: The implications of, and incentives created by, the means by which paediatric cardiac surgical services or staff members were financed or paid.**

22. There was no obvious effect of any of these issues on my own work. After 1991 I was aware that there was a need to reduce the perfusion budget, and for perfusionists to become more cost-aware in order to keep within budget. This would not have affected the service run by Mr Caddy; he simply ordered what was needed and argued about it later if necessary.