

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

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Introduction

1. These additional comments have been prepared by Chris Ham and Judith Smith, the authors of an expert commentary prepared for the Bristol Royal Infirmary Inquiry on the health services management arrangements at the Bristol and Weston Health Authority (BWA) and the United Bristol Hospitals NHS Trust (UBHT) between 1984 and 1995. They are intended to provide clarification and further comment on some issues raised by interested parties in their written responses to the commentary. Those written responses are, along with the evaluative commentary and the wider evidence on which it is based, in the public domain. In this supplementary paper, we address issues of fact and interpretation where we believe that additional clarification is required.

Scope of the evaluative commentary

2. In the terms of reference for the evaluative commentary on health services management commissioned by the Bristol Royal Infirmary Inquiry, we were asked by the Inquiry Secretariat to assess and review documents as selected by the Inquiry's legal team. We were not asked to review all written and oral evidence presented to the Inquiry, but to assess a selection of evidence within the context of what was happening in the NHS as a whole and in Bristol during the period 1984-1995. Attached to this paper is a list of the ten witnesses whose submissions and evidence made up the selection of papers forwarded to us by the Inquiry for review.
3. In our evaluative commentary, we seek to make an assessment of health services management in Bristol between 1984 and 1995, drawing on our personal expertise and experience of health services management policy and research as brought to bear on the strength of the evidence supplied to us. It should be noted that we were asked to comment on issues of general health services management and not on specific areas of management such as nursing management or human resources management. In our commentary we point to the variable nature of the available research on health services management, both in its quantity and quality, and hence our use of our extensive experience in comparing developments in Bristol with those occurring elsewhere. We have sought to avoid drawing conclusions based on the benefits of hindsight, and also to clearly acknowledge that the situation on which we comment was inevitably dynamic in its nature, with management arrangements evolving over time.

4. Throughout the commentary, we are cautious in drawing conclusions where the evidence base is weak. We have instead sought to summarise the main features of management arrangements in Bristol in comparison with developments elsewhere in order to assist the Inquiry to make a judgement about the extent to which Bristol was similar to and different from the rest of the NHS, recognising that documented evidence on what was happening elsewhere is limited.

Matters of fact

5. In our commentary, in paragraph 32, we inadvertently imply that prior to 1994, there were no trust board sub-committees taking specific responsibility for areas of oversight of trust activity. We stand corrected on this point and accept the comment from respondents to our commentary that there were indeed standing committees and advisory groups of the board in place from 1991.
6. We accept the evidence from respondents to our commentary that there was a system of individual performance review in place in the unit/trust from 1986-1991, although we would surmise that the fact that the system was abandoned in 1991 suggests that it had limitations.
7. We note the fact that the trust was awarded a Charter Mark by the government. We would however wish to restate our view that the trust's strategic interest in clinical standards and quality was apparently limited.

Matters of interpretation and overall conclusions

Culture of the trust

8. It is clear from some submissions to the Inquiry that UBHT was particularly concerned to take advantage of the greater degree of independence and freedom from bureaucracy and paperwork offered by trust status. We would add that a spirit of competition in the NHS has always been part of the NHS, with teaching hospitals and research centres like UBHT seeking to provide excellent services. The internal market added a further dimension to this, hence our reference to the culture at the time as one that emphasised entrepreneurialism and competition. Dr Roylance, in his statement to the Inquiry, refers specifically to the 'healthy spirit of competition with other teaching hospitals' (p. 26) at that time.
9. As set out in paragraphs 44-46 of our commentary, we believe that the evidence points overwhelmingly to a trust culture in which clinical freedom was seen as highly valued and where little or no attempt was made to hold clinicians to account for their performance and where the trust board did not see it as its business to take an interest in clinical standards. While the management of other trusts also became involved in clinical standards only slowly, the point we would wish to emphasise is that the dominant culture in Bristol, stemming from the strongly held and clearly expressed views of the chief executive, was antipathetic to any questioning of clinical practice by non-clinicians.

Relationship between central trust management and the clinical directorates

10. The lack of systematic performance review of directorate (as opposed to individual managers or clinicians within directorates) emerges strongly from the evidence we reviewed when preparing our commentary. We are of the opinion that the issue of central strategic management of the activity of clinical directorates was not well handled at UBHT, with an over-emphasis on devolution to directorates militating against close scrutiny of activity at this level.
11. We recognise that the intention at UBHT was that within directorates, clinicians and managers would work more closely together than in pre-directorate models of management. At a trust level, however, UBHT appears to have developed separate forums for discussion of clinical and management issues, as part of a conscious attempt to shield clinicians from what were perceived as distractions from their clinical work. Quarterly meetings between clinical directors and managers were not in our opinion sufficient to achieve the degree of integration required at a strategic level in a trust.
12. Our review led us to the conclusion that UBHT was run on highly devolved lines, and where, with the exception of the finance function, there appear to have been limited processes for monitoring directorate activity. It is our opinion that general managers taking on responsibility for directorate activity would have needed regular and consistent senior management support to enable them to perform effectively. The evidence on this point is mixed as reflected in our comments in paragraph 22 of our commentary.

Management arrangements

13. The development of the clinical directorate model at the Johns Hopkins Hospital in the United States and at Guy's Hospital in London was a precursor to similar developments at UBHT and many other NHS hospitals in the early 1990s. The directorate model, at UBHT as elsewhere, inevitably evolved with the passage of time.
14. In our opinion, the director of operations of the trust acted as a de facto third deputy to the chief executive, as suggested by the evidence related to the role of general managers in directorates. This is underlined by the fact that evidence from the trust chief executive suggests that the incoming chief executive in 1995 took over the function previously provided by the director of operations in respect of the general managers, thereby underlining the nature of the responsibilities carried by the director of operations (Day 25, p.120).
15. The views of the incoming trust chair and chief executive towards the end of the period under review were deemed to be important to our assessment of the evidence, given that they brought an external perspective that enables management arrangements at UBHT to be further placed in a wider normative context.
16. In our review we acknowledged that roles and relationships within the trust evolved over time and that the appointment of a doctor as chief executive influenced the role of the medical director. Our view is that the role of medical

director in Bristol during this period was more limited than was the case in many trusts of similar size and complexity, being largely a non-executive and advisory role, a point supported by the evidence of the trust chief executive.

17. The trust's reliance on the local health authority to set strategic direction was not in our opinion a sufficient reason for not developing local strategies and priorities within the trust. Indeed, we are of the view that most trusts invested time and effort in developing local internal strategies as part of their annual business planning activity, something that apparently did not happen in Bristol.

Summary

We are grateful to the Inquiry Secretariat for the opportunity to reply to the responses of interested parties to our commentary on management arrangements in Bristol. We feel that the main conclusions of our commentary stand, subject to our acceptance of factual corrections and clarification of issues of interpretation noted above. The final paragraph of our original commentary remains in our view an accurate summary of the nature of health services management in Bristol between 1984 and 1995, acknowledging the issues related to the terms of reference of our work as set out in the early part of this paper.

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Enc. List of witnesses whose evidence we were sent to review

Witnesses whose evidence we were sent to review:

Mr Stephen Boardman
Ms Pamela Charlwood
Mr Peter Durie
Mrs Rachel Ferris
Mr Robert McKinlay
Mrs Margaret Maisey
Mr Graham Nix
Mr Hugh Ross
Dr John Roylance
Mr James Wisheart