Paragraph 19

Comparison of the number of directorates with other Trusts is difficult, if not meaningless. Weston Health Services for example, had three directorates – medicine, surgery and support services. Bristol, on the other hand, was in the order of ten times the size of Weston. The choice of thirteen directorates for UBHT is clearly not unusual and the restriction of formal monitoring to twice a year allowed intensive informal monitoring to occur throughout every week.

Paragraph 20

The disparity between witnesses regarding the clinical directorates and their accountability must stem from the evolving scenario throughout the period under review. Three directorates, for example, were pre-existing and needed very little in the way of development. To others it was a totally new experience and in the larger directorates, required the creation of a number of sub directorates. It was inevitable therefore that the timing of change varied and that the restructuring of directorates was a continuing initiative and as late as 1994 and 1995, they were being restructured to achieve a "patient based" speciality rather than a "consultant based" division.

Paragraph 21

It is clear that the majority of the evidence cited is from two witnesses who had almost no experience of the development and functioning of Clinical Directorates. There was in fact a very close relationship between the central Trust management team and each and every clinical directorate. It is quite natural that the incoming Chief Executive found the formal information systems inadequate to inform him of the activities within a Trust of which he had no personal knowledge or experience. Furthermore, he took over a Trust which had been developed and was in an advanced state of maturity with sophisticated information systems which could produce the reports that he clearly required.

Paragraph 22

It was a requirement to delegate management to operational level as part of the Griffiths recommendation. This was achieved gradually over a period of four years and was accompanied by a very close relationship between central management and operational management. The evidence that the centre of the organisation failed to provide adequate support to the staff is spurious and is based on the evidence of those who had no experience of the evolving situation.

Paragraph 23

The responsibility of the provider unit was to deliver the care specified by the purchaser. Although many thought that it would be appropriate for the Trust to develop its own business plan in advance of these contracts, this would quite clearly have imperilled the development of the purchasing role. It was important to ensure that the responsibility for the level of healthcare rested clearly and firmly with the purchasing Health Authority. The business plan of the Trust therefore equated to the summated operational contracts which defined, quite

precisely, the workload of the Trust. The major capital programme was of necessity led by the capital needs to support the delivery of the contracts.

Management by values is a well recognised and widely advocated management style which is particularly valuable in an organisation which is meeting a constantly changing need. The health service by its very nature is constantly changing with new techniques being introduced, new manners of treatment being introduced with, for example, ever shortening lengths of stay. The bureaucratic style of management is admirable for managing a constant situation but there is no doubt that it impedes effective and rapid change. Management by objectives restricts the response to change and employs quarterly or twice-yearly review of staff rather than a constant appraisal, daily or weekly. Describing the Trust as anti-paper is an oversimplification. What is certainly true is that the Trust was committed to avoiding the waste of paper. All paper communications that were necessary were provided and should still be available.

Paragraph 24

It is wrong to assume that any limitation of formal reporting and communication resulted in less communication. In practice it allowed a great deal more effective communication. It is wrong to say that individual objective settings for General Managers were not implemented. A full IPR system was in place in the Bristol and Western Health Authority from 1986 and continued into the time of the Trust formation. It was then thoroughly reviewed and found to be non contributory and so was abandoned for senior managers.

The lack of central aims for the Trust can be readily understood when it is appreciated that the Trust's aim was to deliver all that the purchasers required. Operational and central managerial activity was directed to achieving this aim, which at times required very detailed, collaborative development between appropriate directorates.

Paragraph 25

It is quite wrong to say that directorates and their managers were not encouraged to seek support up the line. The opposite is true and directorate General Managers were accustomed to reporting directly to the Chief Executive with problems as they emerged. The Chief Executive would then discuss with them in detail, would help them form a view as to the right course of action and would guarantee his personal support to them when they implemented the necessary solution. It is easy to understand the conclusion drawn that because operational decisions were made at operational level, that central management had simply withdrawn its support. The opposite is true.

Paragraph 26

The so called internal market was introduced specifically to address the financial problems within the NHS. The new Chief Executives were left in no doubt that their first and overriding responsibility was to prevent overspending. The concept of monitoring the quality of care was being developed in the early 90's, but was confined entirely to that which was measurable and excluded measures of the outcome of clinical care. In the literature at the time, interest in the care of patients and the quality of treatment did not incorporate the monitoring of clinical

outcome. In UBHT these initiatives were enthusiastically embraced and their success was evidenced by the fact that UBHT was the first Trust to acquire a Charter Mark for the whole of its Trust operations. Clearly if reservations had been expressed about the quality of outcome of care, then there was no doubt about the responsibility of the central management and the steps that it would take. However, the concept of prospective monitoring of the outcome of care did not emerge until the second half of the 1990s. This was developed under the title of Clinical Governance which was clearly to depend upon and await the successful development of clinical audit.

Paragraph 27

The very nature of the Health Service meant there was never any problem within the Trust of delivering the required level of patient care. Challenges rested entirely on the ability to do so within the budgets created by the contracts which had been agreed with the purchasers. Nevertheless, the patient throughput was closely monitored, was constantly reviewed and problems that emerged were addressed. For example, with contracts from several districts, the level of work contracted with each district did not always match the clinical severity of the patients being referred from those districts. There was thus some difficulty in meeting the precise terms of contracts whilst respecting the relative clinical urgency of the patients. The Trust did indeed involve Clinical Directorates and Clinical Directors in negotiations with purchasers. Many other Trusts felt they could achieve this without expert advice from their staff. It was the view in Bristol that only the specialist could evaluate and agree a particular workload with the purchasers.

Paragraph 28

The Clinical Directors were represented at the Trust by the Chief Executive, by the Medical Director and in the latter years by the Chairman of the Medical Committee. Clinical Directors met with and discussed their problems with the Standing Committees of the Trust on a regular basis. The Clinical Directors as a whole met monthly with the Executive Director team and at other times whenever necessary. There was a very direct and effective input from Medical Directors to Trust Board decision making.

Paragraph 29

The Medical Director had a very substantial role which was combined with that of being Chairman of the Medical Committee. He therefore was able to represent the views of the medical staff as a whole, he was able to transmit central thoughts and decisions back to all the medical staff, but it was not necessary for him to explain medical matters to the Chief Executive as he himself was a member of the Medical Committee and had, as a Radiologist, a detailed knowledge of the functioning of the Trust services. It is true the Chief Executive had an open door, not just to medical colleagues but to the whole of the UBHT, but so did the Medical Director and all other Directors who were willing to and indeed did meet members of staff who had problems to discuss.

Paragraph 30

The doctors were heavily involved in general management meetings at operational and Trust level. The central management did indeed, where possible, provide a central information and co-ordinating role to relieve Operational Managers of unnecessary bureaucracy. It would have been expensive and counterproductive to delegate these functions for each directorate to provide separately. Thus there was a central finance function which provided all the financial information, support and indeed help and advice to the operational level. There was a central information service which assisted in the production and dissemination of information. Care was taken to ensure that none of the central functions usurped the essential decision making role of the operational management.

Paragraph 31

By definition, the non executive members of the Trust Board were there to make available to the Trust their personal experience and ability. One, for example, took a very active interest in the capital programme of the Trust and in its commercial services. Another spent a great deal of time visiting patient care areas, observing and monitoring and reporting back. Another took a very active interest in the teaching and research that was based within the Trust. Standing Advisory Groups, later renamed Committees, regularly monitored all facets of the Trust's performance.

The Trust Board therefore took a very active role in monitoring and developing the Trust. They did not, on the whole, involve themselves with operational management and every effort was made to ensure that nothing usurped the ability of the Operational Managers to make their operational decisions.

Paragraph 32

It was the practice for medical audit reports, in the early years, to be submitted to the Regional Audit Committee and later copies were submitted to the District Medical Officer. It was the view of the Regional Medical Committee, supported by the Regional Health Authority, that the outcome measures of patient care were to be confidential to the providers of that care. This was in order to facilitate the introduction, development and refinement of audit. Without agreed standards it is impossible for those outside any particular speciality to have a view about the quality of outcome. By 1995 there was no agreed standard against which audited results could be measured and I believe, even today, there are very few robust standards of care which have been established. The Chief Executive and Medical Director separately and jointly were actively attempting to develop clinical audit to the stage where results could be openly compared and standards could be incorporated within the contracts for patient care. The Chairman of the District, and subsequently Trust Audit Committee, who was a member of the Regional Audit Committee, advised strongly that to move too quickly would result in failure. He was strongly of the view that issues of audit should remain confidential, certainly until it was well established.

Paragraph 33

The Trust did not adopt an entrepreneurial stance or welcome the concept of a competition. Certainly the prospect of independence and a reduction of bureaucracy did offer attractive prospects of diverting more money to frontline patient care and improve both the volume and the quality of that care.

Paragraph 34

Whilst some witnesses appear to have described the Trust as dominated by the Chief Executive and based on fear and blame, the overall evidence provided by the witnesses is the opposite of this. All staff were encouraged to challenge the Chief Executive as by such discussion, problems emerged and solutions were found. Managers were very closely supported with encouragement to partake in formal internal and external training courses. It has been explained that throughout the period there was constant evolution and constant change within the Trust and therefore there was no status quo to defend. It is not true to suggest that the Chief Executive was influenced by Charles Handy. He introduced the changes in structure and culture before having met the writings of Charles Handy. He did note however that this author did describe the background principles which made the approach adopted in Bristol more likely to be successful than one based on a triangular hierarchy of managers busily sending reports to each other.

Paragraph 35

It was indeed true that managers as well as clinicians had to take an interest in the quality of care provided but this related at the time to measures of important patient care matters, but excluded the outcome of care. The Trust Board took a very active part in the non outcome measures of healthcare and successfully guided the Trust to the award of a Charter Mark which was re-awarded in 1995. The Trust was ultimately responsible for the quality of healthcare but had to rely entirely upon the advice of carers in cases where the quality of care was deemed unacceptable. When such advice was received, effective action was taken.

Paragraph 36

Formal management structures tend to prevent individuals making their concerns known. They tend to be consumed within the process. At UBHT every member of staff had direct access to the Trust Board, Directors and Senior Managers, to university staff as well as to outside bodies. The Trust made it absolutely clear that expressions of their views outside the Trust, including to the media, would not be constrained but that when doing so staff should not allow it to appear to be an official message from the Trust. It was also expected that, out of courtesy, they would inform the Chairman and the Chief Executive before they went public. There was no distance between the Executive Directors and the Operational Managers and there were meetings between the two groups throughout the week. I do not know of any other Chief Executive who was more available to the staff for which he was responsible.

Paragraph 38

There were so many checks and balances on the activity of the Chief Executive that it is impossible to list them all here. There was an open accountability to the Trust Board. There was an accountability to the Region and subsequently to the Outpost and frequent conversations took place between the Chief Executive and the Regional General Manager and subsequently with the Chief Executive of the NHS Outpost.

Paragraph 39

Bristol and Western Health Authority had a surfeit of very competent and very experienced managers and it would clearly have been unfair to them, in a reorganisation, to recruit extensively from outside thereby increasing the problem of continued employment for its staff. Furthermore, a long experience within a particular speciality was clearly an advantage to a General Manager assuming this new responsibility. However the two Unit General Managers recruited as part of the implementation of the Griffiths Report, were both from outside the Trust and both provided experience from other districts.

Paragraph 40

It has already been explained that, in the absence of the Chief Executive, the Medical Director assumed responsibility for clinical issues which in other Trusts, without a doctor as Chief Executive, are normally provided. The Director of Operations never acted nor was ever designated as Deputy to the Chief Executive and in fact the Medical Director never acted in a Chief Executive role. The Chief Nursing Adviser had no longer any management responsibility for the whole of nursing and all Trusts, at that time, found some difficulty in finding a useful role for the Nursing Adviser to use the very substantial amounts of spare time that had become available. In Bristol, it was decided to create the post of Director of Operations. In other districts, nurses were used as Personnel Officers, as Quality Assurance Officers or in a variety of other ways. These arrangements did not impinge on the time necessary to fulfil the role of Chief Nursing Adviser.

Paragraph 41

The objectives for the directorates comprised the delivery of the contracts which had been agreed. This involved issues of volume, of quality and of cost. Massive support was provided to the directorates. They were, in many cases, performing an entirely new role and needed very substantial support, training and development. The directorates certainly developed at different speeds and there was no purpose to be gained by slowing those well advanced to the development speed of the slowest. The ambiguity in accountability arises from attempts to define a constantly changing and evolving situation.

Paragraph 42

Any attempt by the Trust to produce its own strategy would have undermined the development of the purchasing Health Authority in fulfilling its new role. The retiring Chief Executive

advised his successor to establish a post of Director of Development because he believed it would not be possible for the new Chief Executive to learn about and manage the Trust services as a whole and have time to study the planning and strategic issues which his predecessor had addressed.

Paragraph 43

Clearly unless there is a good reason to do so, time should not be wasted writing things down. There may be some value in discussing various views of what is valuable but there can be no support for the concept that unnecessary paperwork can be justified. Individual performance review of Managers was implemented in accordance with National guidelines. It was abandoned for Senior Managers only after prolonged experience had demonstrated it was counterproductive.

Paragraph 44

Medical audit reports from the District Audit Committee were considered to be confidential to the doctors by the Chairman of that Committee in order to facilitate the development of audit and allay the anxieties of consultants. As there was no comparative data available at that time, all the Trust Board responsibilities related to ensuring that medical audit was being developed and this they did.

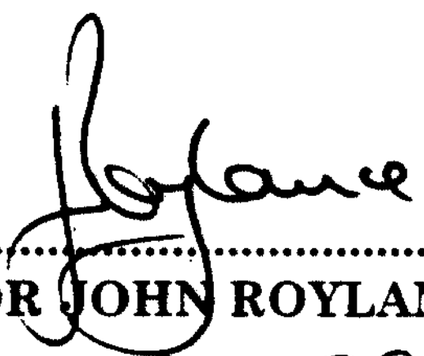
Paragraph 45

Clinicians were absorbed within the management process and were indeed given as much freedom as possible to focus on the delivery of care to patients but within the limits of the cash and resources that were available. The handling of clinical and management issues were fused and were not kept separate as they were in many Trusts who did not address the issue of clinicians being involved in management. As there was a management group which brought together Clinical Directors, General Managers and the central management team, it is difficult to explain the claim that such a group was absent.

Paragraph 46

As a bureaucratic approach would have sustained the status quo when the overriding imperative was for massive change, then clearly a task oriented culture was essential. The concept of co-ordinated, centrally led business planning is at variance with the requirements of the health service within the so called internal market. There was no way in which the Trust could have a strategy independent of the aspirations and requirements of the purchasing Health Authorities. Whilst there was major informal monitoring and support of directorates, there was twice a year a formal review of the activity of directorates which included financial performance, but also included all other facets of the directorates' performance including its workload throughput. The Trust did indeed have a very rigorous performance management which was by continuous assessment and intermittent formal review. Clinical standards at that time did not include outcome measurements. Very effective monitoring of non outcome clinical care was in place and was rewarded by the award of a Charter Mark. The introduction of clinical audit was pursued with enthusiasm by the Medical Director and Chief Executive although the Regional

Health Authority did insist that this should remain a process confidential to the carers and incorporated within the teaching and continual education of staff.



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DR JOHN ROYLANCE

4 Oct 00

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DATED