The BRI inquiry into paediatric cardiac surgery in Bristol (1984-1995)

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Background

1. I joined the NHS in 1972 on the graduate training scheme. My main appointments were as follows. In 1973 I was appointed Hospital Secretary in Bournemouth. In 1975 I became Sector Administrator for Farnborough Hospital which falls under the Bromley Health Authority. In 1979 I was appointed the District General Administrator for West Glamorgan, and in 1981 the Deputy District Administrator in Wandsworth. In February 1986 I came to Bristol as the General Manager for the Central Unit.

2. In late 1989/early 1990, I acted as leader of the Purchaser Team in Bristol for a few months, but was then moved to the Avon Family Health Service Authority (FHSA) and in March 1990 I became their Chief Executive.

3. In the middle of 1996 the FHSA and the Avon Health Authority merged, and I became the Development Director. This role ended on 30 June 1999 when I formally retired from the NHS.

4. My role as General Manager for the Central Unit was to ensure smooth operational functioning of the hospitals in my charge, and with others to strategically develop the services available. The hospitals in my charge included the BRI, the BRHSC and Maternity Hospital, The Dental Hospital, The Eye Hospital, radiotherapy,

medical services and Avon Ambulance Service. This was known as the Central Unit. I was also the budget holder for the Unit, allocating in excess of £50 million. I allocated a budget to each hospital unit.

5. During my time in post, the main issues I remember dealing with were as follows:-

(a) Starting an A.I.D.S clinic.

(b) Clinical nurse grading in 1988/1989.

(c) Reviewing Winford and Barrow Hospitals.

(d) Addressing waiting times, particularly in respect of cataract surgery and certain gynaecological procedures.

(e) Developing the breast surgery unit.

(f) Setting up the new Eye Hospital in 1986/1987.

(g) Dealing with industrial disputes within the ambulance service.

(h) Dealing with nurse shortages generally, but especially for care of cancer patients in paediatrics.

(i) Dealing with a lack of funding from South Wales for cardiac surgery services they were receiving from Bristol.

Issue B: The BRI and its Paediatric Cardiac Surgery Unit

Issue B1: The structure of paediatric cardiac surgical services at the respective sites at the BRI and BRHSC, including:

(a) the services offered;

6. I knew that there was a wish to develop cardiac services generally so that there would be a regional cardiac service. It was clear that our rates of intervention in cardiac disease cases were lower than in other parts of the country. This, together with the fact that cardiac disease is a major health problem in this country, meant that development of the service was seen as essential. There was a lot of debate within the region as to how these services should be developed.

7. The catheter laboratories at the BRI were shared for paediatric and adult investigations until 1987, when the paediatric work and equipment was moved to the BRHSC. The Heygrove theatres at the BRI were redeveloped for cardiac surgery in about 1987/1988. I was involved in planning the redevelopment, i.e. the size and layout of the new theatres, and the new staffing arrangements. The details for the redevelopment plans would have been dealt with by the hospital manager at the BRI at the time.

(b) funding of services, and the incentives created thereby;

8. I was the budget holder for the Central Unit. I allocated budgets to each hospital or sub-unit. I also dealt with matters which had not been resolved at a local level. For example, we were treating cardiology and paediatric cardiac surgery patients from South Wales, but without full funding. Most cardiac surgical cases were referred through our paediatric cardiologists who were continuing to attend "outreach" clinics, even though we were still trying to recover funding for the services which we were already providing. I was involved with Graham Nix in discussions with

the Welsh Office, to agree the adequate funding of the services being provided. We needed proper financing to be able to renew and update equipment and expand the service. Special care costs were particularly expensive and there were discussions with the Region as to how these services were to be funded realistically.

(c) organisational set-up: lines of authority, chains of command, communication and accountability, both professionally and managerially;

9. The organisational structure was as follows. There was the Chairman of the Bristol and District Health Authority plus non-executives. There was a management team headed by the District General Manager, who at the time was Dr John Roylance. In his team there were 2 unit general managers, myself for the Central Unit, and Margaret Maisey who managed the South Unit. There was a Treasurer (now called Finance Director), David Hucklesby; a District Medical Officer, Dr Ian Baker; and a Personnel Director, Ian Stone.

10. Each unit was allocated various hospitals. I have listed above at paragraph 4 those units which fell within the Central Unit. Each hospital had a hospital manager. For example, Miss Janet Gerrish was the manager of the BRI, and Marion Stoneham was the manager of the BRHSC and Maternity Hospital. There were also two accountants within my units, Graham Nix and Tony Parr .

11. As the Unit General Manger, my direct boss was Dr John Roylance, as the District General Manager. There was also a managerial line between Dr Roylance and the Chairman of the Bristol District Health Authority, who at that time was Mr Peter Durie. There was also a managerial line between Dr John Roylance and Catherine Hawkins at the RHA.

12. There were also various committees which supported the Health Authority. For example there was the Performance Assessment Committee, and the Finance Audit Committee.

13. A team meeting with Dr John Roylance was held every week and I also met on a one to one with Dr Roylance every few weeks, or as and when necessary. Dr Roylance was fairly "hands on" in his management style. In general terms, Dr Roylance was always keen to promote the best in Bristol.

14. I had a meeting with my hospital managers at least once a month, I also had one to one meetings, followed up by three-monthly reviews. Each 3 months we agreed objectives, and at the end of 3 months we carried out an assessment of whether those objectives had been achieved. In addition there were also Head of Department meetings. There were also regular union meetings, as well as medical staff committees, where the Chairmen of the Divisions in the medical specialities, e.g. surgery and radiology, would meet. There was a medical staff committee for the BRI and the BRHSC. The two hospitals were essentially run as separate units, although there was naturally some cross over.

(d) the extent to which medical and nursing staff were involved in management and managerial issues;

15. As mentioned above Dr John Roylance and Margaret Maisey were originally clinicians who took on management roles. Given their status one could say that medical and nursing staff were, indeed, involved in managerial issues at the highest level.

(e) facilities available at each site, including their use by other services, eg adult cardiac surgery;

16. I can make no comment in relation to this issue.

(f) staffing: numbers, natures of posts held, criteria for appointment and employing body, training and experience, job plans or descriptions and their review, and patterns of deployment (such as the use of shared appointments and the rotation of skilled staff);

17. There were 5,000 staff in my unit. I was not involved in the appointment of Consultant medical staff directly and can make no further comments on this issue.

(g) regulatory and disciplinary structures;

18. I can provide no information on this issue.

(h) counselling and support for staff;

19. I can provide no information on this issue.

(i) relationship with the University of Bristol and other academic centres;

20. I can provide no information on this issue.

(j) key managers and clinicians: identities, powers and functions, collaboration between disciplines;

21. Apart from what I have set out at B1(c) I can provide no further information on this issue.

(k) nature and scope of "outreach" clinics and other services offered by the paediatric cardiac team to local hospitals

22. Apart from what I have set out at B1(c) I can provide no further information on this issue.

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

23. Apart from what I have set out at B1(c) I can provide no further information on this issue.

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

24. Apart from what I have set out at B1(c) I can provide no further information on this issue.

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

25. Apart from what I have set out at B1(c) I can provide no further information on this issue.

Issue B5: The nature, scope and use of mechanisms and procedures (whether formal or informal) for establishing, monitoring and maintaining (a) safe treatment and care; (b) high-quality treatment and care; (c) professional competence and (d) managing costs; and/or for monitoring clinical outcomes and adverse events

26. The Performance Assessment Committee was chaired by the Vice Chairman of the Bristol and Weston Health Authority, Martha Perriam, who later became the Chairman of the FHSA. She later became Chairman of Weston Health Trust. Both myself and Margaret Maisey were on this committee, and I think Dr Ian Baker was too.

27. The committee considered such things as bed utilisation and waiting lists. At each meeting we would look at a different area, and the consultant relevant to that speciality would attend to provide specialist input to the discussion.

28. In the 1980s it seemed entirely appropriate and acceptable that there was self-regulation in terms of clinical practice and auditing

Issue B6: Protocols and guidelines to assist clinical decision-making and practice

29. I have no information to provide on this issue.

Issue B7: Documentation and the maintenance of high-quality clinical records

30. I have no information to provide on this issue.

Issue B8: The location of responsibility for (a) staffing levels and staff training; and (b) management and co-ordination of the staff team

31. I have no information to provide on this issue.

Issue B9: The information made available to referring clinicians, and to members of the public, on the standards of treatment and care attained at the BRI

32. I am not sure about the detail of information collated or distributed concerning standards of treatment and care; at that time there was certainly no Patients Charter.

Issue B10: Complaints procedures available to members of the public, their use and the responses to such complaints by the hospital, Trust or health authority leadership

33. There was a complaints procedure in place. If complaints were particularly difficult then they would filter through to me. I had a philosophy of spending time with the patient and, if necessary, going out to see them to try to help them work through the issue. Complaints about clinical competence went through medical staff or the GMC. This was not within my remit, and most of the complaints which I would have to deal with related, for example, to complaints about waiting time or staff

attitude. I cannot say that I recall ever having any complaints about cardiac surgery or specifically about paediatric cardiac surgery.

Issue B11: Mechanisms and structures available to staff members to raise, and to secure action upon, clinical or managerial issues of concern to them; and the limitations of such methods

34. As set out at B1(c), there were a huge number of meetings taking place which were both frequent and fairly open. For example, I attended, on occasion, the ward sisters' meetings, which were a fairly open forum in which staff could raise concerns. I would have expected issues raised to include any clinical or managerial issues of concern to the staff.

35. Staff would also raise concerns with me as I passed through the hospital. This was an important part of my own management style, as it was important to me to deal with things in a "hands on" way and be available for comments, both formally and informally. In 1988/1989, for example, whilst meeting informally at the BRHSC, I became aware of nurses' concerns relating to a shortage of trained nurses. As a consequence of this I helped to set up counselling sessions so that nurses could discuss the problems that they had and I also ensured that doctors modified their admissions policy so that the workload itself was eased. In addition we carried out a recruitment campaign to try to increase the numbers of trained nurses.

36. In respect of clinical issues, staff would also raise matters with consultants or senior registrars. They may not have always raised matters with management although they may have spoken to Margaret Maisey because of her clinical/nursing background.

37. In summary, information would come to me from a variety of directions, both formally through meetings or informally as well as information provided to me by my managers. I did not have the impression at the Central Unit that problems were hidden, or that there was any fear of reprisal through "whistle-blowing".

Issue B12: The culture of the BRI, as expressed in such matters as:

(a) the relative power and status of key individuals, or groups such as managers, surgeons, cardiologists, anaesthetists, nurses, or professions allied to medicine;

(b) the self-image and morale of such groups;

(c) identity and loyalties amongst staff members, whether towards other staff groupings, or to outside professional associations or other societies;

(d) leadership, team-working and communication between members of staff;

38. As with any hospital there are key individuals who have particular status or power. In many hospitals these individuals would be the senior consultants and at the BRI Dr John Roylance was one of those. Other influential personnel would include various consultants who, for whatever reason, had developed their status or position; professors who due to the BRI being a teaching hospital would take an important role; and additionally certain members of the nursing staff who either because of the position they were in or because of their personality had a status which made them stand out relative to the rest of the staff. In terms of my position, as I controlled the resources and had access to management I also had a degree of "power" in terms of an overview of the management position.

(e) the responses towards poor performance by a member of staff;

39. With regard to identifying poor performance, either on an individual, or a departmental basis, any large institution will have areas of weakness and will deal with that poor performance appropriately. If these issues were identified at the BRI they were resolved locally, but if not resolved, they would be dealt with under an established procedure. I was involved in any identified poor performance of nurses, very much less so with doctors, who were dealt with separately.

(f) the attitudes towards patients who complained of poor service or care;

40. Where complaints were received from patients in respect of poor service or care, as previously indicated, my philosophy if necessary was to sit down with the patient or even to go and see them to try to talk the matter through and deal with the matter in a caring way. This approach seemed, on the whole, to be an effective way to deal with patients with complaints, in terms of how they were dealt with at my level. Obviously I cannot comment about how members of staff actually dealing with the patients responded to complaints about their care, although I would ensure as far as possible that such complaints were dealt with appropriately.

(g) the attitudes towards staff who complained of poor standards of care and/or towards "whistleblowers"

41. The BRI was no different from any of the very large hospitals I have worked in. They are to some extent bureaucratic, structural, hierarchical organisations. However as far as I am aware complaints were taken seriously.

Issue B13: The extent to which the structures and attitudes described under this Issue, B, differ from those commonly adopted by large organisations involved in risky activities; and the nature of any such differences

42. I have no information to provide in relation to this issue.

Issue D: Referrals

Issue D1: The identity and the distribution of hospitals (and/or general practices, if appropriate), from which children were referred to:

a. the paediatric cardiologists; or

b. the paediatric cardiac surgeons based at the BRI

43. I have no information with regard to precise details of the identity and distribution of hospitals from which children were referred to the BRI for paediatric cardiology treatment. I am aware that in the relevant period whilst I was Manager of the Central Unit, there was an issue in respect of the possible expansion of cardiac services in general, from which there developed serious concern about funding of referrals from South Wales, as I have mentioned at paragraph 8. The history for this was that the paediatric cardiologists would conduct "outreach" clinics in South Wales and would refer cases to Bristol, leaving it to others to sort out the funding for this work.

44. I became involved in referral issues in 1986 when it became apparent that the number of referrals from South Wales to Bristol exceeded the resources available (and by this I mean both finances and staff). I needed to ensure that appropriate funding was acquired for these referrals, as this had a direct "knock-on" effect to the ability of the BRI to have adequate funds to develop the cardiac services as required. With an increase in cases being referred to the BRI the natural consequence of this was that the supporting infrastructure would need to be larger.

45. In those days we did not have the kind of contractual arrangements that are in existence now, and therefore we had to look at where the funding would or should come from to resource the number of referrals. This was all taking place in the context of the growing Cardiac Unit and therefore, as is often the case, where growth occurs, activities and funding did not always correspond. With regard to the paediatric cardiology referrals and funding, we entered into discussion with the

Welsh Office to try to ensure that they were paying for the services that they were receiving. It was felt that we needed to reach agreement with the referring bodies before the situation got out of hand, otherwise future expansion would be jeopardised by the under-funding of the day.

46. There would have been various amounts of correspondence as well as meetings, all discussing this issue and negotiating funding with the Welsh Office. As a general comment, the process would involve Dr Ian Baker as District Medical Officer; looking at the numbers of paediatric cardiology cases likely in any given population. Armed with these figures, Graham Nix would estimate the cost of those cases. Backed up by Ian and Graham, my role would be to bring the information together and link this with the support mechanism needed in the hospital for nursing and back up services etc.

47. Irrespective of any such processes performed by us as managers, the decision on whether or not to refer a case to Bristol would essentially rest with the clinicians. With this background we had to address a very real problem of lack of funding with the Welsh referrals, to a point where a decision had to be made, probably by the District Management team, about whether or not more patients could be taken until the funding position was sorted out.

48. I will go through the documentation which provides a background to this issue and the communication which was going on at that time. Document UBHT 0165/0011 dated 27 November 1986 looks to refer to a visit by the Welsh Office in November 1996, which would have been to discuss funding for the paediatric cardiology referrals. Mr Dhasmana presumably attended that meeting to provide information from the surgeon's perspective on the referrals. I can make no further comment on that document.

49. Documents UBHT 0278/0300, 0278/0301, 0278 /0302, 0278/0299, 0165/0019 and 0165/0020 all relate to correspondence between myself and the Welsh Office on funding for paediatric cardiology referrals from 12 October 1987 to 22 December

1987. The initial documentation discusses with Mr Dhasmana, Dr Joffe, Dr Jordan, Mr Wisheart, Ms Stoneham and Mr Nix my draft letter to the Welsh Office. I canvassed their opinions on the contents of the draft letter, again co-ordinating the financial and epidemiological information available to me to explain the request for funding. It can be seen that the initial letter was sent to Dr Reynolds, the Chief Administrative Medical Officer of East Dyfed Health Authority on 2 November 1987 (document UBHT 0062/0360 dated 2 November 1987). This set out the difficulty in terms of resources, and identified the intention to restrict the number of referrals for 1988, to the levels previously agreed in 1985, unless appropriate funding from the referring body could be provided. It would appear that no particular response was received and as a result a further letter, the draft of which is document UBHT 0165/0020 dated 18 December 1987, was sent to Mr Owen, Director of the NHS in Wales, which confirmed that further action would be taken, such that as from 1 February 1998 the BRI would be unable to receive any new patients aged over 1 year from Wales. Children under the age of 1 were felt to be less of a problem as agreement from the DHSS for supra-regional funding seemed more likely.

50. In terms of referrals elsewhere, the document HA(A) 0119/0051 dated 6 October 1987 has a bearing as it discusses the waiting list initiative in existence around Autumn of 1987. In general there are often waiting list initiatives in hospitals because waiting lists are always of concern. The document in question was to Dr Roylance and advised of my concerns about not hitting our targets of 50 patients for onward transfer to The Brompton Hospital for cardiac surgery. There was a question over whether the patients were reluctant to go to London, and this was potentially more so with paediatrics as a local hospital would be favoured by the visiting family. The waiting list initiative was not in any way limited to paediatric cardiology but was across the board. I recall at some point around that time attending a meeting at The Brompton. In all probability that would have been to discuss the numbers and types of patients to be referred from the BRI. The issue in October 1987 was that a deal had been struck with The Brompton to take a certain number of cases under the waiting list initiative and the BRI was not referring as

agreed. I would have been involved in the negotiations with The Brompton, but I am unsure as to other people who would have been dealing with this. Apart from the difficulty of referring the patients who are unwilling to go to London, I think our inability to transfer as many patients was to a large extent due to having fewer admissions for cardiological investigations, having limited them due to building works going on at that time.

51. With the referrals issue there was also an ongoing resources issue, incorporating both funding and staffing levels. An example of the sorts of concerns I needed to address in my role can be found in document HA(A) 0120/0057, dated 13 December 1988, which refers to an intended meeting to discuss cardiology services in general (this is not specific to paediatrics) on the basis of a financial shortfall for 1988/1989. This sort of exercise was carried out across the board covering other areas within the Central Unit with the support of financial departments and planners etc. Again, the process was to ask someone like Dr Ian Baker to study the likely need in terms of the history already available, and then cross reference that with Graham Nix and other managers and clinicians. The purpose was to deal with medical staffing (predominantly dealt with by Dr Ian Baker) and, in this case, to flag up the fact that the number of procedures carried out was going to outstrip resources.

52. In all such situations there is a continual balancing act by those who allocate budgets. One inevitably has to consider looking to constrain this service, for example by restricting the number of incoming cases (as was the case with the Welsh referral of paediatric cardiology cases). The only options are to either get more resources or to take on fewer cases. At a meeting (the one that must have followed the memo on 13 December 1988, document HA(A)0120/0057 dated 13 December 1988) there would have been various discussions with clinicians about prioritising cases and looking at other options, such as The Brompton referral deal, as well as looking for finance and resources.

53. Documents UBHT 0062/0353, 0062/0360 dated 2 November 1987, 0062/0384 dated 11 January 1988 all address the various discussions relating to the issue of resourcing referrals from Wales. This is the continual presentation of a simple problem of too many patients and not enough resources. It can be seen here that Dr Ian Baker was recommending in January 1988 that we should stick to our guns in terms of limiting the referrals. The clinicians would have been generally unhappy about this as they were looking to expand the department. There was discussion with the cardiologists who had direct input, for example Dr Joffe. Naturally they were quite frustrated as they simply wanted to treat patients. This is evident from document UBHT 0062/0299, dated 12 May 1987.

54. Whilst the assessment throughout 1986/1987/1988 of the disproportionate numbers of referrals to resources was going on, we still got new cases in. Throughout that time, from a management perspective, it remained the view that we could not manage the patients at that continuing rate. My involvement in this, as with many issues at the time, was that I was copied into the various communications and would attend meetings, but predominately would deal with the "fall-out" from the policy decisions, by liasing with staff on the ground.

55. It can be seen that the situation at the BRI, with regard to resources and the Welsh issue, continued for some time. It was not until 1989 that funding deals were agreed with the Welsh Office (document UBHT 0103/0045 dated 20 July 1989). This document in fact appears to be annexed to another document but I do not know to what it was annexed.

Issue D2: The judgement or impression formed by referring paediatricians or other clinicians of the paediatric cardiac surgical services provided by the BRI

56. I am not able to comment on this issue.

Issue D3: The sources of information available to such referring clinicians upon the standards of treatment and care attained at the BRI

57. I am not able to comment on this issue.

Issue D4: The factors influencing clinicians, in deciding to refer children to the BRI rather than to other centres performing paediatric cardiac surgery

58. I am not able to comment on this issue.

Issue D5: Whether there is evidence to suggest that clinicians based outside the BRI but within its "catchment area" were deciding to refer children to centres other than the BRI, and if so, why

59. I am not able to comment on this issue.

Issue D6: Whether any of the paediatric cardiologists based at the BRI decided to refer a child to a paediatric cardiac surgeon outside the BRI; and if so, why

60. I am not able to comment on this issue.

Issue D7: The extent of and reasons for tertiary referral from the BRI to other centres of paediatric cardiac surgery

61. Tertiary referral from the BRI to other centres of paediatric cardiac surgery would occur where the Unit would be unable to deal with the specific patient and a more specialist referral would be needed. This is a separate issue to the waiting list issue which was one of capacity and does not fall within the meaning of what is normally understood by "tertiary referral".

<u>Issue D8: The information (if any) given to parents or guardians at the time of referral to the BRI, upon the services and care to be expected at the BRI and/or at other centres; and the information (if any) given concerning the possibility of referral to other centres</u>

62. I am unable to comment upon this issue.

Issue E: Pre-Operative Management of Cases

Issue E1: The arrangements and services available to manage the transfer of sick children from referring hospitals to the BRI

63. I had no involvement in the setting up of transfers from referring hospitals to the BRI. I have a vague recollection of concerns over the costs of transfers, although I do not recall any details.

Issue E2: Where children were managed, pre-operatively, and under which clinical speciality

64. I am unable to comment upon this issue.

Issue E3: The re-assessment of the clinical condition of children admitted for elective surgery, following admission

65. I am unable to comment upon this issue.

Issue E4: The manner in which decisions to recommend surgery for a child were discussed between paediatric cardiologists and paediatric cardiac surgeons, and other members in the cardiac surgery team; and the means by which such decisions were taken

66. I am unable to comment upon this issue.

Issue E5: Who bore the ultimate responsibility of deciding whether and what surgery was appropriate for a child, who should perform it, and when it should take place

67. I am unable to comment upon this issue.

Issue E6: the organisation and management of theatre lists

68. The organisation and management of theatre lists was a matter for agreement between clinician and Theatre Sister or Manager. If it was a problem it would have been brought to my attention. For example, if there was a recurrent problem with over-running lists or too many patients then this may have been something I was asked to deal with. I am unable to recall anything specific to paediatric cardiac surgery.

Issue E7: The mechanisms in place in order to ensure that surgery (whether elective, urgent or emergency) took place at a time regarded by the clinicians at the time as clinically optimal or appropriate

69. I am unable to comment on this issue.

Issue E8: Whether operations (particularly elective ones) were carried out at a time regarded by the clinicians in charge of the child's care as appropriate; or whether the timing of the operations was affected by matters such as limitations in the number of beds available in the ICU, availability of nursing staff or other staff, or the requirements of adult cardiac surgery

70. These are clinical issues which need to be commented on by the clinicians involved.

Issue E9: If there were delays in surgery, the effect (if any) of such delays upon the outcome for the children affected

71. These are clinical issues which need to be commented on by the clinicians involved.

Issue E10: The qualifications, training, experience and skills of the paediatric cardiologists

72. These are clinical issues which need to be commented on by the clinicians involved.

Issue E11: The service provided by paediatric cardiologists in diagnosing or describing:

a. the structure and anatomy of the child's heart and lungs;

b. the clinical condition of the child;

c. the nature of the surgical procedure required, and any complications that might be encountered by the surgeon;

d. the speed or urgency with which any intervention was required

73. These are clinical issues which ought be commented on by the clinicians involved.

Issue E12: The protocols or clinical guidelines, machinery, equipment or technical services (eg radiological interpretation) available to the cardiologists to assist them in this task

74. I believe there were protocols in existence to cover these issues. I have no specific memory of the contents of any such protocols.

Issue E13: Pre-operative assessment and preparation procedures, including meetings at which treatment and operations were discussed and planned

75. I am not able to comment on these clinical matters.

Issue E14: Pre-operative observation, assessment and care by the nursing staff and other professions (such as physiotherapists)

76. I am not able to comment on this issue, which is for the nursing staff and PAMs to comment upon.

Issue E15: Liaison of staff with parents; and the participation of parents in the assessment and care of their child

77. As with earlier issues, the question of liaison between staff and parents in the paediatric cardiology unit would only really be brought to my attention in the event that there was a complaint or problem. If there was a complaint it might have been looked into by me, having been investigated within the department I would send out a response. Marion Stoneham as General Manager of the BRHSC would often be the person to investigate it on the ground. Again, there would have been a protocol or a set procedure for such complaints to be dealt with. I dealt with the complaint personally if it was more serious, or where there was a multiplicity of complaints, or indeed if there was dissatisfaction with the first response received to a complaint. Again, I am unable to remember anything specific to the paediatric cardiac unit.

Issue F: Management of Surgery

Issue F1: The qualifications, training, experience and skills of the paediatric cardiac surgeons at the BRI

78. I have no knowledge or information on this issue.

Issue F2: The qualifications, training, experience and skills of anaesthetists assisting at paediatric cardiac surgery at the BRI

79. I have no knowledge or information on this issue.

Issue F3:

(a) the qualifications, training, experience and skills of all other members of the surgical team (eg, nurses and perfusionists),

(b) the support and assistance given by such members of the surgical team

80. I was involved in the planning of staffing levels in these areas and in the structure itself, but without detailed documentation I am unable to remember specifics of qualifications and experience etc. I see from the annual report of 1988 (document UBHT 0124/0005) that in 1988 staffing issues were discussed in this factual review of the year. Again, I would have been involved in the process of gathering information on numbers and then information on resources needed (e.g. number of nurses per bed). These details would normally be passed to a planning team, because different skills would be needed to assess all the information. The result of this sort of exercise was the production of a document such as UBHT 0170/0062 (undated) which provided for a possible plan for increasing workload in cardiac surgery depending upon a re-assessment of figures for availability and staffing levels. Again I am unable to recall this specific example but can confirm that I would have been involved in this sort of exercise.

81. Staffing recruitment on the medical side was carried out by Dr Ian Baker. Document UBHT 0092/0016 dated 30 March 1987 is a letter from Jane Jerrard, who worked with Dr Ian Baker in relation to the recruitment of a new consultant in Paediatric Cardiology.

82. I was involved in assessing the need for different positions within the Unit, addressing the skill mix and requirements as that was part of the information I had to look at. An example of this would be the balance between technicians and nurses in areas where they may do similar tasks. In this area Miss Janet Gerrish as manager of the BRI was my assistant. She would gather the information and I would then put it into context of wider implications across the Central Unit.

Issue F4: How the team in the operating theatre was constituted and co-ordinated, and its performance as an integrated team

83. I was only involved in this if there was a particular problem, although I did regularly visit theatre during surgical procedures in order to talk to the staff. This was part of my management style, of being on the ground and getting involved in what was actually going on.

Issue F5: The factors affecting performance in the theatre. Such factors might include familiarity with tasks; design and performance of equipment; hours of work; error management; and so on

84. I believe that the procedures within theatre were strictly governed by the protocols and practice set down. From my visits to theatres I was always aware of the very strict compliance and awareness of the protocols and procedures. Theatre Mangers would clearly be more involved with particular performance issues. They would be brought to my attention if there was a serious problem. I cannot recall any such problems occurring with paediatric cardiac surgery.

Issue F6:

(a) the existence, extent and awareness of any material differences in the manner (including speed) of carrying out surgery at the BRI, when compared to surgical practices current at the time; and

(b) the impact (if any) of such factors upon mortality and morbidity rates

85. I can make no comment upon this issue as I have no information relevant to it.

Issue G: Post-Operative Care

Issue G1: The national standards or guidance in existence, in 1984 -1995, to shape the organisation, the numbers and experience of staff within ICU's such as those of the BRI and the BCH

86. I cannot now remember any specific standards or guidance that was relevant to the period 1984 to 1995. As a Manager, for each part of the work I would be aware of standards and procedures. While it was impossible for me to know such a vast number in detail, at the time I was working as a Manager in the BRI, I would have known where to find such guidelines and how to ask about the standards in existence. By way of example, there would have been standard procedures or policies relating to human resource issues such as grievance procedures. From a clinical perspective there were guidelines for the handing out of drugs on the wards etc. There were nursing procedure manuals and many guidelines were issued. I had to remain up to date with regard to their existence, and to know general principles. When dealing with specific issues I simply needed to ensure I knew where to find the information relevant to the issues. I could not be expected to retain that level of detail.

87. In terms of theatre guidelines, Theatre Managers were responsible for ensuring the guidelines were in line with national standards and also for ensuring that there was updating of such standards. I was aware of anything new, but was not aware of the detail. There was also a process of external sources, with standards being adhered to (for example the Royal Colleges). These checks also addressed staffing levels. I was aware, for example, as to whether the BRI was in line with national standards on staffing levels. As with many of these issues, if there were problems with staffing levels, or with new procedures which were not working, or with guidelines that were not being adhered to, then they came to my attention if a problem became apparent. During the time I was a manager I was aware of a problem with oncology for children and training in this specialist area, but was not aware of any difficulties

with the staffing levels in the Paediatric Cardiac Unit, other than the previously noted "Welsh Issue".

Issue G2: Staffing within the ICU's caring for children following cardiac surgery; numbers, training, experience and skills mix

88. I am not aware and cannot recall any specific details or concerns. If it was anything other than a marginal issue or concern I would have expected to have known about it.

Issue G3: How, if at all, the skills mix and expertise of the ICU staff differed from both published guidance and the standards and patterns to be observed across the country at the relevant time

89. I am not aware and cannot recall any specific details or concerns. If it was anything other than a marginal issue or concern I would have expected to have known about it.

Issue G4: The availability of staff throughout the 24 hour day to assess and to meet, following such assessment, the needs of any child in ICU after paediatric cardiac surgery

90. I am not aware and cannot recall any specific details or concerns. If it was anything other than a marginal issue or concern I would have expected to have known about it.

Issue G5: The development and organisation of immediate post-operative care

91. I am not aware and cannot recall any specific details or concerns. If it was anything other than a marginal issue or concern I would have expected to have known about it.

Issue G6: Liaison between specialities, and steps taken to ensure continuity of care

92. I am not aware and cannot recall any specific details or concerns. If it was anything other than a marginal issue or concern I would have expected to have known about it.

Issue G7: The assistance provided by paediatric cardiologists. The impact (if any) of the fact that these cardiologists were based in the Children's Hospital, upon the availability of such assistance

93. The location of specialists in a large hospital with either a number of sites, or a particularly large site, is always of concern. This was an issue at the BRI and the children's services needed to be re-located. I recall discussions about a Children's Hospital some 12 years ago. This is now being built.

G8: The extent to which the demands or requirements placed upon ICU nurses and other staff by paediatric cardiac cases differed from those imposed by adult cardiac cases or other cases commonly encountered; and the steps taken to address any issues that might arise out of such differences

94. The nurses and clinical staff can provide detail as to the extent to which their jobs differed as between paediatric cardiac cases and other cardiac cases. Insofar as problems that might have arisen out of such differences, the main issue was generally one of training where there was a specialism within the unit. I do not remember a specific problem with paediatric cardiac cases. There was a definite issue with regard to paediatric oncology. This was overcome by trying to recruit more specifically trained nursing staff and to train the people we already had into a more specialist area.

Issue G9: the supply and maintenance of proper and adequate equipment to the ICU

95. The Medical Engineering Maintenance Organisation ("M.E.M.O") dealt with these issues.

Issue G10: The standards of post-operative care delivered at the Infirmary and the Children's Hospital; (including such matters as post-infection rates, and the general standard of hygiene and cleanliness)

96. This was part of the standard nursing procedure. There were infection rates available. I do not remember any specific issues. With regard to hygiene and cleanliness, issues there was involvement between in-house and outside contractors, who had competitively tendered for provision of the services. In terms of post-operative care issues generally at that time, I cannot remember any specific complaints being made, other than some complaints concerning the building noise which occurred around 1988 when works were taking place

Issue G11: The management of discharge and future care

97. This would be dealt with by clinical staff. Unless there was a complaint or a difficulty I would not have been involved.

Issue G12: Liaison of staff with parents; and the participation of parents in the assessment and care of their child

98. This would be dealt with by clinical staff. Unless there was a complaint or a difficulty I would not have been involved.

Issue H: The Split Site

99. I was aware that it was desirable to treat children in the BRHSC, but patients had to go wherever there was the highest level of technical skill and experience, and this was at the BRI for certain specialities.

100. Cardiac surgery initially grew up as a medical speciality, and then paediatric cardiac surgery grew out of it. We developed paediatric cardiac surgery in the best way we could within the resources we had, and that was to provide it at the BRI where the surgical expertise was located.

Issue I: Treatment of Families, including the Bereaved

Issues I1-I5

101. Document UBHT 0062/0292 dated 12 March 1987 identifies the bringing to my attention of a possible need for a counsellor the Paediatric Cardiology Unit, highlighted by Marion Stoneham. This documentation, along with UBHT 0062/323 dated 10 July 1987, discussed the need and the funding. This was eventually achieved through liaison with the South West Heart Circle, who gave us the go ahead for funding for such a counsellor. This reinforced the work already done on an informal basis by the nursing staff.

102. I was predominately dependent upon people such as Marion Stoneham to bring to my attention an assessment of the need for such a counsellor, partly by virtue of liasing with staff and parents about the needs of parents and families with sick children in the Unit.

103. As to how the staff themselves dealt with the families and whether they did so in a sensitive or appropriate way, this would have been brought to my attention through the management structure, the meetings mentioned earlier, or through my own observation when I was able to get to that Unit. By recollection I was not made aware of any difficulty with lack of sensitivity in this area.

Issue J: Post-Mortems and Inquests

Issue J1-J3

104. There is a legal obligation covering this issue. Whilst I cannot now remember it verbatim it was clearly there to be used and followed. I do not remember any issue in this area in respect of paediatric cardiac cases.

J4: Whether consent (if required by law) to:

(a) hospital or coronial autopsies; and/or

(b) the retention of tissue and/or organs of the body

was properly and sensitively sought; and if consent was not required, whether proper and adequate information about this matter was given to parents, in an appropriate fashion

105. At the time when I was responsible for the BRI, I would have been fully aware of the issues of consent surrounding autopsies and retention of tissue or organs. I cannot recall them specifically now. There would have been recognised procedures for sensitivity in terms of staff approaching families on this point. I would not have been aware of any specific issues unless they had been brought to my attention via a complaint or by a member of staff. I do not recall the Cardiac Unit ever presenting a problem.

Issue K: Training and Retraining

Issue K1: The support and assistance made available to all members of staff, to help them keep abreast with developments in clinical practice, and the use made of such facilities

106. There was a clear line management process for identifying the necessary support and assistance to each member of staff. There were certain managerial roles where people reported directly to me. The majority of managers had an individual line manager to report to. The line manager would identify the training needs and action that was needed. There was also a process whereby senior managers would ensure that managers under them actioned the requests for further training to ensure that the staff under those managers were followed up appropriately. There would also be external influences such as the Royal Colleges.

Issue K2: The process of appraisal and training required of a paediatric cardiac surgeon in 1984-1995, before embarking on an advanced operative procedure not previously performed by him

107. I do not have any details with regard to specific processes of appraisal and training in respect of new procedures not previously performed by a particular surgeon between the years 1984 and 1995. I would have expected that in respect of new techniques the consultant would have liased with external organisations. My predominant involvement with appraisals and training would have been through the line management route. In this regard Consultants fell outside the line management structure. They were however subject to peer networks which run the merit system in terms of doctors' pay .

K3: The extent to which those obligations were affected by the fact that:-

(a) the procedure was new, and now well-established elsewhere, or (conversely) that it was well-established elsewhere;

(b) there was an absence of "local" skill or advice, so that any assistance must necessarily have been obtained from outside the institution in question

108. I have no knowledge which might assist with this issue.

K4: the professional or contractual obligations regarding such appraisal and training imposed upon a paediatric cardiac surgeon (both at the BRI, and generally within the UK)

109. I have no knowledge of this issue.

K5: The professional obligations or duties (if any) placed upon the person or persons carrying out, or assisting with, the retraining of a professional colleague

110. I have no knowledge of this issue.

K6 - K17

111. These are clinical issues on which I am unable to comment.

Issue L: Informed Consent

112. This would be a legal and clinical issue. I was concerned that there was a procedure to ensure all the clinical staff were aware of the forms to be filled in and the method of doing this properly. My concern as Manager was to ensure that the system was in place and pick it up if it was not followed. Ultimately this was down to a clinician on the ground and I would not be aware of the details. The way in which this job was achieved was very difficult to monitor at a senior level. At junior level the doctors were overseen by their senior consultants.

Issue M: Review of Cases and Medical and Clinical Audit

Issues M1-M3:

113. I am unable to provide any detail on the obligation and requirements for medical and clinical audit in terms of professional guidance, standards, contractual obligation or institutional obligations for the relevant period.

Issue M4: The proper role of the hospital management, and/or the District or Regional HA management, in:

(a) ensuring that systems of review or audit were in place, were adequately resourced and were functioning properly; and in

(b) responding to the results of any audits

114. As part of the hospital management, my role was to ensure that there was a system in place and to a certain extent, that it was being carried out. I was aware that there was time blocked out by clinical teams to carry out audits. I went to some of these meetings to help my understanding of the process. I was not aware of the adequacy of such systems. I believe this assessment would have fallen upon external auditors such as the Royal Colleges. If I found out that a particular clinical department was not carrying out some form of clinical audit, then I would have been concerned with ensuring that changed. I would not have been involved in the details of this, in the sense of understanding the quality or significance of what was being carried out.

115. In terms of assessing the results of audits, there was a Performance Assessment Committee which I sat on. This would look at the audit review. As stated earlier, I do not recall anything in terms of paediatric cardiac surgery from any of these audit processes.

Issues M5-M12:

116. I am unable to provide any detailed information with regard to these issues in terms of clinical audit.

Issue N: The Expression of Concerns

117. The expression of concern in respect of Paediatric Cardiac surgery occurred after my departure from the BRI. I cannot recall any such comments during the time I was responsible for the BRI. The document UBHT 0056/0159 dated 7 November 1989 was circulated to me in November 1989 for my opinion on the document for "Achieving Better Patient Care". I do not recall any response to this document, either by myself, or by my colleagues at the time, as by this stage I was already moving towards my next job with FHSA. The draft document of UBHT 0056/0159-0177 would have formed part of the continuing response process that I was not involved in. I am unable to comment with any particularity on these issues.

SIGNED : ....

JOHN WATSON

DATED : ......9/9/99......

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