Chapter 7 – Supra Regional Services

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Summary and chronology

1 In 1983 it was agreed between the Department of Health and Social Security (DHSS), the regional health authorities (RHAs) and the Joint Consultants Committee (JCC) that new supra regional service (SRS) arrangements would be introduced. The arrangements came into force at the beginning of the financial year 1983/84 with neonatal and infant cardiac surgery (NICS) being included in the scheme from the start of the financial year 1984/85.

2 The Royal College of Surgeons of England (RCSE) and the Royal College of Physicians of London (RCP) set up a joint working party that reported on 1 September 1986 into the matter of proliferation.

3 In December 1987 the Welsh Office asked the RCP to set up a task force to review cardiac surgery and cardiology in Wales.

4 On 22 January 1988 the Supra Regional Services Advisory Group (SRSAG), for the first time, discussed the possible de-designation of the whole service.

5 In May 1988 the RCP reported the Welsh Office as saying, amongst other things, that South Wales was capable of sustaining its own cardiac service.

6 On 28 July 1992 it was agreed that the SRS for NICS should be de-designated with effect from April 1994.

The national framework

Introduction

7 The SRS was intended to support the national development of highly specialised services, which required particular clinical expertise or experience, might need particular facilities and equipment, and for which the demand was such that they could not economically be provided in each region. It was hoped that by providing a special funding system, dedicated to an individual service, proliferation in the development of these services could be limited.

8 The funds for the SRS were acquired by 'top-slicing' a levy each year from the funds allocated by Parliament for Hospital and Community Health Services. The levy had the effect of reducing (marginally) the overall amount available for RHAs to spend on local health services. The SRS funds were then administered directly by the Department (of Health and Social Security, from 1988 of Health), on the advice of the

SRSAG. The secretariat of the SRSAG liaised directly with the health authorities and later the trusts that provided services funded through this mechanism. The financial implications of SRS for Bristol are set out in Chapter 6.

9 The top-sliced amount was then used to provide secure funding direct from the Department to centres 'designated' to receive such funds as part of a designated service. It was as part of the SRS that, between 1984 and 1994, funds were made available for the designated service of NICS.

10 NICS related to children under 1 year of age only: 'infants' meant children under 1, and the term 'neonates' meant children under 1 month of age. Throughout the period of the Inquiry's Terms of Reference, the arrangements for organising and funding cardiac surgery for older children, those aged between 1 and 16, were the same as those which applied to the vast majority of children's and adult acute healthcare services. Thus, there were no special arrangements for funding paediatric cardiac surgery for children aged over 1. It was funded through the Regional Health Authority (RHA), until the provider-purchaser split took effect in 1991, after which they were provided in accordance with arrangements ('contracts') made between the provider unit and the District Health Authority (DHA) purchasers.

Rationale for supra regional funding

11 The concept of focused, specialised centres for, amongst other specialities, NICS, was something discussed within the medical profession from at least the 1960s.

12 Dr Norman Halliday (Medical Secretary, SRSAG 1983–1994) said in evidence:

> 'The reason for setting up the supra regional service and the reason for selecting any particular service was principally funding … But of course from the Department's point of view, we recognised that there was also a benefit in that. There was a benefit in that we could control the development of the services, which would be beneficial in terms of cost, but also beneficial in terms of benefits to the patients, because the experience worldwide was that the more a doctor does a particular form of treatment, the better are his results. So by controlling the development of these services, we would be giving benefits to the patients.'[1]

13 The process by which the system was gradually established began in earnest from 1974 onwards. It included the setting up of a Joint Working Party between the Department's Medical Policy Division (MPD) and representatives of the medical profession to consider how specialised clinical services should be delivered.[2]

14 This Working Party met regularly and, in 1983, the need for specialist services was agreed between the Department, the RHAs and the Joint Consultants' Committee (JCC) such that, consequently, SRS arrangements would be introduced. A view was

1 T13 p. 12 Dr Halliday
2 WIT 0049 0002 Dr Halliday

taken that, in order to be economically viable and clinically effective, the small number of specialised health services (serving a population substantially larger than that of any one region) could not be funded through the usual mechanism.

15 In his formal written statement Dr Halliday stated that, in relation to designation:

> 'An essential criterion which was agreed with the medical profession during the protracted discussions leading to the establishment of the SRS arrangements was the requirement that a designated service should not be provided outside of designated units.'[3]

16 Dr Halliday defined the 'medical profession' as the JCC, the Royal Colleges and the British Medical Association (BMA).[4]

17 In oral evidence he also described his understanding of the role of advice from the Royal Colleges, in designating particular units as part of the SRS:

> 'I think you would have to ask the Royal Colleges what they were looking for, but what we would expect from the Royal Colleges is their expert opinion as to the facilities available in the unit, the staffing of the unit, the qualifications and experience of the staff, and in their opinion, the ability of that unit to provide that service.'[5]

18 In respect of proliferation, the SRS was able to nurture the chosen specialties, many of which were new forms of treatment or treatments for small groups in the population, thus allowing expertise to develop within the funded Centres. It appears to have had some success in limiting the spread of some specialised services, e.g. transplant surgery. Dr Halliday's view was that the overall supra regional system had 'proved to be a complete success'.[6] He said:

> 'If one can implement the arrangements effectively, you should have the services concentrated in a few centres.'[7]

However, paediatric cardiac surgery had already been provided in a number of units before the scheme began and proliferation in this area was always difficult to control.

19 The SRSAG knew that there were 'too many' units undertaking NICS, as Dr Halliday explained:

> '... the supra regional service arrangements were set up for any service that fitted the criteria. We took neonatal and infant cardiac surgery into the arrangements

3 WIT 0049 0013 Dr Halliday
4 WIT 0049 0018 Dr Halliday
5 T13 p. 18 Dr Halliday
6 WIT 0049 0003 Dr Halliday
7 T13 p. 14 Dr Halliday

> knowing that there were more units than we needed. We hoped we could bring about a rationalisation. That was not achieved. That is not a failure of the supra regional service funding arrangements, that is a failure of trying to change an established service, which had been in existence for decades, and, in the absence of any formal powers that will allow anyone to tell doctors what to do, I do not think it is in the interests of anyone to tell doctors what to do.'[8]

20 The Department had no binding powers to limit services only to designated centres and, indeed, recognised this. For example, on 27 October 1986 Mr Antony Hurst (Administrative Secretary of the SRSAG, 1983–1987) wrote to the South Western Regional Health Authority (SWRHA), indicating that the supra regional arrangements were:

> '… essentially funding arrangements, and we have no powers to determine referral practices which remain a clinical responsibility; HN(83)36 discourages health authorities from providing supra regional services in units that are not designated as supra regional centres, but this is not binding on clinicians.'[9]

The administration of supra regional services: Supra Regional Services Advisory Group (SRSAG)

21 As part of the SRS, an Advisory Group was established with Terms of Reference which included the duty:

> 'To advise the Secretary of State, through Chairmen of Regional Health Authorities, on the identification of services to be funded supra regionally and on the appropriate level of provision.' [10]

22 This advice was to cover which services should be funded, supra regionally, in the forthcoming year; which units should be designated to provide them; and what level of funds should be allocated to each designated unit. Authorities would then be notified of the Secretary of State's decision, reached in the light of the SRSAG's recommendations.[11]

23 The Inquiry heard evidence from Sir Graham Hart, Permanent Secretary at the Department of Health from March 1992 to November 1997, on the position of the SRSAG in the Departmental structure.

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8 T13 p. 82 Dr Halliday
9 UBHT 0062 0213; letter dated 27 October 1986 from Mr Hurst to SWRHA
10 DOH 0002 0022; circular HN(83)36
11 DOH 0002 0022; circular HN(83)36

24 He indicated that:

> 'It was not technically part of anybody's command. It was an advisory group, chaired by a regional chairman who actually stood outside the Departmental structure. It was outside people serviced by officials from within.'[12]

He went on to say: 'I do not think it reported to any official in the Department; it reported unequivocally to ministers.'[13]

25 Sir Graham explained how there was interaction between the SRSAG and the NHS Management Executive (NHSME) and the wider Department.[14] He also described the process:

> 'The Supra Regional Services Advisory Group would meet. They would consider papers. They would take decisions. Those decisions would, as it were, take the form of recommendations to ministers.
>
> 'Officials in the Department on the policy side would then brief ministers, inform ministers, about those decisions … When there was something that needed to be decided or to be done of importance, then either Dr Halliday or one of his administrative colleagues, they would presumably agree between them who would handle it, would put a submission up the line which would go to ministers.'[15]

26 Later in his evidence, Sir Graham again dealt with the process:

> '… it [the SRSAG's recommendation] would come with a submission from officials, saying "Here is a report from the Supra Regional Services Advisory Group", I would expect, "This is what we think about it and here are the issues that you need to consider, you need to be aware", you know, on the pro side, on the con side. "Will you please tell us your decision".'[16]

27 The SRSAG was supported by a Secretariat provided by a Departmental doctor and an official. The Medical Secretary, Dr Halliday, was in post throughout the period 1983 to 1992.[17] He was a Senior Principal Medical Officer and reported to Dr Michael Abrams, Deputy Chief Medical Officer.

28 The Administrative Secretary held the grade of Principal. During the relevant period, Anthony Hurst 1983–1987, Alan Angilley 1987–1992 and Steven Owen 1992–1996 held the post.

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[12] T52 p. 7 Sir Graham Hart
[13] T52 p. 12 Sir Graham Hart
[14] T52 p. 11 Sir Graham Hart
[15] T52 p. 14 Sir Graham Hart
[16] T52 p. 17–18 Sir Graham Hart
[17] WIT 0049 0001; Dr Halliday continued as Secretary to SRSAG after he retired in 1992, until 1994

NICS as a supra regional service (SRS)

29 Numerous reports, papers and notes of meetings were written on the topic of NICS and will be referred to hereafter. For convenience, the following table sets out the principal documents:

Table 1: Principal documents

Date	Title	Author
1 February 1979	Cardiac Services for Children in England and Wales	Gray OP (British Paediatric Association) (University Hospital of Wales), Mann TP (British Paediatric Association) (Royal Alexandra Hospital), Simpkiss MJ (British Paediatric Association) (Poole General Hospital), Joseph MC (British Paediatric Cardiology Section) (Guy's Hospital), Jones RS (British Paediatric Cardiology Section) (Alder Hey Children's Hospital), Watson GH (British Paediatric Cardiology Section) (Royal Manchester Children's Hospital)
1 January 1980	Provision of Services for the Diagnosis and Treatment of Heart Disease in England and Wales	Joint Cardiology Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England
1 January 1980	Second Report of a Joint Cardiology Committee of the Royal College of Physicians of London and the Royal College of Surgeons of England on Combined Cardiac Centres for Investigation and Treatment with a note on the Requirements of Cardiology in Hospitals Outside such a Centre	Royal College of Physicians of London, Royal College of Surgeons of England
1 December 1981	Report of the Working Party on Cardiothoracic Services in Wales	
December 1983	Supra Regional Services Circular HN (83)36	Department of Health and Social Security (DHSS)

Table 1: Principal documents (continued)

Date	Title	Author
4 October 1984	Minutes of the meeting of Consultants from the nine designated Supra Regional Centres called by the Department of Health & Social Security (DHSS) held on 4 October 1984 in Hannibal House, Elephant and Castle, London	DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Holden MP (Newcastle), Hunter S (Newcastle),Jones O (Guy's), Jordan S (Bristol), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Davidson J (Nursing Division), Hurst A (Health Services Division, Chairman, afternoon), McInnes D (Medical Division – Paediatric Services), O'Toole SM (Finance Division), Paterson NFC (Health Services Division), Prophet M (Medical Division, Chairman, morning), Sherriff JM (Health Services Division), Wilkinson JL (Liverpool), Walker D (Leeds)
5 December 1984	Minutes of the meeting of representatives of the designated Supra Regional Centres called by the DHSS held on 5 December 1984 in Hannibal House, Elephant and Castle, London	DeGionvani JV (Birmingham), Dickinson D (Leeds),Hamilton D (Liverpool), Hunter S (Newcastle), Joffe HS (Bristol), Jones O (Guy's), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Walker D (Leeds), Wilkinson JL (Liverpool), Wisheart J (Bristol), Hurst A (Health Services Division, Chairman), McInnes D (Medical Division – Paediatric Services), Staniforth M (Medical Division – Cardiac Services), Sherriff J (Health Services Division, Secretary), Roberts KD (Birmingham), Shaw D (Southampton)
1 June 1986	South Glamorgan Health Authority – Regional Cardiac Service for Wales – Paediatric Cardiac Facilities to be Provided at The University Hospital of Wales Cardiff – 'Approval in Principle' Submission June 1986	Harrhy G (South Glamorgan Health Authority)
1 September 1986	Report of a Joint Working Party of the Royal College of Physicians of London and the Royal College of Surgeons of England	Royal College of Physicians of London, Royal College of Surgeons of England
2 September 1986	Draft Copy – Paediatric Cardiac Services in Wales	Henderson A

Table 1: Principal documents (continued)

Date	Title	Author
2 September 1986	Note of meeting between the Welsh Office and South Glamorgan HA on 2 September 1986 at the Boardroom University Hospital Wales (UHW) Cardiff	McGlinn D (Welsh Office), George M (Welsh Office), Vass D (Welsh Office), Skone J (South Glamorgan HA), Thomas (South Glamorgan HA), Henderson A (South Glamorgan HA), Roberts KD (South Glamorgan HA), Williams R (South Glamorgan HA), Clay L (South Glamorgan HA), Wilson P (South Glamorgan HA), Abrorillo A (South Glamorgan HA)
20 October 1986	Note of meeting held by Medical Officers of the Welsh Office with South Glamorgan Health Authority on 20 October 1986	Crompton G (Welsh Office), Hine D (Welsh Office), George A (Welsh Office), Lloyd J (Welsh Office), Webb S (Welsh Office), Henderson A (South Glamorgan HA), Gray O (South Glamorgan HA), Hughes I (South Glamorgan HA),Skone J (South Glamorgan HA)
10 December 1986	Paediatric Cardiology and Paediatric Cardiac Surgery – A Situation Report	Lloyd J
Late 1986	Paediatric Cardiology Services for Wales – Report on Neonatal and Infant Cardiology and Cardiac Surgery	Welsh Office
22 January 1988	Paper SRS(88)2	SRSAG
May 1988	Royal College of Physicians Report on Advisory Group on Cardiac Services in South Wales	Royal College of Physicians of London
22 February 1989	Report of a visit on behalf of the Specialist Advisory Committee in Cardio-Thoracic Surgery to the Bristol Hospitals – Bristol Royal Infirmary and Frenchay	Ross B, Taylor K
1 July 1989	Interim Report of the Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units in England and Wales	Joint Working Party on Neonatal and Infant Supra Regional Cardiac Surgical Units
28 September 1989	Minute of meeting held on 28 September 1989 in Hannibal House, Elephant and Castle, London	SRSAG
1990	Paper – SRS (90) 6	SRSAG
1990	Paper – SRS (90) 15	SRSAG
26 July 1990	Minutes of the meeting held on 26 July 1990 at Hannibal House, Elephant and Castle, London	SRSAG
3 October 1990	Minutes of the meeting held on 3 October 1990 at Hannibal House, Elephant and Castle, London	SRSAG
1991	Draft SRS (91)	SRSAG
1992	SRSAG – Designation Issues – SRS 92(2)	SRSAG

Table 1: Principal documents (continued)

Date	Title	Author
4 February 1992	SRSAG Minutes of the meeting held on 4 February 1992 in Hannibal House, Elephant and Castle, London	Addicott G, Appleyard W, Carlisle M, Davenport P (Welsh Office), Davies M, Edwards P, English T,Ferguson J, Green M, Halliday N, Jones N, Kearns W, Kemp P, Kent H, Munday S, Owen S, Ross A, Shaw D, Shipton N, Sowerby M, Spence D, Spry C, Taylor A, Turnbull N, Winterton P
31 March 1992	Annual Report for the Period Ending 31 March 1992	SRSAG
1 June 1992	Report from the Working Party set up by the Royal College of Surgeons of England on NICS – Supra Regional Funding and Designation	RCSE
12 June 1992	Infant Cardiac Surgery and the Changing Practice of Paediatric Cardiology – The Case Against Supra Regional Designation	Department of Paediatric Cardiology – Guy's Hospital
28 July 1992	SRSAG Minutes of the meeting held on 28 July in Hannibal House, Elephant and Castle, London	Appleyard W, Carlisle M, Davenport P (Welsh Office), Edwards P, Ferguson J, Garlick J, Halliday N, Howell J, Jones N, Kearns W, Kemp P, Kent H, Owen S, Ross A, Shaw D, Shipman N, Sowler E (Scottish Office), Spry C
8 July 1994	Report of a visit on behalf of the Specialist Advisory Committee in Cardio-Thoracic Surgery to the Bristol Hospitals – Bristol Royal Infirmary and Frenchay	Dussek J, Hamilton D
13 July 1994	Bristol Royal Infirmary – Report to the Hospital Recognition Committee 13 July 1994	Kapila L, May P

30 Likewise, discussions regarding NICS as an SRS took place over several years and are also dealt with in the text hereafter. For convenience the following table sets out the principal meetings:

Table 2: Principal meetings

Date	Title	Author	Attendees
4 October 1984	Meeting of Consultants from the nine designated Supra Regional Centres called by the Department of Health & Social Security (DHSS) held on 4 October 1984 in Hannibal House, Elephant and Castle, London		DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Holden MP (Newcastle), Hunter S (Newcastle), Jones O (Guy's), Jordan S (Bristol), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Davidson J (Nursing Division), Hurst A (Health Services Division, Chairman, afternoon), McInnes D (Medical Division – Paediatric Services), O'Toole SM (Finance Division), Paterson NFC (Health Services Division), Prophet M (Medical Division, Chairman, morning), Sherriff JM (Health Services Division), Wilkinson JL (Liverpool), Walker D (Leeds)
5 December 1984	Meeting of Representatives of the Designated Supra Regional Centres called by the DHSS held on 5 December 1984 in Hannibal House, Elephant and Castle, London		DeGionvani JV (Birmingham), Dickinson D (Leeds), Hamilton D (Liverpool), Hunter S (Newcastle), Joffe HS (Bristol), Jones O (Guy's), Keeton BR (Southampton), Lincoln C (Brompton), Macarthey F (Gt Ormond Street), Munro J (Southampton), Shinebourne EA (Brompton), Silove ED (Birmingham), Stark J (Gt Ormond Street), Tynan M (Guy's), Walker D (Leeds), Wilkinson JL (Liverpool), Wisheart J (Bristol), Hurst A (Health Services Division, Chairman), McInnes D (Medical Division – Paediatric Services), Staniforth M (Medical Division – Cardiac Services), Sherriff J (Health Services Division, Secretary), Roberts (Birmingham), Shaw D (Southampton)

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
2 September 1986	Meeting between the Welsh Office and South Glamorgan HA on 2 September 1986 at the Boardroom, University Hospital Wales (UHW) Cardiff		McGlinn D (Welsh Office), George M (Welsh Office), Vass D (Welsh Office), Skone J (South Glamorgan HA), Thomas (South Glamorgan HA), Henderson A (South Glamorgan HA), Roberts (South Glamorgan HA), Williams R (South Glamorgan HA), Clay L (South Glamorgan HA), Wilson P (South Glamorgan HA), Abrorillo A (South Glamorgan HA)
8 September 1986	Meeting held by the Welsh Office on 8 October 1986 to Discuss a. Burns and Plastic Surgery Unit – Morriston Hospital, b. Paediatric Cardiac Development in UHW Cardiff		Crompton G, Hine D, George A, Ferguson D, Pritchard J, Vass D, Grist M, Gornall D, Harding G, Lloyd L, McGlinn D, Webb S
20 October 1986	Meeting held by Medical Officers of the Welsh Office with South Glamorgan Health Authority on 20 October 1986		Crompton G (Welsh Office), Hine D (Welsh Office), George A (Welsh Office), Lloyd J (Welsh Office), Webb S (Welsh Office), Henderson A (South Glamorgan HA), Gray O (South Glamorgan HA), Hughes I (South Glamorgan HA), Skone J (South Glamorgan HA)

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
21 January 1987	Welsh Medical Committee – Infant Cardiac Surgery and Paediatric Cardiology Services – Meeting held on 21 January 1987 at the Welsh Office		Owen D (Welsh Committee for Hospital Medical Services), Daley D (Welsh Committee for Hospital Medical Services), Broughton R (Welsh Committee for Hospital Medical Services), Davies R (Gwynedd DMC), Duthie H (University of Wales College of Medicine), Edwards A (Clwyd DMC), Edwards H (Welsh Medical Manpower Committee), Evans K (West Glamorgan DMC), Hayes T (Committee for Postgraduate Medical Education, Wales), Jones J (South Glamorgan DMC), Kilpatrick G (University of Wales College of Medicine), Lowther J (Gwent DMC), Palit A (Pembrokeshire DMC), Reynolds G (Welsh Committee for Community Medical Services), Watson M (General Medical Services Committee, (Wales), Crompton G (Welsh Office), George A (Welsh Office), Hine D (Welsh Office), Lloyd J (Welsh Office), Thomas D (Welsh Office), Thomas H (Welsh Office), Saunders M (Welsh Office), Henderson A (University Hospital of Wales), Williams R (Welsh Office), Butchart E (University Hospital of Wales), Verrier Jones E (South Glamorgan HA)
21 September 1988	Meeting of the Executive Committee of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 21 September 1988	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Ross K, Smith GH, Bain W, Parker J, Cleland J, Williams WG, Monro J,Watson D, Ross B, Sethia B, Pepper J, Goldstraw P, Frost-Wellings S
12 May 1989	Meeting of the Executive of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 12 May 1989	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Smith GH, Bain W, Cleland J, Williams W, Watson D, Ross B, Sethia B, Jeyasingham K, Matthews H, Hamilton D, Hilton C, Frost-Wellings S, Jones M
28 September 1989	Supra Regional Services Advisory Group (SRSAG) – meeting held on 28 September 1989 in Hannibal House, Elephant and Castle, London	Supra Regional Services Advisory Group	Angilley A, Barros S, Carlisle M, Davies M, Ferguson J, Grabham A, Greenwood R, Halliday N, Horsley S, Hunt T, Kenward D, Ledingham J, Malley R, Owen S, Revell D, Roy S, Sherriff J, Taylor A

Table 2: Principal meetings (continued)

Date	Title	Author	Attendees
20 September 1990	Meeting of the Executive of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 20 September 1990	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Williams B, Matthews H, Smith G, Dussek J, Elliot M, Jeyasingham K, Lock T, Ross B, Frost-Wellings S, Robinson S
3 October 1990	SRSAG meeting held on 3 October 1990 in Hannibal House, Elephant and Castle, London	Supra Regional Services Advisory Group	Angilley A, Barros S, Carlisle M, Davies M, English T, Grabham A, Halliday N, Kenward D, Malley R, McGlinn D, Roy S, Shaw D, Sherriff J, Taylor A, Whiteley S (Department of Health), Winterton P
21 February 1991	Meeting of the Executive Committee of the Society of Cardiothoracic Surgeons of Great Britain and Ireland on 21 February 1991	Society of Cardiothoracic Surgeons of Great Britain and Ireland	Hamilton D, Williams W, Williams W, Matthews H, Smith G, Dussek J, Jeyasingham K, Ross B, Frost-Wellings S
4 February 1992	SRSAG meeting held on 4 February 1992 in Hannibal House, Elephant and Castle, London		Addicott G, Appleyard W, Carlisle M, Davenport P (Welsh Office), Davies M, Edwards P, English T, Ferguson J, Green M, Halliday N, Jones N, Kearns W, Kemp P, Kent H, Munday S, Owen S, Ross A, Shaw D, Shipton N, Sowerby M, Spence D, Spry C, Taylor A, Turnbull N, Winterton P
28 July 1992	SRSAG meeting held on 28 July in Hannibal House, Elephant and Castle, London		Appleyard W, Carlisle M, Davenport P (Welsh Office), Edwards P, Ferguson J, Garlick J, Halliday N, Howell J, Jones N, Kearns W, Kemp P, Kent H, Owen S, Ross A, Shaw D, Shipman N, Sowler E (Scottish Office), Spry C

31 The system of supra regional funding for designated services came into force at the beginning of the financial year 1983/84 and initially applied to four services but did not include NICS.[18] The Inquiry took evidence as to the inclusion of NICS as a designated service with effect from the following year, and the way in which Bristol came to be a designated centre.

32 In 1967 the Joint Cardiology Committee of the RCP of London and the RCSE prepared a report (for publication in 1968) on the need for special cardiac centres for diagnosis, treatment and research.[19]

33 In 1967 the British Paediatric Association (BPA) reported a need to concentrate operations to remedy congenital heart defects in young children in a few centres only.

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18 DOH 0002 0022; circular HN(83)36

19 *'British Heart Journal'*; 1968 40: 864–8

In 1979 the BPA followed up its 1967 Report with the recommendation that six NICS centres (including one in the South West) should be established.[20]

34 In 1980 the London Health Planning Consortium recommended three centres to be established in London.[21]

35 It was with this background that, in 1980, the Second Report of the Joint Cardiology Committee of the RCP and the RCSE was published.[22]

36 Amongst other things, the Report indicated that: the size of a supra regional centre should depend on the population served; diagnosis and treatment were intimately linked; it was to be expected that the greater the number of operations performed the less should be the rate of mortality; the number of units should be 'certainly under ten'; and that the selection of SRCs should be based on present workload, geographic location and quality of work.[23]

37 In 1982 the Regional Medical Officers suggested nine centres (being exactly those that were designated in 1984).[24]

38 In 1983 the SRSAG considered the provision of treatment for children born with congenital heart disease. At that time, two quite recent reports were available, from the BPA (1979) and the Joint Cardiology Committee of the RCP and the RCSE (1980).

39 The fundamental theme accepted and endorsed by the SRSAG was that provision should be concentrated into relatively few centres to ensure a high standard of diagnosis and treatment. It was also noted that there were too many small units receiving financial support that would be better directed towards developing the larger and more efficient ones.

40 At this time the SWRHA was of the view that '... Bristol is not necessarily large enough to fulfil the criteria of a catchment population of 5 million ...'[25]

41 This estimate was derived from estimates accepted by the SRSAG:

> 'The BPA estimated that the incidence of CHD [congenital heart disease] to be of the order of 7–8 per 1,000 live births. This figure has been accepted more recently by Macartney, Kernohan et al, the JCC [Joint Cardiology Committee of the RCP and the RCSE], and in a report of a joint working party of the Royal College of Surgeons and Royal College of Physicians.'[26]

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20 BPCA 0001 0014; '*BPA Report*' 1967
21 ES 0002 0007; *'London Health Planning Consortium Report'*; 1980
22 RCSE 0003 0017 – 0023; *'Second Report of the Joint Cardiology Committee'*; 1980
23 RCSE 0003 0017 – 0023; *'Second Report of the Joint Cardiology Committee'*; 1980
24 ES 0002 0007; minutes of a meeting of representatives of the designated SRCs, 5 December 1984
25 HAA 0095 0071. This document appears to be dated 14 November 1983 – see HAA 0095 0073
26 DOH 0002 0240; *'SRS Report'* (88)2

42 The SRSAG went on to note that:

'… an estimation of need is dependent upon the birth rate, and it is not possible to forecast with any certainty whether it will move significantly in either direction, but it may be acceptable to suggest that only a marked swing will exert any real influence for planning purposes …'

43 Dr Barry Keeton, consultant paediatric cardiologist, Southampton General Hospital, and a member of the Inquiry's Expert Group, during his evidence to the Inquiry, described his recollection of the process behind the setting up of the SRS for NICS. He said:

'... I recall that prior to the setting up, there were eight centres that had been nominated for supra regional designation, and then my next recollection is that the Regional Medical Officers commissioned a report. I had some personal knowledge of this because the lady who did it came round to visit me and I gave her some help in the data, the statistics from Southampton.

'Following that Regional Medical Office report, there were then 9 centres and that was the point at which Bristol was added on, I think in 1984, to the supra regional list.'[27]

44 Dr Keeton was also asked:

'Q. So your understanding was that the view of the profession, before the RMOs had their meeting, was that essentially Bristol was not a natural candidate for supra regional status and it became one following that meeting.

'A. Yes. It led to some correspondence between members of my group, my surgical colleagues and the Regional Medical Officer, … I can recall his letter very well, saying that he thought that centres were based around people's expertise and not around railway timetables and the geography was not an issue, but the centres should be designated according to their results.

'There were discussions then with the Supra Regional Services about audit results. I attended each year the meeting of the department of the Supra Regional Services Committee, and a member in each of the hospitals was there to present any problems that they had and what their results and things had been from the previous years, but I remember at those meetings we were calling then for the setting up of a country-wide audit on the results of paediatric cardiac surgery, but it never really got off the ground, it was never funded.

27 T51 p. 112 Dr Keeton

'Q. This was back when?

'A. It would be in the early days of supra regional funding. It must have been in the middle 1980s.'[28]

45 Dr Hyam Joffe, consultant cardiologist, also recollected that he 'had a hand'[29] in Bristol being designated. He said:

'When we knew that these centres were being designated, I believed it was important, if possible, for Bristol to provide one of these designated services, partly because of geographical reasons, partly because I believed the unit had the potential to become an outstanding unit; and I was, secondly, I suppose "appalled" is the word, at the fact that there had been no attempt by the people who were making the designations to visit Bristol and see the centre and find out what it had to offer. So I wrote a letter which was supported by Dr Jordan to the individual that I thought was the Chairman of this supra regional group.'[30]

46 Dr Joffe, Dr Stephen Jordan, consultant cardiologist, and Mr James Wisheart, consultant cardiac surgeon, wrote a memorandum[31] expressing their view that:

'... Bristol has an irrefutable claim of recognition as a supra regional cardiac centre for neonates and infants ... Redirection of these [cardiac] patients to a centre elsewhere must result in a demise of meaningful paediatric cardiology in Bristol.'[32]

47 The memorandum pointed out that Bristol had historically provided a paediatric cardiac service to its catchment area:[33]

'The paediatric cardiology service already functions as the de facto Regional and Supra Regional Centre (although not yet officially recognised as such), drawing 28% of new referrals to the unit from Avon, 48% from the rest of the SW Region and 24% from South Wales, North Wessex and elsewhere …

'The long-term management of patients is supervised near their homes through a system of Consultant Cardiac Clinics developed over many years and probably more comprehensive than in any other paediatric cardiology service in England. Regular peripheral clinics are held in Bath, Swindon, Cheltenham, Gloucester, Taunton, Barnstaple, Exeter, Torquay, Plymouth and Truro. Close liaison exists with paediatricians in all these centres, who would resist any curtailment in the services they and their patients receive.'

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28 T51 p. 113 Dr Keeton
29 T90 p. 69 Dr Joffe
30 T90 p. 69–70 Dr Joffe
31 JDW 0001 0150 – 0152; memorandum on the designation of Bristol as a SRC in NICS, July 1982
32 JDW 0001 0150 – 0152; memorandum on the designation of Bristol as a SRC in NICS, July 1982
33 See Chapter 11 for further consideration of the Bristol catchment area

48 The clinicians' memorandum argued that it was:

> '... unrealistic to base any such decision simply on current surgical volume in infants, without taking cognisance of other important factors such as geographical position and communications, association with the University Department of Child Health, historical evolution and ties with paediatricians in the region and adjacent areas of other regions, anticipated expansion and development, and standards of associated paediatric and neonatal services.'[34]

49 The memorandum refers to, and apparently rehearses, arguments put forward in October 1981 favouring Bristol as an SRC including the following: (1) the service already functioned as a de facto supra regional centre; (2) there were two experienced and expert paediatric cardiologists and two experienced cardiac surgeons, one of whom had been specially trained in congenital heart disease surgery; (3) long-term management of patients near their homes through a system of consultant cardiac clinics; (4) the geographic position of Bristol with major rail connections and road services; (5) that the Bristol Royal Hospital for Sick Children (BRHSC) was 'ideally suited' to provide direct access to the expertise of a range of clinicians and healthcare workers.[35]

50 In relation to the geographical case for designation of Bristol, Dr Halliday was asked:

> 'Q. You say more than once, I think, in your statement, that there was evidence that the more operations a unit did, the better they got at it?
>
> 'A. Yes.
>
> 'Q. I am putting it very crudely, but that is the essential principle, is it not?
>
> 'A. Yes.
>
> 'Q. So one would expect the biggest centres to have better results?
>
> 'A. Yes.
>
> 'Q. If one factors that into the equation, it makes a bit of a difference in the geographical case, does it not? The geographical case depends upon, does it not – tell me if I am wrong – the results being equal in the two centres being compared?
>
> 'A. Yes, but if you are designating a service for the first time and you are endeavouring to cover the country, you may well have to identify a unit which at that moment in time is not performing as well as some of the other centres which

34 JDW 0001 0150; memorandum on the designation of Bristol as a SRC in NICS, July 1982
35 JDW 0001 0150 – 0151; memorandum on the designation of Bristol as a SRC in NICS, July 1982

may have been established for many years, but the intention is to develop that service, nurture that service.'[36]

51 A subsequent Departmental paper called *'Centres of Excellence and Supra Regional Units,'*[37] dated 12 September 1988, addressed to managers, identified that centres suitable for designation had to qualify as 'centres of excellence'. It added:

> 'Centres of Excellence: Units which might qualify for this title are those where a special expertise had been developed in a particular area of medicine'.[38]

52 Under the heading 'Overlaps Between Supra Regional Services and Other Centres of Excellence', the same paper said:

> 'All supra regional services will be provided in units which would fall within the "centres of excellence" definition.'[39]

53 There is no evidence in the documentation now available that Bristol was regarded, at the time of designation, as a centre of excellence in relation to NICS.

54 Sir Terence English,[40] who was a member of the Specialist Advisory Committee in Cardiothoracic Surgery between 1979 and 1987, was asked:

> 'Could it be said of Bristol that in 1983 there had been developed there a special expertise in neo natal and infant cardiac surgery?'

He answered: 'No.'[41]

55 In January 1987 Mr Eric Butchart, consultant cardiothoracic surgeon at the University Hospital of Wales in Cardiff, was of the opinion that Bristol was not a centre of excellence:

> '… the designation of sites as Supra Regional Centres relied partly upon them being existing centres of excellence, although Bristol had been exceptional in this respect, and had apparently been chosen for geographical considerations.'[42]

56 The view of Dr Halliday was:

> 'My division kept close contact with all the professions within the various specialties, and attending meetings of the Society of Cardiothoracic Surgeons (SCS)

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36 T13 p. 31 Dr Halliday
37 DOH 0002 0025 – 0027; DHSS Paper EL(88)P/153
38 DOH 0002 0026; *'Centres of Excellence and Supra Regional Units'*, 1988
39 DOH 0002 0026; *'Centres of Excellence and Supra Regional Units'*, 1988
40 Currently the President of the British Cardiac Patients Association; previous appointments include the President of the Royal College of Surgeons of England between 1989 and 1992
41 T17 p. 68 Sir Terence English
42 WO 0001 0281; minutes of extraordinary meeting of the Welsh Medical Committee, 21 January 1987

and the Royal College of Surgeons of England (RCSE) when dealing with paediatric cardiac surgery and cardiology, Bristol did not actually shine as a star, whereas many of the other units such as Birmingham, Harefield, Brompton, Guy's, GOS [Great Ormond Street], would stand out, so it did not seem to be one of the leading lights in this area.

'Q. "Shine as a star" in what sense?

'A. In terms of clinical work that was going on there, in terms of research, in terms of the results that they were getting.'[43]

57 The minimum workload for a centre to be viable, and maintaining sufficient expertise, was explored. Sir Terence said:

'Q. ... Just pausing there, the minimal viable workload for a centre; we spoke earlier of a surgeon needing to do 50 as a minimum operations per year. Is that open-heart operations?

'A. Open heart.

'Q. And that corresponds, does it, with the minimum viable workload?

'A. Yes. I think actually the figure that I had was 40 when this was calculated against the epidemiology of congenital heart disease within the UK and they were first thinking about it, but whether it is 40 or 50, it was considered desirable that that should be roughly the minimum number of open-heart operations performed by a single surgeon per year in the under one-year-old-age group and that there should be at least two surgeons in a unit.

'Q. Yes, that means the unit would have to do 80–100?

'A. Correct.

'Q. Just pausing there, Bristol never did, did it?

'A. No, you have just pointed out that the year before it was designated it had done three.

'Q. Or four?

'A. Or four, correct. But may I add that that, in my view, is not necessarily a reason for not designating a centre, because designation to me involves — the whole concept of supra regional designation was that it was a mechanism by which a particular service could be nurtured and strengthened and developed in certain

[43] T13 p. 27–8 Dr Halliday

parts of the country, to provide service. That was the whole history of the designation of prospective heart transplant units, so, whereas in certain instances — for example, I believe with Newcastle, which was the third unit to be designated for supra regional funding for heart transplantation, they had in fact done some cases beforehand from money which they got, I know not where, but they had done that to prove that they could do the work, but that was at a low level. But they were seeking the designation so that they could get the funding that would follow the designation so that they could develop a proper service, which is indeed what they did.'[44]

58 Dr Halliday's view as to numbers was similar:

'Q. ... Is what you are saying that the track record in terms of numbers of operations done was not really a justification for Bristol becoming a supra regional centre?

'A. Well, it certainly did not perform anything like on a par with the other units, no.

'Q. It is very difficult to see how three open-heart operations would justify that?

'A. Well, if you look at those figures again, you will see it actually goes ten, 11, three, and so on, so there might have been a good reason, a management reason, for only doing three that year.

'Q. But if one took ten, which was the highest it had been before 1984?

'A. If you take ten, then you would have to look at outstanding units such as Harefield, who only did about ten in those years.

'Q. What then did you mean by "weakness?"

'A. It was a small unit. They were not doing many operations.'[45]

59 Dr Halliday explained the case for designation as follows:

'... Bristol was one of the units which the Royal College thought was a suitable unit for designation.'[46]

[44] T17 p. 69–71 Sir Terence English
[45] T13 p. 27 Dr Halliday
[46] T13 p. 20 Dr Halliday

60 However, Dr Halliday characterised the case in favour of Bristol's designation as 'weak'. He said:

'In the case of the designation of the units, the Royal College of Surgeons was given all the evidence we had on all the units that were asking to be considered for designation.

'In the case of Bristol, the case was weak, but there was an important point and that was the geographical cover, because all the other units covered the country well, but the South West was deprived in terms of cardiac surgery, especially for neonatal and infants. So the Advisory Group was concerned to see that part was covered. Indeed, many of the professional reports identified that there was a need for cover in that area.'[47]

61 It was put to Dr Halliday that Bristol was designated for geographical reasons:

'So we have a unit which is doing a small number, and you say it may well correspond with Harefield at ten, but obviously not at three, a unit where the view was – I will come back to the evidence for that in a moment – that it was not a star; and the basis that you are telling me was decided by the Group to designate Bristol was geography?

'A. A main reason was the geography, yes.'[48]

62 Dr Halliday described the view of the SRSAG to the designation of Bristol:

'Q. So what you are saying is really: "Well, if the Advisory Group were looking at this as a matter of their own experience and the criteria, Bristol would not qualify, except on geography, and geography depends upon the quality being maintained and improved; we are assured by the Royal College of Surgeons that they are going to do their best to make sure that happens". Is that essentially it?

'A. That is essentially it.'[49]

63 Dr Halliday added:

'The weakness of the Bristol case was a factor, and I remember clearly that Terence English rang me and spoke to me about this before the decision was taken, and said – at that time, of course, he was not President of the College; I think he was actually President of the Society of Cardiac Surgeons – but he said if in fact the Advisory Group designated Bristol, then through the College they would endeavour to strengthen that unit.'[50]

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47 T13 p. 26 Dr Halliday
48 T13 p. 28 Dr Halliday
49 T13 p. 33–4 Dr Halliday
50 T13 p. 26 Dr Halliday. For Sir Terence's evidence on this point, see para 83

64 Dr Halliday's evidence included this exchange:

> 'Q. Was anything said by Sir Terence – he was then, I think, just Terence – as to what precisely the Royal Colleges proposed to do to encourage the change in referral patterns?
>
> 'A. No.
>
> 'Q. So really, it was left very vague?
>
> 'A. Yes, but we were in a situation where the Advisory Group was concerned to see the country covered. We had the South West, which was not being provided for; we had Wales, which was not within the supra regional service arrangements, they were separate. We always provided services through them. So ideally we would like to see that part of the country covered.
>
> 'The professional advice was that Bristol was a suitable unit. The Advisory Group could have decided, "Well, we do not accept professional advice" and not designated the unit, but given that there was a pressing need, we have all these patients travelling all the way to London, the Advisory Group, I think rightly at the time, decided to designate Bristol.'[51]

65 Sir Terence thought that the original decision to designate Bristol was correct:

> '… and there was nothing to suggest to those who were not intimately involved in 1984, and again in 1986, at the time of the first report, the first Working Party's report which I chaired, that Bristol did not have the capacity to develop in that way if the will were there. That was the reason for thinking it was reasonable to designate it in the first place and to continue it.'[52]

66 Sir Terence also confirmed that the process of development of the unit required close monitoring:

> 'Q. ... The question I put to you is: if that criterion [capacity to develop] were adopted, what would your view be about the proposition that it could only be justified as a variation from the existing criterion if the progress of development was very clearly, very tightly and very carefully monitored?
>
> 'A. I believe that is absolutely right, Chairman.'[53]

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[51] T13 p. 34–5 Dr Halliday
[52] T17 p. 76 Sir Terence English
[53] T17 p. 79 Sir Terence English

67 Thus it was that, on advice from the SRSAG, the Secretary of State recognised nine centres as SRCs for NICS – with effect from 1984–85 – and offered protected funding: *'Bristol Royal Infirmary/Children's Hospital'* was designated as such a unit.[54]

68 In selecting NICS as an SRS, the SRSAG drew a distinction between patients over and under 1 year of age. This created some practical difficulties and the matter was taken up by the SWRHA with Dr Halliday, as recorded in a letter of 21 March 1984 from Dr Marianne Pearce (then Specialist in Community Medicine at the SWRHA) to Dr Ian Baker (then Acting District Medical Officer, Bristol and Weston District Health Authority):

> 'I have informally discussed with Dr Halliday and Dr Alderslade the possibility of including infants selectively deferred for surgery after the first year. They were adamant that this could not be done because the numbers of children would then be so large as perhaps to make regional units viable. I know from previous conversations with our consultants that they regard this as being unreasonable as they are making a selective decision to defer infants. Both the DHSS doctors warn that if the age limit was put up for all units, as it would have to be, the service may be reclassified and not regarded as of supra regional status, as has happened with bone marrow transplant.'[55]

69 Dr Halliday's evidence to the Inquiry, on this point, was that the drawing of a distinction between patients under 1 year of age and those over 1, with the former but not the latter being included in the SRS arrangements, was 'somewhat artificial'.[56]

Developments in Wales until the designation of NICS as a supra regional service

70 The basis of any assessment of there being a likelihood of a sufficient number of NICS operations to reach the threshold which was described as the minimum to ensure that a unit would be reasonably viable depends on the size of the catchment area. The catchment area for Bristol would be larger if Wales was part of it. The Inquiry thus sought evidence as to whether developments in Wales, and aspirations for further development of a Welsh service, affected the position of Bristol.

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54 References in the text hereafter to 'Bristol' refer to the Bristol Royal Infirmary/Bristol Royal Hospital for Sick Children
55 HAA 0095 0069; letter from Dr Pearce to Dr Baker dated 21 March 1984
56 WIT 0049 0015 Dr Halliday

The development of a paediatric cardiac service in Wales

71 Mr Peter Gregory, Director of the NHS in Wales since 1994, told the Inquiry that:

> 'In the late 1970s, partly as a consequence, I think, of the appointment of a new Chief Medical Officer, now Professor Gareth Crompton, it became evident to the Department [Welsh Office] that there was a need for a comprehensive review of services and policy towards the provision of cardiothoracic services [adult and paediatric] in Wales.'[57]

72 A Working Party into cardiothoracic services in Wales was set up in 1979. The Working Party reported to the Welsh Medical Committee. The genesis of the Working Party was explained by Mr Gregory as being due to:

> '... professional concern at the inadequacy of Cardiac Services in Wales in the light of proportionately higher morbidity and mortality in Wales ...'[58]

The *'Working Party Report'* of 1981

73 The Working Party reported in 1981. This was, of course, prior to the establishment of NICS as an SRS. The *'Report of the Working Party on Cardiothoracic Services in Wales' (the 'Working Party Report')* described the paediatric cardiac needs in Wales at that time as follows:

> 'Estimates of paediatric cardiac surgical need are broadly agreed in all major reports. These may be extrapolated to the All-Wales population as an annual need for 48 infant operations (24 of which would be open heart), and an additional 123 older paediatric operations after infancy (95 of which would be open heart), totalling 171. The corresponding figures for Wales excluding Clwyd and Gwynedd are 38 (19) and 97 (75), totalling 134 (94). The number of catheterisations required is identified as about double the number of operations, or a total of c. 350 for All-Wales (270 for Wales excluding Clwyd and Gwynedd).'[59]

74 The 1981 *'Working Party Report'* summarised the recommendations of the Joint Royal Colleges' second report on Combined Cardiac Centres in relation to suitable throughput and projected staffing of a paediatric cardiac surgical unit thus:

> 'The Joint Colleges' Report recognises that a paediatric surgeon should carry out at least 50 neonatal operations per year to retain the special expertise required for neonatal surgery, that two such surgeons are needed in the centre to provide cover, and thus that there should be a limited number (perhaps 10 in England and Wales) of supra regional centres specialising in neonatal surgery, but not divorced from the adult centres. A supra regional neonatal centre should have 2 or 3 paediatric

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57 T10 p. 7 Mr Gregory
58 WIT 0058 0010 Mr Gregory
59 WO 0001 0044; '*Working Party Report* ', 1981

cardiologists, and be closely associated with a Children's Department and an integral part of an adult cardiac or cardiothoracic unit.'[60]

75 The Working Party stated:

> 'It would appear likely that one such supra regional unit would in future be sited in Cardiff *or* in Bristol. However, it is unlikely to be developed in the near future. When it is developed, the choice of site will be influenced by the relative amount of paediatric work then being undertaken in each centre. The choice is thus unlikely to be Cardiff ... It is the view of the Working Group that the diversion elsewhere of paediatric cardiac services for Welsh children would be to the detriment of cardiac services as a whole in Wales. A paediatric unit should thus be developed in Wales.'[61]

76 To the extent that this recommendation was intended to embrace neonatal and infant work, it is inconsistent with the Royal Colleges' recommendations on throughput, since the need, in Wales, for open-heart infant operations, quoted above, was (at 24)[62] less than half the number recommended by the Royal Colleges.

77 The '*Working Party Report'* appeared to accept that the development of a neonatal service in Wales was desirable, although possibly a long-term aspiration. The Report stated:

> 'The need for some 150 post-infancy operations per year clearly justifies the provision of a paediatric cardiac service in the regional centre in Wales, even if complex neonatal problems continue to be referred elsewhere (e.g. to London) until a neonatal centre is established, and even if the needs of Clwyd and Gwynedd continue to be served as now by Liverpool. The need is clear and a paediatric unit is necessary in Wales now.'[63]

78 The Working Party concluded:

> 'For Wales a modest unit would require 2 surgeons with paediatric expertise,[64] and 2 paediatric cardiologists together with paediatric supporting staff. From the point of view of sharing expertise and resources it would best be part of the regional cardiac centre and closely associated with a paediatric department such as that of the University Hospital with other specialised paediatric services. Training in paediatric cardiology is recommended for all paediatric senior registrars and also for all cardiology senior registrars. A paediatric cardiac unit is therefore a highly desirable development for professional training. Continuing liaison between paediatric cardiologists and general paediatricians throughout the region is called

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60 WO 0001 0044; *'Working Party Report'*, 1981
61 WO 0001 0044; *'Working Party Report'*, 1981 (emphasis added)
62 WO 0001 0044; *'Working Party Report'*, 1981
63 WO 0001 0044; *'Working Party Report'*,1981
64 This does not appear to envisage that the surgeons would be dedicated solely to operating on children

for since most screening for heart disease will be carried out by general paediatricians. This would be better co-ordinated by locally based paediatric cardiologists than by paediatric cardiologists visiting from different regions (e.g. London) as at present.'[65]

79 The Working Party was urging that development occur swiftly, so that the prospects of securing a supra regional centre in Wales would be maximised. The Working Party ended its section on paediatric cardiac services thus:

'A PAEDIATRIC CARDIAC SERVICE IS NEEDED IN WALES NOW. THE OPTION OF DEVELOPING THIS INTO THE SUPRA REGIONAL NEONATAL SERVICE SHOULD NOT BE LOST.'[66]

80 The Working Party expanded on this need for such a service in Wales later in the Report:

'The paediatric cardiac surgical needs for Wales are for some 170 operations per year, or 134 if Clwyd and Gwynedd are excluded as being served by Liverpool as at present (cf. 40 at present undertaken in Cardiff). There is an urgent need to develop a paediatric cardiac unit as part of the cardiothoracic centre, though complex neonatal surgery will continue to be referred where possible to specialised units in London. It will then be possible to co-ordinate the paediatric services at least in South Wales (at present partly being served by a visiting consultant from London). A paediatric unit requires 2 cardiac surgeons with paediatric expertise and 2 paediatric cardiologists, with junior staff in rotation with paediatrics and cardiology. It must be on the same site as other paediatric specialties. This development also keeps open the otherwise endangered option of developing further into the supra regional neonatal cardiac centre which is likely to be sited in either Cardiff or Bristol.'[67]

81 In the event, Bristol was designated as a supra regional centre (SRC) for NICS, with effect from April 1984. There was no SRC for this service located in Wales at any time during the years of the Inquiry's Terms of Reference.

82 The actual numbers of open-heart operations performed on the under-1s at Bristol is shown in the following table, taken from a table of surgery for congenital heart disease, provided by the DoH:

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[65] WO 0001 0045; *'Working Party Report'*, 1981
[66] WO 0001 0045; *'Working Party Report'*, 1981 (upper case in original)
[67] WO 0001 0053; *'Working Party Report'*, 1981

Table 3: United Bristol Hospitals surgery for congenital heart disease performed under 1 year of age[1]

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Open-heart surgery	3	6	6	5	2	8	10	10	4	11	14	24	25	29	40	39	46
Palliative closed surgery	10	11	13	13	14	15	19	24	19	30	28	24	21	22	30	16	24
Definitive closed surgery	3	2	5	5	7	7	9	13	11	9	13	40	28	27	28	29	29
Total:	16	19	24	23	23	30	38	47	34	50	55	88	74	78	98	84	99

1. DOH 0004 0028; *'Table of Surgery for Congenital Heart Disease Performed under One Year of Age, 1975 to 1991'*

83 It was put to Sir Terence that Dr Halliday had indicated to the Inquiry that he felt that there was nothing that the SRSAG could do in relation to increasing the numbers of operations in Bristol and that encouragement was entirely a matter for the Royal Colleges. Sir Terence's original response was:

> 'I do not think that there was anything that the two colleges of physicians and surgeons could do, other than to draw attention to the problem.'[68]

He expanded on this answer in oral evidence to say:

> 'I do not think that there was any specific encouragement which either the Royal College of Physicians or the Royal College of Surgeons could have given to the BRI at that time to increase their throughput in paediatric neonatal and infant cardiac surgery.'[69]

84 Accordingly, the Inquiry explored this difference of view, and considered the operation of the SRS, and what mechanisms there were by which the SRSAG could and did monitor the position of Bristol, in order to see both if the numbers of operations conducted increased to the necessary extent, and if the outcomes improved such that Bristol could properly be regarded as a centre of excellence and thus appropriate for supra regional designation.

85 The consequence of Bristol not developing as had been hoped might be thought to have been that it would cease to be designated. On this, there was a difference of emphasis between Sir Michael Carlisle, Chairman of SRSAG from April 1989 to October 1994, and Dr Halliday:

68 T17 p. 97 Sir Terence English
69 T17 p. 99 Sir Terence English

'Q. Sir Michael, can I deal now with the issue of Bristol's continued designation throughout the time that you were Chairman, until it became, with other units, de-designated? Can I ask you, please, to have on the screen, DOH 0002 0022? This goes right back to the start of the supra regional services, HN(83)(36) … that appears to say that every year one of the duties for the group to advise the Secretary of State about is whether the service should continue to be designated; is that correct?

'A. That is correct.

'Q. It also appears to say that once it has reached the decision that the service should be designated, it has each year to make a fresh decision as to whether each unit providing the service should be designated to provide it; is that correct?

'A. I would take issue with that. I think "each unit should be designated" is incorrect. I think the service should continue to be designated, yes. [70]

86 Dr. Halliday, however, said:

'A. … The procedure was that the Department each year would invite regional health authorities to submit bids for any service that they thought might warrant designation … We had before us the reports of the various professional groups …

'These bids were all then submitted to the Royal Colleges for their opinion as to which of the units should be selected. So Bristol was one of the units which the Royal College thought was a suitable unit for designation.

'Q. The Supra Regional Services Advisory Group had to agree of course?

'A. Would have to agree?

'Q. Well, they had to agree before there was any designation?

'A. Yes, of course.

'Q. Because it was not the Royal Colleges' decision?

'A. Of course not.

'Q. It was the Secretary of State's ultimately, and he would do it on the Advisory Group's advice?

'A. Yes.

[70] T15 p. 45–6 Sir Michael Carlisle

'Q. And the Advisory Group would take their input from the Royal Colleges fed through you?

'A. Yes.'[71]

The SRS system in operation

Bristol in the SRS system 1984/85

87 In January 1984 the DHSS distributed the first in a series of annual papers explaining the Secretary of State's decisions (made on advice from the SRSAG) on the future development of the SRS for the next financial year.[72] The SRSAG had asked the Department to initiate a study of the services provided in each NICS unit and the costs involved. This was to lead to later recommendations as to the protection of expenditure for 1984/85 and the setting of funding levels for 1985/86.[73]

88 On 5 December 1984 an inter-unit NICS liaison group meeting was held at the DHSS in London, at which there was:

'A brief account by each of the nine centres about what difference (if any) the supra regional designation of the service has meant, what difficulties stand in the way of the service being improved, and what action might be taken to enable those improvements to happen.'[74]

89 It was also noted that:

'When the question of designating neonatal and infant cardiac surgery as a supra regional service had been referred to the Advisory Group, there had been no hesitation in recommending that the service met the criteria laid out in Annex B to HN(83)36.'[75]

71 T13 p. 20–1 Dr Halliday

72 HAA 0095 0023, HAA 0095 0024 – 0026; *'Secretary of State Annual Report'*

73 HAA 0095 0026, HAA 0095 0024 – 0026; *'Decisions for 1984–85 Following Recommendations from the Supra Regional Services Advisory Group and Regional Chairmen'* (details of finance for the NICS service at Bristol are to be found in Chapter 6)

74 ES 0002 0002; letter from A Hurst to Dr Silove dated 26 November 1984

75 ES 0002 0007; minutes of meeting, 5 December 1984

90 The minutes of that meeting are available,[76] from which it can be seen that Dr Joffe and Mr Wisheart were present.[77] Each unit made a presentation to the meeting, the report from Bristol being:

> 'The children's hospital dealt with supra regional specialities of various kinds. The surgical work was carried out at the Bristol Royal Infirmary which treated only adults. Additional staff were needed since there was only one fully dedicated paediatric cardiac surgeon[78] and there was a shortage of nursing staff. A large amount of "soft" money had been used for the purchase of equipment; on the surgical side: the RHA was embarking on an extensive programme of expansion, and plans for the development of paediatric surgery lay within the development of cardiac surgery generally, which had obvious nursing and manpower implications.'[79]

91 In January 1985 the SRS system was in full operation and timetables had been set for the SRSAG's consideration both of future funding levels for existing designated services and of new applications for designation.[80] This included the requirement of an annual return to the Department from the centres on workload and expenditure (sent in June of each year). The Secretary of State's Decision Paper 1985/86 indicated, amongst other things, that Bristol's protected funding level for that year was the fifth highest of the nine centres.[81]

92 In February 1985 the RCP and RCSE published the Third Report of the Joint Cardiology Committee: *Provision of Services for the Diagnosis and Treatment of Heart Disease in England and Wales*.[82] It concluded, amongst other things, that SRCs were an appropriate means of dealing with NICS and funding should continue, but that nine centres were the 'absolute maximum'. The report indicated that 'no consideration should be given to the establishment of further [SRCs] unless there is a considerable increase in workload which, at present, seems highly unlikely.'[83]

93 On 4 October 1985 a meeting of consultants from the nine SRCs was again held at the DHSS. On this occasion Dr Jordan represented the Bristol SRC. His report on Bristol was:

> 'The Region have agreed to provide and equip a cardiac catheter laboratory and had tentatively accepted a new proposal for an additional cardiologist. There were no staff particularly dedicated to paediatric cardiology. They had acquired an

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76 ES 0002 0007; minutes of meeting, 5 December 1984

77 ES 0002 0006; minutes of meeting, 5 December 1984

78 In fact, at that time, there was no fully dedicated paediatric cardiac surgeon at Bristol – see evidence of Dr Joffe T90 p. 84 and Mr Wisheart's comments on the meeting T94 p. 115–16

79 ES 0002 0009; minutes of meeting, 5 December 1984

80 DOH 0002 0248; *'Secretary of State Annual Report'*

81 UBHT 0278 0521; *'Secretary of State Decision Paper'*,1985/86

82 BCS 0001 0001 – 0006; *'Third Report of a Joint Cardiology Committee'*, 1985

83 BCS 0001 0005; *'Third Report of a Joint Cardiology Committee'*, 1985

ultrasound machine with doppler, and even in some of their peripheral clinics and [*sic*] access to ultrasound equipment.' [84]

94 Dr Jordan also stated that a major part of the cardiac work had been passed on to London units, because of organisational difficulties. There had been an increase in pressure to carry out coronary artery bypass grafts (CABGs) which had adversely affected the number of operations carried out on the under-1-year-olds and had resulted in longer waiting lists.[85]

Plans for a new Welsh Cardiac Unit and its effect on supra regional services (SRS)

95 Meanwhile, developments were taking place in Wales that might have been seen as jeopardising further the number of operations carried out on paediatric patients. They had their origin in January 1984, shortly before Bristol's designation as a supra regional centre took effect, when, according to Mr Gregory:

> '... the Secretary of State for Wales announced plans to provide a Regional Cardiac Centre for adults at the University Hospital of Wales site in Cardiff. The Working Group of the Project Team established by the Welsh Office and South Glamorgan Health Authority agreed that Paediatric Cardiac facilities should be provided immediately as part of the centre.'[86]

96 The Welsh Office had to give 'Approval in Principle' to the plans of the South Glamorgan Health Authority (South Glamorgan HA) for the new cardiac unit. The Health Authority made its submission for such approval in June 1986.[87]

97 The 'Approval in Principle' (AIP) document set out the aspirations of the South Glamorgan HA for a comprehensive paediatric cardiac service. It was, in effect, a proposal to the Welsh Office for support, that is, funding for a new service.

98 The South Glamorgan HA submitted that a 'comprehensive paediatric cardiac service' was needed in Cardiff.[88] Mr Gregory stated that:

> 'In referring to a comprehensive paediatric cardiac service the authority included provision for neonates and infants under 1 year.'[89]

84 ES 0002 0014; minutes of meeting, 4 October 1985
85 ES 0002 0014; minutes of meeting, 4 October 1985
86 WIT 0058 0006 Mr Gregory
87 WIT 0058 0006 Mr Gregory
88 WIT 0058 0006 Mr Gregory
89 WIT 0058 0010 Mr Gregory

99 The submission described the then current (i.e. June 1986) paediatric cardiac facilities provided in Wales thus:

> 'Facilities in Wales for the investigation and surgical treatment of children with heart disease exist only in Cardiff and are scant. No beds are specifically allocated to paediatric cardiology, children being accommodated on general paediatric wards in the University Hospital of Wales as need arises. The cardiac catheter room facilities are shared with the adult cardiology workload. Paediatric cardiac surgery is subject to the same constraints as adult cardiac surgery. There is no full-time paediatric cardiologist; the service is at present provided by one consultant practising both adult and paediatric cardiology.'[90]

100 The AIP submission estimated the needs of a Welsh service as follows:

> 'The need to develop paediatric cardiac services in Wales is agreed. It is necessary for the clinical service to the patients in Wales, for the training of general paediatricians and of cardiologists in Wales, and to provide for expertise in managing congenital heart disease in adult life. The need is for a comprehensive service.
>
> *'The development of a less than comprehensive paediatric cardiac service would not in fact attract a paediatric cardiologist. A paediatric cardiologist will not be attracted without a full paediatric cardiac surgical provision, which necessarily requires a fully trained paediatric cardiac surgeon (including neonatal work). In practice therefore we have either a full paediatric cardiac provision or none.'*[91]

101 Thus the submission was for a full cardiac service, including neonatal and infant work. The main proposals that the Health Authority made were:

> 'The paediatric cardiac service should be established as soon as possible because of the urgency of the clinical need. This requires the appointment of a paediatric cardiologist (trained in general paediatric and neonatal work), a paediatric cardiac surgeon (trained in neonatal surgery) and a paediatric cardiac anaesthetist. Close teamwork is required and it is appropriate to take advantage of the unique opportunity for a linked appointment of well suited individuals. One of the present cardiologists should continue to fulfil part-time the role of a second paediatric cardiologist until he retires; this component of his work should then be taken on by a second paediatric cardiologist. One of the present cardiac surgeons will fulfil the role part-time of a second paediatric cardiac surgeon. The paediatric cardiac work will be shared between the newly appointed anaesthetist and one of the present anaesthetists, each of whom will carry out some other duties. This practical

90 WO 0001 0148; AIP
91 WO 0001 0150; AIP (emphasis in original)

compromise provides for less than 2 full-time paediatric cardiologists, at least in the short term, and less than 2 full-time paediatric cardiac surgeons, but is the appropriate provision, given the size of the catchment population.'[92]

102 It was not envisaged that the paediatric cardiac surgeon would be dedicated solely to paediatric work. This is demonstrated by this passage from the AIP submission:

'The paediatric cardiac surgeon will be fully trained in all aspects of his subject. He will also undertake some adult cardiac surgery, both as a contribution to the service and to ensure adequate continuing experience in relevant aspects of cardiac surgery (e.g. valve replacement).'[93]

103 At a national level, developments in surgery caused consideration of the SRS's strategy. The Decision Paper for 1986/87[94] highlighted the development whereby the number of patients under 1 year receiving surgery was rising slightly because of increasing medical preference for early surgery.

104 The SRSAG saw no need to change NICS provision 'over the next three years', but recognised the need for more work 'to refine the methodology used for costing the provision of the service.'[95]

105 In early 1986 Harefield Hospital applied for designation as an SRC for NICS. There were also two other possible applications for designation (from Leicester and Hammersmith Hospital) and, in April, the Department requested advice from the RCSE and RCP.

106 The Colleges set up a Joint Working Party under the chairmanship of Mr Terence English (consultant cardiothoracic surgeon). Mr English (later to be knighted and to become a member of the SRSAG from 1990–1992, when President of the RCSE) wrote to the nine centres on 16 June 1986, seeking information. The information sought concerned the total numbers of closed and open cardiac operations performed on neonates and infants up to the age of 1 year in the calendar years 1984 and 1985. Mr English ended his letter:

'I should stress that information on mortality is not being sought.'[96]

107 The *'Report of the Joint Working Party'*, dated 1 September 1986, deals with the situation in general, but had comments on some of the centres.[97] Among the recommendations were that the use of the designated SRC system continue (it was

92 WO 0001 0152; AIP
93 WO 0001 0153; AIP
94 UBHT 0278 0445; *'Supra Regional Services, 1986–87';* Secretary of State's Announcement
95 UBHT 0278 0447; *'Supra Regional Services, 1986–87';* Secretary of State's Announcement
96 RCSE 0002 0005; letter from Mr Terence English to NICS Centres, dated June 1986
97 RCSE 0002 0009, 0012–0013; *'Report of the Joint Working Party',* 1986

deemed be 'essential') and that no more than nine centres were currently justified, although Harefield's application should be reconsidered in two years.[98]

108 Paragraph D of the report's recommendations stated:

> 'The Working Party noted that three Units, namely Bristol, Newcastle and Guy's were doing fewer operations per year than desirable for a supra regional centre. Bristol and Newcastle have legitimate claims for development on geographical grounds and should be encouraged ... The workload of these three centres and Harefield should be reviewed in two years' time.'[99]

109 At the same time that the Working Party was deliberating, the SWRHA received a report on *'District Strategies for NICS for 1986/1994'* from Southmead DHA and Bristol and Weston DHA.[100]

110 The view of the Department at the time was that encouragement of Bristol was to be welcomed. Mr Hurst, Secretary of the SRSAG, put it in his letter of 27 October to Dr Pitman, Specialist in Community Medicine at the SWRHA:

> 'We are anxious to do what we can to encourage referrals from Wales because we would like to see activity levels in Bristol rise …'[101]

111 This approach appeared to be at odds with that reflected in the AIP submission made by the South Glamorgan HA, since the latter plainly had the capacity to reduce, rather than increase, referrals from Wales were it to be endorsed.

112 On 2 September 1986 the Welsh Office and South Glamorgan HA met to discuss the AIP submission. The minute of this meeting is short and was described as 'terse' by Mr Gregory in oral evidence.[102] It said:

> '... it was acknowledged that the Approval in Principle Submission would require revision.'[103]

113 The AIP had the strong support of a leading cardiologist, Professor Andrew Henderson, University of Wales Hospital, Cardiff. He was described by Mr Gregory as:

> '... a man of significant expertise and considerable influence in the development of cardiac services. He was a leading contributor to the Welsh Medical Committee

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98 Simultaneously, the conclusion of Professor Andrew Henderson reporting to the Welsh Office, was that 'The recommendations for the 9 designated supra regional neonatal cardiac surgical centres in England were based on now outdated estimates of neonatal workload.' WO 0001 0230. Even after consideration of the *'Report of the Joint Working Party'*, the SGHA still criticised its conclusions. WO 0001 0246

99 RCSE 0002 0013; *'Report of the Joint Working Party'*, 1986

100 WO 0001 0123 – 0142; *'District Strategies for NICS'* 1986/94

101 UBHT 0062 0213; letter from Mr Hurst to Dr Pitman, dated 27 October 1986

102 T10 p. 59 Mr Gregory

103 WO 0001 0224; minute of meeting, 2 September 1986

report of 1981, and he was ... a leading advocate, perhaps the leading advocate in Wales for the development of a comprehensive Welsh cardiac service.'[104]

114 Professor Henderson described what he saw as the inadequacies of the paediatric cardiology service then available in Wales. Dr Leslie Davies provided a clinic in Cardiff (and in some District hospitals),[105] but was by then ill and he died towards the end of 1986. Additionally, some cardiologists from London provided clinics in Wales. Professor Henderson said:

> 'We have not been able to provide the constantly available, co-ordinated expertise at an acceptably near centre for the South Wales population that is needed for present practice. LGD's [Dr Davies's] present illness has converted an increasingly inadequate service to what is now a potentially dangerous situation.'[106]

115 Professor Henderson prepared a document in support of the AIP submission, dated 2 September 1986. He emphasised that in his view advances in surgery and in non-invasive investigations were responsible for increasing numbers of neonatal and infant cardiac operations being carried out.[107] He thought this was a trend that was likely to continue, and he doubted that the previous assumption of 8.5 open-heart operations on infants under 1 per year per million population was still appropriate in 1986. His views were:

> 'The paediatric cardiac surgical workload actually undertaken in a region of comparable size to the population under consideration for Wales is now of the order of 60 to 65 (40%, i.e. 25, infant) open heart plus 35 to 40 closed heart operations per million per year (Southampton data for Wessex region, population 2.2 million). This implies 130 to 140 (ca. 55 neonatal) open heart plus ca. 80 closed heart operations per year for the Welsh centre. It represents a three-fold increase in infant surgical numbers compared with earlier estimates of 8.5 infant (under one year of age) open heart operations per year per million population (2nd Joint Colleges' Report, 1980).
>
> 'Earlier estimates of need have thus changed very considerably as the specialty has evolved and there has been a major shift towards corrective surgery in the neonatal period. The proportion of neonatal operations is likely to continue rising.'[108]

116 Professor Henderson estimated the occurrence of congenital heart malformations to be between ten and 13 per 1,000 live births.[109]

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104 T10 p. 59 Mr Gregory
105 See Chapter 11 for the interrelation of these clinics with referrals to Bristol
106 WO 0001 0226; report, 2 September 1986
107 WO 0001 0225; report, 2 September 1986
108 WO 0001 0225; report, 2 September 1986
109 WO 0001 0231; report, 2 September 1986

117 Mr Gregory was asked about this figure.

> 'Q. The advice that you had as a Department was that it was not 12 to 13, it was 8 at most?
>
> 'A. Yes, that is correct.
>
> 'Q. If that is right, then this is an overstatement by someone who is arguing the case, is it?
>
> 'A. Yes, I think that is how you could interpret it, certainly.
>
> 'Q. It must follow, if one was interpreting this from a Welsh Office point of view, looking at the question of the viability of the service in Cardiff at this stage, that one would see it as being necessary in order to establish a case for paediatric neonatal and infant cardiac surgery, that one would have to, as it were, stretch the elastic around the figures, to justify such a unit on number grounds?
>
> 'A. I think that is what lies behind it, certainly, but just to make clear, Professor Henderson was in a significantly professionally influential position, and one was not casting doubt on the sincerity with which he held these views, it just seemed to the Department that the evidence it had from other sources pointed to a different conclusion.'[110]

118 A meeting of the SRSAG took place on 2 October 1986, when the Joint Working Party Report of 1 September 1986 was considered and it was recommended that:

> '… the workload of Newcastle and Bristol in relation to cost be monitored and efforts to expand workload in those centres be encouraged.'[111]

119 The minutes of this meeting[112] record that the joint Royal Colleges' Report argued that the incidence of congenital heart defects was likely to remain static, because the development of early inter-uterine detection of problems through the use of foetal echocardiography tended to lead to termination of those pregnancies with problems, which counterbalanced any increase in the birth rate. This argument was contrary to Professor Henderson's view that there was an increasing need for neonatal and infant cardiac surgery for a given population.

120 The SRSAG meeting was unpersuaded of the case for NICS in Cardiff. The minutes recorded that:

> 'It would appear from the argument in the report that there is little justification in establishing a centre in Cardiff for the management of a potentially limited number

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110 T10 p. 66–7 Mr Gregory
111 WO 0001 0234; minutes of meeting, 2 October 1986
112 WO 0001 0234; minutes of meeting, 2 October 1986

of babies with cardiac problems on grounds of doubtful clinical effectiveness and cost efficiency.'[113]

121 The deliberations of the SRSAG and its acceptance of the Joint Working Party Report had a major impact on the attitude of the Welsh Office to the suggestion that it should develop its own NICS in Cardiff. Diana Vass, a nursing officer at the Welsh Office, attended the SRSAG meeting in October 1986.[114] Subsequently, Mrs Vass sent a memo, dated 6 October 1986, to Ms J Roberts, who was a Principal in the Health Policy Division at the Welsh Office, reporting to Mr Gregory. It stated:

'I would suggest the most important comment is that we acknowledge a neonatal and infant cardiac service is available for Wales in Bristol – for which resources are protected and that Wales will continue to expect to use the supra regional service and will not be excluded from referring to that service.'[115]

122 The Welsh Office discussed matters at a meeting on 8 October 1986, chaired by Professor Crompton. In his statement Mr Gregory noted that:

'a) a supra regional centre had been designated in Bristol for the neonatal and infant service, whereas Cardiff was not so designated;

b) Bristol was at that time under-utilised.'[116]

123 He went on:

'The meeting concluded that the cardiac development in Cardiff should be postponed until the results of an organisation and management study were known. The meeting also made it clear that the Supra Regional Advisory Group's ruling that children under 1 year old should be treated at the supra regional centre at Bristol should be supported.'[117]

124 The meeting noted that:

'A supra regional centre had been designated in Bristol specifically for the neonatal and infant service, whereas Cardiff was not so designated. Provision at UHW for this service (included in the AIP) would therefore constitute duplication of the service available at Bristol for which the Welsh Office was paying indirectly. Bristol was presently under-utilised, undertaking approximately 50 operations per annum.'[118]

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113 WO 0001 0235; minutes of meeting, 2 October 1986
114 WO 0001 0224; minutes of meeting, 2 October 1986
115 WO 0001 0238; memo dated 6 October 1986
116 WIT 0058 0006 Mr Gregory
117 WIT 0058 0010 Mr Gregory
118 WO 0001 0242; minutes of meeting, 8 October 1986

125 The meeting agreed that the initial development of cardiac services in Wales should consist of three stages, the first of which would be the setting up of a paediatric (i.e. over 1-year-old) unit. The second stage would be theatre provision and the third stage would be the upgrading of facilities for the main cardiac unit.

126 Thus the conclusions of the SRSAG as regards Bristol's continued designation and its desire to 'encourage' work in Bristol, appears to have influenced the Welsh Office's attitude against the proposal that a neonatal and infant cardiac service be developed in Wales.

127 A meeting between medical officers of the Welsh Office and senior clinicians of the South Glamorgan HA took place on 20 October 1986. Mr Gregory's evidence about that meeting was:

> 'The DHA [*sic*] considered it would be unsatisfactory to send all neonatal cases to the supra regional centre at Bristol for treatment, mentioning the danger and distress endured in transporting patients over long distances, and the impracticability of Bristol paediatric consultants providing outlying areas in South Wales with a full service.'[119]

128 The other key influence was finance. The Welsh Office summarised the two key influences on the approach taken:

> 'a. the funds for the project were cash limited, subject to adjustment for inflation, and therefore costs had to be re-examined, neonatal provision being one element of the re-assessment;
>
> 'b. the recommendation of the Royal Colleges was clear and could not be ignored.'[120]

129 The meeting of 20 October 1986 decided that the Welsh Office Medical Group should report to the NHS Director for Wales, making the following points:

> 'a. … that a formal request be made to the Royal Colleges of Physicians and Surgeons by the Welsh Office Medical Group for a sub-committee to provide a re-evaluation of the neonatal cardiac requirements for patients in Wales (Professor Henderson undertook to make preliminary approaches to members of the Royal Colleges committee);
>
> 'b. the project team would examine the costs of the whole scheme with a view to eliminating local additions and arriving at a properly costed scheme;

[119] WIT 0058 0006 Mr Gregory
[120] WO 0001 0247 – 0248; minutes of meeting, 20 October 1986

'c. Welsh Office should consider further the suggestion of the appointment of an independent project director ...'[121]

130 On 28 October 1986, Dr A George, the Deputy Chief Medical Officer (Wales), wrote to Dr Halliday.[122] In the letter Dr George requested the background papers which were considered by the Royal Colleges Joint Working Party in preparing its report of September 1986. He also stated to Dr Halliday:

'If Welsh Office is to hold a line on this type of work [this must refer to neonatal and infant work, since the letter is entitled "Neo-natal and Infant Cardiac Surgery"] being undertaken at Supra Regional Centres, Bristol is so designated for South Wales, we must have an assurance from you that it will not be closed and leave us without a readily available service.'[123]

131 Dr Halliday and the Department were willing to assist the Welsh Office. The RCSE, however, took a different view. In a memorandum of 10 December 1986, Dr Jennifer Lloyd, a Senior Medical Officer at the Welsh Office, wrote:

'... Terence English would not give permission for the Royal Colleges' Working Paper to be circulated. There seems to be a lack of communication between the Royal College of Surgeons and the DHSS on the issue of confidentiality of that paper.'[124]

132 Professor Crompton then wrote on 7 January 1987 to Mr Ian Todd, the new President of the RCSE, seeking the release of the Royal Colleges' Joint Report for consideration by the Welsh Medical Committee on 21 January 1987. Professor Crompton sought to exert considerable pressure on the RCSE, stating:

'It would be unfortunate if a unified approach between the Welsh Office and the Department of Health to the provision of neonatal and infant cardiac surgery could not be maintained because full information was only available to the advisory machine to one of the Departments of State.'[125]

133 Professor Crompton's approach appeared to have worked, since the Report was forthcoming in time for the extraordinary meeting of the Welsh Medical Committee of 21 January 1987.

134 In the meantime, whilst attempts were made to obtain the background papers, the Welsh Office Ministers had decided in November 1986 that in the light of the Joint Working Party's apparent endorsement of Bristol as a supra regional centre for neonatal and infant cardiac services, the proposed Welsh Unit should not include

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121 WO 0001 0249; minutes of meeting, 20 October 1986

122 References to the Department of Health include references to the DHSS, prior to its separation into the Departments of Health and Social Security

123 WO 0001 0250; letter from Dr George to Dr Halliday dated 28 October 1986

124 WO 0001 0262; memo dated 10 December 1986

125 RCSE 0002 0022; letter from Professor Crompton to Mr Todd dated 7 January 1987

such services. This decision was reflected in a note from Mr Ivor Lightman, Deputy Secretary to the Welsh Office with responsibility for Health and Social Care, to Professor Crompton of 26 November 1986, which stated:

> 'Ministers made it perfectly clear at yesterday's Health Policy Board meeting that they accepted the advice from the Royal Colleges that neonatal cardiac surgery should be centred on Bristol with the Cardiff surgeons forming part of the "team" in the way you described. They also made it clear that having had the advice and having received decisions from Ministers we should now get on with it, which means making the position clear to the "opposition" and proceeding with planning on the basis agreed while recognising that we may well take some flak. Naturally, the Press Office and others will have to be warned about that.'[126]

135 In Bristol itself at this time, there was optimism that the number of referrals[127] from South Wales would increase.[128]

136 For the first two years of the SRS (1984 and 1985) there had been a meeting of representatives from the NICS SRCs hosted by the Department in London. Despite an initial suggestion that these meetings become an annual event, the Department now decided to discontinue them. As Mr Hurst put it in a circular letter of 30 October 1986:

> 'Our view is now that the service is sufficiently well established for these meetings to be no longer necessary; the Department is also under pressure to reduce meetings in order to effect financial savings, and I am sure that your time is valuable too.'[129]

137 Dr Eric Silove, consultant paediatric cardiologist in Birmingham, who had attended the previous meetings, wrote to the Department on 17 November, regretting the decision:

> 'I feel it is a pity that you are proposing not to continue with the annual meeting … It proved to be a most helpful forum not only for helping establish the service but also for looking well into the future.'[130]

138 The 'Decision Paper for 1987/88'[131] extended the funding arrangements by also introducing capital funding, with effect from that year. It was also recorded that the

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126 WO 0001 0253; note from Mr Lightman to Professor Crompton dated 26 November 1986

127 The issue of referral patterns from Wales to Bristol and other parts of the country is dealt with fully in Chapter 11. The section on Wales within that chapter also deals with how resources were allocated for the funding of those referrals from Wales to Bristol

128 UBHT 0062 0216; memo from Dr Ian Baker, Assistant General Manager (Planning)/District Medical Officer, to Mr Graham Nix, Senior Assistant Treasurer (Financial Management) at the B&WDHA

129 ES 0002 0026; circular letter dated 30 October 1986

130 ES 0002 0025; letter from Dr Silove to DoH dated 17 November 1986

131 UBHT 0278 0377; SRS 1987–88 Secretary of State's Announcement

advice of the Joint Working Party to continue NICS as an SRS was accepted, 'so that the necessary expertise can be concentrated in a limited number of centres.'[132]

139 Harefield and Brompton Hospitals had been added to the designated centres, but it was envisaged 'that there would be little need for expansion in the total service.'[133]

140 In the interim, there had been a visit to Bristol by Professor Crompton and colleagues from the Health Professional Group of the Welsh Office, in the autumn of 1986. This arose because Professor Henderson had made critical comments about the performance of the Bristol Unit as part of his paper in support of the AIP submission, and Professor Crompton and his colleagues '… were motivated to explore for ourselves whether there was any substantiation of Professor Henderson's critical comments about the Unit'.[134] (These critical comments are explored later, in reviewing concerns expressed about paediatric cardiac surgery at Bristol.)[135] The visit followed an earlier one made by Professor Crompton and his colleagues in about 1984, very shortly after designation.

141 Professor Crompton told the Inquiry that on both visits he met Dr Jordan and Dr Joffe and also Mr Wisheart. On the second occasion Professor Crompton and his colleagues briefly met Mr Dhasmana in addition.[136]

142 Following the visit, Dr Jennifer Lloyd, Senior Medical Officer at the Welsh Office, prepared a written report, dated 27 November 1986, summarising the results of the visit. Her report indicated that contact had been made by Professor Crompton and senior medical colleagues at the Welsh Office with the Department, with clinical and community medicine colleagues at the SWRHA, and at the BRI and BRHSC.

143 As to the visit to Bristol, Dr Lloyd's report said:

> 'The visit to Bristol disclosed that currently (April 1 1985 – March 31 1986) 40 cases from 3 health authorities in Wales had been treated at the Bristol Children's Hospital and 4 at the Bristol Royal Infirmary. Thus the Bristol Service is already providing a substantial part of the service need for this category of case. There is evidence in the past 6 months that 2 more health authorities are also sending cases to Bristol. It is interesting to note that the number of cases from South Wales referred is roughly equal to the number referred within South Western excluding Bristol and Gloucester.'[137]

132 UBHT 0278 0377; SRS 1987–88 Secretary of State's Announcement
133 UBHT 0278 0378; SRS 1987–88 Secretary of State's Announcement
134 WIT 0070 0004 Professor Crompton
135 See Chapter 21
136 WIT 0070 0004 Professor Crompton
137 WO 0001 0257; Dr Lloyd's report, 27 November 1986

144 Dr Lloyd went on:

> 'In frank discussions with the clinicians [i.e. in Bristol] there was a positive wish to increase throughput and continue the trend of improving outcome with the ensuing maintenance and developing of skills.'[138]

145 Dr Lloyd's report continued:

> 'On discussion with the staff it was made clear that the consultants providing the Bristol service accept and indeed welcome a commitment to provide the infant and neonatal cardiac surgery service for South Wales. They acknowledge the natural aspirations of clinical staff in Cardiff to provide the total paediatric service on one site but they point to (and can demonstrate by the Bristol service) the advantages in lower mortality and morbidity due to increasing expertise and adequacy of equipment that result from the greater throughput of cases.'[139]

146 It is not clear to which Bristol clinicians in particular Dr Lloyd is intending to refer. Nor does she explain what evidence, if any, was cited in support of the suggestion that there was a 'trend of improving outcome' to 'continue', nor whether this trend of improvement was said to be an absolute one and/or a relative improvement compared with other centres. Further, it is not clear by what evidence 'the Bristol Service' can 'demonstrate' the 'advantages' referred to as resulting from 'the greater throughput of cases'.

147 Dr Lloyd also stated:

> 'We were unable to obtain from DHSS, who do not hold figures broken down by units, any figures on outcome by centre. We did however raise the question of outcome with Bristol staff. They put to us the accepted point that outcome is influenced greatly by case mix. They were quite open in quoting outcomes for some of the commoner procedures they undertake. They see a gradual improvement in these as expertise grows and specialist equipment becomes available. For most of the more commonly occurring conditions their figures compare well with other centres. They acknowledge however that surgeons in different centres develop special expertise in rarer conditions and that outcomes may therefore vary greatly for these between centres.'[140]

148 It is not clear what, if any, further inquiry was made of Bristol by the representatives of the Welsh Office to seek justification for the argument based on case mix. It is not clear on what basis the implicit suggestion was made that the Bristol case mix was more difficult than elsewhere. The Welsh Office does not appear to have pressed for further information or explanation. Nor does it appear that further information was tendered to it.

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[138] WO 0001 0259; Dr Lloyd's report, 27 November 1986
[139] WO 0001 0259; Dr Lloyd's report, 27 November 1986
[140] WO 0001 0260; Dr Lloyd's report, 27 November 1986

149 The last passage quoted from Dr Lloyd's report includes an implied admission by the Bristol clinicians that their results, for less 'commonly occurring conditions' did not compare well with other centres. The Welsh Office does not appear to have established what these rarer conditions were, and no steps were ever taken to suggest that patients with those conditions should be referred to units other than Bristol. Whilst it seems that the Bristol clinicians volunteered data on the commoner procedures, it appears that they were neither asked for, nor did they provide, data on the rarer conditions.

150 Professor Crompton told the Inquiry:

> 'I believe that the answers we got were honest and seemed to be full. The clear recollection I have is that we were told that indeed they knew that they could do better; that it was their intention to improve year on year; and that the local health authority, whether it was Bristol and Weston or the RHA, I would not know, had by 1986 greatly improved the fabric of the accommodation that was in the Bristol unit.'[141]

151 Dr Lloyd's report is consistent with the recollection of Dr (later Dame) Deirdre Hine, then Deputy Chief Medical Officer (Wales), of the 1986 visit. She stated in her written statement to the Inquiry:

> 'The discussions we had with both the clinical staff of the service and of the Regional Health Authority gave us no cause for anxiety. They indicated that the outcomes for the simpler operations were good and that those for the more complex procedures were improving as the throughput of cases increased. We were, however, unable to obtain any detailed statistical evidence for these claims.'[142]

152 In her December report Dr Lloyd reiterated what she had already stated in her previous report of 27 November 1986. Dr Lloyd expressed a clear preference for a policy of using Bristol for Welsh neonatal and infant cardiac work. Her December report said:

> 'The decision which has to be taken lies between 2 clear options –
>
> '1. to provide self standing comprehensive paediatric cardiology and cardiac surgery based in Cardiff or
>
> '2. to provide paediatric cardiology and cardiac surgery from Cardiff with the element of infant and neonatal surgery based in Bristol. This would be consistent with the views of the Supra Regional Advisory Group.

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141 T21 p. 47 Professor Crompton
142 WIT 0297 0002 Dame Deirdre Hine

'The paediatric and cardiology and cardiac surgery services could most appropriately and effectively be provided for Wales on the basis of the second option. However, this would require careful implementation and planning …

'We would wish to recommend that neonatal and infant cardiac surgery should be provided from Bristol on the basis of a joint service.'[143]

153 Following this report, an extraordinary meeting of the Welsh Medical Committee took place on 21 January 1987. The Welsh Office representatives at the meeting summarised the situation in this manner:

'i. Bristol currently offered the certainty of a service for infants and neonates.

'ii. Problems were apparent with the provision of adult services in Cardiff.

'iii. Difficulties were occurring in recruiting junior medical and nursing staff to work in South Wales, and were unlikely to be easily solved.

'iv. The Joint Working Party Report addressed itself to questions of quality, a difficult concept for small caseloads.

'v. Paediatricians in Gwent had explained that they were very satisfied with the service provided by Bristol.

'vi. Because it had been shown that quality of service was closely related to numbers dealt with in any one unit, there would be a danger of there being 2 "second rate" units at Cardiff and Bristol if the proposals being put to the Committee were accepted.

'vii. Infant cardiac surgery at Bristol might be less certain to continue after the 1989 DHSS Review if doubts were expressed over its service to South Wales patients.'[144]

154 At the January meeting, the Welsh Medical Committee heard representations from Professor Crompton, Dr George and Dr Lloyd on behalf of the Welsh Office and from Professor Henderson, Mr R C Williams, Mr Butchart and Dr Verrier Jones from South Glamorgan HA. Mr R C Williams argued that the Joint Working Party's conclusions in respect of supra regional services were of little or no application to Wales. Mr Butchart argued that Bristol appeared to have been designated as an SRS for geographical considerations, not because it was an existing centre of excellence, as had been the basis for designating the other supra regional units.[145]

[143] WO 0001 0266; Dr Lloyd's report, December 1986
[144] WO 0001 0275; Dr Lloyd's report, December 1986
[145] WO 0001 0278; minutes of meeting, January 1987

155 The conclusions of the Welsh Medical Committee were:

> '… the ideal solution would be for a comprehensive Paediatric Cardiology Service to be developed in Cardiff. However, it recognised that such a service would not be attainable for the foreseeable future, because of the absence of the necessary infrastructure, difficulties in recruiting appropriate junior medical staff and nurses, and reservations about the likely number of patients requiring this form of treatment. Consequently Neo-Natal and Infant Cardiac Surgery should continue to be provided from Bristol. It is further agreed that Paediatric Cardiology should be developed in Cardiff as a matter of urgency, with an immediate need for one Paediatric Cardiologist and a second to be in post as soon as possible.
>
> 'It is also advocated that close liaison should be established between the Paediatric Cardiology Service in Cardiff and the Supra-Regional Paediatric Cardiac Surgery Service in Bristol. In future, a review of the facilities in Cardiff would be necessary if demands increase with advances in diagnosis and surgical techniques.'[146]

156 The Welsh Office accepted this advice. Thus it was decided that cardiac surgery for children aged one year and above should be provided in Cardiff.[147] The Minister's private office (Welsh Office) said that the Parliamentary Under Secretary of State:

> '... has noted the advice contained in Mr McGlinn's [Welsh Office] submission of 3 February. He agrees that the paediatric cardiac unit to be provided at Cardiff should not *at present* be developed to include facilities for neo-natal and infant cardiac surgery and that the Bristol unit should combine to provide the service for South Wales patients. The Minister has commented that in announcing this decision it would probably be wise to say that the matter will be kept under review in the light of future circumstances.'[148]

157 Thus NICS were excluded from the initial stages of the Cardiff development. Professor Henderson remained unhappy. The Inquiry received evidence that the Chairman of the South Glamorgan HA was under pressure from Professor Henderson:

> '... not to restrict the freedom of clinicians to refer patients to those hospitals in which they have confidence.'[149]

146 WIT 0058 0007 Mr Gregory; and WO 0001 0286 – 0287 Welsh Medical Committee
147 WIT 0058 0008 Mr Gregory
148 WO 0001 0291; note dated 10 February 1987 (emphasis in original)
149 WO 0001 0294; note dated 5 March 1987

158 In a note of 5 March 1987, Mr Gregory referred to Professor Henderson's continued concerns, and stated:

> '… the DHA is looking to us to accept that although Bristol is the supra regional centre for South Wales, clinicians in Wales still retain the usual discretion to refer patients from Cardiff to hospitals of their choice.
>
> 'I am not sure what this means in practical terms. On the assumption that this is merely a face-saving exercise for Professor Henderson then I think we may be able to go along with it. If that is the case, all we need is a very brief letter of reply which does not open up the whole issue but does not resile from the decision we have already obtained from Ministers.'[150]

159 In December 1987 the Welsh Office asked the RCP to set up a task force to review cardiac surgery and cardiology in Wales, with a particular emphasis on NICS. It specifically requested that evidence be taken from Dr Halliday.[151] Clinicians in Bristol were aware that cardiologists in Wales had requested the view of the RCP earlier in the year and, on 3 August 1987, wrote to the RCP with their views.[152]

160 The Report of the Cardiology Committee of the RCP said that:

> 'The Advisory Group[153] is unanimous in reaffirming the importance of the development of the paediatric cardiac unit, already approved by the Welsh Office, to include paediatric cardiology and paediatric cardiac surgery, and this to be developed in association with the existing general paediatric department, neonatal unit, and regional cardiac and cardiac surgical centre. The Advisory Group considers that this unit should ultimately provide management for the whole of congenital heart disease. Presuming this concept is accepted, there is a need now to appoint a paediatric cardiologist, who should be expert in cardiac catheterisation, interventional techniques, and echocardiography. He should establish links with local paediatricians in South Wales who are anxious for this service, which should slowly be established. In addition a cardiac surgeon should be appointed as soon as possible. He should be capable of carrying out both paediatric and adult cardiac surgery. There is not the caseload at the present time to justify the appointment of a "pure" paediatric cardiac surgeon. These two new appointees will be the focus for the developments of the new service working to set up new lines of referrals and patterns of care.'[154]

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150 WO 0001 0294; note dated 5 March 1987

151 WO 0001 0317 – 0318; letter dated 15 December 1987

152 UBHT 0133 0029; letter dated 3 August 1987

153 WO 0001 0339; The Royal College of Physicians Advisory Group on Cardiac Services in South Wales. The Advisory Group's terms of reference were: 'To provide medical advice to the Welsh Office on the provision of cardiology and cardiac surgery services to the population of South Wales (2 million)'

154 WO 0001 0344 – 0345; Report of the Royal College of Physicians

161 The Committee further concluded that there was a need for:

> '... about 100 paediatric cardiac operations per year. The Royal College considered that, in due course, the Cardiff unit should provide cardiac surgery for children under 1 year old.'[155]

162 On 22 January 1988 Paper SRS(88)2 was prepared for the SRSAG.[156] It discussed the current situation for NICS and, for the first time, one of the options was de-designation of the whole service.[157] The paper noted that:

> '… returns from the designated units are concerned with quantity not quality, i.e. type of operation performed and mortality rates are unknown factors.'[158]

The Report identified that, based on a two surgeon unit, '… the minimum open-heart workload is likely to be at least 80 cases per year', and that, referring to Bristol in particular,[159] 'Three of the designated units fall far short, i.e. Guy's, the Bristol Royal for Sick Children and the Freeman, Newcastle' and that 'probably [those] three have a very small workload.'[160]

163 The Paper was discussed at the SRSAG meeting on 4 February 1988 and its recommendation was that the Society of Cardiothoracic Surgeons (SCS) be asked to comment and carry out a fact-finding survey, which it agreed to do. It was to advise on whether SRSs for NICS should continue at all. Sir Keith Ross, the then President of the SCS, was approached.

164 Additionally, Dr Halliday and Mr Alan Angilley, SRSAG Administrative Secretary 1987–1992, arranged to visit Wales to discuss current and future service needs for South Wales. On 24 February 1988 Dr Hine wrote to Dr Marie Freeman, Acting Regional Medical Officer for SWRHA. Dr Hine stated in her letter:

> 'I have drawn up the attached Agenda in which, as agreed with you, the two distinct elements, i.e. cardiac surgery under one year and cardiology at all ages together with cardiac surgery over one year, are distinguished from one another. We would be grateful to have any up-to-date figures available to you which illustrate the current demand from Wales on Bristol for either form of service. The latest figures I have relate to the period up to June 1986 and are for infant and neonatal cases only.'[161]

It was plainly the belief of the Welsh Office that the SWRHA was monitoring such numbers.

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155 WIT 0058 0008 Mr Gregory
156 DOH 0002 0240 – 0247; Paper SRS(88)2
157 DOH 0002 0242; Paper SRS(88)2
158 DOH 0002 0242; Paper SRS(88)2
159 DOH 0002 0240 – 0247; Paper SRS(88)2
160 DOH 0002 0242; Paper SRS(88)2
161 UBHT 0062 0398; letter from Dr Deirdre Hine to Mr Angilley dated 24 February 1988

165 The visit to Wales took place on 7 March 1988. In a paper presented to a meeting held during the visit, by the DHSS, it was noted that there were 'highly significant' differences in outcome between centres with high and low output. Bristol was described as 'one of the smallest centres in terms of throughput.' It was 'however seen as having a legitimate claim for development on geographical grounds and the consideration of this has included its proximity to the South Wales population.'[162]

Continued designation of NICS

166 On 19 May 1988 the Executive Committee of the SCS met and, amongst other things, it was reported by the then President, Sir Keith Ross, that the DHSS had requested the SCS to 'consider whether it was in the best interests of all concerned' for NICS to remain in the SRS.

167 The SCS concluded that the SRCs should remain but that the situation should be kept under review. A questionnaire that the DHSS wished to circulate to the SRCs was also tabled:

> 'This was agreed, but it was noted that the questionnaire was extremely superficial.'[163]

168 In September 1988 the SCS set up a small sub-committee chaired by Professor David Hamilton, Department of Clinical Surgery, Edinburgh University, to liaise with the RCP and the British Cardiac Society (BCS), both of which were already looking into the future of paediatric cardiac surgery.[164]

169 On 22 February 1989 there was a visit on behalf of the Specialist Advisory Committee (SAC) in Cardiothoracic Surgery to the BRI and to Frenchay Hospital.[165] The Report concluded that:

> 'The visitors were impressed by the quantity and quality of work performed at both hospitals and particularly by the training offered.'[166]

170 On 12 May 1989 the Executive Committee of the SCS met and received a report from the sub-committee whose Chairman, Professor Hamilton, explained that it had been 'extremely difficult' to obtain the necessary data and that staffing levels and facilities had not yet been assessed. The sub-committee found that, of the ten centres surveyed, '3 of them were considered good; 4 of them fair; one inadequate and one irrelevant and one had not submitted a return (Leeds)'. Professor Hamilton was concerned that confidentiality would be breached if a report were submitted to the Department.

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162 UBHT 0062 0401; *'Supra Regional Centres for Infant and Neonatal Cardiac Surgery'*, March 1988

163 SCS 0004 0004. The Bristol questionnaire, completed by Mr Wisheart, is at UBHT 0193 0016. It contains mortality figures for 1985–1987 inclusive, for both open and closed operations on under-1s (UBHT 0193 0017)

164 SCS 0004 0007; minute dated 21 September 1988

165 RCSE 0002 0213 – 0220; SAC Report, 22 February 1988

166 RCSE 0002 0219; SAC Report, 22 February 1988

However, the meeting concluded, 'after discussion', that 'the DHSS would have the figures anyway and thus the confidentiality was not a concern in their case.'[167]

171 It was noted that Departmental funding was 'based upon population and there was general approval for the continuance of supra regional designation of such centres.'[168]

172 On 28 July 1989 the SCS delivered its interim report on NICS units in England and Wales to Dr Halliday.[169] The report contained this passage: 'Annual audit of work performed (including hospital survival), in this age range should continue to be carried out by the Department of Health.'[170]

173 Sir Terence English commented on the assumption that the Department was undertaking such an audit:

> 'A. Certainly, it was our belief that the Department had access to the UK Cardiac Surgical Register [UKCSR] data which each unit would have filled in, and could have provided to the Department if asked. I believe they were asked about it.
>
> 'Q. So your understanding was that, if you like, if you put yourself in Dr Halliday's shoes, you would have had the Cardiac Surgical Registry returns for each individual unit?
>
> 'A. Yes.
>
> 'Q. So putting yourself in, as you thought, leaving aside whether it is right or wrong, but as you thought Dr Halliday's position was, you would have been able to see how one unit compared against another?
>
> 'A. Yes, and also, if one unit seemed to be doing rather badly ...'[171]

174 In fact, the SRSAG did not obtain each unit's return to the UKCSR until the internal market was introduced in 1991.

175 The 1989 SCS report contained data showing mortality for under-1s after open-heart surgery.[172] Two units (one of which was Bristol) were shown as having statistically significantly higher mortality than the others. Sir Terence agreed that this was the sort of data he would expect questions to be asked about and that it was disquieting.[173] He also agreed that had he looked at this data in any detail, he would have concluded

167 SCS 0004 0015; SCS meeting, 12 May 1989
168 SCS 0004 0015 – 0016; SCS meeting, 12 May 1989
169 DOH 0002 0223 – 0237; SCS Interim Report
170 RCSE 0002 0028; SCS Interim Report
171 T17 p. 117 Sir Terence English
172 DOH 0002 0233; *'The Interim Report of the Working Party on NICS Units in England and Wales'*
173 T17 p. 121–2 Sir Terence English

that it required some serious explanation. He acknowledged that, as a member of the SRSAG at the time, he should probably 'have taken more account' of this data.[174]

176 The report was discussed at the SRSAG meeting on 28 September 1989. It was noted that:

> 'Bristol, Newcastle and Guy's Hospital were operating at sub-optimal levels; this had previously been identified in the 1986 report.'[175]

177 The de-designation of those units that were 'non-viable' and operating at 'sub-optimal' levels was discussed. Dr Halliday was asked about this in evidence to the Inquiry:

> 'Q ... the non-viable units which are referred to in the second paragraph, is that a reference back to Bristol, Newcastle and Guy's, because they were operating at sub-optimal levels?
>
> 'A. Yes.
>
> 'Q. So "sub-optimal" might refer to numbers; it might refer to success rates, and the report itself makes the point that the two tend to go together and the point you have just been emphasising?
>
> 'A. Yes.
>
> 'Q. So the idea was, was it, in the Group, "We really ought to de-designate those units"?
>
> 'A. That we ought to consider de-designating those units.'[176]

178 Dr Halliday explained that he was reassured by the conclusions of the 1989 *'Interim Report of the Working Party',* which recommended that Bristol, 'should be encouraged to increase their numbers annually'.[177] Dr Halliday told the Inquiry that this was 'very reassuring' to him, 'that the problem remained one of non-referral, rather than outcome.'[178]

179 In a subsequent written statement to the Inquiry, Dr Halliday said that the:

> 'relatively high mortality figures naturally raised questions but I personally was reassured by the conclusion of the experts in this field namely that "Two centres

174 T17 p. 123 Sir Terence English
175 DOH 0002 0214; SCS Interim Report
176 T13 p. 59–60 Dr Halliday
177 DOH 0002 0230; Interim Report, T13 p. 57 Dr Halliday
178 T13 p. 56 Dr Halliday

(Newcastle and Bristol) have a less than average turnover of work and should be encouraged to increase their numbers annually".'[179]

180 Dr Halliday visited Bristol, and the two other units in the report 'singled out … as requiring review', in early 1990.[180] The report of the visit, recorded in SRS (90)6, concluded that:

> '... although officials found the Bristol centre to be soundly based and giving every sign that the centre would be a viable designated unit, and despite the fact that geographical spread of the designated centres is desirable, there remains a question mark over the centre's long-term viability in supra regional terms.'[181]

It also stated, in more general terms, that the profession's advice was 'that about seven centres are required to cover the caseload of England and Wales'.[182]

181 At the SRSAG meeting on 26 July 1990 the report of Dr Halliday's visit was considered:

> 'The Chairman invited Mr English [Sir Terence English] to give members the views of the [RCSE] on this service. Mr English considered that this service should remain designated, but with no more than 9 units. It would be helpful to have surgical data from each unit'.[183]

182 As to Bristol in particular, Sir Terence is recorded in the minutes as saying:

> '… this unit should retain designation but [the RCSE] recommended [it] should be pressed to increase the workload.'[184]

Mr McGlinn attended the meeting as an observer from the Welsh Office and he assured the meeting that:

> '... the Welsh Office had no plans to support a neonatal and infant cardiac surgery unit and would continue to look to Bristol to provide a service for Wales.'[185]

183 By September 1990 it was reported that, although outside the SRS system, Cardiff, Oxford and Leicester were all performing NICS.[186] In October 1990 Dr Halliday reported to the SRSAG that Professor Tynan at Guy's Hospital was arguing that the whole NICS service should be de-designated.[187]

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179 WIT 0049 0024 – 0025 Dr Halliday, quoting from UBHT 0061 0204
180 DOH 0002 0200; Paper SRS (90)6
181 DOH 0002 0200; Paper SRS (90)6
182 DOH 0002 0202; Paper SRS (90)6
183 DOH 0002 0196; Paper SRS (90)6
184 DOH 0002 0196; Paper SRS (90)6
185 DOH 0002 0196; Paper SRS (90)6
186 SCS 0004 0026; minute dated 21 September 1988
187 DOH 0002 0168; Professor Tynan would again write a report to this effect in June 1992 – see DOH 0002 0126

184 At the meeting on 3 October 1990, the SRSAG agreed that the NICS should 'ideally be concentrated in no more than six or seven centres and that proliferation occurred to the detriment of patients'.[188] This meeting considered SRSAG Paper (90)15, a discussion document on the units at Bristol, Newcastle, Guy's and Harefield.[189] At the meeting the view in favour of a reduced number of centres was generally accepted, but no clinician was willing for his or her unit to be de-designated. As Dr Halliday put it:

> 'The only difficulty is, I met with all the clinicians involved in this, and every single clinician I met in the designated units and the non-designated units would endorse what is in the minute, that we only need 6 or 7 units. It is the usual thing: "As long as it is not my unit that is closed". So everyone I spoke to endorsed our policy whole-heartedly: "As long as it is not my unit". They did not say that, but that was the connotation'. [190]

185 As regards Bristol, the Inquiry heard evidence that by 1991 Bristol was pleased to be a university teaching hospital designated as an SRS centre for NICS and hoped that it would become a heart transplant centre within two years (it had applied for such designation in May 1991).[191]

186 Mr Wisheart's evidence included this exchange with Professor Jarman:

> 'Q. I wondered if it would give you a bit of kudos, being identified as a supra regional service, a feather in your cap, as it were?
>
> 'A. I suppose there was an element of that but there was also kudos in doing the adult work well. I think cardiac surgery brings its own satisfactions and rewards as well as its disappointments at times.
>
> 'Q. I wonder also whether there had been any thought at that time of becoming a heart transplant centre?
>
> 'A. We had done in approximately 1990. It was either 1990 or 1991 when we appointed a new consultant, Mr Hutter in fact, who had as part of his training a time with Sir Terence English at Papworth and he himself therefore was trained and skilled and competent in this area.'[192]

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[188] DOH 0002 0168; minutes of SRSAG meeting, 3 October 1990
[189] DOH 0002 0053; Paper SRS (90)15
[190] T13 p. 83 Dr Halliday
[191] T94 p. 121 Mr Wisheart
[192] T94 p. 121 Mr Wisheart

187 A Report and Statement of Need dated 27 July 1990, *'Paediatric Cardiology and Paediatric Cardiac Surgery in Bristol – The Case for a New, Integrated Unit'*, was written by Dr Jordan. It stated:

> 'Bristol is now recognised as a supra regional centre which takes patients, not only from the South West Region, but also from parts of Wessex and South Wales … Bristol will almost certainly become a centre for heart and heart-lung transplants within the next year or two. Initially we expect to start with adult patients, but with the developments in this field which are now occurring, such transplantation in children will follow.'[193]

188 On 24 July 1991 Dame Deirdre Hine, then Chief Medical Officer (Wales), wrote to Dr Halliday on behalf of the Welsh Office. Amongst other things, she said:

> 'Within perhaps the next 3–5 years, I expect to see the University Hospital of Wales in a position to offer fully comprehensive paediatric cardiology and cardiac surgery for children of all ages. Within this period a step by step build up of neonatal and infant cardiac surgery will occur. All of this has very clear implications for the current Supra Regional Services Advisory Group strategy governing the pattern of services in the field of neonatal and infant cardiac surgery. It may be that de-designation of the supra regional status of existing units is very much closer than any of us would have anticipated just a year or two ago.'[194]

189 The SRSAG met again on 30 July 1991. On 31 July Dr Halliday wrote to Sir Terence English, who had been absent from the meeting:

> 'The Advisory Group at its meeting yesterday considered ways in which the cardiac surgical service for neonates and infants might be rationalised in order to ensure the continued designation of this service. It was suggested that it would be possible to define within the existing designated service those complex cardiac surgical procedures which should continue to be designated and to identify the units where this service could be effectively provided. If this were possible it would mean that some units presently designated under the existing arrangements could then be de-designated thus bringing about a rationalisation of the service.'[195]

190 Sir Terence replied on 19 September 1991, stating that in his view it would be very difficult to try to relate designation to specific categories of operative procedures.[196] His letter also referred to the possibility:

> '… of some of the smaller or less effective units ... being de-designated in order that the good and responsible units could continue to provide a valuable service.'

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193 WIT 0097 0024 – 0025 Dr Joffe
194 RCSE 0002 0063 – 0064; letter from Dame Deirdre Hine to Dr Halliday dated 24 July 1991
195 RCSE 0002 0066; letter from Dr Halliday to Sir Terence English dated 31 July 1991
196 DOH 0003 0003; letter from Sir Terence to Dr Halliday dated 19 September 1991

Sir Terence identified Bristol, Newcastle, Harefield and Guy's as the units that there were 'questions marks over in my mind'.[197]

191 Dr Halliday wrote to Mr Wisheart on 17 October 1991, indicating that the Department, in conjunction with the SRSAG, had commissioned a management consultancy study of the costs of the SRS.[198]

192 Dr Halliday wrote to Sir Terence on 20 December 1991,[199] enclosing the draft paper SRS (91).[200] In the letter Dr Halliday commented:

> '… it is difficult to refute the logic of the conclusions, given the problems of remaining within the supra regional criteria and continuing the designation of the service.'

193 In draft paper SRS (91) it was stated that:

> 'Members had previously considered a paper, SRS (90)15[201] which had provided more information on the units at risk. Bristol and Newcastle were considered to be essential on geographical grounds ...'[202]

194 It was also noted that 'officials were asked to discuss with both units ways in which the activity might be increased'.[203] This comment seems to confirm Sir Terence's view that supporting the units was a matter for the SRSAG and the local units themselves, rather than for the Royal Colleges.[204]

195 Sir Michael Carlisle in his oral evidence agreed that the reason for Bristol's continued designation was its location. His evidence included this:

> 'Q ... It appears to be suggested ... that the only claim that Bristol had for continued designation was what is called "geography". Broadly, does that correspond with your recollection?
>
> 'A. It does. I seem to recollect that Newcastle and Bristol were two places that were regarded, certainly for a considerable time that I recall, as necessary for geographic reasons.'[205]

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197 T17 p. 148 Sir Terence English
198 UBHT 0277 0141; letter from Dr Halliday to Mr Wisheart dated 17 October 1991
199 DOH 0003 0004; letter from Dr Halliday to Sir Terence English dated 20 December 1991
200 DOH 0003 0005; SRS (91) *'Report on Supra Regional Designation'*
201 DOH 0002 0173; SRS (90) 15 *'Report on Supra Regional Designation'*
202 DOH 0003 0005; SRS (91) *'Report on Supra Regional Designation'*
203 DOH 0002 0173; SRS (91) *'Report on Supra Regional Designation'*
204 T18 p. 200–1
205 T15 p. 48 Sir Michael Carlisle

196 Sir Terence had no input into the drafting of SRSAG Paper SRS (91). He did not agree with its conclusion:

> '... I think it was exceptional because I suspect, and I put it no stronger than that, that Dr Halliday may have seen the Royal College of Surgeons in particular, had consistently advocated that the service continue to be designated and I believe that, round about 1990–1991, the Department began to feel uncomfortable with designation of the service and probably wanted to see it de-designated, and I think that in that circumstance there may have been an exceptional lack of communication which might not have taken place in another setting.'[206]

197 On 8 January 1992 Sir Terence replied to Dr Halliday, stating, among other points: 'I do not believe that Bristol and Newcastle should be considered essential on geographical grounds',[207] although he acknowledged that geography 'was an important factor to be considered ...'.[208]

198 In questioning, it was suggested to Sir Terence that, if geography were discounted, the continuation of Bristol's designation on the basis of 'potential' was misplaced:

> 'Q. That may seem to have the danger in it that it amounts to continued designation, as it were, on a "wing and a prayer"; that although there is no geographical reason strong enough on its own, although there never has been a sufficient track record of numbers, one can hope that the service will develop even though there has been no sufficient development up until now. Would you care to comment on that way of looking at the issue?
>
> 'A. Yes. I think one could look at it in that way.'[209]

199 On 24 January 1992 Professor Hamilton wrote to Sir Terence indicating that Dr Halliday was sending him 'the figures for the last five years from the designated units' carrying out NICS. Dr Halliday had also agreed to attend a meeting with a small working party from the RCSE.[210]

200 Paper SRS 92(2), *'Designation Issues. Neonatal and Infant Cardiac Surgery'*,[211] was considered by the SRSAG at its meeting on 4 February 1992. The paper stated that the number of units in England undertaking NICS was thirteen, whereas the epidemiological evidence suggested that the number of units required to provide the

206 T18 p. 105 Sir Terence English; Dr Halliday called this suggestion 'quite absurd' WIT 0049 0026
207 RCSE 0002 0081; letter from Sir Terence to Dr Halliday dated 8 January 1992
208 T17 p. 137 Sir Terence English
209 T17 p. 140 Sir Terence English
210 RCSE 0002 0085; letter from Professor Hamilton to Dr Halliday dated 24 January 1992
211 DOH 0002 0044; SRS(92)2 *'Report on Designation of NICS'*

service was no more than seven and probably nearer five.[212] The paper also stated, amongst other things, that:

> 'Members accepted the conclusions set out in the paper SRS (90)15 that in general terms, all other factors being equal, there is a strong case for Bristol and Newcastle in terms of geographical spread. [213] They agreed that it would be difficult if not invidious to de-designate the centres in question on the basis of surgical expertise, and doubted whether it was possible to do so on the basis of referral pattern.'[214]

201 Dr Halliday emphasised that the SRSAG alone was not in a position to recommend to Ministers that a unit be de-designated on grounds of surgical expertise. He was asked about the paragraph from the paper SRS 92(2), *'Designation Issues. Neonatal and Infant Cardiac Surgery'*, set out above:

> 'Q. Again, help me with the wording of it. It may or may not be yours, but what was meant in that paragraph: actually surgical expertise in the general sense, or was it the outcomes of particular procedures?
>
> 'A. Well, I think the two go together. I think we were talking about outcomes of particular procedures. I think the difficulty we are in here is all the documents that we considered this morning highlight that almost from day 1 we were facing a situation where we might have to de-designate this service, or units within the service.
>
> 'The problem was that however much we tried, and however much advice we got from the various medical organisations, no-one recommended de-designating particular units, so we were faced with the situation where the only option was to de-designate the service. That is why we talk about the importance of geography, the problems about de-designating on expertise, or referral problems. Unless someone could provide us with the evidence which would allow us to take that decision, we had no alternative but to de-designate the service.'[215]

202 At a meeting of the SRSAG on 4 February 1992, Sir Terence offered to set up a working party to look at the question of designation of NICS. He told the meeting that:

> '... the most recent reports concluded that keeping 90–95 per cent of neonatal and infant cardiac surgery work concentrated in 6 or 8 centres was most beneficial to patient care.'[216]

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212 DOH 0002 0047; SRS(92)2 *'Report on Designation of NICS'*
213 A change from the wording of SRS (91) at DOH 0003 0005 of 'essential on geographical grounds'
214 DOH 0002 0044; Paper SRS (92)2
215 T13 p. 106–7 Dr Halliday
216 DOH 0002 0033 – 0036; minutes of SRSAG meeting, 4 February 1992

203 Dr Halliday, on behalf of the SRSAG, formally accepted the offer on 6 February.[217] It was agreed that the Working Party would report by 1 July to be in time for the SRSAG meeting later that month.

204 Mr Steven Owen, then Administrative Secretary of the SRSAG, visited Bristol on 6 February 1992. He recalled receiving some mortality data during his visit, which he said he passed to Dr Halliday. A note of the meeting sets out this data.[218] Dr Halliday was asked about this in evidence:

> 'Q. ... Yesterday we were told by Mr Owen that he visited Bristol in February 1992. When he visited Bristol then, he was passed mortality figures which did not mean a lot to him, so he passed them on to you. First of all, do you recollect that?
>
> 'A. Yes. I mean, I was getting data fairly regularly, yes.
>
> 'Q. The second question: do you recollect what, if anything, you did with those figures?
>
> 'A. The difficulty is, as I have said, having figures in isolation, without the machinery to analyse it, is of no particular value. It would have been strange for me to be given – I mean, I was not given any figures with the suggestion that there was a problem here. I was given figures as I was on many visits. Sometimes my administrative colleagues would visit the units with the object of dealing with financial matters, and would be handed data. They would come back to me, or Dr Prophet,[219] and would hand us that data.
>
> 'If, however, we were given the data and told that there was a problem with that data, that would be a different matter.
>
> 'I have no recollection of any data being presented to me from Bristol with the caveat that there was a problem.
>
> 'If there had been a problem, I would have clearly gone to the College for advice, but to be given data without the suggestion that there was a problem, would not have given me the opportunity to raise this with the College. I mean, it would be pointless me giving them the data from one year and saying, "What do you think of this?".'[220]

205 On 12 February 1992 Sir Terence wrote to Professor Hamilton asking him to be the Chairman of the Working Party[221] and he accepted. Professor Hamilton wrote to Mr Wisheart on 10 March, asking him for relevant data.[222]

217 DOH 0003 0012; letter dated 6 February 1992
218 DOH 0004 0045; note of meeting, 6 February 1992
219 Senior Medical Officer in Dr Halliday's division who had the policy resonsibility for paediatric cardiac surgery
220 T13 p. 113–14 Dr Halliday
221 RCSE 0002 0146; letter from Sir Terence English to Professor Hamilton dated 12 February 1992
222 UBHT 0061 0241; letter from Professor Hamilton to Mr Wisheart dated 10 March 1992

206 Professor Hamilton delivered the *'Working Party Report'* to Sir Terence, with his covering letter, on 19 June 1992.[223] In relation to the number of centres it was recommended that:

> '… 9 centres now be recognised for supra regional designation and funding … [They] are: Great Ormond Street, Birmingham, Liverpool, Leeds, Wessex, the Royal National and Brompton Hospital, Bristol, Newcastle and Leicester.' [224]

207 The effect of the advice was that Harefield and Guy's should be de-designated, and that Leicester should be designated. Thus, there would be a net reduction of one in the number of SRCs, from ten to nine.

208 Sir Terence was asked by Counsel to the Inquiry for his initial reaction to the recommendation that Bristol continue to be designated:

> 'Q. What argument would you derive from the data and from what you have already told us as to your knowledge of Bristol, which would justify its continued designation as a centre for the neonates and infants?
>
> 'A. That it was functioning at a lowish level, certainly not the lowest; and that it was still regarded as being an important centre.
>
> 'Q. In terms of your own reasons for supporting it earlier, geography was not essential, and potential appears to be belied by the trend downwards?
>
> 'A. Potential still has not been realised, I agree.
>
> 'Q. Is it not the case that if you were to apply your own approach to it, you would have said: "Well, this trend really argues against there ever being a realisable potential here, now."
>
> 'A. I certainly did not think that at the time that I received this report.
>
> 'Q. If you had the benefit of hindsight, do you think you might have taken that view?
>
> 'A. I think that I should have initially given a more critical analysis, or given more critical analysis to Table 1 of the report, but I had asked a group of very responsible clinicians to look at this. They had accepted the terms of reference; they had collected a lot of data, come up with a report that I could understand their reasoning for wishing to continue to advise that the service be designated and how this could be achieved. And the recommendations to ask Guy's to either amalgamate with another London unit or fail to continue to get funding, and similarly, to ask Harefield to amalgamate with the Brompton or face withdrawal of

223 RCSE 0002 0162; letter from Professor Hamilton to Sir Terence English dated 19 June 1992
224 RCSE 0002 0167; *'Working Party Report'*

funding, and to recognise that Leicester was doing good work, these all struck me as being perfectly reasonable at the time.' [225]

209 On 2 July 1992 Sir Terence (as President of the RCSE) wrote a letter to Dr Halliday, enclosing the *'Working Party Report'*, of which at this stage he was fully supportive. His letter concluded:

'The working party collected a lot of data on which to base their recommendations and should ... be congratulated on a report which has the full support of the Royal College of Surgeons.'[226]

210 Sir Terence also wrote to Professor Hamilton on 2 July 1992, thanking him for a 'balanced and authoritative report' that had the full support of the RCSE.[227]

211 In a letter to the Inquiry received after the conclusion of the hearing of oral evidence, however, Professor Hamilton related that, although mortality was quoted in one of the Tables, '... it is possible that insufficient attention was given to these figures by the working party'.[228]

212 On 15 July 1992 Dr John Zorab, Medical Director of Frenchay Hospital, Bristol and a consultant anaesthetist, wrote to Sir Terence.[229] He enclosed an article from the 'MD' column in *'Private Eye'*.[230] His letter stated, *inter alia*:

'Sometime last autumn, I made one or two efforts to get to see you in order to discuss the delicate and serious problem of mortality and morbidity following paediatric cardiac surgery in Bristol. I have no vested interest in this and the problem is outside my immediate sphere of influence but great anxieties were being expressed by some of my colleagues at the Royal Infirmary. In the event, I never made contact with you and the matter passed from the forefront of my mind.

'Matters have come to a head once again and the enclosed piece from *'Private Eye'*, whilst possibly having some inaccuracies, quotes some statistics which have been confirmed elsewhere. One of the newer consultant cardiac anaesthetists feels that the mortality rate is too distressing to be tolerated and is job-hunting elsewhere.'[231]

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225 T18 p. 126–7 Sir Terence English
226 DOH 0003 0013; letter from Sir Terence to Dr Halliday dated 2 July 1992
227 RCSE 0002 0179; letter from Sir Terence to Professor Hamilton dated 2 July 1992
228 WIT 0044 0004 Professor Hamilton
229 RCSE 0002 0188; letter from Dr Zorab to Sir Terence English dated 15 July 1992
230 SLD 0002 0005; *'Private Eye'*
231 A full description of the events resulting from this letter is set out in Chapter 27

213 At its meeting on 28 July 1992, from which Sir Terence was absent, the SRSAG:

> '... noted the Royal College of Surgeons Working Group Report which recommended that the service should continue to be designated and the number of designated units should be reduced from the current 10 to 9.'[232]

214 Sir Michael Carlisle told the Inquiry that by 1992, NICS was consuming 'nearly 25 per cent' of the SRSAG budget.[233] He said there was evidence that NICS was beginning to have completed its early developmental stage. It 'was a mature service that was taking rather more of the supra regional services finances than it should.' He continued: 'I mean, it [de-designation of NICS] was not a financial decision.'[234]

215 The minutes of the July meeting continued:

> 'Dr Halliday reported that since receiving the Royal College of Surgeons' report, he had been approached by Sir Terence English, who indicated that since submitting the report he now had reservations about the continued designation of the Bristol unit.
>
> 'The Advisory Group discussed the issue at length but concluded that it was unrealistic to expect to restrict the delivery of the service to those units for which the Royal College of Surgeons' report recommended continued designation ...'[235]

De-designation of NICS

216 In the event, the SRSAG decided to de-designate the whole NICS, stating that this was 'a fairer decision in terms of medical and surgical rights of patients than to restrict designation to a few surgical units.' [236]

217 On this point Sir Michael was asked:

> 'Q. One of the difficulties that we have in making sense of what is said there is that the thesis, up until now, and the advice, has been that it is in a patient's best interests that there should be a designated service. It is contrary to a patient's interests that there should be proliferation of services, and it would be desirable to use whatever efforts one could, within obviously the limits of time, to restrict proliferation of services?
>
> 'A. Correct.
>
> 'Q. One appreciates that there may have to be a bowing to the inevitable, but is there any particular reason that you can help us, why is it described as a "fairer

232 DOH 0002 0099; minutes of meeting of SRSAG, 28 July 1992
233 T15 p. 41 Sir Michael Carlisle
234 T15 p. 41 Sir Michael Carlisle
235 DOH 0002 0099; minutes of meeting, July 1992
236 DOH 0002 0099; minutes of meeting, July 1992

decision in terms of the medical and surgical rights of patients" than the continuation of a system with sufficiently few designated units to achieve the objects of the system?

'A. I have a little difficulty with that, in retrospect, I have to confess. I think it goes back to the proximity of service, the geographical element. I am sorry, I cannot help you more than that. I find it a slightly ambiguous paragraph myself, in retrospect.'[237]

218 Sir Terence said that he was unable to understand the logic of the reference to 'fairer in terms of medical and surgical rights'.[238]

219 This same point, about fairness, was put to Mr Steven Owen:

'I find it difficult to answer that question after this period of time, frankly, but I think it is simply a recognition that the nature of the service had changed, proliferation was widespread, and it was simply accepting reality. I think the de-designation decision itself was an acceptance of reality.'[239]

220 Sir Michael was asked whether matters would have taken a different course had the Working Group recommended a greater reduction in the number of centres being funded by the SRSAG for NICS:

'Q. Suppose that Professor Sir Terence English's Working Party had come up with the suggestion that there are six names, six centres, which the Royal College recommended for continuing designation. Do you think that probably the Advisory Group would have said, "Okay, we will retain designation for those six"?

'A. I think it is highly likely.

'Q. So it follows, does it, that the real problem or the real cause of de-designation of the service was not the fact that it was a mature service and was not the input from Guy's, it was simply a function of numbers?

'A. It was proliferation.'[240]

221 In his supplementary statement of 18 December 1999, Dr Halliday said that:

'... my assessment of the likely outcome of the Supra Regional Services Advisory Group meeting [on 28 July 1992] was that the NICS service would be de-designated. The [SRSAG] had no alternative. In such circumstances Sir Terence's

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[237] T15 p. 78–9 Sir Michael Carlisle
[238] T18 p. 168 Sir Terence English
[239] T12 p. 89–90 Mr Owen
[240] T15 p. 42–3 Sir Michael Carlisle

reservations were not important. Of course I had no way of knowing how serious these reservations were.'[241]

222 Dr Halliday continued:

'Had the NICS service continued to be designated but Bristol was to have been de-designated then Sir Terence's reservations would have been extremely important and the [SRSAG] would have wished to know in detail what these reservations were. I would therefore have been pressing Sir Terence for details. In the context of the [SRSAG] meeting however the details of Sir Terence's reservations were irrelevant.'[242]

223 Dr Halliday saw July 1992 as the end date of SRSAG's involvement with NICS:

'A. ... It was de-designated in 1992. It was funded for two years after that, but that was not a matter for the Advisory Group.

'Q. It remained, did it not, the responsibility of the Advisory Group?

'A. No, it did not, no.' [243]

224 Professor Hamilton wrote to Sir Terence on 3 August 1992. It appears from the letter that Professor Hamilton and Sir Terence had spoken twice, in July 1992, some days prior to the SRSAG meeting, and that Professor Hamilton had also spoken to Sir Keith Ross (a fellow member of the Working Party) on the morning of Monday 27 July 1992. Professor Hamilton said in the letter:

'I hope that you had a highly successful trip to and safe journey back from Pakistan, and are refreshed after a demanding but successful term as President.

'Following our telephone conversations of Thursday evening, July 23rd, and Friday afternoon, 24th, I was not entirely happy about our agreement to take Presidential and Chairman's action over the Working Party's report. On reflection, I realised a possible specific source of "breach of confidentiality" which could arise, and a further feeling that the de-designation of one of the units would probably "leak out" in the course of time. Also, the members of the Working Party were unanimous in their findings and gave considerable thought to their recommendations. Like you, I was unable to contact Keith Ross but did so early on Monday morning, the 27th, after he had returned home from holiday. He was equally concerned that we had changed the report and suggested, on reflection, that we should both speak with Norman Halliday to reverse the decision and the instructions that you had given him.

241 WIT 0049 0034 Dr Halliday
242 WIT 0049 0034 Dr Halliday
243 T89 p. 170; Dr Halliday explained that Chris Spry, a member of the SRSAG, brokered a funding arrangement with Regional General Managers which lasted until the spring of 1994

'... the Working Party could be requested by the Advisory Committee on supra regional funding to *reconsider* the mortality figures of specific units (or unit), and possibly to amend its findings.' [244]

225 Sir Keith gave written evidence to the Inquiry. He said:

'It is safe to say that when David Hamilton telephoned me at home on 27th July 1992, when I had just returned from Scotland, I had no idea of the events leading up to the telephone call. I am sure David Hamilton did his best to explain the sequence of events, but under the circumstances (and I have no clear memory of the conversation), I must have agreed with his concern regarding the working group's conclusions being altered. Whether he or I suggested telephoning Dr Halliday is immaterial, but he had to be given our views. There was no way that I could have talked with Terence English who was either in, or on his way to, Pakistan, nor was there time to reconvene the working party before the SRSAG meeting, which was due the next day or the day after …

'Finally, I have no recollection of suggesting to Dr Halliday that the Working Party could be requested to reconsider the mortality figures of specific units with a view to possibly amending its findings. I would like to think that I would have recommended this, but as explained above, this never happened.'[245]

226 When he was shown Professor Hamilton's letter of 3 August 1992, in the course of his first appearance at the Inquiry, Dr Halliday said:

'This letter changes the whole context. My discussion with Sir Terence, or at least his discussion with me about his concerns about Bristol simply meant that he had reservations about Bristol and therefore he was not entirely happy with the report from the College.

'This letter would suggest that there appears to be more to it than that, and I cannot comment on that.'[246]

227 Dr Halliday accepted that the letter suggests that the discussions between Professor Hamilton and Sir Terence had involved the issue of mortality findings.[247]

228 Sir Michael Carlisle was emphatic that he had no knowledge of the contact between Professor Hamilton, Sir Keith Ross, Sir Terence English and Dr Halliday and knew nothing of the discussions suggesting alterations to the Working Party's report.[248]

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244 RCSE 0002 0197; letter from Professor Hamilton to Sir Terence English dated 3 August 1992 (emphasis in original)
245 WIT 0031 0006 – 0008 Sir Keith Ross
246 T13 p. 90 Dr Halliday
247 T89 p. 164 Dr Halliday
248 T15 p. 77 Sir Michael Carlisle

229 After returning from Pakistan and learning what had occurred at the meeting on 28 July 1992, Sir Terence had indicated that he wished to speak to the issue of de-designation of NICS at the next meeting of the SRSAG, in September 1992.[249]

230 Sir Terence spoke at the meeting, but he does not claim to have mentioned concerns specifically about Bristol. Sir Terence accepted in evidence that he should probably, at least, have set out his concerns about Bristol in writing to Sir Michael. Sir Terence said:

> 'A. I think that my last meeting of the Group [*sic*], I certainly spoke to my concerns about the de-designation of the service. I do not think I did mention Bristol specifically at that time. That is where the matter rested. I then left the Group. I know that Professor Browse [President, RCSE, from July 1992] knew of my concerns, but I think he did not feel any need to take them any further forward, and indeed, should not have, unless I had specifically asked him to, and I did not.
>
> 'Q. Because he left them with you?
>
> 'A. Yes.
>
> 'Q. So it was, as it were, your responsibility?
>
> 'A. Correct.
>
> 'Q. And you had expressed them orally to Dr Halliday, but not otherwise?
>
> 'A. Right.
>
> 'Q. And never, it seems, from what you have said, thereafter expressed those concerns?
>
> 'A. That is right.
>
> 'Q. Do you think, perhaps, that you ought to have done so?
>
> 'A. I think it is a difficult question. I think that I probably should have written at least to the Chairman of the Group, Sir Michael, formally about it, if I had not brought it up to the open meeting, the last one I attended. I suspect that probably is what I should have done.

[249] RCSE 0002 0200; letters (from Sir Terence to Mr Owen), RCSE 0002 0202 (Mr Owen's reply) and RCSE 0002 0205 (from Sir Terence to Sir Michael); none of these letters made reference to any problems at Bristol

'Q. Although it may be difficult now in retrospect to say why you did not, can you help as to why you might not have done?

'A. I think I was very cross that the Group had failed to accept the very considered advice of the professional Working Party that they had commissioned. That may have had something to do with it.

'Q. So you felt outwith the Group?

'A. I did, rather.

'Q. You simply did not think about raising the issue anywhere else?

'A. No. No. And would not. As I say, I think the right thing probably would have been to have written formally to Sir Michael.'[250]

231 Sir Terence said that after the 29 September meeting (his last as a member of the SRSAG), he felt that the matter was closed and beyond his further intervention.[251]

232 At the end of his evidence, in response to a question from the Chairman, Sir Terence acknowledged that, in retrospect, he should have done more to bring his concerns about Bristol to the attention of others. He said:

'... I do accept the implied criticism, and indeed, the criticism that I should have done more to bring my concerns to the Supra Regional Services Advisory Group specifically about the mortality and the concerns expressed by Dr Zorab, than I did, and in retrospect I think I should have.'[252]

233 The decision of the SRSAG, to designate NICS, stood, coming into effect (taking into account financial implications) in April 1994.[253]

Monitoring of quality

234 Dr Ian Baker, Consultant in Public Health Medicine, B&DHA since October 1991, took the view that although he had a responsibility to ensure that the service for the over-1s was producing an acceptable outcome, the supra regional service for the under-1s was 'supervised through their [i.e. the SRSAG's] own arrangements'.[254]

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250 T18 p. 174–5 Sir Terence English
251 T18 p. 187 Sir Terence English
252 T18 p. 202 Sir Terence English
253 DOH 0002 0156; minutes, 29 September 1992
254 T36 p. 73–4 Dr Baker

235 Those involved in the SRSAG itself did not share this view. Mr Angilley, Administrative Secretary of the SRSAG, said:

> 'The statutory responsibility for the provision of health care and therefore for standards is firmly in the hands of the local health bodies that provide that service.'[255]

236 Dr Peter Doyle[256] inclined to the view that 'the clinicians' had the responsibility for monitoring the outcomes of care,[257] as opposed to the SRSAG, but also said subsequently that he had 'no idea' who had the responsibility for monitoring the quality of outcome.[258]

237 The question as to what, if any, responsibility was accepted by the DoH for the designation and performance of an SRC, and to what extent it took the view that it had, as direct paymaster, control over such units was dealt with by a number of witnesses.

238 Sir Alan Langlands, Chief Executive of the NHS Executive,[259] placed responsibility on the local hospital, subsequently the Trust:

> 'In the case of NHS Trusts, Supra-Regional funds were allocated directly from the Department of Health to the NHS Trust responsible for the Supra-Regional Unit with effect from 1 April 1991. The NHS Trust took on managerial and clinical responsibilities for the proper use of those funds.'[260]

239 As to Districts, Sir Alan saw them as having had no real responsibility for SRSs:

> 'There is, or was at that time, a clear responsibility on district health authorities to ensure that the health and health service needs of their population were being adequately met and that means the whole range of services from primary to tertiary services. But beyond that, I can see that there is no real responsibility here and that the responsibility is much easier to define in relation to individual clinicians, the Trust where that service was located and the NHS Executive who, through these advisory groups, were running the national commissioning arrangements and allocating money.' [261]

240 Nonetheless, the evidence was that responsibility for the quality (in the sense of clinical outcome) of SRSs was confused. This confusion was considered by Sir Alan to be a failure for which the NHSME was to some extent responsible. In response to a question from Professor Jarman, he stated:

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255 T11 p. 18 Mr Angilley
256 The Medical Secretary of the National Specialist Commissioning Advisory Group (successor to the SRSAG) since 1994
257 T67 p. 11 Dr Doyle
258 T67 p. 13 Dr Doyle
259 Sir Alan Langlands was Deputy Chief Executive of the NHS Executive 1993–1994, and thereafter became Chief Executive
260 WIT 0335 0044 Sir Alan Langlands
261 T65 p. 64–5 Sir Alan Langlands

'… there was confusion and … the distinctive roles and responsibilities of each of the players was not adequately clarified. I think that the Department of Health, the NHS Executive in particular, must take some responsibility for that. It falls into my category of systemic failure. You cannot expect people to behave sensibly in this position unless they are absolutely clear where they fit in. So I think the position is as described, I think there was a failure there, a confusion.

'Q. Just to take that further, that may be related to the fact, as Sir Graham Hart said to us, that the NHS had no proper measurement of the quality of care it was providing. I just wonder whether you feel that the reason for confusion you mention and the lack of proper measurement that he mentioned could have been related to the fact that, as he said, ministers were unwilling to get involved in dealing with the profession, the medical profession particularly, with regard to matters of clinical performance?

'A. I think I would separate the points. I hold up my hand to the fact that there was confusion here. There is no denying it. The fact that I have not been able to adequately explain it today or cover it effectively in my statement suggests that there was confusion. I think that is wrong. I think that I and the NHS Executive should take responsibility for that. I could mount all sorts of things in mitigation about how busy everybody was at the time and what a terribly complex change it was, but I do not. I think it is wrong that these roles and responsibilities were not clarified. On the subject of proper measurement, I am conscious of the fact that this is an area you know more about than I do, but I think there is a separate point there, which is that services like this all around the globe are trying to find effective forms of measurement. I think we are towards it in the data sets, the audit processes that I described earlier in relation to cardiac surgery. So I would want to separate the two points.

'Q. There was a third point.

'A. On the third point about the attitude of Ministers, well, again, I think it depends on timing. I can never remember a situation where Ministers said "We are reluctant to get involved in the clinical processes". But I do remember a culture where it would have been unusual for Ministers to get involved in the detail of clinical activity, but equally, in this period of the early 1990s, there were some very dramatic cases, for example in relation to mentally ill people where Ministers did intervene and did want to see very fast improvements in service and did require the NHS Management Executive, as it then was, to behave in a managerial way. I would think that position is now more pronounced and that current Ministers have no hesitation about intervening in areas where they feel, rightly in my view, responsible and where they feel they have to act, so that the actions they have taken in reinstating the very important quality assurance arrangements in relation to the breast and cervical screening services I think was an absolutely justifiable intervention, which no clinician in their right mind could have suggested was inappropriate. So I think attitudes have been changing over time, and I think that

really the point I want to get across here is a sort of evolutionary point: that through all of this, the relationship between the government medical profession and the public has been changing and I think Sir Donald Irvine brought this out very well in some of his evidence, which suggests that issues of public accountability and self-regulation have to be in keeping with the current public mood. They cannot somehow be rooted in the past or in sort of romantic notions of clinical freedom in a bygone age. We are living in a different world.'[262]

241 That there was confusion and uncertainty as to responsibility for the monitoring of clinical outcomes in the SRSs, with a view to ensuring appropriate quality of care, was endorsed by a number of other witnesses. Professor Crompton expected the SRSAG to do it:

'I would have expected from the beginning, when they established the supra regional centres, that there would have been a system of data capture and analysis and publication from each of the centres, distributed freely to the Department of Health and to Regional Health Authorities who were sending patients there from Wales or wherever and that the Supra Regional Services Advisory Group would have been in full knowledge of all the facts relating to this important initiative. If that was not the case, then I am surprised.'[263]

242 The SRSAG supervisory mechanisms were described by Mr Angilley in his statement:

'As Secretary to the Advisory Group, my work included the monitoring of activity levels and costs at the designated centres against the Group's expectation when it agreed levels of funding. In the early years we carried out no detailed monitoring of cost and activity through the year and relied on annual figures submitted by the designated centres. These figures showed actual and forecast levels of activity and cost. The Advisory Group used this information to produce recommendations on funding of each centre in the following financial year. My background as an economist led me during my period in post to seek improvements in the costing and activity statistics provided by the centres. The introduction of contracts in 1991 was accompanied by quarterly activity figures as well as an annual report from the unit. The contract set out the format of the annual and quarterly reports.'[264]

243 As to performance in SRCs, the SRSAG looked to the Medical Secretary to raise any issues and the Medical Secretary, in turn, looked to the College members on the SRSAG to comment on performance.

244 The Colleges could visit or, if requested, report but they did not initiate reviews. It was not until 1991 that there was a suggestion that the Colleges should 'police' the system.[265]

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262 T65 p. 103–6 Sir Alan Langlands
263 T21 p. 72 Professor Crompton
264 WIT 0034 0002 – 0003 Mr Angilley
265 SCS 0004 0032; minutes of meeting, 21 February 1992

245 However, Sir Terence English told the Inquiry:

> 'I do not believe that the Royal College of Surgeons or Physicians, or any other Medical Royal College, can be held responsible for performance in individual units. I think the value of the Colleges resides in their capacity to provide professional advice when invited, and to do so in as objective and fair a way as possible. I think if there are difficulties that crop up in a unit, a College or two Colleges can combine to provide a visitation that can be quite extensive, and then very helpful to management. I think the Supra Regional Services Advisory Group had a responsibility – a difficult responsibility, but a responsibility nonetheless – for performance in the units that they designated, because they were funding them.'[266]

246 Dr Halliday made clear in his evidence that the SRS was a funding arrangement, and that the SRSAG did not have responsibility for monitoring the quality of the care provided by supra regional units:

> 'I was the architect of the Supra Regional Service arrangements. It was I who drafted all the papers, made all the proposals and negotiated with the profession. At no time did we consider that the Advisory Group which would eventually be set up would have monitoring responsibilities for any of the services. Their role was to advise the Secretary of State on which services would be centrally funded. It was a funding arrangement.'[267]

Moreover, he stated:

> '... the statutory duty for provision of health services rests with the Health Authorities… The Supra Regional Services Advisory Group did not alter the statutory arrangements.'[268]

247 Dr Halliday saw the local hospital management as having the role of monitoring quality, prior to the 1991 reforms. During the first occasion on which he gave oral evidence, he said:

> 'None of the supra regional services functioned in isolation. They were almost invariably part of a general hospital. So the management of the general hospital would have to manage the unit which was designated supra regional. I would have expected them to look after the provision of facilities and all outcome measures that they would want to use in any sphere, as they would with any other service.'[269]

248 The evidence of Professor Sir Kenneth Calman, Chief Medical Officer for England (CMO) from 1991–1998, was that:

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[266] T18 p. 200–1 Sir Terence English
[267] T89 p. 134–5 Dr Halliday
[268] T13 p. 112 Dr Halliday
[269] T13 p. 113 Dr Halliday

'A. I considered that it would be the responsibility of the Supra Regional Services Advisory Group to ensure that there was a process for monitoring; and that that process and the outcome was reported to the Supra Regional Services Advisory Group.

'Q. It is not quite exactly what you said before.

'A. I am trying to clarify it for you.

'Q. Before you said they would be responsible for monitoring it, they could go upwards to the Department of Health or go to specialists.

'A. They were responsible for ensuring the system was in place for monitoring the outcome. They could not do the monitoring themselves. They would get the data once it had been monitored and if there was a problem, presumably they would talk to an appropriate person within the Department of Health.

'Q. So they were responsible for getting a system and looking at the results?

'A. I think in general, that is the Department of Health's responsibility: ensuring that there are systems in place which monitor the data. They do not necessarily monitor it themselves. So I am sorry if I have confused you. I do not think I have confused myself on this, because I think they did have a responsibility to ensure that it was being monitored, and that the results would be fed into them.

'Q. So when you say "they" it is the Department of Health and the SRSAG, working together, [which] had the responsibility for making sure there was a system and looking at the results to see if there was a problem?

'A. Yes.'[270]

249 Sir Kenneth was asked about the same topic by the Inquiry Chairman:

'Q. ... was it your evidence that there ought to be a system for monitoring as well as a system for seeking advice, or was it your evidence that the SRSAG itself should do the monitoring?

'A. I do not think the SRSAG itself could do the monitoring, because it would not be set up to do that, but it should be ensuring that there was a system in place to do the monitoring.

[270] T66 p. 98–9 Professor Sir Kenneth Calman

'Q. And looking at the results?

'A. I think looking at the results too.

'Q. And examining the results?

'A. Yes.'[271]

250 When this evidence was put to Dr Halliday (when he gave oral evidence for the second time, in December 1999), he agreed that the SRSAG had a responsibility for ensuring a system was in place for monitoring outcomes, but only in the latter part of the period, after the introduction of contracting in 1991:

'Audit was not a major interest of the Department of Health at the time. Myself, I kept it as a policy issue within my division all the time that I headed the division, which was for 15 years.

'Each year I was constantly told that medical audit was not part of the Department's responsibility and that I should drop it, and I argued that I should retain it as long as I met all my other targets in terms of work. As long as pursuing that activity did not affect my other work I should be allowed to retain it, and I did.

'So we were very active in encouraging medical audit in the field, despite the fact that it was not Departmental policy at the time.'[272]

251 Dr Halliday emphasised that the SRSAG was dependent on the 'medical profession for any data which it had as to surgical outcomes and surgical performance …'[273]

252 Sir Michael Carlisle stated that the SRSAG was not 'a rubber stamp committee'. However, he too emphasised the degree of reliance that the SRSAG placed on senior members of the medical profession for interpretation of data and 'early warnings' about problems with the service. Sir Michael's evidence included this exchange:

'Q. What you are perhaps telling us, and again, correct me if I am wrong, is that if it occurred to you that there might be serious grounds for concern with any particular unit, leave aside one doing neonatal cardiac infant surgery, that your first port of call would have been to the medical men to say, "Well, look, give me a view on this. What is this all about?"

'A. Absolutely right. One relied upon them, I suppose in a manner of exception reporting, to come forward if there were known perceived problems in any unit where they had knowledge and expertise. We had a substantial network formally and informally for medical people. I have referred to the President of the Royal

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271 T66 p. 100–1 Professor Sir Kenneth Calman
272 T89 p.138 Dr Halliday
273 T13 p. 3 Dr Halliday

College of Surgeons; there were other eminent medical people on that group, and I think there was a sufficiently powerful group of people and network of people to be able to pick up evidence, albeit verbally, of problems.

'In those cases, those had been brought or raised at the committee, at the [SRSAG], I would have seen action was taken to do something about enquiring more about it.

'Q. So you, in wishing to take things forward in the best interests of patients, as you did, you were really reliant upon the input that the medical men had to give you?

'A. Absolutely so. It is not my area of expertise to interpret medical data.'[274]

253 With effect from 1991 service level agreements, described as 'contracts', were entered into for the delivery of SRSs. Sir Michael accepted that, 'as a contractor, the Department of Health obviously had an accountability [for the way in which SRSs were managed].'[275]

254 On a final matter concerning performance and monitoring, Dr Halliday was asked how often it was that a supra regional unit was de-designated on the grounds of poor clinical performance. He was unable to recollect an example of this:

'We have de-designated services, but I cannot recollect us ever de-designating a particular unit. It is very difficult to de-designate units, because although you might find that the profession supported the decision, there might be a reluctance, you know, a decision to de-designate the service, there might be a reluctance to de-designate a particular unit. There are often very good reasons for that. For example, Guy's was a unit that was constantly being referred to as one that should be de-designated, but it is very difficult, when you go along to see the unit and you find in fact they are leading the world in prenatal diagnosis, they are one of the leading international units in interventional catheterisation, and say, "De-designate this unit". It is very difficult'.[276]

The information collected by and available to the SRSAG

255 When Sir Michael Carlisle became Chairman of the SRSAG, in April 1989, he perceived a need to improve the system of assessing bids for supra regional funds. The minutes for the SRSAG meeting of 28 September 1989 stated that:

'The Chairman noted that the White Paper reforms raised large issues for the supra regional services. He felt that the current method of assessing bids for additional funding left a good deal to be desired; the broad brush approach would need to

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274 T15 p. 29–30 Sir Michael Carlisle
275 T15 p. 3 Sir Michael Carlisle
276 T13 p. 102–3 Dr Halliday

give way to a system of contracts. The Group needed to know much more about the costs of providing supra regional services …'

'When the principles were resolved, there would be a need for reliable accounting data as well as information on outcomes of treatment.'[277]

256 Sir Michael emphasised that his desire to see a system of collection of information about the quality of SRS was not part of the de-designation debate, but was something he saw as an important management tool:

'Q. So the position is, is it, that in 1992 the units in the various different services were not giving very detailed information about outcomes to the Group?

'A. I, of course, did not see much evidence of that. It may be that Dr Halliday and others – not others, Dr Halliday in particular – who had strong liaison with units, may have seen more information than I did, but I do not think it is wrong to say there was more emphasis on the volumetric than the qualitative data …

'You can see from the 1989 paper that I was very keen that some outcome information should be brought forward to complete the total picture, so that our judgement as a group in the corporate sense could be better informed. So we have an interest in it. What we did not have was the information …

'This was nothing to do with designation or de-designation; it is about running good services. I should like to have seen, this was the very first step, the annual report and the annual report of the units, leading up to a situation where I hoped that there would be periodic performance reviews of the units and services within the Supra Regional Services Advisory Group. We could not do every service and every unit every year, but we could start to commence that process … I was hoping through reports and performance reviews to establish some process whereby the total picture of what is going on could be more evident, not just for management purposes but also so we could advise the Secretary of State that continued investment in these services was appropriate or not.'[278]

257 Sir Michael explained that the SRSAG lacked what he called 'hard management information'. He said that, despite this, 'I think we got a reasonable feel for most things except outcome'.[279]

258 Dr Halliday said that the SRSAG received anonymised data from the SCS each year and this allowed the SRSAG 'to identify the trends in terms of mortality in all the units, but we could not identify the units'.[280] However, Dr Halliday did not know how the SCS collected its data, nor the form in which it was made available by it to cardiac

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[277] DOH 0002 0214; minutes of meeting, September 1989
[278] T15 p. 11–14 Sir Michael Carlisle
[279] T15 p. 16 Sir Michael Carlisle
[280] T13 p. 46 Dr Halliday

units across the country.[281] He described the Society as 'very secretive' and referred to 'difficulties' which the SRSAG had 'in getting any progress from the Society'.[282]

259 Dr Halliday said that it was only when contracting began, in 1991, that the SRSAG 'insisted'[283] that the returns to the UKCSR were included in the monitoring returns sent annually by units to the SRSAG.

260 Sir Terence took the view that 'it would have been perfectly proper to have analysed quality of output in terms of mortality, and de-designate it if necessary.'[284] Having said that, he recognised that nothing other than crude measures of mortality were available:

> 'I think that the output of crude mortality is there as a sort of warning, if you like, that if it raises an issue, that then you need to go in and do a much more detailed and difficult analysis.'[285]

261 Dr Halliday explained that if the SRSAG had information about an apparently under-performing unit, it would produce a paper and recommend to the Chairman of the SRSAG that the President of the appropriate Royal College set up a working group to review the situation.[286]

262 Dr Halliday was asked:

> 'Q. Suppose the Working Group reports and says, "Well, it is not doing very well; on the other hand, it is not doing desperately badly". What would the likely outcome be? Would the service likely remain designated, or not?'
>
> 'A ... I think people would sweat over midnight oil about what we should do, but the difficulty would be, if that is the professional advice that it should continue, how do you stop it?
>
> 'Q. It all comes down to – this started the question I was asking you – it depends on the professional input you get in the Supra Regional Services Advisory Group from the Royal Colleges?
>
> 'A. I do not know who is better to judge the practice of medicine than the doctors …'[287]

281 T89 p. 143–4 Dr Halliday
282 T89 p. 144 Dr Halliday
283 Sir Michael Carlisle's word – T15 p. 15
284 T18 p. 109 Sir Terence English
285 T18 p. 110 Sir Terence English
286 T13 p. 108 Dr Halliday
287 T13 p. 108–9 Dr Halliday

The number of neonatal and infant open-heart operations at Bristol

263 Departmental Paper SRS (83)17[288] was prepared in 1983 for consideration by the SRSAG as part of the process of considering NICS for SRS status. It includes tables showing regional rates of operation for under 18 years of age, together with estimated needs for NICS (based on the 1979 British Paediatric Association Report[289] and the Second Joint Cardiology Committee Report of 1981).[290]

264 Bristol figures for 1983–1984 are to be found in a document prepared by the Bristol clinicians, as part of the creation of the SRS in Bristol.[291] The figures for 1984–1985 show that Bristol carried out 13 open-heart and 39 closed-heart operations.[292]

265 At the meeting of consultants from NICS units held on 4 October 1985 figures were presented to indicate the number of open-heart operations at each of the nine centres for 1984–1985. Bristol figures appear as set out in the paragraph above.[293]

266 It was clear to the Birmingham representative, Dr Silove:

> '… that several of the figures were spurious and in particular the representatives from Leeds and Newcastle suggested that the actual figures were very much less.'[294]

267 There followed an exchange of correspondence between Dr Silove and Mr Hurst, Administrative Secretary of the SRSAG 1983–1987.[295] In his letter of 2 January 1986 to Dr Silove, Mr Hurst wrote:

> 'I hope you will appreciate that Regions are responsible for the data they submit to the Department and that the Department is obliged to accept their submission.'[296]

268 On 6 January 1986 Dr Silove replied:

> 'I do appreciate that the Regions are responsible for the data that they submit to the DHSS. However, at the 4 October meeting several of the clinicians present indicated that the data from those Regions was a fiction.'[297]

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[288] WIT 0482 0349 Dr Moore
[289] BPCA 0001 0014; 1979 BPA Report
[290] RCSE 0003 0017; 1981 JCC Report
[291] UBHT 0278 0577 – 0579; there are also calendar year figures (see DOH 0004 0028 and Mr Wisheart's evidence, T41 p. 128–33)
[292] UBHT 0278 0507 and UBHT 0278 0487; form entitled NICS and a table in Secretary of State's announcement on SRS for 1986–1987
[293] ES 0002 0019; table entitled Neonatal and Infant Cardiac Surgery
[294] ES 0002 0021; letter dated 9 December 1985
[295] ES 0002 0020 – 0024; correspondence between Dr Silove and Mr Hurst
[296] ES 0002 0024; letter from Mr Hurst to Dr Silove dated 2 January 1986
[297] ES 0002 0023; letter from Dr Silove to Mr Hurst dated 6 January 1986

269 The Bristol figures, in summary, for the period from 1983–1984 until 1992 are in the table below:

Table 4: Table of open and closed figures

	1983–1984	1984–1985	1985–1986	1986–1987	1987–1988	1988–1989	1989–1990	1990–1991	April 1991–January 1992
Open	3	13	16	26	28	33	39	45	32
Closed	36	39	52	55	57	56	60	82	42

270 Dr Halliday was shown the figures for the number of NICS operations at Bristol. His evidence included this:

> 'Q. ... whatever the assurances that had been made to you by the Royal College of Surgeons on this rather nebulous basis, nothing in fact was happening very much to improve the throughput at Bristol?
>
> 'A. Well, it is increasing, but it is not significant.
>
> 'Q. That must have been a matter of concern, then, to the [SRSAG]?
>
> 'A. It was, yes.
>
> 'Q. It would imply, because of the low numbers, that the outcomes were unlikely to be as good as they would be in one of the larger centres?
>
> 'A. Well, as we have agreed, all the evidence suggests that the more operations you do, the better you are. But of course there are always exceptions to that and I can give you many examples of people who have done only a few operations, but their results are quite outstanding: the cardiac surgeon in St Bartholomew's Hospital, for example, who only did three heart transplants but his success rate was 100 per cent. So there are many factors that influence this.
>
> 'The other thing I think you need to take into account is at the time Bristol were only doing 11, 14, 24. There were other units in the country doing 11, 13, 24, and were getting outstanding accounts.' [298]

[298] T13 p. 36–7 Dr Halliday

271 In relation to the Bristol figures Dr Halliday said:

> 'Q. So the Advisory Group were in a position in the 1980s to identify an under-performing unit?
>
> 'A. Yes.
>
> 'Q. Did they do so in respect of Bristol?
>
> 'A. Bristol was always a worry. It was a particular worry to me, but it was a worry in a sense that I could not understand why referrals were not increasing, and I made many visits to Bristol, to the Welsh Office, and met many people in the South West, clinicians I mean mainly, but also managers, to try and identify what the problem was. It never became clear. …[299]
>
> 'Q. What I am asking, did it appear to you that there were questions to be asked in respect of Bristol?
>
> 'A. Questions to be asked in respect of Bristol?
>
> 'Q. Because you were able to compare its performance with the national, and the question is in two parts: did it seem to you that the performance was less good than the average, the first question; and the second question: if so, what if any steps did you take about it?
>
> 'A. The evidence did suggest that Bristol was not performing as well as the other units.'[300]

272 Sir Michael Carlisle told the Inquiry that he knew that 'it has always been a struggle' for Bristol to increase its referral numbers.[301] However, as Chairman, he had no role in attempts to increase the number of referrals to Bristol.[302]

The encouragement/strengthening of the Bristol Unit

273 Dr Halliday placed some emphasis on the fact that the Royal Colleges inspected the supra regional units regularly.[303] He was not able to be specific as to the content of the strengthening steps which might have been expected from the Colleges.

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[299] Dr Halliday told the Inquiry that he did not perceive the split site as a barrier to Bristol's development
[300] T13 p. 46–8 Dr Halliday
[301] T15 p. 53 Sir Michael Carlisle
[302] T15 p. 53 Sir Michael Carlisle
[303] T13 p. 102 Dr Halliday

274 Dr Halliday was questioned by Mrs Maclean of the Inquiry Panel on the nature of support for Bristol from the Colleges:

> 'Q. ... You suggested that you were looking to the Royal Colleges for support in the development of Bristol. I wonder if you could give me some examples of the kinds of things you meant by that support?
>
> 'A. Actually, I did not say I was looking to the Royal College for support, I said that the Royal College had offered their support. You see, the Colleges are responsible — one point perhaps I should have made earlier is that we are very fortunate in the way that our Royal Colleges assist us, because they are not formally part of the National Health Service. They have no responsibility for the provision of services. Their role is educational and the training of doctors. Yet despite that, they are only too happy to contribute their time, and sometimes money, to look at the things we want them to address. So I think we are very lucky in that sense.
>
> 'In the case of Bristol, we were in a situation where the Advisory Group had decided, based on all the evidence we had, that we should designate the neonatal and infant cardiac surgery. If we did not have a centre in the South West, a significant part of the population would not be served. We had to take into account Wales as well, although Wales was not part of the supra regional service arrangements.
>
> 'When it was suggested that Bristol be designated, even then we had concerns, because it did not seem to be, you know, as good as the other units in terms of facilities, staffing and so on. When the College offered, through Sir Terence, to say that they would assist us in strengthening that unit, my interpretation of that would be that the College had "powers", in inverted commas, through their visits to say whether the facilities were effective, and if they were not effective, they could withdraw their recognition of it being a training post. That is a very powerful weapon for managers.
>
> 'The second thing is that they can influence their young consultants coming along, or Senior Registrars, and suggest to them that if they would like to apply to Bristol, it would be in their long-term interests. So I expected them, both in terms of their visitations and encouraging staff, good staff, to take posts in Bristol, that they would strengthen the unit.
>
> 'But it is not something I could actually interfere with. The College has its own way of ensuring its standards are met.'[304]

[304] T13 p. 120–2 Dr Halliday

275 Sir Terence rejected the view that the SAC or the Hospital Recognition Committee (HRC) was better placed than the SRSAG to gather intelligence on NICS. He told the Inquiry:

> 'As far as neonatal and infant cardiac surgery is concerned, the College would become informed and involved at whatever time they were asked to look at a particular problem or to do a particular piece of work for the Group, but otherwise the detailed information that we would gather from the five-yearly visit of the SAC and the five-yearly visit of the HRC to a particular designated unit, that information, although strong on training, in terms of the total service, would be less than I would have expected the Supra Regional Services Advisory Group to have held themselves, because they designated these units and they had the purse strings and they were monitoring them.'[305]

Sir Terence was asked about the extent to which the SAC for cardiothoracic surgery had regard to the 'quality' of surgery performed by the consultants providing the higher training in the specialty:

> 'A. I think this was approached variably by different members of the SAC, different visitors. Some would enquire informally into it, others would like to see the results from the previous few years. We had ours available at visits with mortality statistics against them; others did not. It was not a requirement as such. It was perhaps something — well, it certainly did not receive as much attention as the quality of the training which the individual was receiving.
>
> 'Q. Quality of training was the whole purpose of the visit?
>
> 'A. Correct.
>
> 'Q. So inevitably, quality of outcome would not, could not, receive as much consideration as that, but I think what you are telling me – I want to be sure I am right about it – is that whether formally or informally, it was the expectation of all concerned that those visiting the unit would ask about quality of outcome, or quality of surgery?
>
> 'A. I think the reality of it was that generally, throughout surgery, it was not regarded — it was not common to enquire specifically about mortality at SAC visits. I am not sure about that, but as a generalisation, I think that is true.'[306]

276 Sir Terence explained that to the extent that the SAC visits looked at 'quality' they did so by reference to factors other than the surgical results of the consultants:

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[305] T17 p. 37 Sir Terence English
[306] T17 p. 26–7 Sir Terence English

'They would be primarily interested in what the facilities were in that hospital: the number of operating sessions that were staffed and available for training; the number of times that the Registrar could attend an outpatient clinic, ward rounds with consultants, how many times he or she was operating on their own or with consultant help, or assisting consultants. They had a logbook which was introduced in the late 1980s, I think, which all trainees, when they were registered with the SAC, had from then on to keep, and it was an account of every operation that they were involved with, either as the first operator or as the assistant, and they were required to keep information on mortality in that.

'That would always be discussed at the time of the visit. But that was looking at the trainee's operative outcome in terms of mortality rather than his boss's, or the unit's.'[307]

277 Visits by the HRC and the SAC to the same hospital at about the same time could produce different pictures of the institution inspected, as was the case at Bristol in 1994.[308]

278 Sir Terence told the Inquiry that, by 1986, when he chaired an RCSE and RCP Working Party[309] looking at NICS:

'… it was apparent that Bristol had not developed to the extent that we may have expected; that there was a problem with respect to the development at that time. It had certainly not increased its numbers hugely. But it was felt that there was still the potential there and that it would be worth reviewing it and seeing how it went in the next few years.'[310]

279 The 1986 Working Party concluded that on the basis of current and future likely demands for NICS, it was not possible to justify more than nine centres for England and Wales. Indeed, on the grounds of cost-benefit considerations alone, the view was that it might be advantageous to concentrate the work in as few as six larger centres. Sir Terence agreed that this conclusion would have meant that smaller centres such as Bristol, Newcastle and Guy's would have been vulnerable to de-designation.[311]

280 Sir Terence told the Inquiry that the Working Party intended the SRSAG and the local hospital management in Bristol to do the 'encouraging' of Bristol:

'Q. Were you there suggesting that the Supra Regional Services Advisory Group itself should do the encouraging?

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[307] T17 p. 28–9 Sir Terence English

[308] Compare the SAC visit of 8 July 1994 (RCSE 0002 0222) with the HRC visit of 13 July 1994 (RCSE 0002 0234). See, generally, T17 p. 39–56. Within the Royal College of Surgeons, Sir Terence told the Inquiry that, in essence, any cross-referencing between two such Reports would be more a matter of accident than design; see also T17 p. 57–8

[309] RCSE 0002 0009; RCP *'Working Party Report'*; note that Professor Hamilton was also a member of this Working Party

[310] T17 p. 87 Sir Terence English

[311] T17 p. 90 Sir Terence English

'A. Yes, and more generally than that: that one would hope that it would have filtered down from there to the hospital itself, to the management of the hospital and to the staff involved in that hospital; that a report like that, which would inevitably go to the supra regional units themselves, one would hope, that they would take account of it.

'Q. The encouragement that was to be given: what form did you think that would take?

'A. I think all sorts of ways: the provision of the facilities, if this was the block, appointment of an additional surgeon or anaesthetist skilled in paediatric anaesthesia – wherever the block lay, it ought to be corrected.' [312]

281 Sir Terence said that he did not think that there was anything that the Royal Colleges could do other than to draw attention to the need to 'encourage' Bristol:

'I do not think that there was any specific encouragement which either the Royal College of Physicians or the Royal College of Surgeons could have given to the BRI at that time to increase their throughput in paediatric neonatal and infant cardiac surgery.'[313]

282 He added:

'... this was a service which had been designated by the Advisory Group [SRSAG]. They had asked an opinion in the Colleges as to what the present situation was; they were given that opinion, but controlling the purse strings, as I have already said, really gave the Department a huge potential for some control over development. I can only suspect that that was not exercised in this particular case where it perhaps should have been.'[314]

283 Sir Terence explained that he saw the role of the Royal Colleges as being essentially reactive, setting up committees and producing reports when requested to do so by the SRSAG. He said:

'... I would put it to you that the Colleges have the responsibility of providing a professional report on a particular service or a particular issue when asked by the Supra Regional Services Advisory Group, who, on the basis of that report, ought to then require the local hospital to improve that service, because they are funding it.'[315]

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312 T17 p. 95 Sir Terence English
313 T17 p. 99 Sir Terence English
314 T17 p. 100 Sir Terence English
315 T17 p. 104–5 Sir Terence English

The inability to control 'proliferation'

284 Sir Michael Carlisle emphasised that the powers of the SRSAG were limited:

> 'But to get back to your question, we have no directional powers. Much is made of "designation" or "de-designation", but I do not feel we were doing anything else but trying to get the profession to control the proliferation of this service, and others, voluntarily.' [316]

285 The question was put to Sir Graham Hart, Permanent Secretary at the DoH from 1992 to 1997, whether the Secretary of State for Health could take steps to limit proliferation. Sir Graham said:

> 'My understanding is that ... some of the units that were doing these procedures outside the supra regional services arrangements had a good record. So why should he [the Secretary of State], in a sense, intervene? I think he created the right kind of environment in which the tendency would be towards limitation and specialisation, but he was not, as it were, putting down an absolutely rigid framework within which there was no room for movement at all.' [317]

286 In supplementary written evidence to the Inquiry dated 9 February 2000, Sir Terence said:

> '… the "profession" never had the power to rationalise the service. All we could do was to provide authoritative reports on what we felt was best for the service, in the belief that if we recommended de-designation of units in order to preserve the continued designation of the whole service, this would be acted upon by the SRSAG and the Department of Health. Being centrally funded services gave the SRSAG the power to cut off funding for units, which may not have made them stop immediately but which would have been a big disincentive to carry on the work.' [318]

287 In a supplementary written statement to the Inquiry dated 18 December 1999,[319] Dr Halliday made the point that control of proliferation was all the more difficult in the NHS after the reforms of 1991, since trusts had more freedom to decide which services they would provide and, at least in the early post-reform years, competition was encouraged.

288 Dr Halliday accepted that:

> 'In the interest of patients and the service generally all the evidence points to the need to concentrate the services in as few units as possible.'[320]

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316 T15 p. 57 Sir Michael Carlisle
317 T52 p. 25 Sir Graham Hart
318 WIT 0071 0067 Sir Terence English
319 WIT 0049 0034 Dr Halliday
320 WIT 0049 0019 Dr Halliday

He commented that:

> 'Managers in non-designated units who allow such services to be provided, must be held responsible. If funding was not provided, the clinicians could not undertake the work.'[321]

289 In his supplementary statement, Dr Halliday also accepted that the DoH, the Welsh Office and the Royal Colleges were not able to influence the referral pattern to the Bristol Unit.[322]

290 Dr Halliday accepted that the supra regional arrangements themselves were not sufficient to bring about the degree of control over the development of the service which would be needed to keep down the number of centres undertaking NICS.[323] He was asked:

> 'Q. ... If we go back to your statement, 49/3, the second sentence of your paragraph 3, you dealt with one reason for setting up Supra Regional Services Advisory Group arrangements and you say: "Another equally important reason was to control the development of such specialised services." Have I misunderstood what you meant by that?
>
> 'A. You have not misunderstood, but the arrangements themselves were not sufficient. I mean, clinical medicine is not something that is easy to control, as we see from every country in the world, so that a system like this required additional powers from other sources before they could actually impose control.'[324]

291 At the end of the first session of Dr Halliday's evidence, the Chairman questioned him about the difficulties of the supra regional provision of NICS:

> 'Q. ... The impression I have is that as a service – let alone we are talking about any particular unit – this particular service concerned with neonatal and infant cardiac surgery, etc., was doomed from the start, in that the very criterion of one year had an element of arbitrariness in it. The criteria for supra regional services could not appear to ever be met, at least in some of the units. There were either going to be too many units or there was not enough throughput; there was already an existing and established service; there was therefore an inability to make dirigisme from the centre actually work. There were no financial sticks, only carrots. And there was always the issue of clinical freedom, whatever that may mean, operating against

321 WIT 0049 0019 Dr Halliday
322 WIT 0049 0016 Dr Halliday
323 T13 p. 13 Dr Halliday
324 T13 p. 16 Dr Halliday

the interests. Would that be a fair set of observations, or have I got it completely wrong?

'A. No, that is entirely fair, but the other element of that is the situation where the Department was aware that there were allegations by reputable, experienced clinicians that there were children who were not being diagnosed and treated in this speciality. You cannot ignore that.

'We were aware that there were parts of the country in which we were very poorly covered, and other parts of the country which were over-generously provided, so there had to be something done about the service. The supra regional service advisory arrangements appeared to offer that mechanism, and it has worked in other services very effectively.

'We then consulted with appropriate Colleges and their view was that it should be a designated service. In fact, their view is to this day that it should be a designated service, but I agree with you, it has not worked. But we did try.

'I think that is all one would expect a Department to do: to try to make the system work. If it is not possible for a variety of reasons, and there are no powers to ensure that it happens, then there is nothing we can do.'[325]

[325] T13 p. 127–9 Dr Halliday

Chapter 8 – Management and Culture of the UBH and the UBHT

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The scope of this chapter

1 The focus of this chapter is the structure and culture of management at Bristol during the years of the Inquiry's Terms of Reference. The Inquiry also had access to authoritative expert evidence on the general managerial pattern in the NHS during the Inquiry period.

2 The chapter will chart the introduction of general management, the purchaser-provider split, the establishment of the United Bristol Healthcare (NHS) Trust (UBHT) and the development of clinical directorates at Bristol.

Dr Roylance's overview

3 Dr Roylance told the Inquiry that, over a period of years, there had been successive management changes designed, in his view, to address the mismatch between resources and demand in the NHS. He saw the introduction of general management to the NHS in the mid-1980s as one such change. In summarising his view of the changes over time, Dr Roylance said:

> 'The National Health Service is characterised by an accelerating gap between what is possible and what is affordable. Unless that fundamental issue is accepted and understood, nothing else makes a lot of sense.
>
> 'Over time, various initiatives to bridge that gap have been instituted. They include first of all, increased funding, and if there were time, I would demonstrate that the more money that is put into the Health Service, the bigger is the shortfall between what is considered possible and what is affordable.
>
> 'So although we all welcome increased funding, it will not bridge the gap.
>
> 'Then there was "Let us manage the Health Service (the Griffiths Report and so on) and make it more efficient, more effective and more business-like". As we have all seen, there is a tendency for that to divert money from healthcare into management. If you have what I call "professional managers" invited into the Health Service, it is not surprising that the amount of management is increased. In my judgment, in many Trusts, they are mostly managing management and not healthcare.
>
> 'Then there is the pious hope that evidence-based medicine would solve the problem and bridge the gap. That was fairly recent, five, six, seven years ago. In my view, all that does is sharpen the argument for more resources, because although

there may be a slight delay, it will justify enormous expenditure on new developments.

'There is the view, the very proper view, that the gap might be substantially reduced by health promotion … in my personal belief, until you separate health promotion – perhaps give it to local authorities as a responsibility – and recognise the Health Service as a disease service, you will not make any progress there …

'Could I say that the last initiative – this is part of the background of management – was what I would describe as "concealment" of the shortfall. That is by the GP fund-holding system, where you give the GP the money and he does not send anyone to hospital until he can pay for it …

'… a Chief Executive in a teaching hospital trust is constantly assailed with demands for more funds. These are not expressed in gentle terms … there are aggressive demands that patients are dying, the service is unacceptable. This comes in all the time.

'In my last year as Chief Executive, the novel idea of clinical governance came in. It was a new idea and it followed the previous corporate governance which crudely could be said, "You must not put your hand in the till", but clinical governance was a very new concept that the managing authority, the trust and the Chief Executives, should be responsible for the quality of clinical care.'[1]

General management

4 General management was introduced in Bristol in 1985. Dr Roylance was appointed as District General Manager (DGM) of the Bristol & Weston District Health Authority (B&WDHA) on 1 April 1985. He noted:

'The creation of the post of District General Manager ("DGM") was in response to the reorganisation of the NHS as recommended in the Griffiths Report. It was my responsibility as DGM to introduce the "general management function" in place of the then existing consensus management system.'[2]

He was 'instructed … to produce a management structure for B&WDHA by 30 April 1985.'[3]

5 At this time the B&WDHA was divided into two 'Units', known as Central and South. The Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC) were both part of the former (see Figure 1).[4] The BRI was itself a sub unit and the BRHSC and the maternity hospital were (together) another sub unit.

1 T25 p. 162–9 Dr Roylance
2 WIT 0108 0004 Dr Roylance
3 WIT 0038 0009 Ms Charlwood
4 WIT 0106 0012 Mr Nix

Figure 1: Bristol and Weston District Health Authority unit structure

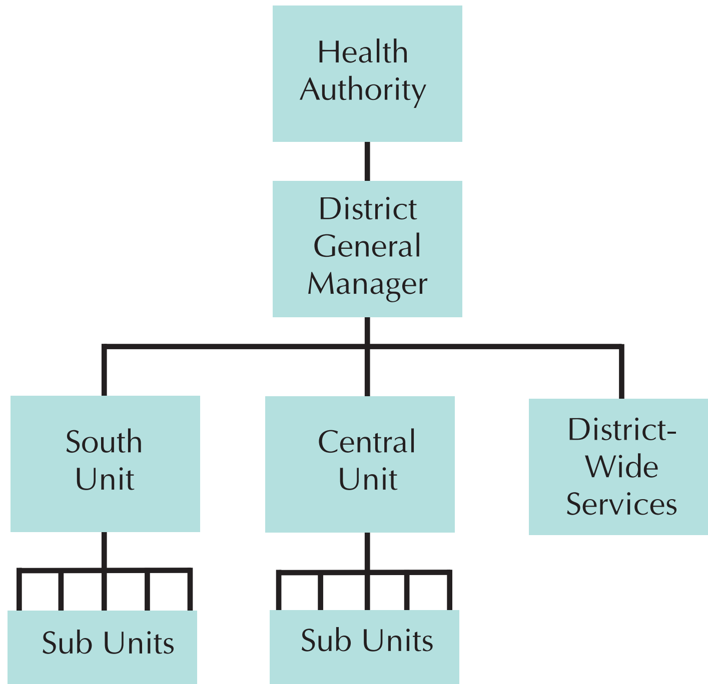
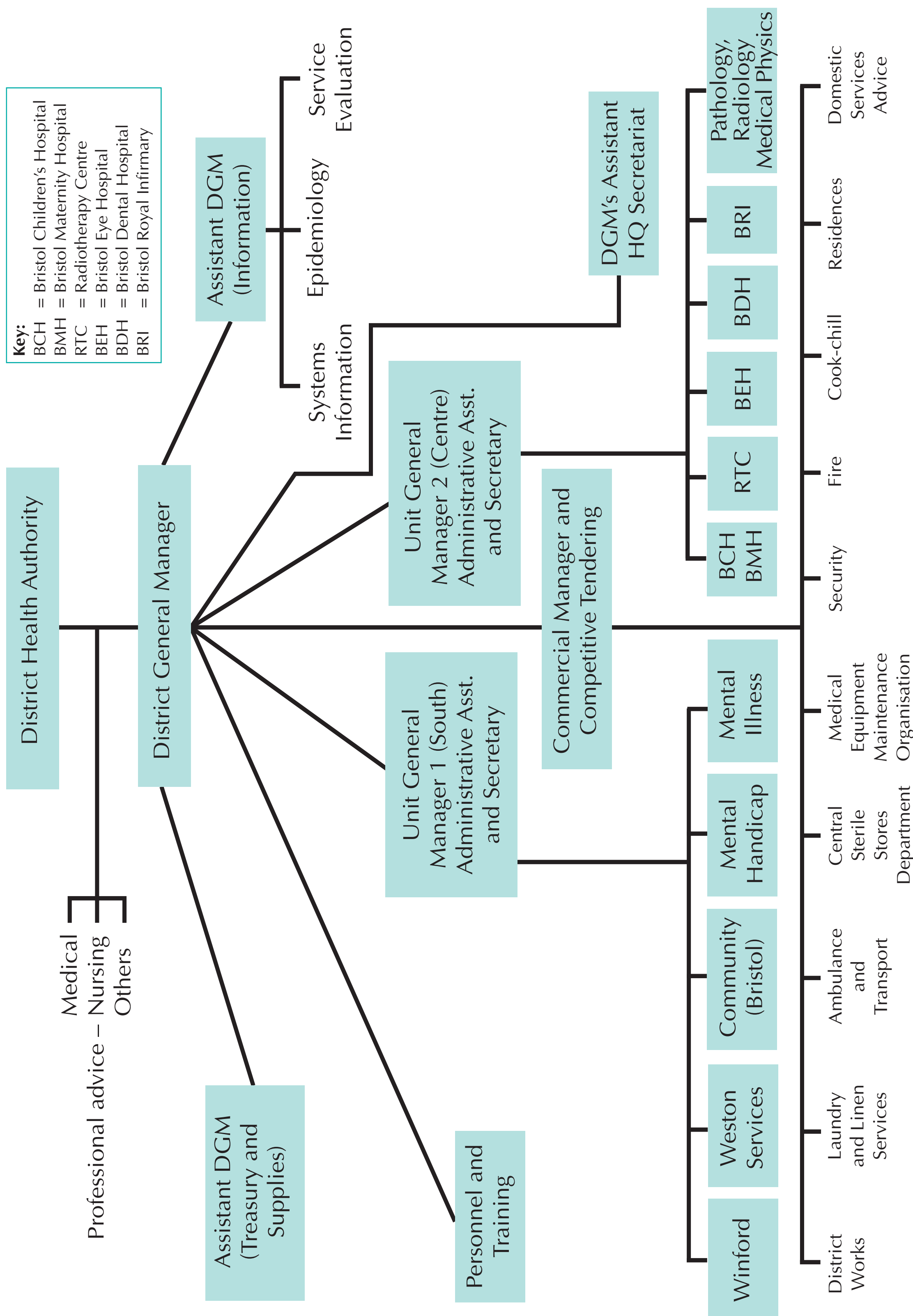
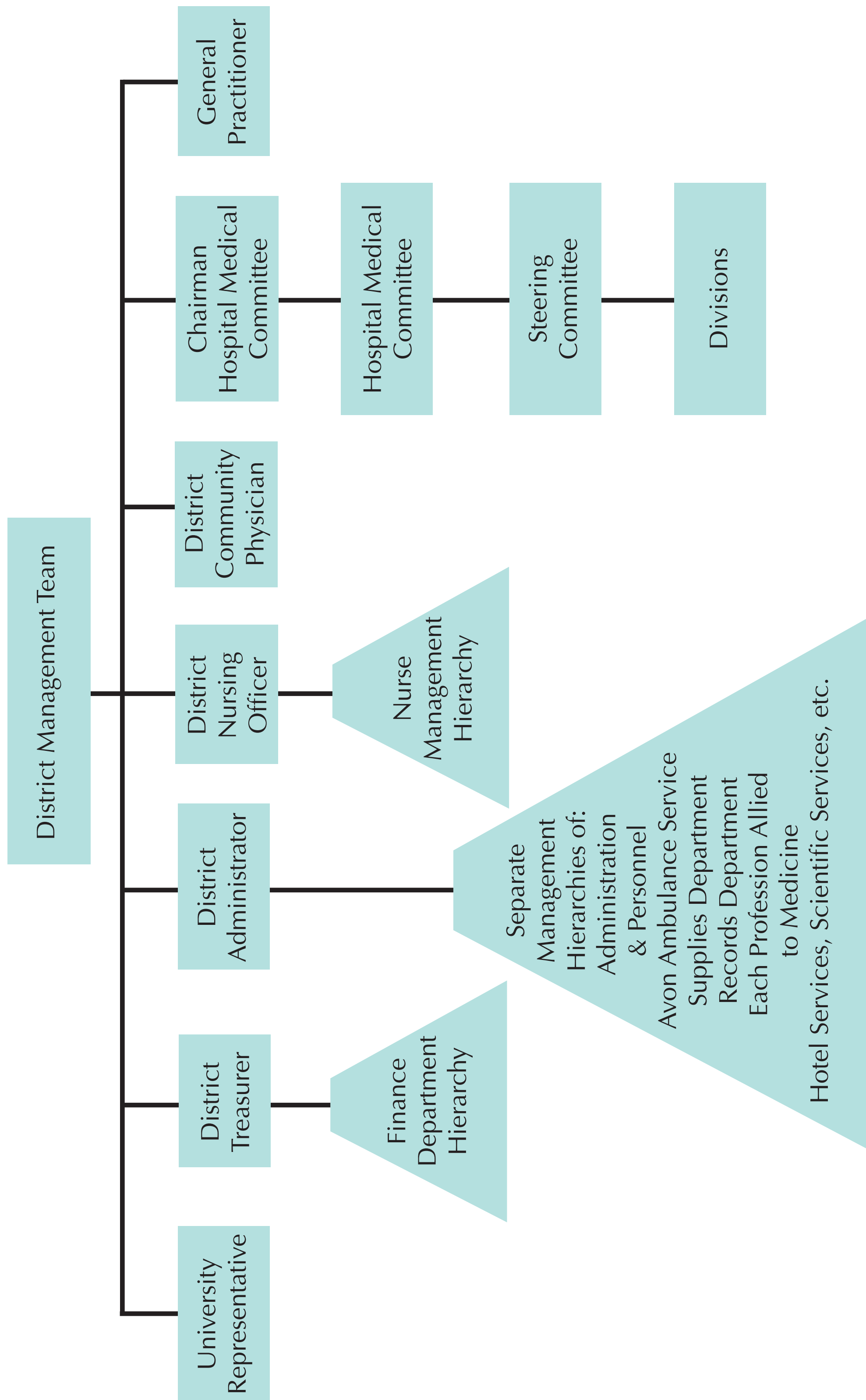


Figure 2: Management structure of B&WDHA, 1985[5]



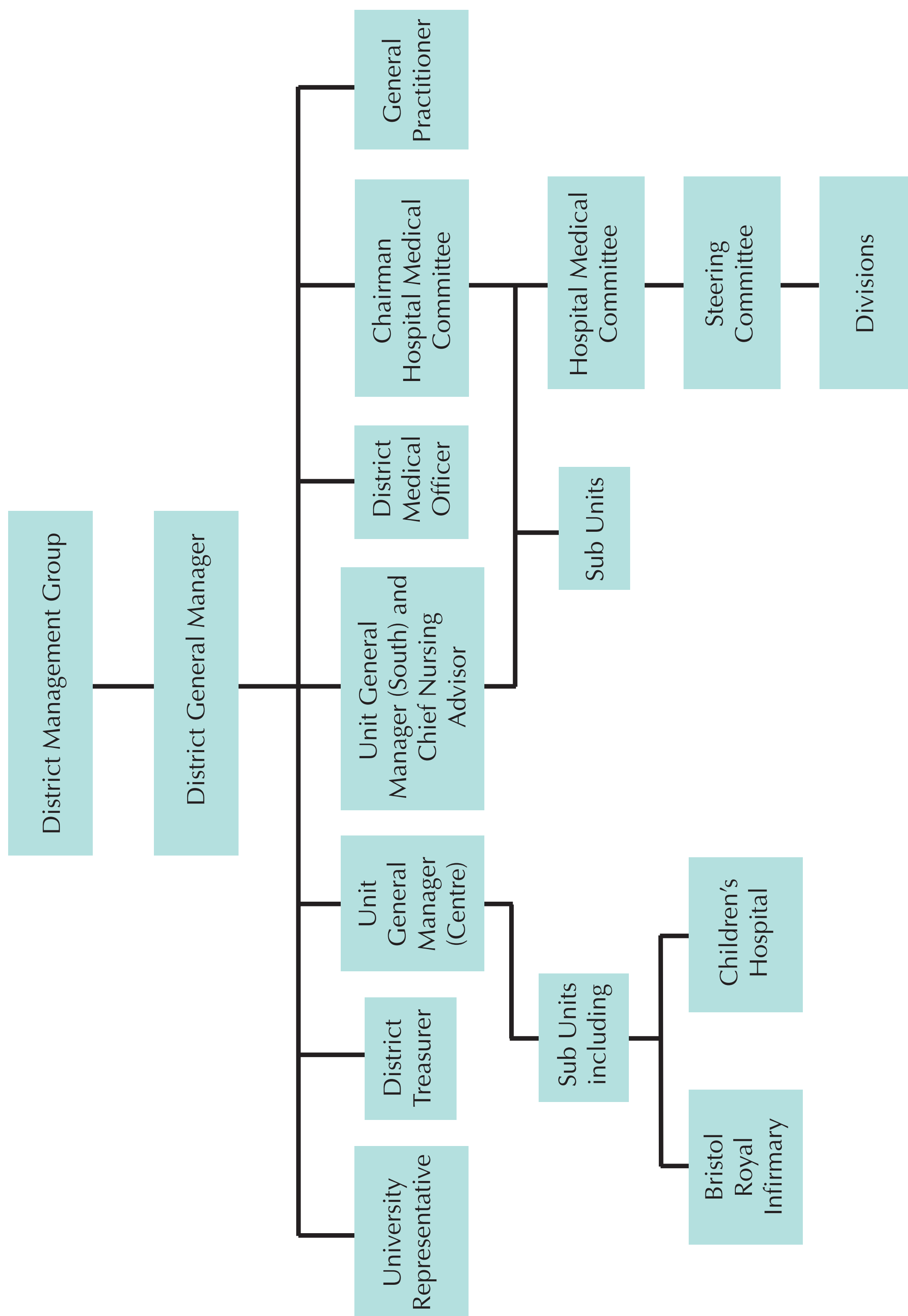
[5] WIT 0038 0067 Ms Charlwood

Figure 3: District Health Authority circa 1985[6]



6 WIT 0108 0040 Dr Roylance

Figure 4: District Health Authority circa 1987[7]



[7] WIT 0108 0041 Dr Roylance

6 In May 1985 the B&WDHA approved the new general management structure.[8] In oral evidence, Dr Roylance explained the new organisation represented by general management, and his part in it:

> 'So in 1985, being appointed the first Director General Manager, I had two primary responsibilities; there were others, but the two primary responsibilities were to introduce the general management function, by which I mean getting rid of functional management, nurses being managed by nurses, physiotherapists by physiotherapists, administrators by administrators. It could be said at that time when I took up the District General Management role there were about nine different health services in the district coming together only at district level.
>
> 'In introducing the general management function, it was expressly required to delegate operational management decisions as near to the bedside as possible.
>
> 'To relate that to the financial issues that I have just mentioned, the district had been overspending annually by something of the order of a million pounds, which was at that time well over 1% of budget. Until that time, there had been various sources of what the Health Service calls non-recurring money which bailed out the districts at the end of each year and those sources had by then dried up. So in addition to introducing the general management function, it had the very real task of redressing the overspending and ensuring that the health district provided the best possible care from within the finite resources allocated to it.'

7 He added:

> '… It goes without saying that the business we were in was treating patients, was preventing ill health, was diagnosing and treating ill-health that occurred, and offering palliative care where curative care was not possible; that is the business we were in. I was taking it as read that in the reorganisation, that was directed to improving the quantity and quality of that patient care. But my appointment was contingent upon a particular form of management to achieve that, and so the answer to your question; what was the business we were in, what was the organisation to which I had been appointed the District General Manager? It was a healthcare organisation. Therefore, the responsibility of the organisation was my responsibility; that was patient care.'[9]

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8 See also Chapter 5
9 T24 p. 9–11 Dr Roylance

8 Mrs Margaret Maisey[10] described the reasoning behind the directorate system in oral evidence:

> 'A. The whole philosophy behind the introduction of Clinical Directors and directorates was to involve medical people in management. Even at the introduction of general management, medical management had stayed the same as it had since 1948, so far as I can make out. It was a separate entity. It managed itself. Clinical directorates was an effort to move those people into a management role, to understand why they could not have the money that they thought they ought to have; why management had to address the issues to satisfy the Department of Health, to whom we were all accountable, which I have to say, doctors did not always believe.
>
> 'Q. I understand one of the key features of the directorate system was that the Clinical Directors who were clinicians were going to be responsible for managing a directorate, they were going to be "in charge of their own show" to a large extent?
>
> 'A. That is right.'[11]

9 Mrs Maisey also described the personal effect of the changes:

> 'The effect on my own career was significant. For example, the introduction of General Management meant that if I was to influence policy and resourcing I had to give up my full-time vocational nursing career which I did when I became a Unit General Manager at the B&WDHA South Unit.'[12]

10 Mr Graham Nix, Director of Finance and Deputy Chief Executive, UBHT, described the effect of the introduction of general management as 'making the top of the pyramid sharper'[13] because:

> 'Prior to this, you would have actually had a district management team with a District Administrator, District Treasurer, public health doctor, and the Chairman of HMC would have actually managed the organisation as a team, working to the Health Authority, rather than in this situation, when Griffiths was making one person responsible for the organisation and its delivery.'[14]

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10 Mrs Maisey's roles were: South Unit General Manager and District Nurse Adviser (1986–1989); Central Unit General Manager and District Nurse Adviser (1989–1991); UBHT Director of Operations and Trust Nurse Adviser (1991–1996); and UBHT Director of Nursing (1996–1997)

11 T26 p. 53–4 Mrs Maisey

12 WIT 0103 0002 Mrs Maisey, who also sets out at WIT 0103 0046 – 0057 a brief history of management in the NHS 1980–1992

13 T22 p. 17 Mr Nix

14 T22 p. 17 Mr Nix

11 Dr Roylance explained that, in the early days of general management, doctors were not part of the management structure (although Dr Roylance was himself a radiologist):

> '… we had not, at that time, incorporated the medical staff into the management structure. That was fairly standard throughout the Health Service, which first of all started to create a general management structure, but it did not include the doctors. We evolved this slowly because there was a considerable reluctance and anxiety on a number of the functional management, shall we say, professions allied to medicine, who, up until that time, had a district manager of their professional staff as a separate hierarchy within the trust, and it took time to determine how that could be changed into a professional advisory structure and the members of the profession to be incorporated appropriately into the sub units.'[15]

12 Miss Catherine Hawkins, South Western Regional Health Authority (SWRHA) Regional General Manager from August 1984 to December 1992, did not endorse the selection of Dr Roylance as DGM. She said:

> 'I think it is sufficient to say that he would not have been my first choice for the district management job in 1984 … John Roylance was a brilliant doctor and a very, very good Medical Director, but I did not see him as a General Manager in the true sense of management.'[16]

13 She went on to say:

> '… it was more difficult for him as a doctor managing doctors, and therefore, because he had been there for quite some time, it was very hard for him to appreciate the real role and function of a manager as opposed to being one of the colleagues in a set up of a teaching hospital, which is a very different climate to a non-teaching authority.
>
> '… he did not fully understand the role of a General Manager. He did the best he could, to the best of his ability, but he was not a trained manager in the real sense.'[17]

14 On the other hand, Dr Ian Baker, then District Medical Officer, thought:

> '… that John Roylance was a reassuring District General Manager of longstanding within the District, and I think that helped where other senior managers may have required support … Dr Roylance himself saw himself as a doctor and felt it was appropriate to lead healthcare, health services, provision as a doctor, to accept the

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15 T24 p. 29 Dr Roylance
16 T56 p. 21–2 Miss Hawkins
17 T56 p. 123 Miss Hawkins

general management challenge and position, and I think he viewed doctors as being in a similar position when it came to clinical divisions and directorates.'[18]

15 In the late 1980s, Dr Roylance was involved in a research project undertaken by Dr Sue Dopson[19] in relation to management matters. Dr Dopson provided the Inquiry with various notes and transcripts of interviews she conducted with Dr Roylance. One extract which discusses the power of his role illustrates Dr Roylance's view of himself as DGM:

> 'It's more in other people's minds than mine. I do my best to tell everybody that I haven't got power, they must do it, but I can actually bully anybody to do anything. I have enormous power which I'm not prepared to use except in very specific situations. I can hire and fire anybody, I don't need to ask anybody's permission for anything.'[20]

16 Dr Dopson commented:

> 'He exercises power primarily through influencing other people, not directly.'

She added later:

> 'He is comfortable with the power, "I believe democracy is a myth, it's based on the belief that the majority have some monopoly of wisdom and they usually haven't. The second thing is people think they understand and they don't."'[21]

17 In Judith Smith and Professor Christopher Ham's paper, commissioned by the Inquiry and entitled *'An Evaluative Commentary on Health Services Management at Bristol: Setting Key Evidence in a Wider Normative Context'* (the Ham/Smith paper), they commented on the fact that it was unusual that Dr Roylance was appointed General Manager. They wrote:

> 'The decision to appoint a doctor (Dr Roylance) as a district general manager was unusual as only 15 of 188 DGMs in England in 1986 came from a medical background (Ham, 1999). Even more unusual was the decision to appoint a doctor from a clinical background to this post. Most of the clinicians who became general manager were appointed at the unit level rather than to district posts; and the doctors who were appointed as DGMs tended to come from public health backgrounds or related posts.'[22]

18 Dr Roylance agreed that he was unusual in being a clinical consultant in general management. He explained that clinicians in general management tended to have a

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18 T36 p. 38–9 Dr Baker
19 Dr Dopson is a university Lecturer in Management Studies and a Fellow in Organisational Behaviour at Templeton College, Oxford University
20 INQ 0027 0023; interview with Dr Roylance, 5 June 1987
21 INQ 0027 0023; interview with Dr Roylance, 5 June 1987
22 INQ 0038 0004; Ham/Smith paper

community physician background.[23] He had a wealth of experience in the district and had at one time been the Chair of the Hospital Medical Committee (HMC). He said:

> 'I really had very intimate knowledge of the district at the time, how it had got there, what the past history was, what the aspirations of people were … I think I knew all the consultants personally. I knew a large number of other people personally, too.'[24]

19 Dr Roylance told the Inquiry that, before general management, the exercise of clinical freedom was independent of resources, and management had to use quite crude measures to try to prevent overspending. He said:

> 'The exercise of clinical freedom … was entirely independent of resources and … management, up until that point, had to use quite crude measures to try and prevent the major overspending of a service, things like closing operating theatres, closing wards, so it was not possible to overspend, because there was a complete separation of the exercise of clinical freedom from the responsibility of staying within budget.
>
> 'That is what the general management function was intended to address.'[25]

20 Dr Baker described the management chain in the era of general management, with particular reference to paediatric cardiac services. He said:

> 'With the advent of District General Management in 1985 management of services was from the District General Manager, Dr J Roylance to the Unit General Manager of the Central Unit (initially Mr J Watson followed by Mrs M Maisey) to Sub Unit General Managers who existed separately for the BRI and BRHSC. Professional advice at District level was given by the Chair of the Hospital Medical Committee. He was fed advice by Chairs of the Clinical Divisions of which there was one for paediatric services and one for surgical services.'[26]

21 In his statement Mr James Wisheart, consultant cardiac surgeon and Medical Director UBHT (1992/94), set out a description of the managerial and medical advisory structures prior to 1990–1991.[27] In relation to management during this period, Mr Wisheart's description was:

> 'Within the management structure lines of responsibility were upward through more senior managers, through the General Manager and the District Management Group to the Health Authority. The medical structure was advisory and in

23 T24 p. 40–1 Dr Roylance
24 T24 p. 43–4 Dr Roylance
25 T24 p. 42 Dr Roylance
26 WIT 0074 0010 Dr Baker
27 WIT 0120 0011 – 0012 Mr Wisheart

management terms did not have any executive responsibility. In practice, of course, the clinicians and the managers worked very closely together.'[28]

22 On the management side, communication was along the lines established by general management. On the clinical side, lines of communication would operate in various ways dependent on the circumstances, for instance outpatient clinics, ward rounds, formal and informal clinical meetings and, where necessary, clinico-pathological conferences.[29]

23 Dr Hyam Joffe, consultant cardiologist, thought that:

> 'Within the BCH [Bristol Children's Hospital] cardiac unit, communication among doctors and between doctors, nurses, radiographers and technologists was entirely satisfactory'[30] and 'Communication between consultant cardiologists at BCH and the consultant paediatric cardiac surgeons at BRI were effective and harmonious.'[31]

24 Mrs Fiona Thomas, Clinical Nurse Manager, in her written statement to the Inquiry, described the arrangement from the point of view of nurses:

> 'As staff nurse, 1986–1988, my reporting lines would have been first to the sister in charge and then to the In-Service Manager. I had very little or no contact with the managers during this time. I do not recall the managers visiting the Unit. The Unit was very much run by the surgeons.'[32]

25 Dr Stephen Jordan, consultant paediatric cardiologist, described the service as:

> '… consultant run and there was little perceived need for outside management involvement except in terms of nursing staff, technical staff and support services.'[33]

26 Dr Joffe described the organisation at the BRHSC when he joined in 1980:

> 'On my arrival in England in 1980, I was surprised to find that there was no hierarchical system among consultants. All consultants were considered equal in status, whether very senior or newly appointed, apart from a certain deference to age. This continued throughout the 1980s until the reforms of 1991, when those consultants appointed as Medical or Clinical Directors gained status and executive power, but only in managerial terms.'[34]

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[28] WIT 0120 0011 – 0013 Mr Wisheart
[29] WIT 0120 0013 – 0014 Mr Wisheart
[30] WIT 0097 0166 Dr Joffe
[31] WIT 0097 0167 Dr Joffe
[32] WIT 0114 0003 Fiona Thomas
[33] WIT 0099 0011 Dr Jordan
[34] WIT 0097 0138 Dr Joffe

27 As to medical and nursing staff, Dr Joffe said that they:

> '… contributed very little to management during the 1980s. Following the establishment of trust status in 1991, their involvement in managerial issues has been much greater.'[35]

28 On paediatric cardiac services in the 1980s, as a whole, he said:

> '… the medical and surgical elements were placed managerially into the departments of general paediatrics and general paediatric surgery, respectively.'[36]

The purchaser-provider split and the establishment of the UBHT

29 The Government's plan for the reorganisation of the Health Service was set out in the 1989 White Paper *'Working for Patients'*.[37] The main thrust of the change:

> '… lay in the creation of a competitive environment through the separation of purchaser and provider responsibilities and the establishment of self-governing NHS trusts and GP fundholders.'[38]

30 The UBHT formally came into existence on 1 April 1991. Thereafter, the UBHT was the 'provider' of healthcare services at the BRI and the BRHSC (and elsewhere) and the B&WDHA (later the Bristol & District Health Authority, B&DHA) was the purchaser of that healthcare.[39] Dr Roylance described his responsibility in these changes:

> 'In 1991 it was my responsibility as District General Manager to divide the District into a continuing District Health Authority, which became the purchasing authority for the District.'[40]

35 WIT 0097 0139 Dr Joffe
36 WIT 0097 0139 Dr Joffe
37 *'Working for Patients'*. London: HMSO, 1989. (Cm 555)
38 INQ 0038 0006 – 0007; Ham/Smith paper
39 See Chapter 6 for a further explanation of the purchaser-provider split
40 WIT 0108 0005 Dr Roylance

31 Dr Roylance told the Inquiry that, in relation to cardiac services:

> 'The people who decided [what] the pattern of cardiac disease treatment should be … were the purchasing health authorities, not the providers and not the Trust Board.'[41]

He also said:

> 'The decision of whether cardiac services should be increased and that money should be allocated to it at the expense of the allocation of the same money to other services is the sole responsibility of the purchaser.'[42]

32 Ms Deborah Evans[43] explained the position in the District at the time of the purchaser-provider split:

> 'There were many challenges. I think that there was an enormous technical change in the Health Service at that time, which was to do with being able to track all the patients that were resident in a particular Health Authority and to follow them through hospital care and turn all of that into service agreements; but also, looking at the public health side of it, health authorities had a responsibility for the first time only to look at the needs of their local populations and not to be involved in running services. So I think the changes gave rise to an increased and more particular focus on local health needs from a public health point of view, which was helpful, and I think the other side of the separation from the provision of services meant that managers and clinicians had to go through a huge cultural change in getting used to huge organisations working together on the planning of healthcare.'[44]

33 Dr Roylance expressed himself a keen supporter of the purchaser-provider split.[45] However, Dr Roylance emphasised that a trust, as a provider unit, could not dictate what services the health authority should purchase. He said that at times this made strategic planning difficult. Dr Roylance mentioned the split site cardiac service in this context. He told the Inquiry:

> 'There is another strategic plan … and that was to rebuild and reprovide the Children's Hospital. We had to do that on no more than an understanding that the purchasers would continue to purchase children's services from us and indeed some children's services which are currently purchased from others.
>
> 'Q. … I was going to ask you, if it was the case that strategic planning meant no more than being able to respond to that which other people had determined and

41 T24 p. 152 Dr Roylance
42 T24 p. 160 Dr Roylance
43 Associate Director, and latterly Director, of Contracting for B&WDHA from April 1991, and Director of Contracting for B&DHA from October 1991
44 T31 p. 23–4 Ms Evans
45 T24 p. 165 Dr Roylance

their strategic plans, how on earth does one plan a major development such as the development that is just taking place?

'A. I have to say, with difficulty, and I was very pleased that before I left, plans had reached an achievable position and the Children's Hospital is being built, but I would not like to minimise the very substantial difficulties with that.

'Q. So put another way, the planning for the future of the Trust and the hospitals within it may depend upon the reaction of other people, but on the other hand, the reaction of purchasers may to an extent be anticipated and plans placed, formed, on that basis?

'A. I think that is right. …

'Q. So there is scope for strategic planning, notwithstanding that whether the plans ultimately come to fruition may depend upon the co-operation of others who hold the purse strings?

'A. If you strategically plan a new unit like the Children's Hospital and then do not get contracts for it, I think somebody ought to have the situation discussed with them. I mean, what I am saying here is that the cardiac disease was a major cause of death and demand in the regional services is high and so on, and this is an issue that we are not meeting the demand for cardiac services and we were not committed to developing the service. Of course the Trust is and was committed to developing the service, but only as far as the purchasers were committed to buying that service.

'Q. … it would no doubt be helpful, would it not, … for the Trust Board or the Trust to have a strategic plan, if it wished to do so, to encourage purchasers to behave so that investment and development of cardiac services might take place?

'A. That is usurping the purchaser role. That is the provider saying that we, as providers, would like to provide this service.[46]

'Q. … is there anything intrinsic in the system which means it is the usurpation of the purchaser's role for the provider to encourage the purchaser to make a particular purchase and anticipate that he might do so?

'A. Yes. In the decision of the purchaser to place contracts, there is a negotiation. The negotiations, by necessity, are specialty by specialty. What is needed is to influence the purchaser in their determination of the balance of resources they wish to put to each service. … What I think I am trying to say in great detail is that the provider trust has a very real and challenging problem of being in a position to provide whatever service the purchasers in their wisdom decide they need. But it

[46] T24 p. 155–8 Dr Roylance

is not the role of the provider as a trust. It may be as members of the public, but as a trust it is not their role to decide the pattern of care that the purchasers should provide. …

'Q. … then the provider must necessarily anticipate to some extent the demands which a purchaser is likely to make upon it?

'A. Yes, and it is for the directorate who are entering into that sort of conversation to advise the Trust Board what he believes the purchaser might buy.'[47]

Internal opposition to trust status

34 In the period 1989 to 1990 the UBH were considering the move to trust status. In the July 1990 '*Application for NHS Trust Status*', the proposed intention of a move to trust status was summarised as follows:

> 'The proposed United Bristol Healthcare Trust will take the new opportunities offered under the Act to involve local people more and to develop its services to provide not only the best health care for patients but also the best teaching for doctors, dentists and health care professionals of the future. We have chosen to express these aims of the Trust in the two words "Teaching Care".'[48]

35 However, not all consultants and hospital staff supported a move to trust status. In fact a majority of the staff were suspicious of the potential change and whether there would be any associated benefits.[49] Mr Peter Durie[50] recalled:

> '… there was considerable concern by doctors in particular that somehow the creation of trusts was going to break up the NHS. Those of us who were putting in the application were absolutely convinced that was not so. We were totally committed to the National Health Service and still are, and did not see that this put the NHS at risk at all. We believed that over the months we would be able to persuade sufficient people that the risk they saw did not exist.'[51]

36 As early as 10 May 1989, at a meeting of the B&WDHA Steering Committee, there was discussion about obtaining the views of medical staff towards a move to trust status:

> 'Dr Thomas advised that he intended to ballot all medical staff in the Bristol and Weston Health Authority to ascertain their views as to whether they wished to support the option of self-government for the UBH [United Bristol Hospitals]. Mr Wisheart considered that the information at present available was insufficient to allow for any informed opinion but that medical staff should still be balloted.'[52]

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47 T24 p. 160–2 Dr Roylance

48 UBHT 0060 0006; *'Application for NHS Trust Status'*

49 UBHT 0074 0253; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*

50 Mr Durie was Chairman of B&WDHA from April 1986 to March 1990 and Chairman of the UBHT from April 1991 to June 1994

51 T30 p. 56–7 Mr Durie

52 UBHT 0113 0565; Steering Committee meeting, 10 May 1989

37 At the meeting of the B&WDHA on 18 September 1989:

> 'The Chairman invited Ms Betty Underwood and Mr John Vickery representing the Joint Trade Union Committee of Bristol and Weston staff to talk to the Authority about their views of the Government's White Paper on the future of the NHS.'[53]

38 Amongst the various concerns expressed by these representatives, was whether the views of staff would be heard in the making of major decisions. Mr Vickery said that:

> '... the Authority's staff wanted consultation on important matters. At the meetings with general management, the staff side was always passed information but normally there was no chance to influence decisions and he thanked the Authority, therefore, for the opportunity to put before it the Unions views on the White Paper. In developing the theme of consultation he used the analogy of schools where parents could be balloted as to whether they wished their children's school to become self-governing, whereas there was no such choice in the NHS White Paper. He concluded by saying that the Health Service existed for the benefit of the general public to provide health care at the point of need.'[54]

39 In the interim, the NHS required business plans to be put in place and that the DHAs prepare to separate the purchaser and provider functions. Dr Roylance introduced a paper on changes to the management structure to the B&WDHA at their meeting on 16 October 1989. The minutes of the meeting recorded:

> 'The Secretary of State had asked for business plans to be prepared by the end of March for Bristol health services and Weston health services. These would be the subject of informal consultation during preparation and formal consultation by the Regional Health Authority. It would be submitted to the Secretary of State with the results of consultation and the comments of the RHA.
>
> 'Dr Roylance said that he had therefore created three management teams as set out in his paper. No substantive changes to any person's contract would be made until the end of March 1990 and all the changes had been achieved by secondments. Mr Durie said that as a Health Authority, all Members continued to hold the statutory obligations and duties to provide the best health care with the available resources. The White Paper would not be implemented until an Act of Parliament was passed in late 1990 or early 1991.
>
> '… Mr Durie confirmed that the Chairman of the Hospital Medical Committee would remain the Authority's formal advisor. He explained that the instructions now being received from the NHS Management Board meant that the Authority would have to divide into the purchaser and provider roles. This was separate from any moves towards possible self-governing status for any part of the District's

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53 UBHT 0249 0148; B&WDHA meeting, 18 September 1989

54 UBHT 0249 0149; B&WDHA meeting, 18 September 1989

services. When the business plans were complete, the Authority would assess whether it considered that self-governing was the correct future for its services.'[55]

40 At a later meeting of the B&WDHA in November 1989, it was noted that:

> 'Through the Dean of the Faculty of Medicine there were extremely good relations with the University and this would remain.'[56]

41 Professor Gordon Stirrat[57] agreed that great efforts were made to include the University in the move to trust status. He said:

> 'I know very well that the then Chairman of the authority, Mr Peter Durie, was extremely anxious to make sure that the University was on board as far as this was concerned. They worked very hard and worked hard with my predecessor as Dean and then subsequently myself to try to make sure that we were part of the application. So that really was my main direct contact.
>
> '… I think Mr Durie did a very, very good job of putting the case for the Trust, and I think a great deal of credit goes to him for that, both in relation to my health service colleagues but particularly in the University.'[58]

42 At a meeting of the HMC on 20 December 1989, Mr Stephen Boardman, Director of Planning and Estates, and Mr Nix presented the Bristol Business Plan and discussed it in light of the forthcoming ballot of staff. In the minutes, Mr Boardman is recorded as saying:

> '… that the Business Plan was basically an application for a self-governing trust and that Bristol and Weston amongst many other districts had been invited to submit such applications by the end of March 1990. The alternative to non-acceptance of an application was to have a DHA managed provider unit.'[59]

43 Mr Boardman then went on to explain how the directors of a trust would be appointed:

> '… the Chairman of the Trust would be appointed by the Secretary of State and the five non-executive directors by the Regional Health Authority. The bill allowed for five executive directors who would be appointed by the Chief Executive and Chairman but four of them had to be from nursing, medical, finance and

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55 UBHT 0249 0144; B&WDHA meeting, 16 October 1989
56 HAA 0142 0091; B&WDHA meeting, 20 November 1989
57 Professor of Obstetrics and Gynaecology at the University of Bristol and Honorary Consultant at the UBHT from 1982. He was also B&WDHA Chairman of the Division of Obstetrics and Gynaecology from 1988 to 1990, Dean of the Faculty of Medicine from 1991 to 1993, and Pro-Vice Chancellor from 1993 to 1997
58 T69 p. 13–14 Professor Stirrat
59 UBHT 0098 0366; HMC meeting, 20 December 1989

management leaving only one director who could be appointed without a specific function.'[60]

44 According to Mr Durie, however, it was already known in Bristol who the executive directors would be prior to the inception of the Trust as a 'shadow trust' had been established. Mr Durie explained that:

'That was all part of the process of working up the Trust application. Part of it was to show credibility: that if we were given trust status, we had the competence to run this new Trust and those people had already shown their competence in the Health Authority so it was an evolutionary one.'[61]

45 In fact, in the executive summary of Bristol's '*Application for NHS Trust Status'*, much was made of the continuity in leadership:

'The style and structure of management in the Trust will be founded on continuing strong leadership.'[62]

46 Dr Stephen Jordan, consultant cardiologist, described the position within the hospital under the auspices of the 'shadow trust':

'… starting April 1990, we had sort of shadow trusts. Everything was worked out in exactly the same way as it was going to be the following year but no money actually changed hands, if you like, and no one actually physically signed contracts and so on.

'For the year before that, that is the year beginning 1st April 1989, we were busy drawing up the shadow contract for the following year. We were instructed to do this on the basis of the workload for the previous two years and on the strict understanding that one thing that would not happen would be any … expansion of workload in relation to the new Trust status. I mean this was part of the general "aura" of the new status: that although it was going to sort of start off with the ability to change everything, the promise was it was not going to actually change suddenly and therefore it would be related directly to what was going on before.'[63]

47 Dr Roylance described the benefits of the purchaser-provider split as follows:

'When we were at District … we had a finite sum of money, which everybody, including me, agreed was woefully inadequate, and we had what people have described as an "infinite demand"… And this I tried to say is a fundamental challenge to the health service. You do not resolve it by pretending it was not there or wishing it was not there, you have to address it. I believe one of the major steps

60 UBHT 0098 0367; HMC meeting, 20 December 1989
61 T30 p. 25 Mr Durie
62 UBHT 0060 0011; *'Application for NHS Trust Status'*
63 T79 p. 163–4 Dr Jordan

> which helped in addressing that issue was to separate the very difficult task of deciding what was necessary from the challenge of delivering what was decided. …'[64]

48 Dr Roylance emphasised his view that it was one of the functions of the purchaser to satisfy itself that the healthcare it was purchasing was producing a maximum benefit for the community.[65]

49 Dr Stephen Bolsin, consultant anaesthetist, wrote to Dr Roylance on 25 July 1990 after having read the '*Application for NHS Trust Status'*. The evidence as to the significance of a comment in the final paragraph of this letter is reviewed in Chapter 25. He was asked about this letter and his attitude towards a move to trust status in the course of his evidence to the Inquiry. He said:

> 'I think my attitude was that I was not necessarily sure that they were going to improve patient care and under those circumstances a change would not necessarily be for the better. I think I was reasonably ambivalent to trust status for the hospital.
>
> '… I think I had not been persuaded by any of the meetings that we had had as anaesthetists or doctors that trust status had advantages for us as clinicians involved in the delivery of patient care.'[66]

50 According to Dr Roylance he had many letters of this kind:

> '… a lot of people spoke to me, to try and evaluate what the impact of trust status was. This was such a letter. I had a lot of them, of people wanting to know whether trust status would make their aspirations more realistic or less realistic and I told them it would not affect that.'[67]

51 At a meeting of the HMC on 16 May 1990, Mr Durie was invited by the Chairman, Mr Christopher Dean Hart, to speak in favour of trust status, and Mr Geoffrey Mortimer, who was at that time the Chairman of the B&WDHA, was asked to state the case for remaining as a directly managed unit. Mr Durie explained why he and Mr Mortimer had been chosen to talk on the issue:

> 'Because Mr Dean Hart knew that I was in favour of what is now UBHT … because of the benefits … Mr Mortimer was the Chairman who took over from me … in 1990. He was strongly opposed to the whole concept of trusts anywhere … Therefore, Mr Dean Hart had somebody who was in favour and somebody who was vehemently against.'[68]

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64 T25 p. 153–4 Dr Roylance
65 T25 p. 21–2 Dr Roylance
66 T80 p. 92 Dr Bolsin
67 T88 p. 72 Dr Roylance
68 T30 p. 21 Mr Durie

52 The minutes record that Mr Dean Hart said that:

> '… consultants in Avon had voted overwhelmingly against trust status on the information then available. Since that time further information had been forthcoming from the Department of Health and from those who had been asked to produce a business plan.'[69]

53 Amongst the reasons cited by Mr Durie in favour of trust status were the following:

> 'The size of the proposed Bristol Trust was such that it would make an easier working relationship with purchasers whilst it would also, through its board membership, have a direct relationship with teaching matters. With its non-executive members it would have a much stronger marketing base than other providers and these members would act as a sounding board for proposals from the executive members.
>
> '… the proposed management team for the Bristol Trust had a proven financial and managerial record and he felt that it was right to apply for trust status as early as possible as it was unlikely that the government would allow the first ones to fail.'[70]

54 However, Mr Mortimer was concerned that:

> '… Trusts were a moving target and the government had brought in more controls on them than envisaged in the White Paper and he believed that the capital freedom amounted to very little.'[71]

55 He believed that:

> '… the advantages of directly managed units were that they existed currently and were still evolving and that the purchaser/provider role in such units had been well proven in industry. The retention of the link at DHA and DGM level provided a means of ensuring the overall interests were given priority.' [72]

56 Mr Mortimer resigned shortly after this meeting, in September 1990. Dr Marie Thorne, Head of the School of Organisational Behaviour, Bristol Business School, in her paper *'Cultural Analysis of UBHT'*[73] wrote that this period of transition was characterised by the fact that:

> 'Insecurity, and anxiety increased but solidarity of the Trust group was reinforced by identifying a common enemy. Workloads increased through managing the conflict and attention was deflected from the primary aim.

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69 UBHT 0098 0258; HMC meeting minutes, 16 May 1990
70 UBHT 0098 0260; HMC meeting minutes, 16 May 1990
71 UBHT 0098 0260; HMC meeting minutes, 16 May 1990
72 UBHT 0098 0261; HMC meeting minutes, 16 May 1990
73 UBHT 0296 0001 – 0008; *'Cultural Analysis of UBHT'*

'… Chairman resigns and opposition becomes far more manageable.'[74]

57 When Dr Thorne was asked about this in her evidence to the Inquiry she said:

> 'The "common enemy" I suppose were the resisters, because my understanding was that the idea had been started that they would go for trust status and this was supported I think by the Chairman and the Regional Head of the South West Regional Health Authority, and therefore people were trying to go ahead with this …'[75]

58 According to Mr Boardman, the process of garnering support for the Trust was not just about identifying 'common enemies' but neutralising them. He said:

> '… the unit becoming a Trust was going through significant organisational change. Dr Roylance had to win over the stakeholders in that organisation, the key opinion formers who were the clinicians, and therefore he needed at the very least to keep important opponents neutral. One way to do that is by making sure that if an important opinion former is in an important department which looks like it is going to be swallowed by a larger one, to ensure that did not happen and to allow those opinion forming departments to stay with some degree of autonomy as clinical directorates. That is how I think Dr Roylance handled that significant organisational change …'[76]

59 A ballot of consultant medical staff was taken in January 1990:

> '… on the question: "With the present information, do you support any attempts to convert your hospitals into the whole or part of a self governing trust or trusts?" On an 88% response, 81% of Bristol consultants voted "No" against 11% "Yes". In a March 1990 ballot, general practitioners in Avon voted on effectively the same question and on an 81% response, 77% voted "No" with only 8% replying "Yes".
>
> 'There is little indication of any significant subsequent change in this balance of opinion within the Bristol section of the District.'[77]

60 These figures come from a July 1990 report of the B&WDHA Member Committee to Review Draft NHS Trust Applications. This Committee was appointed by the B&WDHA in April 1990 to review the proposals for trust status and make recommendations.[78]

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74 UBHT 0296 0002; *'Cultural Analysis of UBHT'*
75 T35 p. 95 Dr Thorne
76 T33 p. 51–2 Mr Boardman
77 HAA 0141 0045; report of Member Committee, 16 July 1990
78 HAA 0141 0043; report of Member Committee, 16 July 1990

61 It was noted in the July 1990 report that the following were of concern:

> 'Absence of a clear strategy for the future in the proposal is a source of concern to many people, particularly those who feel that their specific service interests do not appear to be in the forefront of the sponsor's thinking … whilst the University clinical professors have noted that "there is very little mention of teaching and almost none of research in the Trust documents". There is a feeling that the sponsors' objectives have not been thought through beyond the achievement of independence and corresponding concern as to where this may lead.'[79]

62 The report noted that:

> '… the Committee heard a near-unanimous view that the Bristol Provider Unit is not ready for Trust status against an April 1991 timetable.'[80]

63 In a later ballot in around October 1990, of the 131 votes 66 were still in favour of remaining as a directly managed provider unit.[81] Mr Durie believed this attitude still prevailed as:

> '… in the papers there was a lot of very wild statements about the freedom of trusts and what the trusts would do. There was comment about trusts would cut the amount of money paid to nurses and everybody else.
>
> '… Doctors … they are very busy people. Their main concern is treating patients. They were not involved or wishing to be greatly involved in the real pros and cons, and if they were reacting to what they read in the press, I am not surprised if they were coming out against it.' [82]

64 However, the B&WDHA '*Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal*' came to the following conclusion:

> 'The Authority supports the proposal to establish an NHS Trust for UBHT services and recommends the Regional Health Authority to commend to the Secretary of State that such a Trust to be established to commence on 1st April 1991.'[83]

65 The paper also concluded that:

> '… whilst management need to have due regard to continuing anxieties expressed by staff, the ballots should not be regarded as the sole reason for refusing Trust status. In particular, the Authority is not convinced that the Trust issue, for many

[79] HAA 0141 0046; report of Member Committee, 16 July 1990
[80] HAA 0141 0047; report of Member Committee, 16 July 1990
[81] UBHT 0074 0266; October 1990 Ballot
[82] T30 p. 58–9 Mr Durie
[83] UBHT 0074 0257; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*

staff, is clearly understood and separated from more general views about NHS reform.' [84]

66 Other conclusions of the Authority about the proposal to become a trust included the following:

> '1. An NHS Trust is the most beneficial environment within which to manage the new contractual arrangements, and offers the greatest opportunity of delivering benefits to patients.
>
> '2. There are financial, personnel and other management benefits which arise out of Trust status. Although these advantages are difficult to predict, and individually may be marginal, they could, taken together, be significant.
>
> '3. The Health Authority has full confidence in the ability of its managers to manage an NHS Trust.'[85]

67 The Trust eventually came into being, despite reluctance on the part of many of the consultant staff. Mr Roger Baird, consultant general surgeon, said:

> '… if you are the Chief Executive or whatever and you work out how it has to happen, obviously you listen in a reasonable way to what other people say, but in the end, are responsible for it. …
>
> 'I suspect he [Dr Roylance] worked out with his management team what the best deal was going to be for us, and then he had to sell it to us.'[86]

68 Further, Mr Baird said:

> 'The great thing about John Roylance was that at least we all knew where we stood. Quite honestly, most of the clinicians just wanted to get on, and still do, with treating patients. If they trusted him, as we did, and he said this was the way to go, then with one or two exceptions, which he was able to deal with, he was able to get his own way.'[87]

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[84] UBHT 0074 0255; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*
[85] UBHT 0074 0256; *'Draft Response to South West Region Consultation Exercise on the United Bristol Healthcare Trust Proposal'*
[86] T29 p. 47 Mr Baird
[87] T29 p. 53–4 Mr Baird

The development of the clinical directorate structure

69 By 1989 a clinical directorate management structure was beginning to develop in Bristol, in response to national encouragement[88] and the impending introduction of the purchaser-provider split and NHS trusts as the providers of acute healthcare.

70 In the Ham/Smith paper, the reason behind the adoption of the clinical directorate structure was explained:

> 'The principle behind the clinical directorate model is that these "semi-autonomous units", based on a medical specialty or group of specialties, enable full budgetary and clinical decision making to be combined in a single entity … The model was believed to offer the most appropriate way of building on the principles of the Griffiths Report in relation to devolution and accountability, and to offer a way of properly engaging medical and other professional staff in the management of NHS trusts.'[89]

71 The paper went on to describe what was happening at the time in the national context:

> 'In the early 1990s, some large NHS Trusts elected to have as many as sixteen clinical directorates (Disken et al., 1990), the rationale for this being to maximise the involvement of senior medical staff in the management of the Trust. In these cases, directorates were usually grouped into collectives of directorates sharing a general manager and other administrative functions. The more usual number of directorates, however, was between six and ten, the reason being that most organisations felt they could not afford the management costs associated with a greater number of directorates, along with concerns about coordination and control.'[90]

72 In conclusion, Ham and Smith said that the UBHT had gone further in emphasising the involvement of clinicians in management in two ways:

> 'First, the approach adopted was one of maximum delegation to directorates from an early stage in their evolution. And second, the central management of the trust was kept light to give the directorates as much scope as possible to take on their new responsibilities.'[91]

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88 T24 p. 45 Dr Roylance
89 INQ 0038 0011; Ham/Smith paper
90 INQ 0038 0012; Ham/Smith paper
91 INQ 0038 0023; Ham/Smith paper

73 In due course, with the introduction of the purchaser-provider split and with the institution of the UBHT, the clinical directorates came to acquire a key role in the managerial structure of the UBHT.

74 As to the local view, Dr Roylance said:

> 'In the 2 years of preparation before the establishment of Trust status, a number of further management changes were made. The most significant of these was the creation of some 12 Clinical Directorates, each managed by a Clinical Director, who was a consultant, and a General Manager … The aim was for the Clinical Director to be "in charge of" the doctors and for the General Manager to be responsible for everyone else, and to ensure that the necessary administration and support services were in place for the Directorate to run efficiently.'[92]

75 The change from general management to trust status with clinical directorates took place with many of those who had held responsibility in the general management structure remaining in management positions. It was said by Ham and Smith in their paper that:

> 'The management arrangements put in place for the shadow trust, and subsequently the NHS trust, built on those that had gone before, and there was continuity of personnel between the pre and post trust structures. The main change implemented during this period was the further development of a clinical directorate approach as part of the changes to management arrangements that stemmed from the introduction of management budgeting and resource management across the NHS as a whole.'[93]

76 The view of the purchasing DHA was given by Ms Evans in her written statement:

> 'Prior to UBHT becoming operational in April 1991, a management system of clinical directorates was proposed. This was an approach which became almost universal across acute Trusts in the NHS, and may have stemmed from a widely publicised initiative to involve clinicians in management at Guy's Hospital, London (described in *"Managing Clinical Activity in the NHS",* C Ham and DJ Hunter, Kings Fund 1988).'[94]

77 This clinical directorate system was a significant change in that it deliberately drew clinicians into management. The UBHT had a system involving some large directorates with sub-directorates within them:

> '... from the point of view of a purchasing Health Authority, this directorate system provided us with clear managerial and clinical points of contact.'[95]

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92 WIT 0108 0006 Dr Roylance
93 INQ 0038 0007; Ham/Smith paper
94 WIT 0159 0010 Ms Evans
95 WIT 0159 0010 Ms Evans

78 Dr Thorne's evidence emphasised that the clinical directorates were intended to be one of only three formal layers of organisational structure in the Trust. The others were the Trust Board and the individual ward level. She described the changes as follows:

> 'The commitment to put patients first was reflected in the way that the changes in organisation structure were described – as an inversion of the normal managerial hierarchy. The staff at HQ were presented at the bottom of the hierarchy acting as a support to the other layers, whilst patients were placed at the top with all the front line staff who "served their needs". This was an attempt to signal that the senior managers saw the delivery of healthcare as the most important part of the organisation's work. The organisation structure was reduced to three formal layers: Trust Board; Clinical Directorate; and ward level. This was to create clear lines of accountability, improve the speed of decision making and communication and to speed up the rate of change.'[96]

79 Mr Durie was asked about the directorate system:

> 'Q. Let us take the most important manager in the directorate, the General Manager of a directorate; their objectives would be met, therefore, by the Clinical Director in conversation with the General Manager, against a background of the ethos set by the Trust Board. Is that a fair summary?
>
> 'A. I am not sure. Why I am saying that is that I would not be directly involved in that process, so I am guessing exactly what the Chief Executive and the Personnel Director and Clinical Directors decided they would do. They would be meeting monthly and I would expect them to be talking about this objective-setting at some of those monthly meetings.
>
> 'Q. So you cannot tell me exactly what went on, but that is what you would have expected?
>
> 'A. I would have expected that it was not done in isolation at Clinical Director level: there would be input certainly from personnel and probably from the Chief Executive as well.
>
> 'Q. So the key concept in the actual running of the Trust was the clinical directorate system?
>
> 'A. They were essentially – yes. By having the clinical directorates, they were the people treating patients and providing the healthcare.
>
> 'Q. And the Clinical Director was given this new role as I think in your analogy, which Mr Wisheart says is a reasonable analogy, but like all analogies not perfect,

[96] WIT 0171 0006 – 0007 Dr Thorne

they were the Chairmen of the directorate and the General Manager was the Chief Executive of the directorate?

'A. Yes.

'Q. So the leadership qualities of the Clinical Director, managerial and leadership qualities, would be very important to the success of a directorate?

'A. Correct.

'Q. How did the Trust satisfy itself that the Clinical Directors or assistant Clinical Directors had the necessary leadership as opposed to clinical qualities?

'A. The Chairman of the Hospital Medical Committee and the Medical Director, who quite often were the same person, and Dr Roylance as Chief Executive with his medical knowledge and background, knew well the strengths and weaknesses of the various consultants in all the specialties. It was important initially to try to ensure that the person who became the Clinical Director was somebody who was respected by his peers.

'You also try to ensure that that individual was also ready to be numerate and likely to be a good leader, so there were really three factors all interwoven in deciding who should the right person be.

'Q. That decision was Dr Roylance's decision?

'A. He made the final decision, but in fact again the process came about from a lot of talking and discussion with the people concerned who knew what was happening in that area.

'Q. Did you as Chairman or the Non-Executive Directors have any role in the appointing of Clinical Directors, in the selection of them?

'A. No. I say "no"; as Chairman you are overall responsible for everything, but I do not remember – I cannot recall now being involved in discussions, although I might have been. If there was a discussion about should it have been A or B in a certain specialty, I could have been brought in on that discussion informally, but I do not recall it.

'Q. To what extent is it fair to say that the Clinical Directors of the Trust in 1991 were all existing senior clinicians at the – let us take the Bristol Royal Infirmary – at the Bristol Royal Infirmary with whom Dr Roylance had worked closely for a number of years?

'A. The answer is, "yes"; because he had been there a long time, the answer to the second half is "yes", too.

'Q. There was no Clinical Director who did not fall into that description?

'A. Not initially. I think it is worth enlarging why not. There was considerable suspicion among consultants in particular about the move to Trust status. I think they had some reason, because there had been very wild remarks being made politically about what might happen in Trusts and the freedom they might have.

'That being so, it was important to try to ensure that the Clinical Directors had the confidence of those working under them.'[97]

80 Professor John Vann Jones[98] compared the relative positions before and after the institution of the UBHT. He stated:

'The new Directorate structure gave some financial freedom to Directorates, to determine how their resources would be utilised, and to determine their own priorities for developing services, benefiting directly from cost savings and efficiencies within the Directorate …

'Before the advent of Trusts it was necessary to put forward a case for any development. This was very cumbersome and slow because it had to be considered at area or regional level, and it had to be fitted into area or regional policy. The concept of Trusts produced a little more flexibility. For example Clinical Directors identified their own priorities.'[99]

81 Ham and Smith in their paper argued that:

'The board took an approach of delegating authority as far as possible, confirming the clinical directorates as the core units of management in the trust.[100] For this purpose, the trust was divided into thirteen clinical directorates, the clinical director of each directorate was a medical consultant, and this role was seen as that of a "non-executive chairman of the directorate" ... The trust board sought to delegate to directorates the authority they needed to manage their services, wishing to avoid becoming bogged down in operational detail and hence having time to focus on major issues.'[101]

82 Mr Wisheart described the directorate system after 1991 in his statement:

'The Directorates or, perhaps, the sub-directorates were "the functional units of the Trust", inasmuch as they provided an identifiable package of service to the patient, or for the purpose of contracting. The Clinical Directors and the Associate Clinical Director had the main role of leadership within this framework together with their

97 T30 p. 29–32 Mr Durie
98 Consultant cardiologist, BRI; Professor Vann Jones was the Clinical Director for General Medicine from 1 October 1989 until 30 September 1993
99 WIT 0115 0002 Professor Vann Jones
100 INQ 0038 0008; Ham/Smith paper citing WIT 0086 0006 Mr Durie
101 INQ 0038 0008; Ham/Smith paper citing WIT 0086 0006 Mr Durie

Directorate General Manager and Nurse. Their duties included management responsibilities for which they were formally responsible to the Chief Executive. Clinical Directors initially were usually senior doctors but, in principle, could have been from any discipline, medical, nursing or the professions allied to medicine. The Clinical Directors exercised leadership in the management of the Directorate including the organisation of its clinical work. However the Clinical Director was not responsible for the manner in which consultant colleagues exercised their clinical freedom and responsibility in relation to the care of their individual patients.

'Within each Directorate or sub-directorate the executive group of three would meet as required and in addition it was usual for there to be a larger meeting of the staff working within that Directorate. In cardiac surgery, this larger meeting was called the Cardiac Surgical Board. It was a more formal expression of the teamwork that had existed before and … included at least representatives for all the groups working within the Directorate. This board, therefore, gave the non-medical voices a stronger say than they had before.'[102]

83 Mr Boardman told the Inquiry that he thought that 13 (the initial number of directorates) was too many :

'Through my subsequent experience with the NHS management executive, and as a specialist management consultant, it was clear that many Trusts operate with fewer directorates. In my opinion 13 was too many and consequently Dr Roylance did not appear to have proper control over them. He almost encouraged directorates to be loosely affiliated to the Trust. For example, each directorate formulated its own business plan with little central direction, and essentially all 13 plans were then bundled together. There was no real overall corporate strategy/planning … UBHT always delivered financially (Dr Roylance was known to run a tight ship and thus UBHT appeared to be well managed), but in other aspects the plan was not coherent.'[103]

84 Mr Boardman went on to say in his supplementary statement to the Inquiry:

'… I should now like to say that with hindsight I realise it would have been possible to structure the organisation with a smaller number of clinical directorates. I remain of the view that overall there was no real overall corporate strategy or planning and in this sense, Dr Roylance did not appear to have control over the clinical directorates.'[104]

[102] WIT 0120 0016 Mr Wisheart
[103] WIT 0079 0007 Mr Boardman
[104] WIT 0079 0281 Mr Boardman

85 Dr Roylance rejected this criticism. He said:

> 'It is not true to say there was any difficulty because of numbers in supporting and developing 13 Clinical Directors and their General Managers.'[105]

86 Further, when asked if he could have had fewer directorates within the UBHT, Dr Roylance said:

> 'No. If there had been an anxiety about numbers, the only managerial step I could have taken would have been to put an intervening level of management and put an assistant chief executive managing six seats, so to speak. There was no way I could put together two directorates and pretend they had a single interest.'[106]

87 When Mr Boardman was asked whether a smaller number of clinical directorates would have been better, he replied:

> 'That is a value judgement. I am not saying it would be better. I am saying there were other ways of doing it, and there are benefits but also non-financial costs to doing it with a smaller number. I think with a smaller number, some of the coordination would have been easier … it is not for me to say which is better or worse, but rather that there are other ways of organising and you have to weigh up the costs and benefits of that way of organising.'[107]

88 Mr Robert McKinlay, Chairman of the UBHT Board 1994–1996, agreed with Mr Boardman 'that coordination would be a problem with such a large number of directorates'.[108]

89 Bristol traditionally had had small central management with devolved management units. Ham and Smith in their paper described Bristol in the era of general management thus:

> '… a structure of two main units and eleven sub-units was preferred to a structure of say five units … BWHA apparently preferred to have a smaller general management core (the district general manager and two unit general managers [UGMs]) and a greater number of devolved sub-units of management.'[109]

90 One of the reasons advanced to explain why Dr Roylance did not find it difficult to support and develop the 13 clinical directorates was that all of the responsibility for

105 T24 p. 67 Dr Roylance
106 T26 p. 12 Dr Roylance
107 T33 p. 49 Mr Boardman
108 WIT 0079 0279 Mr McKinlay
109 INQ 0038 0005; Ham/Smith paper

running the directorates rested with the clinical directors and their general managers. One of the general managers, Mrs Rachel Ferris, recounted:

> 'My experience led me to believe that it was accepted in management circles that Dr Roylance was known for saying "don't give me your problems, give me your solutions." All my peers were told that responsibility for dealing with issues must be pushed back to the Directorates. My perception was that if this did not happen, then it was seen as a failure on the part of the Manager … I saw Mrs Maisey's role as controlling the General Managers in order that Dr Roylance could get on with other things …'[110]

91 Ms Evans explained that the clinical directorate structure at the UBHT was more fully developed in the period 1991–1995 than in some other trusts. The reasons for this, she felt, were:

> 'Two things, really: one is in terms of a system whereby clinicians were the Clinical Directors responsible for a specialty or group of specialties, and were thereby very much involved in the management of those specialties, but also very much involved in the dialogue with purchasing health authorities about what the Trust should be providing and how that might work …
>
> 'The second one would be something about the implications of a clinical directorate structure for the management of a trust, and, in the UBHT's case, being such a large trust with so many specialties, that led to a fairly federal structure of clinical directorates … it made good sense to have strong local management at directorate level.'[111]

92 There were regular meetings between the various levels of management. This was reported in the Ham/Smith paper as follows:

> 'The general managers in the clinical directorates, who were accountable directly to the chief executive, met regularly with the director of operations/chief nursing adviser in the executive management group. The trust's executive directors met in the executive directors group … on a weekly basis.'[112]

93 Further, 'The director of operations did take on a key role on behalf of the chief executive in working alongside directorate general managers.'[113]

94 As for the clinical directors, they:

> '… met on a monthly basis with the chief executive and medical director in the clinical policy board/management board. The involvement of the clinical directors

110 WIT 0089 0032 Mrs Ferris
111 T31 p. 12–13 Ms Evans
112 INQ 0038 0008; Ham/Smith paper
113 INQ 0038 0013; Ham/Smith paper

in the mainstream management of the trust appears to have been dependent on the role of the chief executive as go-between and lynchpin between the directorates and the central management.'[114]

95 Mrs Ferris, as the General Manager of Cardiac Services from November 1994, described how she saw the lines of accountability:

'Within cardiac services, I perceived that I was working very closely with the Clinical Director, the relationship with the Clinical Director was such that … we considered ourselves to be sort of a unit; we worked together very closely, so I was obviously accountable to the Clinical Director, but it was not like that in terms of our general work. I did not see a line management relationship between me and the Clinical Director of cardiac services. I perceived us as a unit that worked closely together. Beyond that, I saw myself as accountable to Margaret Maisey, and I saw the Clinical Director as accountable to John Roylance.'[115]

96 As for other groups, physiotherapists were responsible through their professional head to the Trust's Director of Nursing who was also responsible at Trust level for the Professions Allied to Medicine. Perfusionists were responsible to both the surgeons and, particularly, to the anaesthetists.[116]

97 Mr Wisheart's view was that, from the time of setting up the Trust, there were defined lines of responsibility and accountability from the Associate Clinical Director to the Clinical Director to the Chief Executive. This included management of the framework structure within which patient care was provided but did not include details of how an individual patient was cared for nor how any individual consultant exercised their clinical duties. In relation to accountability, Mr Wisheart was of the view that:

'... in the period 1990–95 accountability increased for doctors in relation to their management responsibilities. Each consultant was responsible to the Associate Clinical Director, who in turn was responsible to the Clinical Director, the Chief Executive, etc. Each doctor became more conscious of their obligation to openly review their clinical work within the audit process, but there was no *routine* requirement to report the findings of audit outside the audit group.'[117]

98 Dr Roylance described the development of the system of devolved management:

'In the many discussions about the interrelationship between the Directorate General Manager and the Clinical Director, the suggestion emerged – I remember who made it – that we should not argue about who was accountable to whom; that was a sterile conversation; we should put them in the managerial bubble and say

114 INQ 0038 0017; Ham/Smith paper
115 T27 p. 16–17 Mrs Ferris
116 WIT 0120 0021 Mr Wisheart
117 WIT 0120 0026 Mr Wisheart (emphasis in original)

between them, they would manage the directorate. That is how it started. The bubble was accountable to me.

'As time went on, over the next three years or so, it became clearer that the Clinical Director would be accountable to me and the Manager would support the Clinical Director, so that was an evolutionary thing, but it was in order to overcome considerable anxieties. You will remember that for the very first time we were introducing consultants into the general management function.'[118]

The role of clinical director

99 Dr Roylance told the Inquiry that:

'… the Clinical Director was responsible for everything that happened in his directorate. He had a substantial amount of support, but in terms of accountability, he or she was accountable to me for the proper conduct of affairs within the directorate. So the accountability line was quite clear.'[119]

100 Professor Vann Jones was one of several clinicians to give evidence of the burden which being a clinical director placed on a consultant. He said:

'… I still had to take care of my heavy clinical load, both in cardiology and in general medicine, as well as maintaining my research and teaching commitments. No help was forthcoming from the Trust for the additional load of Clinical Director.'[120]

101 Mr Baird, who was at one time Clinical Director for Surgery, was also asked about the responsibilities that came with being a clinical director:

'Q. Clinical Directors had relief, did they, from their clinical duties in terms of not having to do sessions per week – some sessions?

'A. Well, most of them did what they did before and just worked a bit harder. I mean, some of them gave up something …

'Q. So in 1989–90 the rule, rather than the exception, was for people such as yourself to work in effectively your own time and for nothing?

'A. I can only speak for myself, because I know that other people, even Associate Clinical Directors within my directorate, accepted extra sessions to do that work, but I chose not to and it did not bother me much … Traditionally, we have, if the week is considered 11 half days, which is what it is in contract terms, perhaps about half of that is fixed and the other half is flexible for things like emergency

118 T24 p. 49–50 Dr Roylance
119 T24 p. 74 Dr Roylance
120 WIT 0115 0003 Professor Vann Jones

duties, administration, teaching, research and so on. I used to fit my work as Clinical Director into that time. And even if I was, for example, as I was this morning, at a fixed clinical session, you can still pop in and keep things going in-between times. You can keep the kettle boiling, you know.

'Q. So what you are describing is a situation in which people, because they were working for the greater good, would carry out a full clinical load and do whatever work they may have had as Clinical Director on top?

'A. Yes.'[121]

102 However, Dr Roylance outlined measures designed to ease the burden on clinical directors. He said:

'There was a national agreement that doctors assuming such roles as Clinical Director could either be paid two additional sessions' salary in respect of the out-of-hours work, the extra work they were going to do, or that money could be used to employ a locum to do part of the incumbent's work. So the national agreement was that for a job like Clinical Director, across the week there were two additional sessions of work that could and would be funded. I do not remember about individuals, but I do know that some Clinical Directors accepted the additional pay and put in the additional hours; some used the money for a locum to take some of the burden from their shoulders, and some declined either and said they would take it all in their stride. But the choice was theirs.'[122]

103 The clinical directors met monthly as the 'Management Board'. Its function was explained by Dr Roylance:

'It was not an Executive Committee that itself made decisions. In the general management philosophy, the General Manager or in this case the Clinical Director who was assuming the General Manager function had to retain personal responsibility for the decisions that were made and it was not possible to let them fudge it and say "Nothing to do with me, the Management Board made the decision".

'… doctors up to that stage actually made policy and we had to slowly develop the idea that it was the Trust Board that agreed policy, on the advice of the management, through the Management Board, and the professions through professional advisers, so that it was a properly made decision, but this was a communication function in which I made sure that at least once a month I would meet them all together and we would discuss issues and they would discuss issues from their point of view and, as I say, resolve issues which transcended the directorate structure.'[123]

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[121] T29 p. 61–3 Mr Baird
[122] T24 p. 91 Dr Roylance
[123] T24 p. 63–4 Dr Roylance

104 Some of the clinicians chosen to be clinical directors or associate clinical directors had little in the way of managerial experience. One such person was Mr Janardan Dhasmana, consultant cardiac surgeon, who was the Associate Clinical Director of the Associate Directorate of Cardiac Services from January 1993 to September 1994. Both Mrs Ferris, the General Manager for Cardiac Services, and Mrs Fiona Thomas, the Clinical Nurse Manager for Cardiac Services, recalled his problems in chairing meetings. Mrs Fiona Thomas said:

> 'He was not quite sure when to stop people from talking and how to stop arguments.'[124]

105 Mrs Ferris said that he:

> '… found it difficult to chair meetings and to ensure that decisions got made. This was particularly so where there was open conflict or even hostility in meetings.'[125]

106 In her oral evidence to the Inquiry, Mrs Ferris said:

> 'My recollection is that Mr Dhasmana deferred on a number of occasions to Mr Wisheart. Mr Wisheart was very experienced at managing meetings; he was very good at managing meetings. He often allowed Mr Wisheart to do that, because he found it difficult.'[126]

107 Both Mrs Ferris and Mrs Fiona Thomas said Mr Wisheart would intervene at these moments and that Mr Dhasmana would defer to him. Mr Dhasmana explained that this was because he:

> '… had no such earlier experience and had asked Mr Wisheart for his advice and help … Mr Wisheart did not take over as a chairman but tried to play an elder statesman's role in order to resolve differing views after a prolonged discussion.'[127]

108 Mrs Ferris also felt that Mr Dhasmana did not fully comprehend all the issues facing her as a general manager. She said:

> 'I expected to be able to discuss with my Clinical Director, the strategy and planning issues and the decisions that needed to be made before meetings took place. I found that it was not possible to do this with Mr Dhasmana. I also felt that he found it difficult to understand some of the concepts with which I, as General Manager, had to work. This essentially involved working within the existing system for the benefit of the services that we were offering to patients. I needed to focus on

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[124] WIT 0114 0008 Fiona Thomas
[125] WIT 0089 0017 Mrs Ferris
[126] T27 p. 75 Mrs Ferris
[127] WIT 0114 0043 Mr Dhasmana

what was required of us under contracts, targets and other budget matters, but Mr Dhasmana found these issues difficult to understand.'[128]

109 Mr Dhasmana, on his appointment to the post of Associate Clinical Director, attended a course on 'Management skills for the newly appointed consultant'. He was not provided with a job description or written guidelines to assist him in carrying out his new managerial responsibilities. Mrs Ferris said she found it:

> '… surprising he was not given any guidance in how he should be effective in the Associate Clinical Director role. The course he attended would not have given him anything like that, although I am aware that the role of the Associate Clinical Directors, and indeed the Clinical Directors, was still very much evolving and developing and in fact, the Clinical Director roles did differ from directorate to directorate, depending on the style of the directorate, the style of the clinicians … but I would be concerned that he had not received any guidance.'[129]

110 Professor Vann Jones, although he had managerial experience as the Clinical Director for General Medicine from 1 October 1989 to 30 September 1993, was reluctant to serve when asked to become the Clinical Director for Cardiac Services. He said:

> 'During 1993 the Chief Executive of the new Trust (formed 1 April 1991) had started to discuss the possibility of creating disease based Directorates. The first two to be considered were cardiac services and gastroenterology. In the absence of an obvious alternative candidate I reluctantly agreed to become Clinical Director of Cardiac Services. Again, I was the first Clinical Director of a new Directorate. I started in mid October 1993 and continued until the spring of 1996.
>
> 'In its initial stages, the Directorate of Cardiac Services was little more than a concept … I and my General Manager, Lesley Salmon, had to try to establish what form the new Directorate of Cardiac Services would take.'[130]

111 Mrs Ferris was also critical of the lack of guidance she was given when she became General Manager of the Directorate of Cardiac Services in 1994. She said:

> 'I took up the post of General Manager, Cardiac Services on 7 November 1994. When I had been appointed to previous posts, I had asked my immediate manager for an indication of the key priorities and issues for the new job. In this new post, I asked Mrs Maisey, Director of Operations, for advice about the immediate priorities for the Directorate. My recollection is that I was told that the most important thing was to get the paediatric cardiac surgical services transferred to the Children's Hospital. I understood this to mean that I would need to give priority to completing the enabling work for the physical transfer of the paediatric cardiac surgical service. Apart from this, I had little guidance from executive level about the

128 WIT 0089 0018 Mrs Ferris
129 T27 p. 67–8 Mrs Ferris
130 WIT 0115 0002 Professor Vann Jones

forward strategy or objectives for the Directorate, or generally what was expected of me as the newly appointed General Manager for Cardiac Services.'[131]

112 When Dr Roylance was asked about Mrs Ferris' feeling that there was a lack of guidance, he said that she may have felt this way because she was promoted before she was ready for that level of responsibility. He said:

> 'One could say that we may have been guilty of promoting her before she was ready … If you read her account carefully you will see that she was counselled and advised by her predecessor … and she had been in the Trust a long time and had been to management development meetings, she knew that her job by that time was to support and make effective her Clinical Director. If she was somebody who had a culture of wanting everything neat and tidy with a policy and a protocol all written and her authority all defined, you can see that appointing her to a directorate that did not exist, which had to be developed and so on, may be for a time, quite unsettling.'[132]

The relationship between the clinical directors and the general manager – the 'managerial bubble'

113 The key managerial relationship in each directorate was that between the general manager and the clinical director. Dr Roylance's concept of how the clinical director and the general manager should work together evolved over time, from the 'managerial bubble' to the clinical director being accountable to him, with the general manager supporting the clinical director.

114 Dr Roylance explained further the reasons for this evolution:

> '… each partnership of Clinical Director and General Manager … formed a working relationship which was based upon their individual expertise and abilities, and their willingness to undertake tasks. They developed the role together. Slowly, as I think was predictable, and probably directorate by directorate, they found it easier to converse and to be understood by others if it was absolutely clear that the Clinical Director took final responsibility and the General Manager's responsibility was to make them successful.'[133]

131 WIT 0089 0004 Mrs Ferris
132 T25 p. 141–2 Dr Roylance
133 T24 p. 57 Dr Roylance

115 Miss Lesley Salmon, Associate General Manager of Cardiac Services 1991–1993 and General Manager, Directorate of Cardiac Services 1993/94, gave her view of lines of responsibility:

> 'Q. To whom were General Managers accountable?
>
> 'A. I think the use of the word "accountable" is interesting. I felt that I was managerially responsible as a General Manager to John Roylance, but I had some accountability to the Clinical Director for the directorate in terms of the way I worked and what I did.
>
> 'Q. You use the word "responsible". Can I take you to WIT 0170 0004, Kathy Orchard's statement that we looked at already, briefly, paragraph 9.
>
> 'By all means take a moment to read the whole paragraph. The passage I am focusing on is the last sentence. [134]
>
> 'Do you agree or disagree with that paragraph?
>
> 'A. It is interesting, actually. I did see myself as being directly responsible to John Roylance. Whether I saw the Clinical Director being directly responsible to Dr Roylance, I am not sure.
>
> 'Q. Who did you see the Clinical Director as being responsible to?
>
> 'A. To some extent, to the Medical Director, but I suppose in the fact that the Clinical Director was to some extent a management position, albeit not a direct line management responsibility, that he did have some responsibility to Dr Roylance as Chief Executive.
>
> 'Q. The Panel have heard the analogy quoted of the Clinical Director being akin to the Chairman and the General Manager being akin to the Chief Executive.
>
> 'Normally a Chief Executive would be responsible to the Chairman of a Board. To what extent do you think that analogy held good when you were a General Manager?
>
> 'A. I do not think it was that clear. I was quite clear that I was accountable for the quality of the work that I did to the Clinical Director, and to a large extent, he did guide and direct my work, although it was more of a partnership than perhaps otherwise. But I was also clear that I was responsible to the Chief Executive as a manager.' [135]

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[134] 'Directorate General Managers and Clinical Directors were responsible individually to Dr Roylance as Chief Executive and then to the Board'

[135] T31 p. 127–8 Miss Salmon

116 In her statement and in response to questions, Miss Salmon indicated that she encountered practical difficulties, particularly with one part of the team: 'There was a degree of tension between myself and … the head of the perfusionists … he did not feel that I should be managing the team' although she 'was not aware of any difficulty with the actual clinical delivery of the service.'[136]

117 Miss Salmon described the position of the general manager in terms of relationships with those higher in the hierarchy of management:

> 'Q. The second point is actually at WIT 0109 0014, the last sentence in paragraph 55, where you talk about the culture at the time was one in which personal relationships with an individual Executive Director was possibly more important than hierarchical relationships.
>
> 'Perhaps you could provide me with some explanation of that sentence?
>
> 'A. It was my view at that time that, particularly with Dr Roylance and perhaps with other executive directors, that because you were a General Manager did not necessarily mean that you were somebody whose opinion would be particularly listened to or respected, but that there were individual managers who did have good relationships and who did have, so to speak, the ear of the Chief Executive.
>
> 'Q. So are you saying, to use a colloquialism, your face fitted or it did not?
>
> 'A. I do not think it was so much a case of your face fitting, but there were individual people who, for whatever reason, but I could not explain to you because I do not know myself, had a good working relationship with Dr Roylance. I do not believe that I was one of those individuals.'[137]

How did cardiac services fit into the managerial structure?

118 Initially, from when the directorates were first set up in the run-up to trust status, adult cardiology was part of the Directorate of Medicine, paediatric cardiology was part of the Directorate of Children's Services, and cardiac surgery (including paediatric cardiac open-heart surgery) was part of the Directorate of Surgery.[138] This remained the case until 1993, when the Associate Directorate of Cardiac Services was introduced in a move to structure the care provided in relation to patient groups rather than professional groups.[139]

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136 T31 p. 159 Miss Salmon
137 T31 p. 159–60 Miss Salmon
138 T24 p. 68 Dr Roylance
139 T24 p. 71 Dr Roylance

119 Mr Wisheart explained briefly the management structure surrounding cardiac surgery. He said:

> 'As far as cardiac surgery was concerned all open-heart surgery, both adult and paediatric, lay within one directorate, initially the Directorate of Surgery and from 1993 the Directorate of Cardiac Services. Cardiac surgery was a sub-directorate within those larger Directorates and as a sub-directorate had its own manager, its own finance and its own facilities. It was run by a Board whose executive members were the associate clinical director, the directorate nurse and the directorate general manager.'[140]

120 Initially Mr Wisheart was the Associate Clinical Director of Cardiac Surgery. In 1993 he relinquished this role as:

> '… there [were] issues of workload and there [were] issues as to whether, as Medical Director, I had to make choices or decisions which might have involved cardiac surgery in relation to other directorates. I think it would have been then an invidious position to be in. It is better that cardiac surgery should have a lead and a spokesperson who can speak independently on behalf of cardiac surgery, not fettered by the wider responsibilities.'[141]

121 Mr Wisheart summed up the role of a clinical director as being 'to deliver the service, remain in the black and to maintain the quality.'[142]

122 Mr Dhasmana assumed the role of Associate Clinical Director of Cardiac Surgery in January 1993.[143]

123 Closed-heart surgery for children and paediatric cardiology lay within the Directorate of Children's Services which was based in the BRHSC. It had its own management, finance and facilities. However, care of patients took place freely across directorate boundaries, as required by clinical need.[144]

124 Dr Joffe served as Clinical Director of Children's Services from April 1991 to December 1994. This included the Associate Directorate of Paediatric Cardiology.

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140 WIT 0120 0050 Mr Wisheart
141 T40 p. 133 Mr Wisheart
142 T41 p. 4 Mr Wisheart
143 T86 p. 144 Mr Dhasmana
144 WIT 0120 0050 Mr Wisheart

125 So far as cardiology was concerned, after 1991, Dr Joffe indicated that it:

> '… was separated from general paediatrics managerially and became an associate directorate in its own right, within the Directorate of Children's Services. As an associate directorate, the unit attained additional support from one of the assistant general managers. These positions were often held by former senior nurses who were able to bring their clinical experience and understanding into this role.'[145]

126 Dr Joffe said that:

> 'Clinical Directors worked closely, and very successfully, with the general managers (Mr Ian Barrington, in our case) whose role was to oversee the day to day activities of the Directorate and/or hospital. This arrangement promoted greater cohesion and a sense of purpose among the staff at all levels.'[146]

127 As described by Ms Evans, the management of cardiology and cardiac services together was an issue which Avon Health Authority (Avon HA), 'regarded as important because it felt that an integrated directorate could have a direct bearing on clinical decision making for certain parents.'[147] *'Hospital and Community Health Services in Bristol and District Purchasing Intentions for 1993/94'* stated that in respect to Children's Services, 'Cardiology and cardiac services will be purchased together as for adults'[148] and 'To improve the delivery of service, we intend to stimulate providers to manage these as a unified cardiac service by purchasing them as such.' [149]

128 From 1 April 1994, the Directorate of Cardiac Services came into being. The innovative feature of this new directorate was that it was disease-based rather than professional-based. Professor Vann Jones was the first Clinical Director and Miss Salmon was General Manager.[150] For 12 months previously, adult cardiology and cardiac surgery had been combined as an Associate Directorate of Cardiac Services.[151] In 1994 they came together in a directorate. This led Dr Roylance to explain that the title of Directorate of Cardiac Services was something of a misnomer, since the Directorate was intended only to embrace adult cardiac services. Dr Roylance said:

> '… paediatric cardiac surgery was, as soon as we could, moved to the Children's Hospital to a paediatric environment, and a little time before that, adult cardiac surgery was merged managerially with adult cardiology. The Directorate of Cardiac Services, strictly speaking, should have been called the Directorate of Adult

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145 WIT 0097 0139 Dr Joffe
146 WIT 0097 0142 Dr Joffe
147 WIT 0159 0022 Ms Evans
148 WIT 0074 1417 Dr Baker
149 WIT 0074 1422 Dr Baker
150 T24 p. 70 Dr Roylance
151 UBHT 0007 0128; Executive Committee meeting minutes, 13 May 1994

Cardiac Services, and was, shall I say, independent of the moves in paediatric services.'[152]

129 Professor Vann Jones explained the difficulties encountered in establishing a disease-based directorate:

'In its initial stages, the Directorate of Cardiac Services was little more than a concept. The paediatric cardiologists were part of the Children's Directorate, the cardiac surgeons part of the Directorate of Surgery, and the adult cardiologists members of the Directorate of Medicine of which, of course, I had just ceased to be Clinical Director. I and my General Manager, Lesley Salmon, had to try to establish what form the new Directorate of Cardiac Services would take, e.g. would it include the cardiac anaesthetists and/or the cardiac radiologists, or would they remain with the Directorates of Anaesthetics and Radiology respectively, etc?'[153]

130 Professor Vann Jones went on:

'My role in these early stages of the Cardiac Services Directorate was to determine who should be in the Directorate so that in due course the appropriate budget could be allocated and the Directorate could then decide its own priorities. Paediatric Cardiology was primarily the responsibility of the Children's Hospital and in any event paediatric cardiology was never envisaged to be part of the Adult Cardiology Service.'[154]

131 Initially, when the Associate Directorate of Cardiac Services had been proposed, a steering group was to be appointed which would consist of a cardiologist, a cardiac surgeon, a cardiac radiologist and a cardiac anaesthetist. This group was to elect its own Chairman to act as Associate Clinical Director.[155]

132 Once the Directorate had been established, Professor Vann Jones established the Cardiac Services Management Board. The individuals who had examined the proposal to form the new Directorate were invited by Professor Vann Jones:

'… to help us in our task of establishing new and effective working relationships within cardiac services.'[156]

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[152] T24 p. 69–70 Dr Roylance
[153] WIT 0115 0002 Professor Vann Jones
[154] WIT 0115 0020 Professor Vann Jones
[155] UBHT 0081 0240; Directorate of Surgery paper, 16 March 1993
[156] UBHT 0084 0181; letter from Professor Vann Jones dated 18 October 1993

133 At the inaugural meeting of this Board, there were cardiac surgeons, anaesthetists, radiologists and cardiologists. The membership:

> '… was felt to be correct at present, recognising that it could change if required in the future.'[157]

134 Whilst all of these groups contributed to the Management Board, it does not appear that all were within the Cardiac Services Directorate. Mr Dhasmana said:

> 'The clinical service in the paediatric cardiac service was provided by medical, nursing and support teams of perfusionists, technicians, physiotherapists, counsellors and social workers at both hospitals. Each of these teams had their own organisational structures and chains of command … Clinically the chain of command and accountability came under the umbrella of the Associate Directorate of Cardiac Surgery and the Directorate of Cardiac Surgery since 1994.'[158]

135 In 1995 paediatric cardiac surgery was separated from general paediatric surgery and joined with paediatric cardiology to become the Associate Directorate of Cardiac Services in the BRHSC, with the budget re-allocated accordingly.[159]

136 Accordingly, throughout most of the period when there were clinical directorates, until 1995, cardiology, cardiac surgery, and paediatric cardiac surgery had been maintained as distinct entities under different directorates. It was not until 1995 that they were brought together (see Figure 5).

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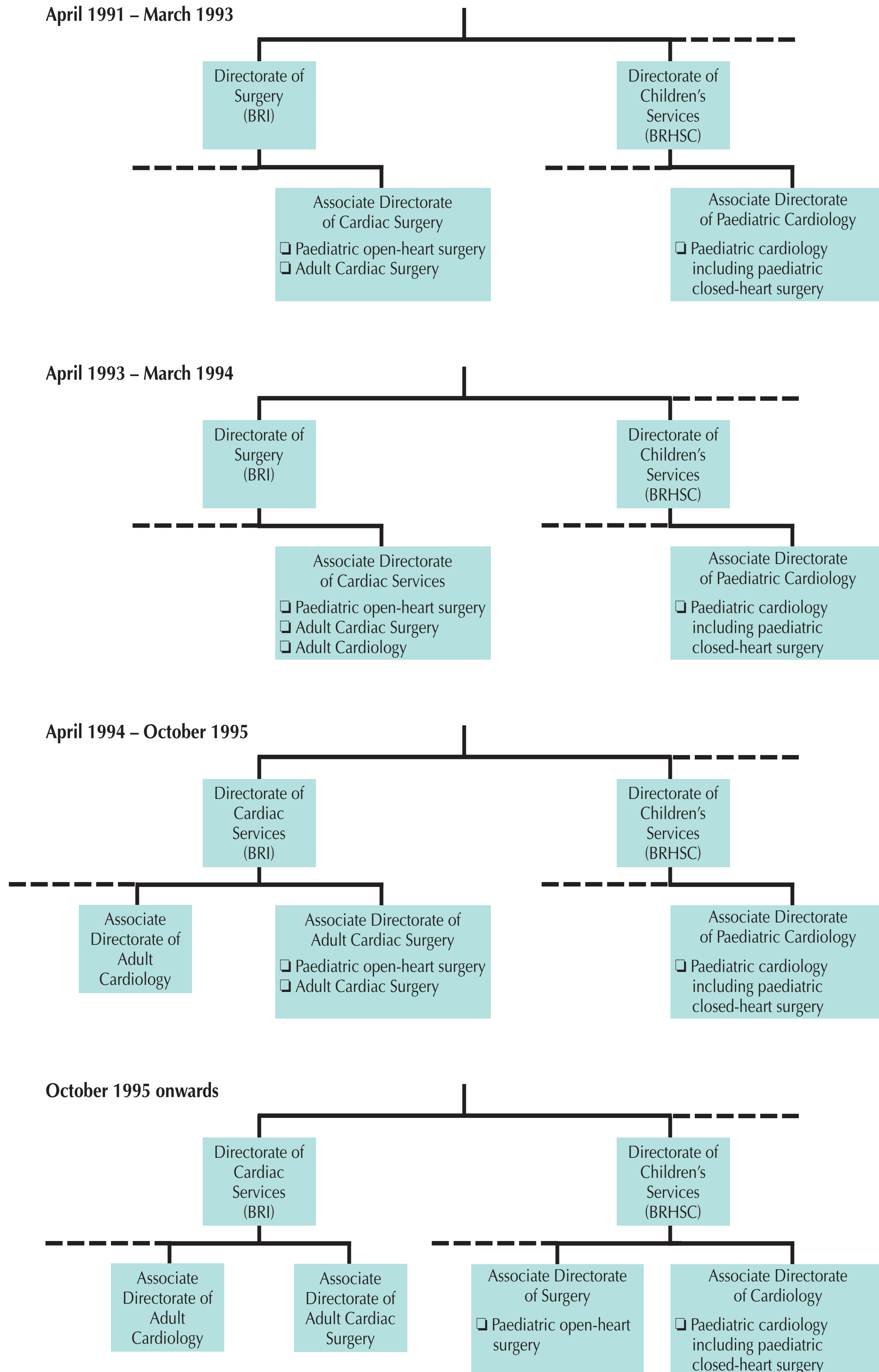
157 UBHT 0084 0177; Cardiac Services Management Board minutes, 25 October 1993
158 WIT 0084 0042 Mr Dhasmana
159 WIT 0097 0139 Dr Joffe

Figure 5: How the paediatric cardiac service fitted into the clinical directorates system



Dr Roylance's key management concepts

137 Dr Roylance told the Inquiry that 'healthcare is led by consultants'.[160] They were self-teaching and self-correcting.[161] Dr Roylance explained that it was 'impossible' for managers to interfere.[162] It was 'a fact' that only clinicians could identify defects in the performance of other clinicians.[163]

138 Dr Roylance saw the role of management as being to 'provide and co-ordinate the facilities which would allow the consultants to exercise clinical freedom'.[164]

139 Dr Roylance explained some of the difficulties in managing consultants in the following passage:

> '… anybody who wishes to manage consultants should do their apprenticeship in the voluntary sector where none of the staff are paid and they can all please themselves. Unlike consultants in that area, I am told it is much easier to get rid of them without an industrial tribunal, but consultants are not manageable. Some people say … it is like "herding cats".'[165]

Therefore, he said:

> '… one has to adopt a leadership style and one has to free up their abilities and recognise their culture.'[166]

140 Dr Roylance's management philosophy attached importance to the following:

a) Management 'by values' and not 'by objectives'. At a meeting of the UBHT Executive Committee on 21 May 1993, Dr Roylance tabled a discussion paper on Trust values. He said that:

> 'UBHT had delegated responsibility to operational level and had pursued a policy of management by values and not by objectives. For this style to achieve continued success, the Trust Board needed to reinforce its values. Dr Roylance asked the Board to reflect what values should explicitly be presented to the workforce.'[167]

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160 T24 p. 14 Dr Roylance
161 T24 p. 14 Dr Roylance
162 T24 p. 14 Dr Roylance
163 T24 p. 17 Dr Roylance
164 WIT 0108 0018 Dr Roylance
165 T25 p. 168 Dr Roylance
166 T25 p. 168 Dr Roylance
167 UBHT 0006 0202; Executive Committee meeting, 21 May 1993

b) Delegating responsibility to operational level. Dr Roylance's oral evidence to the Inquiry included the following exchange:

> 'Q. … the clinician at the bedside made the decision which he or she thought was in the best interests of the patient?
>
> 'A. Yes.
>
> 'Q. And management felt that it could not, and should not, interfere?
>
> 'A. And does not, in any part of the Health Service.'[168]

Bristol's management culture

Oral culture

141 Dr Roylance saw his role as that of a communicator. He said:

> 'I spent the whole of my time in communication. I did little else, because in my position it was the passage of information of one sort or another that was my role. So that I spent the whole of my time communicating, not just a bit of it; I spent my time going around assisting managers, assisting, when we had them, clinical directors, commercial managers. I spent a lot of my time improving their chances of success by talking to them, counselling them, by holding countless training [courses] and of course the very structured committee arrangements and Working Party arrangements of this Trust.'[169]

142 Dr Roylance said that he hoped that the description of the process of management at the Trust as an 'oral culture' was a:

> '… fairly accurate description. What it means is that people talk to each other. I think that is very important, and I think it is a highly efficient and highly effective way of managing, that people should talk to each other.'[170]

143 Dr Roylance saw himself as someone who encouraged people to think twice before 'they diverted their efforts to a non-contributory consumption of paper' but at the same time as someone who 'did not excuse anybody for not writing down that which ought to be written down.'[171]

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[168] T24 p. 15 Dr Roylance
[169] T24 p. 34 Dr Roylance
[170] T24 p. 30 Dr Roylance
[171] T24 p. 32 Dr Roylance

144 Dr Thorne wrote a paper for a UBHT Executive Group Workshop on 3 June 1992, entitled '*Cultural Analysis of UBHT'*. In this paper, Dr Thorne referred to the oral culture. She said:

> '… the organisation at Executive Director level is primarily an oral culture – consequently to produce great reams of written material at this stage is counter cultural. The counter cultural nature of that material would give it greater meaning and "embeddedness" than I might want to convey. At UBHT if it is written down it is either very important or ignored.'[172]

Club culture

145 Dr Thorne's paper also referred to a perceived 'club culture' at the UBHT. She wrote:

> 'UBHT sees itself as a "family or club", you are either a UBHT type of person or you are not. Thus people who fit may do very well and progress rapidly on merit, those who do not either move sideways, down or out … Where and how people move is a key indicator of their ability, presence and status. However, the "in"/"out" distinction is not a lifelong category and it is possible for anyone to "shoot themselves in the foot" through incompetence, failure to follow the cultural imperatives, or by breaking an unwritten rule of cultural conduct … It is not appropriate to challenge the message and strategy publicly because it is translated as questioning loyalty. Loyalty to the Chief Executive is a critical cultural attribute – hence disloyalty is viewed with severe disapprobation.'[173]

146 Mr Boardman described a club culture in similar terms. He said:

> 'Dr Roylance actively tried to create a "club culture" for both the immediate executive team and the wider cadre of general managers. This was done explicitly, often using one of the models cited in Charles Handy's management textbook *("The Gods of Management")*. This helped create a culture where:
>
> '(i) you were either a UBHT "type" or not;
>
> '(ii) progress appeared to depend on your "fit" within the club rather than performance;
>
> '(iii) to challenge policy or strategy was perceived as disloyalty;
>
> '(iv) people who transgressed the club's unwritten rules were required to be "put back in their box" until they conformed once more.'[174]

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172 UBHT 0296 0001; *'Cultural Analysis of UBHT'*
173 UBHT 0296 0004; *'Cultural Analysis of UBHT'*
174 WIT 0079 0014 Mr Boardman

147 According to Mr Boardman, this 'club culture' did not create a self-assessing or critical environment. He said:

> 'I think the general culture of the organisation would not have encouraged whistle-blowers … I think this goes back to the club culture, where whistle blowing is a manifestation of disloyalty, because what you are saying to the organisation is, "we are not doing as well as we could be". I think to say "we are not doing as well as we could be" is disloyalty. It is a message which club cultures do not wish to hear.'[175]

148 Dr Roylance was asked about steps taken to protect whistleblowers from victimisation. He replied:

> 'I do not know what sort of victimisation you might imagine. I made absolutely certain that management would prevent victimisation.'[176]

Light touch from the centre

149 Dr Thorne's paper highlighted a decentralised management style employed by the UBHT's management. She wrote:

> '… the core of the leadership style is centred on a belief that it is not the manager's job to solve problems but to present them back to the individual to sort out for him or herself.'[177]

150 Dr Roylance, for his part, said that this was 'overstating it.'[178] He told the Inquiry that when people went to him with problems, he would:

> '… spend a very considerable time ensuring that they got themselves into a position to see the right solution, to make the right decision, and then to implement it. And I would give them my full authority and support for them to do it. What I knew would be unhelpful would be for them to unload the decision on to me and for me to assume the role of unit or sub-unit general manager and solve the problem. Of course I could solve the problem; that is why I was in the position I was in.'[179]

The role of the UBHT Medical Director

151 The first Medical Director of the UBHT was Mr Christopher Dean Hart,[180] since he was, at the time of the formation of the UBHT, the Chairman of the HMC.

175 T33 p. 84 Mr Boardman
176 T25 p. 80 Dr Roylance
177 UBHT 0296 0007; *'Cultural Analysis of UBHT'*
178 T24 p. 37 Dr Roylance
179 T24 p. 38 Dr Roylance
180 Mr Dean Hart was Medical Director from 1991 to 1992

152 Dr Roylance said in his statement that:

> 'At UBHT the role of the Medical Director was probably rather different to that in many smaller trusts. Although the post was designated as one of the executive directors, his role was, in many ways, non-executive and advisory. The Medical Director's position within the organisation was not one of authority or of command, but was advisory: he headed the medical advisory structure and was responsible for giving medical advice to the Trust Board.'[181]

153 Dr Roylance explained that the Medical Director had no line management role.[182] He said that the Medical Director:

> '… was elected by the medical staff as a Chairman of the Medical Committee, and he was appointed by the Board to Medical Director because he was Chairman of the Medical Committee, I have to say. It was not a coincidence; the Board wanted the Chairman of the Medical Committee as their Medical Director; unlike the other executive directors, he did not get paid as a Medical Director because he was a consultant. He was paid the national two-session allowance which we have been talking about, the two sessions, but he was not paid as a Medical Director, which is why I keep saying he was very much like a Non-Executive Director.'[183]

154 Mr Wisheart, himself a former Medical Director of the UBHT,[184] said that he felt that the role of Medical Director lay somewhere between an executive and a non-executive director. He said:

> 'There was no one who was directly responsible to him and his initial remit … was simply that he was to advise the Board on medical matters.'[185]

155 Dr Roylance described the role of the Medical Director and how it differed from that in other trusts. He said:

> 'The Medical Director advised me, as Chief Executive, and the Trust Board on medical issues. I met formally with him at Trust Board meetings and at HMC meetings on a monthly basis, and at weekly meetings of the Group of Executive Directors. I also saw him frequently on an informal basis. I believe that the structure of trusts which we were required to adopt was designed with organisations in mind that were very much smaller than UBHT. Thus, at UBHT the role of the Medical Director was probably rather different to that in many smaller trusts. Although the post was designated as one of the executive directors, his role was, in many ways, non-executive and advisory … he headed the medical advisory structure and was responsible for giving medical advice to the Trust Board.'[186]

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181 WIT 0108 0009 Dr Roylance
182 T25 p. 123 Dr Roylance
183 T25 p. 124 Dr Roylance
184 Mr Wisheart was Medical Director from 1992 to 1994
185 WIT 0120 0018 Mr Wisheart
186 WIT 0108 0009 Dr Roylance

156 Mr Baird, who was the Acting Medical Director at the UBHT from November 1996 until March 1997, described the primary role of the Medical Director in 1999 (i.e. after the period of the Inquiry's Terms of Reference) as being:

> '… in partnership with the Director of Nursing … to lead on professional issues in the group of Executive Directors, in Clinical Committees of the Board and the Trust Board itself.
>
> '… A major responsibility of the Medical Director is to assist and support clinical directors in their management of consultant staff, particularly in the areas of performance, health and conduct. This is an important but time-consuming aspect of the role. Links with Clinical Directors are fostered at monthly meetings, at reviews of their job plans, and when the Clinical Directors take up and leave office. The requirement for regular advice is growing.'[187]

157 Mr Wisheart said that as Medical Director it was his obligation to liaise with clinical directorates, all consultant staff, the Chairman of the HMC, executive directors and medical staffing personnel. As such, he was accessible to all those people and that particular part of his role evolved as other issues developed that were not part of his role when he first took up the post.[188]

158 Mr Wisheart succeeded Mr Dean Hart as Chairman of the HMC and Medical Director in April 1992. However, once Mr Wisheart's two-year term as Chairman of the HMC had ended, he remained as Medical Director, and the two posts were split. He explained this change in the following terms:

> 'When the [UBHT] was set up its policy was that the Chairman of the Hospital Medical Committee should be the Medical Director. When my appointment as Chairman of the Hospital Medical Committee began I was invited by the Trust to be the Medical Director. When my two-year term as Chairman of the Hospital Medical Committee finished it was clear that the job of Medical Director had developed to the point where one person could not realistically do both tasks. For that functional reason the two jobs were separated and I continued as Medical Director.'[189]

159 Dr Gabriel Laszlo became Chairman of the HMC and was welcomed at a meeting of the Trust Board on 14 January 1994. The minutes of that meeting record:

> 'The Chairman also welcomed Dr Gabriel Laszlo who would take over as Chairman of the [HMC] from the beginning of April. Until now the roles of Chairman of the [HMC] and Medical Director had been combined, but over the three years since becoming a Trust it had become evident that, with clinical commitments, the combination of the two roles was becoming untenable.'[190]

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187 WIT 0075 0002 Mr Baird
188 T40 p. 41–2 Mr Wisheart
189 WIT 0120 0019 Mr Wisheart
190 UBHT 0020 0007; minutes of meeting, 14 January 1994

160 Mr Wisheart was asked about the use of the word 'untenable'. He said:

> 'The combination of the two roles, together with one's clinical commitments, had become too heavy, yes. But I think he believed that that would probably apply to any active clinician who also had the chairmanship of the Medical Committee and the Medical Directorship to carry out.'[191]

161 Professor Gordon Stirrat had raised the issue of workload with Mr Wisheart in the later part of the period covered by the Inquiry's Terms of Reference. Mr Wisheart told the Inquiry that he was:

> '… satisfied that I could cope with those responsibilities which I had accepted at that particular time. I do not regard myself as being in any way different from a significant number of my colleagues who worked equally hard in one area of their professional life or another. I just happened to choose to do my work where it was rather visible within the Trust and within the NHS.'[192]

162 Counsel to the Inquiry put it to Mr Wisheart that, in contrast to the two sessions per week he was allocated in order to discharge his duties as Medical Director, the current (at the time of his giving evidence) Medical Director had seven sessions per week. Mr Wisheart explained that the obligations of the Medical Director had increased during his period of office:

> '… when I began as Medical Director it would have been very difficult to identify what work I had to do as Medical Director that was different from my work as Chairman of the Medical Committee, but by the end of the two years in 1994, a whole portion of work had developed which had not existed two years earlier.'[193]

163 On the arrival of Mr Hugh Ross at the UBHT as Chief Executive in 1995, Mr Wisheart was asked to devote more time to the responsibilities he had as Medical Director. Mr Ross said that he:

> '… found that the then Medical Director Mr James Wisheart was assigned only two sessions per week for the Medical Director's role which I felt was inadequate time to devote to the job of Medical Director at UBHT. Not only that, but at that time the Medical Director was not supported by Associate Directors to share the considerable load.'[194]

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191 T40 p. 40 Mr Wisheart
192 T40 p. 72 Mr Wisheart
193 T40 p. 71 Mr Wisheart
194 WIT 0128 0004 Mr Ross

164 However, Mr Ross acknowledged that throughout the NHS, there was no standard model for the role of medical director. He said:

> 'From the start of trust status, some trusts had full time Medical Directors right from the start; other trusts, like the one I ran in Leicester, had a Medical Director who only devoted two sessions to the job and I supported that Medical Director with other people to share the load. A whole variety of models were in place.'[195]

165 Mr Ross explained that he was of the view that:

> 'It is important for Medical Directors to continue with some medical and clinical responsibilities in order to keep their feet on the ground … and make sure they stay in touch with clinical practice, but I think it is fair to say that a trust the size of UBHT could easily have justified a Medical Director working the majority of their time on Medical Director duties, if not full time, such was the load.'[196]

166 In contrast to the clinical directors who had no extra assistance to enable them to carry out their role, the Medical Director did have support staff to assist him with the extra workload beyond his clinical commitments. Mr Wisheart said he:

> '… had an additional person at Trust headquarters who helped me with all my work as Chairman of the Medical Committee and Medical Director.'[197]

Mrs Margaret Maisey's dual role

167 Mrs Maisey was both Director of Operations and Chief Nurse Adviser of the UBHT from its inception on 1 April 1991 until mid-1996 when she became the Director of Nursing. She then held this post until she left the UBHT in September 1997.

168 Mrs Maisey held a position of some significance within the UBHT. She said:

> '… certainly I had influence, I had John Roylance's ear when I wanted it, I could speak to the Board if need arose. I do not think it ever did, particularly, but I did have influence, and I could make sure that works went up the road and, I do not know, did the work they said they would do and had not got round to doing. I could make some of these departments, lean on them to do things.'[198]

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195 T19 p. 35 Mr Ross
196 T19 p. 36 Mr Ross
197 T40 p. 39 Mr Wisheart
198 T26 p. 158 Mrs Maisey

169 Mr Durie was asked about Mrs Maisey's relationship with Dr Roylance in the following exchange:

> 'Q. So it was known throughout the Trust that Mrs Maisey was, to put it in legal language, Dr Roylance's "agent"?
>
> 'A. I think I understand that in legal language. If I do, yes.
>
> 'Q. It might be more colloquially put in terms of her being Dr Roylance's "eyes and ears" throughout the Trust?
>
> 'A. Not only eyes and ears. She was also a doer.
>
> 'Q. When Mrs Maisey would express a view about a matter, the person to whom the view was expressed would believe or would understand that the view Mrs Maisey expressed was liable to be Dr Roylance's view also.
>
> 'A. That is right.'[199]

170 An article in *'Private Eye'* dated 18 June 1993 described Mrs Maisey as 'Dr Roylance's sidekick'.[200] Mrs Ferris described Mrs Maisey as playing:

> '… a very particular role for the Chief Executive … She herself, I think, on many occasions, described herself as the Rottweiler of the Trust, so I think her own view was consistent with that.'[201]

171 Ms Janet Maher, General Manager UBHT,[202] described Mrs Maisey's power or influence as being due to her closeness to Dr Roylance. According to Ms Maher, Mrs Maisey had:

> '… a very strong power base and was seen as being strongly linked with Dr Roylance. I believe that some General Managers were frightened of her, although I do not believe she meant to be frightening to them. I would say that she always had the best interests of staff and patients at heart.'[203]

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199 T30 p. 38–9 Mr Durie

200 SLD 0002 0007; *'Private Eye'*

201 T27 p. 83–4 Mrs Ferris

202 Ms Janet Maher held several positions in Bristol. From 1989 she was the shadow General Manager of what was to become the Directorate of Medicine at the BRI. From 1991 she was the General Manager for the Directorate of Medicine. In April 1993 she became the General Manager for the Directorate of Surgery. In March 1998 she was appointed General Manager at the BRI responsible for Medicine, Surgery, Anaesthesia, Bristol General Hospital and Keynsham Hospital. She held this post until she left the NHS in March 1999

203 WIT 0153 0010 Ms Maher

Mrs Maisey as Director of Operations

172 Dr Thorne told the Inquiry that Mrs Maisey's role, as Director of Operations, was different from that which she had carried out as a Unit General Manager in the pre-trust days. She said:

> '… as far as I understood it to be, she was Director of Operations and sort of Chief Nursing Adviser, in a professional capacity, which was why she was on the Board as the chief kind of Nurse Adviser. … she had moved from having this enormous kind of hierarchical management role as a General Manager to having a Board level role where she was actually supporting people and fire fighting, beetling around, trying to help people, solve problems, identify issues before they became very problematic.'[204]

173 Mrs Maisey had little guidance about what was expected of her in her role as Director of Operations. In her evidence to the Inquiry she said:

> 'I think what you have to remember is that there had never been a Director of Operations before in the Health Service to my knowledge … these titles were new … We did not have a hang up with titles in UBHT; we were concerned that the things that needed to be done got done.'[205]

174 Mrs Maisey was asked:

> 'What would you say were the main areas of responsibility, the main three or four areas that defined your role as Director of Operations as it subsequently developed?'

She replied:

> 'Quite a lot of my time was spent with individual General Managers and/or Clinical Directors, discussing how they were going to develop their directorates. Sometimes that was about geographical moves, sometimes it was about financial problems, sometimes it was about staffing, all sorts of things, some of which they would have had experience with, and some of which they might not have.'[206]

175 Ham and Smith in their paper discussed Mrs Maisey's role in relation to general managers:

> 'The general managers in the clinical directorates, who were accountable directly to the chief executive, met regularly with the director of operations/chief nursing adviser [Mrs Maisey] in the executive management group.'[207]

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204 T35 p. 108 Dr Thorne
205 T26 p. 52 Mrs Maisey
206 T26 p. 75 Mrs Maisey
207 INQ 0038 0008; Ham/Smith paper

176 Further they argued:

> 'The director of operations did take on a key role on behalf of the Chief Executive in working alongside directorate general managers but the evidence suggests that the way in which this role was performed was not always viewed positively.'[208]

177 Ms Maher recalled Mrs Maisey's role as follows:

> 'The Director of Operations was there to support General Managers but not to manage them as such. I would say that Margaret Maisey, as Director of Operations, had a lot of influence and power, but no direct management responsibility for the General Managers of the Directorate … General Managers of Clinical Directorates met with Margaret Maisey as the Director of Operations once a month.'[209]

178 Dr Roylance explained that at these meetings, Mrs Maisey gave the general managers 'a great deal of managerial support'.[210]

179 However, Mrs Ferris said:

> 'I felt unable to talk to Mrs Maisey or Dr Roylance because there was a history of lack of support or guidance. Although I attended the monthly General Managers' meetings and the weekly Management Development Group, I did not feel able to be open or to confide in my immediate colleagues and managers. It seemed to me that managers would watch to see who was "in favour" and those who were not were avoided. I felt that there was a culture of fear and blame.'[211]

180 Further, she said:

> 'The Director of Operations had a personal management style of "management by fear" rather than encouragement. Although I challenged her on a number of occasions, I felt I did so to my own detriment.'[212]

181 When Mrs Ferris was asked to elaborate on these comments in her evidence to the Inquiry, she said:

> 'The General Managers were in fear of the action that would be taken by Mrs Maisey if they did not fit into the perceptions or requirements that she had of them, which I think is different to being worried and performing well in their post, in that they are worried about what would happen. There was a real fear of the arbitrary way in which some managers were in favour and some managers were out of favour.'[213]

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[208] INQ 0038 0013; Ham/Smith paper
[209] WIT 0153 0003 – 0004 Ms Maher
[210] T24 p. 60 Dr Roylance
[211] WIT 0089 0025 Mrs Ferris
[212] WIT 0089 0034 Mrs Ferris
[213] T27 p. 81 Mrs Ferris

182 When Mrs Maisey was asked about Mrs Ferris' perception of her style of management, she said:

> 'Of all the management styles that I might have considered adopting, it is not one that I would want to be labelled as, and I cannot conceive that the team with which I worked would not have put me right if they thought that that was how I was being perceived. There was an openness and a frankness and an honesty and a preparedness to "say it as it feels" about our team working … particularly amongst the executive group. They would have given it to me straight, if they thought that is how I was comporting myself.'[214]

183 Miss Salmon said she felt she had:

> '… very little influence or authority as either an Associate General Manager or a General Manager with [Margaret Maisey] or [Dr Roylance]. The culture at the time was one in which personal relationships with an individual executive director [were] possibly more important than hierarchical relationships.'[215]

184 Mrs Ferris felt that there was no support provided to general managers and that:

> '… the attitude of Mrs Maisey and Dr Roylance when asked to help deal with particular problems, was either to ignore them, or to make the manager feel inadequate for having raised them, or to respond aggressively. My experience was that Mrs Maisey's approach was particularly aggressive.'[216]

185 Mrs Maisey confirmed that it was not usual to set objectives for the general managers of the clinical directorates. She said:

> 'I did not see it as essential that Clinical Directors set objectives for their General Managers. If their General Managers wanted objectives then it might be that the Clinical Director could help them, but I cannot conceive of the Clinical Directors that I can think of now, of any who would feel that they ought to sit down and work out themselves the objectives of General Managers. I think they would probably be happy to be involved in a debate with the General Managers about objectives that the General Managers themselves had set in the same way that I would.'[217]

186 Some, such as Ms Sheena Disley, did not see Mrs Maisey as having a significant input in their day-to-day activities. Sister Disley was asked what impact Mrs Maisey had in her capacity of Nurse Adviser to the Trust from 1991, on her work as a ward sister. She replied, 'I think we were a fairly self-contained unit. Clearly we knew who she was, clearly I think she was not a significant presence on the unit at that time.'[218]

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214 T26 p. 89 Mrs Maisey
215 WIT 0109 0014 Miss Salmon
216 WIT 0089 0035 Mrs Ferris
217 T26 p. 85 Mrs Maisey
218 T32 p. 100–1 Ms Disley

Mrs Maisey's nursing responsibilities

187 Mrs Maisey was appointed Unit General Manager of the South Unit in the B&WDHA in 1985 and took up post 'early in 1986'. She also assumed the role of Nurse Adviser to the Health Authority.

188 Mrs Maisey explained the change which the introduction of general management brought about to the management of nurses:

> 'When general management came in, it swept away all those nurse managers. Most specifically, it swept away … 17,000 nursing officers in England and Wales … They were replaced with … General Managers, most of whom were not nurses and many of whom have never managed nurses. But the nursing officers used to monitor everybody.'[219]

189 The introduction of general management meant that nurses were managed not by nurses, but by general managers.

190 When the UBHT came into being, it was required to have a nurse as one of its executive directors.

191 Mrs Liz Jenkins, the Assistant General Secretary of the Royal College of Nursing (RCN), agreed that it was important to have someone with a nursing role at trust board level.[220]

192 When Mrs Jenkins was asked what she saw as the purpose and function of a director of nursing, she replied:

> 'I have to say, it will depend on what their job was, and there were all sorts of hybrid jobs. Some Directors of Nursing had responsibility for the budget, for the nursing and the accountability for that; others did not … Some had personnel functions added to their jobs. So there were many different jobs during that period of time [1984–1995] that were described as or incorporated the person who sat as the "nurse" on the Board.
>
> 'My own personal view is that whether you had the management of nursing and the finance for it in your power or not, you were on that Board to provide the best possible nursing advice for the benefit of patients to that Board and that therefore, my own view is that you would have a strong responsibility for ensuring that patient care within your domain was as safe and as good as it possibly could be, given the financial constraints that you would have.'[221]

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219 T26 p. 152–3 Mrs Maisey

220 T34 p. 54 Mrs Jenkins. The NHS Trusts (Membership and Procedure) Regulations 1990, SI 1990 No. 2024 state at Reg. 4(i)(c): 'The executive directors of an NHS Trust shall include … a registered nurse or a registered midwife …'

221 T34 p. 53–4 Mrs Jenkins

193 She went on to say:

> '… the nursing role on a Trust Board has a responsibility for ensuring that the other colleagues on that Trust Board understand the issues of patient care and that they therefore ensure that they are not making decisions that conflict with patient care or safety.'[222]

194 However, it was not entirely clear what the ambit of the nursing director's responsibilities should be. Dr Roylance said:

> 'You will recognise that if you introduce the general management function, then there is no managerial role for a District Nurse, because nurses are managed by General Managers. When we became a Trust, along with other trusts – large trusts – there was a problem of what an appropriate role would be for the nursing director, the Director of Nursing, on the Trust Board, because … by definition she could not manage nursing. That and the general management function could not co-exist.'[223]

195 Dr Roylance added:

> 'A number of solutions were produced across the country on how to develop a role for the Director of Nursing, so when we became a Trust, which is after we created directorates, we agreed … that an appropriate role for her would be a Director of Operations.'[224]

196 Mrs Maisey explained her role in these terms:

> 'The title of Director of Operations and Chief Nurse Adviser … meant that as each Directorate had its own Nurse Adviser, I became the focal point for the Trust as a whole for these Nurse Advisers. This was the main change in my nursing role from before 1991. I was not Director of Nursing. Director of Operations was a new role to provide support and guidance to the General Managers in setting up their new Directorates and to manage the Trust's support services such as catering, maintenance and capital building works, patient information, information technology and complaints.'[225]

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222 T34 p. 54 Mrs Jenkins
223 T24 p. 48–9 Dr Roylance
224 T24 p. 49 Dr Roylance
225 WIT 0103 0022 Mrs Maisey

197 Thus within each clinical directorate there was a nurse advisor who could be approached for advice by any nurse within that directorate. If a matter needed to go further, Mrs Maisey was 'the professional link to the Department and to the policy making bodies for the profession.' [226] Mrs Maisey said:

> 'In all the different roles I had, I always expected to be approached if there were problems with nurses, whatever the problems were. I would always expect to be involved, assuming they were serious and unsolvable by any obvious route.'[227]

198 Ham and Smith in their paper outlined a drawback of Mrs Maisey's having this dual role:

> 'The responsibility given to the director of operations/chief nursing adviser by the chief executive meant that de facto she acted as a third deputy to the chief executive. A further consequence of this was that the operational aspects of the director of operations/chief nursing adviser role were significant and to some degree took time away from the role of chief nursing adviser.'[228]

199 The Inquiry heard evidence of a perception among ward nurses that Mrs Maisey was seen as an inaccessible figure. Ms Sheena Disley, a ward sister at the UBHT, said in her witness statement:

> 'I think I saw Margaret Maisey twice in all: I didn't feel she was someone I could confide in or expect to act on the problems I may have had.'[229]

200 Sister Disley's oral evidence included this exchange:

> 'Q. Was it the case that you did not feel you could confide in Mrs Maisey because she was in a separate building, or was it that you did not feel you could confide in her because she was not the type of person you could confide in, or both?
>
> 'A. I think because she was obviously very thinly spread about a large area, we saw less of her. I think it is difficult to confide in somebody that you are not familiar with, you do not have a relationship with them.
>
> 'Q. … You would have liked more support from higher up the nursing chain?
>
> 'A. I think as a group of nurses, as a hospital full of nurses, I sometimes felt that we lacked direction, that we lacked a clear leader, and I think ... since Lindsay Scott has been in post,[230] that there is a much more significant voice for nurses now … There have been arenas for nurses to meet Lindsay Scott and for nurses to identify

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226 T26 p. 162 Mrs Maisey
227 T26 p. 95 Mrs Maisey
228 INQ 0038 0023; Ham/Smith paper
229 WIT 0085 0004 Ms Disley
230 Ms Lindsay Scott, the Director of Nursing at the UBHT from 1997 to date

> their concerns about where they work, about what is happening in the Trust. She has also been very active in the development of the nursing strategy.'[231]

201 However, according to Mrs Fiona Thomas,[232] there was not often any call for her to seek out the help or assistance of Mrs Maisey in the latter's nursing role:

> 'My responsibility was to the Associate General Manager, and to … the Clinical Director. And we were very much kept in that sort of remit. We did not really need to go elsewhere, apart from certain bits and pieces, so there was very little time I needed to actually think that I needed to have a Director of Nursing at that time.'[233]

202 When Mr Ross assumed the role of Chief Executive in 1995, Mrs Maisey's role changed. From 1996, she was the Director of Nursing rather than Director of Operations and Trust Nurse Adviser. Mr Ross himself assumed a lot of the responsibility that Mrs Maisey had previously had as Director of Operations. According to Mrs Maisey, this difference in roles meant that she:

> '… got more involved in the nursing issues of the day … I got more involved with the College, the University, to which we had contracted out the basic nursing training. I was drawn into nursing policies and processes in a much more detailed way than I had been previously.'[234]

Mr Ross explained the rationale for his reorganisation of the role of the Nursing Director on the UBHT Board:

> 'I felt strongly the right standards of patient care could only be achieved with a contribution from a nursing professional. So the Director of Nursing's role now is essentially … around professional standards, care, development, teaching, training, a whole range of issues around standards of service and so on.'[235]

The role of the Trust Chairman

203 In 1994 the NHS published the '*Code of Accountability for NHS Boards*'.[236] This described the Chairman's role thus:

> 'The chairman is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

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231 T32 p. 104–6 Ms Disley

232 Fiona Thomas was Clinical Nurse Manager of Cardiac Surgery from November 1993 to December 1996. She is currently Clinical Nurse Manager of the Cardiothoracic Clinical Directorate

233 T32 p. 22 Fiona Thomas

234 T26 p. 154 Mrs Maisey

235 T19 p. 41 Mr Ross

236 Department of Health, April 1994

'A complementary relationship between the chairman and the chief executive is important.'[237]

204 Mr Durie was Chairman of the B&WDHA from 1 April 1986 to 31 March 1990 and then Chairman of the UBHT from 1 April 1991 to 30 June 1994. In the period between his two chairmanships:

'… I was no longer involved with the National Health Service, except I think I had the title … some funny title they dreamt up for people who helped work out applications for Trust status.'[238]

205 Thus, like Dr Roylance, Mrs Maisey and Mr Nix, in particular, his evidence straddles the management and culture at Bristol both before and after the inception of the UBHT. When Mr Durie took up his post as Chairman of the Health Authority the only guidance he received on what was expected of him was a briefing from his predecessor and a discussion with the Chairman of the RHA.[239]

206 Mr Durie, the first Chairman of the UBHT, described his view of the role:

'The Chairman's role was somewhat ill-defined, but my personal belief was that it was up to me to ensure that the hospital services under me provided the most effective healthcare to the greatest numbers within the financial limitations imposed. That said, as Chairman of the [B&WDHA] and latterly UBHT, I was keenly aware that it was not my function to take over from the full time executive or to provide parallel management. I saw myself more as Chairman first of the Health Authority and then of the Trust Board, responsible for ensuring that in addition to treating today's patients, there was the organisation and the management structure to prepare clear plans for the future. In so complex and diverse an organisation, I thought it important to be known personally and also to be seen as approachable.'[240]

207 Dr Roylance shared Mr Durie's view of the role of Chairman. Dr Roylance was asked:

'Would the Chairman of the Trust qualify as senior management?'

He replied:

'No, he is not a manager at all. The Chairman and Non-Executives set policy and supported management, which was performed by the Executive Directors. There was no question about that … the Trust Board set policy, and it was left to the managers to implement it. We were the managers. The Trust Board did not manage anything … the Trust Board was a policy making body. I headed the management

237 HOME 0004 0073 – 0074; '*Code of Accountability for NHS Boards*'
238 T30 p. 12 Mr Durie
239 T30 p. 8–9 Mr Durie
240 WIT 0086 0002 Mr Durie

function to implement that policy. I did not expect the Trust Board to manage and they did not expect to.'[241]

208 Mr Robert McKinlay was Chairman of the Board from July 1994 to November 1996. He described the role in his written statement:

> '… the Chairman is on the scene much more frequently than the other Directors, and he or she becomes the bridge between the Executive team and the Board. The Chairman needs to know what is going on to a greater degree than the other non-executive directors, in order to give on the spot advice to the Executive team and guide the deliberations of the Board. In addition, on many occasions the Chairman is required to be the representative or spokesman for the Trust.'[242]

209 He went on to say that:

> 'To implement the policy of the Chairman having a good understanding of what is going on, the Chairman should attend as many committee meetings as possible, which was my practice. In addition, there should be regular meetings with Executive Directors. I would meet the Chief Executive at least once per fortnight on a planned basis, when he would bring issues to my notice and vice versa. I would meet with the other Executive Directors individually on a planned basis every 4–6 weeks. In practice, by being around in the Trust and attending meetings, I would meet the Executive team and the other non-Executive Directors frequently.'[243]

210 To stay informed as to what was going on in the wider hospital community, Mr McKinlay paid:

> '… regular visits to the various hospitals and services, both during the day and at night … These visits were invaluable in seeing how the doctors, nurses and administrators were facing up to the day to day challenges, and to put into perspective proposals for change, either physical or operational, which the Board was being asked to consider.'[244]

211 Dr Thorne was asked what the role of the Chairman was as she understood it from her work at the UBHT. She replied:

> 'I think the role of the Chairman was to take a strategic overview and to manage the work of the Board effectively. I think that means actually managing the cohesion of the Board and actually looking at the competencies of the constitution of the Board, because that is inordinately important, having the right balance of people. I think that is a very important role for a Chairman to play, and I think it is also about actually being in some senses a figurehead whom people recognise as a

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241 T88 p. 104–5 Dr Roylance
242 WIT 0102 0006 Mr McKinlay
243 WIT 0102 0008 Mr McKinlay
244 WIT 0102 0008 Mr McKinlay

symbol of a kind of strategic level, but are almost dissociated from the executive role because I also think that is important. So they have to ensure the non-executives do not try to become operational, because that is the road to disaster.'[245]

The role of non-executive directors

212 Dr Roylance, in the course of his evidence to the Inquiry, explained the role that non-executive directors performed. He said:

> 'They were non-executive and they were meant to be the parallel of Non-Executive Directors of a commercial company whose primary responsibility is to shareholders and profit. The primary responsibility of the Non-Executive Directors was to patients, so it was their responsibility to do two things: bring lay information about the community and skills that they brought with them from their background. In other words, they were people with business experience to give us the benefit of a business approach to things, and they were very active.'[246]

213 In one of the NHS *'Working for Patients'*[247] documents entitled *'Self-governing Hospitals'*,[248] published in 1989, it was stated that: '… the board of directors will be responsible for determining the overall policies of the Trust, for monitoring their execution, and for maintaining the trust's financial viability.'[249]

214 The same document also said, '… All the non-executive members will be chosen for the personal contribution they can make to the effective management of the hospital and not to represent any interest group.'[250]

215 Mr McKinlay gave an extensive description of the role of the Trust Board and its Chairman in his statement to the Inquiry:

> 'The role of the Trust Board and its Chairman, while having structural similarities to the commercial model, is essentially different. An NHS Trust is required to provide the highest quality service possible to members of the public within the funds made available by HMG. There is no profit motive in the NHS. While the Board acts as stewards for HMG's funds, the "customers" are the members of the general public, who in the end are also the "shareholders". How the Board should act in relation to customer service will be discussed below, but it is worth noting that, unlike a commercial business, the supply of "customers" to the NHS is effectively unlimited and sub-division into "product streams" is at best of limited applicability in a large Trust like UBHT.

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245 T35 p. 22 Dr Thorne
246 T26 p. 1–2 Dr Roylance
247 NHS Reforms, *'Working for Patients'*, Working Papers, HMSO Cm 555
248 Working Paper No 1, '*Self-governing Hospitals*', 1989
249 HOME 0003 0042; Working Paper No 1, '*Self-governing Hospitals*', 1989
250 HOME 0003 0042; Working Paper No 1, '*Self-governing Hospitals*', 1989

'In a Trust the Chairman and non-Executive Directors need to work with the Executive team to find the right balance between financial control and responsibility, and "customer service", ie the quality of treatment and care given to patients. In my view, high quality patient care is the paramount requirement, but the funds available are limited and have to be managed carefully. To find the right balance, the non-Executive Directors and Chairman need to work in a more positive, pro-active way than would be usual in a commercial business. They need to be Directors and sounding boards for the Executive team, giving them as broad a spectrum of advice as possible.

'If we now turn to the practice rather than the principles, although I have said that the Trust Board should be pro-active, they are not there to run the Trust on a day-to-day basis; that is the task of the Executive team. Guided by the Chairman, the Board is there to set policies, both financial and operational; approve investments; appoint senior members of staff; assist in ensuring that sound systems for setting standards and measuring performance are in place; and to look to the future. They are also there to help resolve specific issues of any sort addressed to them by the Executive team.'[251]

216 Mr Durie explained that the Board's non-executive directors would try to fulfil their roles on the basis of information provided to them at meetings and by observation as they went about the Trust. He recalled:

'We were very concerned at trying to improve the patient care; we were not … looking at the clinical outcomes but we were very concerned about were they being properly looked after when they arrived at the hospital etc etc.'[252]

217 Mr Moger Woolley, who was appointed a non-executive director at the Trust's inception, viewed his role as not '… to run the day to day activities of the Trust. My role as a non-executive director of UBHT was to sit at the Board table and to question the executives on their roles and how they were carrying them out.'[253]

218 Mr Woolley went on:

'I felt that the role I adopted, of stimulating debate and ensuring that matters were thought through, was appropriate for a non-executive director. I did not feel that it was necessary for my view to prevail.'[254]

251 WIT 0102 0006 – 0007 Mr McKinlay
252 T30 p. 42 Mr Durie
253 WIT 0357 0002 Mr Woolley
254 WIT 0357 0002 Mr Woolley

219 Mr Louis Sherwood, a non-executive director from the Trust's inception until November 1998, felt:

> '… that we [the non-Executive Directors] were there to sharpen up the financial management of the Trust. That was the most substantial contribution that I could make as a Non-Executive Director with a broad, general business background. Many of the Board's papers were financial ones, and we spent a lot of time on financial issues.'[255]

220 Mrs Maisey outlined various tasks performed by the non-executive directors:

> '… they came to the committees; they each of them chaired one of the executive committees …The Capital and Services Development Committee and the Patient Care Committee and the various committees that we had were all chaired by one or other of the non-executives … they took roles according to their expertise and skills.'[256]

221 Mr Nix, in his statement, when citing the benefits of trust status, viewed the non-executive directors as having a more active role. He said a benefit of trust status was that 'the expertise of the non-executive directors will be used to direct care more appropriately. They will also take a leading role as laymen and women ensuring all patients are treated as individuals.'[257]

222 However, Ham and Smith in their paper described the non-executive directors as not wanting to get involved in details. They said:

> 'From the evidence available, it appears that the board focused mainly on high level issues and was not drawn into the detail of service delivery. Peter Durie … personally committed three days a week as chairman and this time was spent in meetings and walking around the hospitals and services for which the trust was responsible. He would meet the chief executive on a regular basis and he supported the delegation of authority to clinical directorates because "it ensured that the Trust Board did not get bogged down in detail. The Board could concentrate on major issues".'[258]

223 However, Mr Durie's successor, Mr McKinlay:

> '… acted to strengthen the management structure by forming board committees chaired by non-executives to "take on a more inquisitive role" … The changes which he introduced were intended to strengthen co-ordination and monitoring

255 WIT 0110 0002 Mr Sherwood
256 T26 p. 119 Mrs Maisey
257 WIT 0106 0016 Mr Nix
258 INQ 0038 0018; Ham/Smith paper

from the centre given his perception that existing arrangements were not adequate.'[259]

224 Mr Durie was asked about the ways in which non-executive directors monitored what was happening in the Trust:

'Q. The mechanism by which you and your non-executive colleagues would monitor the executive management of the organisation was what?

'A. … We would see ourselves undertaking that role by the results that were reported to us when we met formally as a Board, by us observing, as we went around the Trust in between Board meetings. Those were our two key ways of understanding that what was being done was satisfactory.'[260]

225 The Inquiry heard that shortly after he became Chairman Mr McKinlay made proposals about the reorganisation of some of the committees of the Trust: 'I made some proposals for revamping what had been Advisory Groups into board committees, with more what I thought were clearer terms of reference.'[261] He produced a document to Board members setting out his proposals, and setting out the Board's three Committees: the Patient Care Standards Committee, the Medical Audit Committee and the Audit Committee. These Committees are considered in greater detail in Chapter 18.

226 Of the Patient Care Standards Committee Mr McKinlay wrote:

'This committee would be expected to oversee *all* aspects of patient care. Provided we can establish a satisfactory set of definitions it would need to enter into the field of medical outcome inasmuch as this affects the performance of the Trust as a whole but steer clear of medical audit. I believe the answer lies in studying medical outcome on a statistical basis while leaving the underlying clinical factors to the Medical Audit Committee.'[262]

227 Mr McKinlay commented on this in his evidence to the Inquiry:

'I think there was a tightrope of a sort. There was no tradition or culture in UBHT that the Board or the committees of the Board should be involved on outcome, medical outcome, even on a statistical basis. I felt that that is something that should evolve. To be more specific, I thought that was something that was wrong. I thought the Board should have some knowledge of statistical outcome, but there was a tightrope to be trod to find a way of easing it into place.'[263]

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[259] INQ 0038 0019; Ham/Smith paper
[260] T30 p. 41 Mr Durie
[261] T76 p. 6 Mr McKinlay
[262] UBHT 0021 0700; Board paper, 18 January 1995 (emphasis in original)
[263] T76 p. 8–9 Mr McKinlay

228 The minutes of the meeting of the Patient Care Standards Committee on 7 November 1995 recorded Mr McKinlay asking, '… how the Trust could identify the relevant professional standards and compare local performance. He commented that few of the audits concerned outcome'.[264] Mr McKinlay was asked in evidence whether any answer was provided to that question, and he replied that it was not. His evidence included this exchange:

> 'Q. Did you ever form a view as to how that question could have been answered?
>
> 'A. I think the answer could have been that it was not the tradition or culture in UBHT to publish in any open way outcome results.
>
> 'Q. Did you understand that to be a less open approach than other comparable Health Service organisations?
>
> 'A. The people that I talked to within the Trust, which would be probably largely Dr Roylance, but some others, I gathered the impression that they felt they were not really any different from other trusts. But I did not have any independent way of verifying that.'[265]

229 Mr McKinlay was also asked how the non-executive directors kept abreast of the quality of care within the UBHT. He replied:

> 'I feel that a Board has to be aware of the measures by which its business will be judged … I think the Boards have to have the measures that allow them to be confident that is happening. I think in the Health Service medical outcome is a measure that the Board should take an interest in … I believe that quality within medical performance can only be provided by those who are the providers, the experts, but the Board should be able to assess as to whether the standards which they think are relevant are being met.'[266]

230 Mr McKinlay was questioned by Professor Jarman about the information available to him:

> 'Q. … you stated in your witness statement … that "the board and executive management required that the Trust provided a high quality, safe treatment and care" then later on … you say that "Standards against which questions could be posed and followed up did not exist in this systematic fashion". You have said a number of times that you thought there should be analytical data available to analyse problems. Did you see any of the … reports of the paediatric cardiac surgery of the BRI?
>
> 'A. No.

[264] UBHT 0016 0007; minutes of meeting of Patient Care Standards Committee, 7 November 1995
[265] T76 p. 14 Mr McKinlay
[266] T76 p. 18–19 Mr McKinlay

'Q. Reports of that type were freely available and you wanted reports of that type; did you request them?

'A. No, I did not, I did not know that reports of this type were available. What I had asked for as an audit report did not have this kind of information in it … I primarily wanted a system put in place where standards were set and performance against those standards were measured. At the time when I was projecting that view in the Trust, we are talking about November 1995, I was not aware that there was a problem in mortality in paediatric cardiac surgery. I was putting forward something to me that was perfectly normal. …

'I requested the audit report, I did not request this information because the audit report did not track you through to this information. This information, by the time I was asking for the audit report, was the content of the information that Hunter and de Leval had produced and which was produced by the Trust in January 1995 … January 1996.'[267]

231 Mr Sherwood recalled visiting various parts of the hospital in order to oversee what was happening:

'As Board members we were all encouraged to visit and follow the activities of various departments. Apart from any personal interests, we were allocated to particular parts of the Trust by the Chairman. I took on responsibility for following medicine, radiology, obstetrics and gynaecology, and ENT. I visited these departments fairly regularly. We were encouraged to go everywhere in the Trust, but specifically asked to look at the areas to which we were allocated.'[268]

232 Dr Thorne, in her evidence to the Inquiry, explained her understanding of the role of the Trust Board. She said:

'… the role of the Trust Board was to help in identifying what this vision would be, to help clarify the nature of the organisation, and to actually set the tone of the organisation itself. So [the Trust Board was] very interested in "What kind of Trust do we want to be?" so "We will be a Trust, but what kind of Trust do we want to be and therefore what are the implications of that?" as long as all the kind of fiduciary duties and all the other things which are absolutely and terrifically important.'[269]

233 According to Mr Durie, the Board:

'… had the role of being aware of what was happening and having to make the decisions of where limited resource was to be applied and it also could be a facilitator of trying to help the clinical directorates as necessary.'[270]

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267 T76 p. 88–90 Mr McKinlay
268 WIT 0110 0003 Mr Sherwood
269 T35 p. 20–1 Dr Thorne
270 T30 p. 29 Mr Durie

234 The directors on the Trust Board also had guidance from the NHS on their responsibilities. In the wake of the 1989 '*Working for Patients*' White Paper, the NHS Management Executive released a paper entitled *'NHS Trusts: A working guide'*.[271] According to Sir Alan Langlands,[272] this guidance set out the roles and responsibilities of trust boards and 'set out the basis on which they would be monitored and held to account by the DoH.'[273]

235 Sir Alan explained the responsibility of members of a trust board in his evidence to the Inquiry. He said:

> 'They were expected to behave as part of a single National Health Service. If I can give you some examples, they were expected to pursue national priorities and planning guidance produced by the Department of Health; they were expected to work to comply with patient charter standards and during the period, I guess, 1992 to 1995, they were expected to operate a series of codes … each Trust was expected to establish a system of corporate governance, which of course now has echoes in the way in which we define clinical governance, which included audit committees and required them to have standing financial instructions to a certain format, required them to produce annual reports, required them to engage in quite a detailed system of internal and external audit.'[274]

236 The working guide, referred to above, explained the differences that would occur with the introduction of trusts:

> 'A key element of the changes is the introduction of NHS Trusts. They are hospitals and other units which are run by their own Boards of Directors; are independent of district and regional management; and have wide-ranging freedoms not available to units which remain under health authority control.
>
> 'Whilst remaining fully within the NHS, Trusts differ in one fundamental respect from directly managed units – they are operationally independent.'[275]

237 The working guide also discussed who would be on the board of directors and what the directors' responsibilities would be:

> 'Each Trust is run by a Board of Directors consisting of:
>
> - 'a non-executive chairman appointed by the Secretary of State;
> - 'up to five non-executive directors, two of whom are drawn from the local community and are appointed by the regional health authority, the remainder of

271 NHS Management Executive, *'NHS Trusts: A working guide'*, HMSO, 1990
272 Chief Executive of the NHS Executive in England from April 1994 to 2000
273 WIT 0335 0043 Sir Alan Langlands
274 T65 p. 20 Sir Alan Langlands
275 WIT 0335 0053 Sir Alan Langlands

whom are appointed by the Secretary of State. Where a Trust has a significant commitment to undergraduate medical teaching, one non-executive director is drawn from the relevant University;

- 'an equal number of executive directors, up to a maximum of five, including the chief executive, the director of finance, and, for the vast majority of Trusts, a medical director and a nursing director.'[276]

238 This guidance was reinforced in April 1994 in an NHS publication entitled *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*.[277] This said:

> 'NHS boards comprise executive board members and part time non-executive board members under a part-time chairman appointed by the Secretary of State ... There is a clear division of responsibility between the chairman and the chief executive: the chairman's role and board functions are set out below; the chief executive is directly accountable to the chairman and non-executive members of the board for the operation of the organisation and for implementing the board's decisions. Boards are required to meet regularly and to retain full and effective control over the organisation; the chairman and non-executive board members are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities.'[278]

Pathways for expressing concerns

239 After the UBHT was established, there were in general terms two separate pathways which could be taken by those members of staff seeking to raise concerns about any aspect of the delivery of healthcare in the Trust: the professional advisory route, leading to the Chairman of the HMC and the 'three wise men'[279] on the one hand; and the management route through the clinical directors ending, ultimately, with the Chief Executive on the other.[280]

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[276] WIT 0335 0056 Sir Alan Langlands

[277] HOME 0004 0068 – 0075; *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*, Department of Health, 1994

[278] HOME 0004 0073; *'Corporate Governance in the NHS: Code of Conduct, Code of Accountability'*, Department of Health, 1994

[279] A Health Circular issued in July 1982 (HC(82)13) had required all DHAs to introduce procedures to prevent harm to patients resulting from the physical or mental disability of medical staff employed by them. Dr Roylance explained to the Inquiry that in practical terms this included incidences of suspected incompetence of staff (see T25 p. 6). The Circular recommended that the HMC of each DHA set up a panel of members, the Special Professional Panel, from the senior medical staff. From this panel a small sub-committee would then be appointed to receive and take action on any report of incapacity. In Bristol, the panel comprised the Chairman elect, the Chairman and the past Chairman of the Medical Committee, and they became known as the 'three wise men' (see T25 p. 6–7)

[280] T25 p. 75 Dr Roylance

240 Dr Roylance was questioned about this in the course of his evidence:

> 'Q. Would you have expected a member of hospital staff, whether medical or non-medical, to have had other means of raising concerns about unacceptable practice before getting to the stage of going to the three wise men or one of them?
>
> 'A. There was a whole mosaic of routes that were available and were used and it is difficult to answer specifically unless I really hypothesise a situation … It would be very likely to be through their district professional adviser, and then to Margaret Maisey or me.'[281]

241 There was no formalised system governing with whom a particular concern or complaint should be raised. In Dr Roylance's view, such a system would have:

> '… constrained and restricted the opportunities of staff to choose an appropriate route to resolve a situation.'[282]

242 The evidence as to the raising of concerns about paediatric cardiac services in Bristol, and the possible alternative routes which were or could have been followed in raising such concerns, is dealt with fully from Chapter 20.

The relationship between academics at the University of Bristol Medical School and the UBHT clinicians

243 The UBHT is a teaching hospital trust and, as such, has close links with the academic departments of the Medical School at the University of Bristol.

244 Dr Roylance described these links, in some detail, in his statement:

> 'There has always been an extremely close and intimate relationship with the University of Bristol. All senior NHS medical staff carried honorary recognition as University Professors, lecturers or clinical teachers. All University clinical staff had formal honorary contracts with the District which were then transferred to the Trust on its inception. All appointments committees for senior medical staff included representatives of the University of Bristol and all appointments committees for senior University clinical staff included representatives of the District and subsequently of the Trust. University representatives were appointed to the District Health Authority and to the Trust Board. There were, in addition, innumerable standing and ad hoc committees with representation both of the NHS and the University.
>
> 'In particular, there were standing University liaison committees at regional and district level and I was a member for a time of each of these committees. With the creation of the Trust there was created a Joint Committee for Medical and Dental

281 T26 p. 24–5 Dr Roylance
282 T25 p. 76 Dr Roylance

Education and Research with representatives of both University and NHS and chaired by the University Deputy Vice-Chancellor who was a non-Executive Director of the Trust Board. From 1990 there was an increasing relationship with the University of the West of England, at first in relation to management, training and development, and later in the education of nurses and of the professions allied to medicine.

'Together with the Chairman of the Trust I met the Vice Chancellor of the University and the Clinical Dean at least 3 times a year to discuss matters of joint interest. I also instituted a monthly lunchtime meeting, together with the relevant senior managers of the Trust, with the Dean of the Faculty and senior members of the University. All operational matters of immediate joint interest were discussed, particularly those affecting the clinical experience afforded to medical students.'[283]

245 Mr Wisheart encapsulated the view of the UBHT towards the University when he said:

'It was always the view of the Trust that they should work closely with the Faculty of Medicine of the University of Bristol and that they had a lot of common responsibilities, so there were a number of committees and groups which met to try to encourage and nurture and promote that high degree of cooperation.'[284]

246 However, there was a certain tension in that the University would opt to appoint the best academic candidate without regard to the needs of the UBHT to provide the community with a certain service. Dr Roylance explained:

'The university always took the view that they wished to appoint the best applicant and were uneasy about specifying too narrowly the speciality of the potential Professor. So that, if I can explain it out of this, that when a Professor of Gastroenterology retired, … we finished up with his replacement Professor as an endocrinologist. That always produced a certain amount of stress on the NHS side because we had to continue to provide the gastroenterology and to establish an endocrinology service.

'There were issues, but the University (and quite properly) wanted the best academic and would not normally conform to our wish to narrow the speciality down in the advertisement.'[285]

247 Mr Boardman saw this conflict in needs as both a strength and weakness. He said:

'… I think there is no doubt that having a medical school alongside the hospital adds the enormous strengths; you attract the top people in your field, there is no doubt about that. I think the weakness is that there are times when the core business, the core function of the hospital or the Health Service, has to be to deliver

283 WIT 0108 0013 Dr Roylance
284 T40 p. 54 Mr Wisheart
285 T88 p. 76 Dr Roylance

services which meet the local needs of the local population. But at times there is a tension whether the requirements of the University may be to recruit a specialist Professor in a particular field whose discipline could be at the cutting edge of medicine, which is not actually in an area where the local purchasers particularly want or particularly need to buy a particular service.'[286]

248 Dr Thorne was asked what she thought Dr Roylance's emphasis would be if it came to a conflict between the needs of the Trust and those of the University:

'Q. So would it be fair to say that those coming from a university background would have other priorities of research and innovation, and Dr Roylance's was that the focus should be on the patient actually receiving the service?

'A. I think his accent was on actually enabling that tension to co-exist, because he had always seen himself very much as a teacher, was absolutely wedded to the commitment of development and therefore what he wanted to ensure was that unlike a district general hospital, UBHT should be actually at the forefront of changing services and encouraging people to question their practices but not overspend.' [287]

249 Within the remit of cardiac surgery, however, several of the surgeons recognised that there was little relationship between their discipline and the University of Bristol prior to the 1990s. Mr Jonathan Hutter, consultant surgeon, said that:

'… there was no close relationship between the Department of Cardiac Surgery and the University of Bristol prior to about 1990.'[288]

250 Mr Dhasmana recalled that:

'Up to 1992 there was no direct administrative or managerial connection with the University of Bristol … The academic department of Cardiac Surgery was established in October of 1992 …'[289]

251 The Bristol Heart Institute, a collection of a number of academic departments of which cardiac surgery was one, was established in 1995 as a new organisation by Professor Gianni Angelini, Professor of Cardiac Surgery, University of Bristol.

252 At a meeting of the cardiac surgeons on 12 October 1995, the Bristol Heart Institute was discussed. The minutes of that meeting recorded:

'The establishment of the Bristol Heart Institute was welcomed as a positive development for the Cardiac Services Directorate. Mr Dhasmana asked for

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[286] T33 p. 66 Mr Boardman
[287] T35 p. 73–4 Dr Thorne
[288] WIT 0096 0038 Mr Hutter
[289] WIT 0084 0046 Mr Dhasmana

clarification of the role of the clinical service within the Institute. Professor Angelini confirmed that the opportunity was available for the clinical service to be part of the Institute. However, as a formal management structure was not planned, a Management Board would not be identified.'[290]

253 Mrs Ferris, as the author of these minutes, described the atmosphere at the meeting in her oral evidence:

'… these are very innocuous minutes which do not reflect that this was a very difficult meeting and the whole of item 1 about the Bristol Heart Institute represented a very difficult discussion about whether or not the Bristol Heart Institute was valuable to the cardiac services directorate, whether or not the cardiac services directorate could benefit from the Bristol Heart Institute. It focused on how the cardiac services directorate fitted into the Bristol Heart Institute and I know there was some concern from surgeons as to whether almost the Bristol Heart Institute would take over the cardiac services directorate, which is why there is the reference there to the formal management structure. There was the fear expressed that the creation of the Heart Institute would mean the cardiac services directorate would be absorbed into that and there would be a management structure with Professor Angelini as the person in charge of both the academic department of cardiac surgery and the clinical service.'[291]

254 When Mrs Ferris was asked who in particular feared Professor Angelini taking over, she replied:

'I recall Mr Hutter was very concerned about that. I think Mr Dhasmana to a lesser extent, and I think that whilst not sort of openly critical, I know that James Wisheart was very questioning of what this would actually mean. So it was a sort of, if you are looking for a division between surgeons, it was really Mr Bryan, Professor Angelini trying to reassure … Mr Hutter, Mr Wisheart and Mr Dhasmana that this Bristol Heart Institute was in fact an umbrella for the academic service and would not swamp, absorb or take over the cardiac services directorate.'[292]

255 However, Professor Angelini maintained in evidence that he had no intention of taking over clinical practice. He explained:

'The Bristol Heart Institute was conceived with the approval of the University. In fact, … the Bristol Heart Institute is a Research Centre within the University, nothing whatsoever to do with the NHS. It has two functions. One is to bring under the same umbrella all the cardiovascular research done in Bristol. This comprises as well as clinicians, biochemists, pharmacologists, physicians and so forth. It has an executive board made of various members, clinical and non-clinical, who meet once or twice a year. The purpose of this is to give strength to any proposal which

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[290] UBHT 0229 0005; meeting of cardiac surgeons, 12 October 1995
[291] T27 p. 115 Mrs Ferris
[292] T27 p. 116 Mrs Ferris

comes from Bristol, because there is a large body of research groups working in that area. This is particularly relevant nowadays, because, for example, the MRC [Medical Research Council] would not consider any proposal from individual people.

'As a second aspect, I wanted the Bristol Heart Institute to be a separate, if you like, entity in clinical terms and the reason was because I was very concerned as early as the end of 1994, that the performance of the adult cardiac surgery was substandard.

'As a result of this, I did not want to incur the same problems as the paediatric, and somehow I wanted to distance myself from the rest of the Unit. As a demonstration of this, in 1994 and 1995 the Bristol Heart Institute produced an annual report which not only had research achievement, but also clinical results … It was the first time that institution, the Bristol institution, had produced data which was open to the general public.'[293]

256 Professor Angelini also explained that there are now several such Institutes within the University:

'There is a Neurology Institute. There is now an Institute of Endocrine Neuroscience. These are created by the University. This institute was set up following a request from the then Dean of the Medical School for me to group all the cardiovascular research in Bristol. It was not even my idea in the first instance. There are many other Institutes within the UBHT, but it does not mean they are going to contract us to do the operation. We just have an honorary status with the Trust. We do the operation the same as any other NHS consultants.'[294]

257 The evidence as to the tensions apparent in the setting up of the Institute reflects evidence as to the nature of relationships between staff of various disciplines (and amongst those of the same discipline) engaged in paediatric cardiac surgical services.

The management of the UBHT under the leadership of Mr Ross

258 Mr Ross told the Inquiry that when he took up his post in succession to Dr Roylance, he discovered that Mrs Maisey was in large part responsible for day-to-day operational matters, rather than Dr Roylance. He said:

[293] T61 p. 52–4 Professor Angelini
[294] T61 p. 57 Professor Angelini

'I felt that almost all of the day to day operational management of the Trust in terms of the business of the Trust had been devolved to the Director of Operations, which was a model, as I say, it is not unusual, but not one that I had previously worked with myself.'[295]

259 Mr Ross had heard the clinical directorates under Dr Roylance described as 'semi-detached'.[296] Dr Thorne, by contrast, thought the clinical directorates were 'quite well integrated'.[297] However, despite the 'semi-detached' description, when Mr Ross arrived at Bristol he found that the clinical director's role was one that he was familiar with from his earlier experience in the health service. He said:

'[It] was a fairly standard Clinical Director role; there was no job description for the post that I could find and I set out to create one, but the role had been spelled out … quite carefully by my predecessor, because of his feelings about the importance of involving the senior doctors in the Trust fully in the management of the Trust … But it was a Clinical Director role, not unlike that I was familiar with elsewhere.'[298]

260 However, Mr Ross felt there was little central direction at the UBHT when he arrived. He said:

'I did feel, when I came to the Trust, that the devolution to the directorates had gone too far and that the overall performance of the organisation was not as tightly controlled and managed as it needed to be. As the new Chief Executive, I felt a little nervous about that, if I am frank, and have worked since then to try and get the right balance between the local ownership and responsibility that I talked about and the need to performance manage the whole organisation in a very tight and proactive manner, especially as the expectations placed upon the Trust by government grow greater with each year.'[299]

261 Mr Ross also encountered the 'club culture' at Bristol. He said:

'… it certainly was a strong feeling when I arrived from General Managers that issues like promotion within the Trust and so on were not decided necessarily on objective grounds, based on individual reviews and performance reviews and so on, but on some less easily measurable factors and things like fit or, you know, whether you were in, those were the sorts of things they said to me they thought were more influential in deciding issues of promotion and so on than perhaps objective measurements of their success in doing their job.'[300]

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295 T19 p. 13 Mr Ross
296 T19 p. 22 Mr Ross
297 T35 p. 111 Dr Thorne
298 T19 p. 17–18 Mr Ross
299 T19 p. 21 Mr Ross
300 T19 p. 53 Mr Ross

262 Mr Ross explained that the oral culture fostered by Dr Roylance had been preserved under his own leadership of the UBHT. Mr Ross said:

> '… that is still the culture. The pace and complexity with which we work demands that many things are said once and done, and I think if we put everything in writing, the whole organisation would grind to a halt. So there is still an oral culture at director level to a large extent and I think it is fair to say that is what I inherited.'[301]

263 However, he added:

> '… I think if things get put in writing, it means they are important, and they need to be put into writing because they are important.'[302]

[301] T19 p. 46 Mr Ross
[302] T19 p. 47 Mr Ross

Chapter 9 – The Split Service

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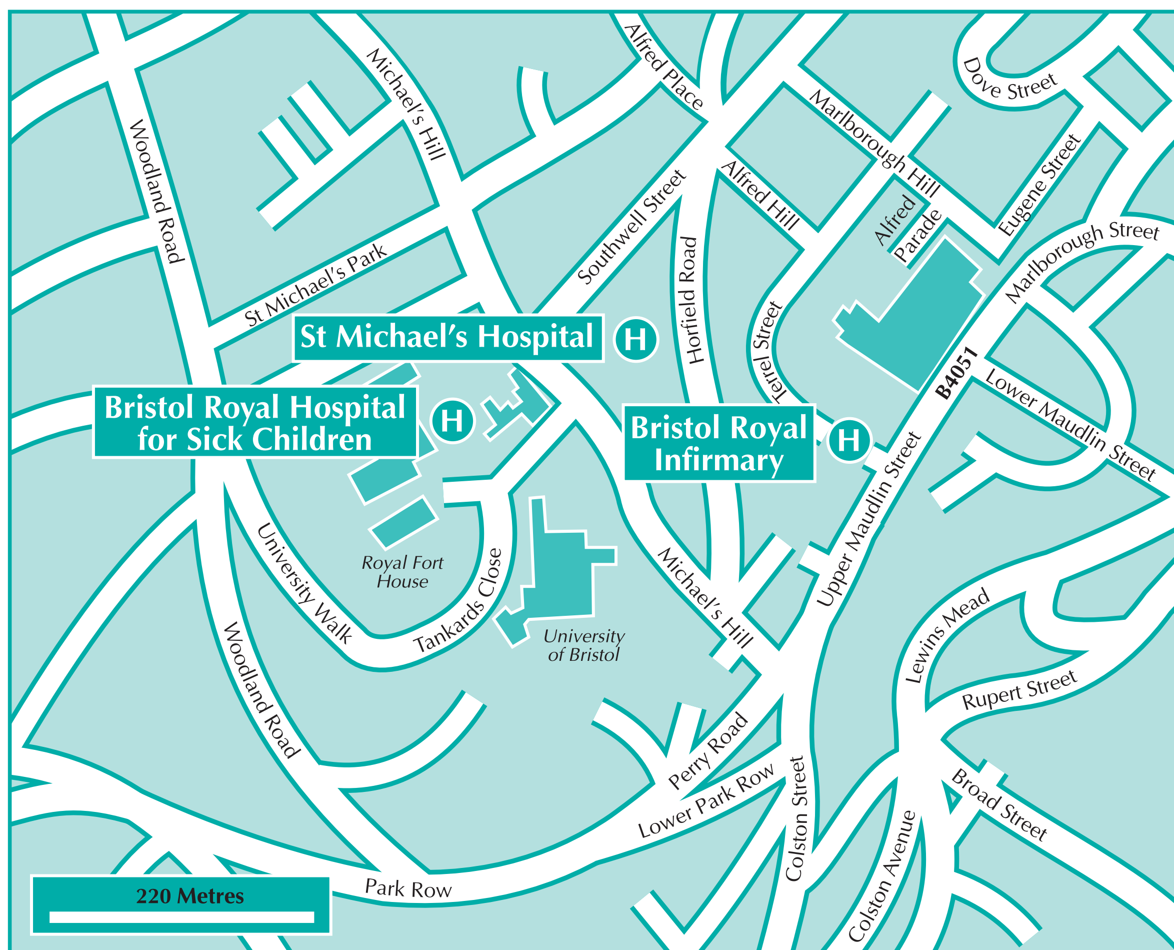
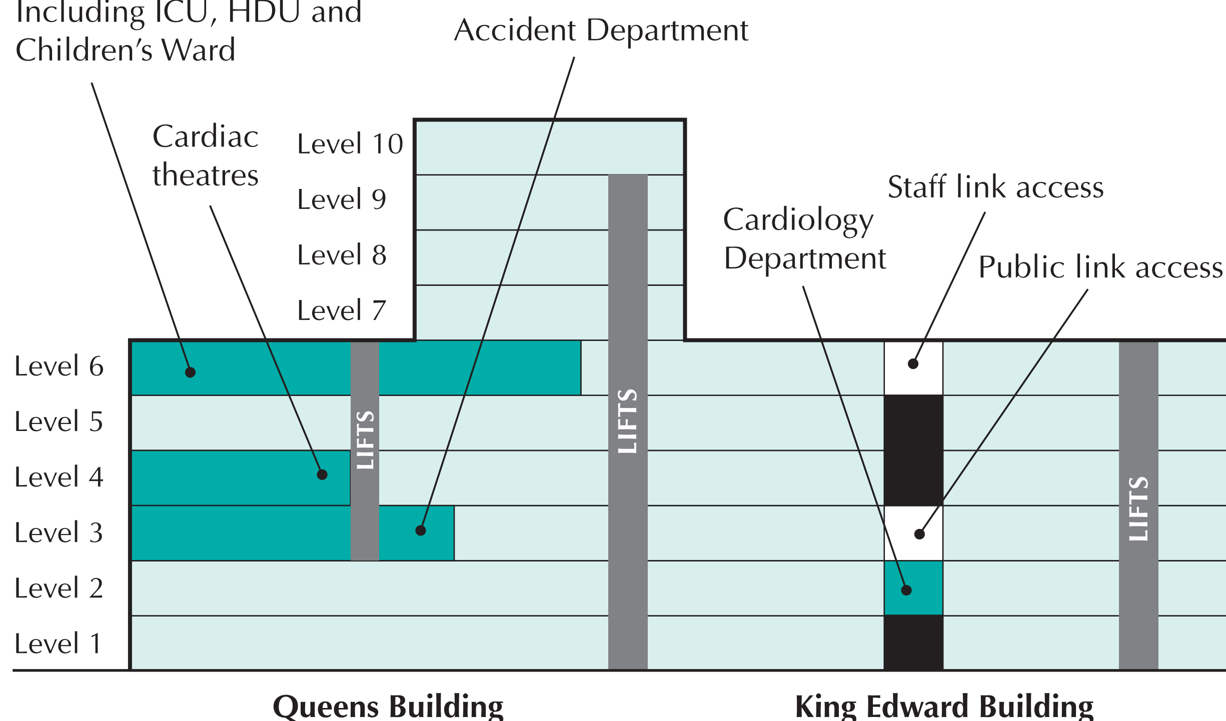
Introduction

1 The services involved in paediatric cardiac surgery were split between two sites: the Bristol Royal Infirmary (BRI) and the Bristol Royal Hospital for Sick Children (BRHSC) (sometimes referred to in evidence as the Bristol Children's Hospital (BCH). The purpose of this chapter is to describe the evidence commenting on the effects of the split service and efforts to address its effects.

Location of relevant Bristol Hospitals during the period of the Inquiry's Terms of Reference



Bristol Royal Infirmary departmental relationships during the period of the Inquiry's Terms of Reference



View from Upper Maudlin Street (not to scale) **ICU:** Intensive Care Unit **HDU:** High Dependency Unit

2 Before, during, and since the period 1984–1995, Bristol has been served by a group of hospitals, including the BRI and the BRHSC. Prior to 1 April 1991 this group was the United Bristol Hospitals (UBH)[1] and, following Trust status, the United Bristol Healthcare (NHS) Trust (UBHT).[2]

3 For the purposes of the Inquiry, the term 'split service' refers to the fact that, throughout the period of the Terms of Reference, until October 1995, the paediatric cardiac surgery service was split between the BRHSC and the BRI. The cardiologists were based at the BRHSC, as was the performance of closed-heart surgery. Open-heart surgery was performed at the BRI.[3] The service was united in one building on 16 October 1995 when open-heart surgery was moved to the BRHSC. Until then, different facilities existed for children at the BRI and the BRHSC respectively. The Intensive Care Unit (ICU) at the BRI served both child and adult patients.

[1] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, formerly the Bristol Royal Children's Hospital a.k.a. Bristol Children's Hospital, Bristol Eye Hospital, Bristol Maternity Hospital, Bristol General Hospital, University of Bristol Dental Hospital; between 1960 and 1974 they were joined by: Bristol Homeopathic Hospital and Farleigh Hospital (Mental Handicap)

[2] The Bristol Royal Infirmary, Bristol Royal Hospital for Sick Children, Bristol Eye Hospital, Bristol General Hospital, Dental Hospital, Barrow Hospital, Keynsham Hospital, St Michael's Hospital, Bristol Oncology Centre

[3] The Inquiry heard that as a result of the split service, children who received treatment on both sites would have two sets of medical records

4 This chapter sets out the evidence relating to the effects of the split site and the consequent split service, and efforts made to address them.

5 Differences in the nursing care at the two sites are described in Chapter 13 and Chapter 15 as are the effects of the split site and consequent split site service on the cardiologists.

6 The organisation of counselling and bereavement services over the two sites is described in Chapter 16.

Comments by those outside the Bristol service

7 Professor Peter Fleming, Head of the Division of Child Health, Department of Clinical Medicine, University of Bristol, was Chairman of the multidisciplinary working party on paediatric intensive care convened by the British Paediatric Association (BPA) which produced a report in 1993, *'Care of Critically Ill Children'*. The report, based on data for 1991 and a smaller data set for 1993, included information from the South West and specifically from the ICU at the BRI and the BRHSC. Returns were received from 80% of the hospitals in the UK. The report showed that 20.5% of children received intensive care in adult intensive care units and, of these children, 23% were under 1 year of age.

8 Professor Fleming in his written evidence to the Inquiry stated:

> 'Overall, the quality of care offered in the Paediatric Intensive Care Unit at the Bristol Children's Hospital was, and remains, of a very high standard.'[4]

9 Children were also cared for in the ICU at the BRI together with adults. Professor Fleming went on:

> 'It is, however, important to say that one of the major conclusions of the working party was that, in general, throughout the country, the quality of care in terms of availability of appropriately qualified staff, awareness of the special needs of children and physical organisation of the units to deal with children's special needs in adult intensive care units was deemed quite unsatisfactory. The working party concluded that it was inappropriate that children should be admitted to adult intensive care units and that, in general, intensive care for children should be provided and properly staffed and equipped with paediatric intensive care units.'[5]

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4 WIT 0505 0002 Professor Fleming
5 WIT 0505 0002 Professor Fleming

10 Dr Jane Ratcliffe, Honorary Secretary of the Paediatric Intensive Care Society (PICS), was asked by Counsel to the Inquiry how common it was in the 1980s and early 1990s for the cardiologists to be on one site and the surgeons on another:

> 'I cannot think of another unit where the cardiologist and cardiothoracic work were in a different site. I can think of several units, that there were separate cardiothoracic sites, but they were together, in effect, so I am not able to think of one.
>
> 'I find it very worrying, because you need somebody to consult very rapidly. I know that the geography of the Royal Infirmary and the Bristol Children's Hospital is not across town, but even so, I think I would find it very difficult in working practice to try and work and do justice to both sites.'[6]

11 Dr Susan Jones, President of the Association of Paediatric Anaesthetists of Great Britain and Northern Ireland (APA), discussed the Confidential Enquiry into Peri-Operative Deaths (CEPOD) report in the following exchange:

> 'Q. When it [the CEPOD report] concluded paediatric anaesthesia should not be undertaken by those who had only occasional experience in the field, what was the reaction of the APA, or, indeed professional anaesthetists, to that conclusion?
>
> 'A. I think the APA certainly supported that conclusion. I think the majority of sensible anaesthetists supported that conclusion, and indeed, since that time, I think for a lot of anaesthetists, it has acted as a catalyst, the CEPOD report, and an awful lot of anaesthetists have flatly refused to anaesthetise small children and infants if they felt it was outside their competence. They have insisted the children are moved to a more appropriate centre.
>
> 'Q. CEPOD had recommended that you should not undertake paediatric anaesthesia if you only had occasional experience in the field. Are you able to help us, then, on the implementation of that recommendation, because it was not, I understand, an immediate event after CEPOD had reported?
>
> 'A. No, I think that they were recommendations; they were not totally enforceable. I think it just gave people, any sensible thinking people, a document to which they could refer and say, "I think we should move these children. I think we should plan to move these children. I do not think we should be doing these in our hospital any more".'[7]

12 Dr Jones continued in the following exchange:

> 'Certainly we would not recommend admitting children to an adult ward … I think surgeons, generally, and those treating children and adults do not want the children

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6 T7 p. 162–3 Dr Ratcliffe
7 T8 p. 13–14 Dr Jones

moved to another site. That is a generalisation. Things are often historical. One starts with a unit that is basically an adult one, and then children have been taken on board, as it were, the whole thing is blown up, and it becomes very difficult to dismantle the mixed unit. You actually have to put the children into another hospital, or into another children's hospital. It is actually very expensive to move — setting up, the capital needs are high, the infrastructure, the actual staff costs of moving a unit and everybody looks twice at the costs these days.

'Q. When you say that a surgeon might get in the way of such a move, is that a comment on the organisation of hospitals to reflect surgical specialties, or is that a comment on personalities?

'A. A bit of both really. I think that when people do children and adults, the children often come out second best, I think. They are often smaller in number anyway.'[8]

13 Dr Jones told the Inquiry that it was fairly common in 1993 for children to be admitted to a part of an adult ICU ward. She went on:

'I think that it has been changing gradually, anyway, as big paediatric tertiary referral centres, mainly at children's hospitals, have actually expanded their intensive care unit and, indeed, provided retrieval teams so that they can actually go to a DGH [District General Hospital], or wherever, to actually pick up these children and transfer them back.'[9]

14 Sir Terence English, President of the Royal College of Surgeons of England (RCSE) from 1989 to 1992, commented in the following exchange:

'Q. … the split site that existed at Bristol was … an additional black mark … against Bristol continuing to be a designated centre … ?

'A. I think it may have been an inhibition to the proper development of the service, yes, and in that respect, may have been seen as an undesirable feature, but not necessarily a black mark.'[10]

15 Professor Gareth Crompton, Chief Medical Officer for Wales 1978–1989, told the Inquiry:

'I remember that this was a matter of considerable anxiety. It was clearly an arrangement, the split site; it was not conducive to best standards of patient care.'[11]

16 Professor David Baum, then President of the Royal College of Paediatrics and Child Health (RCPCH) and Professor of Child Health, University of Bristol, was asked about

8 T8 p. 25–6 Dr Jones
9 T8 p. 28 Dr Jones
10 T17 p. 109 Sir Terence English
11 T21 p. 53 Professor Crompton

the approach of healthcare professionals in 1984 to nursing children on mixed adult and paediatric wards:

> 'At that time, if one were looking at or were preparing a policy document, I have no doubt that the conclusion would have been very firmly, these should be separate entities. That would apply if one was talking about the mix from adolescence and adult, let alone younger children and babies, let alone if they were profoundly ill.
>
> 'In the ten to 15 years since the time that you are addressing, we have progressed somewhat, but it has only been in the last two or three years that under the heading of paediatric intensive care services, as you know, the Government has come down on the side of not only having a policy, but actually implementing a policy, so that in all parts of the land we are still at the implementation phase, there should be a separate fully equipped, fully staffed paediatric intensive care unit. That has still not been totally achieved for the nation in May 1999.'[12]

17 Professor Baum went on:

> 'I spent many of my formative years running to another hospital across a car park and through a tennis court with a sick baby in my arms to go from the delivery ward to the neonatal intensive care unit. It was becoming apparent that this was a bad arrangement. It took several years to have the budget and the will to rearrange that so that they were cheek by jowl. It was very difficult to get it right in the historical context.'[13]

18 Miss Sue Burr, Paediatric Nurse Advisor to the Royal College of Nurses (RCN), commented:

> 'I do not have access to the staffing levels of paediatric intensive care. I would not have thought that that was uncommon, and in fact we do have situations, and you have the evidence, I am sure, in relation to the number of children who are nursed even now in adult intensive care units that I think one of the quite recent reports showed that there was a large number of these units which did not employ any registered children's nurses at all. So I do not think that the situation at the BRI was that uncommon.'[14]

19 Asked by Counsel to the Inquiry about the process of transferring a patient from one site to another, Dr Duncan Macrae, Director of Paediatric Intensive Care at the Royal Brompton Hospital, London, told the Inquiry:

> 'I think the process is the same, there needs to be just as much preparation to undertake a ten-minute transfer as there needs to be to transfer a child hundreds of miles. The preparation, the stabilisation, packaging, loading safely into the vehicle,

12 T18 p. 40–1 Professor Baum
13 T18 p. 45 Professor Baum
14 T34 p. 40 Miss Burr

is exactly the same whether or not the distance is one hundred yards or one hundred miles.'[15]

20 Dr Macrae went on:

> 'The risks of long transfers are mainly down to inadequate preparation … These [inadequate oxygen supply or battery life] are avoidable factors, as is a child cooling down because it is not adequately protected from cold, by being wrapped up. As are things like secretions building up in the tracheal tube because there has been inadequate humidification. These are all things that in the present age transport teams are trained to address, but I think it is fair to say that across the country ten or more years ago, many of these issues received scant attention and I am certainly aware of transport over relatively short distances that was conducted very poorly because of those failures. But, as I say, there were very limited facilities for the specialist types of transfer that we can undertake today.'[16]

21 Mr Leslie Hamilton, consultant cardiac surgeon, also told the Inquiry about the transfer of patients in the following exchange:

> 'Q. This chimes with views given to us yesterday by Professor de Leval and Mr Stark, the children coming from Bergen in Norway to Great Ormond Street might often arrive in a much better condition than children coming up the road from Luton, simply because of the quality of care they had had during the transfer process.
>
> 'A. I think the experience in Perth in Australia at the moment, where they do not currently have a paediatric cardiac surgeon, they transfer patients 4,000 miles, something in that order, to Melbourne and they have no problems. I do not think distance is an issue.'[17]

22 Mr Hamilton commented on the effect of the split site and the split service on the communication within a care team such as the one at Bristol, where the cardiologists were on a different site from the surgeons:

> 'I think it is more philosophical than physical. I think communication is an attitude within a group, rather than being physically there to talk in person. I think if you have the environment that people get on and have the same long-term view and the same aims, then communication should not be a problem.'[18]

23 Mr Martin Elliott, consultant cardiothoracic surgeon, was invited to apply for the Chair of Cardiac Surgery at the University of Bristol in late 1991. He was approached initially by Mr Wisheart and then by Professor John Farndon. Mr Elliott stated in his

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15 T51 p. 117–18 Dr Macrae
16 T51 p. 118–19 Dr Macrae
17 T51 p. 117 Mr Hamilton
18 T51 p. 144 Mr Hamilton

written evidence to the Inquiry that he 'was interested in the opportunity and visited Bristol on a number of occasions to discuss the position and to review facilities, organisation and potential for change.'[19]

24 After 'much thought' Mr Elliott stated that he decided not to apply.[20] He wrote to Mr Wisheart on 3 January 1992 to inform him of his decision.[21] In response to Mr Wisheart's request Mr Elliott prepared a more detailed report of the reasons not to apply.[22]

25 Mr Elliott stated in his written evidence to the Inquiry:

> '… the arrangements then in place in Bristol for surgery for children with congenital heart defects were unsatisfactory, indeed I was of the opinion that it was inefficient and potentially dangerous.'[23]

26 Mr Elliott referred to the split service and went on:

> 'Perhaps the simplest way to explain why this arrangement was unsatisfactory is to consider an imaginary case managed under the two regimes, Bristol and the Ideal Unit. The imaginary patient I propose is a new-born baby admitted *in extremis* to the Bristol Children's Hospital with a provisional diagnosis of coarctation of the aorta. The child would need to be admitted to either a high dependency unit or a neonatal ICU and need urgent resuscitation by paediatrically trained staff. Ventilation might be required and an immediate examination by a paediatric cardiologist would be undertaken. An echocardiogram would be done and a treatment plan defined. If the diagnosis was indeed coarctation of the aorta then surgery could be undertaken in the Children's hospital on the next available list, (hopefully the next day although the logistics of this in Bristol might have made this difficult). If, however, the echocardiogram was to reveal a VSD and an interrupted aortic arch, then repair would require open-heart surgery. In Bristol the patient would have had to be transferred to the BRI, to the adult ICU in preparation for open-heart surgical repair. Contact with paediatricians would have been lost and the level of the support would have fallen. An urgent space would have had to be found on the operating list, almost certainly at the expense of adult patients, and the surgery undertaken.

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19 WIT 0467 0003 Mr Elliott
20 WIT 0467 0003 Mr Elliott
21 JDW 0003 0102; letter from Mr Elliott to Mr Wisheart dated 3 January 1992
22 WIT 0467 0011 – 0027; Mr Elliott's paper *'The Chair of Cardiac Surgery in Bristol'*
23 WIT 0467 0003 Mr Elliott

'Post-operatively, our imaginary patient is likely to have been sick. Skilled treatment would be required. If we further imagine an acute deterioration a day or two later, the surgeons may have been operating at the BRI or the Children's, there was no paediatric intensivist, and ECHO would have to be done by the radiologists, and the cardiologists would be at the Children's or outlying clinics. The risks were obvious.

'In the Ideal Unit the change in diagnosis would have only limited impact. There would be no need for patient transfer, there would always be a list available to children and there would be no need to displace an adult patient (or more than one since these patients need prolonged ICU care). The consequences for the adult programme would also be considerable. …

'Thus, to me, the split site issue was one of the major reasons not to apply for the post. I thought it inefficient, archaic, inhibitory to progress and potentially dangerous.'[24]

27 Mr Elliott continued:

'Clearly all senior people at the BRI and Children's Hospital carry some responsibility for this issue. There was a conventional, if complex, matrix of responsibility in place at Bristol which should have been able to make appropriate changes. However, the very existence of the split site, the complexity of the management structure and the politics surrounding the, then, new Trust arrangements, inhibited change and obfuscated forward thinking.'[25]

28 He stated:

'… it was clear to me that one of the people most wanting to make change was James Wisheart … Almost all the clinicians I met were in favour of transferring all paediatric heart surgery services to the Children's.'[26]

29 Mr Elliott had a meeting with Mr Peter Durie, Chairman of the UBHT, to discuss, amongst other things, his concerns about the split site. Mr Elliott stated that he found Mr Durie's suggestions as to how to deal with this issue 'totally unacceptable'.[27]

24 WIT 0467 0004 – 0005 Mr Elliott
25 WIT 0467 0006 Mr Elliott
26 WIT 0467 0006 Mr Elliott
27 WIT 0467 0007 Mr Elliott

30 Mr Elliott stated:

> 'Mr Durie outlined the structure of the new Trust organisation, and the financial arrangements. He stated that there was no way that resources could be made available to correct the split site issue in the short or medium term … I had said that there might be a possibility of getting new business (more patients) from neighbouring regions (Wales, the South West) if we were able to develop a high quality service, but that it would be impossible without the children's services being centralised away from the BRI. I also pointed out that this would free up resources to increase throughput of, and potentially income derived from, adult practice.'[28]

31 Mr Elliott went on:

> 'Mr Durie made it quite clear that in his view it would be up to me, as the new incumbent, to generate the income to pay for the changes required. I thought that this was not going to be possible. Making the changes was the only rational way to improve both service and income, and the only way to generate the basis for safe, modern neonatal cardiac surgery. I thought it was wrong to place the burden of income generation from clinical practice on the new Chairholder. The changes had to be made BEFORE any income could be generated.'[29]

32 Mr Durie was asked by Counsel to the Inquiry about the split site in the following exchange:

> 'Q. One of the three reasons given … by Mr Elliott for not taking the job is the split site. How big an issue was the split site for you in 1991/92?
>
> 'A. It was not a big issue for me because it was not unique. In Bristol quite a lot of the specialties for paediatrics were not happening in the Children's Hospital. Just to name a few, within the UBHT there was ENT happening in a general hospital; ophthalmology happened in the Eye Hospital. Trauma in fact still happens in the BRI. So from our point of view, not everything being in one site was not surprising, and just in Bristol alone, you then had Southmead dealing with all the paediatric nephrology and Frenchay dealing with all paediatric neurosurgery and medicine, so it did not come to me as a very high worry or high priority.
>
> 'Q. You say in your statement it has never been suggested that the split site was having an adverse effect on surgical outcomes, so far as you were aware.
>
> 'A. That is correct.' [30]

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[28] WIT 0467 0007 Mr Elliott
[29] WIT 0467 0007 Mr Elliott (emphasis in original)
[30] T30 p. 69–70 Mr Durie

Comments by referring paediatricians

33 A number of referring paediatricians commented on the split service. Dr Perham, a consultant paediatrician at Derriford Hospital, Plymouth, wrote:

> '… my impression … is of a somewhat disjointed service which particularly seemed to be the result of problems related to a split site delivery.'[31]

34 Professor Obsorne, a consultant paediatrician at the Royal United Hospital, Bath, wrote:

> 'I knew they were operating under difficult circumstances on a split site.'[32]

35 Dr Vulliamy, a consultant paediatrician at the Breconshire War Memorial Hospital, Powys, commented:

> 'I had held the Paediatric Cardiac Surgical Services in Bristol in high regard though I was aware there had been limitations on the type of procedure that would be undertaken. The separation between the BCH and BRI seemed to present some practical difficulties.'[33]

36 The split site was a matter about which Dr Jordan had spoken to referring paediatricians. He expressed his concerns to them that:

> '… we still had not, right up to the time that I retired, got the cardiac surgery moved up the road. That is of particular importance to paediatricians because paediatricians are really very keen on the idea that children should be looked after in a paediatric environment.'[34]

Comments by nursing staff in the UBH/T

37 Fiona Thomas, Clinical Nurse Manager, stated in her written evidence to the Inquiry:

> 'The set up [at the BRI] was that children and adults were nursed together in the same ward. The segregation of children was attempted to the best of the staff's ability by using beds 1 and 2 to care for the children. This was not always possible due to the pressure on beds. … The staff level to manage the ITU was about 70 full-

31 REF 0001 0147 Dr Perham
32 REF 0001 0021 Professor Osborne
33 REF 0001 0095 Dr Vulliamy
34 T79 p. 143 Dr Jordan

time nurses, but with holidays, nights and days off, to a lay person it may seem that there was always new staff coming and going, but this was due to the very large number of staff employed on ward 5. The nursing staff do not work in a trial and error way, they do what is appropriate for the child at that time. A child's condition can change very quickly and care needs to be adapted accordingly.'[35]

38 Ms Pauline Chinnick, who has held various nursing posts at the BRHSC since 1983, stated in her written evidence to the Inquiry that as regards the mixed adult and child environment:

> '… it was recognised that the situation was difficult as it could upset adult patients and the parents of children on cardiac ICU. It also, in my opinion, diluted knowledge and skills and made nursing staff less able to build up expertise.'[36]

39 Ms Chinnick went on:

> 'Parents also became frustrated with the split site in that the cardiac surgeons were not so readily available on the ward at BRHSC. Parents could make comparisons with surgeons of other specialties on the ward, who appeared more available.'

However, she also noted:

> 'The cardiac surgeons would visit BRHSC even if it was very late. For example, on occasions, they came after midnight.'[37]

40 Mr Graham Brant was a staff nurse on Ward 5B from March 1991 until he was promoted to senior staff nurse later that year and then to charge nurse in May 1993. He stated in his written evidence to the Inquiry that children on Ward 5 in the BRI, 'missed out on some of the facilities of the Children's Hospital, e.g. child sized tables and chairs, paintings on the wall …'.[38]

41 Mr Brant stated that:

> 'Most of the nurses at the BRI were not RSCNs [Registered Sick Children's Nurses], but they had paediatric nursing experience.'[39]

42 He described the wards at the BRHSC as 'very cramped'.[40] He stated that there was more space in the ICU at the BRI, such that children were separated from the adults as much as possible. Mr Brant expressed the view that the nursing care of the paediatric patients at the BRI was of the highest order and 'at times the care may have been better for paediatrics than the adults as the senior nurses had looked after the children while

35 WIT 0172 0006 Fiona Thomas
36 WIT 0532 0041 Ms Chinnick
37 WIT 0532 0041 Ms Chinnick
38 WIT 0513 0013 Mr Brant
39 WIT 0513 0013 Mr Brant
40 WIT 0513 0013 Mr Brant

the adults tended to be looked after by the junior staff'.[41] He stated that from a nursing point of view, communication and collaboration between the two centres (the BRI and the BRHSC) was very good. He stated that he did not think that there was a problem between doctors on either site. He concluded:

'… with hindsight it is easier to say that it is better for the patient for all cardiac surgery to have been performed at the BRHSC, but as it was not we did the best we could and I did not think that the care was at all compromised.'[42]

43 Ms Joyce Woodcraft, an RSCN and RGN who worked at the BRHSC from 1977 to April 1994, told the Inquiry that, although there were difficulties in the surgeons integrating their ward rounds at the BRHSC with their work at the BRI, it was something they were able to achieve.[43] She was asked by Counsel to the Inquiry about the transfer of patients from the BRI to the BRHSC in the following exchange:

'Q. And how well did communication between the two sites work, to manage a transfer, in your experience?

'A. The staff at the BRI would phone us and inform us, as I say, of drips and drains and particular drugs that the child was on before they were transferred up.

'Occasionally we would get — they would forget to phone us to say that the child was actually on the way, and that could cause a problem if we were in the middle of an acute situation. If they phoned we might have said "can you hang on for half an hour or an hour" or something. That was not a frequent occurrence.

'It did happen occasionally, but not — I would not have said it was a routine, that they all came up without being announced, not in my experience.

'Q. Again, "occasionally" can mean once a year, twice a year, once a month?

'A. I would not like to say.

'Q. Something that you can remember occurring, but not with great frequency?

'A. Yes, but not as a big deal, really.'[44]

41 WIT 0513 0013 Mr Brant
42 WIT 0513 0014 Mr Brant
43 T57 p. 34–5 Ms Woodcraft
44 T57 p. 37–8 Ms Woodcraft

Comments by those providing support and counselling

44 The Reverend Leonard Burn, a retired Hospital Chaplain to the Central Bristol Hospitals from 1981 to 1983, stated in his written evidence to the Inquiry that the split site 'was inconvenient, but not a problem'.[45]

45 Father Bernard Charles, a part-time Hospital Chaplain at the BRI and the BRHSC from 1991 to 1996, stated in his written evidence to the Inquiry:

> 'It seemed to me that the needs of children receiving cardiac care were different from those of adults and that it was unfortunate that both were cared for, post operatively, on the same ward [at the BRI]. I obtained the impression that conditions were a little cramped, making it difficult for parents to be at the bedside of sick children for long periods, and that facilities for parents to rest and relax, and be accommodated, were lacking.'[46]

46 Canon Charmion Mann (Assistant Chaplain and then Chaplain at the BRHSC from 1988 to 1994) stated in her written evidence to the Inquiry:

> 'I felt it was probably disconcerting for parents to have two groups of carers [at the BRHSC and the BRI] looking after their child. There was necessarily a break in the continuity of care. We (the staff) within the BCH were aware that the BRI was not staffed as a children's hospital and felt that it was a shame that the site was split.'[47]

47 The Reverend Robert Yeomans (Spiritual Adviser to the UBHT from 1993) stated:

> 'I felt having children and adults together was particularly beneficial. It created a family environment and for many people it seemed to accelerate the healing process … For many adults it put their illness into context, and they loved watching the children play…'[48]

48 The Reverend Helena Cermakova (Chaplain at the BRHSC and St Michael's from 1995) stated that she 'did not sense during this time (early 1995, when I joined the BRHSC) that the split site caused any difficulties'.[49]

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45 WIT 0284 0010 The Reverend Burn
46 WIT 0277 0009 Father Charles
47 WIT 0273 0006 Canon Mann
48 WIT 0274 0013 The Reverend Yeomans
49 WIT 0272 0006 The Reverend Cermakova

49 Mr Rhett Dunford, a social worker at the BRHSC from 1990 to 1994 before moving to the BRI, contrasted facilities at the two sites:

> 'At the Children's Hospital parents had accommodation and support of other families. It was a child centred environment. This was not available for them at the Bristol Royal Infirmary. It was difficult for parents if children were admitted straight to the Bristol Royal Infirmary as they appeared to miss out on some of the pre-operative preparation.'[50]

50 Miss Helen Stratton, Cardiac Liaison Nurse at the BRI from 1990 to 1994, told the Inquiry:

> 'Helen Vegoda felt quite strongly that it was her role to look after the parents at the Children's Hospital and my role was at the Bristol Royal Infirmary.'[51]

51 Miss Stratton said that she wished her role to be more integrated between the two sites:

> 'I was also aware that there was this cavern between the nurses at the BRI and the nurses at the Children's Hospital and I wanted in some small way to see how that could be improved, whether that was through communication, whether that was through going to the Children's Hospital and speaking with people informally and setting up the Paediatric Cardiac Nurses' Association which I did whilst I was there as well.'[52]

52 Miss Stratton told the Inquiry that this 'cavern' related essentially to the two groups of patients:

> 'I know a lot of the nurses at the Children's Hospital felt quite strongly because they were trained paediatric nurses that the children should not be having surgery on an adult unit. Their views were obviously shared amongst a number of people.'[53]

53 She went on:

> 'I think the split site meant that there was a communication problem. I mean, not between Helen Vegoda and I, in as much as we met on a regular basis, but I think with the nursing staff just because they were not both in the same hospital there were inevitably communication problems. I am not aware of any particular instance where I thought, "Gosh, you know if people had communicated that or the children had been nursed in the Children's Hospital all the time that would not

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50 WIT 0384 0006 Mr Dunford
51 T46 p. 46 Miss Stratton
52 T46 p. 96–7 Miss Stratton
53 T46 p. 97–8 Miss Stratton

have happened". I cannot specify instances, although I am sure people will be able to do that, but I cannot.'[54]

54 Mrs Jean Pratten, founder of the Bristol and South West Children's Heart Circle, told the Inquiry:

'… there were two separate managements, as I mentioned earlier, of each hospital so the whole of the cardiac services for children were not integrated in one unit; there were two completely different sections.'[55]

55 Mrs Vegoda told the Inquiry that before Miss Stratton took up her post:

'… one of the difficulties of the split site and the fact that I was going down to ward 5 was that I did not really get to know the nurses well. We did not sit together and have time to discuss the role. I went down there to see families and sort of came out again. That was not my base. So I do not think I necessarily developed a close rapport with the nursing staff, but that was the main reason, and also the fact that there was a lot of nursing staff and … they were continually changing.'[56]

56 Mrs Vegoda went on:

'… it would have been very helpful right at the beginning had there been somebody covering Ward 5. I think the split site was very difficult.'[57]

57 As regards the effect of the split site on parents, Mrs Vegoda told the Inquiry:

'I think the split site was really quite difficult for parents to cope with, for a number of reasons. Primarily that they had got used to the Children's Hospital and they then went to a strange building, a strange hospital and one that was not dedicated to children. So it was not ideal …

'… I do remember parents commenting on the fact and being, I think, aware that this was not a paediatric environment. For example, I think some parents commented on the fact that the nursing staff were not particularly aware of feeding difficulties of, say, young children post-operatively. I cannot remember anything specific at the moment, but just a general awareness that this is not a paediatric setting.

'What particularly was commented on, and for some parents it was very stressful, was the first time they were shown around Intensive Care in Ward 5. They found that extremely difficult because it was a mixed unit with adults in it.'[58]

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[54] T46 p. 164–5 Miss Stratton
[55] T47 p. 26 Mrs Pratten
[56] T47 p. 138 Mrs Vegoda
[57] T47 p. 139 Mrs Vegoda
[58] T47 p. 164–5 Mrs Vegoda

58 Mrs Pratten in her written evidence to the Inquiry stated:

> 'The split site proved extremely hard for parents to cope with. For many years the catheter lab was in the BRI and parents of children in the BRHSC were left anxiously waiting for their child's return at the whim of the ambulance service. It was always very hard for parents to have to face their child's open heart surgery in an unfamiliar hospital, with an age range of patients from 0–80.'[59]

Comments by parents/patients

59 Many parents commented on their experience of the split site and service.

60 Penelope Plackett, mother of Sophie who underwent surgery in 1988, stated in her written evidence to the Inquiry:

> **'Transfer to the BCH:**
>
> 'When I returned to the BRI, I was told Sophie was being moved to Bristol Children's Hospital. I was very unhappy about this. At the cardiac catheterisation and biopsy at the Children's Hospital, the staff on the baby unit were uncaring. They seemed to spend their days drinking tea and chatting to one another, emerging every four hours to feed the babies. The transfer to the Children's Hospital went ahead. I only saw the nurses when they came with Sophie's drugs, and her care was left entirely to me. She was being bottle fed but I could not get her to suck or swallow. I asked for help with her feeding over and over again, but nobody came to my assistance.[60]
>
> **'Problems at the BCH:**
>
> 'Mr Dhasmana persuaded me, much against my will, that I needed a break and should go home to Exeter for the weekend. I did so, although I did not feel that I could trust the staff to give Sophie proper care and attention. When I returned to Bristol, she had an appalling case of nappy rash with noticeable burns on her skin. She had obviously been left in a soiled nappy for a long time. I hated every second of the time Sophie and I spent at the Children's Hospital. I hated the nurses and whole place. It was a nightmarish blur.'[61]

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[59] WIT 0269 0010 – 0011 Mrs Pratten
[60] WIT 0012 0010 Penelope Plackett
[61] WIT 0012 0011 Penelope Plackett

61 Janet Baker, mother of James who also underwent surgery at Bristol in 1988:

> '… thought the BRI was brilliant. It was bright and jolly and there were nice toys around and the staff seemed very nice. The contrast with my experience of the Bristol Children's Hospital could not have been more extreme.'[62]

62 Another parent, in their written evidence to the Inquiry, described Ward 5 in 1991 as:

> '… an adult ward, but the children who were there were together at one end, although that meant they were some way away from the nurses' station. It seemed a gloomier place than the Children's Hospital …'[63]

63 Christine Ellis, mother of Richard, expressed concern that in 1991:

> 'There did not seem to be the same pastoral care in the BRI as there was in the Children's Hospital …'[64]

64 John McLorinan, father of Joseph, told the Inquiry of his view of the general environment as between the BRHSC and the BRI in 1991:

> 'I suppose in the children's ward one feels very much supported and cushioned and cradled, and in the BRI, where they have the heart cases, one was more aware that people might die more often and things like that. It was not really geared for children and families. It was a bit frightening and worrying like that, and obviously the practical care of Joe was more difficult for the staff, but I think the staff made every effort to overcome that.'[65]

65 Alison Thomas, mother of Dafydd, in her written evidence to the Inquiry, stated that in 1992:

> 'I found the experience of having to travel with Dafydd from the Children's Hospital to the BRI on the morning of surgery highly traumatic. Dafydd and I were being transferred from everything we knew and felt secure within the Children's Hospital to an unknown destination in terms of experience. All I knew was that I had seen the IT Unit the day before and didn't like it. The nurses at the Children's Hospital had been friendly and caring … we did not know the nursing team that would receive Dafydd. It gave rise to a great sense of insecurity. I could have done without that at that very stressful and important time in my life and that of Hugh my husband and of Dafydd. We were also saying goodbye to Helen Vegoda who had

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62 WIT 0018 0003 Janet Baker
63 WIT 0135 0006; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified
64 WIT 0023 0011 Christine Ellis
65 T2 p. 173 John McLorinan

been a great support during the period leading up to the operation and also all the other parents who had been friendly with us.

'I remember being very pleased when Dafydd was able to be released from the IT Unit back to the Children's Hospital. On return to the Children's Hospital, although it seemed antiquated compared to the high-tech of the IT ward, nonetheless one was back in the caring child orientated environment. That is not to say that Dafydd did not receive care and attention in the IT unit or that the nursing team could have been any more caring than they were with myself, Hugh and Dafydd.'[66]

66 Alison Thomas told the Inquiry:

'Being up at the Children's Hospital, surely it would make more sense for children to be treated at the hospital that they were admitted to, rather than being shipped, having had a pre-med even, by ambulance on the morning of an operation down to another hospital. In fact, Dafydd took rota virus down there with him and it could have closed the whole unit down, I believe. Certainly, in my opinion, it was an awful lot less than perfect.' [67]

67 Another parent described his concern about the facilities at the BRI in 1993 in his written evidence to the Inquiry:

'As part of the pre-operation procedure we were shown round ward 5 at the BRI, including the part of the ward where the patients would be kept in intensive care following the operation. Our general impression was that it was somewhat less satisfactory than in comparison to the Children's Hospital where we had been very happy with the atmosphere and the facilities.'[68]

68 Alison Lyne, mother of Charlotte, stated that in 1993 when she was at the BRI after the BRHSC: 'I felt like I had been abandoned'.[69]

69 In 1994, when Helen Sadler's son, Edward, was moved from the BRI to the BRHSC she stated that: 'We were told that he might benefit from the change to more congenial surroundings'.[70]

70 Helen Johnson, mother of Jessica, told the Inquiry that the ICU at the BRI in 1995 was 'limbo land, because there were adults in there as well as children and the adults were totally, you know, unconscious …'.[71]

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66 WIT 0029 0010 Alison Thomas
67 T5 p. 103 Alison Thomas
68 WIT 0134 0005 – 0006; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only partial consent to publication of the statement, as they did not wish to be publicly identified
69 WIT 0408 0004 Alison Lyne
70 WIT 0287 0013 Helen Sadler
71 T44 p. 144 Helen Johnson

71 Commenting on the mixed adult–child environment, in her written evidence to the Inquiry, Brenda Rex, mother of Steven, described Ward 5 as it was in 1986:

> 'We walked over to the BRI and were shown round the ward by a sister. We were horrified to find both children and adults were placed on the same ward. I was told that work was underway to establish a nursery ward for babies and younger children.'[72]

72 Sandra Suckling, mother of Jason, stated that in 1988:

> 'Ward 5 had adults in it with the adults being at one end and children at the other. I felt that this was in some ways quite nice and I remember there was an old man in his seventies on the cardiac unit. He used to watch the children playing. He told me that he was very worried about having his own surgery and he said watching the children gave him the strength to go ahead with his pending heart surgery.'[73]

73 Another parent stated that in 1992:

> 'The nurses at the BCH were better at treating children than those at the BRI. There was more of a sense of personal responsibility there. At the BRI the nurses were dealing with adult patients and children at the same time. There seemed to be a higher ratio of nurses to patients at the BCH. At the BRI it often felt as though the children were being left unattended. Also the doctors at the BCH were better at dealing with children.'[74]

74 Philip Wagstaff, father of Amy, told the Inquiry that in 1993:

> '… the impression of the ITU was that I was surprised that it was a mixed adult and children's unit as such. When we saw it the night before, I believe there was only one or two children in there, and the rest of the beds were adults who had undergone heart surgery. And obviously the adults were very poorly, and we found it distressing seeing all the other patients in there. It just struck us as unusual that they were all mixed in at that stage.'[75]

75 Alison Lyne stated that in April 1993:

> 'One of the nurses showed me around the Intensive Care Unit, it was full of adults and I found it very sterile and depressing. It would have been nice to have seen some concession made towards the babies and children such as pictures and mobiles. I felt that I was invading the adults' privacy.'[76]

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72 WIT 0219 0010 Brenda Rex
73 WIT 0536 0008 Sandra Suckling
74 WIT 0423 0008; this parent was one of a number of parents who gave a witness statement to the Inquiry and gave only limited consent to the publication of the statement, as they did not wish to be publicly identified
75 T2 p. 29 Philip Wagstaff
76 WIT 0408 0005 Alison Lyne

76 In her written evidence to the Inquiry Debra Hill, mother of Thomas, stated that in April 1995:

> 'Thomas was surrounded by croaky old men and ladies on their last legs, even in Intensive Care'.[77]

Staffing levels

77 Christine Ellis, mother of Richard, commented on staffing levels in 1991 in her written evidence to the Inquiry:

> 'After his period in the ITU Richard was transferred back to the ward in the BRI that he had first been admitted to for a period of time. The staff in that ward suggested that he was better to be transferred back to the Children's Hospital because they did not have the ability to give the one to one attention and the particular attention to an infant that was required and accordingly Richard was transferred by ambulance back to the Children's Hospital …'[78]

78 Deborah Gillard, mother of Christy, stated of her experience in 1989:

> 'The standard of care on the general ward had struck [us] as lower than it might be; babies were often left to cry for long periods of time, and the staff included many bank nurses, who did not seem as attentive as the regular staff.'[79]

79 Andrew Hall, father of Laurence, referring to 1994, stated:

> 'It did not appear that set teams were allocated to each individual patient and there was always a lot of new faces around; in particular, a lot of temporary agency staff working on the ITU.'[80]

80 Michelle Cummings, mother of Charlotte, told the Inquiry of her experience in 1987 in the following exchange:

> 'Q. And you say in your statement that there were no specially trained nurses around?
>
> 'A. I meant ITU nurses. There were no intensive care nurses.
>
> 'Q. Obviously there were no children's nurses?
>
> 'A. Yes, but I meant she was not having intensive care nurses looking after her, which, you know, I mean, the attention that these children get when they are in ITU. There was also the other issue over the risk of infection on a general surgical

[77] WIT 0381 0006 Debra Hill
[78] WIT 0023 0011 – 0012 Christine Ellis
[79] WIT 0161 0004 Deborah Gillard
[80] WIT 0172 0003 Andrew Hall

ward, so close, which again, could not be addressed because of the circumstances.'[81]

81 Belinda House, mother of Ryan, told the Inquiry of her experience in 1990: '… most of the nurses were more relaxed nursing the adults'.[82]

82 In oral evidence Linda Burton, mother of David, told the Inquiry of her experience of the ICU at the BRI in 1991:

> 'Staff never sat down, they were constantly on the move, testing and reading and administering drugs, very caring, very attentive.'[83]

83 Nursing and staffing levels in the ICU are dealt with later in Chapter 15.

Transfer back from the BRI to the BRHSC

84 Susan Jenkins, mother of Nathan, stated that, in 1984, she:

> '… was approached by the nursing staff, and they asked did I mind Nathan being transferred back to the Children's Hospital because he was taking up a bed that someone else could have'.[84]

85 Robert Briggs referred in his written evidence to the Inquiry to the rapid rise in heart rate and temperature of his daughter, Laura, following transfer back to the BRHSC in 1988:

> 'We were told at the time that this incident may have arisen because of the transfer from one site to the other, and particularly in retrospect we feel that it was somewhat undesirable that she should have been moved so soon after her operation. At the time we did not question it because we were firstly worried for Laura and then relieved that it had all been sorted. We do not understand why it should have been necessary to move her quite so soon and it seems to us that it created a risk that preferably should have been avoided.'[85]

86 Bernadette Powell described how, in 1991, her daughter, Jessica, was moved back to the BRHSC by ambulance:

> 'Between the time I left the hospital and the time of my mother's arrival (about 11am), Jessica was moved to the Bristol Children's Hospital by ambulance. I could not believe that this had been done without either our knowledge or our presence.

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81 T3 p. 155 Michelle Cummings
82 T6 p. 93–4 Belinda House
83 T5 p. 30 Linda Burton
84 WIT 0252 0014 – 0015 Susan Jenkins
85 WIT 0136 0006 Robert Briggs

I had been in the hospital minutes before, and someone could have told me she would be moved. I was very upset, and was back in Bristol by lunchtime.' [86]

87 Michelle Cummings told the Inquiry of the transfer of her daughter, Charlotte, from the BRI to the BRHSC in 1987:

'She was moved by ambulance to the Children's Hospital, straight through casualty, and up to the Intensive Care and they did not even know we were coming. There was no intensive bed for her, no life support machine, and they were still hand ventilating her, so we went through to the baby unit and they were full up. There was no cot for her in there, because they were hoping they could have set up a mini intensive care in one of the rooms for her.'[87]

Comments by the UBHT

88 The UBHT in its written evidence to the Inquiry commented on the split site and service:

'Since the publication of the report on the Welfare of Children in Hospitals in the late 1960s/early 1970s it has been the policy within the National Health Service that children should be nursed separately from adults, wherever possible, in dedicated children's units and nursed by Registered Sick Children's Nurses. The policy of UBHT in the 1980s to move children's cardiac surgery to the Bristol Royal Hospital for Sick Children was in accordance with this policy, but in practice it was thwarted by lack of capital funding.

'It should be noted that it is often not possible in District General Hospitals to provide separate intensive care facilities for children, although in major specialist paediatric centres such as the Bristol Royal Hospital for Sick Children, there are separate specialist paediatric intensive care units.

'As the statements of the witnesses confirm, patients and parents were shown the intensive care unit and the extensive monitoring equipment which would be attached to the patient post operatively. Assurances were given that staff were sensitive to modesty. Curtain tracks were around patients to enable procedures to be undertaken with as much privacy as possible. Patients were only accommodated in the mixed sex, adult/children's intensive care unit for the minimum period possible, following which children were transferred to a separate children's side ward.'[88]

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86 WIT 0240 0007 Bernadette Powell
87 T3 p. 149–50 Michelle Cummings
88 WIT 0030 0013 UBHT

89 Fiona Thomas, Clinical Nurse Manager, stated:

'The Bristol Royal Infirmary is adult focused compared to the Bristol Royal Hospital for Sick Children. … The nursery on Ward 5 cared for both pre and post operative children. This would have been no different to the equivalent ward in the Bristol Royal Hospital for Sick Children.'[89]

Comments by clinicians in Bristol

90 Mr Wisheart told the Inquiry that the problem of the split site was known in 1984, but that it took until October 1995 to resolve.[90]

91 He explained in his written evidence to the Inquiry:

> 'Although the need for this development had been recognised as a theoretical proposition for a very long time there were at least two reasons why it did not become a practical one until after the late 80s. The first was that before 1987 there were no catheter facilities within the Children's Hospital, so the children had to be transferred to the BRI for diagnosis, and back again to the BRHSC. The second was that at the time the whole cardiac surgical enterprise was so small that to divide it into two would have weakened it seriously, even if it had been actually possible from the financial and personnel standpoint.'[91]

92 Mr Wisheart went on:

> '… it is wrong to describe the operating theatre and intensive care unit as *adult* facilities into which children were placed. It is correct to say that they were facilities which were created *both for children and adults.*'[92]

93 Mr Wisheart was asked by Counsel to the Inquiry about the concerns expressed by parents about transport between the BRI and the BRHSC:

> 'I think the shape of the problem is little different for catheterisation of children and open heart surgery, and I think that they are really talking of the problems associated with the transport of very sick children backwards and forwards on the same day before and after the investigation.
>
> 'The issue of transport occurred or persisted, if you like, with a relatively small number of children who needed to be transferred for urgent surgery to the

89 WIT 0151 0012 Fiona Thomas
90 T40 p. 130 Mr Wisheart
91 WIT 0120 0051 Mr Wisheart
92 WIT 0120 0094 Mr Wisheart (Mr Wisheart's emphasis)

Infirmary, but of course the other problems were that the children were being cared for at a site which was some distance from the Children's Hospital.'[93]

94 Mr Wisheart indicated that there were organisational problems arising from the split site: the difficulty in recruiting and retaining paediatric nurses; the failure to attract Mr Martin Elliott to the Chair of Surgery; and the rejection by the Joint Committee on Higher Medical Training Visitor, Dr Elliott Shinebourne, in 1992, of the proposal to create a Senior Registrar post in paediatric cardiology at the BRHSC.

95 Asked by Counsel to the Inquiry whether the decision to move the paediatric surgical workload to the BRHSC was eventually taken so as to increase further the number of adult patients who could be treated at the BRI, Mr Wisheart replied: 'I would not put it that way'.[94]

96 The issue was explored in the following exchange:

'A. It is absolutely right to say the increase in adult work was the occasion or opportunity which permitted the children's work to be moved, but there was a clear and independent motivation and desire to do that.

'Q. Would you go this far: that it was the proposed expansion in adult surgery which was the impetus for the move to the Children's Hospital?

'A. I think I would still stick to "occasion".'[95]

97 Mr Wisheart was asked about the funding application made by Dr Joffe in June 1992 to help resolve the split site issue. He was asked if he played a part in the formulation of the application:

'I think I asked him to do that — or we agreed that he should do it, would be better, I am sorry.'[96]

98 He went on, in the following exchange:

'A. I think it would be fair to say that the technical details of funding are something that clinicians have a vague awareness of but it is not their prime interest. So that for funding opportunities or potential, I mean, we would be looking for advice to the financial experts within the Trust or at Region, or whoever.

'The question that I have asked myself, on seeing this, is, when we prepared our proposals in 1990, why did we not knock on this door then? In a sense, all I can say is that the proposals were prepared and they went to all the appropriate authorities

93 T40 p. 128–9 Mr Wisheart
94 T40 p. 120 Mr Wisheart
95 T40 p. 125 Mr Wisheart
96 T41 p. 147 Mr Wisheart

at District as it then was and Region, and nobody prompted us to think that this was an avenue to go down.

'Q. So the plain truth is that, notwithstanding experience of having made an application for capital funding earlier, and having had to live daily with the effect of lack of resources generally, no-one actually thought of it?

'A. I think Mr Nix [the then Assistant Treasurer/Financial Manager (Acute) of B&WDHA] has said somewhere that he and his colleagues at Region nearly privately created the application in 1987, and I think our awareness of it was really very limited. It was merely a financial device operated by the financial people, and it did not work, but there we are.'[97]

99 Dr Joffe told the Inquiry that he did not attempt to obtain funding under the Supra Regional Service (SRS) system to deal with the split service[98] before 1992, as he was not aware 'of the opportunity to request capital sums from the Supra Regional Services Group until 1992/93'.[99]

100 Mr Wisheart told the Inquiry that the appointment of a specialist paediatric cardiac surgeon and the resolution of the split site issue were both proposed and decided upon before the allegations in respect of paediatric cardiac surgery became public. He went on:

'This was the unit making what it thought was best plans for the future, at that time, with the assistance of the Trust, of course, as a whole.'[100]

101 Mr Dhasmana stated in his written evidence to the Inquiry that he was involved in 1988 in discussions with Dr Pitman, consultant in public health medicine at SWRHA, regarding a cardiac services strategy for the Region. He stated that he indicated his agreement to the transfer of the children's services to the BRHSC:

'I believe that it would be a step in the right direction if we did aim to achieve this goal as children would then be looked after in one place for all their cardiac problems. … I personally would support the move to split children's services from here and hope that the staffing level would be raised in a few years' time.'[101]

102 He told the Inquiry:

'The problem with the BRI, because it is a place in the hospital where it is mainly an adult service, so whenever we wanted to recruit a paediatric trained nurse in the cardiac surgery, we were not very successful because nurses who were trained in

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97 T41 p. 148–9 Mr Wisheart
98 JDW 0003 0142 – 0144 Dr Joffe
99 T90 p. 34 Dr Joffe
100 T92 p. 2 Mr Wisheart
101 UBHT 0163 0003; letter from Mr Dhasmana to Dr Pitman dated 12 September 1988

children's care, they are in high demand everywhere and there is a shortage in almost all hospitals so obviously they get absorbed there quickly.'[102]

103 Dr Jordan, referring to the visit in 1991 by Dr Elliott Shinebourne which resulted in a decision not to approve the appointment of a Senior Registrar, told the Inquiry:

'My recollection is that they had no problems with the investigational side but they did not like the fact that there was no open-heart surgery on the same site.'[103]

104 Dr Jordan's views are indirectly referred to by a draft report[104] of March 1984, which urged that the transportation of critically ill infants should be avoided.

105 Dr Martin told the Inquiry that transfer from the BRHSC to the BRI 'might be a factor that could potentially increase the risk of surgery in some of these patients and that was of concern'.[105]

106 Dr Martin's evidence included this exchange:

'Q. You have already said that in the course of transfer a couple of children were less stable than you would have wished. No doubt that is a reflection of the fact that there is a split site?

'A. … This is also obviously talking about parents' experience and patients' experience rather than necessarily talking about clinical care. So as I understand it that is referring to the overall environment and change of environment.'[106]

107 Dr Martin went on:

'With regard to patients having open-heart surgery, with our busy commitments at the Children's Hospital it was often very difficult for me to get to the Royal Infirmary on an absolutely regular and fixed basis. Not everyone may know the geography of the area, they are separated by about a five minute walk downhill but it is a very steep hill coming back so it does involve some effort, if you like, going up and down, it does involve some time going up and down … but your commitments at the Children's Hospital often made it very difficult to get down there at set times … That made it very difficult to be actively involved in the day-to-day management of these patients, or minute-to-minute management of those patients.'[107]

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102 T86 p. 18–19 Mr Dhasmana
103 T79 p. 159 Dr Jordan
104 UBHT 0295 0240; draft report dated March 1984
105 T77 p. 13 Dr Martin
106 T77 p. 27 Dr Martin
107 T77 p. 33–4 Dr Martin

108 Dr Martin then explained the interaction with the surgical team in the following exchange:

> 'A. … I personally found it difficult to get actively involved in the care of the patients down there [at the BRI]. Patients were under the care of surgeons, the surgical team were looking after the patients in conjunction with the anaesthetic team. It was very difficult to arrange a time when you could be there when other people were there to discuss the individual case, so usually when I went down I would find there was no one else actually physically there that I could talk to about the case and —
>
> 'Q. The communication between yourself and the surgeon would necessarily have particular difficulties because of that?
>
> 'A. It would be difficult, yes. There would be occasions when surgeons or anaesthetists might specifically ask for an opinion about this or that and of course we would give that opinion and there would be some discussion. But just in the day-to-day management it was very difficult to get very actively involved.
>
> 'That was not due to not wanting to, it was very difficult. You felt a little bit of an outsider when you went down there to visit patients; that was not my primary base; you felt as though people did not know you quite as well. You were not primarily directing their care so any advice you might give, whilst I am sure people would say it would be listened to, it may not have been acted upon.'[108]

109 Dr Martin stated:

> '… we thought that by perhaps incorporating a unified site it was more likely we would be able to improve the care of the younger children, particularly neonates and infants, because on the site based at the Children's Hospital we would have had a full range of paediatrics specialists, a greater input from paediatric nurses and we felt that might impact particularly in the younger age group. We did not know for sure but that was an impression we had.'[109]

110 Dr Burton, a consultant anaesthetist, who had worked at the UBH/T from 1959 to 1991, stated in his written evidence to the Inquiry:

> 'There were several disadvantages of working in a split site. Probably the most significant disadvantage was the problems caused by the simultaneous arising of difficult situations in both places. It was, of course, impossible to solve these problems personally and one had to rely on telephone contact with the other hospital. When dealing with the children, the disadvantages of not working in a paediatric teaching hospital were very obvious.'

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[108] T77 p. 35–6 Dr Martin
[109] T77 p. 17 Dr Martin

He also notes in his statement the problems of lack of medical cover.[110]

111 Dr Joffe told the Inquiry:

> 'One of the factors that we struggled with throughout this period was the split site and the question of whether that was a factor in producing worse results than there should have been and while it was very difficult to identify specific issues, I think there was an overall feeling that if the unit was centralised and under one roof … and if the staffing was at its optimum levels, that we might be able to get or we should get better results. But that was the situation that there was at the time and although the request or the recommendation was made for unification of paediatric cardiac surgery from as far back as 1981, certainly when I arrived after 1980, there was no progress at that stage for a variety of reasons. Probably the major one being the fact that the unit at the BRI was needing to increase its adult throughput …'[111]

112 Dr Joffe also told the Inquiry:

> 'I forgot to mention in terms of the question about the availability of paediatric cardiologists at the BRI that Dr Jordan specifically made a point of going to the BRI every day and often twice a day, so it was not as if there was no presence whatsoever at the BRI. He found it slightly easier than I could because earlier on he was still involved in adult cardiology, had an office at the BRI, and needed to be there anyway, and indeed, he and later Dr Martin were running an outpatient clinic for adolescents and adults who had grown from the childhood period, usually post surgery, at the BRI. Therefore, they had some time when they had to go. So, apart from the weekends, I would say that on a daily basis there was at least one call by a paediatric cardiologist who would look at all the patients, not only his or her own, but all paediatric cardiac cases, and make recommendations about management, if necessary.'[112]

113 Dr Joffe added, in the following exchange:

> 'Q. To what extent was it the physical separation of the two buildings, one being up the hill, one down the hill, that made it difficult for you? You mentioned that Dr Jordan had an office down at the BRI which meant that he did go to the BRI?
>
> 'A. Yes, for a time. That stopped in the late 1980s, I think.
>
> 'Q. You did not have such an office?
>
> 'A. Well, I did initially, when we first started —

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110 WIT 0555 0005 Dr Burton
111 T90 p. 25–6 Dr Joffe
112 T90 p. 64–5 Dr Joffe

'Q. But thereafter not?

'A. No.

'Q. Was it the physical separation that made a difficulty?

'A. Yes, the physical separation was real, although of course not insurmountable. The distance between the two hospitals was really quite small: 150, 200 metres, maybe. But the hill, when you were walking up it, felt as if it was almost half a mile, rather than 200 metres. It was extremely steep, so it was difficult coming back up; it was easy going down. This may sound trite, but it does make a difference, and it also makes a difference in terms of the ordinary communication that exists in a unit where consultants and various doctors can meet with each other and bump into each other in a corridor, and so on, which facilitates overall management.'[113]

114 In addition to evidence from clinicians involved in the care of children in the relevant period, the Inquiry also received evidence about the split site and service from other clinicians in Bristol.

115 Professor John Vann Jones, consultant cardiologist, and Clinical Director of Cardiac Services from 1993 to 1996, told the Inquiry:

'I must say, my own feeling was that this was the wrong environment for children. As I have already said in my statement, when I did paediatric cardiology, having been an adult cardiologist and thrown into this unusual circumstance, I felt very uncomfortable with it because these youngsters have many metabolic problems that develop extremely quickly. They are tiny little things. They become acidotic very easily; they have their ventilation suppressed very easily. If you do not actually have general paediatricians in the building and you do not have a paediatric cardiologist in the building all the time, and you do not have dedicated paediatric anaesthetists you are going to have more morbidity. That problem needed to be resolved.'[114]

'… if I am in the clinic and someone asks me to go to the ITU two storeys away I can be there in 15 seconds. Obviously you cannot do that in a building the best part of half a mile away. So these sorts of children can go dramatically wrong dramatically quickly. Any cardiac patient can. So there is no way it can have anything other than a negative impact, but I do not think it is quantifiable.'[115]

113 T90 p. 66–7 Dr Joffe
114 T59 p. 164 Professor Vann Jones
115 T59 p. 165 Professor Vann Jones

116 Dr David Hughes, consultant paediatric anaesthetist, referred in his written evidence to the Inquiry to efforts made to transfer the paediatric cardiac service to the BRHSC:

> 'I believe the first proposal was raised in the late eighties and a working party was set up to look at the implications including costings of the service. A new operating theatre and an extension to PICU was required. This proposal, supported by the National Heart Foundation did not come to fruition and nothing materialised until the issue was raised once again in the early nineties when, I believe, a proposal was put forward to develop adult cardiac services at the BRI. I think it was clear from the implications of this adult expansion that it would require extra beds and it would be necessary to transfer children's cardiac services to the BRHSC.'[116]

117 Dr Robert Johnson, a consultant anaesthetist, stated in his written evidence to the Inquiry:

> 'I did not personally provide any anaesthetic services at the BCH after 1978 but from about 1971, when I was a trainee at the BRI and worked in both the BRI and BCH, I had always believed and understood that the split site working, between the BRI and the BCH, for cardiac surgery was unsatisfactory.'[117]

118 Mr Eamonn Nicholson, a clinical perfusionist at the BRI since 1988, stated that when he was working at Guy's Hospital in the 1980s there was 'a walled-off unit within the ICU for children, with specially trained nurses allocated to that unit'.[118] He stated that when he joined the BRI in 1988 he noticed that there was no separate paediatric intensive care unit. He stated that he also noted that the ICU was on the sixth floor while the operating theatres were on the fourth floor: 'This meant that we had to transport patients and this was difficult.'[119]

119 He stated further that when he joined the BRI in 1988 he 'was puzzled that there was no back-up service provided at the Bristol Children's Hospital. Perfusionists were located only at the BRI.'[120]

120 Mr Nicholson stated that, although there was a designated children's area within the ICU:

> '70-year-olds would sometimes have to be placed there and it was generally recognised by all staff that it was not ideal to have mixed nursing.'[121]

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116 WIT 0511 0015 Dr Hughes
117 WIT 0403 0011 Dr Johnson
118 WIT 0489 0015 Mr Nicholson
119 WIT 0489 0015 Mr Nicholson
120 WIT 0489 0015 Mr Nicholson
121 WIT 0489 0016 Mr Nicholson

121 He concluded that:

> 'Since the move to the Children's Hospital in 1995 we have followed practice in Australia, with pre-operative meetings between cardiologists, surgeons, perfusionists and anaesthetists. I have found these meetings interesting. They assist in giving me insight into potential difficulties of a particular operative procedure, or a particular patient's needs …'[122]

Comments by those involved in management and finance on the split site

122 Avon HA pointed out in its written evidence to the Inquiry that:

> 'The Bristol and District area was not alone in having in-patient children's care provided from a number of hospital sites. This was the case in many cities including those which had children's hospitals which were separate from other district general hospital provision, and the location of which did not always fit with the development of specialties such as renal services, cardiac services, neurosciences and plastic surgery.'[123]

123 Avon HA stated that in 1983 the Bristol and Western District Health Authority (B&WDHA) had received advice from the Management Advisory Service of the NHS. The B&WDHA's Planning Group undertook a series of consultations and the Division of Children's Services 'argued strongly for programmes towards centralisation of children's inpatient services on the BCH site'.[124]

124 Avon HA stated that after a further review of acute and related services by B&WDHA's Policy Planning and Resources Committee:

> '… at a meeting on 31st October 1986, the representatives of the Division of Children's Services continued to press for integration of children's services'.[125]

125 On 16 October 1990 Dr Baker wrote to Miss Deborah Evans, Contracts and Quality Manager, B&WDHA:

> '… paediatric cardiologists were anxious for the new "contract" to contain "some expression" of the need for children to receive cardiac surgery in a children's

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122 WIT 0489 0016 Mr Nicholson
123 WIT 0074 1778 Avon HA
124 WIT 0074 1777 Avon HA
125 WIT 0074 1778 Avon HA

department. This was accordingly expressed in the 1991/1992 service agreement between the B&WDHA and the UBHT.' [126]

126 In July 1993 B&DHA began a:

'… "strategic review" of selected services for its residents … One of the key elements of change highlighted was to identify 15 hospital specialties that might benefit from some consolidation, including general paediatric surgery'.[127]

127 Avon HA stated that this proposal for a review was influenced by the paper *'Towards the Millennium: Specialist Services for Children in Bristol',* issued in February 1993.[128] The paper recommended, amongst other things: '… a move towards a single children's inpatient service in Bristol'.[129]

128 Avon HA stated that:

'The Authority developed and undertook an intensive programme of involvement with advisors up to the Autumn 1994. Six service area working groups were established, one looking at Acute Hospital Services … In the Acute group, six particular services were examined, including specialist children's services.'[130]

129 In its advice, dated 9 June 1994, the Bristol & District Paediatric Committee:

'… explicitly advocated that where children's services had developed alongside their adult counterparts, they should meet a nationally-recommended standard for children's care and that could be achieved only by "realignment from organ-centred to age-centred patient care".'[131]

130 In her written evidence to the Inquiry, Miss Deborah Evans indicated that the management of cardiology and cardiac services as a single unit was regarded as an important issue for the Avon HA 'because it felt that an integrated directorate could have a direct bearing on clinical decision making for certain patients'.[132]

131 She stated that:

'In 1993/1994 and thereafter Bristol and District Health Authority issued a single specification for children's cardiac services (i.e. cardiology and cardiac surgery combined) and another single specification for adult cardiac services (cardiology and cardiac surgery combined).'[133]

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126 WIT 0074 1778 Avon HA
127 WIT 0074 1779 Avon HA
128 WIT 0074 0160 Avon HA; there appears to be an earlier draft of this document dated September 1992 at HAA 0081 0056
129 WIT 0074 1779 Avon HA
130 WIT 0074 1779 Avon HA
131 WIT 0074 1779 Avon HA
132 WIT 0159 0022 Ms Evans
133 WIT 0159 0022 Ms Evans

132 Dr Pitman, consultant in public health medicine at the South Western Regional Health Authority/South and West Regional Health Authority (SWRHA/S&WRHA) from 1980 to 1996, in her written evidence to the Inquiry stated that, in March 1984, the SWRHA was considering how to deal with the proposed expansion of cardiology. She referred to a draft report:

> 'At the present time, patients' lives are constantly being placed at risk by the need to transfer very young children between the Bristol Children's Hospital and Bristol Royal Infirmary every time a catheter investigation is needed.'[134]

The report proposed that the catheterisation rooms at the BRI and the BRHSC be re-equipped.

133 Dr Roylance told the Inquiry that he was aware, in 1985, of some views favouring a move of paediatric cardiac surgery to the BRHSC but:

> 'That was not a universally supported view.[135] There were still those who thought that the expertise in cardiac surgery lay at the BRI and that it might be better to import paediatric expertise into the BRI. But I was aware and by 1987, I think by then, I think it was by then or soon after, more neonates were being operated on than before which precipitated the problem and made it clearer to everyone that it would be better if the neonates were in a paediatric unit.
>
> 'So I knew, at that time, and we tried from that time, James Wisheart in particular, with my enthusiastic support, to try and find a means of achieving that desired aim, so that around 1987, I think there was no longer an argument that it would be preferable for children to be nursed in a children's hospital, at that time … So the desire was there. The achievement was much more challenging.'[136]

134 Dr Roylance explained how this was achieved:

> 'We engineered a situation, a very welcome situation, whereby, to achieve the latest increase in adult cardiac surgery, we either had to build more adult cardiac facilities at the BRI or build children's facilities at the Children's Hospital, so creating space for the adult surgery.'[137]

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[134] WIT 0317 0005 Dr Pitman and HAA 0095 0029
[135] The Inquiry did not hear a single voice raised against it
[136] T24 p. 109–10 Dr Roylance
[137] T24 p. 110 Dr Roylance

135 Dr Roylance went on, in the following exchange:

> 'A. … we found a solution in the 1990s.
>
> 'Q. But the solution was one which really depended on funding?
>
> 'A. Absolutely.
>
> 'Q. Had there been a source of funding available to move the children's cases from the Royal Infirmary to the Children's Hospital earlier than the 1990s, would you have taken advantage of it?
>
> 'A. Yes, but if there were funds available for that move, we would have spent it on that move.'[138]

136 Dr Roylance was asked by Counsel to the Inquiry whether he was aware that, from 1987 to 1988, capital was potentially available (depending on the application being accepted) for the development of SRS:

> '… sources of funding were usually brought to my attention. I cannot tell you now whether it was. I will say that the Advisory Group recommended that priority be given to applications relating to services where significant workload expansion was expected, and I suspect that that was the reason why this was not a pathway which could be trodden.
>
> 'You see, we were relying on a significant workload expansion in adult cardiac surgery. What we had been saying and what we were talking about, a significant workload expansion was not expected, as I understand it, in 1987 and 1988.
>
> 'I cannot be certain, all I can use is my experience and these documents, and what is implied is that in order to get capital for expansion, one had to demonstrate a realistic expectation of that expansion. We were looking for money for translocation, not expansion.'[139]

137 In a letter of 31 January 1992 Arthur Wilson, Deputy Regional General Manager at the SWRHA, wrote to Dr Roylance concerning capital funding:[140]

> 'I am writing to invite you to produce a proposal for cardiac services that takes into account: a) increased capacity b) unification of children's services and c) steps to meet quality and cost concerns of purchasers.'

Mr Wilson's letter sought the proposals by 9 March 1992 for consideration by the RHA.

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138 T24 p. 111 Dr Roylance
139 T24 p. 112–13 Dr Roylance
140 UBHT 0038 0411; letter dated 31/1/91 but received 9/2/92 therefore should have been dated 31/1/92

138 Dr Roylance described his understanding of the development of paediatric cardiac surgery:

> 'When paediatric cardiac surgery was started, it was considered that the essential expertise that was needed to be concentrated was that of cardiac surgery and they were performed right across the country by surgeons, cardiac surgeons, who performed operations on adults and children.
>
> 'In other specialties, that is still the case, but as more and more neonates were operated upon, it became increasingly apparent that a paediatric facility was more important than a cardiac surgical facility. Therefore, paediatric cardiac surgery was, as soon as we could, moved to the Children's Hospital to a paediatric environment, and a little time before that, adult cardiac surgery was merged managerially with adult cardiology.'[141]

139 Dr Roylance explained:

> 'As I understand it – I think paediatricians may put a more extreme view – it was about creating a better environment in which care could take place; it was not about the success of that care. I mean, we were by no means the only unit which had a split site between paediatric cardiology and paediatric cardiac surgery. Because of the way the specialty developed, that is the case in a number of other units, I cannot tell you which ones, but I do know that that is not a unique situation by any means.'[142]

140 Dr Roylance was asked by Counsel to the Inquiry about the views of Mr Elliott, in the following exchange:

> 'Q. Did you know that Mr Elliott had expressed the views that I have revealed in this line of questioning, that there was, as he saw it, disadvantage in the split site to the point of potential danger?
>
> 'A. Yes, but not to the point of danger. As I have already explained to you, I did not actually see the paper written by Martin Elliott until after the appointment of Gianni Angelini, or some time around there, but he did not say it was dangerous, he said there was the potential for danger. I clearly read that in a different way from what you are suggesting. Quite clearly, I do.
>
> 'Q. If it were suggested to you, then, revisiting my earlier question, that the service or part of the service was a potential danger to patients in a particular respect, is that something that you – as a manager unable to reach a clinical view because you

141 T24 p. 69 Dr Roylance
142 T26 p. 19 Dr Roylance

were not a clinician in that particular service – would nonetheless wish to take advice upon?

'A. If the gist of the advice I was given throughout was that a situation was undesirable but in no way unacceptable, then I would regret the undesirability and attempt to correct it.

'If anybody had suggested to me that they were describing a situation that was unacceptable, then I have told you what I would do about it. Just at the top there [indicating screen], I do not know what it refers to, "was totally unacceptable to me", not "totally unacceptable". The tone of this and the implication was that he supported our view that consolidation of the service on one site was highly desirable. He at no stage says, "and you should not be providing the service the way you are". It is not said. I think if he thought we should not have been providing the service in the way that we were, he would have told me. He would have told somebody, not just the person providing the service.

'Q. The last question, perhaps, before we have our afternoon break: a situation in which a service may be potentially dangerous, or is potentially dangerous: is that acceptable or unacceptable, would you say?

'A. It depends what the words mean. The words as I understand them, it means acceptable but undesirable. You are putting to me that [it] is different. I do not believe anybody who believes that a service is dangerous and should be stopped would ever leave that ambiguity.'[143]

141 Mr Nix, in his written evidence to the Inquiry, stated that throughout the 1980s the B&WDHA had collaborated with the SWRHA in efforts to finance the expansion of cardiac surgical services. The SWRHA had set up a number of working parties in the early 1980s which made recommendations relating to the expansion of the service and for funding requirements for both capital and revenue.[144]

142 The Report of the Strategic Planning Working Party, presented to the SWRHA in March 1984, addressed a number of options for the increased provision of adult/paediatric cardiology. The preferred option was to provide a biplane cineangiograph machine[145] because:

'Favourable Factors

'3.6.4i Avoids the high risk of transporting critically ill infants between BCH and BRI.

[143] T88 p. 114–15 Dr Roylance
[144] WIT 0106 0040 Mr Nix
[145] This is an X-ray machine for recording angiography on cine film, and the recordings are done in two planes simultaneously

'3.6.4ii Maintains ready access to expert Paediatric support — Neonatal, Anaesthetic, Intensive Care, Nursing, etc.

'Other Factors

'3.6.6iv This arrangement would avoid the current situation where the investigation of many urgent paediatric cases has to be deferred until the end of the routine sessions.

'Conclusion

'3.6.7 This option is the only one that enables the appropriate developments to be made in both Adult and Paediatric fields without compromising the clinical needs in either area.'[146]

143 Mr Nix stated that an assessment of the costs of transferring paediatric open-heart surgery to the BRHSC was undertaken in the late 1980s:

'… not only was affordability an issue at the time but there was also concern about the availability of trained medical and perfusion staff to cover the two sites'.[147]

He stated that further assessment was undertaken in the early 1990s as part of a review of the need to expand the capacity for adult cardiac surgery.

144 Mr Nix indicated that other capital projects and developments were competing for scarce resources. He set out some of the major developments which took place throughout the 1980s and 1990s:

- 'Expansion of cardiac surgery from 275 cases to around 1,100 cases per annum
- 'Building of the new Bristol Eye Hospital
- 'Building of the Avon Orthopaedic Hospital
- 'Replacing several of the linear accelerators used for the treatment of cancer
- 'New general hospital at Weston Super Mare
- 'Transfer of learning disability patients into small family homes in the community
- 'Building four new operating theatres at the BRI

146 HAA 0095 0055 – 0056
147 WIT 0106 0042 – 0043 Mr Nix

- 'Developing a Bone Marrow Transplant unit for Children now dealing with about 80 cases a year

- 'Transferring the beds for the elderly from Manor park to the BGH [Bristol General Hospital], closer to where the patients live.'[148]

145 He went on:

'A further review of service provision in 1993/94 identified a financially viable plan to move paediatric open-heart surgery to the Children's Hospital. This plan was to be financed by the purchasers providing greater funding for an expanded adult cardiac surgery service. Because of the overall size of the expansion in adult surgical services required, the possibility of transferring children's surgery to the Children's Hospital was investigated and found to be affordable. … Funding for the capital investment was found from the Trust's capital, NHS Executive Regional Office capital and from charitable sources. Development work at the BRHSC started in late 1994 and finished in November 1995.'[149]

146 Mr Nix told the Inquiry that cardiologists, paediatric and adult alike, had been arguing for paediatric open-heart surgery to be moved to the BRHSC for some time by the start of the 1990s.[150]

147 Mr Nix was asked by Counsel to the Inquiry about an application for funding led by Dr Joffe, made in 1992:

'Well, up until Friday evening last week, I was not aware that we had made a submission. There were no papers in any of my files related to this yet you had mentioned something to me and I spoke to Kate Orchard, the Manager of Cardiac, and she said she was asked about it at the GMC, and on Friday I spoke to Mr Wisheart and asked did he know anything about it and on Friday evening I saw a copy of a paper that had been submitted in 1992. In fact I saw two papers. The first was one that I had written which was what work would need to be undertaken to make a submission and that was dated the 9 June, and then, about a fortnight later, the very short paper had been submitted. It was sent down under a compliments slip from Dr Joffe and on that compliment slip it indicated that Mr Owen had suggested that the application should be made and that an application that had been sent in was an interim statement. I do not recall being involved.'[151]

148 WIT 0106 0043 – 0044 Mr Nix
149 WIT 0106 0044 Mr Nix
150 T23 p. 78 Mr Nix
151 T23 p. 35–6 Mr Nix

148 Mr Nix agreed that opportunities were available for applications to be made for capital funding to the Supra Regional Services Advisory Group (SRSAG) in the late 1980s: '… clearly there were'.[152]

149 Asked whether the need to increase capacity in the BRI to meet the demand for adult cardiac surgery was the reason why paediatric cardiac surgery moved to the BRHSC, Mr Nix said:

> 'Yes, and it brought with it, because of the demands from purchasers and the need that was shown in our waiting lists and the number of emergencies, that finance was available to cope with both the cost of the capital investment and the ongoing revenue cost of running the service at the Children's and at the Royal Infirmary.'[153]

150 Mr Nix told the Inquiry that the concerns expressed by Dr Jordan in his paper of 7 December 1990 were addressed in the mid-1990s because they were allied to the need to increase the capacity for adult cardiac surgery.[154]

Comments by the Trust Board

151 Mr Robert McKinlay, Chairman of the UBHT 1994–1996, stated in his written evidence to the Inquiry:

> 'The effect of the quality of care of operating on children within the BRI is a matter for clinicians. In the discussions which took place in specifying the new children's hospital, much emphasis was given by staff to the treatment of children within an environment dedicated to children.'[155]

152 Miss Lesley Salmon, Associate General Manager of Cardiac Surgery from 1991 to 1993, then General Manager of Cardiac Services until 1994, told the Inquiry of her view of the Trust Board's concern in the following exchange:

> 'Q. … how would you characterise the attitudes, so far as you are able to, concern of the Trust Board, the directors of the Trust, to the split site throughout your period, 1991 to 1994?
>
> 'A. It was not my impression that the Trust Board in general felt that the split site for paediatric surgery was of great concern in terms of the management of the service or the quality of the service.

[152] T23 p. 39 Mr Nix
[153] T23 p. 81 Mr Nix
[154] T23 p. 81 Mr Nix
[155] WIT 0102 0017 Mr McKinlay

'Q. Were you aware of anyone who was trying to persuade them to a contrary view?

'A. On the Board, or outside of the Board?

'Q. No, any pressure to the Board to try and make the Board think that it was a problem?

'A. I think that certainly the group I was a member of within the Directorate of Surgery principally, there were those individuals amongst us who felt that for various reasons it was important. Certainly I think that Janet Maher would have felt strongly. Probably the clinicians and managers of the Clinical Directors would almost certainly have felt strongly about it, and I believe did. I think that Chris Monk, the anaesthetic consultant, was also a supporter of that view. Those are the ones that spring to mind.

'Q. What was your view?

'A. My view was that the service should move to the Children's Hospital.

'Q. For the benefit of the children or the adults, or both?

'A. Both, but principally for the children.'[156]

153 Mr Stephen Boardman, Director of Corporate Development for the UBHT, from April 1991 to July 1992, was asked by Counsel to the Inquiry to comment on Mr Wisheart's written evidence that:

'… we wished to move the open-heart paediatric surgery to the Children's Hospital; when the plans to do this were advanced they were overtaken by new proposals to re-provide the entire Children's Hospital.'[157]

154 Mr Boardman replied:

'Can I give you the context of my answer? When I was drafting my statement, I did not recall the transfer of the split site as being a major issue at all. It is a long time ago now and I have long since left the Trust, so it is not my everyday working environment … I then reviewed the documents I still had available at home and I was surprised to find that there were references in them — these were documents for which I was responsible and these particular documents I have mentioned, the application for Trust status and the like, and I flicked through the documents, found these references, thought "That is interesting". I had forgotten that that was going on at the time.

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156 T31 p. 125–6 Miss Salmon
157 JDW 0007 0020 Mr Wisheart

'So that is the context to me giving the answer to this.

'James' statement that he pursued it, or two goals were pursued enthusiastically, I am sure — it is very likely true that the surgeons were enthusiastic to make this move, but it never became a proposal that was actively got to the Board at a level where the Board or the predecessor of the Board, the management team, were saying, "Yes, this is a proposal which we need to devote time and effort into making it happen" with — you know, looking at the details of how we were making it happen. It never got advanced to being a major project for me to take up.'[158]

155 A first draft of a report for consideration by the Cardiac Expansion Working Party, distributed on 12 May 1994, stated:

'Plans for a new children's hospital are well advanced, including provision for integrated cardiac services, but the new building is unlikely to be commissioned before the end of the decade. This is too far ahead to meet immediate and medium term demand on the service.'[159]

It was noted in the report that the most recent previous report was in 1990 and that:

'To date it has been concluded that the cost of such relocation, involving the construction of a new cardiac theatre, additional ITU beds and additional staffing, has been prohibitive.'[160]

158 T33 p. 30–1 Mr Boardman
159 JDW 0003 0185; Working Party Report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'*, 12 May 1994
160 JDW 0003 0185; Working Party Report *'Options for Development of Adult and Paediatric Cardiac Services in UBHT'*, 12 May 1994