Advice to the Inquiry into Hyponatraemia-related Deaths on the nature of the governance relationship between Sperrin Lakeland Trust and the WHSSB and DHSSPS in relation to Lucy Crawford (Raychel Ferguson preliminary)

Addendum to the advice previously provided on 25th April 2013

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Statement of interests: I was Chief Administrative Medical Officer and Director of Public Health of the Eastern Health and Social Services Board from 1989 to 1993. I have written and spoken extensively on clinical governance and this has included speaking engagements in Northern Ireland. I was a member of the General Medical Council from 1989 to 1999.

On the 25th April I provided advice to the Inquiry on the nature of the governance relationship between Sperrin Lakeland Trust and the WHSSB and DHSSPS in respect of Lucy Crawford (Raychel Ferguson preliminary). I was asked to address a number of specific questions and gave my responses to the queries.

When I provided that advice I had not seen the Management Executive circular METL 2\93 titled 'Accountability Framework for Trusts' and dated 1st October 1993.[1] I have now had an opportunity to see this important circular.

The circular states in paragraph 3 that Trusts are 'independently managed provider units which are statutory bodies and remain within the HPSS.'[2]

This circular lays out a triple accountability of Health and Social Services Trusts to 1) the public, 2) to purchasers, and 3) to the Management Executive. The form of accountability that appears to have been applied in the writing of the circular varies between these three 'accountabilities'. It is difficult to adduce the nature of the accountability to the public as the paragraph regarding this is brief and contains a number of expectations of the Trust in relation to the public but hardly builds a relationship of accountability.

In relation to the accountability to purchasers the circular is more explicit. It clearly states in paragraph 4.ii that; 'The primary accountability for the quantity, quality and efficiency of the service they provide will be to their purchasers.' It also states that that; ' …the line of accountability will be initially to the purchaser(s) and from there to the ME if there are strategic implications …'.[3]

[1] 323-001a-002
[2] 323-001a-002
[3] 323-001a-003

The same paragraph of the circular (4.ii) states, in relation to the quantity, quality and efficiency of the service, that; 'The contracting mechanism will provide the means for these to be specified and monitored.' My reading of this circular would indicate that the WHSSB had a clear duty in respect of holding to account the Sperrin Lakeland Trust for the quality of the care it provided to the population. It reinforces the points I made in my earlier advice in relation to the paucity of detail on quality of service, and its monitoring, contained within the service and budget agreement between the WHSSB and the Trust. In any event, the contracting mechanism is not at all a suitable means of dealing with the occurrence of a serious untoward event such as the unexpected and not fully explained death of a child.

The circular causes me to strengthen my previous advice. I am now of the view there was a clearly spelt out responsibility on the WHSSB in relation to the quality of the service being provided under contract for their population. This responsibility did not extend as far as holding managerial responsibility for the actions of the Trust or its staff, but it did extend to a duty to hold the Trust to account for the quality of the service provided and a duty to intervene, using whatever mechanism was effective, in the event of the quality of that service having damaged or put at risk the health of the population either individually or collectively.

This does not however mean that the DHSS should not have been informed by the parties or did not have a role. Indeed in the 1993 Management Executive circular, in paragraph 18 in the section titled 'Ground Rules for Intervention', it explicitly states that; 'It (intervention) may be judged necessary in certain circumstances eg:- items of concern relating to patient or client care; …'[4] The same paragraph also states that such intervention does not preclude relevant actions by the appropriate Board in its role of purchaser.

[4] 323-001a-007

Additional question

I addition I have been asked the following question:

In your opinion who had responsibility for clinical care and clinical safety in the year 2000 (a) in the Royal Belfast hospital for Sick Children and (b) in the Erne Hospital? In particular what responsibility if any did the Royal Group of Hospitals Trust have for clinical care and clinical safety in RBHSC and how did such responsibility arise, and what responsibility if any did the Sperrin Lakeland Trust have for patient safety and patient care in the Erne Hospital and how did such responsibility arise?

The responsibility for the management of the entire range of services and facilities in the RBHSC passed to the Royal Group of Hospitals Trust, and for the Erne Hospital to the Sperrin Lakeland Trust, upon the establishment of those organisations as Health and Social Services Trusts.[5,6]

The function of a Hospital is to provide clinical care and thus the responsibility for that care, including issues of efficiency, effectiveness and safety, rested with the relevant Trust from its creation. The accountabilities of Trusts in respect of their activities were laid out in the Management Executive circular of 1st October 1993.[7] This circular made it clear that Trusts were accountable for the quality of the services they provided.

Trusts, on their establishment had a new relationship with their senior medical staff. Prior to the establishment of Trusts the employment and funding of medical staff in hospitals was a function dealt with by Health and Social Services Boards as a centralised function. This was in contrast to the employment of the bulk of hospital staff whose funding, employment and direct management were functions carried out within the Management Units

[5] The Royal Group of Hospitals and Dental Hospital Health and Social Services Trust (Establishment) Order (Northern Ireland) 1992. AS – INQ 305-160-021

[6] The Sperrin Lakeland Health and Social Services Trust (Establishment) Order (Northern Ireland) 1996. 1996/116

[7] 323-001a-002

of the Boards. The accountability of consultant medical staff was therefore, prior to creation of a Trust, direct to the relevant HSSB and matters relating to their employment and, if needs be discipline, were dealt with by that HSSB. The Chief Administrative Medical Officer (later titled Director of Public Health) was the Chief Officer at the HSSB with responsibility for these matters.

From the establishment of a Trust the hospital medical staff were accountable within the management structure of that Trust. The Chief Executive of the Trust was the person to whom they were ultimately accountable within the management structure. In practice a system of clinical directors (usually medical staff) and medical directors evolved and the responsibility was usually, but not always, delegated to them within the Trust management system. The Chief Executive in turn was accountable to the Board of the Trust.

Doctors, like most other clinical professions within the health service, are a self-regulating profession and, as such, the GMC controlled the medical register and thus access to the rights and obligations that come with registration. A doctor is thus dually accountable for his or her actions; the accountabilities being to their employer and to their regulator. These are not mutually exclusive. The health service from its inception has had processes in place to deal with issues of personal conduct and professional competence amongst the medical staff they employ.

The medical Royal Colleges have traditionally had an important role in respect of postgraduate medical education, the bulk of which is provided within the health service. As part of this responsibility the Royal Colleges, at the time of the events to which the Inquiry relates, would have conducted visits to ascertain the suitability of hospitals as training locations for junior doctors. Alongside this the Colleges and other medical bodies would have a role in developing clinical policies and providing professional advice to the health service on issues such as the organisation of services. They could at no

stage have been regarded as having any responsibility or accountability for quality of care issues within HSSBs or Trusts.

Clinical care within the hospital setting is not the domain of any one clinical profession. Care is provided on a team basis and although individual members of a team may be on different professional registers and members of different national professional organisations they are usually employed by the same employer and are accountable to that employer, usually a independently-managed Trust. Professional leadership in Trusts is usually vested in Medical Directors and Nursing Directors who are in turn accountable to the Chief Executive.

The development of clinical governance across the UK in the late 1990s in the wake of a number of serious clinical failures, was not creating a brand new duty for Trusts or Chief Executives. As Liam Donaldson and I wrote in 1998; '*The development of clinical governance is designed to consolidate, codify, and universalise often fragmented and far from clear policies and approaches …*'.[8] Although some Trusts had properly grasped their responsibilities, we had seen too many instances of organisations, and their leadership, refusing to take ownership of issues around the quality of care being provided to patients.

It was notable at that time, that while most, if not all, Trusts had committee structures and regular Board agenda items relating to financial and activity matters there was little structured consideration within organisations of issues relating to quality of care. A key part of the thrust for clinical governance was to ensure that the executives of the organisation accounted to

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[8] Scally, G., & Donaldson, L. J. (1998). The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ (Clinical research ed.)*, *317*(7150), 61–5. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1113460&tool=pmcentrez&rendertype=abstract

the Trust Board in respect of the quality of care being delivered and their activities in relation to its improvement.

In summary, from their establishment Health and Social Services Trusts had the responsibility for provision of clinical services to patients. The quality of those services was an integral component of their provision and, as was made explicit in the 1993 Management Executive circular, they were primarily accountable for the quality of those services, to the purchaser of those services. Although external professional organisations had a role in relation to standards, notably training, this in no way diluted the responsibility of the Trust, its Board and its Chief Executive for issues surrounding clinical service provision, including quality.