

Chapter 6. Accountability Structure

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1. Introduction

- 1.1 Readers are now aware of the aftermath of what has happened in Liverpool namely the human suffering caused by organ retention. We will now move on to explain the origin and development of the various collections of organs discovered by the Inquiry in Liverpool. A detailed analysis of what occurred between 1986 and 1995 is given in Chapter 8, the period when Professor van Velzen was appointed and worked in Liverpool.
- 1.2 It is useful to consider the nature of NHS and University management to help understand how events unfolded. A glossary of medical terms with which the general reader will soon become familiar is also to be found on page 521.
- 1.3 The National Health Service (NHS) is a complex organisation, dependent upon collaborative inter-organisational relationships. This chapter simplifies the history and explains the varied changes in structure that the NHS in England has undergone, especially in relation to Alder Hey and the North West. It provides an introduction to

the duty of accountability and responsibility to which the NHS in England must adhere. For the purposes of this report, only acute hospital services and those bodies to whom they report are included. In addition to the provision and management of health services, the close relationship that exists between the NHS and Universities for teaching and research purposes is explained as well as the role of the Ethics Committees who are responsible for the formal approval of clinical research.

2. The Establishment of the NHS

2.1 The National Health Services Act 1946 made the Minister of Health responsible for the constitution of Regional Hospital Boards, Hospital Management Committees and Boards of Governors of teaching hospitals.

2.2 A Statutory Instrument entitled National Health Service (Designation of Teaching Hospitals) designated the Royal Liverpool Children's Hospital as a teaching hospital. Sections 12, 13 and 14 of the Act set out the legal status, duties and responsibilities of the Hospital's Board of Governors,

‘It shall be the duty of the Board of Governors of every Teaching Hospital, as from the appointed day, in accordance with Regulations and such directions as may be given to the Minister, generally to manage and control the hospital on behalf of the Minister, and in particular:

(a) To provide for the University with which the Hospital is associated such facilities as appear to the Minister to be required for clinical teaching and research.’

The Board of Governors of the Hospital and the University of Liverpool were jointly responsible for appointments of senior management of the Hospital.

2.3 The Health Services and Public Health Act 1968 Section 6(1) extended these powers to administer specialist patient services outside the hospital, such as at a health centre or clinic. This was the only addition to the responsibilities of the Board of Governors until wholesale NHS reorganisation in 1974.

3. National Health Service Reorganisation 1974

3.1 The National Health Service Reorganisation Act 1973 abolished the Board of Governors from 1 April 1974. Responsibility for the Hospital passed formally to the Liverpool Area Health Authority (Teaching), which was associated with the University

of Liverpool and came into operation on 24 August 1973. A Chairman ran the Authority with 19 members drawn from nominations by the University of Liverpool, appointments by Mersey Regional Authority and by Liverpool District Council. As it was a Teaching Authority there was provision for three additional members to be appointed.

- 3.2 Further guidance in December 1976 provided for 26 members (excluding the Chairman) to include additional local authority members to be appointed from 1 August 1977. A further circular in April 1979 changed the constitution of membership of the Authority to include general members, nominations from the City Council with reserved staff and University places.
- 3.3 In February 1982 new District Health Authorities were introduced. Membership was reduced to 18 with two additional members if the organisation was a Teaching Authority. Liverpool was listed as a District Health Authority designated for Teaching Purposes and this Authority took charge of the Royal Liverpool Children's Hospital on 1 April 1982. The Liverpool Health Authority (Teaching) had a membership of 18 members, three appointed on nomination of the University of Liverpool, nine appointed by the Regional Health Authority and two appointed by the Local Authority. As it was a Teaching Authority, there were a further two members appointed.

4. National Health Service Reorganisation 1990 – The Establishment of NHS Trusts

- 4.1 The National Health Service and Community Care Act 1990 led to the establishment of a Health Service Trust, The Royal Liverpool Children's Hospital and Community Services National Health Service Trust, from 1 April 1991. This Trust was to own and manage accommodation and services at Alder Hey and associated hospitals such as Myrtle Street, including management of teaching and research facilities. Accountability was through the Trust Board of a chairman, five non-executive directors and five executive directors. The University appointed one of the non-executive directors because of the significant teaching and research commitment. Liverpool Health Authority gave assistance to the Trust before the Operational Date.
- 4.2 In 1996 the Trust changed its name to The Royal Liverpool Children's National Health Service Trust. This is the Trust accountable at present for Alder Hey Hospital.

5. The Role of Management

- 5.1 The role of NHS managers has evolved through the decades, starting with the Hospital Management Committee and sub-committee structure in the 1950s and 1960s. The management task was largely administrative. The 'chief executive' role was confined to that of hospital administrator, more of a facilitator and person 'who got things done' rather than someone with wide ranging managerial and executive powers. Professional staff, in the main consultants, had responsibility for the clinical service provided and how it was provided. In this respect they were unfettered by any managerial influence.
- 5.2 It was not until the 1960s and 1970s that a serious look was taken at the roles and responsibilities of managers and the role of clinicians in management. In the latter case, doctors became involved in management through Executive Committees of clinical divisions. Chairmen of these committees could often have a very effective and powerful say in service delivery.
- 5.3 NHS reorganisation in 1974 prompted change at local hospital level through establishment of multi-disciplinary management teams who managed on a consensus basis. The hospital administrator, working with functional heads of departments and senior nursing staff, made day-to-day decisions on running the hospital. This was supported and managed at a higher level through a new structure made up of district managers reporting to Area Health Authorities who in turn were accountable to new Regional Health Authorities.
- 5.4 A fundamental overhaul of management resulted from the Griffiths Report published in 1983. It revealed a lack of management at all levels of the NHS, the need for monitoring of performance of NHS organisations and for greater accountability of use of resources. It questioned clinical autonomy, called for a simplified management structure and aimed to strengthen management in terms of leadership, effectiveness and professionalism. Reorganisation in 1982 had already witnessed the formation of new District Health Authorities replacing old districts and areas.
- 5.5 Performance measures were now possible through the introduction of statistical data of hospital activity. Griffiths recommended annual performance reviews of regions, districts and hospitals. General managers were appointed at regional, district and unit (hospital) levels. They were given wide ranging responsibilities to improve performance of the NHS through leadership, change, cost improvement and the inclusion of professional staff into the overall aims and objectives of the organisation. It was anticipated that this fundamental shift in culture and responsibility of management would take up to ten years to achieve. Management training thus became a vitally important issue and General Management Training Schemes were introduced.

- 5.6 At this time, it was recognised that clinicians should be more involved in the management of hospitals. This was put into effect through a gradual process of developing clinical directorates. Clinical services were organised into directorates with the clinical director assuming a leadership and management role. In the early days, the unit general manager could only negotiate with and influence clinical directors, who in turn negotiated with and influenced colleagues, rather than managing through clear lines of accountability. In effect, the clinical director's managerial responsibilities were added on to clinical responsibilities.
- 5.7 The major reorganisation of 1990/91 included the establishment of the NHS Executive as the operational arm of the Department of Health. Its role was primarily to oversee performance of the NHS through Regional Health Authorities down to Health Authorities, newly established hospital Trusts and hospitals remaining as District Managed Units (DMUs). The reorganisation prompted a more prominent role for professionals in management and greater accountability of the clinicians themselves for their clinical work. This was through the introduction of medical audit in which all doctors were required to participate. Clinical directors were generally organised under a medical director who was also an executive director on the Trust Board, in turn accountable to the chief executive and Board.
- 5.8 Chief executives replaced unit general managers (UGMs) who had to compete for the posts. Some UGMs, as in the case of the Royal Liverpool Children's NHS Trust, were not appointed as chief executive. These were a 'new breed' expected to deliver a much higher profile executive role and were accountable directly to Secretary of State via the NHS Executive. With the new role came substantial increases in salary commensurate with the additional responsibilities.
- 5.9 Hospitals wishing to become NHS Trusts in 1991 had to demonstrate a high degree of managerial competence and control. For example, they had to provide evidence of financial and organisational fitness including effective information systems. Management had to demonstrate the necessary skills and prove that doctors and nurses were actively involved in management. The Regional Health Authority scrutinised applications for Trust status to ensure these conditions were met before submission to the NHS Executive and finally Ministers for approval.
- 5.10 By 1991, with the establishment of Trusts, the greater involvement of clinicians in management through the clinical and medical directorate structures and the developing audit and clinical audit initiatives, the groundwork was laid for a more effective and accountable organisation.
- 5.11 The 14 Regional Health Authorities in England were abolished by Secretary of State on 31 March 1996. In their place, the NHS Executive established eight Regional Offices in England whose role it was to performance-manage the NHS in the region through Health Authorities and directly with NHS Trusts. That performance management role exists to this day.

6. The University

- 6.1 The University of Liverpool and the Royal Liverpool Children's Hospital NHS Trust have a responsibility to deliver training and education for medical students and to facilitate research in medicine. This demands a productive relationship between the University and the Trust, with shared managerial responsibilities and established lines of communication.
- 6.2 Medical students, as part of their education and training, require access to clinical situations and to patients. Students need to be taught by clinically expert academic staff who are actively involved in research. This is essential and forms the basis of complex relationships between the University's Medical Faculty and the Trust. The Medical Faculty or Medical School at the University has relationships with a number of local Trusts known as teaching hospitals, and one such is with the Royal Liverpool Children's Hospital NHS Trust. Students are supervised and taught by both University and NHS staff. Clearly these arrangements need to be regulated.
- 6.3 Academic staff of the University and Medical School are responsible directly to the University through the head of the University department and then the Dean of the Faculty of Medicine. In turn the Dean is accountable to the Vice Chancellor. However, academic staff are also accountable to the Trust for their clinical teaching duties and clinical activities in the NHS. This dual accountability is achieved through a contractual arrangement with both the University and the Trust. For example, a University clinical professor would have an honorary NHS consultant contract. Such a member of staff would have fractions of time, e.g. 5/11ths with the University for teaching and research purposes and 6/11ths dedicated to the relevant Trust patient clinical care activities. Thus the individual would be responsible to the head of the department of the University for one part of the contract and to the clinical director at the Trust for the other. Generally this individual would be paid through the University with the NHS clinical part of the salary paid by the NHS. Both the University and the Trust would perform recruitment but the University is the main employer. This dual responsibility was explored in oral evidence given by Professor Orme. He said,
- ‘all University clinical academics in the Faculty of Medicine have a contract in which they provide six sessions to the NHS, ... and their responsibility in that lies not to the Dean of Medicine but to the Chief Executive and Medical Director of the Trust, and they are answerable in disciplinary terms to the NHS in exactly the same way as an NHS consultant.’
- 6.4 Frequently, full-time NHS Trust clinical staff are asked to contribute to the teaching of medical students. Those individuals may be given an honorary contract with the University to perform this task and 1 or 2/11ths of their time would be dedicated

accordingly. Funding for the training of medical students from the NHS viewpoint is through a mechanism called SIFT (Service Increment for Teaching). The NHS Regional Office controls allocation.

- 6.5 In addition to the University's formal responsibility for educating medical students, it should provide facilities for research in medicine. For this purpose it receives a grant for medical and educational research from the Higher Education Funding Council for England (HEFCE).
- 6.6 All University clinical staff are expected to undertake teaching and research. Additional funding for research is received in a variety of ways: NHS Research and Development funding, commercial support for clinical trials, support from UK Research Councils, or from charitable or commercial sponsors. Responsibility for monitoring expenditure depends on the source but HEFCE funding is managed by the University and NHS Research and Development levy funding by the NHS.
- 6.7 These complex sets of arrangements involve both the Trust management and University, the latter via the Faculty of Medicine. The two organisations should maintain constant and close dialogue. Relationships are normally directed between the Dean of the Faculty of Medicine and the Medical Director of the Trust, or at the immediate level below being the head of the University Clinical Department and the relevant clinical director at the Trust.
- 6.8 The potential for confusion in lines of accountability for jointly appointed academic staff is summed up by Professor MacSween from Glasgow. Writing on 29 October 1992 to Professor Orme about academic appointments he said,

‘where appointments of this type have been made the routine has not always been satisfactory, leading to separation of the academic and service (NHS) components with eventual and undesirable fragmentation. I think this must be avoided.’
- 6.9 A further complexity relates to accommodation. Medical Schools are usually located within the NHS Trust or Trusts. The Liverpool University Medical School is located within the Royal Liverpool and Broadgreen University Hospital NHS Trust but has a range of teaching facilities located in other local NHS Trusts including the Royal Liverpool Children's Hospital NHS Trust. In the case of the latter, the accommodation of the Institute of Child Health, part of the Medical School, is located on the Alder Hey site. Universities usually pay for teaching accommodation through leasing arrangements.

The Audit Structure

7. Internal Audit

- 7.1 Internal audit was predominantly focused on finance, but not clearly defined before the 1974 reorganisation. New management arrangements in 1974 defined internal audit of hospitals as within the Regional and Area Treasurers' responsibilities. Until the early 1980s the function tended to be performed by small teams of middle ranking grades, although larger authorities could attract more qualified staff. The state of internal audit is captured in a 1981 Public Accounts Committee report by the description 'weak and ineffective'.
- 7.2 Developments in the 1980s, such as production of the NHS Internal Audit Manual in 1987, led to an agreed definition of internal audit and minimum accepted standards. These covered 'soundness and adequacy of financial and other management controls, compliance with established policies, plans and procedures, suitability and reliability of financial and other management data within the organisation'. Emphasis was given to the management's 'responsibility to establish systems of internal control for operations for which it is responsible to ensure that these are properly run.' However, in general, internal audit plans continued to focus on internal financial control rather than the wider managerial or policy areas.
- 7.3 The emerging Corporate Governance agenda in the last decade has driven the establishment of Audit Committees in every NHS Trust and Authority. This provided internal audit with an independent reporting line to the Board and outside the direct control of Executives. It also gave internal audit greater freedom to move away from finance-led audit to the wider management and health policy agenda, the latter covered by the developing area of medical audit and clinical governance.

8. External Audit

- 8.1 In the 1970s and 1980s, the Secretary of State for Health appointed auditors for external audit of NHS bodies. The Finance Division of the Department of Health was responsible for undertaking this statutory duty. The key objectives of external audit were primarily financial but some Value for Money audits were undertaken. Hospital pathology departments would have been scrutinised from the point of view of the use of resources, staffing, accommodation, cost, output and accounting.
- 8.2 Responsibility for external audit passed to the Audit Commission in 1990. The Commission is an independent body with statutory responsibilities to ensure efficiency and effectiveness of public services, including the NHS. It appoints external auditors

to Health Authorities and Trusts, from the District Audit Service or from private firms. They review and report on all financial aspects, performance, efficiency and effectiveness of use of all resources. They also sign off annual accounts and produce reports of national and local efficiency studies.

9. Clinical Audit

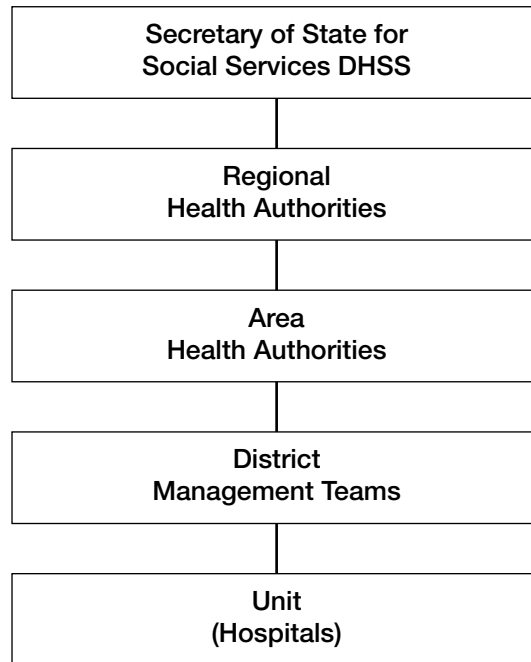
- 9.1 The NHS reforms of 1991 established the principle that all clinicians should participate in medical audit and in 1993 a strategy was established to move towards multi-professional clinical audit. Progressive implementation has been given greater emphasis and impetus through the introduction of the clinical governance agenda in 1997/98. This provides a framework through which NHS organisations are accountable for continuous improvement in the quality of services, involving full participation by all doctors including specialty and sub specialty in external audit programmes.
- 9.2 The most recent development is the establishment of the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement. NICE is developing national clinical standards, oversees a range of functions at the Department of Health and is the national centre for clinical audit. The Commission, currently being established, will have a performance management role to ensure minimum clinical standards are met, maintained and improved.

10. Ethics Committees

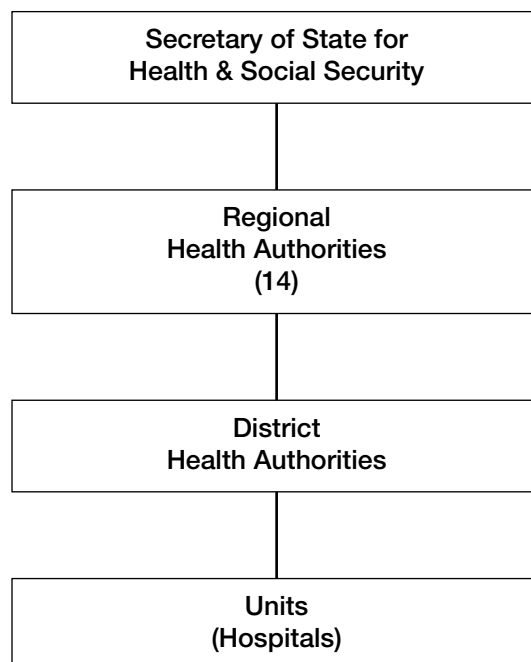
- 10.1 Medical research is widely considered to be essential. Ethical approval for medical research is of equal importance. Whilst management responsibility ensures the availability and use of resources and finance, independent advice needs to be sought regarding ethical considerations. During 1991, District Health Authorities in England were required to take responsibility both to establish Local Research Ethics Committees (LRECs) and to provide administrative support. Each committee must have procedures in place for appointing members and have Terms of Reference agreed with the NHS organisations it advises.
- 10.2 The LREC exists to provide independent advice to any NHS body about proposed research projects within the geographical area of the health district. It is neither representative of nor beholden to any NHS organisation. The NHS organisation involved makes a final decision on whether to proceed with the research project, taking account of advice received from the LREC. Liverpool Health Authority has two Ethics Committees, one for adults (aged 16 and over) and one for children (aged under 16).

- 10.3 Members do not sit on the committee in any representative capacity. The meetings are held in private and the minutes taken are confidential to the committee to promote free discussion.
- 10.4 The LREC must be consulted about research proposals involving NHS patients, the recently deceased in NHS premises, the use of fetal material and IVF involving NHS patients, where access to patient records is required or where access or use of NHS facilities or premises is required. Once approval for a research project has been given, it is the NHS organisation, research sponsor and researcher who are responsible for ensuring the research follows the agreed protocol and for monitoring progress. No NHS body should agree to such a research proposal without the approval of the LREC. No such proposal should proceed without the permission of the responsible NHS body.
- 10.5 Universities have no remit to provide a clinical service and therefore rely upon their staff to work through the respective NHS Trust to obtain ethical approval for research from the LREC. University staff are also bound by their own discipline's ethical standards. Any significant deviation from the original proposal should be reported to the LREC.
- 10.6 From July 1997, in addition to a Local Research Ethical Committee, a Multi-Centre Research Ethics Committee (MREC) was established in each of the eight Regions across England. The Research and Development Directorate of the NHS Executive was given the responsibility for the MREC system. The purpose of the MREC is to advise the LREC on research proposals that will be carried out within five or more LREC geographical boundaries. Once MREC approval has been obtained, the LRECs in each locality will have the opportunity to then accept or reject the proposal for local reasons.
- 10.7 Now, after simplified charts of the organisations, the detailed account can begin.

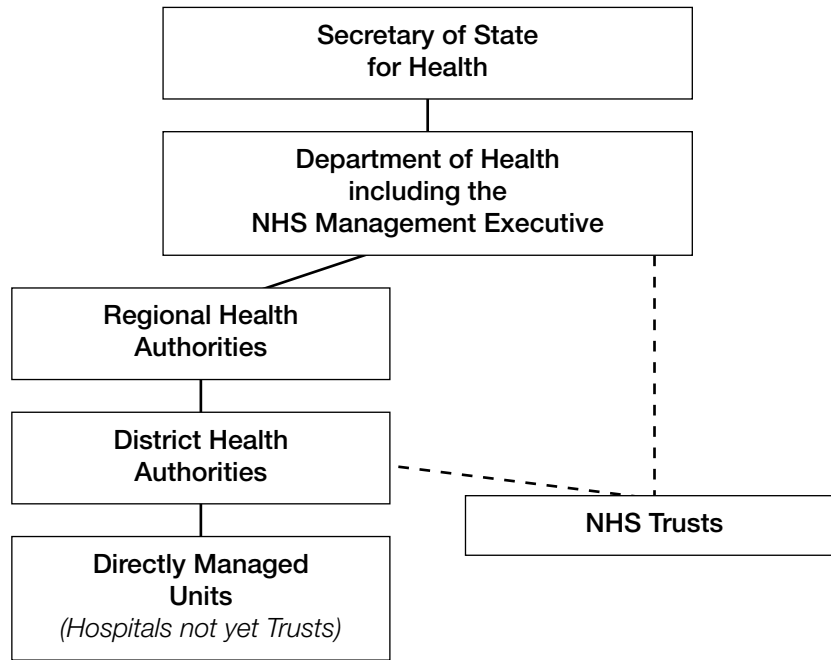
Simplified NHS (England) Organisation Chart 1974



Simplified NHS (England) Organisation Chart 1982



Simplified NHS (England) Organisation Chart 1991



Simplified NHS (England) Organisation Chart 1996

