

House of Commons  
Committee of Public Accounts

**INAPPROPRIATE  
ADJUSTMENTS TO NHS  
WAITING LISTS**

Forty-sixth Report of Session 2001–02



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*Report, together with  
Proceedings of the Committee,  
Minutes of Evidence and Appendices*

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## Committee of Public Accounts

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### Contacts

All correspondence should be addressed to The Clerk of the Committee of Public Accounts, Committee Office, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 0207–219–5708. The Committee’s e-mail address is: [pubacom@parliament.uk](mailto:pubacom@parliament.uk).

### Footnotes

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# FORTY-SIXTH REPORT

**The Committee of Public Accounts has agreed to the following Report:**

## **INAPPROPRIATE ADJUSTMENTS TO NHS WAITING LISTS**

### INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. Most patients are treated promptly by the NHS, but a significant number wait for treatment. At 31 March 2002 some 195,000 people in England had been waiting over 13 weeks for an outpatient appointment and 1,035,000 were waiting for treatment.<sup>1</sup> We took evidence in November 2001 on progress in reducing waiting lists and waiting time, ways of improving performance and steps being taken to give patients better information and choice on where to be treated.<sup>2</sup>

2. In January 2002, we took further evidence on the basis of the Report by the Comptroller and Auditor General into *Inappropriate Adjustments to NHS Waiting Lists*.<sup>3</sup> We looked at the extent and causes of inappropriate adjustments made by some NHS Trusts, how investigations into the adjustments were handled and what action was taken, the impact on patients and the steps being taken to prevent a recurrence.

3. In the light of this examination, the Committee draws four overall conclusions.

- In at least 10 hospitals, managers and staff made inappropriate adjustments to their waiting list data and statistics to hide the fact that they were missing government targets. In some cases, the actions will have prolonged the suffering of patients during which their condition may have worsened.
- The arrangements for identifying those involved and for taking disciplinary action fell well short of good practice. In some cases the inquiries were not rigorous or complete and some of those allegedly responsible were allowed or encouraged to resign during the process. Some trusts breached NHS guidelines on agreeing confidentiality deals as part of severance packages, which cost the NHS some £260,000, and in some cases they did not include clawback arrangements when those involved went on to work elsewhere in the NHS. The Department of Health have promised a new standard for future disciplinary investigations and a variety of actions to strengthen the arrangements on confidentiality agreements, clawback and future employment of those involved.
- NHS trusts took steps to develop action plans covering the 6,000 or so patients affected by the adjustments, including sending patients to other trusts and to the private sector for treatment. However, the Department of Health still do not know the extent to which patients' health suffered as a result of delays in treatment or whether compensation will have to be paid. They should complete their investigations quickly.
- It is unacceptable that NHS employers should reach confidentiality agreements that prevent full disclosure of the circumstances to another employer, particularly in the NHS. The Department should act quickly to outlaw the use of confidentiality agreements, and the Treasury should remind other public bodies that such agreements are inconsistent with proper accountability for public money.

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<sup>1</sup> C&AG's Report, *Inpatient and outpatient waiting in the NHS* (HC 221, Session 2001–02), paras 1–2; Q53

<sup>2</sup> 45<sup>th</sup> Report of the Committee of Public Accounts, *Inpatient and Outpatient Waiting in the NHS* (HC 376, Session 2001–02)

<sup>3</sup> C&AG's Report, *Inappropriate adjustments to NHS Waiting Lists* (HC 452, Session 2001–02)

4. Our more specific conclusions and recommendations are as follows.

- (i) The inappropriate adjustment of waiting lists involved at least 10 trusts and over 6000 patients. The risk of distorted figures will increase now that there are even more challenging targets to reduce waiting times. The Department of Health have introduced triggers to identify cases for review and independent checks on waiting list statistics by hospital, starting in 2002–03.
- (ii) Following the 2002 Budget, the Government announced plans to establish a new Commission – the Commission for Healthcare Audit and Inspection – which will validate published performance assessment statistics on the NHS, including waiting list information.<sup>4</sup> The introduction of independent validation, with the results published, is particularly important in rebuilding public confidence in reported waiting lists and times.
- (iii) The inquiries into the original nine cases often took too long and were inconclusive. There were procedural and other weaknesses, and many of those affected complained of inaccuracies and lack of fairness. None resulted in completed disciplinary action, and weaknesses in the investigations completed could have prejudiced the prospects of a sustainable outcome. The Department should quickly introduce a standard format for future investigations of this sort, and give trusts clearer guidance and a clearer framework for disciplinary action.
- (iv) These cases also raise doubts over whether each of the 189 trusts in England can be expected to have the expertise to handle complex disciplinary cases in a consistent way. The Department should explore further the case for much stronger central support, especially in the human resource and legal issues.
- (v) Of those under investigation, five resigned during the investigations, and four of the suspended staff have been re-employed within the NHS. Because under the current arrangements each employer is a separate entity, disciplinary action could not continue once the staff resigned. The Department are taking action to change the basis of NHS contracts in this respect and should complete this work soon.
- (vi) Four trusts reached confidentiality agreements with those who resigned, and in some cases their terms of departure militated against the trusts disclosing the circumstances to potential new NHS employers. All NHS employers should carry out thorough pre-enrolment checks on all the staff they employ, and the Department plan to make this mandatory.
- (vii) Four chief or deputy chief executives of the trusts involved subsequently resigned or had previously left, receiving compensation payments totalling over £260,000. In one case the agreement provided for clawback of compensation in the event of such re-employment, but in two they did not. The Department should now implement their plan to make it mandatory to include clawback arrangements in any future severance packages.

#### THE EXTENT AND CAUSES OF THESE INAPPROPRIATE ADJUSTMENTS

5. The Comptroller and Auditor General identified 9 trusts which had inappropriately adjusted their waiting lists, 3 of them for some three years or more, affecting nearly 6,000 patient records. The numbers involved ranged from five patients at University College London Hospitals NHS Trust, to 1,800 at Surrey and Sussex Healthcare NHS Trust.<sup>5</sup>

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<sup>4</sup> *Delivering the NHS Plan*, Cm 5503

<sup>5</sup> C&AG's Report, para 2 and Figure 1

6. Levels of seriousness ranged from University College London where none of the five patients had their care affected, to Barts and the London NHS Trust where the inappropriate adjustments went on for a number of years, and which posed potential threats to the patients affected, because their treatment was delayed.<sup>6</sup> (Figure 1)

<b>Figure 1: Duration and type of irregularities</b>		
Trust	• Irregularities	Duration
Guy's & St Thomas'	• Inappropriate suspensions	4 years
Redbridge Health Care	• Inappropriate suspensions	2–3 months
South Warwickshire General	• Delays adding patients to the waiting list	4–5 months
University College London	• Patient records altered	2 weeks
Barts and the London	• Patient records altered • Inappropriate suspensions • Patients deleted from the waiting list • Other inappropriate adjustments	4 years
Plymouth Hospitals	• Inappropriate suspensions • Patient records altered • Delays in adding patients to the waiting list • Other inappropriate adjustments	1 year
Salford Royal Hospitals	• Long waiting patients not reported • Inappropriate suspensions • Outpatients not put on list till month of appointment • Patients not put on the waiting list	3 years
Stoke Mandeville	• Inappropriate suspensions • Non-deliberate administrative and systems errors, including failure to re-instate suspended patients	5 months
Surrey and Sussex Healthcare	• Patients not added to the waiting list • Inappropriate suspensions • Patients offered admission during their holiday period • Patients offered non-existent short notice admission dates	1 year

7. Two of the key indicators of problems with the accuracy of reported waiting lists are the percentage of patients suspended, and the number waiting more than 12 months for treatment. The Comptroller and Auditor General suggested that the Department might investigate the 13 trusts where suspensions exceeded 10 per cent and where patients waiting more than 12 months exceeded 2 per cent (Figure 2).<sup>7</sup>

<sup>6</sup> C&AG's Report, para 2 and Figure 1

<sup>7</sup> *ibid*, para 3

<b>Figure 2: NHS Trusts with over 10 per cent of their waiting list designated as 'suspended' and with over 2 percent of patients waiting over twelve months</b>	
Royal United Hospital Bath NHS Trust	Wrightington, Wigan & Leigh NHS Trust
Epsom & St Helier NHS Trust	Good Hope Hospital NHS Trust
Isle of Wight Healthcare NHS Trust	Wirral Hospital NHS Trust
Nuffield Orthopaedic Centre NHS Trust	West Suffolk Hospitals NHS Trust
Countess of Chester Hospital NHS Trust	Royal Devon & Exeter Healthcare NHS Trust
Dartford & Gravesham NHS Trust	Winchester & Eastleigh Healthcare NHS Trust
Royal Liverpool & Broadgreen University Hospitals NHS Trust	

8. In the light of the Comptroller and Auditor General's findings, the Department launched reviews of each of these cases and at the time of our hearing had not found any inappropriate manipulation. However in May 2002 the Department issued a press release announcing that while no evidence had been found in 12 of the cases, the review at the Royal United Hospital Hospitals in Bath had found:<sup>8</sup>

- suspended lists being used inappropriately;
- failure to report breaches of targets for long waits;
- a series of adjustments to figures held on the patient administrative systems prior to waiting list figures being reported; and
- poor systems, inadequate training, confusion, lack of leadership and inadequate financial management.

9. The Chief Executive had already left the trust. But as a result of the inquiries the Chair resigned with immediate effect and the Director of Finance was suspended. A team has been sent into the trust to sort out the situation, and ensure that waiting lists are managed better in future. A disciplinary investigation is underway.

#### HOW INVESTIGATIONS INTO THE ADJUSTMENTS WERE HANDLED AND WHAT ACTION WAS TAKEN

10. Figure 3 summarises the action taken in the nine original trusts where inappropriate adjustments took place. We looked specifically at how the investigations were handled and the terms on which staff left the trusts involved, including the use of compensation payments and confidentiality clauses.<sup>9</sup>

<sup>8</sup> Qs 3-5

<sup>9</sup> C&AG's Report, Figure 1

<b>Figure 3: Action taken with individuals allegedly involved</b>	
<b>Trust</b>	<b>Action Taken</b>
Guy's & St Thomas'	Junior staff involved – no action considered appropriate.
Redbridge Health Care	Individual only accepted responsibility for 85 of the 250–300 inappropriate suspensions. Suspended and asked to resign during the disciplinary enquiry. Re-employed within the NHS. (Note 3)
South Warwickshire General	Individual suspended on full pay. Agreed to resign. Compromise agreement included a confidentiality clause and paid £22,500. No provision for clawback if re-employed. Reference made no mention of inappropriate adjustment, but new NHS employer aware of circumstances.
University College London	Individual resigned before adjustments came to light. Re-employed within NHS.
Barts and the London	No disciplinary action taken against manager allegedly responsible; considered to be 'organisational failure'.
Plymouth Hospitals	Two individuals suspended on full pay; they subsequently reluctantly resigned. Compromise agreements paid £146,000, and had confidentiality clauses; also provision for clawback if re-employed in the NHS. Both were. References did not fully reflect enquiry findings but new NHS employers aware of circumstances.
Salford Royal Hospitals	Responsibilities still being investigated.
Stoke Mandeville	Disciplinary action started against three individuals, who were suspended on full pay from June 2001. Two have since retired or resigned.
Surrey and Sussex Healthcare	No individual identified. Chief Executive left having failed to meet waiting list targets and received £95,000 in compromise agreement which included a confidentiality clause but no provision for clawback if re-employed within the NHS. Trust subsequently considered recovering part of the payment, and withheld £7,500.

(a) How the investigations were handled

11. At all trusts there was an inquiry. At four trusts this was internal, at five it was external. Most inquiries took between two and 12 weeks to complete, though in one case it took almost a year. In two cases trusts considered there were weaknesses in the inquiry report that impacted on their ability to take disciplinary action, and many of the staff involved have commented on what they consider to be major failings in the accuracy and completeness of the inquiry reports.<sup>10</sup>

12. At five of the trusts disciplinary action was considered against those allegedly involved. At the time of our hearing, disciplinary inquiries were still underway at two trusts. However, in the other cases, despite investigations into the irregularities, no one has been dismissed.<sup>11</sup>

<sup>10</sup> C&AG's Report, para 2

<sup>11</sup> Qs 11, 115–116

13. The Department accept that in many of the cases the processes were inconclusive. In some cases they did not satisfactorily identify those responsible, and even where they did they did not follow through with disciplinary action. The decision-making and the preparation for disciplinary action often took too long. As a result, the Department are putting in place a standard format for investigations of this sort, and expect this to be agreed by the end of May.<sup>12</sup> They accept the need to give trusts clearer guidance and a clearer framework, and perhaps more support, but they do not see the need for some form of expert group, on the lines of the NHS Litigation Authority, to handle complex disciplinary cases. They believe this would run counter to moves to give the NHS greater freedoms and more responsibility locally.<sup>13</sup>

(b) The use of compensation payments and confidentiality clauses in settlements

14. At four trusts, seven staff were suspended. Four chief or deputy chief executives subsequently resigned or had previously left, receiving compensation payments totalling over £260,000. In one of these cases, the agreed termination took place before the irregularities were discovered.<sup>14</sup>

15. The Department told us there was a need to distinguish between suspicion of involvement in irregularities and proof. What people had done was to take pragmatic decisions as Chairs and Boards that it would be less costly, less disruptive for patients, and in the wider interests of the NHS to allow staff to leave. They would weigh up the potential legal and compensation costs involved, the prospects of success if challenged in an industrial tribunal, and whether it might be better not to have a long, protracted disciplinary process but get new people in quickly and move on. They would then reach a view, with professional advice, on the solution that best protected the public purse.<sup>15</sup>

16. Four of the suspended staff have been re-employed within the NHS. In one case the compromise agreement provided for clawback of compensation in the event of such re-employment, but in two they did not. In some cases their terms of departure militated against the trusts disclosing the circumstances to potential new NHS employers.<sup>16</sup>

17. All NHS employers are expected to carry out thorough pre-employment checks on all the staff they employ. Where staff have moved on, currently it is not possible for the NHS to continue disciplinary action against them because each trust is a separate employer. The Department plan to take action to remedy this situation in future, by strengthening arrangements for termination of contract. They also plan to look at whether it is possible to claw back money from those who received compensation payments and then went on to work elsewhere in the NHS, and to issue directions to deal with claw-back if similar cases arise in future.<sup>17</sup>

18. As regards confidentiality clauses, the NHS had issued guidance making clear that they should not be used, following earlier reports from the Committee of Public Accounts. Nevertheless, confidentiality agreements had been concluded in 4 cases at the initiative of the trusts.<sup>18</sup> In one case (Plymouth), the trust had misinterpreted the guidance. The Board had been aware that confidentiality agreements should not be used to gag whistleblowers, but they thought it appropriate to have an agreement that prevented the departing employee from talking badly about the trust. The Department confirmed that they would be making it clear confidentiality clauses have no place in the public sector. In doing so, they will

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<sup>12</sup> Qs 11, 111–113, 184

<sup>13</sup> Qs 15–16

<sup>14</sup> C&AG's Report, para 2

<sup>15</sup> Qs 83–88

<sup>16</sup> C&AG's Report, para 2

<sup>17</sup> Qs 12–13, 17, 88–91, 100–104, 185–188

<sup>18</sup> C&AG's Report, para 2

check for consistency with other Government Departments and will share their experience with them.<sup>19</sup>

#### IMPACT ON PATIENTS

19. The inappropriate adjustments to waiting lists will have had differing degrees of impact on the patients concerned. In some cases, there was no impact, with patients waiting no longer than they would otherwise have done, and unaware of any irregularities. In others, patients waited longer than they should and their condition deteriorated during the longer wait. Particularly serious are those patients who were inappropriately suspended (at least 700 identified), were never put on the waiting list (at least 435 identified) or who were deleted from it (total number unknown). If action had not been taken to correct these irregularities, the trusts had no way ensuring that these patients received the treatment they needed.<sup>20</sup>

20. At one end of the spectrum were trusts such as University College London, where there were only five patients involved, none of whom had their patient care affected, and South Warwickshire General where, though the total number of patients was high, few if any had their treatment delayed. At the other end, were trusts such as Salford Royal Hospitals where over 200 patients were denied the opportunity to be treated within 18 months, and Barts and the London where inappropriate adjustments went on for a number of years, posing potential threats to the patients affected because their treatment was delayed.<sup>21</sup>

21. Once the inappropriate adjustments came to light, trusts took prompt action to identify all patients who may have been disadvantaged, and to ensure that they were the subject of remedial action. Such actions included sending patients to other trusts and the private sector for treatment, and re-instating suspended patients to the waiting list.<sup>22</sup>

22. The Department of Health do not believe that any patients died as a result of these cases, but they have asked trusts to review the impact on patients. The Department expect that by the end of May, the trusts will have reported back to them on the extent to which patients who may have been harmed have been told it was the result of waiting list manipulation, and the extent to which cases have led to compensation to patients.<sup>23</sup>

#### ACTION TO PREVENT A RECURRENCE

23. In response to the Comptroller and Auditor General's Report, the Department of Health took initiatives to ensure that any inappropriate adjustments to waiting lists are identified and that effective action is taken against individuals and within organisations where similar cases occur in future.

- They introduced a series of triggers, for example where the number of patients suspended from the lists totalled 10 per cent, to identify cases for review.<sup>24</sup>
- They had asked the Audit Commission to initiate a series of spot checks on waiting list statistics hospital by hospital, starting in 2002–03.<sup>25</sup>

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<sup>19</sup> Qs 18, 30–34, 44–49, 88, 164–174

<sup>20</sup> C&AG's Report, para 25

<sup>21</sup> *ibid*, para 26

<sup>22</sup> *ibid*, para 27

<sup>23</sup> Qs 120–128, 144–145, 175–177, 197–204

<sup>24</sup> Qs 2, 82

<sup>25</sup> Qs 2, 117

- Waiting times for all NHS consultants will be published on the internet, so individual patients will be able to see if their experience bears out claims on waiting times. They are also moving to a system of booked admissions by 2005.<sup>26</sup>
- Any manager found to have distorted waiting figures will face dismissal on grounds of gross misconduct. This will be supported by a new mandatory code of conduct for NHS managers, as recommended by the Bristol Royal Infirmary inquiry. Anyone breaching that code will not be re-employed in the NHS. The Department are looking, in particular, at how the Code will deal with people who resign from one NHS Trust before disciplinary action has been completed and then seek employment elsewhere in the NHS.<sup>27</sup>

In addition, they now have much better systems for whistleblowing and are putting in place an inspection system through the Commission for Health Improvement, and they will publish more information on NHS Performance.<sup>28</sup>

24. In April 2002, in *Delivering the NHS Plan*, the Government announced the creation of a new Commission for Healthcare Audit and Inspection (CHAI), which will bring together the work of the Commission for Health Improvement, the health value for money work of the Audit Commission and the private healthcare role of the National Care Standards Commission. The new body's role will include validating published performance assessment statistics on the NHS, including waiting list information.<sup>29</sup>

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<sup>26</sup> Qs 6, 105–106, 205

<sup>27</sup> Qs 13–14, 55–58, 87–91, 95–96, 100–104

<sup>28</sup> Qs 9–10

<sup>29</sup> *Delivering the NHS Plan*, Cm 5503

MINUTES OF PROCEEDINGS OF  
THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2001-02

MONDAY 14 JANUARY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr David Rendel
Geraint Davies	Mr Gerry Steinberg
Mr Nick Gibb	Mr Alan Williams
Mr George Osborne	

Sir John Bourn KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Glenn Hull, Second Treasury Officer of Accounts, was further examined.

The Comptroller and Auditor General's Report on Inappropriate Adjustments to NHS Waiting Lists (HC 452) was considered.

Mr Nigel Crisp, Permanent Secretary, Department of Health, and Chief Executive, NHS Executive, was further examined; Mr Andrew Foster, Director of Human Resources, Department of Health, was examined (HC 517-i).

\* \* \* \* \*

[Adjourned till Wednesday 16 January at half past Four o'clock.

\* \* \* \* \*

MONDAY 1 JULY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Brian Jenkins
Mr Ian Davidson	Mr David Rendel
Geraint Davies	Mr Gerry Steinberg
Mr Frank Field	Jon Trickett
Mr Nick Gibb	Mr Alan Williams
Mr George Howarth	

Sir John Bourn KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Brian Glicksman, Treasury Officer of Accounts, was further examined.

\* \* \* \* \*

Draft Report (Inappropriate Adjustments to NHS Waiting Lists), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 3 read and agreed to.

Paragraph 4 postponed.

Paragraphs 5 to 24 read and agreed to.

Postponed paragraph 4 read and agreed to.

*Resolved*, That the Report, as amended, be the Forty-sixth Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

\* \* \* \* \*

[Adjourned until Wednesday 3 July at Four o'clock.]

# MINUTES OF EVIDENCE

TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

MONDAY 14 JANUARY 2002

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Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Geraint Davies  
Mr Nick Gibb  
Mr George Osborne

Mr David Rendel  
Mr Gerry Steinberg  
Mr Alan Williams

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SIR JOHN BOURN KCB, Comptroller and Auditor General, further examined.

MR GLENN HULL, Second Treasury Officer of Accounts, HM Treasury, further examined.

## REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

### Inappropriate adjustments to NHS waiting lists (HC 452)

#### Examination of Witnesses

MR NIGEL CRISP, Permanent Secretary, Department of Health, and NHS Chief Executive, and MR ANDREW FOSTER, Director of Human Resources, Department of Health, examined.

#### Chairman

1. Good afternoon, ladies and gentlemen, and welcome to the Committee of Public Accounts. We welcome today Mr Crisp. Perhaps you would introduce your colleague.

(*Mr Crisp*) Can I introduce Mr Andrew Foster who is the Director of Human Resources for the NHS and Department of Health.

2. Thank you. Today, of course, we are talking about an issue which is of enormous importance, namely, inappropriate adjustments to NHS waiting lists. Perhaps I can just introduce a few topics so that my colleagues can go through them in more detail if they wish. I want to start off by talking about the extent of inappropriate adjustments. If you turn to page 5, paragraph 12, Mr Crisp, you will see that only five of the nine cases of misstatement were spotted by the NHS's own systems. How then do you know that this is not just the tip of the iceberg?

(*Mr Crisp*) Can I, first of all, say that, as you have said, this is an extremely serious issue and one we take extremely seriously and one we have taken seriously for some time as well. The history of this is that when we identified the first one of these, which did indeed come about because of it being raised externally to the NHS, we first of all in London and then across the country drew the attention of Chief Executives to the issue about the number of patients on suspended waiting lists, so that we were therefore deliberately wishing to check with them whether other people had been doing what had been happening in Redbridge. We followed that up and we follow that through regular monitoring. As a result of that and the raising of awareness in this issue in the NHS, a number of other cases have become apparent which have now been looked at by the Audit Office. We have now gone further than that. We are formally introducing triggers at the point at which we want to review with individual trusts whether their waiting

lists are being properly managed and they will be the sort of things that are identified in the National Audit Office Report—where we have got a suspended waiting list of more than ten per cent, where we have got very long waiting lists or where we have got concerns about waiting lists. In addition to that, what we have done is we have now, as you know, written to the Audit Commission to ask them to introduce a series of spot checks which we are in the process of agreeing how that will happen, and at a later stage in the meeting perhaps I can expand.

3. You mentioned this point about triggers which is very interesting. If I now refer you to paragraph 3 of the Report on page 3, you will see that there are 13 trusts mentioned in that paragraph. How have you assured yourself that there has not been manipulation in the case of these 13 trusts?

(*Mr Crisp*) Again on the basis of what I just said, most of those 13 had passed the trigger points that we already had in place so we had already been undertaking reviews with those cases.

4. What have you found?

(*Mr Crisp*) We have not yet found any inappropriate manipulation in the ones that we have looked at. All have now been contacted. There are some things that require a degree of explanation. Could I take an example with you and talk it through, would that be reasonable at this point?

5. Yes, thank you.

(*Mr Crisp*) One of the trusts, which is the trust with the highest number of suspensions in the country (which is not on the National Audit Office list simply because it does not have long waiters) is the one that has the highest number of suspensions, at 700, which is about the same as other trusts which have that level of throughput of patients, but because it has concentrated very hard on its waiting lists and therefore it has a much smaller waiting list, the

14 January 2002]

MR NIGEL CRISP AND MR ANDREW FOSTER

[Continued

**[Chairman Cont]**

proportion of suspensions is what you might expect from a trust of that size but they show up as a much higher percentage. So you will find there are perfectly legitimate reasons why there are anomalies in suspensions and I could give you some other examples as well.

6. You have not yet, despite the fact that these are trusts that there might be a problem in because of the trigger mechanism that appears to come up, found any problems. Does this lead you to believe that perhaps this is less of a problem in the NHS than we might have feared or do you want to share any views you have from your initial enquiries about the nature of this problem throughout the NHS?

(*Mr Crisp*) It is significant for the patients involved—and I think none of us should underestimate the fact that for the approximately 6,000 (which was the best estimate that the NAO Report picked out) this is a very serious matter. I do think from our review of it that a) it is at the margins of activity, it is small percentages of what is happening and b) and perhaps I can make this as a very strong point, we are moving to a much more open system about information in the NHS and that has got a number of points, one directly relevant to your inquiry on waiting lists when we were last in this room together. We will be publishing from the new financial year waiting times by individual consultants on the Internet and by individual hospitals. That will pick up a point made particularly by Mr Steinberg about that information not being available. We will also be moving to booked admissions. This means that it will be that much more easy for patients to check themselves that we are handling their administration appropriately.

7. But you are setting ever more challenging targets.

(*Mr Crisp*) They are more challenging targets, indeed that is right.

8. Are you not worried that this will put further pressure on Chief Executives?

(*Mr Crisp*) I have no doubt that the targets are stretching but the vast amount of evidence shows they can be achieved without resort to anything inappropriate, whether it is changing waiting lists or anything else, and we have seen that throughout the country. I do recognise, and it is important that we should all recognise in looking at this, that the targets for waiting lists are challenging, and rightly so because people in this country want us to bring down waiting lists. I also think when you look at these trusts you will see a number of them are run by very good people where they have a number of other difficulties as well as the ones that are described here. People are working under pressure in the NHS but that is no reason to resort to the sort of practices which are highlighted in some cases here.

9. Are you confident that the spot checks that you have referred to will be a sufficient counterbalance to distorted figures and do you think that you should have introduced some kind of formal external annual validation for key NHS performance indicators?

(*Mr Crisp*) If I pursue the second part of the question first which is further about openness, we are making much more information available to patients, as I have said. We have now got much better

systems for whistle blowing so that individuals can draw this to our attention internally. We are now putting in place an independent inspection system through the Commission for Health Improvement and we have said, and we will be saying, that they will be having a much bigger role in publishing information so that information will be coming much more from an independent source on NHS activity.

10. But not yet formal external annual validation for key performance indicators?

(*Mr Crisp*) If the information is being pushed by someone like the Commission for Health Improvement then they will need to satisfy themselves. Your last Report said that the level of data quality of waiting lists was probably satisfactory and that it was probably appropriate that we did not put much more resource into making them absolutely precisely accurate, and that there was a trade-off to be drawn between the amount of expenditure on doing that and getting the absolute accuracy of the figures. This is live management information. I personally think the biggest safeguard is when patients can look at the Internet or get somebody to look for them on the Internet and see the waiting time for that individual consultant is of the order of three months, or whatever it is, and can also have a booked appointment so they can see how they rate, and giving patients information is probably the single biggest safeguard we can bring.

11. Other colleagues can pursue questions on the extent of inappropriate adjustment. I now want to ask you questions about how the investigations into the adjustments were handled. At the end of the day, despite investigations into these irregularities, no one was dismissed, the process in some cases was clearly inadequate, many of those accused complain about its quality and fairness. What are you doing to ensure that, in future, investigations are undertaken quickly, professionally and fairly?

(*Mr Crisp*) Again, I am sure we will cover some of this. I do accept that some of the investigations in hindsight were not satisfactory. In fact, what took so long in a number of cases was the decision-making and preparation for disciplinary action outside the investigation, although some of the investigations were good. What we are doing is putting in place a standard format for investigations of this sort and we will be introducing that just as soon as we can.

12. Others can ask further questions on that. The last area I want to deal with you of course concerns the disciplinary action taken and the compensation payments that were made, which I am sure you were expecting us to ask you about. If you look at page 9 and if you refer to paragraphs 28 and 29, you will see that individuals there were subject to these inquiries, they resigned during the process, they were then re-employed within the NHS and the NHS apparently cannot pursue disciplinary action against them. This seems to an outsider to be an extraordinary state of affairs. How can this be?

(*Mr Crisp*) That happened in some cases, not in all cases.

13. I accept that.

(*Mr Crisp*) And the information is described there. We also want to take action to prevent that happening in future and what we are doing

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[Continued

**[Chairman Cont]**

specifically around the guidelines by bringing them up to the force of direction around some of the issues to do with termination of contracts and so on, we can talk about in more detail in a moment. I think the other strong point here is that we are introducing a Management Code of Conduct so that if somebody is adjudged to have broken that Management Code of Conduct in one setting as a manager of the NHS, they should not be employed as a manager anywhere else in the NHS. That does not exist yet. It is a recommendation of the Bristol Royal Infirmary inquiry and it is one we are bringing in and we are taking steps to do that. The point at the moment is that different NHS organisations are different employers and they have the right to employ people. We will be introducing this new arrangement whereby senior managers, or managers, in the NHS will be expected to conform with the Code of Conduct.

14. That is the problem, that you are currently dealing with a number of different trusts and your powers are somewhat limited. I take it that answer means that there is now going to be a framework within the NHS to allow continued action against staff who move around? That is what I take your answer as meaning.

(*Mr Crisp*) Yes, on the management issues specifically, just as there is on other professional issues.

15. Right. Coming out from this Report it is clear that NHS trusts, or some of them, do not have the skills to handle these complex disciplinary cases. Do you think that there should be an NHS Litigation Authority?

(*Mr Crisp*) You mean specifically internally for dealing with disciplinary issues?

16. Yes, an expert group to deal with these sorts of problems?

(*Mr Crisp*) The way that we are moving in the NHS is to actually give more freedom and more responsibility to local organisations. What I think there should be is perhaps clearer guidance and a clearer framework and perhaps more support for people to do that. Sometimes we ask relatively inexperienced people, some of those non-executives, to take big and difficult decisions and I think this Report does raise the question as to whether we always give them enough support. What we are not going to do though is renationalise managers' contracts within this and make it a national system, we are going the other way.

17. The thing which will really shock colleagues and other people outside is that four senior managers who left received payouts totalling £260,000 even though they were allegedly involved in these irregularities. What are you doing about this state of affairs?

(*Mr Crisp*) Can I firstly say that in one of those the agreed termination happened before the irregularities were found, so it is actually two cases involving three managers. What we are doing about precisely that is we are making it clear firstly by bringing guidance up to the force of instruction in regard to how you terminate a contract, secondly we are making it absolutely clear to people that we expect them to go through a disciplinary procedure

in these cases and that it is not appropriate where the integrity of the organisation, and therefore indeed the integrity of the NHS, is called into question that we do those sort of compromise agreements in future.

18. The last question I want to you ask you about, which again is a matter which irritates this Committee and we have raised it on many previous occasions, is that compensation agreements have confidentiality clauses which we do not think is acceptable in the public sector. What is your guidance about such clauses and what are you going to do to ensure that they are not used again?

(*Mr Crisp*) May I make two points. Firstly, this is one of the issues where our guidance, which fits in with your views, is guidance at this stage and we will add to it the force of direction to make sure that happens. I can talk you through again, either now or in response to one of your colleagues, what actually happened in one or two of the individual cases.

Chairman: I have no doubt this will come up again. I will now pass over to Alan Williams.

**Mr Williams**

19. Thank you, Chairman. Mr Crisp, you are relatively new to this particular role. I have been on this Committee over 12 years and I find this the most sickening report I have seen in that 12 years. Would you agree that it is the lowest form of cynicism for managers to protect their own backs and their own jobs at the risk of extending and aggravating the suffering of patients waiting for treatment?

(*Mr Crisp*) I too find some of the things in this Report shocking where what you have described is the case. Let us be clear that we all have the right to expect better standards from NHS managers and in general we get them.

20. In that case can you now tell me how many board members have been dismissed since you were made aware of the contents of this Report?

(*Mr Crisp*) What we have done since I have been aware of the contents—

21. That is all I want to know.

(*Mr Crisp*) Since December 19, none.

22. None. If you look then at the case of Barts, if you look at page 12 the inquiry found lack of managerial ownership and control, lack of accountability, lack of clarity regarding roles and responsibilities, lack of trust board awareness, lack of internal reporting of problems and constraints, lack of clear audit trail and a lack of clear senior managerial leadership, otherwise everything was okay there. Are you telling me that a report like that does not merit sackings at the very top?

(*Mr Crisp*) Let me talk about Barts & the London. At the same time as this was effectively happening, from the Department we had put in our own inquiry into a very wide range of issues at Barts & the London. As a result of that inquiry ultimately both the Chair and the Chief Executive decided to resign. That is not referred to within this but that is because, as you said, there were a catalogue of issues around Barts & the London. In addition, you will see from this Report that the three most senior managers—I think it was three in this case—who were involved in

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[Continued

[Mr Williams Cont]

this, or appeared to be involved in this, had actually left by the time the investigation was completed and were not re-employed.

23. You can have that many people who conveniently decide to resign, which is part of the cover-up, allowing them to resign, and yet we are told in paragraph five that the actions caused patients to wait for treatment longer than the urgency of their condition would suggest was reasonable, or possibly even safe, and these actions were potentially dangerous to patients and you tell us that all the board has done is sit back and watch some senior officials resign. If I can go on to the next question.

(Mr Crisp) May I respond? The Chair and the Chief Executive are not some senior officials.

24. Let me put in context what I am about to say. In paragraph seven, that same board considered in February last year the need for disciplinary action when they considered the Report, the board concluded that there had been organisational failure, therefore it would be inappropriate to single out individuals for disciplinary action. It seems that it was a sort of spontaneous institutional collapse of morality but that no-one actually made a decision at any time that contributed to that collapse of morality. Does that sound like a board exercising its functions properly?

(Mr Crisp) I think what this Report does not distinguish is that it is a board of a different membership. I think by February 2001—I will have to check this, I have not got it written down in front of me—the previous Chair and Chief Executive had resigned by that time. In fact, I know that they had resigned by that time. So the Chair and Chief Executive—

25. At what stage did they resign?

(Mr Crisp) They resigned at some stage during the year 2000 and I cannot give you the date.

26. Was the inquiry under way then?

(Mr Crisp) The bigger inquiry was under way, the one I said that we had set up to look at the whole issues to do with—

27. So they ducked and ran?

(Mr Crisp) I do not think it was at all like that. I think this was a question of a number of issues coming out of that inquiry in the light of which they took the view that it was appropriate that they should resign. This was, therefore, a new board, a new Chair and a new Chief Executive who were, therefore, considering what had happened in the past, the previous Chair and Chief Executive had gone, the two Directors of Operations, who were the senior managers, potentially involved in this had also left. It seems to me that the board took the only decision that it could take in those circumstances, that the only person left within their employ was a relatively more junior manager. This is not a satisfactory state of affairs by any measure.

28. As I say, the board then ducked and ran, there was no disciplinary action against them and they may well be working elsewhere in the health service, I do not know. What about in the case of Surrey? In the case of Surrey they deliberately connived at fiddling the records by asking people when they were going on holiday and then when they got it in writing when

people had their holidays booked they phoned them and offered them dates for appointments in their holidays and when they could not accept them they took them off the list or suspended them. Similarly, they phoned them with non-existent cancellations offering very short notice appointments and, again, when they were declined they were suspended from the list. Surely that is corrupt and if it is corrupt it should have been acted upon. What action was taken against the board and what action was taken against the management as opposed to negotiating comfortable resignations for them with settlements?

(Mr Crisp) Again, if you look at this case in detail, and I am not pretending this is satisfactory, you will understand that, and also that I am shocked by some of the things that I have seen here and we need to do better.

29. I am sure you will.

(Mr Crisp) What happened in this case was that for a range of wider issues an agreement was reached with the Chief Executive that she would leave before these issues were discovered. What then happened was the trust took the view that the highest priority was to tackle the issues for the patients, get them treated absolutely as quickly as possible, which is true of all these cases, and given that the Chief Executive had left it was inappropriate to discipline anybody else within this situation. That was the view that they took.

30. This looks like a conspiracy of convenience, these resignations. The resignations mean that they have entitlements to notice, to pension settlements, possibly to redundancy or departure deals, as we have seen. What comes over is the sheer duplicity of the whole set-up, the gagging clause that the Chairman has referred to. I sat in the two hearings way back in 1994, one in relation to education and one in relation to a consultant, where this Committee ruled that gagging clauses were inadmissible. That was in 1994. Your predecessor accepted that recommendation. That was in 1994 but it was only in 1999 that you issued guidance. Why did it take five years to give guidance and why is it now in answer to the Chairman you have had to already backtrack and say “of course, it is only guidance”? Why has it taken so long to do too little? Not you, the organisation.

(Mr Crisp) I understand that. The first point is I thought, and somebody behind me might check for me, that we had issued guidance before 1999. If I am not able to give you that assurance now I will make sure that we send you a note afterwards. The point is, I am not backtracking, this has always only been guidance. I am sure you know the relationship between the Department of Health and the NHS and that most of what we do with the service is to give guidance as to how things should be done. In certain cases the Secretary of State takes power of direction.

31. How soon can we expect action to ban such agreements?

(Mr Crisp) Soon.<sup>1</sup>

<sup>1</sup> Note by witness: We intend to issue directions during 2002. Draft directions are currently with the Department's solicitors prior to consideration by Ministers.

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[Continued

**[Mr Williams Cont]**

32. Okay, let us know immediately it is done and let us have copies of whichever rules you issue. In conjunction with the gagging clause there were one or two other corrupt arrangements where references were agreed as part of the deal to persuade people to enter into the gagging clauses so they could not squeal against their senior managers and their colleagues and, in addition to giving them references to go to other employers who were going to take on possibly incompetent staff, they also used taxpayers' money to make settlements that most of us here would feel these people were not entitled to. This is why I say this is corrupt rather than incompetent.

(*Mr Crisp*) There were two cases, three if you include the case where the person resigned before this came to light, where payments were made as part of compromise agreements. Let me just deal with the confidentiality clause issue in the case of Plymouth. At the top of page 18 you can see the confidentiality clause. It starts "Mindful of its obligations to permit this Agreement to be subject to proper public scrutiny," ie, this Committee and others, "the Employer will. . ." do various things. I have spoken to the Chairman about this and I asked the Chairman of that trust why they did not follow the guidance. There was a clear view expressed that they were aware of the guidance, but they had misinterpreted it. They were aware that confidentiality agreements should not be entered into where there was any risk of gagging whistle-blowers, but what they were concerned about, in their view, was that it was appropriate to have an agreement with a departing employee which prevented them talking badly, effectively, about the trust. There are two different issues there. We will be making it clear that confidentiality clauses, in the words you have used, "have got no place in the public sector", with the possible minor exceptions (which are your exceptions) where there is commercial interest.

33. You have chosen two examples—

(*Mr Crisp*) There are only three.

34.—Of pulling together all of what I call "corrupt" efforts to obtain silence because in the case of Plymouth they agreed a reference for senior management who resigned, but for none of the three individuals did the reference refer to the findings of the inquiry reports. So there is the use of the reference as a further inducement to persuade people to keep quiet. Then in addition, as the Chairman has implied, they kept them on pay for three months at a cost of £67,000, so they gave them £176,000 compensation to buy their silence. This trust squandered a quarter of a million pounds of taxpayers' money partially to protect its own back.

(*Mr Crisp*) The agreements were £146,000 rather than a quarter of a million—

35. That was because there was a refund.

(*Mr Crisp*) There was a refund of £30,000.

36. There was a refund of £31,000.

(*Mr Crisp*) I am just reflecting that that was the figure rather than the quarter of a million.

37. The quarter of a million is when you add together the "gardening" leave they were given and what is not mentioned here, but I assume were the pension entitlements and other fringe benefits they had over the time they were on gardening leave.

(*Mr Crisp*) In a moment I will ask Mr Foster if he would just explain what guidance was given because guidance was given before 1999 on conditions of service. However, in this case, and having gone through this in some detail with the chair, I am aware of the decision-making process that the board went through and there are a number of considerations, including, as again your chair has indicated at the start, fairness towards employees and making sure that we have first of all in our mind fairness towards patients, that is our top priority, but also fairness towards employees. It is right that these things should be investigated, it is right that they should then go through a disciplinary procedure. What happened in this case is that the board took the view, having received advice on it, that it was better, it was less costly, there was less disruption to the trust to reach a compromise agreement as a pragmatic way forward, rather than to go through the disciplinary procedure and hold people properly to account and maybe inflict some other damage. That is not the way we will do it in the future but that is the position and that is the series of decisions that this board made over that period.

38. Do you not think that the sacrifice of a few clearly responsible heads might underline that you mean what you say and, secondly—and I finish on this because my time is up—the Department of Health has produced a press release saying that waiting list manipulation is unacceptable and it says: "In future, any manager found to have deliberately distorted waiting figures will face dismissal on grounds of gross misconduct." We obviously welcome that. Can you tell us—because your Executive covers only England and the NHS covers Wales and Scotland—whether that ruling includes Scottish and Welsh trusts but, nevertheless, do you know if this stronger disciplinary conduct will apply in Wales and Scotland as well as in England?

(*Mr Crisp*) I should have remembered to get myself briefed on Wales and I did not. I do not know the answer to that, I am afraid.

Mr Williams: It is not your responsibility.

#### Chairman

39. Thank you. Mr Williams. You mentioned, Mr Crisp, on the question about confidentiality clauses a very important word, the word "soon". We will probably need further particulars on what "soon" means and you may have to write to us.

(*Mr Crisp*) Indeed we will.<sup>2</sup>

Chairman: Mr Bacon?

<sup>2</sup> Ref footnote to Q 31.

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[Continued

**Mr Bacon**

40. Mr Crisp, I wanted to ask you about the Report but there are a couple of questions I would like to ask you first. In my area in Norfolk, we have just had the new Norfolk and Norwich Hospital opened, one of the biggest hospitals in the country. Could you tell us, because there are a lot of people in Norfolk who want to know the answer to this question, how could the NHS allow one of the largest hospitals in the country to be built without a road to get to it?

(*Mr Crisp*) I am not sure that that is what this Committee meeting is about and certainly I have not briefed myself—

41. I just wanted to ask you that question first. It seems to me that if you were the Chief Executive of Tesco's and you were building a new supermarket, you would want to be sure that the customers were able to get to your new supermarket.

(*Mr Crisp*) I am sure that we can provide you with a perfectly reasonable answer to that through the normal channels but I am not in a position to say today.

Chairman: Let's get back on the straight and narrow path.

42. It is a matter of great interest to everybody in Norfolk because nobody understands how it could have happened. I will come on to the Report but, first, do you agree with Stuart Emslie's assessment of the amount of fraud going on in the NHS?

(*Mr Crisp*) Once again you are referring to something that is not in front of me, but I think you are referring to a newspaper article reporting comments made by Stuart Emslie at a private seminar about the maximum potential losses that might be happening if all of these things were going wrong. Is that the one you are talking about? His presentation was that if all these things are going wrong, then up to a maximum of whatever the figure was there may be recoverable loss here, not all of which will be recoverable because nobody should have the illusion that any organisation operates without losses.

43. He is talking about losses of 16 to 20 per cent of the budget, £7 to £10 billion. What I am asking you is do you agree with his estimate?

(*Mr Crisp*) His presentation was merely saying this is the sort of potential size, it was not precise, and I therefore do not have anything to agree or disagree with.

Chairman: Let's stop this now and get back to the Report.

44. I would like to turn to page 11 of the Report and follow up a question Mr Williams asked about confidentiality clauses and the guidelines which were issued some years after this Committee said it did not like confidentiality clauses, indeed it was strongly opposed to them. It says in the Report, to help you, that the guidance was issued in 1999—HSC1999/198 is the reference on page 11. So I repeat Mr Williams' question, which you did not answer, why did it take five years to issue the guidance?

(*Mr Crisp*) Can I ask Mr Foster to reply as he has the details to hand.

(*Mr Foster*) We have now had time to check that and, in fact, the guidance that was issued in 1999 replaced previous guidance from 1995 which in turn replaced guidance from 1994, so this was not the first time guidance had been issued but was simply updating prior information. Can I also say on the subject of confidentiality that any employing organisation engaged in potentially serious disciplinary procedures would have to take external advice to protect itself in future. Whilst, as Mr Crisp has said, we all accept that there is no room for gagging clauses, nonetheless there are certain arrangements relating to compromise agreements which are effectively enabling the body which is charged with public funds to limit its liabilities in case of potential future legal action and it is under some circumstances appropriate, therefore, to limit what might be said so that it could not prejudice future legal action. I am trying to draw a distinction between a gagging clause which prevents information which should be in the public domain from being so, and certain other quite tight circumstances where there is potential legal action or where there is potential commercial involvement where it is appropriate to be clear what can and cannot be said in the future.

45. Is that why it says on page 11: "The NHS Executive agreed with the Committee that as a matter of general principle, confidentiality clauses should play no part in severance arrangements"? Are you talking about the exceptions to that general principle?

(*Mr Foster*) I am saying that there are some extremely good evidence-based exceptions.

46. As a proportion of the total number of severance arrangements, how often would these exceptions crop up?

(*Mr Foster*) I would not be in a position to even make a reasonable estimate on that, I am afraid.

47. How do you know that it is not happening all the time then?

(*Mr Crisp*) My understanding is that we have taken the same position as you have on this. I think you have recognised in what you have said—and Mr Williams is nodding—that there are certain very exceptional exceptions but that is very rare and I am not aware of any.

48. It mostly does not happen?

(*Mr Crisp*) It does not apply in any of those cases.

49. Let's pursue this question, forgetting severance for a minute, of confidentiality agreements generally. You have issued guidance, it is still on going on, and yet there are people out there who are not aware that they are not supposed to have confidentiality agreements. You are not interested in renationalising contracts, as you call it, you just hope that they follow the guidance. What mechanisms do you have to ensure that when you issue guidance they do something about following it?

(*Mr Crisp*) The answer is that we issue a lot of guidance, as you will be aware, and indeed we are trying to cut down on some of that and issue only that which is absolutely necessary. Every one of these trusts that we are talking about is a big organisation and they should have a competent HR director. If I were a Chief Executive who was not aware of such

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[Continued

**[Mr Bacon Cont]**

confidentiality clauses, I would expect to be getting good professional advice, if I was at the point of sacking somebody, through my HR director and through the lawyers. What you will find in each of these cases—and it is either three where there are confidentiality clauses or two where there are confidentiality clauses, I cannot remember—they took legal advice and they took HR advice. That seems to be entirely appropriate, rather than amateur general managers, if I can put it like that, looking at a book of rules, we should be looking to professionals to support us in making these decisions.

50. This may be a question for Mr Foster because it is about Mr Colin Jones who was sacked in December as the Chief Executive of the Nuffield Orthopaedic Centre NHS Trust. In his NHS career how much money in total has Mr Jones been paid in compensation?

(Mr Crisp) Once again I think this is a separate question. There was nothing to do with waiting lists involved in that particular case and I do not have the details to hand concerning Mr Jones' case.

51. But it is directly related to the legal advice given to the relevant trust.

(Mr Crisp) It may be.

52. Is it correct that the first payment to Mr Jones when he was sacked as Finance Director of the Oxfordshire Health Authority was declared by the District Auditor to be *ultra vires*?

(Mr Crisp) I do not know and, again, this is an issue which can be picked up in the normal way as a question. It is an issue that we will be looking at because it has been drawn to our attention.

53. He got £150,000 for that which if it were *ultra vires* they would be able to claw back.

(Mr Crisp) It depends whether you want to talk about waiting lists or Mr Jones.

54. You said that this did not involve inappropriate adjustments to waiting lists.

(Mr Crisp) Exactly.

Chairman: I think you will have to pursue this elsewhere.<sup>3</sup>

55. I just say this, Mr Crisp, this individual got £300,000 of taxpayers' money, he got £300,000 for being sacked twice by the organisation of which you are the Chief Executive, and I would be interested to know what you think about it.

(Mr Crisp) Can I restate what I said at the beginning which is the issues that we are raising—and that may or may not be another one, so let us look at it—are extremely serious and they are extremely serious not just for patients but also because they damage the reputation of the very many, very good, very committed people of high integrity working in the NHS. That is why I am even more serious than you are about making sure we operate to the highest standards. That is why we will have a Management Code of Conduct and that is why we will deal much more rigorously with these issues in the future. One of the things I want to reassure your Committee of is that we have learned the lessons that have been drawn out for us from the

NAO Report. Two of these cases are continuing, as you are aware, and we are making sure that we are dealing with those in a way that we have not necessarily dealt with cases in the past.

56. Could I ask you about the Management Code of Conduct. You said that once it has been issued that people in breach of it, and therefore disciplined and dismissed, cannot be re-employed within the NHS as managers, you were very careful to say that. Are you saying, therefore, that there are plenty of other ways people could be, despite their track record, re-employed in the NHS?

(Mr Crisp) We are in a position where the NHS employs a huge range of different staff. There are two points here. Firstly, we are going to have to work it through very carefully to make sure we can make it stick for managers because there is an issue here about how long something would need to stay in place, but I do think it is perfectly appropriate that in due course somebody might be re-appointed in a completely different role, and I do not think we should preclude that in future.

57. The phrase "Management Code of Conduct" sounds like the sort of thing you would expect any employer to have, but why is it that you are just thinking about having one?

(Mr Crisp) Very few employers actually have a detailed Management Code of Conduct. We have statements about behaviour but when I am talking about Management Code of Conduct, I am talking about something that is mandatory and that we expect people to sign up to, that they will do X, Y and Z and they will not do A, B and C, and that in signing up to that as part of their terms of contract and so on then that is part of the agreement that is made between the employer and the employee. I do not know how widespread that is in other industries. It is certainly an important issue and one which we are—We have drafts.

58. Is there any reason why you could not have a little contract compliance unit that ensured that the contracts of senior managers complied with your guidelines or code, whatever you want to call them, before they were allowed to be signed by NHS trusts? You are the NHS Chief Executive, could you not make that happen?

(Mr Crisp) This is one of the issues that we are looking at.

Mr Bacon: Thank you.

**Mr Steinberg**

59. Moving on to a slightly different track from that of my colleague, a different route. The root of the whole problem is long waiting lists, is it not?

(Mr Crisp) It is part of the root, yes, absolutely.

60. So why do some consultants have extra long waiting lists? I can understand that some consultants get many more referrals but why else do some consultants have these huge waiting lists?

(Mr Crisp) It can be a whole mix of issues including, as you said, some people have a particular reputation for shoulders or whatever it is. It can be that in some cases we have not got enough

<sup>3</sup> Ref Chairman's closing remark. Ev 22–23, Appendix 1.

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[Continued

**[Mr Steinberg Cont]**

consultants in that speciality in that area. It can be in some cases because of management issues either for the trust or for the individual consultant.

61. Is it because consultants do not do enough work?

(*Mr Crisp*) In some cases that might be true but in general our view is that consultants do more than they are contracted to do across the NHS as a whole. There will be some exceptions in any fairly large group.

62. Have you ever checked with consultants who have really long lists how much private work they do?

(*Mr Crisp*) Some of that work has been done through a number of different studies. There is no direct pattern, which is the obvious question.

63. I am not sure about that. I am not going to give you information because that would be unfair but a certain Chief Executive of a trust told me that he experienced in the job that he has at the present time and in the one previously consultants that he could not handle, he could not manage, because they were a law unto themselves. They decided how much work they would do, they decided how much private work they would do and they were not prepared to help the system and they had long lists.

(*Mr Crisp*) I think there are two points here. The first one you make, which is actually managing hospitals, managing professional people within a setting like a hospital, is very difficult and there can be some cases where precisely what you describe is true. These are difficult jobs that people are doing and most of these trusts, if you look at them, are not only suffering from a particular issue like a waiting list fiddle of some sort, they have also got other points they are trying to deal with.

64. So is there any mechanism to have a look, where you have lists of 12 months or longer, at those particular consultants who have those lists? Are they monitored to see how much work they actually do?

(*Mr Crisp*) There are two things. Firstly, can I just go back to our conversation of three months ago when you asked me about two consultants at the same hospital having different waiting times for outpatients. We will in future publish that on the Internet so the patients can see that. That is in direct response to—

65. That is after five years. Will doctors also be given that explanation so that a doctor cannot say to me “I have not got time to look and see how long lists are, I just refer to the hospital”?

(*Mr Crisp*) GPs already have that information, as we had the discussion in October.

66. Will you ensure that GPs use that information?

(*Mr Crisp*) I think, and I said it earlier, that the biggest method for making sure this gets better is giving patients more power and more information and when patients have that information it will be better. To go back to your particular point about do we look to see if it is the consultant who is at fault, what we do where we have waiting list problems of whatever sort, and some of them may be about long waiters or particular problems, is in general we will ask one of our NPAT teams—National Patient Access Teams—to look and to identify the problems. What we tend to find is they are a mix of things, they

are not just one thing. They are not just a difficult consultant, if that was your hypothesis, there may be a whole mix of different things.

67. It will be interesting to have a look at the 13 trusts who meet the criteria of ten per cent of patients who are suspended and more than two per cent of patients waiting more than 12 months, which is on page three, to monitor and see how much work they do.

(*Mr Crisp*) Particularly on the 13, that is not something that we are doing to look at the 13 in isolation from others, that is a particular group of 13 which the NAO has suggested. However, consultant workload is one of the issues that we do look at. Can I again bring in Mr Foster on this because he has got some direct experience.

(*Mr Foster*) I would like to make the general point that the information we have is that the vast majority of consultants, as Mr Crisp has said, actually work significantly in excess of their contractual obligations, and it is very unfortunate that—

68. Absolutely, but it is a very small minority we are talking about here anyway.

(*Mr Foster*) Absolutely and I would not want the vast majority to be tarred by some of these allegations about a relatively small number of individuals.

69. But you agree that there are these relatively small numbers of people?

(*Mr Foster*) There are anecdotal instances of a few individuals, yes, indeed there are. What I would say in answer to your general question is first of all we are in the process of negotiating a new consultant contract and the Government has announced proposals to take more direct control of consultants' working week to remove some of the distinctions of the 1948 contract that have left certain areas ambiguous, so we will have a much clearer control, allied to a much more sophisticated information system where we will be able to gather increasingly more sophisticated information about consultants' workload and as we become reassured by the robustness of that information increasingly publish it. So that is part of the same drift of making the information available to patients so that it is transparent for all.

70. What about the consultant who invites a patient in for an operation, the patient goes in the evening beforehand and is woken at six o'clock in the morning for the operation, the consultant then comes in and says “I have not got the parts to do the operation”, it is a hip operation, “go and see your MP and tell him”? Why was the patient called in in the first place if he knew that the parts were not there the night before?

(*Mr Crisp*) I think we cannot answer the individual occasion.

71. No, of course not, I would not expect you to. This is what worries me greatly about some of the statistics and some of the attitudes coming from some of our consultants frankly. I will move on. Why do people have to wait 12 months? If a manager is doing his job properly, or a consultant, and they see the lists are over 12 months long, why do they not do something about it, why do they allow it to go on for

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[Continued

**[Mr Steinberg Cont]**

12 months? It just seems common sense to me that the hospital would see there is a waiting list of 12 months and say "we have got to do something about it". Why do they not? It is no good saying because they are short of that particular speciality.

(*Mr Crisp*) I think the biggest single issue is capacity.

72. Why do they not—what is the word—hive it off to another trust?

(*Mr Crisp*) As you are aware, that is what we are doing. As you will be aware, we are introducing at some point for next year for coronary heart disease patients in the first place the option if they have waited six months of going somewhere else to help drive down this waiting list. The single bottleneck on that is having the capacity elsewhere for people to go to because whilst some hospitals have got very short waiting lists we have still got too many that are 12 months. We need to bring the whole thing down and that means more capacity, and more capacity is coming but it will take time.

73. Let me move off that point now, we have got a bit bogged down. Page four, paragraph seven, here we are told, this was the fiddling that went on, "... the adjustments were made in the context of pressure on trusts and particularly Chief Executives to meet key departmental targets." How much credence is there for that excuse?

(*Mr Crisp*) The wording here is very carefully worded, it is in the context of pressure, it is in the context of a lot of different things, if I may put it like that.

74. Was it pressure or just plain cheating?

(*Mr Crisp*) There is no evidence that it was pressure because if it was then everybody would be doing it, would they not?

75. That is my point.

(*Mr Crisp*) Pressure is no excuse for doing these sorts of things. Just to take the point further, other trusts when have they have got 18 month waiters have come and told us, they have held up their hands and been honest, and that is why this should not slur everybody.

76. You have anticipated the question I was going to ask. If the majority of trusts were able to achieve the Government targets, why were these trusts not able to? If they knew that they could not meet these targets, why did they not do something about it, why did they not come and report it?

(*Mr Crisp*) To be entirely fair, some of these trusts had a range of difficulties and problems that they were trying to deal with and individuals within the system presumably, and I can only say presumably, felt that their only option was in some way to cheat to make it better. They may have thought they were doing that in the interest of I do not know what, I have no insight into it.

77. What role does the Government have in dealing with the cheats?

(*Mr Crisp*) I think our role, and I am speaking here as a Chief Executive rather than Government in that sense, is where we discover that something is going wrong we act as quickly as we can to put it right. I take a degree of comfort that in every one of these cases the first thing that happened was the patients'

welfare was taken into account. I do think it is important that Government sets up the sort of arrangements that you have obviously got that exposes this problem so that we can tackle it. Those are the things that I think are right for us to be handling centrally.

78. The Report clearly states that perhaps pressure was the reason and that the targets may have been too severe but my understanding, if you read the Report, is that the targets are going to be even more severe, are they not? The targets are not 12 months now but are six months.

(*Mr Crisp*) They were 18, then they will be 15 and then they will be 12 and so on. I do not accept that pressure was the reason and I did not think you accepted that pressure was the reason.

79. No.

(*Mr Crisp*) I think pressure is part of the context but these are difficult jobs and that is why we have good people on the whole managing these organisations, and good non-executives.

80. If people were prepared to cheat because of the targets that were set then, the targets are going to be more severe now, how are you going to be certain that there are not going to be more who will cheat because the targets will get worse, as far as they can see it?

(*Mr Crisp*) I think the two big points are, firstly, the openness one, so that it is patients who can actually see what the arrangements are in their local trust and can identify how they fit in with that. I think that is a very big and powerful message and the NHS needs to be becoming much more patient driven in that sense. The second thing is we have put in here, as you said, in the press release and elsewhere, a number of safeguards about quality, including the Audit Commission spot-checks. These will help us move on.

81. You probably will not answer this question but I will try anyway. Are the targets that are being set reasonable or not?

(*Mr Crisp*) I believe that they are reasonable. I believe we can do it. I can see movement in the right direction. I can also see that some trusts are well down the track already. I think at this moment, of course, we have got a financial settlement that will see us through to the targets over the period of that financial settlement.

Chairman: These are policy matters, we do not need to go into that.

82. Has every trust been checked to see that everything is okay?

(*Mr Crisp*) It depends what you mean by that. As you will be aware from your last Report, the National Audit Office took the view that our information was satisfactory for its purpose with some exceptions. What we are doing here is wherever there are trigger points which give us worry about the trust, and I have indicated what some of those will be, then we will make sure that there is a detailed inspection. We do not actually audit every waiting list position.

83. I will move on to a different topic now. I do not think one could do this Report without asking some questions on the topic that Mr Williams brought up.

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[Continued

**[Mr Steinberg Cont]**

When I read it, I wrote down that the NHS must be the only organisation where employees who face disciplinary charges come out of it better off. Let us look at some of the financial positions. On page three, and Mr Williams brought this up, it says that at four trusts seven staff were suspended, four eventually resigned receiving something like £260,000 compensation. At Plymouth two received £146,000 with confidentiality clauses and clear references. Then we have the one that Mr Williams brought up on page 7, Surrey and Sussex, fiddling, manipulation, fraud, and yet he walks away with £95,000 compensation with a confidentiality clause and no claw back. In both cases it was clear that it was not just manipulation, it was clear fraud. These compensation payments cannot be justified and yet it happens time and time again, not just in the NHS but other public services.

(Mr Crisp) And you may want to enquire whether it happens in the private sector as well. I have no doubt that people make pragmatic decisions. What we need to be clear about is that some of the people we are talking about here in these cases certainly do not accept that they were in the wrong and that was, in part, because disciplinary procedures were not completed. I want to be careful in saying that. What people did here was they took the pragmatic view as chairs or as boards that it would be less costly, there would be less disruption for patients—

84. How can you say it will be less costly to pay somebody £95,000 for not doing their job properly? How can it cost you more if disciplinary action is taken?

(Mr Crisp) Let me bring in Mr Foster again.

(Mr Foster) A body taking a decision of this nature would take external advice. We see reference in some of these cases to advice from lawyers about the percentage chance of success in an industrial tribunal. An employer would have to take into account what the prospects of success would be were their decision challenged in a tribunal and would have to take into account the likely legal costs associated with fighting the case, and they may well be advised therefore that to take a certain course of action to pursue disciplinary procedure risks loss of case, risks significant compensation and risks significant legal costs, and so they are faced with a choice to make (professionally advised) as to whether to compromise on a lesser sum. That is the sort of issue that employers are faced with and they have a duty to protect the public purse and they have a duty to spend the minimum amount of public money on these cases. I can quite understand circumstances where they may be so advised.

85. I am told time is up so I cannot pursue that. I am sorry, I find that an incredible answer. Regardless of what lawyers are telling you, it is about time that somebody took a stand and said, "This person is incompetent, this person did not do the job properly, he or she is sacked and we are not paying £95,000 in compensation, take us to court."

(Mr Crisp) We also have to prove these things. These are issues of judgement and it is a minority of cases.

Mr Steinberg: Let me give you an example in the North East of England not in the Health Service but in the police force. A certain policeman has been

suspended now for three or four years but the constabulary will not allow him to resign because at the end of the day they are going to take it right to the very end. Whether the man is guilty or not, I do not know, but they have not allowed him to resign so the case can be brought.

Chairman: A good question but unfortunately you are not responsible for the police force.

Mr Steinberg: The NHS could do something similar.

Chairman: Thank you very much, Mr Steinberg. Mr Geraint Davies?

**Geraint Davies**

86. Can I start where Mr Steinberg left off because he ran out of time. Mr Foster, what you seem to be saying, if I understand you correctly, is if the legal and other possible down side costs of pursuing a certain case clearly outweigh the cost of seeing it right through, then obviously you may have a situation where you have a confidentiality clause and someone who has basically manipulated and distorted the figures ends up elsewhere in the NHS in a similar position presumably doing the same. Do you think there is a conflict here between the financial interests of an individual trust perhaps and the wider interests, financial for the moment, of the NHS and, more importantly, the interests of possible patients who may find themselves not being treated because of your microscopic commercial decision?

(Mr Foster) As Mr Crisp has said, this is a matter of judgment. We are talking about people who have not been proven to be guilty of this and the employer, on external expert advice, making a judgment as to the likely success of going through proper proceedings. I am not saying that every single one of those judgments is necessarily correct but I can understand the circumstances under which an employing trust is told, "If you take this course of action it will cost you a certain amount, if you take the other course of action, there is a risk of it costing you a lot more. If it costs you a lot more, you have then got to explain to your auditors in your accounts why you have used money which is allocated for patient care for taking a particular course of action."

87. So you would accept that there is a conflict of interest between auditors on the one hand and the treating of future patients? Can I ask you, Mr Crisp, to comment in your response on this quote from your press release from December 2001 which concludes: "In future, any manager found to have deliberately distorted waiting figures will face dismissal on grounds of gross misconduct. This will be supported by a new Code of Conduct for NHS managers. Anyone who breaches that Code of Conduct will not be re-employed as a manager—anywhere in the NHS." Is that your position or is your position Mr Foster's that this will happen as long as the numbers add up and if they do not this chap or this woman will have another go elsewhere?

(Mr Crisp) What I was going to say, Mr Davies, was I take your point. I think what Mr Foster has been explaining to us is the position that people have to consider in making their judgment. It is not a conflict of interest, I think it is a different set of considerations that a trust board has to decide. They

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have to decide how they are spending money from the public purse and, as Mr Foster said, explain that to their auditors if they are doing it in a way that appears to be different from what their auditors would be saying. They also have to take into consideration the greater good of the NHS in the light of what we have been saying. I think this Report has helpfully brought this out.

88. Can I ask you something slightly different but similar, namely, if, on the balance of risk, it was decided by managers not to pursue an individual manager who may be culpable but had agreed to resign (given the circumstances of fiddled waiting lists) and it is decided not to pursue him and a confidentiality clause is released, are you now saying that you will undertake to make sure that the information is made available not only to subsequent trusts but to the public?

(*Mr Crisp*) Let's be careful exactly what we are saying here. What we are saying is that we will put in directions which will deal with the issue of confidentiality, so take that out of the equation, we will not have confidentiality agreements, it will also deal with claw-back if there is any payment here, and it will also deal with references, so that references are available. If somebody has not gone through a disciplinary procedure then you have to be very careful about precisely what the references are saying. But there is another consideration which trust boards take into account (and this is why we have good chairs and experienced people on boards) which is what is the best deal for their local patients as well, because in some cases it is better to not to have a long, protracted disciplinary process but to get somebody in there quickly to move it on.

89. Say that you and I are running a trust together and the Chief Executive "Frank Jones" suddenly discovered there was a big problem with fraudulent waiting list statistics, manipulated outputs and Frank said, "I am resigning, I am going to get another job," and the board said, "Why don't we have a fresh start, get on with it. We know what was going wrong with it from our investigation, Frank Jones has gone, let's get on with it." The alternative is to pursue him in a situation where it is very expensive and time-consuming and uncertain in terms of the evidence and it is unclear whether we will find him guilty or not guilty and the easy way forward is to let him go and he will end up presumably with a hand-out and running another trust.

(*Mr Crisp*) I think that under-estimates the quality of the people we have got as non-executives on our trusts.

90. What are you doing to stop that easy choice being made in individual trusts?

(*Mr Crisp*) I have to say I do not think anyone has made any easy choices here. I think, having talked to a number of people, that people have agonised over this because you have to balance getting on with things and making a clean start, fairness to the individual, rightness to the NHS, and the accountability issues that Mr Foster has pulled out. What we are saying is that we are going to make it easier for trust boards in the future because, as the press release says, we are going to say that our expectation is that people will be held to account.

91. If I were sitting on a board and a Chief Executive's position came up and somebody applied for this who was on the chicken run, who had escaped before the results of an inquiry had emerged—and you mentioned the case of Barts where people did the chicken run before the outputs came through—would I somehow know that as an interviewer, for argument's sake, through your system or would I know in retrospect that I would be able to sack that person if I found information which came to light after he was appointed, and are these systems now in place?

(*Mr Crisp*) The two points are that you should either have a reference from a current employer, or the individual applying for the job with you should tell you at interview, otherwise you have got a case in terms of your appointment process for dismissing them if relevant information is not provided.

92. In the case of Barts and the London—I do not know if you know the answer to this—was it not the case that the Chief Executive went off and only junior staff were left. Do you know what happened to the Chief Executive of that trust? Did he get another job?

(*Mr Crisp*) On Barts and the London there were four people who left if you look at the statistics. There was a wider review on the back of which the Chief Executive, who was and is indeed an extremely honourable man, took the view that as this was happening under his stewardship, it was appropriate that he should go, although he was not directly involved, and he has left and is not working in the NHS.

93. When did he leave?

(*Mr Crisp*) I do not have that date here but it was some time in 2000. The chair also resigned and the two senior managers are not working in the NHS, I checked that, so none of the four people involved are working in the NHS.

94. You were the London Regional Director until 1999.

(*Mr Crisp*) That is why I am familiar with the situation.

95. He left and did he get another job, did you say?

(*Mr Crisp*) No.

(*Mr Foster*) Can I say something about this point which you have been pressing us on because we have said that we will be producing a new Code of Conduct and there are certain issues we will have to consider about how it operates, so that, for example, at the moment if a consultant is about to undergo disciplinary procedures and then resigns so that disciplinary proceedings cannot be concluded, nonetheless, an alert is issued to the various bodies to ensure that he is not re-employed without the issue being sorted out. We must find a similar mechanism to address exactly the problem you are raising so that you cannot simply get away from this just by resigning. You have got to have a tagging mechanism—

96. And you are putting that in place?

(*Mr Foster*) We will have to find the best mechanism of doing that.

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[Continued

**[Geraint Davies Cont]**

97. My understanding, correct me if I am wrong, is that we are talking in this Report about nine out of 300 trusts? Are you saying there is only a problem like this in those nine or is that the nine we know about?

(*Mr Crisp*) They are the nine that we have found. I ought to say that these are the ones that came up, five from the NHS and four from people alerting, that we found over a period of about four years.

98. You are confident that it is not more than 12, for argument's sake?

(*Mr Crisp*) You have added another three.

99. I know I have.

(*Mr Crisp*) I am pretty confident that this is the order of magnitude at most that we are talking about. There may be one or two others.

100. So we are talking about 6,000 out of five million patients affected, so small numbers of people, and you are taking these initiatives in terms of the Internet and whistle-blowing and the Commission for Health Improvement. I think that is very good, but given we are talking about this niche problem, it is all the more important that those people who are identified as being serial manipulators of data, who are affecting patients welfare, should be tagged, as Mr Foster puts it, and we should ensure that they do not end up in another job. Of the people in the summary on page 2 who have left, without going through them all, do you know of any people in senior positions in the nine cases who suddenly left what was obviously a sinking ship and who now find themselves in other positions of senior management in other trusts?

(*Mr Crisp*) Let's pick up the point that Mr Foster made. I think we need to distinguish between a suspicion and proof.

101. Yes, this is a difficulty of life.

(*Mr Crisp*) But even where there is only a suspicion, somebody at an interview ought to disclose to a future employer there has been a problem. That seems to me to be appropriate.

102. Where we have got suspicion and somebody goes for a new job and the balance of justice says we must give them another chance, are we taking special measures to interrogate the statistics to ensure that there is not any serial manipulation?

(*Mr Crisp*) If the same thing has happened again in another place?

103. Yes. Do you check them knowing that they might be villains in the past?

(*Mr Crisp*) No, we are not, but I think the senior people who I can identify who have moved on into the NHS in this, and there is a relatively small number, are not in similar sorts of jobs and in some cases are in more junior jobs than the ones that they were in before and not in jobs where they could be in a position to do that.

104. They might end up there within the context of management structures?

(*Mr Crisp*) That is conceivable. All their employers know about this and no doubt also know about this hearing.

105. Can I just ask you a simple question about the logistics of this Internet management of who has got the lowest waiting lists. It is something that Mr Steinberg has mentioned a few times. First can I ask something about the simple practicalities of this. If you look up on the Internet the varying sizes of waiting lists by consultant, is it the case that that information will be instantaneously out of date because everybody will say "I will opt for Dr Jones" and then he will be the longest rather than the shortest and it will be counterproductive?

(*Mr Crisp*) I think that is a risk we should take. The example Mr Steinberg gave me last time was 18 weeks and four weeks, or something, for two consultants. I have no doubt that this will result in some equalisation of that. It may also make it more 18 weeks and more four weeks because there may be a particular reason or a particular speciality.

106. It must be the case that this data will be instantaneously updated and it might be the best strategy to go for the third down the list because everyone will be going for number one and number two.

(*Mr Crisp*) There are all kinds of games theory that one might apply to this, I appreciate that. We are going to do it. At the moment we provide this information to GPs in a written form, I think on a monthly basis, I would have to check what that was from individual trusts. The issue, as you say, is keeping it absolutely up to date.

107. Can I just ask you about suspensions, because I do not have much time now. Presumably there are a number of legitimate reasons for suspending people from waiting lists, are there not?

(*Mr Crisp*) Yes.

108. What are they?

(*Mr Crisp*) Illness would be the classic example.

109. To summarise, my understanding of this Report is that there is a very small number of trusts who are providing abuse and fraud and you have got strategies in place both to improve the service and you are tracking and tagging the people involved and taking a much harder line on that and you do not accept the proposition that increased pressure on waiting lists is an excuse to expect this problem to grow. You expect this problem to actually fall, is that right? Do you predict now that there will be less cases of this in a year?

(*Mr Crisp*) I would strongly believe that partly because of all of this publicity but actually I do think patients knowing more about the NHS will be a very powerful lever. Can I just make one final point because I think there are a lot of very honest people of considerable integrity who have been caught up in this in some way because they may have been parts of boards where this may have been happening. I think we need to be very careful about damning everybody in these organisations or, indeed, damning these organisations because this has happened. They have been relatively marginal even within the organisations.

110. So we are talking about something in the order of 6,000 out of five million patients, you accept that this is of key importance to those people and you need to drive that figure down?

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[Continued

**[Geraint Davies Cont]**

(*Mr Crisp*) Absolutely. And it was five at UCL, which is a very large hospital, and they were done for what the person thought were good reasons.

**Mr Gibb**

111. How confident are you that all the people genuinely responsible for these irregularities have been identified?

(*Mr Crisp*) I think within the limits of where we are that has happened. I have, as a result of this, had discussions with, or interviewed, one or two additional people to make sure I have understood what was going on. I think we have identified those we can identify.

112. You think there might be others you have not been able to identify?

(*Mr Crisp*) Inevitably in one or two cases it has not been absolutely clear who was at fault.

113. I was slightly alarmed by your answer to one of my colleagues that you were not able to prove some of these cases and, therefore, you had to make these compromise arrangements. That does alarm me. We have clearly got what Mr Williams has called one of the worst examples of irregularities he has seen in the course of this Committee and you are not able to prove that a number of people were actually responsible for what are very clear-cut irregularities identified in the Report.

(*Mr Crisp*) This is not universally the case but in some of these investigations, and bear in mind two are continuing, so two of these nine are not completed and in some cases it has been very clear, such as the UCL one and so on, in some of these cases the quality of the investigation was such that it identified all the patients, and that was our first concern, and it identified what needed to be done and what action needed to be taken to get it right, and there are great long action lists about that. In some of these cases they did not satisfactorily bottom out precisely who was responsible, and even where they thought they had they did not then follow it through with a disciplinary action which would lead us to be confidently saying whose fault it was. That is a failing in this and one that we want to make sure does not happen in the future.

114. You often say that phrase “something we do not want to see in the future” and you say you want to see higher standards in the future but all you seem to have the power to do, Mr Crisp, is issue guidelines, directives, codes of conduct, but it seems to end there. What power do you have to ensure that the health service is run as a national organisation efficiently and in accordance with all the guidelines issued centrally? Is not a comparison in the private sector with a franchise operation where there is absolute discipline from the centre to ensure that the franchise maintains its reputation and there are conferences, training seminars, continual meeting of all these top people and training for low level managers to ensure that these guidelines and codes of conduct are adhered to?

(*Mr Crisp*) I think your approach is exactly right and exactly the one that we are moving to. There is only so far you can get from sending out directives from the centre, whether you are a private

organisation or a public organisation. It is why we have created the Modernisation Agency which is the good practice agency, as you may be aware, within the NHS, precisely because in the NHS, which is a huge set of organisations, we need vibrant local organisations that can make decisions and we need to support them. What we are doing where we find anomalies even if they are at the margins, as by and large they are in this case, we need to make sure that we put in place the right national guidelines but also the support to people.

115. Where are we in those two inquiries that are still outstanding?

(*Mr Crisp*) I understand that they have both now moved to disciplinary proceedings being taken. We are on to the disciplinary phase.

116. Will we see a report at some stage?

(*Mr Crisp*) I imagine if you ask for one we can let you know what has happened in the two outstanding cases.<sup>4</sup>

117. In the Report it talks about you going to implement these spot-checks which we have touched on already. How frequently will they be and how extensive will those spot-checks be?

(*Mr Crisp*) Bearing in mind this is all pretty new, and I contacted Sir Andrew Foster of the Audit Commission on 19 December, where we have got to is the Audit Commission is doing a data quality check across the NHS next year anyway, this is in the next financial year, and we are adding to it a request that where we have identified trusts that we have any concern about because of these trigger points that I mentioned earlier, they will tackle those particular issues early within that system. They also are saying to us they want to consider whether there are other conditions or other circumstances where they would want to do that. We are actively engaged in discussion about exactly how it will work.

118. Similarly, there is an action plan on page 34 of the Report that all these nine trusts that have been fingered are going to implement. Is that action plan going to be implemented by all 300 trusts or is it just for those nine?

(*Mr Crisp*) I cannot find the action plan.

119. It is page 34. Paragraph 34, page ten.

(*Mr Crisp*) What we have got here is this will happen to the particular ones that are exemplified here, absolutely, but actually all of these things are effectively good practice and fall into the context of what we are talking about. For example, on the bottom one, “better capacity planning and modelling”, we have issued some advice on that already, that was something we were doing already. We have from the Modernisation Agency anyway a waiting list handbook, which again was discussed at this Committee at its last health hearing, and it picks up a lot of these issues. This is about remedial work with these nine but it is also about good practice for everybody else.

120. How many of these patients, of the 6,000, affected by these irregularities will have died as a result of what has happened?

<sup>4</sup> Ev 22, Appendix 1.

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[Continued

**[Mr Gibb Cont]**

(*Mr Crisp*) I do not believe that any have. We have taken this question seriously and the National Audit Office made the point in looking through the cases that in many cases this was a mere technicality, such as all the ones at South Warwickshire, for example, did not affect the time for treatment. In some cases there may be some patients who have suffered and we are asking the trusts to review that.

121. So at some point we will know whether there have been any deaths?

(*Mr Crisp*) We will have the information from the trusts of their assessment of it. I have no evidence that is the case at all at the moment. These cases have been worked through because everyone has been being provided with treatment plans if they were missed off the list for whatever reason.

122. When do you expect to get that information?

(*Mr Crisp*) Again, soon-ish.

123. Can we have that as well?

(*Mr Crisp*) Yes.<sup>5</sup>

124. Have any of the patients who have been affected by these irregularities been told that it is the manipulation of the waiting list that has resulted in their delayed treatment?

(*Mr Crisp*) I do not think I can give you a straight answer on that. I know that some have but the numbers that have I do not know.

125. Do you not think it is your duty to tell them all that this has happened?

(*Mr Crisp*) I would think where they are identifiable that it would be appropriate that they know. I suspect in most cases that has actually been done.

126. Will they be offered compensation?

(*Mr Crisp*) That is a matter for individual trusts to pick up.

127. Do you not think, therefore, that the NHS should have a provision for liability?

(*Mr Crisp*) No. If you look at it these are nine very, very different cases and I think individual trusts need to consider their own position on this, as in everything else, and that is a matter for them, but they really are very different.

128. But they will all possibly involve compensation to these patients who have been inconvenienced?

(*Mr Crisp*) No, I do not think that is the case. If you look at some of these, they are very much technical. The South Warwickshire ones did not involve patients being treated any later than they would have been treated otherwise, which is presumably the point that you will be wanting to make around compensation, or therefore coming to any harm. I think these are individual issues which need to be picked up by the trusts.

129. Was the remuneration of any of the Chief Executives of the nine trusts involved in the irregularities affected by waiting list figures before these irregularities were uncovered?

(*Mr Crisp*) I asked that question and we have reviewed that in most of the cases and have found that people did not get performance related pay, if that is your question.

130. Yes, it is. How are these people remunerated if they are not remunerated on the basis of their performance?

(*Mr Crisp*) Again, if you look at these individual cases you will find that many of them were in trusts which were not doing very well anyway and, therefore, they were not hitting their waiting lists. This is perhaps part of the reason why manipulation may have taken place. Therefore, if they were not hitting their waiting lists or their other targets they would not be getting performance related pay.

131. But might they have had an increase in pay had they achieved better waiting list targets?

(*Mr Crisp*) If they had achieved better waiting list targets?

132. Yes.

(*Mr Crisp*) Again, it depends on the circumstances because some trusts operate performance related pay and some do not. Not all of them are on a universal system. If in some cases they had managed to do things then they might have got a benefit but we have actually gone through to look at these.

133. In these nine instances are there any instances where either (a) they did have an increase in pay as a result of their waiting list figures or (b) they would have had an increase in their pay if they had achieved better results?

(*Mr Crisp*) The answer to the first one is we have not found any. The answer to the second one is I guess if people are hitting targets they are more likely to get performance related pay.

134. But if they are not hitting targets, if they were hoping to try to hit targets by manipulating the waiting lists but they failed and they did not get the pay it is still criminal fraud, that is the allegation.

(*Mr Crisp*) I think the allegation here is actually about 18 month waiters which by and large is not a specific target, it is a requirement, if I can put it like that. Performance related pay would be more likely to be available for people who have reduced waiting lists substantially. Many Chief Executives do not have provision for performance related pay in their contracts anyway, that is not universal.

135. In response to Mr Williams' question about Barts you said that the Chief Executive and Chairman resigned. This Report only mentions one name and that is a relatively junior manager, the admissions manager. What was the name of the Chief Executive and Chairman who resigned?

(*Mr Crisp*) I am not sure if I should be—They are on the public record. It was not in relation to this particular issue, it was in relation to a wider set of management issues around the trust which meant they decided they should resign.

Chairman: Could you write to us on this?

136. Can you confirm that they did not resign as a result of irregularities in the waiting lists?

<sup>5</sup> *Note by witness:* The process of contacting the NHS Trusts involved and asking for their assessment of those cases highlighted in this Report, is ongoing. Some of the cases refer to adjustments made 5 or 6 years ago and there are difficulties in identifying individual patients. We will continue to pursue this and will be happy to share the details with the Committee once the reviews are completed to the Department's satisfaction.

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[Continued

**[Mr Gibb Cont]**

(*Mr Crisp*) My point in answer to Mr Williams was that it was a different trust board that considered things. The first trust board Chairman and Chief Executive, who were Chairman and Chief Executive during this period, resigned over a set of wider issues about the overall progress that the trust was making.

137. But Mr Williams' point was that no senior trust member has resigned over these irregularities. Barts was the worst case of all these nine cases and nobody resigned. You gave the impression in response to Mr Williams that they had resigned in part due to these irregularities and now you are saying they did not resign.

(*Mr Crisp*) I am sorry if I gave that impression. I thought what I said was that independent of this we had a wider review going on of the performance of Barts and its relationship with its neighbouring PCTs and its trust and health authority.

138. Let's go back to the question Mr Williams asked then. Here it is said: "The Board concluded that there had been organisational failure and that it was therefore inappropriate to single out individuals for disciplinary action." They said that the whole methodology of manipulating figures had become custom and practice and therefore that was a matter of corporate responsibility. Who is taking that corporate responsibility?

(*Mr Crisp*) The Chair and Chief Executive had been in a post for about a month.

139. I agree it should not be them. This was happening presumably before that month so who is responsible for that custom and practice?

(*Mr Crisp*) The board, as I understand it, took the view that this was an unsatisfactory practice that had become custom and practice within that organisation, that they were new in this situation, but for different reasons, the two senior managers who appeared to be potentially implicated in this had already left and that therefore the most sensible thing they could do would be to say that "we are as an organisation are culpable, we need to put into place an action plan, not only about specific actions but about changing the culture of this organisation."

140. What date were the recent Chairman and Chief Executive of Barts appointed?

(*Mr Crisp*) I think you will find that this was an acting Chair and Chief Executive in the interim period before the substantive Chair and Chief Executive were appointed, so there was a very, very substantial set of management changes.

141. You refuse to tell me who the Chairman and Chief Executive were who resigned, for various reasons. Who were the two Directors of Operations who resigned?

(*Mr Crisp*) I think they are named in here and, I am afraid, if they are not, I do not know their names.

142. One is named in Appendix 2 and that is the Admissions Manager. It just seems that that is the culture, a point other colleagues have brought up, that you are very happy to name and blame relatively junior people, yet particularly when they use the phrase "it became a matter of corporate responsibility", there seems to be an almost institutionalised cover-up to protect these very senior people.

(*Mr Crisp*) I think that is unfair. The people who were chosen to be named here were chosen by the National Audit Office, not us. I can tell you the names of the two Directors of Operations (who were on a job share) who were referred to in this if you would like me to do that, that information is available, and we have three Chairs and three Chief Executives over this period within Barts and the London and we can provide you with those names, but it was not our choice. Indeed, we would have preferred not to see junior members of staff named here but this is not my report.

Mr Gibb: My time is up.

**Chairman**

143. On that point of naming, the fact of the matter is that these inappropriate adjustments had been made, and this process was going on whilst these people were resigning, and therefore I think Mr Gibb is entitled to ask for their names if he wants to. You can either give us the names now or, if you do not know them, you can write to us.

(*Mr Crisp*) I will write to you on that basis partly because I cannot remember the chair's name.<sup>6</sup>

144. Mr Gibb also raised another important point that possibly the condition of some of these patients was exacerbated because of the way that they were treated and he wanted and we want reassurance that they will or have all been told what went wrong because there could be issues of compensation involved here and if their condition was exacerbated, surely they should be entitled to compensation? How could they receive compensation if they do not know what happened?

(*Mr Crisp*) As I say, I think there are some issues that we have still got to pick up with the trusts around that and we will ask those questions. The point I have made is that for the vast majority of these patients we know that is not the case and the National Audit Office has said that is not the case. If there are particular cases, they are for the individual trusts to deal with because each of these cases is different.

145. Well, you have a responsibility as well. I do not think you can just shuffle it onto the individual trusts.

(*Mr Crisp*) The responsibility for compensation is with the trusts. My responsibility (which I did say I would be exercising) is asking them whether they had identified any patients who were in this category.

Chairman: Thank you. Mr David Rendel?

**Mr Rendel**

146. What would you expect trusts to do in order to meet the 18-month waiting list target or 15 month waiting list target or in future the six-month target if they think they are likely to go above it?

(*Mr Crisp*) The first position is to tell us. If by that you mean the immediate action, I would be expecting people to contact their regional office and indeed pass on the information to me and indeed for 18-month waiters we have a requirement that it is passed on to me.

<sup>6</sup> Ev 22, Appendix 1.

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[Continued

[Mr Rendel Cont]

147. What can you then do?

(Mr Crisp) We centrally ask them pretty straightforward questions about what they are doing about it and whether they have used all the resources that they have got, how they are handling this, how are they going to make it happen, are they using the private sector, all that set of questions.

148. So if they have a patient who is about to go above the 18-month target waiting time, you would expect them, for example, to use the private sector straightaway?

(Mr Crisp) I would expect them to do two things. Firstly, I would expect them to make sure they got that patient treated just as soon as they could. The second thing I would expect them to do is to explain to us—

149. What does “just as soon as they could” mean? If you tell them they can go private, presumably they can do it tomorrow?

(Mr Crisp) They can do that anyway. Maybe they can get it tomorrow or maybe not, but what you do know is that most of these 18-month waiters are for people who have got some quite specific sort of complaint. Therefore, if you have a particular problem with a shoulder you may not be able to get it done in the private sector tomorrow or, indeed, the patient may not be prepared to travel the distance to get the operation done in the private sector. It will depend on the operation as to “just as soon as possible”.

150. If a patient comes up to 17 months and they can see they are going to go above 18 months and private treatment is available, then you will say that that patient should be treated at once privately?

(Mr Crisp) And that is what happens. If private treatment is available locally, they probably do that and it does not come to us. We get very few cases of 18-month waiters. The other question I ask is how has this been allowed to happen?

151. If what you say happens and they can go and have patients treated privately, that presumably means then that the NHS is using money to treat somebody privately who has reached the target limit rather than treating somebody who has greater clinical need who has not?

(Mr Crisp) No. If you are wanting to pursue the question of clinical priorities, we are clear, and we are clear because the vast majority of the trusts do this, that you can balance your waiting lists so you hit not only the clinical priorities but also make sure that you deal with the long waiters. That is the point of my second question so that when somebody tells me they have got an 18-month waiter I am saying, “What are you doing about that patient?” And, secondly, “Why are you in that position?” If you are in that position, tell me how you are employing all the good practice that Mr Gibb referred to, for example have you got the Modernisation Agency visiting and are you making sure that it does not happen? We do know from the vast majority of trusts that you can run a balanced waiting list.

152. Presumably they would not have ever got to that position unless they reckoned that that patient was not getting treatment this month because they have always got somebody who has a higher priority,

either because they had waited even longer or because they were of a higher clinical priority. You cannot get to 17 months unless you are constantly taking the decision that there is always somebody else who has got a higher priority.

(Mr Crisp) That is the reason why they are waiting relatively long, but more likely what has happened is they have had a slot and for some reason it was cancelled. It may have been cancelled on the day or something of that sort because an emergency came in. There are very few cases where 18-month waiters have not already had a date and, in fact, they had usually had a date that had been cancelled because a more urgent patient came in at the time because urgent patients take priority. But we need get the balance right between—

153. When they get to 18 months then you are prepared to say there should be special measures taken to push that person, if necessary, through a private hospital rather than spending that money on what previously up to that 18-month point should have been a priority?

(Mr Crisp) If we have got to that point then they will doing that as part of a wider set of issues, and that is the point of my second question. If they have got a problem with one patient, have they got a problem with several or have they got a problem with urgent patients? What are they doing about that? If your point is trying to make me say that we distort our priorities at that point for political reasons or something of that sort, I think what we do is we say what is the problem in this trust? Why have we got to this situation? Is it an individual who has been overlooked? Is it an individual who through some bad luck has been cancelled?

154. I do not see how you can possibly avoid changing your priorities against clinical guidance if you are to have a waiting list system of this sort. Can I move on, I do not want to waste all my time, and can I refer you to an article in *The Sunday Telegraph* this Sunday which said that at the John Radcliffe in Oxford a few years ago patients were being marked with an “M” to show they had a management priority and that they were to be treated whatever happened in order to make sure they improved the waiting list times. Firstly, can I have your assurance that that does not happen any more?

(Mr Crisp) I do not know. I am not aware of the practice so I would not have thought that happened. A management priority? As opposed to a clinical priority?

155. Did you see the report in *The Sunday Telegraph*?

(Mr Crisp) No.

156. That does worry me.

(Mr Crisp) I read an awful lot of newspapers but nobody has drawn that one to my attention, I am afraid.

157. That is staggering. There was an absolutely clear report that people were being marked with a letter M to give them management priority above clinical priority. If that was not drawn to your attention I hate to think how the NHS has been managed.

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[Continued

**[Mr Rendel Cont]**

(*Mr Crisp*) They have been running quite a lot of stories, have they not, and I have seen some. I do not remember the particular point, nobody drew it to my attention.

158. As far as you know, that does not happen any more? Can I have your assurance that as far as you are concerned there is not a trust under your control, so to speak, or your guidance where anybody is ever given a management priority above a clinical priority such that waiting list targets are met?

(*Mr Crisp*) We are very clear what we have told people to do which is to give clinical priority. There are methods for doing that, not least because on every operating list you have got room for some major patients and some minor patients, and you need to balance your operating list and you can get in lower medical priority patients at a reasonable pace.

159. I do not know how I can follow that up, Chairman, because it staggers me that he does not know about it but we will leave it for a moment. In answer to Mr Steinberg you said at one point that some people felt that they needed to cheat and that was the unfortunate reason why this has arisen, they could not overcome the 18-month problem unless they cheated. You then went on to say that you do not know why they felt that. Is that correct?

(*Mr Crisp*) I think I also said I can only speculate, I have no idea.

160. Has anyone asked them why they felt it necessary to cheat?

(*Mr Crisp*) I am sure that people have; I have not. I think people probably asked them why has this happened, why have you done this?

161. You do not know what their answer was?

(*Mr Crisp*) No and I think it is probably difficult to generalise.

162. Do you not think, given that this problem has arisen, it is important to know why people felt they had to cheat?

(*Mr Crisp*) In individual cases that may well be true but I think our responsibility is to make sure that it does not happen again rather than to get involved in individual disciplinary issues.

163. Is not one way of making sure it does not happen again knowing why it happened in the first place? Is that not an important part of thinking about what you could do to make sure it does not happen again?

(*Mr Crisp*) I understand the logic of your point, I am trying to think whether or not it has any practical application, whether you would find out anything by doing that which was helpful.

164. I think it would have been the very first question I would have asked, why did this happen. Can I come then to the confidentiality questions which have been raised by a number of colleagues. You have said that you have discovered that it is necessary now to make the guidance firmer.

(*Mr Crisp*) Make it a direction.

165. Make legislation so it becomes a directive, that has to happen. The one thing that we have said in this Committee on a number of occasions is that we need to see more cross-ministry working, if you like. What discussions have you had with other

ministries about whether they allow confidentiality agreements in this case and whether they give it out as guidance or as a directive?

(*Mr Crisp*) I have not personally had any involvement with anybody else on this. I do know that we have been looking at confidentiality requirements in the light of general Government policy. Others may be in a better position to do that, I have not personally done anything about that.

166. Are you going to?

(*Mr Crisp*) I am not sure that I personally will be. The next directive that we send out will be consistent with what you have said to us, that is the first point. Secondly, I think it is a fair question to ask whether it will be consistent with what other Government departments may be doing. We will certainly check that.

(*Mr Foster*) I think it will be my responsibility to do that. I will be overseeing the production of new guidance and it will be perfectly proper to make sure that it is consistent with the rest of Government policy and other departments.

167. Can I just ask the Treasury to confirm that if we have a recommendation that we should go along with this, ie the guidance should become a directive, that information that the NHS at least have found it important to change guidance into a directive will be passed on to other ministries?

(*Mr Hull*) It already has been passed on to other ministries. In a letter dated 25 January 1994 to Principal Finance Officers it states "The Committee", that is this Committee, "recognised that it might be appropriate to seek such undertakings on certain operational matters, but was concerned that the terms should not be so restrictive as to be potentially damaging to public accountability, ie that the terms could impede a person from answering PAC questions."

168. If I may say so, that recommendation by this Committee was followed up by the NHS issuing guidance. They have now discovered they need more than guidance, they need a directive. What I am suggesting is that regulation simply led to guidance but can we please make sure that the other ministries note the fact that the NHS at least has found we need more than guidance, we actually need a directive.

(*Mr Crisp*) We have taken the point and we will make sure that it is shared with colleagues in other departments.

169. When did you discover that the confidentiality agreements had been signed yourself?

(*Mr Crisp*) In the three cases at, I am sure, three different points.

170. But you knew about them before you saw the Report?

(*Mr Crisp*) Some of them. We would have known in the preparation of this Report, yes.

171. In all cases did you ask why the guidance was not followed? You have now told us in Plymouth's case why guidance was not followed.

(*Mr Crisp*) I asked personally why the guidance was not followed. We have asked in the other cases why the guidance was not followed and in the two cases that I am aware of, two out of the three, it was for the reason of perceived ambiguity in the guidance

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[Continued

**[Mr Rendel Cont]**

that I explained earlier. It was not about public accountability, the gagging clause, it was about subsequent—

172. Did you ask why guidance had not been followed before the Report came out?

(*Mr Crisp*) Because they thought they were following the guidance.

173. Did you ask why the guidance had not been followed before the Report from the NAO came out?

(*Mr Crisp*) I personally got involved as the Report was— On that particular case it was subsequent to the Report being produced, that was when I personally got involved.

174. Why did you not follow it up before? Was it not an obvious thing to follow up as soon as you knew that guidance had not been followed? Why did you wait until the NAO Report came out?

(*Mr Crisp*) There is a difference between me personally doing something and people doing things on my behalf. I could not tell you exactly when people may have done that on my behalf but you can imagine there is only time for a certain number of interviews or phone calls in a day.

175. Can I ask about the compensation, just one or two follow-up questions from what Mr Gibb was asking. How many patients affected have received compensation already?

(*Mr Crisp*) None that I am aware of.

176. Two or three years later none of them have yet received any compensation?

(*Mr Crisp*) I think that is the case, yes.

177. You do not know if any compensation is going to be due?

(*Mr Crisp*) No.

178. We were told earlier that there was an attempt by putting in these confidentiality clauses to ensure that the trust concerned might avoid some future action, possible future costs. Was there at any time any suggestion in discussing these confidentiality clauses and whether they should be included or not that that might mean if there was a confidentiality clause signed that it might be easier to avoid claims of compensation by patients? Did anyone ever even mention that as a possibility?

(*Mr Crisp*) No.

(*Mr Foster*) There was no suggestion of that.

179. Have you discussed whether that was mentioned at all or do you think that hopefully it was not?

(*Mr Crisp*) I think what Mr Foster said was there was no suggestion that had happened. We can certainly go back and ask the question in the three cases.

180. I think it is very important that we do not try to stop people getting compensation by signing confidentiality clauses.

(*Mr Crisp*) I do not think for a moment that was what was in people's minds from the discussions that we have had, but let us cross check the record on that.

(*Mr Foster*) It is likely that they would have been acting on the advice of employment lawyers and that would have been the prime consideration. We will check.

181. One final question, if I may. Most of the employees concerned, not necessarily the Chairman and so on, have been re-employed by the NHS. I think there is only one who has not been re-employed by the NHS.

(*Mr Crisp*) No, that is not true. Two of the three at Barts have not been re-employed.

182. I thought they were Chairmen of the Board.

(*Mr Crisp*) It was a job share of the Director of Operations and those two have not been re-employed. It is more than that. Some have been re-employed.

183. Clearly a number have.

(*Mr Crisp*) Some have, yes.

184. If I were a trust and I had it reported to me that somebody had lost their job as a result of being involved in this sort of thing, I would need an awful lot of persuasion to re-employ such a person and yet it seems that they have found it on the whole quite easy to get re-employment. Does that not say something about the difficulty that NHS trusts are having at the moment to get good management staff? If they are happy to employ people who have been thrown out in this sort of situation it is staggering and it is very worrying that they are having to employ people who have been thrown out and they cannot get anybody better.

(*Mr Crisp*) I think some of the people here, with the exception of the incident that we are talking about, have had a great deal of management experience and skill and people have taken the view, in the knowledge of what has happened and probably in the knowledge of some discussion with the individuals about why it may have happened, to go back to your earlier point, that on balance that was the right way for them to go. That is not what we would be expecting to happen in the future for the reasons we talked about earlier.

Mr Rendel: Thank you very much. Can I ask for a couple of notes. Mr Crisp did say earlier that there is going to be standard format of investigation and I wonder if we can have a note as to what that standard format of investigation will be. Also, on how many of the nine trusts concerned do treat private patients in those trusts as well, following up what Mr Steinberg said.<sup>7</sup>

#### Mr Osborne

185. Can I apologise for not being here for the bulk of the meeting but I had a meeting about job losses at the edge of my constituency which was only arranged today. I have tried to gather some of the areas that have been covered. Can I begin with a written question that I asked Mr Hutton, or rather I asked the Secretary of State for Health but Mr Hutton replied. I asked the Secretary of State for Health under what circumstances an NHS trust can withhold the employment history of staff seeking

<sup>7</sup> *Note by witness:* Discussion continues within the Department as to the fine detail of the standard format of any future investigation. We expect these discussions to conclude shortly. We accept the key principles that the investigations should be independent and external. We will be happy to share the details with the Committee once finalised. All of the nine trusts concerned treat private patients.

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[Continued

**[Mr Osborne Cont]**

employment in another part of the NHS and I got the answer "All NHS employers are expected to carry out thorough pre-employment checks on all staff they employ. The checks include taking up references which must be accurate and truthful." For how long has that been NHS policy?

(Mr Crisp) I do not know how long it has been NHS policy but we could find out. Certainly that is what we need to do and what we need to reinforce. One of the things that we have talked about in your absence is that some of the human resources issues here, and that is why I have the Director of Human Resources with me, need to be followed up with the force of direction rather than just guidance. There will be something in the new arrangements that is specifically referring to references in the way you have talked about but having the force of instruction.

186. You have just said "something we need to do", but, with respect, the question I asked was is it that NHS service employees are expected, ie expected now, and expectation is not the same as guidance, is it? You are not guiding them, you are expecting them.

(Mr Foster) The policy you describe there is a very longstanding policy for the NHS that we should take appropriate employment checks but the guidance, technology, systems and procedures for doing so is constantly updated. Indeed, we are due to issue updated instructions about pre-employment checks across a wide variety of fronts in the near future, not related to this issue at all, on things like protection of vulnerable adults and so on. We have to constantly react to changing legislation elsewhere to make sure that our guidance and instructions to trusts is most up to date. It is not new, it is just that it changes frequently.

187. If it is not new that references must be accurate and truthful, how could a trust issue a copy of a reference which made no reference to the waiting list adjustment incident for which Mr Riley in South Warwickshire was suspended? If it is a longstanding policy to provide accurate and truthful references it seems strange that there is no reason as to why he had been sacked.

(Mr Foster) Indeed, and that is one of the failings that has been revealed in this Report. That is why the next set of guidance relating to these issues is to be mandatory rather than merely guidance.

188. Have you considered disciplinary proceedings against the people who negotiated these settlement contracts?

(Mr Crisp) That is a question that I am following up. The answer is yes. Again, in the press release that we issued initially we did say that we were looking at whether there was room for any further action on any of these cases, including any potential for clawing back money in the cases where that had not happened.

189. What I am talking about is not the people who adjusted the waiting lists but the other people at the trust.

(Mr Crisp) The Board?

190. Who negotiated the severance. Do you have any timescale of when you might come to some conclusions on these things?

(Mr Crisp) I regret to say I have probably said "soon" on a number of occasions this afternoon because there are about half a dozen or so outstanding issues, of which this is one.

191. I have no problems with "soon".

(Mr Crisp) The point is we need to deal with these things and move on. I would want to do it quicker rather than slower.

192. Can I ask you about investigations by the National Patients Access Team. At paragraph 14, on page five, it says in the second half of the paragraph: "At two further trusts the National Patients Access Team had previously identified weaknesses in waiting list management and areas for improvement; though in both cases no further detailed enquiries were undertaken . . ." Can you explain that?

(Mr Crisp) Yes. I am just looking for a note on the particular case because we have asked that question as to why we did not discover it. I cannot immediately find the note. The basic point was NPAT had been invited to go in and look at a general range of issues to do with waiting lists, not to do with the issue of potential manipulation of figures specifically. It is also worth saying that the potential manipulation of figures in some cases has been quite difficult to spot, unless you are specifically looking for that, because it is a relatively few number of patients added to a suspension list. They have been looking at the wider range of waiting list policy, given advice, given recommendations, and then moved on and have been invited back late.

193. So even, to use the jargon, the NPAT teams, if that is not a contradiction in terms, had identified weaknesses in waiting list management but there were no further enquiries undertaken?

(Mr Crisp) The process has been, firstly, that the problems have been identified, possibly by the trust itself. As a result of the problems being identified there has been agreement that the NPAT should go in, should look at the overall systems, should look at the ways in which we manage waiting lists, which are very often to do with people issues rather than numbers on forms. They are actually the sort of issues Mr Rendel was referring to of how do you manage a waiting list so that you make sure the long waiters are coming down as well as the clinically important waiters are coming down. There is a lot of good practice around that. That is what they will have gone in for. They were not sent in specifically to look at alleged manipulation. As I say, that can be quite difficult to spot because it may be small numbers.

194. In the case of Salford Trust, which is Appendix 6, paragraph four, it says here that the first problems with waiting lists were identified in October 1998 by the Data Quality and Coding Unit and then they were visited by the NPAT in November 2000, again about waiting lists. There must have been alarm bells ringing that they had got a big problem in Salford with waiting lists and yet it was not until 5 July 2001 that a District Audit was called for.

(Mr Crisp) Yes.

195. So that is three years and that includes three years in which 435 gastro-intestinal patients awaiting endoscopy procedures were not included, 148 of

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[Continued

[Mr Osborne Cont]

whom were inappropriately suspended, and I imagine they were in a fairly serious condition to be in hospital, so they knew they had a problem at Salford.

(Mr Crisp) As you know, Salford is one of the two cases which has not yet concluded and therefore we need to look in detail at the investigation here and look at what disciplinary action has been taken. It is worth noting that in October 1998 I do not think NPAT was in existence.

196. The Data Quality and Coding Unit was and maybe it still is in existence.

(Mr Crisp) There was advice available and you are quite right, the problems there have been going back some time.

197. Can I finally ask about what my colleagues Mr Gibb and Mr Rendel talked about, the 6,000 patients, just because I have missed this. What exactly are you doing to contact the 6,000 patients to let them know that this Report has been published and there has been a problem and we have had a parliamentary hearing on the subject?

(Mr Crisp) As you are probably aware, there has been more publicity in these cases in advance of the NAO Report because each of these cases has been a very big local *cause célèbre* because they were identified before the NAO Report and the NAO Report has reported on them. So there has been a lot of local press. The points that I made are that, firstly, in some cases these were very technical small adjustments, like the Warwickshire ones where patients clearly were not affected. In some cases there is a suspicion or a suggestion that patients were affected materially in some way. We are going back to the trusts to ask them to report back to us on that in some detail so that we know what the position is and we know how and when the patients have been informed. I do not think that those were particular questions or it was a particular question that was picked out by the NAO Report, and therefore we are now doing that.

198. Therefore your roundabout point is that “unless it is serious we are not going to get in touch with them”?

(Mr Crisp) It depends. There will be judgments to be made when we get there.

199. You are there now, are you not, you have got 6,000 patients whom you know have in some way or other been badly treated by the NHS and I would have thought it was fairly routine. If there is a problem with a particular operation or procedure in a hospital, you regularly contact hundreds of patients, so it should not be beyond the wit of the NHS to contact these 6,000.

(Mr Crisp) That is perfectly true. What I do not know sitting here is what has been done in all of these cases already and therefore a judgment needs to be made, but if I think of the South Warwickshire ones where the length of time they waited is not materially affected—and I am not sure whether they have been informed or not and it may be appropriate to inform them—let the local people make that judgment when we see it.

200. It may not have greatly affected their waiting time, who is to say, but it may have caused a great deal of anguish to have had operations cancelled, not being given clear dates, being put on a suspended list. The end result might be that they got their operation when they were going to get it anyway but in the meantime there are 6,000 people out there who may well have had a pretty miserable time.

(Mr Crisp) If you look at the South Warwickshire case, and I take that as a particular case, there were no dates involved, this was a delay in terms of putting people onto a waiting list and it did not affect their outcome in terms of when they would have been treated. The point that I am making here is that these are nine different cases and they do concern the relationships between individual trusts and their neighbouring organisations and in some cases what has happened here is that the trust simply did not report the numbers into the system, they did not do anything to the patients in any sense or any way at all, they simply did not tell us they had ten 18-month waiters or 15 waiters in this category. That has no impact at all on the patient, that is about the trust and the relationship between the NHS organisation and the NHS centrally. As I said earlier, I believe that the route into this is to give much more information to patients. We will put in checks and balances to make sure that we scrutinise—

201. This is a great place to start. Why do we not give more information to patients now? Let's contact the 6,000 patients. You might leave off the ones in Warwickshire and drop 2,000 from the list and take the 4,000 and say in this new, open NHS that this bad thing has gone on in the past—

(Mr Crisp) I hear the point and I take it seriously. The point that I made earlier was that we will be giving all patients the opportunity to see the length of waits for individual consultants in all hospitals in the country. That will provide a lot of information and will enable us to make sure that this sort of thing does not happen again.

202. If they go into hospital in the future they will be kept well informed, they will not be told what has happened in the past?

(Mr Crisp) I take the point you are making seriously, and you obviously hear the point that I am making. The technical case of they simply did not report you were on the waiting list to the Chief Executive of the NHS, that may or may not be something we want to tell patients, we need to tell patients.

203. The amazing thing is I think the very first PAC meeting I came to six months ago was with you when we were talking about compensation and litigation and the one overriding message from the NAO Report at the time was that if the NHS did more to inform patients and offer apologies and so on, you could dramatically reduce the litigation bill. I am not a lawyer but I imagine you have got a few hundred cases coming your way, although it will probably be in ten years' time and it will be your successor who will be explaining why they were not offered an explanation and offered an apology rather than yourself.

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MR NIGEL CRISP AND MR ANDREW FOSTER

[Continued

**[Mr Osborne Cont]**

(*Mr Crisp*) Again, if you had been here earlier in the meeting you would have heard me say that part of the PAC last time was also talking about how do we give patients openness and so on and I was saying how we are carrying that forward. I hear the point you are making about these particular patients. I am at a disadvantage in that I do not know what has actually happened in these nine trusts. I am not saying that I am not going to do anything about it, I am simply telling you that after 400 questions, this is the 401st, I do not have a briefing on it.

Mr Osborne: I knew we would get there in the end.

Chairman: Thank you very much. There are one or two more questions, I am afraid, but we are almost at the end and you have done your best to answer our questions. You will understand that the Committee is still worrying away at this problem of compensation and your lack of control over the trusts. We take this very seriously, that you will have sufficient power to require trusts to act properly so that patients know what happens. I think my colleague, Mr Williams, has one more question he wants to put to you on that subject.

#### Mr Williams

204. It follows on from what Mr Gibb said. As the Chairman has indicated, these are trusts that have breached the relationship there should be between them and their patients and, therefore, I do not think the Committee are sanguine that they can be relied upon to ensure that their patients are fully informed if they have suffered as a result of these instances. In the case of Barts it did say that it caused patients to wait for treatment longer than the urgency of their condition would suggest was reasonable, or possibly even safe, and the inquiry noted that these actions were potentially dangerous to the patients. I think it would be irresponsible—I do not mean this in an unpleasant sense to you—if we did not ensure that no-one could turn around to you or to us and say we have not monitored this situation, as I think Mr Gibb would like. Therefore, I would be grateful if you could require each of these hospitals to be told they are to notify you in the event of cases arising where there is reasonable evidence to suggest that patients may have suffered as a result of this situation. I can ask you to do it or I can instruct you to do it and tell us, but I would happily leave it to you if you would take on responsibility for doing it.

(*Mr Crisp*) I did say in the course of this that there were some unanswered questions that we were still following up and I did actually say that this was one of the questions. What I had not done was take the point about talking to patients. I did say we want to know from the trusts whether they believe or have any evidence of anyone being damaged or harmed through this process and when we have got that I will happily provide that to this Committee.

Mr Williams: Are you happy with that, Mr Gibb?

Mr Gibb: Yes.

#### Mr Rendel

205. One follow-up question on what has been said just now about giving patients more information. I take on board your comment that if patients have a lot more information about what waiting lists should be and they find that they are having to wait a lot longer that may throw up information about somebody fudging the waiting lists in the way that they have been doing in these nine cases and it may help to prevent that in the future, but how is that going to work in practice if, for example, a consultant has a number of patients coming forward for operations and some of them will have a clinical priority which is clearly higher than others? It may be that a patient with a fairly low clinical priority gets put off for several months and ends up waiting for perhaps nine or 12 months when he or she can see that the consultant's average waiting list is only two months. If they then ring up and say, "Hang on a second, I have been waiting five times as long as I should have been", what is going to happen then?

(*Mr Crisp*) There are two things that are happening here. The first one is putting that information on the Internet. The other one is, of course, we are moving to a system of booked admissions so patients will have a date at the point when the decision is made that they need to be admitted, which will be even more helpful and in the long run that will deal with your question. In the short term your question is obviously an important one and that is partly why we are going to have to pilot this because we will find that some unexpected things will happen. As somebody said earlier, will that not just mean that waiting lists will equalise, things will change because people will be referred? I think the point is it will put the power with patients to ask those questions and to say, "If you are saying that the waiting list for my consultant is six months, why am I waiting nine months or ten months or 12 months," or whatever. That is the first step in changing the system is to start to put the pressure on it externally. If we can get onto booked admissions I think we will solve this problem but, as we know from our earlier meeting, that is three years off.

#### Geraint Davies

206. On 19 November you made a point that there was not consistent methodology in terms of waiting list measurement across different trusts. In light of the importance of this Report and that Report will you now be putting out instructions to trusts on the precise definitions of how to measure waiting lists in terms of methodology, because otherwise people may come under fire inadvertently for doing the wrong thing?

(*Mr Crisp*) We do. I cannot remember the exact point at the earlier session, but we do put out definitions and we refine them wherever we see there are problems. As a result of both that Report and this Report we will be making them even more clear for people, which I think is a very important point. I do take these points about openness as being very important, I have said it several times, and I think this will provide a lever to make things happen. The

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MR NIGEL CRISP AND MR ANDREW FOSTER

[Continued

**[Geraint Davies Cont]**

transparency about definitions will also be very helpful and I think, finally, the issue that this Report has revealed for us is that in a small number of cases people have manipulated the figures for whatever reason so we need to have higher standards because cases like this are damaging to the NHS and also to the patients, and we will be introducing arrangements to make sure we get higher standards.

Chairman: Thank you, Mr Crisp. Mr Bacon asked you earlier the basis on which Mr Colin Jones was dismissed from Oxfordshire Health Authority

and Nuffield NHS Trust. I understand that this may be relevant because it relates to the quality of the legal advice that is available to NHS employers so we would like you to write to us later with the basis on which he was dismissed.<sup>8</sup> May I thank you, finally, for appearing before us and for obviously taking these matters very seriously and for promising to take action to rectify them. Thank you very much.

<sup>8</sup> Ev 22–23, Appendix 1.

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## APPENDIX 1

### Supplementary memorandum submitted by the Department of Health

*Questions 115 and 116: Where are we in those two inquiries that are still outstanding and will we see a report at some stage?*

The disciplinary at Stoke Mandeville took place at the end of March and resulted in the dismissal of the Chief Executive. This is subject to appeal and the appeal is currently timetabled for the end of July.

Four Senior Managers at Salford Royal Hospitals NHS Trust were featured in the Independent HR Report. The outcome of the disciplinary procedures with each of these individuals is as follows:

- The Chief Executive at the time that the inappropriate adjustments took place had resigned from the Trust before the completion of the District Auditor's Report and the Independent Review. Having formally received and considered a copy of the report of the Independent Review, the Chairmen of the individual's new employing organisation took the view that formal disciplinary action was not warranted.
- The Director of Strategy and Development has been subject to a formal disciplinary procedure. However, at the time that the disciplinary procedure was invoked the director was absent from work through sickness and subsequently resigned.
- The General Manager, Surgical Services was also subject to a formal disciplinary hearing, which resulted in a formal written warning.
- No formal disciplinary action was considered appropriate by the Trust in respect of the Director of Finance and Information because of the peripheral nature of the individual's role in waiting list/times management.

*Question 143: Can you provide the names of the senior personnel at Barts and the London whilst this process was going on?*

The Chief Executives at Barts and the London during this process were as follows:

- Mr R Pett, until his resignation on 30 September 2000.
- Mr J Asbridge, acting CE from 1 October 2000 to 9 September 2001.
- Mr P White, from 10 September 2001—currently still in post.

The Chairmen were as follows:

- Mr B Gilmore, until his resignation on 31 July 2000.
- Mrs E Gilding, acting Chair from 1 August until 31 December 2000.
- Mr M Vandersteen, from 1 January 2001—currently still in post.

*Question 50 and Chairman's closing statement: What was the basis on which Colin Jones was dismissed from Oxfordshire Health Authority and Nuffield NHS Trust?*

Mr Colin Jones, former District Treasurer of Oxfordshire Health Authority, was made redundant in March 1990 as a result of re-organisation. Following solicitor's advice, the HA paid a termination settlement of £149,052.80 which comprised of:

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60 weeks' redundancy payment	£43,969.80
three months' salary in lieu of notice	£9,553
two and a half years' salary (as compensation)	£95,530

The NHS Executive subsequently established that Mr Jones was only entitled to the first two parts of the settlement and therefore the compensation element (£95,530) was considered *ultra vires*.

The HA initiated recovery proceedings by serving a Writ in the High Court but Mr Jones's solicitors responded by declaring they would fight any attempt to recover monies received. Following Counsel's Opinion that there was no basis for bad faith, with regard to Mr Jones receiving the payment, the advice was that his defence could well be successful.

Having examined Counsel's Opinion and the pertinent facts of the case it was considered not to be cost effective to proceed with recovery action. The HA provided assurance that their management systems would not leave the Authority vulnerable to any such re-occurrence and as a result Treasury gave approval to write off the £95,530.

With regard to Mr Jones's dismissal from the Nuffield Orthopaedic Centre NHS Trust, this took place on 8 January 2001 when the Chairman notified Mr Jones by letter. The Board took the decision following Mr Jones's failure to attend disciplinary hearings set up to hear allegations of sexual harassment against him. During this time issues concerning management shortcomings and financial probity had also been raised which the Board concluded needed to be taken into account. All the while, Mr Jones had been on extended sick leave since July 2000, but he had confirmed his intention, by letter, to return to work on 29 January 2001.

In response to the termination of his contract, Mr Jones initiated legal action in the High Court claiming damages for breach of contract including wrongful dismissal. The original claim was for a sum in excess of £300,000.

For the impending court case, specialist employment legal advice was taken. However, after due consideration, it was concluded that the Trust would be more than likely to lose the case if it was taken to court. The principal conclusions that led to this advice were:

- It would not be possible to prove, to the standard required by the Court, that shortcomings in general and financial management were the personal responsibility of Mr Jones. To justify the action to dismiss him in the way he was, any management shortcomings attributed to him personally would have needed to amount to something close to gross misconduct; the Court would be highly unlikely to take that view.
- Notwithstanding the attempts which were made to hold a disciplinary hearing, the court would take the view that Mr Jones had been given insufficient opportunity to defend himself against the charges made.
- Even if the case was fought on the grounds of the original sexual harassment issues only, it would stand only a limited chance of success.

An out of court settlement has been reached. This avoided the need for a court hearing that may have been a significant drain on the public purse, damaging to staff morale and undermined local public confidence in the Trust. The settlement provided for Mr Jones to receive a lump sum compensation payment of c. £40,000 together with the preservation of his NHS pension rights, both an initial lump sum and an annual pension. In order to preserve his pension rights, the Trust was required to make a payment to the NHS Pension Fund of c. £155,000 thereby bringing the total cost of the settlement to the NHS of £195,000.

Mr Jones is currently working as Chief Executive with a charitable organisation, namely the National Back Pain Association. However, as stated by my colleague, Mr Foster, at the hearing, it is our intention to put in place a mechanism to ensure that cases like this one, result in the individual not being employed in the NHS again.

Department of Health

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[Continued

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## APPENDIX 2

### **Supplementary memorandum submitted by the former Chairman and Non-Executive Directors of Stoke Mandeville Hospital NHS Trust**

We feel that it is important that we should tell you of some of the problems which Stoke Mandeville Hospital NHS Trust faced during the year 1999–2000 which culminated in it breaching the Government's 18 months' waiting list target.

They included:

1. Being without a substantive Chief Executive from June 2000 until January 2001 and the resulting substantial workload that the Acting Chief Executive/Director of Operations was carrying.
2. A massive agenda which included one major and two smaller PFI schemes; the reconfiguration of clinical services and a proposed amalgamation of Trusts.
3. Cumulative cuts in budget over the previous three years which resulted in the closure of two wards, two theatres and the loss of 60 nursing and support posts.
4. A major outbreak of MRSA which closed 22 beds in February 2000 and prevented joint surgery for three weeks.
5. Lack of staff leading to the closure of 20 of the 100 surgical beds.
6. Lack of nursing home and other community provision resulting in 20 of the 100 surgical beds being blocked at any one time.
7. An increased number of referrals and increased complexity of cases both spinal and orthopaedic e.g. joint revisions/primary hips.
8. The absence through illness/maternity leave of three Assistant Directors of Operations and the inability to replace them on a temporary basis.

The policy of the Trust Board was clear and reinforced regularly at meetings, namely that no 18-month waiters would be allowed and that there were to be no irregularities in the management of its waiting lists. Information on the overall position against all Government targets, including numbers of 15, 16 and 17 month waiters was given each month to Trust Board members and waiting lists issues were a major feature of Trust Board meetings. Until October 2000, the Chief Executive of Stoke Mandeville Hospital NHS Trust was an acknowledged expert in waiting list management.

The Trust was required to deliver all the Government targets and pressure on management was immense. The hospital needed support and help, which was promised by the Region but not delivered. Indeed, it would be fair to say that the SE Regional Office and NHS Estates through their actions added to the workload and pressures on the Trust.

When the breach of the 18 month target was discovered, the Regional Office were immediately informed. There was no delay and no attempt to cover up. We would contend that there was no "collusion in fraudulent mismanagement of waiting lists on a wide scale at all levels of the organisation going back to 1998", which the Regional Chairman stated to the Chairman was the finding of the National Patient Access Team in February 2001. This finding was submitted to Ministers and was the basis on which the Chairman's resignation was required. The final report from the NPAT Team excluded all reference to fraud and collusion and none was found by the District Audit investigation.

Three of the four Non-Executive Directors resigned because of the failure of the Regional Chairman to consider their advice and in protest at their Chairman's enforced resignation.

Everyone involved with the hospital deeply regrets that some patients waited more than 18 months for treatment. Of the 131 patients involved, 64 were systems or administrative errors. They should not have occurred but they were not deliberate and there was no attempt to cover up. Twenty-four remain unclassified owing to the unavailability of notes as the patients were receiving treatment. The remaining 43 were deliberate suspensions. There can be no excuse for the suspension of the 15/20 unauthorised suspensions by a middle manager. There is, though, some disagreement as to whether the remainder should have been counted as breaches of the 18 month target. Some of these patients were offered alternative appropriate treatment plans but preferred to wait longer and some patients were awaiting the second of a bilateral procedure and were suspended until they were medically fit. The procedures followed at Stoke Mandeville in relation to these patients was similar to that followed elsewhere in the Region, however, District Audit counted both these categories as breaches.

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We feel that there were serious shortcomings in the manner in which the problems at Stoke Mandeville Hospital were handled by the SE Regional Office that exacerbated an unfortunate situation to the detriment of the NHS, the hospital, its patients and staff.

We hope that lessons will be learnt as to the way problems should be handled in the future.

Signed by:

*Gillian Miscampbell OBE DL*  
Past Chairman  
Stoke Mandeville Hospital NHS Trust

*Ian Taylor TD DL*  
Past Vice-Chairman  
Stoke Mandeville Hospital NHS Trust

*Alison Phillips OBE*  
Past Non-Executive Director  
Stoke Mandeville Hospital NHS Trust

*Glyn Andrews*  
Past Non-Executive Director  
Stoke Mandeville Hospital NHS Trust

*December 2001*

## Annex A

### STOKE MANDEVILLE HOSPITAL NHS TRUST 1994–2000

Stoke Mandeville Hospital is situated near Aylesbury in mid-Buckinghamshire. It is home to the National Spinal Injuries Centre and is an Acute General Hospital serving the needs of the population of mid-Buckinghamshire and parts of the adjoining counties of Bedfordshire, Hertfordshire and Oxfordshire. It hosts the Regional Burns Unit as well as well-established sub-regional specialities of Plastic Surgery, with clinics in Northamptonshire, Bedfordshire and Hertfordshire, and ophthalmology, rheumatology and orthodontics. It has about 520 beds and 2,170 wte staff. Around a quarter of a million patients attend the hospital each year.

Its site was, until 1999, approximately 90 acres and its buildings include wartime huts that suffer from subsidence, (six wards had to be taken out of use as a result in 1997–98) and are in constant need of repair. Backlog maintenance across the site is a significant issue. The Remaining buildings are 1970s Oxford method frame buildings, the National Spinal Injuries Centre built in 1995 as a result of the Jimmy Savile Appeal and some recent modern buildings such as the Maternity Unit. The most recent Cancer Care and Haematology Unit opened in 2001 was, like the Spinal Injuries Centre, built by charitable donations raised locally

Stoke Mandeville Hospital became a Trust in 1994. On 27 June 1994, Tom Sackville, the Minister for Health wrote to the then Chairman of Stoke Mandeville Hospital NHS Trust saying that the Business Case for capital development had Government approval. In June 1995, in a written answer to a question from David Lidington, the MP for Aylesbury, he replied “this scheme (Stoke Mandeville Redevelopment) has received Full Business Case Approval and is planned to start from 2 December 1995.”

Later that summer, the Trust was informed that their scheme needed to be tested against a potential PFI option and that they should run the Treasury funded scheme in parallel with a PFI scheme. This was done, though the field of potential consortia was not strong as this was a scheme which had already been approved for Treasury funding. In October 1995 Stoke Mandeville was informed that there would be no Treasury money for the scheme and the Trust would need to pursue a PFI solution. In 1996 following the collapse of the consortium the Trust advertised again and by July 1997 the Trust were just about to go to Preferred Bidder status with a second consortium. Meanwhile approximately £3,500,000 had been spent on the infrastructure required such as roads, drains, a roundabout etc. In 1997 the General Election took place and the Labour Government was elected. A stop was put to all PFI schemes whilst the new Government assessed the position and despite heavy pleading, SMH was not one of the 12 schemes, which were considered sufficiently advanced to gain approval. In 1998 SMH advertised for the third time for a PFI partner. That scheme has now reached the point of moving to Preferred Bidder status but has been temporarily on hold, as it has been one of the three pilot schemes involved in exploring alternative options for the management and future employment of Facilities Management staff.

There are three elements to the Stoke Mandeville Hospital site. About 40 acres to the south which belong to the Trust, the remainder being split into two tranches which were leased to the Trust but stayed in the Secretary of State’s ownership in 1994 when Stoke Mandeville Hospital gained Trust status. The presumption then was that, as the hospital was about to be redeveloped and would not require its full site, the surplus land

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would be sold and the proceeds would go some way to funding the Treasury approved scheme. Of the two tranches leased to the Trust but remaining in the Secretary of State's ownership, the middle tranche currently has the North corridor wards, the Coronary Care Unit and the Gastroenterology Unit all in wartime huts, and an operating theatre. The most northerly tranche accommodates a number of doctor's residences and three nursing accommodation blocks.

In 1998 the Anglia and Oxford Regional office sold, on a single tender basis, the most northerly tranche of land to Persimmon Homes for housing development, without advertising the site and without any reference to Stoke Mandeville Hospital who were in occupation of the site. It was a transaction that the Trust Board considered did not comply with guidance or best practice. When it learned of the sale, the Trust Board raised the question of the probity of the Regional Office's action with both the Regional Chairman and Chief Executive. NHS Estates (Leeds) later commissioned an Independent Enquiry by solicitors into the transaction. The Trust Board was not allowed to see their Report, which we understand criticised both individuals and the process that had been followed by the Regional Office. The Trust Board was, however, told by both the solicitors and NHS Estates (Leeds) that no blame attached to Stoke Mandeville Hospital, its Board or its employees. At a meeting held with representatives of NHS Estates (Leeds) and a Regional representative of NHS Estates in May 2000, the Board was promised an immediate letter for the record exonerating the Trust. Despite many reminders and much pressure, no letter was forthcoming until very recently, when a letter was, we are told, received by the new Trust Chairman.

As a result of the sale, the Trust was required to replace both the doctors' and nurses' accommodation that were on the Persimmon site. Negotiations took place with a number of Housing Associations and separate PFI bids were made for their replacement. In 1999, the Trust Board selected the Beacon Housing Association as the preferred bidder. However, the SE Regional office, who had taken over from the Anglia and Oxford office, stopped the deal going ahead, on the basis that the Trust should consider building on the site sold to Persimmon or the site still in the Secretary of State's ownership, options which had never before been offered to the Trust. Indeed, the Trust had been requested to clear the Persimmon site as soon as possible so as to give vacant possession to Persimmon. The Trust was told that the NHS Estates wished to renegotiate the deal with Persimmon. Because of the delay, substantial sums of money had to be spent on the old nurses' accommodation to make it acceptable for existing nursing staff and also fit for the nurses who were coming from the Philippines to ease the nursing shortage at Stoke Mandeville. As a consequence of the late intervention by NHS Estates, the scheme had to be re-advertised and started again from scratch.

To date neither the main PFI bid for the redevelopment of the hospital nor the PFI bids for the doctors' or nurses' accommodation have, as far as we can ascertain, been signed off.

In 1997-98 the Trust had reduced its maximum wait in all specialities to no more than 12 months. This was highly regarded by the local GPs and was in part instrumental in its success during the fund holding years. The Hospital's performance was the best in the County. The same year Bucks Health Authority decided that there was a need to equalise access across its three acute hospitals. Stoke Mandeville's income from Bucks Health Authority was reduced by £2 million. As a consequence and in order to balance the Income and Expenditure account, swingeing cuts were made, which included the closure of two wards, one surgical and one long-stay elderly, and two operating theatres, the loss of nursing posts and a tightening of the budget for management. Altogether 60 posts in nursing and support jobs were lost. Savings were made but with inevitable detriment to the waiting list position. In the year 1998-99 the Trust, as a result of very tight management, met its targets albeit with some difficulty. In 1999-2000, Stoke Mandeville was required to make a further saving of £1.6 million. There was always the underlying threat from Bucks Health Authority and the Regional Office that they would not approve Stoke Mandeville's PFI bid unless Stoke Mandeville Hospital met all its financial duties year on year. Additionally, the Regional Office and Bucks Health Authority insisted that fully worked up savings plans were in place, thus demonstrating that the PFI scheme would deliver the required savings. The Trust always held that savings at this level were unachievable given the number of patients requiring treatment and the deficiencies of the site. However, the Trust did achieve a further £1 million plus of savings in the year 1999-2000, ending with a deficit on the I & E account of £866,000. Despite this, through rigorous management, it met almost all its waiting list targets.

The Trust was awarded a whole hospital Charter Mark for its excellence in Public Service in 1996 and again in 1999.

Management of Stoke Mandeville Hospital was well regarded by the Region and the cost of management, as a proportion of income, placed it among the most efficient in management cost terms. From 1997-99 Ken Cunningham, the Chief Executive of Stoke Mandeville Hospital NHS Trust was appointed Chairman of the Anglia and Oxford Region Waiting List Task Force and was their representative on the National Waiting List Action Team. In 1999 he was appointed as a Member of the SE Regional Patients Access Team.

As a result of his Regional Waiting list responsibilities Mr Cunningham was regularly absent from Stoke Mandeville Hospital supporting other Trusts with waiting list problems. The Nursing Director of the Trust was also the Chairman of the Bucks and Northants Education and Training Consortium and the SE Regional Office's Nurse Champion for Improving Working Lives. She too was regularly absent on Regional duties

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during 2000. It is a matter of record that the absence of these two senior executives caused difficulties and the Chairman of the Trust, Gillian Miscampbell, raised her concerns with the Regional Office as to the amount of Stoke Mandeville Hospital senior management time being used by the Regional Office.

#### STOKE MANDEVILLE HOSPITAL 2000–01

Stoke Mandeville Hospital Trust Board always paid strict attention to the waiting list situation. Monthly reports were presented to the Trust Board by the Executive showing the overall situation against all Government targets, with specific information as to 15, 16 and 17-month waiters. Until the February 2001 Board meeting, when it was told of the Northamptonshire patient, no 18-month waiters or problems were notified.

The policy of the Trust Board was clear and reinforced regularly at meetings, namely that no 18-month waiters would be allowed and that all steps must be taken to prevent 18-month waiters occurring. This was stated regularly at Trust Board meetings and at individual meetings between the Chairman and Chief Executive. Attention was drawn to irregularities which were taking place elsewhere. This was the subject of discussion by the Trust Board and strict instructions were given that there were to be no irregularities in the management of Stoke Mandeville's waiting lists. In parallel with this, the Trust was cultivating a "no blame" culture in its endeavour to learn from mistakes and improve safety and service.

Regular reports were also presented to the Board as to waiting lists, the bed position, activity, staffing and the problems the hospital had in admitting elective patients. Discussion of these issues formed a major part of Trust Board meetings and very full briefing papers over and above the Board papers were provided to Board members. The Board relied on the information provided to it by the Executive. There was rigorous scrutiny of the information and data provided in which the Community Health Council representatives, who attended the Board meetings participated.

In April 2000 the Trust was made aware of three potential 18-month waiters. In accordance with the Trust's policy of openness and honesty, these potential breaches were immediately notified to the Regional office. In the event, no breaches occurred. However, the Trust Board were assured that steps had been taken by the Chief Executive, Ken Cunningham and the Director of Operations, Sue Nicholls to ensure that there would be no repeat of the problem. In addition the Region sent a representative to Stoke Mandeville in June 2000 to verify the waiting list situation and agree the management action that had taken place. We understand that she expressed herself satisfied with the steps that were being taken.

On 1 June 2000, Ken Cunningham was seconded for six months to Surrey and Sussex NHS Trust as Acting Chief Executive. It had major waiting list problems. Such Nicholls became Acting Chief Executive. She maintained her role as Director of Operations. Paul Martin, Chief Executive of the Two Shires Ambulance Trust joined Stoke Mandeville as Acting Deputy Chief Executive on a seconded basis to gain experience in the Acute sector. As Paul Martin was only due to be with Stoke Mandeville until November and had no experience of an acute hospital, he undertook specific projects that were time limited.

Three of Stoke Mandeville Hospital's four Assistant Directors of Operations were absent over extended periods of time through sickness or maternity leave, putting additional strain on Sue Nicholls in her Director of Operations role.

In August 2000, Surrey and Sussex advertised their Chief Executive post and Ken Cunningham was appointed. He gave six months notice at the end of October. It was acknowledged by the Regional office that Stoke Mandeville had a very extensive agenda and was short of management resources. The Chairman, Gillian Miscampbell, was asked to release Ken Cunningham immediately but refused to do so unless and until the Region provided additional support to Sue Nicholls. The Region gave assurances that support would be forthcoming if the Chairman released Ken Cunningham. The Chairman wrote to Barbara Stocking, the then Chief Executive of the SE Region, on 13 October, "As you know, the very strong advice that I am getting from both the clinicians in this hospital and from Non-Executive members of the Trust Board is that, bearing in mind the agenda we are facing over the next six months, we cannot continue with the present management arrangements till next April. Their strong view is that Ken Cunningham should work out his notice so as to enable this Trust to fulfil its agenda." Assurances were given that support would be forthcoming and the Board was told that it should commence procedures to find a replacement Chief Executive.

No support was forthcoming from the Region until in mid-December it was agreed that Lynda Atkins would join SMH from the Regional office as Acting Director of Operations on 8 January and that Paul Martin would extend his secondment until February 2001 to enable him to complete some of the projects in which he was involved.

For some time work had been being undertaken by clinicians on a potential clinical reconfiguration of services between Stoke Mandeville Hospital and the South Bucks Trust because of the clinical advice, which was coming from the Royal Colleges, and the training needs and working hours of junior doctors.

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*14 January 2002]**[Continued*

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In late December 2000, the two Chairmen were summoned to see William Wells, the Chairman of the SE Region, and told that the Regional Office had decided that the two Trusts should amalgamate. This was just before the scheduled interviews with the shortlist of candidates for the Chief Executive's position. As a result, two of the short listed candidates withdrew. During January 2001, meetings took place between the two Chairmen and two Chief Executives and on 7 February they were all summoned to see William Wells and Ruth Carnall, the Acting Regional Director of the SE Region, and told that it had been decided that the two Trusts were to amalgamate in April 2002.

This was always a very tight schedule and required a substantial amount of work if it was to be achieved. Stoke Mandeville expressed concern at the timescale in the light of the agenda it was already coping with and suggested that, bearing in mind the procedures that need to be followed and the consultation period required if an amalgamation was to take place, that either October 2002 or April 2003 were more realistic. However, we were told that the April 2002 date had to be achieved, notwithstanding the fact that the reconfiguration of clinical services discussions, which had been taking place for some time, between clinicians at the two hospitals, would not have been completed before the public consultation process commenced.

We understand that it has now been admitted that April 2002 is unrealistic and that the date has been put back to April 2003.

#### IMMEDIATE EVENTS SURROUNDING THE IDENTIFICATION OF 18-MONTH WAITERS AND THE RESIGNATION OF THE CHAIRMAN AND NON-EXECUTIVES

*23 January 2001*

A patient from Northamptonshire rang to enquire when she would be treated. Investigations showed that she had seen a consultant some 23 months previously and there had been an error between the consultant/his secretary, which resulted in that patient being omitted from the waiting list.

The patient was immediately given a "to come in" date. The Chairman and Trust Board were told of the situation the moment the information of the breach came to light and the Regional office was also informed. An investigation was started by the Hospital into what had gone wrong.

A thorough investigation led by Acting Director of Operations, manned by Stoke Mandeville Hospital and the local Primary Care Group staff, was established. Further breaches were identified, firstly of a similar nature with that consultant's list. Stoke Mandeville Hospital staff undertook a continuing thorough investigation of all aspects of waiting lists and daily reports were made to the Regional Office. There was no question of cover-up.

The Hospital requested an independent review from the Regional Office.

*Wednesday 7 February*

Sue Nicholls (Chief Executive) and Gillian Miscampbell (Chairman) were summoned to the Region at 9 am for a half hour meeting with William Wells (Regional Chairman) and Ruth Carnall (Regional Chief Executive), together and then separately. William Wells told the Chairman that, "she must consider her position; that she had two options—resign or be sacked." Ruth Carnall told Sue Nicholls that she could not continue as Chief Executive of Stoke Mandeville. As the Chairman was going to leave on 9 February, a meeting with William Wells was fixed for Monday 26 February, on the Chairman's first day back.

*Thursday 8 February*

Stoke Mandeville Hospital Trust Board met on its regular monthly meeting. This was followed by a meeting between the Chairman and the Non-Executive Directors. The purpose of the meeting was to report the content of the meeting with the Regional Chairman, William Wells, and the option of "resign or be sacked".

*Friday 9 February*

The Chairman went abroad on leave. She returned on Saturday 24 February.

*Saturday 10 February*

The Non-Executive Directors wrote to William Wells, the Regional Chairman, with a copy to Ruth Carnall, the Acting Chief Executive, saying "if failures are attributable to a Board Member, then they are attributable to the whole Board: we have collective responsibility and have collectively accepted in good faith the regular reports which have been made to the Board on this important issue." The Non-Execs set out the

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agenda facing the hospital and their view that “Given the excessively heavy agenda that the Trust is now shouldering, the removal of the Chairman and Chief Executive would have devastating consequences for . . . that agenda”

The replies from William Wells and Ruth Carnall were dismissive. William Wells described the letter to Gillian Miscampbell on the 26 February as “a silly letter from your Vice-Chairman.”

*Tuesday 13 February*

The National Patient Access Team (NPAT) visited Stoke Mandeville for one day from 7.30 to 3.30. They interviewed 12 people. They did not interview or ask to interview the Chairman or Non-Executive Directors.

*Wednesday 14 February*

The NPAT report was sent to Ruth Carnall, Regional Director of the SE Region. Stoke Mandeville Hospital was subsequently told that the Report had been submitted to Ministers. No draft or copy of the document was shown to the Chairman or any of the Stoke Mandeville Directors.

*Monday 26 February*

Gillian Miscampbell met William Wells. She was informed that the report was shocking; that it was the worst case ever; 160 long waiters had been identified, some going back four years. She was told that the Report was with Ministers and that there were findings of collusion in fraudulent mismanagement at the highest level. She was told that the situation was unforgivable and her position untenable. That the evidence of fraud and collusion would count against her with the Minister. William Wells quoted “this manipulation of the waiting list appears to be collusion on a wide scale and at all levels of the organisation since 1998”. Gillian Miscampbell was told that both Ken Cunningham and Sue Nicholls were implicated and that, whilst the Region would do their utmost to “save Ken, Sue Nicholls would have to go”. She was also told that she had the choice of being sacked or could resign. William Wells said that he would not wish for Gillian Miscampbell, after her long service, the ignominy of the Minister telephoning and sacking her, but that she would be sacked if she did not resign.

She was denied access to the Report on the questionable grounds that it was with the Minister. William Wells had a copy in his hand from which he quoted. The Chairman insisted on seeing the NPAT report before reaching a decision and it was agreed that, in common justice, she should have that opportunity. There was a Trust Board meeting on Thursday 1 March. It was agreed that she had to take that meeting and that the Report would be sent to her on Friday 2 March. She would consider it over the weekend and would speak with William Wells on Monday 5 March with her decision. On return, the Chairman informed the Non-Executive Directors of the content and outcome of the meeting with William Wells.

William Wells wrote to the Chairman after the meeting but sent it to the wrong address so that she never got the letter and only received a copy in response to another letter on 23 April. The letter said “The National Patients Access Team has now produced its report and I regret to say that their findings are that there has been a significant manipulation of the waiting lists which appears to arise from collusion on a wide scale and at all levels of the organisation since approximately 1998. Manipulation of the waiting lists on the scale which has been perpetrated by your Trust over the last three years is completely unacceptable and I hold you personally responsible as Chairman of the Trust Board”.

*Wednesday 28 February*

Gillian Miscampbell wrote to William Wells, in the light of what he had told her was in the Report, which neither she nor anyone at Stoke Mandeville Hospital had been allowed to see, that it was “her intention to submit her resignation”, but that she would speak to him on Monday when she had had a chance to see the Report.

*Thursday 1 March*

Stoke Mandeville Hospital had its regular Trust Board meeting. The Chairman arrived home late afternoon to find a fax from William Wells saying that he had seen the Minister, who had accepted her resignation, which had not been submitted, and that her “resignation would take effect from early next week and would be reasonably contemporaneous with the publication of the report” which she had not been allowed to see.

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*Friday 2 March*

The NPAT Report was faxed to Gillian Miscampbell in the late afternoon. A meeting was held with the Non-Executive Directors who were apprised of the Report's findings. Non-Executive Directors have never been sent a copy, and would not know to this day of its contents unless the Chairman had shared information with them.

Gillian Miscampbell considered the Report over the weekend.

*Sunday 4 March*

Gillian Miscampbell wrote to William Wells "Firstly may I make it absolutely clear that I have not yet resigned. Your letter and discussion with the Minister was somewhat premature". The letter stated that she was not prepared to resign and refuted any question of any charge of collusion or involvement in wrongdoing. "You really cannot expect me to resign and at the same time publish an unsubstantiated allegation." The letter went on to say that Gillian Miscampbell recognised that, "as Chairman, I am accountable to the Secretary of State for the performance of the Trust and I understand the political imperatives of having someone to blame. If, however, I am to be required to resign, I should tell you that any question of implied dishonesty on my part will be vigorously disputed by me and that this matter must be resolved before I am asked to take a decision. I am not prepared, after 20 years' service to the NHS, to have my good name brought into question by an unfounded allegation."

*Monday 5 March*

William Wells telephoned Gillian Miscampbell and agreed that she was justified in her concern and it was agreed that William Wells would write a letter exonerating the Chairman and Non-Executive Directors. His letter said, "I can confirm absolutely that the allegations as to how waiting lists were mismanaged bear no implications as far as the Chairman and Non-Executive Directors of the Trust are concerned. The details of the management of the waiting lists are not the responsibility of the Chairman or Non-Executive members of the Board; as a consequence any allegations that are made in the report do not apply to the Chairman or Non-Executive Directors.

However, as you realise and agree, the fact that there are a significant number of over 18 month waiters at Stoke Mandeville is the responsibility of the Chairman and Non-Executives and it is for the failure to deliver an essential plank of Government policy that the Chairman should resign".

The Region gave no publicity to this statement.

The briefing from the Region led to radio and television items and articles in the media of "mismanagement of the waiting lists, cover up, Chairman resigned".

(It should be noted that William Wells' letter of 5 March said that the Chairman "should resign". In a fax to her dated 1 March, he said "I have discussed this with the Minister and he accepts your resignation". Subsequently, the Minister confirmed 6 March as a matter of record as the date on which the Chairman resigned).

*Tuesday 6 March*

Resignation of Gillian Miscampbell took effect.

*Wednesday 7 March*

Three of the four Non-Executives resigned. Their offer to meet the Regional Chairman had been ignored and their advice dismissed out of hand. A further reason was the process and treatment of the Chairman, Gillian Miscampbell.

*Thursday 8 March*

The replacement Chairman was introduced to Stoke Mandeville Hospital.

*Monday 5 March*

Sue Nicholls attended a meeting with Ruth Carnall and was again told that she could not remain in post. She was shown a letter from the Director of the NPAT Team saying that reference to collusion should be dropped from the NPAT Report. She agreed to step aside pending an external enquiry.

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12 April 2001

Gillian Miscampbell wrote to Ruth Carnall asking to see the letter from the Director of the NPAT Team, "As Sir William quotes that statement as the basis on which my resignation was required, in common justice, I believe I am entitled to see that letter and to know if the current version of the NPAT Report still includes that statement, or if, as I have heard, there has been some amendment to the Report dated 14 February."

April 2001

Gillian Miscampbell received a copy of the final version of the NPAT report which excluded the sentences "On available evidence, this manipulation of the waiting list appears to be collusion on a wide scale and at all levels of the organisation since approximately 1998" and "Staff at all levels of the Trust either colluded in the inappropriate suspension of patients or should have known of the problem." These two sentences had been in the NPAT Report that had been sent to Ministers in February and as William Wells told Gillian Miscampbell on the 26 February "The evidence of fraud and collusion would count against her with the Minister".

26 April 2001

Ruth Carnall, Regional Director wrote to Gillian Miscampbell saying that "As a former Chairman you were not involved in day-to-day management and will not therefore be expected to know about detailed management arrangements. Copies of the Report . . . include the full text . . . The only change is in the reference to "collusion". This has been deleted as it is an inference, rather than established fact".

#### THE DISTRICT AUDIT INVESTIGATION

District Audit was asked to do an investigation by the new Chairman of Stoke Mandeville Hospital. They took evidence from a number of people including the past Chief Executive, Ken Cunningham, and produced a Draft Report, on which comments were made by most of those who had been given a copy. As far as we can tell, no account was taken of any of the comments made by the previous Chairman, Non-Executive Directors, Mr Cunningham, or Miss Nicholls; as a result the Report is, in our view, significantly flawed.

The Trust treated 22,000 elective patients each year. Of the 131 patients identified as long waiters, systems errors, where patients were wrongly classified or legitimate suspensions had not been lifted, accounted for 35 patients. This represents 0.19 per cent of the patients successfully treated. Administrative errors accounted for 29 patients, 0.13 per cent of those patients successfully treated. Whilst any errors in administration or systems are to be deeply regretted, it is difficult to know how that would compare with any other Trust, which underwent the same degree of scrutiny. Twenty-four patients are unclassified owing to the "unavailability of their notes as the patients were receiving treatment". Neither Stoke Mandeville Hospital's new management nor District Audit have been able or been prepared to give detailed information in respect of the 43 suspended patients. It has been impossible to ascertain how many of them were patients waiting the second of a bilateral procedure, patients who self deferred having declined a reasonable treatment plan or those patients who were suspended without reason.

There can be no excuse for this third category, which we understand amounted to 15 to 20 patients. They should not have been suspended and why Sue Thornton, the Business Manager for General Surgical Specialities, inappropriately suspended them will never be known. She was not given instructions to deal with these patients in this way by either her immediate superior, Nigel Pearce or by the Director of Operations/ Acting Chief Executive, Sue Nicholls or Ken Cunningham. On previous occasions when she had problems admitting a long waiter, she had brought the matter to the attention of her superiors for resolution. The Trust Board policy was clear. Patients had to be treated before 18 months and no irregularities in management were allowed. We understand that she has now retired. Despite the criticisms that may now be properly made as to her actions in relation to 18-month waiters, it should be noted that she was a good theatre sister and had done excellent work for the hospital in helping to set up the Day Surgery Unit, before being promoted to the position of Business Manager, General Surgical Specialities.

As to the first category, the patients who were awaiting the second of a bilateral procedure, the practice employed at the Trust was in common use throughout much of the South East Region. A second procedure was suspended until such a time as the patient was medically fit to undergo the procedure. This policy has, we understand, now been enshrined in the Trust's new Waiting List Policy, which has been signed off by the Modernisation Agency.

The second category was patients who could not be treated under their named consultant if the 18-month deadline was not to be breached. These patients were offered alternative treatment plans that included treatment by their consultant in the local private sector, treatment by another consultant within the Trust or treatment within a neighbouring Trust. Many patients accepted one of these alternatives but those who did not were suspended on a self-deferral basis. Prior to suspension, the patients gave their informed and written

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consent to this course of action, preferring to wait for their named consultant to treat them. Post suspension plans were agreed with them and their GPs were informed. District Audit counted both these categories of patients as breaches of the 18-month rule.

Some of the breaches arose because District Audit opted to apply Patient Charter definitions for calculating the total wait rather than Korner definitions, which have always been used at Stoke Mandeville and many other Trusts in the Region. All Trusts are required to base their monthly performance reports to the Regional Office on Korner definitions and as a result it has been common practice to manage waits using the same definitions. As previously stated, neither the Trust nor District Audit have been able to provide information to support their declaration of 131 18-month plus waiters and as a result it is not possible to ascertain how many of the alleged breaches have arisen for this reason.

#### MATTERS WHICH SHOULD BE TAKEN INTO ACCOUNT

It is to be deeply regretted that Stoke Mandeville Hospital failed in its duty to treat all patients within the 18-month target but some consideration needs to be given to the problems the Hospital faced:

- The agenda the hospital management faced was enormous. Through no fault of its own, it had had to manage three attempts at a major PFI redevelopment with all the attendant problems and workload.
- It was also running separate PFI proposals for doctors' and nurses' accommodation, which because of the land issues had to be re-worked, and a separate project for a Private Patients Unit.
- There were major land and building problems because of the elderly nature of the estate, and the dubious arrangements for the sale of the leased land.
- The re-configuration of services and the demand for the amalgamation of Stoke Mandeville Hospital NHS Trust and South Bucks NHS Trust by April 2002.
- The increased number of referrals to the hospital over the past two years confirmed by the recent visit and audit by the Modernisation Team.
- The increased number of complex operations, both spinal and orthopaedic eg hip revisions which can take approximately six hours if bone grafting is required, compared to one and a half hours for a primary hip.
- The need to meet the overall target of no more than 5,101 patients on the waiting list plus the other waiting list targets, against the background of the shortage of beds, staff and appropriate theatre time.
- A major MRSA outbreak which necessitated closing 22 surgical beds in February 2000 and prevented joint surgery for three weeks.
- A shortage of staff which resulted in about 20 of the 100 surgical beds being closed at any one time.
- A failure of provision in the community which resulted in a further 20 surgical beds being blocked at any one time.
- The loss of its Chief Executive and the failure of the Regional Office to fulfil its commitment to provide support.
- The amount of Executive management time that was being provided to the Region by the Chief Executive and the Director of Nursing.
- The absolute requirement to meet its I & E Budget if the Region and Bucks Health Authority were to sign off the PFI proposals.
- The cumulative cuts in Stoke Mandeville Hospital's budget over the previous three years and the effect on the Hospital as a result of those cuts by way of loss of beds, theatre time and staff.
- The absence through illness or maternity leave of crucial Assistant Directors of Operations and the inability to replace them on a temporary basis.
- The very substantial workload which Sue Nicholls and the management team were carrying.

The District Audit Report did not find that there was "collusion in fraudulent mismanagement of waiting lists on a wide scale at all levels of the organisation going back to 1998", as was stated by the Regional Chairman and alleged in the original NPAT Report. It did find that "there was no indication that a major problem was developing or that concealment was taking place" and it concluded "that from the information available to them, Board Members could not have suspected any concealment. Had they done so, we are confident that a serious view would have been taken".

As Chairmen and Non-Executive Directors of the Trust, we have complete confidence in the probity of both Mr Cunningham and Miss Nicholls. Had either of them known of the 18-month problem, we would have been immediately informed.

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One middle-ranking member of staff suspended 15 to 20 patients without any authority so to do because, as we understand it, she misguidedly thought she was protecting the reputation of the hospital. There were a number of administrative and systems errors, which should not have occurred. There were also a number of patients who, in our view, should not have been counted as 18 month plus waiters as they had either preferred to self defer or were waiting for a second procedure.

Stoke Mandeville is an excellent hospital. The way this matter was handled took no account of the well being of the hospital, its patients and staff. No one should condone wrongdoing and no one on the Trust Board would have done so. The actions taken, apart from the real damage that was done to individuals, damaged the hospital's reputation, its ability to keep good staff, its ethos and being. It has also led to a growing concern within the Health Service generally of the "Blame and Shame" culture which has led to a number of people being required to resign though no blame could personally be attached to them. Ministers appoint and can remove Chairmen, but given that position, Ministers have a responsibility to act reasonably and fairly in the public interest. There are also questions as to whether the way this matter was handled met the standards of probity, governance, natural justice and fairness that should be mandatory in the Public Service.

Everyone involved with the hospital deeply regrets the fact that a number of patients waited longer than 18 months and that the Government's target was breached.

However, the hospital and its staff needed support to overcome the problems, some of which had been needlessly exacerbated by the Regional Office.

One has to ask who has benefited from the manner in which this matter was dealt with, certainly not the NHS, patients or indeed Stoke Mandeville Hospital and its hardworking, committed and conscientious staff.

*Gillian Miscampbell OBE DL*  
Past Chairman  
Stoke Mandeville Hospital NHS Trust

*Ian Taylor TD DL*  
Past Vice-Chairman  
Stoke Mandeville Hospital NHS Trust

*Alison Phillips OBE*  
Past Non-Executive Director  
Stoke Mandeville Hospital NHS Trust

*Glyn Andrews*  
Past Non-Executive Director  
Stoke Mandeville Hospital NHS Trust

*December 2001*

### APPENDIX 3

#### **Correspondence from Mr Antony Fletcher, Chairman, Ethical Audit, to the Chairman of the Committee**

For some time we have been attempting to draw attention to the mismanagement of surgical waiting lists, and hoping to persuade the three Royal Colleges to bring them back under Consultants' control.

I enclose our Audit Report on this, together with a startling account of one surgeon's recent experience (**Annex A**).

#### THE MANAGEMENT OF SURGICAL WAITING LISTS

"Patients should be selected for admission from the waiting list by the Consultant or his nominee."

"No patient should be removed from the waiting list without the permission of the Consultant."

From "Guidelines for the Management of Surgical Waiting Lists" issued by the Royal College of Surgeons in June 1991. The College say that there is nothing more on this topic issued since then.

It is obvious common sense, as well as proper clinical practice, that medical consultants should have total control of their waiting lists, and take full responsibility for the patients listed. Only they can make a fully informed medical assessment of each patient's condition and needs. Such decisions should never be taken by someone without medical qualifications. If through pressure of work the consultant needs to delegate these decisions, this responsibility must be delegated to a medically qualified assistant who will now which cases need to be discussed with the consultant, who ultimately is always responsible.

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Inevitably financial and other resources of the NHS are limited, and decisions regarding medical priority need to be taken in the light of resources available both now and later. Here hospital management has the responsibility to negotiate with consultants as to how the hospital budget should be apportioned. Then it will be for the consultant to decide on the priorities appropriate for each patient's condition.

All these self-evident points, laid down 10 years ago in consultation with the Department of Health, have been slowly eroded. In many instances consultants have lost control of their lists, which have been manipulated by administrators without the consultant's approval. The consultants have been obliged to treat or operate upon patients produced in the order laid down without their control. They may disagree strongly with the priority decided by others, but if this is challenged there may be repercussions.

There is plenty of evidence that waiting lists are being influenced by political considerations so that the Government can claim that lists have been reduced without revealing that this is not because patients have been treated but because their priority has been "adjusted" by the Health Authority, under pressure from the Department of Health. This is a disgraceful form of window dressing, which, far from helping patients, can only act to their disadvantage.

It is proposed that the Royal Colleges of Surgeons, Physicians and Gynaecologists should be asked to provide an up-to-date comment on whether they agree with this derogation of medical responsibility and, if not, what action they will take to return it to that described in the 1991 Guidelines.

*Antony Fletcher*  
Chairman  
Ethical Audit

*November 2001*

#### **Annex A**

Over a weekend the urology waiting list was "reduced" by 340 patients.

On enquiry I was told that patients who required operations/procedures that did not occupy a hospital bed were no longer to be counted as on the waiting list. These patients include those who would be waiting for diagnosis/treatment of conditions such as bladder cancer and patients waiting for lithotripsy treatment for their kidney stones. There can be no valid reasons for excluding these patients from the list of those "waiting for treatment," apart from cynical manipulation of the figures.

In addition, should additional resources become available to further reduce waiting lists—as sometimes happens—this group of patients will no longer have access to these funds, because they are no longer on the list. Thus they will have to endure relatively longer waits.

There is absolutely no doubt that successive government initiatives have distorted clinical priorities. Over the years there has been great pressure to expand day surgery, not only because it is efficient, but also because with simple and short procedures large numbers of patients can be rapidly removed from the waiting list. The result is that patients with more complex problems have to wait considerably longer for their treatment as there are less inpatient places on the operating list, which are more expensive than day cases.

For example: if you have an inconvenient ganglion on your wrist you will wait for three to six months, but if you cannot walk properly because of a defective hip, you will have to wait for one to two years. In my department, if you have an irritable penis which requires circumcision, the average wait is four months, but if you are over 65 and cannot get a night's sleep because you have to get up four or five times, you will have to wait an average of 14 months for your prostate operation. It is not difficult to assess which of these deserves more rapid treatment.

Turning to the much vaunted two week wait for patients with possible cancer, though we have to see these patients within two weeks of referral from their GP, there have been no additional staff or other funding to facilitate this. As a result an 80 year old man with possible early prostate cancer—low clinical priority—is seen very soon but a 40 year old with a kidney stone causing potential long term kidney damage—high clinical priority—now has to wait even longer to be seen, because he or she does not have cancer!

In addition, even though we see cancer patients quickly, it is seldom possible to make a firm diagnosis at the initial consultation, so further tests are necessary. Because of the shortage of pathologists and radiologists this part of the process takes as long or longer than before, so there is no overall benefit to these patients. Yet the Government can legitimately claim that all patients with possible cancer are being seen within two weeks, which makes for good public consumption.

There are several flaws in the new proposals, particularly relating to the waiting times from referral to treatment. At first glance these seem sensible, but generally they are thoroughly impractical. For an easily identifiable condition such as a hernia, it is simple to measure the time between the GP's initial diagnosis and the operation. But for something more difficult to assess, there can be many different circumstances that will

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affect the time from referral to treatment, and this will distort the figures. For difficulty in passing water, I might decide to operate and will put the patient onto the waiting list; or I may want more information and arrange tests. Then drugs might be tried, and only if these fail will I decide to operate. There are innumerable similar examples.

My latest problem describes just how little control we have of clinical priorities. The Trust is overspent and the telescopes which I use to remove kidney stones are broken and will cost £3,000 to repair. I also have a patient who has been waiting 17 months for a penile prosthesis which costs £3,000. My clinical view is that the repair of the telescopes should have priority, but this has been rejected because if the penile prosthesis patient waits any longer he will slip over the 18 month wait limit and the hospital will be in trouble with the Region. Once again clinical judgment is rejected by administrators.

*Byron Walmsley FRCS*  
Consultant Urologist  
St Mary's Hospital  
Portsmouth

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SESSION 2001–02

		<i>Publication Date</i>
1	Managing Risk in Government Departments (HC 336) .....	23/11/01
	Government Reply (Cm 5393) .....	14/02/02
2	Improving Construction Performance (HC 337) .....	05/12/01
	Government Reply (Cm 5393) .....	14/02/02
3	The Cancellation of the Benefits Payment Card Project (HC 358) .....	06/12/01
	Government Reply (Cm 5393) .....	14/02/02
4	The Renegotiation of the PFI-type Deal for the Royal Armouries Museum in Leeds (HC 359) .....	12/12/01
	Government Reply (Cm 5450) .....	28/02/02
5	Ministry of Defence: Major Projects Report 2000 (HC 368) .....	28/11/01
	Government Reply (Cm 5450) .....	28/02/02
6	Ministry of Defence: Major Projects Report 2000—The Role of the Equipment Capability Customer (HC 369) .....	28/11/01
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7	Sale of Part of the UK Gold Reserves (HC 396) .....	19/12/01
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13	Regulating Housing Associations' Management of Financial Risk (HC 470) ..	09/01/02
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14	The Millennium Dome (HC 516) .....	01/02/02
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15	How English Further Education Colleges can Improve Student Performance (HC 528) .....	07/02/02
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16	Access to the Victoria and Albert Museum (HC 559) .....	14/02/02
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17	Ministry of Defence: Maximising the Benefits of Defence Equipment Co-operation (HC 586) .....	15/02/02
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18	Inland Flood Defence (HC 587) .....	01/03/02
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23	Report on Inland Revenue Appropriation Account (HC 631) .....	22/03/02
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29	Non-competitive Procurement in the Ministry of Defence (HC 370) .....	19/04/02
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