Witness Name: Robert Nicholls CBE

Statement No.: WITN7522001

Exhibits: WITN7522002-004

Dated: 31 January 2023

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF ROBERT NICHOLLS CBE

Contents

Section 0: Opening Comments

I, **Robert Nicholls CBE**, will say as follows: -

0.1. My full name is Robert Michael Nicholls, although I am commonly known as Bob. I was born on GRO-C 1939. My address is known to the Inquiry.

0.2. I am providing this witness statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 16 November 2022, which focuses on when I undertook various roles in the South Western and Oxford Regions between 1981 and 1992.

General Remarks

0.3. I am very grateful for the opportunity to contribute to the Inquiry and wish to begin my statement by making a few brief opening comments.

0.4. This first is to express my deepest condolences to those who have been infected and affected by this tragedy. I have the greatest sympathy for the people whose lives have been impacted by what happened and I hope that the Inquiry is able to at least provide them with some answers. I am, therefore, concerned to assist the Inquiry as far as I can.

Limitations of this Statement

0.5. I hope that what I set out below is of some use in trying to piece together a full understanding of events, however it is now around 30 years since I left my role at the Oxford Regional Health Authority ("ORHA"), and more than 40 years since I was working in the South West.

0.6. In preparing this statement I have reviewed copies of documents supplied by the Inquiry and some further material that has been made available to me by the Government Legal Department. Where relevant, or of more general assistance, I have exhibited this below.

0.7. My independent recollection of these matters is, however, limited and - at the age of 83 - my memory of past events is not what it used to be. In respect of some of the issues raised in the Rule 9 request, I have no recollection of the specifics and I am completely reliant on the documents that I have been

provided with. When that is the case I have said so, and have tried to reflect on why I may have taken a particular view.

0.8. I have therefore endeavoured to answer the Inquiry's questions as fully as I am able to, despite these limitations of time and available documentation.

0.9. If more documentation comes to light then I will add to, or amend, the below accordingly.

Structure of this Statement and Exhibits

0.10. A table of contents is included at page 2 of this statement for ease of navigation. I have adopted the same section numbering that is used by the Inquiry in its request.

0.11. Where a document has been drawn to my attention by the Inquiry or is already available on the Inquiry's database, I have included the document ID number in the body of this statement. Any other documents I have exhibited as my own.

Section 1: Introduction

1.1. I have been asked to set out my professional qualifications and employment history.

1.2. In terms of professional qualifications, these are as follows:

1.2.1 BA (Hons) Geography, Upper Second, University College of Wales (1961)

1.2.2 Diploma in Social Administration, University of Manchester (1963)

1.3. In 1965 I also obtained a Diploma in Health Service Management and later became a fellow of the Institute of Health Services Management in 1993.

1.4. As for employment history, I have set this out in the table below:

Table 1 – Employment History

1961 to 1964	National Administrative Trainee, University of Manchester (attached to the Liverpool Region)
1964 to 1972	Variety of posts in commissioning, planning and operations at district and hospital level in Torquay and London, including Assistant Clerk to the Governors at St Thomas' Hospital
1972 to 1974	Deputy Group Secretary, Southampton University Hospital Management Committee In this role I had special responsibility for liaising with the new medical school, managing para-medical departments, and commissioning new developments.
1974 to 1977	District Administrator, Southampton and South West Hampshire Health District (Teaching) I was the Chief Operating Officer and Co-ordinator for the District Management Team. This was a multi-district area, serving a population of 375,000 with a revenue budget of £65 million.
1977 to 1981	Area Administrator, Newcastle Area Health Authority (Teaching) As the Area Administrator I was the Chief Operating Officer, Co-ordinator of the Area Management Team, and Secretary to the Authority. The Area served a

	population of 300,000 with a revenue budget of £85 million.
1981 to 1985	Regional Administrator ("RA"), South Western Regional Health Authority ("SWRHA") In the early 1980s this Region had a population of just over 3 million. It employed approximately 500 staff, including consultant medical staff at the local hospitals. I was responsible for leading the planning and development of health services, and monitoring performance, in the Region. I was also Secretary to the Authority and co-ordinated the Regional Management Team.
1985 to 1988	District General Manager ("DGM"), Southmead District Health Authority ("DHA") As DGM I was Secretary to the Authority and leader of the District Management Team, which provided health services to a population of approximately 260,000 in and around the Bristol area. The DHA had an £80 million revenue budget and major capital programme. It employed around 2,500 staff.
1988 to 1992	Regional General Manager ("RGM"), ORHA, and Chief Executive from 1991 In this role I was Secretary to the Authority, Senior Responsible Officer ("SRO") and leader of the Regional Team of Officers ("RTO"). The Region had a population of approximate 2.8 million at the time and so the ORHA was given a £1,000 million revenue and capital budget. It employed around 800 staff, including medical consultants whose appointments and contracts were made through the Authority until the establishment of Foundation Trusts in the early 2000s.
1993 to 1995	Executive Director of the London Implementation Group and member of the NHS Executive I was charged with supporting ministers and Health Authorities, HEFCE and the University of London to make changes to London's health service and medical education following the Tomlinson Report. The Group had a £2 million direct budget and 35 whole time equivalent staff, who I managed.
1995 to 1996	Project Director for the North Thames Region and member of the NHS Executive In this position I explored and developed interactions between service, education and research systems. I

	led a number of national projects, including the development of a primary care led NHS and the securing of funding for post-graduate medical and dental education.
1996 to 2008	Health Service Management Consultant Working independently, I led service and organisational reviews and assisted with strategy, development and change management for Health Boards and NHS Trusts across England and Northern Ireland. I advised the British Council and overseas health systems on health reform and management, and also provided managerial advice to a private sector health company.

1.5. I retired from the NHS in 1996 although, as above, continued to work as an Independent Consultant for just over 10 years. I also held a wide range of non-executive, council member, chair and trustee roles in private, public, and professional regulation, as well as charity organisations:

1.5.1 Non-Executive Director for the Nestor Healthcare Group plc (1996 to 2003)

1.5.2 Lay Member of the General Medical Council ("GMC") and Chair of the Preliminary Proceedings Committee (1996 to 2006)

1.5.3 Health Management Adviser (part-time) to the British Council, later Associate Consultant (1996 to 2006)

1.5.4 Chair of the National Clinical Assessment Authority (2003 to 2005)

1.5.5 Regional Commissioner in London (part-time) for the National Health Appointments Commission, later Vice Chair of the Board (2005 to 2008)

1.5.6 Chair of the General Pharmaceutical Council ("GPC") (2009 to 2014)

1.5.7 Chair of the Intensive Care National Audit and Research Centre Charity (2015 to 2018).

1.6. I was appointed a Commander of the Order of the British Empire for my services to health care as part of the Queen's Birthday Honours in 1995.

Memberships

1.7. I have been asked to set out my membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference.

1.8. I have always had particular interests and involvement in the education, development and pay of staff; in health promotion; and working with professionals in resource utilisation. I doubt much of my work in relation to this will be of relevance to the Inquiry, although I have set out my more significant memberships below for the sake of completeness.

1.9. From the 1960s through to the late 1990s I was a member, then Chair, of the October Club, which was an administrators' discussion group. I co-authored the paper 'Too Many Tiers?', which was about the 1974 NHS re-organisation and led to an audience with the then Secretary of State, Sir Keith Joseph.

1.10. Throughout the 1970s and 1980s I was a member of regional and national councils of the Institute of Health Service Management (see paragraph 1.3 above). I was elected National President for the Institute between 1983 and 1984. In partnership with the Royal College of Physicians, we devised and launched the Medicine for Managers Programme in 1988. This was a programme of seminars for health service managers who were not medically qualified. It aimed to improve relations with doctors by explaining how those in different specialties worked, the challenges they faced, and the implications for the future of changing patterns of disease and advances in medicine. The programme ran for several years.

1.11. In the 1970s I was a member of the King's Fund Education Committee and of the Thwaites' Working Party on Senior Management Development.

1.12. Between 1983 and 1985, and then again between 1989 and 1992, I was a member of the Regional Health Authority ("RHA") Chairmen's Sub-Group on Pay.

1.13. I was a member of the Health Education Council, Chairman to the Information Technology Advisory Group and a member of their Executive Committee between 1984 and 1987.

1.14. In 1986 I was a member of the NHS Training Authority Management Education Review Working Party.

1.15. As is set out in more detail below, whilst I was the DGM for Southmead I was nominated by RGMs to be part of a Steering Group (1986 to 1987). This was a joint group, comprising of representatives from the NHS and the Department of Health and Social Security (later the Department of Health) ("DHSS/DH"), which focused on how the Blood Transfusion Service ("BTS") was being managed across the country.

1.16. I was a member of the National Blood Transfusion Service ("NBTS") Co-ordinating Committee in 1989, which I also go into greater detail about below.

1.17. In Oxford, as RGM, I attended the Academic Board of the Medical School and was a member of the Common Room, Green College; External Associate of the Health Care Management Institute, Templeton College; Associate Fellow and later Alumni of Templeton and Green Colleges; and a member of a Research and Ethics Committee.

1.18. Between 1988 and 1998 I was a member, then Chairman, of the Management Advisory Service Trustees.

1.19. For two years, from 1991, I was a member of the Interim Joint Consultants Committee.

1.20. Between 1992 and 1993 I was a member of the Calman Working Party on medical education and training.

1.21. From 1992 to 1996 I was a member of the Chief Executives / Chief Medical Officer's Working Group with the medical profession.

1.22. During my time as a lay member of the GMC:

1.22.1 I was involved in committees and working groups and helped to produce guidance documents on management for doctors. The first, 'Management in Health Care: The Role of Doctors', was published in 1999. The second, 'Management for Doctors', was published in 2006; this contained more general advice and guidance as a supplement to 'Good Medical Practice'. I can provide copies of these to the Inquiry if required.

1.22.2 I gave evidence to the Shipman Inquiry (2002 to 2005), on behalf of the GMC.

1.22.3 I was also the GMC's nominee to the Royal College of Physicians Working Party on Medical Professionalism from 2004 to 2005, which produced the report 'Doctors in Society'.

1.23. As Chair of the GPC, I frequently attended meetings with other regulators and also served on the Medical (later "Health") Education England Committee.

Involvement with other Inquiries, Investigations or Litigation

1.24. I have not provided evidence to, nor been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and / or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products.

Section 2: My Roles at South Western and Oxford Regional Health Authorities (the "SWRHA" and the "ORHA")

The South West

2.1. Whilst in the South Western Region in the 1980s I held two distinct roles. As is set out above in Table 1, I was first the Regional Administrator ("RA") for the SWRHA from June 1981 until March 1985. Then, from April 1985 to August 1988, I was the District General Manager ("DGM") for Southmead District Health Authority ("DHA"), which was a separate statutory authority.

2.2. My functions and responsibilities as RA for the SWRHA included co-ordinating the Region's Management Team, acting as Secretary to the RHA, as well as leading the planning for, and developing the overall management of, the health services in the South West.

2.3. When RA, I was accountable to the SWRHA's Board (see below) through its Chairman, who was Sir Brian Bailey at the time I started. He was then succeeded by Vernon Seccombe (later Sir) in 1983.

2.4. I recall that the South West Region had a reputation for innovation and collaboration on big strategic issues. In addition, it contributed to national attempts to refine the financial allocation system through the membership of the Resource Allocation Working Party ("RAWP") of Trevor Rippington, now deceased, who was the Regional Treasurer. The South West, through the work of David King (District Administrator and then DGM for Exeter), also took the lead in getting patients in large mental institutions out into smaller units in local communities.

2.5. Some of the major challenges I had to deal with as RA for the SWRHA were: the development of decent information systems (a project which was being led nationally by the SWRHA's Vice Chair, Edith Korner, now deceased); the constant push upwards to try to get fair revenue and capital allocations and

doctor training posts; and a constant push downwards on DHAs to produce "efficiency savings".

2.6. I moved to Southmead DHA in April 1985, after having failed to obtain the RGM position for the SWRHA. This was instead taken up by Catherine Hawkins, who had been appointed the RHA's Nursing Officer ("RNO") in 1984 and was previously the Head Nurse at the RVI in Bristol.

2.7. In my role as DGM for Southmead I was responsible for managing the full range of health services being offered to North East Bristol and North Somerset. I was accountable to the DHA and its Chairman, who I recall at the time was a Mr Mellor.

2.8. I remember that a major priority whilst I was DGM was the introduction and development of organisational arrangements. This included innovative work in developing information and budgeting systems. A further priority was the development of plans for rationalisation of clinical services in the District in collaboration with a wider plan for Avon and a push for capital to assist its implementation.

2.9. In terms of the SWRHA's general structure, it initially operated on the basis of consensus management. This had been introduced following the 1974 reforms and first major re-organisation of the NHS. By the time I was involved, aspects of the management of public health and primary care had been brought together. The Authority operated on the basis of the management arrangements set out in the well-known "Grey Book" ('Management Arrangements for the Reorganised NHS', DHSS, HMSO London, 1972).

2.10. When I started as RA in 1981, there was a large Board of around 18 appointed and nominated members, with a non-executive chair appointed by the Secretary of State and the Regional Team of Officers ("RTO") in attendance. The RTO comprised of various individuals, including (although not limited to) the Regional Medical Officer ("RMO") (at the time, Dr Martin Reynolds), RNO, Regional Treasurer, and the RA (also Secretary to the Board). Sometimes other senior officers attended meetings, such as Regional supplies, personnel, and works officers. The Director of our Regional Transfusion Centre ("RTC"), like others, may have attended occasionally. The purpose of the RTO was to bring

the heads of key management functions together and for all major decisions to be reached by consensus.

2.11. Although there may have been a Regional Scientific Officer at the SWRHA, they were not a member of the RTO and I cannot assist as to the nature of their role or responsibilities.

2.12. In 1982 there was then a further re-structuring of the NHS, during which time DHAs were set up. Avon Area Health Authority was replaced by Bath, Bristol, Frenchay and Southmead DHAs.

2.13. This was followed, one year later, by a more business-like model being introduced. This was as a result of the Griffiths Report, published in 1983, which recommended adopting the general management function at all levels. General Managers were proposed for RHAs and were to be appointed after competitive processes. Applications were encouraged from outside the NHS, as well as from health professionals. A number of individuals with different backgrounds were appointed, which was one reason why the GMC produced the guidance I have referred to at paragraph 1.22.1 above.

2.14. The SWRHA received funding from the DHSS/DH. This was by way of an annual revenue allocation, based on a weighted capitation formula with allowances for demography and other factors. I believe there may have been some specific, additional funds earmarked for particular services or projects. This could have changed over time, although I do not recall that happening whilst I was at the SWRHA.

2.15. If the SWRHA wanted to seek additional funding from the DHSS/DH, I recall that both formal and informal routes were used. Advanced submissions on operational plans and budgets would have been made, along with submissions or business cases for major capital projects. Less formal approaches, such as the Regional Chair approaching ministers directly, might have also been adopted, although I have no documentation to assist the Inquiry in this regard.

2.16. The SWRHA's geographical remit was fairly broad, stretching from the north of Gloucestershire to Cornwall and the Isles of Scilly. At the time I was there, there must have been over a dozen major acute general hospitals, 5 or 6 large mental hospitals and many smaller hospitals and other facilities within the Region. I

can only recall there being one haemophilia centre in Bristol, at the Royal Infirmary, but there may have been more. I have had sight of scans of a Directory, printed by the Blood Products Laboratory ("BPL") in collaboration with the Haemophilia Society in 1991 **[HSOC0017344]**. It indicates that, by then, there was a regional haemophilia centre in Exeter; haemophilia centres in Bristol, Plymouth, Taunton, Torquay and Truro; and one associated haemophilia treatment unit in Barnstaple (pages 29-31).

2.17. There was also a National Tissue Typing Reference Laboratory at the Southmead Hospital site.

2.18. As far as I can recall, there was no overall system regulator for the SWRHA in the 1980s. It was not until the late 1990s that organisations such as the Commission for Health Improvement ("CHI") and the National Institute for Health and Care Excellence ("NICE") started to be set up. The Care Quality Commission ("CQC") was not established until 2009. Workers and health facilities in the Region were, nevertheless, subject to reports and inspections from professional and academic bodies, as well as environmental and health and safety regulators.

2.19. The SWRHA was accountable to the DHSS/DH and formal, annual reviews with ministers were introduced around 1982. The agendas for these were prepared by DHSS/DH Regional Liaison Officers and agreed with the RTO in advance. The meetings themselves could be wide-ranging, although often focused on financial performance, the implementation of national policies, policy initiatives, major capital developments, and any serious complaints or enquiries. They were taken very seriously by the Regional Chair and the RTO; I recall they were an important part of the accountability chain, although were generally held in a constructive spirit.

2.20. In addition, Regional Chairmen, RGMs and other professional Officers had regular meetings and contact with their colleagues from other regions and DHSS/DH officials. Contact with the DHSS/DH was often through designated DHSS/DH Liaison Officers, but also along professional functional lines.

2.21. I think the degree of oversight or influence exercised by the DHSS/DH over RHAs depended on the level of confidence the Department had in each region's

performance and its relationship with key players. Adverse media coverage would, also, tend to increase communications. In the South West, the Region was generally trusted to implement policy that was coming from the Department, although I do remember that the DHSS/DH had a greater interest in the Region when there was the sort of shift I have referred to above from large mental health institutes to smaller units offering community care.

2.22. I have been asked to describe the nature and extent of any relationship between the SWRHA and the BPL. Although I am aware that RTCs were supplying the BPL with blood plasma, there was no direct relationship between the Authority and the BPL as far as I can recall. I certainly do not remember having any involvement in discussions between the South Western RTC and the BPL.

The ORHA

2.23. In September 1988 I was appointed Oxford's RGM and was in the role for just over four years, until November 1992. In 1991 I became Chief Executive to the Authority.

2.24. I had strategic, developmental and performance management responsibilities for health services across the Oxford Region. My role was, therefore, very wide-ranging, and centre-driven policy changes seemed to increase during my time at the ORHA. An early priority was the implementation of a Nurse Grading Structure, which caused both national and regional protests and disputes. There were national proposals for changing supplies and estates services, which required internal and external discussions and planning. Another major priority was the overhaul of the Region's capital programme to be funded substantially by land sales for housing, which turned out to have been grossly over-estimated. The national industrial action taken by the Ambulance Service in 1989 also impacted on my role; as Oxford managed its own Service, I became involved in time-consuming talks with the Advisory, Conciliation and Arbitration Service ("ACAS") to help to try resolve the dispute.

2.25. Whilst at Oxford I was accountable to the RHA through its Chairman, who in turn was accountable to the Authority and the Secretary of State for Health. It became increasingly clear during my time at Oxford, however, that there was

an additional line of accountability for RGMs (and later Chief Executives). This was because RGMs were also Senior Responsible Officers ("SROs") for their organisations. As the SRO for the Oxford Region, I was, therefore, also accountable to the Chief Executive of the NHS, who was Duncan Nichol (later Sir), although reporting was often through Regional Liaison Officers.

2.26. At the time I started with the ORHA, and until his retirement in 1990, the Regional Chairman was the long-serving Sir Gordon Roberts. In my last two years at Oxford he was succeeded by Sir Stuart Burgess, formerly Chief Executive of Amersham International. It was during Sir Stuart's term as Chairman that I felt my SRO line of accountability to the NHS Chief Executive was emphasised.

2.27. The RMO for the ORHA was the late Dr Ronnie Pollock, although towards the end of my time at Oxford he retired and Dr Muir Gray became the Director of Health Policy and Public Health.

2.28. The two Treasurers / Finance Directors were David Edmundson (who I believe undertook the role between 1983 and 1989), and then Mike Biddle (who was there between 1989 and 1992). Bob Spray became the Director of Finance after I left.

2.29. My time at Oxford was one of major organisational, structural and cultural change, driven by a succession of national reports and white papers. Although the concept of general management was well-established by 1988, in 1989 the 'Working for Patients' white paper was published, which introduced further, major changes to the organisation's structure and managerial systems.

2.30. The white paper's key principles were the separation of commissioning (including GP Fundholding) from provision of services, the delegation of decision making to the lowest practical and efficient level, and the establishment of self-governing provider organisations, such as Foundation Trusts.

2.31. Regional priorities at the time therefore included the revamping of our major capital programme, the introduction of information systems to support the implementation of the purchaser/provider split, and the encouragement and enactment of elements of key national reforms.

2.32. My lawyers have been able to find a letter which was sent by Duncan Nichol, the Chief Executive of the NHS Management Board ("NHSMB"), to all RGMs on the 22 March 1989 **[NHBT0118859_007]**. That letter asked all regions to review their functions and organisations to ensure that management tasks were delegated to the most appropriate level. It also annexed guidance on the approach that the NHSMB expected regions to follow in conducting that exercise **[DHSC0004458_003]**. This suggested that regions created space to concentrate on their core functions and that service functions should be separated and organised in the most cost-effective manner.

2.33. A major pre-occupation at Oxford during the late 1980s was, therefore, with the separation of the ORHA's core functions (the monitoring and promotion of the population's health, the forward planning of health services, the allocation of revenue to the new commissioning authorities, ensuring national and regional priorities were delivered, setting objectives and monitoring and reporting performance) from its services (supplies, estates, computing, public relations, consultancy (including organisation and method), office support, ambulance and blood transfusion). The Oxford Regional Services Consortium was established to run our services and was led by Russell Taylor, who was also the Regional Personnel Manager.

2.34. When I started with the ORHA it was still a large body of appointed and nominated members. At around the same time as Sir Stuart Burgess became Chair and after the white paper had been published, RHAs became unitary Boards which, I recall, comprised of a non-executive chair, 4 non-executive directors and 5 executive directors – the Regional Management Team. That is when RGMs became Regional Chief Executives. Although I cannot be certain, I believe that it was also around this time that the SRO role was expanded to include the quality of patient services, as well as finance.

2.35. Again, although there may have been a Regional Scientific Officer at the ORHA, I am unable to assist as to their role or responsibilities.

2.36. As with the SWRHA, the ORHA was funded by the DHSS/DH and was allocated revenue on a weighted capitation basis with some direct funding for regional specialties. I recall additional funds being given to the ORHA for teaching and

research schemes, and other initiatives, that were being run from its various sites. A more sophisticated weighted capitation formula was used for distribution to the new Commissioning Authorities from 1991.

2.37. Geographically, the ORHA was responsible for NHS facilities across the four counties of Berkshire, Buckinghamshire, Oxfordshire and Northamptonshire. I have been unable to find a complete list of hospitals, but each county had at least two major acute hospitals. I only recall there being one haemophilia centre in Oxford itself, although I have had sight of a document that suggests there was also a centre in Northampton and another two associated haemophilia treatment units in Kettering and Slough **[HSOC0017344]** (page 28). I do not recall ever having any dealings or knowledge of these centres and presume their main relations were with Oxford's RTC and other members of the Regional Management Team (see below).

2.38. As with the SWRHA, I do not believe there was any form of health system regulation in place during my time at the ORHA, although individuals and services were still subject to professional and other statutory forms of regulation.

2.39. In my role at Oxford, I regularly attended RGM meetings with senior NHS and DHSS/DH officials. I occasionally attended meetings with Regional Chairs. I have not kept any minutes of such meetings, although recall them being two-way, to receive and discuss policy as well as to communicate or clarify directives being issued by the DHSS/DH or other Government departments. They were also an opportunity for any progress on implementing plans, performance, or emerging problems, to be reported.

2.40. Annual, regional reviews by the DHSS/DH continued, but my memory suggests that they were not always conducted by ministers. I recall there being more contact and pressure to implement changes from the Department, by letters and calls from the Regional Liaison Officers and down professional lines, as time went on.

2.41. As for any relationship between the ORHA and the BPL, I am again unable to help the Inquiry much in this regard. By 1990 the Director of our RTC ("RTD") would have been part of the Services Consortium, although the Centre seemed

to have operated at arms' length and I have no memory or record of dealings with the BPL through it or the RTD.

Section 3: Reorganisation of the BTS

The Joint Steering Group

3.1. In 1986 a Steering Group was established to examine the BTS and how blood transfusion and any related blood products were being managed and dealt with through RTCs. The Group comprised of individuals from the NHS, like myself, and civil servants who attended on behalf of the DHSS, as it then was.

3.2. I have had sight of a letter, written by Mr Davies to Mr Hart on 22 May 1986 which, at paragraph 2, reads:

> *"RGMs' nomination would be Bob Nicholls (presently DGM, Southmead) although he has not been approached yet".* **[DHSC0003517_112]**

At this point in time I had no knowledge of any discussions taking place as to why I could suitably represent RGMs as a lower-ranking DGM.

3.3. I have been asked about the circumstances which led to the study being commissioned. As I was not part of initial discussions about why the Group was needed, I can only base my knowledge on documentation that was sent to me after having been appointed. I should add that I have no specific recollection of this today.

3.4. A letter was sent to me by the Secretary to the Group, Dr Moore, on 9 July 1986, attaching a short paper with details of the Terms of Reference and a list of fellow members **[DHSC0002441_096]**. I can only assume that that document was **[NHBT0053348]**, which I have been provided with by the Inquiry. I cannot now recall having had sight of it, but assume I did at the time.

3.5. **[NHBT0053348]** sets out the following Terms of Reference:

> *"a. to examine the blood transfusion and related services provided by RTCs and CBLA in order to:*
>
> *i. assess the current and forecast needs of the NHS and private health sector for such services;*
>
> *ii. identify those services in which RTCs can or cannot be expected to be self-sufficient; and*
>
> *iii. identify the way in which RTCs and CBLA interact.*
>
> *b. to advise on how supply and demand for blood and blood components (and activities relating to them) in individual regions can best be reconciled and co-ordinated to meet Regional needs, Supra-Regional*

> *needs, and ensure a cost effective service; whether financial and organisational changes are needed nationally.*
>
> *c. to report."*

3.6. I then received further correspondence from Dr Moore on 18 August 1986 **[DHSC0002441_063]**, which enclosed papers outlining the methodology envisaged by the study team and a background paper on the NBTS. My legal team have been able to source the latter **[NHBT0010832_002]**, which states at page 4, paragraph 10:

> *"There are sufficient concerns about co-ordination of blood related services to justify a serious study of the national scene. The aim of the study is to identify (and wherever practical) quantify current problems (e.g. Regional imbalance in supply and demand); and reach a view on how they might be overcome. The study will examine whether organisational and financial changes (e.g. cross charging or increased co-ordination and planning) might solve these problems. It will not start with any preconception that any change is necessary or desirable, but will assess the benefits and costs which changes might produce."*

3.7. The first meeting of the Group was held on 11 September 1986, although I was unable to attend. I assume that the minutes of that meeting would have been sent to me at the time, although I do not have any specific recollection of receiving and / or reading them **[DHSC0002441_037]**.

3.8. As one can see, subsection (a)(i) of the above Terms of Reference was amended ever so slightly in that the word 'needs' was replaced with the word 'usage' (paragraph 2).

3.9. The record of discussion also shows that there was a general dissatisfaction with the NBTS at the time, it being described as "unco-ordinated" (paragraph 3). This has prompted me to recall that there were problems with blood supply and plasma production between regions, and concerns about maintaining quality standards.

3.10. The second meeting then took place on 16 December 1986, which I attended. The minutes note that an oral progress report was given by Mr Kelly and Mr Saunders, two members of the study team **[DHSC0002442_035]**. This covered various issues, including management and functions, blood collection by RTCs, quality assurance and quality control, regional services and supply and demand. In terms of answering why the study had been commissioned, I can

see that again mention is made of there being "a lack of effective and common management information particularly in the realms of performance and costs", which then presented difficulties in assessing options and "was an obstacle to accountability". The minutes go on to say that there was, at that time, "no clear remit defining NBTS activity" (page 1).

3.11. The minutes from this meeting also record that the sizes of teams at RTCs did not appear to be related to their efficiency, and "[r]egions had different criteria for determining which donors to bleed" (page 2).

3.12. As for developments in test procedures in transfusion microbiology, these seemed to happen "largely at the discretion of RTCs or as a result of demands made upon them". It was recorded that "[c]o-ordination may produce resource savings" (page 2).

3.13. Moreover, whilst all RTCs produced the major blood components, other products were produced to "greatly varying degrees". The minutes go on to record:

> "*The decision to make these products seemed to be governed by factors of local RTC policy, cost, and clinical demand."*

3.14. Most RTCs believed that more quality control was needed (page 4). I can see that I also expressed surprise that it varied so widely nationally (page 8).

3.15. Overall, it was observed that "the variations, overlaps and duplications of functions" suggested a need for greater co-ordination or organisational change to produce:

> *"…savings, standardisation of materials and procedures, better products and service and equality of service, and in relation to plasma and platelet requirements and the supply problems in London to ensure the rational and maximum exploitation of basic raw materials."* (page 7)

3.16. Rather importantly, however, it was noted that even when seeking greater and more effective co-ordination, "the question of funding could be a potential and continuing problem" (page 7). Indeed in answer to a question apparently put by me, it was reported that a proposal for cross-charging was to be postponed until the management study had been completed (page 8).

3.17. I have little recollection of the above issues being discussed although, having reflected on them, it seems to me that there was a real need for this study at

the time. Various concerns were being expressed and the Terms of Reference appear sensible; they gave the Group sufficient scope, without leading to a preferred conclusion, and offered a way forward in terms of exploring various organisational changes that could realistically be made.

3.18. The next meeting took place on 28 April 1987. Again, I attended. From the meeting's minutes **[DHSC0002442_021]**, I can see that there was discussion on Papers 1/87 (Management Information and Costing Systems) **[DHSC0003580_033]**, 2/87 (Charging Systems**) [DHSC0003580_034]** and 3/87 (Options for Change) **[DHSC0002442_030]**, which my lawyers have again found and I exhibit to assist the Inquiry. Although I cannot recall, a reasonably balanced approach would suggest that these were drafted by members of the study team. The annotations on these documents do not appear to have been made by me.

3.19. In light of the study thus far, members agreed that recommending "no change" to the present system would be "unacceptable", and "not to seek to improve present arrangements would be disastrous for the Service" **[DHSC0002442_021]** (page 2). Looking back this seems a strong comment, but the study team appears to have picked up a wide variety of concerns from users of blood and blood products, specialist consultants, DHSS officials and managers of the RTCs and the BPL, that needed to be addressed.

3.20. Intermediate and national options were therefore discussed. I suggested that the NHSMB, rather than the DHSS, should be the top tier of any system (page 2). I believe I would have said this because, at the time, attempts were being made to separate the management of the NHS to its Board, leaving the Department developing policies, battling the Treasury for revenue and capital funds, and supporting its ministers with cross-Departmental discussions.

3.21. When discussing the potential of a national model, I also considered that a top slicing for a new organisation would not be welcome, with there being an opportunity cost (page 3). This pushed the BTS towards cross-charging, which was still attracting support as a way of improving efficiency.

3.22. The advantages and disadvantages to having a nationally organised service are set out at pages 15 to 17 of the Options for Change paper **[DHSC0002442_030]**.

3.23. I appear to have said, during the course of the meeting, that if the suggestion was that major savings of £6m plus were achievable only with a major national organisation, it should be more clearly stated in the final report (page 3).

3.24. My legal team has managed to find a copy of the report that was published by the DHSS **[CBLA0002392]**, which I do not recall seeing at the time.

3.25. The report, nevertheless, set out the problems that the study identified in the BTS and detailed four specific, underlying issues (page 115):

3.25.1 the absence of reliable management information

3.25.2 the inability of two London regions to meet the needs of their hospitals from within their existing collection programmes

3.25.3 the absence of co-ordination between individual RTCs and also between the BTS (the collective RTCs) and CBLA

3.25.4 inefficiencies both within and between individual RTCs as a result of points 1 and 3.

3.26. It stated that the problems facing the BTS were - in the team's view - structural, and so lent themselves to organisational solutions. The report then presented three organisational options for the future of the BTS, outlining the strengths and weaknesses of each.

3.27. Neither I, nor my lawyers, have been able to locate minutes from the meeting at which the report was discussed, although I have been supplied with a letter by the Inquiry that I wrote the following day to a member of the study team, Mr Kelly **[DHSC0003993_043]**.

3.28. Having reflected on that letter, I appear to be setting out my "personal opinions" on centralisation, as opposed to the opinion of the RGMs whom I was representing as part of the Group. I state:

> *"I would much prefer to have one powerful co-ordinating committee which would need good back-up support and which would develop and issue policy guidance on national issues relating to the Blood Transfusion*

Service. I would connect this to the main management process of the NHS by having it chaired by a member of the NHS Management Board (? The Director of Procurement). I would then make up its membership with the Chief Executive of CBLS, the Chairman of the Regional Transfusion Directors, the Chairman of a special professional advisory group or the CMO Special Adviser, a representative of the RGMs, and a representative of the relevant DHSS Department."

3.29. I go on to say that this body could be expanded, if necessary, by adding the Directors of the BPL and the Blood Products Reference Service, two additional RTDs and representatives of the Regional Treasurers and RMOs. At its smallest it could be a body of six, and even with additions no more than twelve, to deal with:

3.29.1 advising on policy issues facing the BTS

3.29.2 co-ordinating policies between the NHS, the RTDs and the CBLS

3.29.3 monitoring progress and advising the NHSMB on the implementation of policy.

3.30. It is clear from this letter that I felt that adequate control over these policy-based areas was lacking in the current system. I must have taken the view that the central co-ordination of policy and standards, with the best scientific advice being available, was therefore necessary. I note, however, that my letter stresses the need for a "composite organisational approach" to be taken; it stops short of recommending direct management by the NHSMB of the NBTS, perhaps because of the continuing absence of management information, including accurate costing.

3.31. At the end of my letter to Mr Kelly I refer to "difficult territory". Without having sight of the minutes from this meeting it is hard for me to recall quite what I was referring to. One would assume that there was a range of opinion expressed during the meeting, as there often was when centralisation verses decentralisation was being debated, although I am unable to assist the Inquiry further in this regard.

NBTS Co-ordinating Committee

3.32. In 1989, I was a member of the NBTS Co-ordinating Committee, of which Graham Hart from the DHSS/DH was Chair. The Committee's remit is helpfully set out in a document that we would have had sight of at the first meeting and discussed **[NHBT0010495_002]** (page 2), specifically:

> *"1. To advise the Director of Operations NHSMB, (and in respect of Wales the Director NHS Wales), on the national strategic planning and operational issues of the National Blood Transfusion Service and general co-ordination between the RTCs making up the NBTS and the NBTS and CBLA.*
>
> *2. To advise on the strategic and operational plans and budget of the National Directorate and to monitor the achievement of these operational and budgetary goals.*
>
> *3. To act as a channel of communication with RHAs and to help secure alignment between Regional and National plans."*

3.33. The first meeting was held on 24 January 1989 **[NHBT0010492]**. It was at this that I was asked to "consider how RTCs should be tied in with the Regional management structure" **[DHSC0002447_041** also refers**]**. I was, as is clear from the timeline I have set out above, at this point working with the ORHA as RGM.

3.34. As above, the white paper 'Working for Patients' was published in early 1989. We were therefore also aware, as a Committee, of the key principles being expounded nationally and the guidance that was later circulated by Duncan Nichol **[DHSC0004458_003]**. This would have created a dilemma, because despite there being a general push to delegate and for services to be separated from core functions, the guidance annexed to Mr Nichol's letter instead indicated that the BTS should not be considered for management at district levels (page 3). With the benefit of hindsight, it seems a compromise was possible, however, with the establishment of a national authority. With this, the BTS could concentrate on policy, quality standards and production targets, but there could also be monitoring of the performance of regional or independently-managed service providers.

3.35. I have been referred by the Inquiry to a paper, a supplement, I prepared in advance of the NBTS Co-ordinating Committee's second meeting

[NHBT0010494]. In that, I set out that of the ten regions I had had responses from, four wished to see movement towards full national management. A number were willing to explore supra-regional groupings. Three mentioned the possibility of a regional or national agency or self-governing trust (page 1).

3.36. I go on to say that the specific requirements for the management of BTS to remain with RHAs was against the general spirit of organisational flexibility, as envisaged by the white paper and the principle of regions delegating or contracting out as many of their service functions as possible. Here, one can see the dilemma I mention above taking practical effect.

3.37. I have been referred specifically to paragraphs 3.4 and 3.5, where I suggest that the possible benefits of self-governing status for the BTS should be further explored unless ruled out politically, and write that there was greater acceptance then, than the year before, about the possibility of a nationally managed service. I do note the caveat, however, that that was providing its cost effectiveness could be demonstrated.

3.38. In terms of the possible benefits that centralisation could have, these were much the same as previously discussed: economies of scale; better management of peaks and troughs in demand and supply; the more rapid introduction of scientific and technical advances; and better quality control.

3.39. In relation to this, I have had sight of some correspondence between the National Director and the Director of Operations with the Regional Medical Director for East Anglia **[DHSC0002447_061** and **DHSC0002447_060]**. I can see that I also passed this correspondence on to other RGM colleagues **[NHBT0010494]** (page 1, paragraph 1.2).

3.40. Dr Gunson, in his reply to Dr O'Brien, the Regional Medical Director at the East Anglian RHA, states:

> *"My argument basically is that until the initiatives, which are being introduced into Regional Transfusion Centres by the National Directorate can be assessed, then the favoured option is to maintain the status quo with respect to RHA management."* **[DHSC0002447_060]**

3.41. I have been asked by the Inquiry if I agreed with this approach. It appears, from my supplement, that I was encouraging further, detailed work to be done before

any final recommendations could be made. Improvements in management information systems and costings were still being developed. As I recall, accurate, focused projections had not been completed at this point to say whether a national body, or more supra-regional arrangements, would be more financially effective. The assumption is therefore that I did not consider it unreasonable for Dr Gunson (and others) to argue for the status quo to be kept at that time.

3.42. Moreover, I note from the minutes of the second meeting of the Committee on 4 July 1989 that this same point was discussed **[DHSC0003978_110]**. Although some RGMs, through me, had argued against retention of the status quo (see paragraph 18), members of the Committee appear to have come to the view that as blood supply was "politically sensitive and charging issues would need to be handled carefully", "the status quo should be maintained for the time being" (paragraph 19). The minutes go on to record:

> *"…longer term management arrangements would be considered when the MIS was in operation and was more experience of working through the Directorate – not be ruled out."*

3.43. As no dissent from me is recorded, I must have still supported that same view.

3.44. I have been asked if I felt the reorganisation of the Blood Services in 1988 had gone far enough in solving the NBTS management problem. I have no information or memory as to what, specific, changes were made in 1988. I have also not had sight of any relevant documentation. I therefore could not say whether any reorganisation went far enough.

The National Blood Authority ("NBA")

3.45. I have also been asked by the Inquiry to comment on whether I agreed with the eventual establishment of the NBA. I was not involved in the establishment of the NBA, and nor was I on any committee set up for that purpose.

3.46. I have had sight of a letter written to me by Mr Dobson on 19 September 1991, enclosing a consultation document on the proposal to establish the NBA **[DHSC0006835_077** and **WITN7522002]**. I have also had sight of my reply, sent directly to Mr Canavan **[DHSC0004584_090]**.

3.47. The rationalisation behind having a single, national body to act as sole contractor for the collection and supply to NHS hospitals of both cellular and plasma-derived blood products has its merits. Indeed, the arguments were the same as before: that it would not only increase quality and supply, but be more cost-effective.

3.48. Having read the consultation document that was supplied at the time, and my letter in response, I believe my reluctance to fully support central management was partly because of the continuing lack of a sound business case and whether the move would bring about the changes that were required for improved efficiency, and partly because it was contrary to the policy thrust coming from the DHSS/DH for other services. Looking back, however, with blood and blood product services not being seen as suitable for delegation to district level, or too clinically sensitive to be encouraged to go for Foundation Trust status, the only realistic option was for the management of the Service to be subsumed into a more centralised model, accountable to the NHS Executive.

3.49. I have also had sight of a paper that was prepared by the NHS Management Executive for the RGMs meeting on 10 September 1992 **[NHBT0002202]**. I cannot now recall whether I attended that meeting, although usually would have done so. Paragraph 13 at page 4 of that paper sets out:

> *"The principle of establishing a NBA and its objectives were widely supported in consultation with the NHS last year. The Technical Working Group has made recommendations within its remit to meet the concerns expressed over operational aspects of the NBA. Ministers have accepted those recommendations in the main but are minded to go further and integrate the RTCs into the new Authority. This will give greater assurance to the task of improving the quality and efficiency of blood supplies to the NHS users…"*

3.50. I do not recall taking issue with the establishment of the Body in this way at the time, and do not think I can answer this question in any greater detail.

Section 4: Relationship between the SWRHA and the South Western RTC

4.1. The South Western RTC was located in Bristol. As RA or DGM for Southmead, I cannot remember having oversight or influence over it in a professional capacity. I am therefore unable to assist much with dealings between the SWRHA and the Centre, although the Authority would have had operational responsibility for the RTC, implementing any policy from the DHSS/DH.

4.2. In the 1980s I recall that RTCs had a fair amount of cross-relation with each other, albeit no overall national direction. They were providing expert services and generally operated at arms' length, being run by medical professionals who were well-respected and skilled in what they did.

4.3. The South Western RTC was managed by an RTD, who I believe would have been accountable to the RMO or another senior RHA manager. It is possible that over time that relationship changed. In preparing this statement I have been referred by my lawyers to a document, drafted by Dr Gunson in March 1989 **[WITN7522003]**. This document would have reached me whilst at Oxford. Appended to it is a list of various management arrangements for RTCs, which was presumably current. In relation to the South Western RTC, it states that the Director reported to the RGM, "with whom he agrees policy for the Service". The document goes on to say that the "RHA provides financial, personnel and supplies support. Maintenance is contracted to a District" (page 4, paragraph 11). I cannot confirm who the RTD reported to, not being RGM, although the latter point about support and maintenance accords with my recollection.

4.4. The South Western RTC was funded by the SWRHA. To my knowledge, the allocation of both revenue and capital would have taken into account the Region's population and various functions that were being undertaken by the RTC; if further funding was sought, it would have been considered. I have no memory of any disputes at the time, although I do not recall being involved in the direct allocation of funds. I do not believe that the funding arrangements that were in place changed during the time I was at the Authority.

Section 5: Relationship between the ORHA and the Oxford RTC

5.1. The Oxford RTC was initially based at the Churchill Hospital and later moved to a purpose-built building at the John Radcliffe Hospital in Headington. It was managed by an RTD during my time at the RHA, who was Dr Colin Entwistle. I understood him to be accountable to the RMO, which is confirmed in the document drafted by Dr Gunson that I have already referred to above **[WITN7522003]**. Dr Entwistle may have also had dealings with our Regional Personnel Manager, Russell Taylor. I did not have any personal oversight or influence over the decisions that were being made by the Oxford RTC or its Director.

5.2. The appended document to Dr Gunson's paper states that in this Region the ORHA "provides personnel and supplies support and settles accounts for non-pay items. [The ORHA] pays salaries and wages. Maintenance of RTC is provided by the John Radcliffe Hospital" (page 4, paragraph 10). This accords with my recollection.

5.3. In terms of funding, I was aware at the time I joined that the Oxford RTC was being funded by the ORHA, as in the South West. This would have been funding for both running costs and general capital. Again, I do not recall being part of any discussions, nor having any influence over, how decisions as to funding of the Oxford RTC were made. They may have been with Mr Taylor, or the Regional Treasurer. I cannot remember any major issues coming before me or the RHA Board. I do, however, recall that in the early 1990s the Region received special, additional funding to help deal with an increase in AIDS cases. Some of this funding could have then been allocated to the Oxford RTC.

5.4. I have had sight of a letter from the NHS Management Executive that was addressed to all RGMs, as well as others **[NHBT0000192_001]**. Attached to this are two documents, and at Annex B mention is made of RTCs moving away from direct funding by regions from 1 April 1991 (page 3). I do not recall the specifics of this change, and / or whether it indeed came into effect, but provide this information to the Inquiry in case it is of assistance.

Section 6: Role played by the SWRHA in plasma procurement at South Western RTC

6.1. I have had sight of a letter, signed by me, which was written to the DHSS in relation to the supply of plasma to the BPL from the SWRHA **[DHSC0002215_017]**. I should say at the outset that I do not recall writing this letter. It appears to contain information that would have been outside of my direct knowledge, although I would have read it and signed it off, being content with what was contained therein.

6.2. In the Schedule of Documents provided by the Inquiry the letter is also said to have been addressed to Mr Rogers, although to clarify it was instead addressed to a Mr Shaw and the name "Rogers" was written above. I believe Mr Shaw was one of the Regional Liaison Officers acting under the NHS Chief Executive. I do not recall being the person to write "Rogers" onto the document.

6.3. This letter was written in response to a letter from Mr Shaw dated 18 December 1981 **[DHSC0001507]**. His letter outlined the plasma procurement targets that would be needed for the increased production capacity proposed for the BPL across all Regions. As can be seen from the comment at page 2, although Mr Shaw wrote this letter directly to Peter Cooke Esq at Oxford, it was also copied to me and fellow RAs across the country. It is clear that targets had been set for all regions.

6.4. Mr Shaw speaks of earlier letters, written to RAs in September 1980 and February 1981 (and so before my time at the SWRHA), that detailed the need to increase the supply of fresh frozen plasma to the BPL, "so as to enable it to take full advantage of the upgrading programme which is now nearing completion". The letter goes on to speak about the principle of self-sufficiency and how 435,000 kilograms of fresh plasma would be required to enable the redeveloped Laboratory to meet the NHS's foreseeable need for blood products.

6.5. Annexed to Mr Shaw's letter was a document with possible plasma supply targets for 1984/85, which were said to be related to the populations of

Transfusion Centres' catchment areas and to assume a standard quality of plasma. The target set for the South Western Region was 30,000 kilograms.

6.6. In the reply I signed to Mr Shaw **[DHSC0002215_017]**, I stated that although the SWRHA was "committed to the investment of resources for plasma supply purposes", its view was that the appropriate plasma supply target for the Region was 20,000 kilograms. I said that the 30,000 kilogram target was "too high" and would have considerable resource implications. I also suggested that, as a result of technological advances, a reduced volume of blood could be required from each region to produce the same amount of blood product in the near future.

6.7. I do not recall the RHA ever having been involved in discussions about setting the initial target appended to Mr Shaw's letter and, as I had only moved to the South West six months prior, I personally do not remember being invited to comment on the issue before receiving this letter. I can see that I have copied in the RMO, RTO and two other individuals into my response. I believe Dr Fraser was the Director of the RTC at the time. No doubt discussions would have been had between us, particularly given the language used in the letter, although I cannot now recall being involved in them.

6.8. Some years later, on 10 August 1984 I, along with other RAs, was sent a letter by Assistant Secretary to the DHSS, Mr Parker **[DHSC0001334]**. In this, Mr Parker makes reference to a meeting of the RAs with DHSS officials on the 5 January 1982. Due to the passage of time, I cannot now say whether or not I attended this meeting. I can find no record of it.

6.9. In his letter, however, Mr Parker states:

> *"I am concerned to learn from several Regional Transfusion Directors that they are pessimistic about their chances of attaining the continued growth in plasma procurement so as to reach the targets set for 1988. Regional Health Authorities in some cases have not provided the necessary additional funding, and in others have not been prepared to give a long-term commitment to continued expansion to meet the targets set."*

6.10. Although Mr Shaw's letter originally set the targets for 1984/85, it is clear from Mr Parker's correspondence that the date had, by this point, been moved to

1987/88. His letter also shows that the Department was in dual correspondence with RHAs and RTDs.

6.11. Mr Parker asked for the SWRHA to reconsider the steps it was taking to ensure the plasma procurement target set for the Region would be met. He invited comments by the end of the following month.

6.12. My legal team has found a letter, drafted by Winston Tayler on 27 September 1984, which is said to have been written on my behalf **[WITN7522004]**. I cannot now recall having had sight of this letter, although it appears a reasonable response. It repeated that "significant investment" would be required for the Authority to meet the suggested target, with 13,500 litres being the projected figure for 1984/85. Mr Tayler stated that plans were, nevertheless, being drawn up to increase figures to 30,000 by 1987/88, with the development being processed through the Authority's management planning system.

6.13. Reading this back today, it appears that the targets set by the DHSS/DH for the SWRHA did not change, despite my earlier representations, although the date by which regions were expected to meet them did.

6.14. I do not recall having sight of any further correspondence that was sent in relation to targets for plasma supply during my time with the SWRHA.

6.15. As to whether extra support and funding was provided to the South Western RTC to assist it in meeting the DHSS/DH's targets, I was always under the impression that sufficient revenue was being put aside by the RHA. What is perhaps of note more generally, though, is that it appears no extra financial help was being given to the regions by the Department to achieve its goal **[DHSC0002442_035]** (page 5).

6.16. I do not recall there being specific consequences for regions if targets were not met. Considering this now from a practical perspective, however, it may have resulted in failures by the region to meet increasing demand and / or a delay in national self-sufficiency being achieved.

6.17. I cannot recall there being any direct benefit to the South Western RTC if targets were exceeded. After the introduction of cross-charging (albeit later in the timeline of events) I presume one benefit would have been financial, but again I say that looking back.

6.18. I have also been asked to set out what role, if any, the SWRHA played in the introduction of cross-charging. This system did not come into force whilst I was at the Authority, but instead in 1989. Although it was being discussed in the context of the Steering Group (see the minutes of the meeting from 16 December 1986 **[DHSC0002442_035]**). I was not attending as a representative for the SWRHA, but RHAs more generally. I also refer back to the comment at page 8 of those minutes, where it was confirmed to me that cross-charging as a policy had been suspended pending the final report.

6.19. I therefore cannot say what effect cross-charging had on the plasma supply in the South Western Region after its introduction in 1989. Equally, given the timing, I could not definitively say what role the SWRHA played in its introduction, although I have been able to find a letter drafted by A Wilson, the Assistant General Manager for Finance and Information for the SWRHA, at a time when I was the RGM for Oxford. I can see that I was copied into that letter **[NHBT0097027_055]**, which was sent when cross-charging was still a proposal. I provide a copy in case it is of assistance to the Inquiry in this regard.

Section 7: Role played by the ORHA in plasma procurement at Oxford RTC

7.1. In preparing this statement I have had sight of the witness statement provided by Dr Entwistle and published on the Inquiry's webpage **[WITN6917001]**. In this, at paragraph 18, he states that funding for plasma procurement at Oxford RTC came from the RHA "until the implementation of the newly formed NBA in 1994". That accords with my understanding; plasma procurement at the Oxford RTC would have been funded in this same way as in the South West throughout the 1980s.

7.2. On the basis of the documentation that I have discussed above at Section 6, it is clear that the Oxford RTC also had targets set by the DHSS/DH that were expected to be reached, after some re-adjustment, by 1987/88. As this was a national effort, the purpose would have been the same.

7.3. In terms of whether extra support and funding was provided to the Oxford RTC to assist them in meeting the targets, I am again unable to say what the position was with any clarity, although would anticipate that such a question could be better answered by the Regional Treasurer. I do not remember ever receiving any additional funding from the DHSS/DH specifically for blood products.

7.4. To my knowledge, any consequences and benefits would have been as above.

7.5. Cross-charging came into effect whilst I was at the ORHA and I agree that it could have been introduced, in part, to incentivise RTCs to increase the amount of plasma they were sending to the BPL. I have been referred by the Inquiry to a document, which is undated, but discusses this "new approach" **[NHBT0057426_002]**. I do not recall having sight of the document back in the 1980s or 1990s.

7.6. I have been asked what role, if any, the ORHA played in the introduction of cross-charging. I can see that in March 1989, all RGMs were sent a letter by the DHSS/DH explaining that a new National Directorate had been set up and that cross-charging would be coming into force from 1 April 1989 **[NHBT0114118]** (pages 1-7).

7.7. I have not been able to find any correspondence of a similar kind to the letter at paragraph 6.19 above from myself, or the ORHA, to the Deputy National Director of the NBTS or anyone else involved in the implementation of the cross-charging system. I anticipate that had there been any correspondence, it would have come from my Regional Treasurer or Director of Finance.

7.8. I am therefore unable to recall and, in the absence of any documentation, cannot indicate what role the ORHA played in the introduction of cross-charging. I also have no evidence to give about what effect cross-charging had on plasma supply in the Region for these same reasons.

Section 8: Arrangements for Obtaining and Allocating Factor Concentrates

8.1. I have been asked to set out my understanding of the arrangements in place in both the South West and Oxford in relation to the purchase, holding and allocation to haemophilia centres within each region of NHS factor concentrates and commercial factor concentrates.

8.2. I do not recall ever dealing with the purchase, holding or allocation of factor concentrates. As far as I can remember, this was something that would have been done by the centres themselves; it was a clinical and commercial decision that would have been made by those on the ground. I therefore cannot say which haemophilia centres in each Region were supplied with such products, nor what role (if any) either Authority played.

8.3. I can only assume that the SWRHA and ORHA provided funding to the haemophilia centres in each Region, although I have seen no documentation, and have no independent recollection, to confirm this. Such questions may be better answered by the Regions' Treasurers.

8.4. I have no recollection of any contract being made by the SWRHA or the ORHA with any pharmaceutical company for the purchase of factor concentrates.

8.5. I do not recall the SWRHA or the ORHA seeking to exercise any influence over, or provide any advice or guidance in relation to, what were clinical decisions about the choice of products used to treat patients in haemophilia centres and hospitals in each Region. Neither I, nor my lawyers, can find any documentation that might assist any further in this regard.

Section 9: Other Matters

9.1. I have been asked if I have any other comments to make on matters relevant to the Inquiry's work. Although willing, the answers I have provided above cover the ground as fully as possible and I can think of no further evidence to give that could assist.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed..... GRO-C .....

Dated..... 31/1/2023 .....

Exhibits Table

Date	Notes / Description	Exhibit Reference
February 1991	Haemophilia Centre Directory	HSOC0017344
22.03.1989	Letter from Duncan Nichol, Chief Executive of the NHS Management Board, to all RGMs, DGMs and General Managers of Social Health Authorities re: delegating responsibilities	NHBT0118859_007
Undated	Guidance on delegating responsibilities annexed to the letter from Duncan Nichol, Chief Executive of the NHS Management Board, to all RGMs, DGMs and General Managers of Social Health Authorities	DHSC0004458_003
22.05.1986	Memo from A J Davies to Mr Hart re: the NBTS study	DHSC0003517_112
09.07.1986	Letter from Dr Moore to Mr Nicholls with details for the Steering Group	DHSC0002441_096
July 1986	Paper on the management services study of the BTS	NHBT0053348
18.08.1986	Letter from Dr Moore to Mr Nicholls enclosing papers for the first Steering Group meeting	DHSC0002441_063
Undated	Background Paper for the Steering Group - Need for a Study	NHBT0010832_002
11.09.1986	Minutes of the first Steering Group meeting	DHSC0002441_037
16.12.1986	Minutes of the second Steering Group meeting	DHSC0002442_035
28.04.1987	Minutes of the third Steering Group meeting	DHSC0002442_021
Undated	Paper 1/87 – Management Information and Costing Systems	DHSC0003580_033
Undated	Paper 2/87 – Charging Systems	DHSC0003580_034
Undated	Paper 3/87 – Options for Change	DHSC0002442_030
October 1987	DHSS Report on the NBTS, titled “An Organisational Study”	CBLA0002392
22.10.1987	Letter from Mr Nicholls, Southmead DHA, to Mr Kelly, NHS Management Consultancy Service, DHSS, re: the management services study	DHSC0003993_043
10.01.1989	Remit of the NBTS Co-ordinating Committee and List of Members	NHBT0010495_002

24.01.1989	Minutes from the first NBTS Co-ordinating Committee meeting	NHBT0010492
23.06.1986	Memo from J C Dobson to Mr Hart re: the NBTS Co-ordinating Committee meeting and a directorate accountability review	DHSC0002447_041
26.06.1989	Supplement to report, "Management arrangements in the light of the white paper", NBTS Co-ordinating Committee, by Mr Nicholls, RGM for the ORHA	NHBT0010494
19.04.1989	Letter from the Dr J M O'Brien, RMD for East Anglia RHA, to Dr H Gunson, National Director of the NBTS, re: management of the regional BTS, Mr Nicholls cc'ed	DHSC0002447_061
25.04.1989	Letter from Dr H Gunson, National Director of the NBTS, to Dr J M O'Brien, RMD for East Anglian RHA, re: management of the regional BTS, Mr Nicholls cc'ed	DHSC0002447_060
04.07.1989	Minutes of the second NBTS Co-ordinating Committee meeting	DHSC0003978_110
19.09.1991	Letter from J C Dobson on behalf of the DH, to Mr Nicholls, ORHA, re: the NBA proposal	DHSC0006835_077
Undated	Consultation document on the DH's NBA proposal	WITN7522002
22.10.1991	Letter from Mr Nicholls, ORHA, to Mr J Canavan, re: the NBA proposal	DHSC0004584_090
Undated	Paper prepared for an RGMs meeting on the 10 September 1992	NHBT0002202
17.03.1989	Paper prepared by Dr H Gunson, National Director of the NBTS, and annexed material, on the organisation of RTCs	WITN7522003
May 1991	Letter from the NHS Management Executive to all RGMs and General Managers of Social Health Authorities, and annexed material, re: the NBTS	NHBT0000192_001
18.01.1982	Letter from Mr Nicholls, SWRHA, to Mr Shaw / Mr Rogers, DHSS, re: plasma supply targets	DHSC0002215_017
18.12.1981	Letter from Mr Shaw, DHSS, to Peter Cooke Esq, RA for the ORHA, re: plasma supply targets, Mr Nicholls cc'ed	DHSC0001507

10.08.1984	Reply from Mr Parker, DHSS, to Mr Nicholls, RA for the SWRHA, re: plasma supply targets	DHSC0001334
27.09.1984	Reply from W J Tayler, on behalf of Mr Nicholls, to Mr Parker, DHSS, re: plasma supply targets	WITN7522004
27.01.1989	Letter from A Wilson, Assistant General Manager (Finance & Information) at the SWRHA, to Dr Moore, Deputy National Director for the NBTS, Mr Nicholls cc'ed	NHBT0097027_055
25.10.2021	Witness Statement of Dr Colin Entwistle	WITN6917001
Undated	Proposal titled "Distribution of BPL products and supply of plasma to BPL: A new approach"	NHBT0057426_002
31.03.1989	Letter from the DHSS to all RGMs and General Managers of Special Health Authorities re: cross-charging	NHBT0114118