CHAPTER FOUR

The Monitoring of General Practitioners from 1980 to 1998: the Arrangements for Monitoring in Tameside

Introduction

4.1 In the 1980s, the primary care organisations (PCOs) began to assume some responsibility for monitoring the operation of certain aspects of general practice. As time went on, they began to take steps directed at improving the quality of care provided by general practitioners (GPs). In this Chapter, I shall examine the arrangements for the monitoring of GPs between 1980 and September 1998, when Shipman ceased to practise. I shall also describe the steps taken by successive PCOs in Tameside to monitor the GPs in their area during the time that Shipman was in practice there. I shall go on to consider whether more should have been done in that respect by those organisations, by reference to the steps being taken at the same time by PCOs in other parts of the country.

From 1980 to 1990

Changes in Structures

4.2 The Health Services Act 1980 gave the Secretary of State for Health and Social Security (SoS) power to dispense with area health authorities (AHAs) in some areas, and to replace them with district health authorities (DHAs). In 1982, the AHAs were abolished and responsibility for the family practitioner committees (FPCs) passed to the DHAs. The Tameside DHA replaced the Tameside and Glossop AHA. In 1985, the FPCs became autonomous authorities, independent of the DHAs and directly accountable, first to the Department of Health and Social Security (DHSS) and, from July 1988, to the Department of Health (DoH). From the late 1980s, the FPCs had a more active role in planning the organisation and development of primary healthcare services.

4.3 From 1985, the FPCs were fully responsible for the provision and management of general medical services in their area, although they had limited tools at their disposal with which to control the quality of those services. Nevertheless, they made use of those they had. Mr William Greenwood, Assistant Administrator (later Deputy General Manager) of the Tameside FPC from 1983 until 1990, told the Inquiry that, by the mid- to late 1980s, he had instituted a system of regular reviews of the log of complaints about GPs kept by the FPC. He recalled one instance when those reviews revealed a pattern of complaints from patients of a certain practice who were having difficulty in getting appointments within a reasonable time. That resulted in Mr Greenwood visiting the practice in question to discuss the problem. Discussions of this type would often result in an agreed solution. However, unless a GP was in breach of his/her terms of service, the FPC was entirely reliant on its powers of influence and persuasion to effect change. It could take no action to compel a GP to comply. The inability of the FPC effectively to control entry to, and removal from, its medical list gave rise to particular frustration, all the more so since members of the public tended to assume that the FPC was capable of exercising a much greater degree of control over GPs than was in fact the case.

'Promoting Better Health'

4.4 In the mid-1980s, the Government carried out a review of primary healthcare services, which culminated in the publication, in November 1987, of a White Paper, 'Promoting Better Health'. The White Paper contained a large number of proposals designed to improve the standard of primary care provision. The Government intended that FPCs should become the means of securing improvements in the level, quality and cost-effectiveness of local services. Their responsibilities were to be extended and their managerial role strengthened. For example, FPCs were to be given a role in encouraging effective and economical prescribing. In addition, FPCs (in collaboration with DHAs) were to set targets for measures (e.g. vaccination, immunisation and screening for cervical cancer) designed to prevent disease. Financial incentives were to be available to GPs who met those targets and who participated in other initiatives designed to promote health. These proposals marked the beginning of the widescale use of financial incentives as a means of persuading GPs to improve the standard and quality of their services. Sir Nigel Crisp, Permanent Secretary of the DoH and Chief Executive of the NHS in England, gave oral evidence to the Inquiry. He described how financial incentives have been used to secure the co-operation of independent contractor GPs, which would not otherwise be forthcoming. As I shall describe in Chapter 5, the new (2004) General Medical Services Contract makes extensive use of financial incentives to encourage improvements in quality.

4.5 From the late 1980s, senior staff at the FPCs were no longer known as 'administrators'. Instead, they became 'managers'. The number of staff employed by the FPCs began to increase. Personnel with a wide variety of skills were recruited to assist FPCs in developing their new management role. Performance reviews of FPCs by Ministers and senior officials of the DoH were introduced. Computerised systems to facilitate the recall of patients for immunisation and screening were installed by FPCs. The scene was set for the start of a process of change which has continued to the present day.

4.6 In April 1990, amendments to the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 (the 1974 Regulations) came into force. The terms of service set out the framework within which GPs operated. The amendments to the terms of service put into effect many of the proposals which had been contained in 'Promoting Better Health'. In particular:

(a) The general requirement in the 1974 terms of service that GPs should render to their patients 'all necessary and appropriate personal medical services' was expanded to include, *inter alia*, the giving of appropriate advice in connection with general health and the offering of various kinds of vaccination and immunisation.

(b) A new term of service obliged GPs to obtain the approval of the FPC for the times and places they proposed to be available for consultation by patients.

(c) Another new term of service required GPs to answer oral or written enquiries from the FPC about prescribing or referrals to other NHS services. Such enquiries could relate to one prescription or referral, or could be more general in nature. FPCs were required to appoint medical advisers to assist them in carrying out such enquiries. These advisers were to be independent of the local medical profession.

(d) There were requirements for GPs to offer a consultation and examination to newly registered patients, to patients who had not been seen for the last three years and (annually) to patients aged 75 and over.

(e) GPs were placed under an obligation to take reasonable care to satisfy themselves that any person employed to assist them was suitably qualified and competent. FPCs were given power to issue guidance to assist GPs in assessing qualifications, experience and competence. However, the assessment itself was a matter for the GP alone.

(f) There were a number of provisions requiring GPs to provide information (including an Annual Report containing specified information) to FPCs.

(g) As from 1st April 1991, any GP attaining the age of 70 was to be removed from the medical list.

(h) The arrangements for remuneration of GPs were amended to include various types of incentive payments.

'Working for Patients'

4.7 Meanwhile, in January 1989, the Government had published another White Paper, 'Working for Patients', heralding important changes to the arrangements (in particular the funding arrangements) for primary health care. An important objective of the changes was to strengthen the management role of FPCs yet further.

4.8 The 1989 White Paper proposed that the composition of FPCs should be changed significantly. Membership of a FPC was to be reduced from 31 (including the chairman) to 11. The chairman was to be appointed by the SoS. The proportion of professional members was to be reduced, and those professional members who remained were to be appointed by regional health authorities (RHAs) to act in a personal, rather than a representative, capacity. One of the purposes of this change was to distance the FPC from the professionals whose contracts it was responsible for managing. Chief executives (who were also to be members of the FPC) were to be appointed, at a higher salary than had hitherto been paid to the senior staff of a FPC.

4.9 Larger GP practices were to have the option of holding their own budgets ('fundholding'). From those budgets they would have to meet the cost of obtaining a range of hospital services for patients, as well as the cost of employing practice staff and improving practice premises and prescribing costs.

4.10 Changes were proposed also in the arrangements for non-fundholding practices. For the first time, cash limits were introduced for infrastructure costs, i.e. the costs of developing and improving practice premises, employing practice staff and acquiring computer equipment. In addition, non-fundholding practices were to be allocated indicative prescribing amounts (IPAs). These were notional, rather than actual, budgets: hence the term 'indicative'. They were to be calculated by reference to past prescribing costs and to the average costs incurred by practices in similar circumstances. One of the aims

behind these proposals was to make GPs more careful about their use of resources and to encourage savings where possible.

4.11 The 1989 White Paper also expressed the Government's intention of establishing a system of medical audit in general practice.

The Implementation of 'Working for Patients'

4.12 The proposals contained in the 1989 White Paper were substantially brought into effect by the National Health Service and Community Care Act 1990. In September 1990 family health services authorities (FHSAs) replaced FPCs. They were to be accountable to the RHAs. Thus, the new Tameside FHSA was accountable to the North West RHA. The purpose of the change was to relieve the DoH of direct involvement in local management and to bring responsibility for primary health care and hospital services together at a strategic level, thus making it possible to co-ordinate policy initiatives spanning both services.

From 1990 to 1998

Changes on the Ground

4.13 During the early 1990s, the FHSAs began to use the new tools they had been given to develop their management role. They grew in size. Tameside FHSA doubled the number of its staff to about 50. The FHSAs employed medical advisers, many of them from the Regional Medical Service (RMS), which had been part of the new DoH since the latter's creation (it had formerly been part of the DHSS) in 1988. In 1991, the RMS was transferred to the Department of Social Security (DSS) and thereupon ceased to have any general responsibility for GPs.

4.14 The level of prescribing costs incurred by GP practices was a matter of considerable concern to FHSAs. If a fundholding practice overspent on its prescribing budget, the FHSA was responsible for paying the excess. That had an obvious impact on the FHSA's own budget. If a non-fundholding practice failed to keep within its IPA, the excess was met from central funds held by the DoH. However, the FHSA would be under pressure from the RHA to use its influence to modify the activities of high cost prescribers in its area. In practice there was little a FHSA could do if a practice overspent, unless it could successfully establish that a GP was guilty of excessive prescribing: see paragraph 4.21.

4.15 Initially, therefore, the work of medical advisers was primarily concerned with promoting rational and cost-effective prescribing practice. At this time, the main emphasis was on cost factors. Efforts were made to discourage GPs from prescribing expensive proprietary drugs. They were encouraged instead to prescribe cheaper, generic equivalents. The advisers used prescribing data provided by the Prescription Pricing Authority (PPA) to inform their discussions with GPs. The PPA is a special health authority which processes all NHS prescriptions written by GP and nurse prescribers in England. Prescriptions are submitted by community pharmacists and dispensing GPs who receive payment from the PPA. The PPA also collates and disseminates (to GP practices, PCOs and other NHS bodies) data about drugs prescribed and the costs thereof. From April 1991, medical

advisers were also authorised by the SoS to inspect GPs' controlled drugs registers (CDRs) and stocks of controlled drugs, to ensure compliance with the statutory requirements relating to the keeping of controlled drugs.

4.16 The FHSAs also began to recruit pharmaceutical (or prescribing) advisers (usually part-time) to assist with the more technical aspects of prescribing. The pharmaceutical advisers brought with them a higher degree of specialist knowledge about drugs and their properties than was possessed by the medical advisers. Local incentive schemes were set up to promote cost-effective prescribing. If a non-fundholding practice underspent on its IPA, it would receive additional funds to invest in the purchase of equipment or other improvements. Agreed formularies (i.e. lists of drugs to be prescribed) were developed for GPs' use. The emphasis shifted to the promotion of good quality prescribing practice, as well as cost savings. FHSAs began to employ community pharmacists who would discuss with doctors the prescribing needs of individual patients or groups of patients. Pharmaceutical advisers did not possess the same powers to enquire into a GP's prescribing as did medical advisers. Nor did they have any authority to inspect GPs' CDRs or stocks of controlled drugs. If they had any reason for concern about a GP's handling of controlled drugs, they would refer that concern to others for investigation.

4.17 The receipt of a range of incentive payments for the provision of additional services and other activities made it necessary for systems of verification of claims for payment to be developed. GP practices were required to set up systems for collecting data to support their claims for incentive payments. That process was facilitated by the increasing computerisation of GP practices which began at about this time. The collection of this data, together with other information which practices were now obliged to supply to them, enabled FHSAs to build up a more accurate picture of the care being provided by individual practices.

4.18 FHSAs established medical audit advisory groups (MAAGs) to encourage GP practices to carry out audits of their activities. The profession insisted that audit should be led by members of the profession, should be formative (i.e. educational) in nature, should be confidential and should not be linked to management processes. As a consequence, audit results were reported annually to the FHSA in an aggregated, anonymised form. FHSA managers had no access to the results of audits carried out by individual GP practices. These were seen only by GP members of the MAAG and by the staff responsible for supporting the MAAG.

4.19 There was no longer any significant overlap between membership of the FHSAs and that of local medical committees (LMCs). Nevertheless, FHSAs continued to consult closely with LMCs. Tameside FHSA (whose one medical member was not a member of the LMC) instituted routine monthly meetings with the LMC. In general, the two co-operated well, although some difficulties were experienced when the FHSA was called upon to implement Government policies (such as the fundholding arrangements) which were unpopular with some GPs. Relationships with LMCs varied from area to area, depending upon the personalities involved.

Developments in 1992

4.20 The National Health Service (General Medical Services) Regulations 1992 consolidated and amended the 1974 Regulations and included new terms of service (the 1992 terms

of service) which were largely unchanged from those which had been in force previously. The 1992 terms of service (amended over time) remained in force until April 2004.

4.21 Also in 1992, the National Health Service (Service Committees and Tribunal) Regulations 1992 introduced a new procedure for dealing with allegations of excessive prescribing. Prescribing could be excessive by reason of either the quantity or the number of drugs prescribed. FHSAs were given the power to refer such cases to professional committees. Those committees consisted of a doctor with substantial experience of clinical pharmacology (chosen from a panel selected, after consultation, by the SoS) together with two GPs, one of whom had been nominated by the LMC. This procedure replaced the previous arrangement whereby LMCs had been responsible for adjudicating in such cases: see Chapter 3. The professional committees could determine the amount of any financial penalty to be imposed. Dr David Edwards was a former regional medical officer (RMO) and co-Medical Adviser (with Dr David Archer) to a consortium of the Tameside, Wigan and Stockport FHSAs in the early 1990s. He was, he believes, the first adviser to use this procedure successfully. This was after he had left the consortium and moved to Wigan. The evidence received by the Inquiry suggests that it was invoked only on very rare occasions thereafter.

4.22 The LMCs continued to have responsibility for determining issues relating to medical certification and record keeping, as well as for considering complaints made by one GP against another and involving a question of the efficiency of services. The evidence received by the Inquiry suggests that these latter procedures were not used frequently, although Mr Greenwood remembered one occasion when the LMC for Tameside considered concerns reported by the partners of a practice about the clinical activities of one of their colleagues. LMCs also continued to be involved in the procedures for dealing with doctors who appeared unfit to discharge their obligations under the 1992 terms of service by reason of physical or mental illness. In 1980, the General Medical Council (GMC) had introduced its new procedures for dealing with doctors whose fitness to practise was seriously impaired by ill health. The more intractable cases of illness could, therefore, be referred to the GMC.

Shipman's Move to the Market Street Surgery

4.23 In 1992, Shipman moved from the Donneybrook practice to the Market Street Surgery, where he practised single-handed until his arrest in 1998. He was already on Tameside FHSA's medical list. He was merely leaving one practice and setting up another in the same area. No application to the Medical Practices Committee was necessary. All Shipman was required to do was to establish to the satisfaction of the FHSA that he had suitable premises from which to practise, that his arrangements (e.g. his times of availability) would adequately meet the needs of patients and that the other necessary administrative arrangements had been made. The FHSA had no power to prevent the move, although it would have been open to it to withhold funding for infrastructure costs had it chosen to do so.

4.24 Having found the premises at 21 Market Street, Shipman wrote to Mr Barry Thomas, General Manager of the FHSA, asking him to view the premises and give his approval. At

the FHSA's request, he also submitted an outline business plan. Subsequently, Shipman met Mr Thomas, Dr Roger Freedman (the Medical Adviser at the time) and the secretary of the LMC. As a result of that meeting, the premises were approved.

4.25 Mr Greenwood said that the FHSA would have had mixed feelings about Shipman's move. On the one hand, he was the first doctor to move outside the two large practices which operated from Donneybrook House and would thus have provided some welcome diversity in the types of practice on offer. On the other hand, the creation of a new practice involved additional costs to be met by the FHSA. Another factor was that, unusually for the time, the Tameside FHSA had a policy of not supporting single-handed practice unless an applicant could demonstrate that s/he would provide a better quality of services locally. In the event, the FHSA must have been satisfied that that was the case since it supported Shipman's move. Mr Greenwood believed that Shipman's stated intention to hold open surgeries (at a time when patients were experiencing real problems in getting appointments with other practices) might have been a significant factor in the FHSA's decision.

The Mid-1990s

4.26 In the mid-1990s, there were a number of organisational changes in the NHS. In 1994, the number of RHAs was reduced from fourteen to eight. The North West RHA was merged with the Mersey RHA. With effect from 1st April 1996, the RHAs were abolished altogether and their functions were taken over by eight Regional Offices of the NHS Executive. The North West Regional Office covered Tameside. These Regional Offices were responsible for the performance management of primary care as part of their responsibility for the management of healthcare systems in their areas.

4.27 At the same time, the DHAs and FHSAs were abolished and their functions were devolved to a hundred new unitary health authorities (HAs) of which the West Pennine Health Authority (WPHA) was one. The WPHA covered the areas previously administered by the Tameside and Oldham FHSAs, together with the Glossop area, which had previously been part of the Derbyshire FHSA. The primary care team at the WPHA was led by Mrs Jan Forster, Director of Primary Care. The two Medical Advisers, Dr Alan Banks and Dr Frances Bradshaw, shared the position of Assistant Director. Under the HA structure, local GPs were not formally involved in the management of local primary care services. However, there was close co-operation between the WPHA and the LMC.

Complaints and Discipline

4.28 In April 1996, changes were also made to the complaints and disciplinary systems governing GPs. These were separated so that the determination of a patient complaint no longer led automatically to the possibility of disciplinary proceedings. Each practice was required to have a complaints procedure, and patient complaints were initially dealt with at practice level. If that failed, conciliation and, possibly, a hearing by an independent review panel (IRP) could follow. The IRP would produce a report, setting out its findings and, if appropriate, making recommendations for changes to the GP's practice. However,

neither the IRP nor the HA which received the report could compel the compliance of the GP in question. I shall describe these arrangements in detail in Chapter 7.

4.29 All HAs were required to set up medical disciplinary committees, whether alone or jointly with other HAs. If a HA received information which it considered could amount to an allegation that a GP had failed to comply with his/her terms of service, it had a number of options. The HA could:

- take no action or
- refer the matter for investigation by another HA's disciplinary committee and/or
- refer the information to the NHS Tribunal, the GMC or the police.

4.30 If the allegation was being dealt with through the complaints procedure, the HA had to await delivery of the IRP's report or the abandonment/withdrawal of the complaint by the complainant before taking disciplinary action by referring the complaint to another HA's disciplinary committee. The process was cumbersome and lengthy. It is perhaps not surprising that, as I shall explain in Chapter 7, it was little used.

4.31 One effect of the changes to the complaints procedure was that, after 1996, HAs only rarely became aware of the subject matter of individual complaints made about GPs. Practices were obliged to make an annual return to the HA, stating how many complaints had been made to them, but that return did not include information about the nature of the complaint made. Moreover, the system depended on practices being frank about the number of complaints received. HAs did not have a full picture of the complaints being made in their area. This deprived them of a valuable means of monitoring quality of care and services. It ran counter to the increased role which, in other respects, they were playing in the management of primary health care.

The Position in 1998

4.32 By 1998, considerable progress had been made by HAs in the collection of data about GP practices and in the encouragement of practices, by means of financial incentives, to improve the range and quality of their services. Nevertheless, there were still considerable limitations on the ability of the HAs to deal with those GPs who were not amenable to change. The medical advisers had powers only to enquire about prescriptions and referrals and to inspect GPs' arrangements for keeping controlled drugs. Otherwise, they had no right to enter practice premises. They had to proceed by means of persuasion and the use of influence. Ultimately, they had no sanction against a GP who overspent his/her IPA, provided that s/he was not guilty of 'excessive prescribing'. Dr Banks, former Medical Adviser to the Tameside FHSA/WPHA, told the Inquiry that prescribing was 'a very powerful tool' available to GPs. If they became alienated, they could spend a lot of money on prescribing and, by so doing, have an adverse effect on the FHSA/HA's budget. Because of that, he said, he was anxious not to alienate Shipman. At first consideration, Dr Banks' attitude to Shipman might seem rather pusillanimous. For a doctor deliberately to increase his spending on drugs as part of a 'power game' would be quite unacceptable. However, I have much sympathy with Dr Banks' position and attitude. A doctor's right to prescribe as s/he thinks fit in the patient's interest has always been jealously guarded and

it could be very difficult to demonstrate that a doctor was prescribing expensive drugs for improper reasons. The evidence suggests that Shipman would have been well able to quote published papers to justify his prescribing decisions. Moreover, he was a very prickly, difficult and sometimes arrogant personality. I can understand why Dr Banks thought that a confrontation might be counter-productive.

4.33 Following the changes of 1996, HAs had less involvement with patient complaints. Indeed, as I have said, they received incomplete information about complaints which were made and consequently had less opportunity to gain intelligence about poor practice. Disciplinary action for breach of a GP's terms of service was taken rarely and referrals to the NHS Tribunal became even less common. HAs still had only a very limited power to remove a doctor from their lists. Their only recourse, if dissatisfied about some aspect of the GP's practice that did not amount to a potential breach of his/her terms of service, was to refer the doctor to the GMC. Dr Banks told the Inquiry that, in his view, matters of clinical competence were for the GMC and could not be dealt with at local level.

The Problem of the Poorly Performing Doctor

4.34 During the late 1980s and early 1990s, there was mounting awareness of, and concern about, doctors whose conduct, competence and/or quality of care was substandard. It was recognised that by no means all these doctors were being brought to the attention of the authorities. Even if they did, they could not readily be dealt with by the existing procedures.

4.35 The only mechanism by which such problems could be tackled at that time was by invoking an informal procedure whereby the LMC would appoint 'Three Wise Men' to enquire into a GP's performance and would attempt to resolve any problems which were identified. Every HA was advised to enter into an agreement with the LMC for the setting up of such a procedure. However, the procedure had no statutory basis and the GP could not be compelled to co-operate. Not surprisingly, the procedure frequently failed to resolve the problem.

4.36 The Medical (Professional Performance) Act 1995 (the 1995 Act) introduced what became known as the GMC's performance procedures. Prior to the introduction of these procedures, the GMC had been able to take action only if a doctor had been found guilty of serious professional misconduct or was suffering from a serious impairment of health. The 1995 Act, which came into effect on 1st July 1997, gave the GMC power to suspend or impose conditions upon the registration of a doctor whose professional performance was found to be seriously deficient. The aim was to enable the GMC to take action where complaints about a doctor's clinical performance over time suggested a pattern of serious deficiency.

4.37 Local arrangements were to be put in place to assist in identifying doctors (both GPs and hospital doctors) who were performing poorly and to ensure that, wherever possible, action was taken at a local level to remedy their failings. Only when that remedial action failed should a referral to the GMC become necessary.

4.38 Around the time of the introduction of the new GMC procedures, a considerable amount of guidance was issued to HAs concerning the arrangements which they should put in

place to deal with poorly performing doctors. I shall describe those arrangements in Chapter 5. It took time for the necessary arrangements to be put in place. In most areas, the procedures did not come into operation until 1998 or later. When eventually they were in operation, they represented a very significant adjunct to the complaints and disciplinary mechanisms previously available to the PCOs.

The Arrangements in Tameside

4.39 I shall now turn to consider the arrangements for monitoring GPs which were in place in Tameside during the period of Shipman's practice there. Could and should those arrangements have led to his earlier detection or, at any rate, should they have alerted the authorities to the fact that he was aberrant in some way? Were there effective mechanisms which could have been put in place but were not? How did the arrangements in Tameside compare with those elsewhere?

4.40 As I have already explained, the bodies successively responsible for organising primary care in Tameside did not know until 1998 that Shipman had criminal convictions (including convictions for forging prescriptions) associated with the misuse of controlled drugs. They were therefore unaware that he posed any particular risk, in relation to his prescribing practices or otherwise. Their conduct must be viewed in that light. It has been suggested to the Inquiry that the Tameside FPC and its successors should be criticised for failing to 'unearth' information about Shipman's past history. I shall deal with that suggestion later in this Chapter.

4.41 Shipman was, in many respects, a competent doctor. He kept abreast of current medical literature and of developments within the field of general practice. He was an enthusiastic proponent of preventive medicine. When target payments for vaccination, immunisation and cervical cytology were introduced, he consistently attained those targets. His Market Street practice established sound systems for monitoring and treating patients suffering from chronic disease, such as asthma. It is possible (as some have suggested) that Shipman created an appearance of greater professional competence than he in fact possessed. In any event, it is unlikely that routine examination of the limited amount of data available to the Tameside FHSA/WPHA about his practice activity would have raised any concerns about his competence or professional conduct. The routine checks which were carried out by the WPHA in later years to verify Shipman's claims for payment for items of service showed no significant discrepancies. Inspections of his practice premises found them to be in good order. Moreover, as I shall explain in Chapter 6, although complaints were made against Shipman, they were not such as would have raised serious concerns about his conduct or competence. Most conventional monitoring techniques would, therefore, have failed to identify him as a potential source of problems.

4.42 I intend to focus on those aspects of Shipman's practice which, had they been subject to specific enquiry, might have been identified as abnormal in some way, and as meriting further investigation. Those aspects are the number of deaths among his patients and the circumstances surrounding those deaths, his prescribing (in particular, his prescribing of opiates) and the quality of his medical records. I shall also consider other information

which, during the later years, was held by the Tameside FHSA/WPHA and which might have contained significant material.

The Number and Circumstances of Patient Deaths

4.43 Before Shipman's arrest, it had not been the practice of PCOs to monitor the death rates among patients of individual GPs. There were a number of reasons for this which I shall explain in Chapter 14. There can be no criticism of the PCOs in Tameside for the fact that they did not undertake any monitoring of this kind.

4.44 At present, there is no system for collecting and analysing information about the circumstances of deaths. Thus, no one in authority was alerted to the abnormally high proportion of Shipman's patients who had died at home, or who had suffered sudden, unexpected deaths or who had died (on Shipman's own admission) in his presence or shortly after a visit from him or whom he had 'found' dead. No one in authority was aware of the fact that six deaths had occurred on his surgery premises. None of the PCOs responsible for Tameside over the years held such data or had any means of obtaining it. They cannot, therefore, be criticised for being unaware of it.

4.45 Under the new coroner system proposed in my Third Report, all deaths would be reported to the coroner, and far more information would be available about the circumstances surrounding each death. That information would come from the person (usually a healthcare professional) who confirmed that death had occurred, from the doctor who gave an account of the deceased's medical history and from a member of the deceased's family or someone else with knowledge of the deceased. Information from these various sources would be cross-checked. The coroner system would hold all the relevant data. It would be possible to monitor that data and investigate any apparently unusual patterns or other features. At present, this exercise just cannot be done.

The Period from 1977 to 1990: the Tameside Family Practitioner Committee

4.46 As I explained in Chapter 3, the role of the FPCs prior to the mid-1980s was extremely limited. It was concerned with matters of administration, rather than professional conduct or clinical practice. FPCs carried out no form of activity that could be described as the 'monitoring' of the GPs on their lists. Nor, during this period, could a FPC expect to receive expressions of concerns from one doctor about another. As I shall describe in Chapter 10, the culture at that time was such that few doctors would have regarded it as their professional duty to report a colleague, even if they had had concerns about his/her fitness to practise. On the rare occasions when a concern was expressed, it would be dealt with by the LMC rather than the FPC: see paragraph 4.22.

4.47 Virtually the only source of information which might have led to the identification of a 'problem doctor' would be complaints from patients or their representatives. It is significant, therefore, that Mr Greenwood had, by the mid- to late 1980s, instituted a system of reviews of the complaints log held by Tameside FPC. As I have explained, Mr Greenwood recalled that his review revealed the existence of an administrative problem affecting one practice. It would not have revealed a problem with Shipman. At no

time during his career did a complaint or pattern of complaints emerge, such as would have led to wider suspicions about his activities. As I shall describe in Chapter 6, some complaints were made about him. However, they gave no indication of his criminality.

The Period from 1977 to 1990: the Regional Medical Service

4.48 As I have said, the RMOs made regular visits to GPs during this period. The Inquiry received evidence from three former RMOs. Dr Jack Edwards, a former GP, was a RMO from 1965 until 1992 and covered the Tameside, Trafford and Stockport areas. Dr Archer, another former GP, joined the RMS in 1987 and was based in Manchester, covering four FPC areas, including Tameside. In January 1988, he was seconded to the Trafford FPC and did not thereafter visit GPs in Tameside until he returned there as Medical Adviser to the Consortium of the Tameside, Wigan and Stockport FHSAs. Dr David Edwards, who left general practice in 1986 to join the RMS, covered the Wirral and Cheshire areas (excluding Stockport). In June 1990, he left the RMS and joined the consortium of the Tameside, Wigan and Stockport FHSAs as co-Medical Adviser with Dr Archer.

Shipman's Prescribing

4.49 No reports of practice visits by RMOs to GPs in Tameside have survived. Dr Archer was, however, able to refer to notes of visits (including visits to the Donneybrook practice) recorded in his diary. All the witnesses agreed that one of the topics discussed at their meetings with GPs was prescribing. Dr Archer said that the topic would be discussed in general terms. He would stress the need for economy in prescribing. He would advise GPs to take care when prescribing new drugs. He would encourage them to report adverse reactions to drugs.

4.50 In general, RMOs would have only basic information about the prescribing costs of each practice. More detailed data was made available to them only if the practice had been identified by RMS Headquarters as a high cost prescriber. The usual rule was that, if a practice's prescribing costs were more than 25% above the average, the RMO would be required to visit the practice to discuss ways in which the GP(s) in question might modify their prescribing habits.

4.51 None of the RMOs who provided evidence to the Inquiry remembered Shipman having been identified by (or to) them as a high prescriber. Dr Archer's notes of visits to Donneybrook House in December 1987 and January 1991 contain no mention of any concerns about him. This may well have been because Shipman's prescribing costs at that time formed part of the prescribing costs for the whole Donneybrook practice. Prescribing data available to the RMOs would have related to the practice, not to individual doctors within the practice. If the Donneybrook practice had not been identified as having high prescribing costs, more detailed data would not have been obtained. Thus, the RMOs would not have been aware of Shipman's prescribing costs relative to those of his colleagues at the practice.

4.52 Between 1977 and 1990, Shipman killed 71 patients. Although the Inquiry has no information about his acquisition of opiates during this period, I have no doubt that he was

diverting diamorphine, which had been prescribed in the names of patients, for his own purposes. He had done that in Todmorden (with pethidine) and was to do it again (with diamorphine) when at the Market Street Surgery. The basic prescribing information generally available to RMOs would not have shown that Shipman was prescribing opiates. Indeed, as I have explained, it would not have shown details of Shipman's prescribing at all.

Enquiries into Shipman's Keeping of Controlled Drugs

4.53 The RMOs were responsible for checking GPs' CDRs and stocks. Four members of the Donneybrook practice recalled their CDRs being inspected. Only one (Dr Ian Napier) remembered a RMO inspecting his stock of controlled drugs. Dr David Edwards told the Inquiry that Shipman had informed him that he did not keep controlled drugs and did not have a CDR. He does not remember whether Shipman gave a reason for this. It was not unusual. A significant proportion of GPs did not keep stocks of controlled drugs. Dr Edwards would therefore have had no reason to doubt what Shipman said. There seems little doubt that, whichever of the RMOs had asked about his arrangements for controlled drugs, the answer would have been the same.

4.54 It should also be noted that, during this period, regular inspections of pharmacists' CDRs were carried out by police chemist inspection officers (CIOs). They would have been focussing their attention solely on controlled drugs and had, by virtue of their position, a considerable amount of knowledge and experience about their use. They noticed nothing suspicious about Shipman's prescribing. That being the case, it would appear unrealistic to suggest that the RMOs should have done so from the information contained in the practice prescribing data.

Shipman's Record Keeping

4.55 The Inquiry was told that, until the 1960s, the practice had been for RMOs to inspect GPs' medical records to ensure that they were being maintained in accordance with the terms of service. That practice had ceased (certainly in Hyde) well before Shipman arrived. The Inquiry has been unable to ascertain why the practice fell into disuse. Inspecting records is a time-consuming process and it may be that it had been discontinued for that reason. It is possible that it had come to an end as a result of resistance within the medical profession to inspection of its records. It was certainly unpopular. Dr Geoffrey Roberts, formerly secretary of the LMC for Tameside, told the Inquiry that he had tried to institute a system of inspections of surgery premises in 1980. He made one inspection, which included looking at records, but said that the GP in question 'took great exception' to this. It may be that the RMOs met with a similar reaction when they carried out their inspections. Be that as it may, it is clear that, by 1977, the practice had long been discontinued.

4.56 Had Shipman's medical records been subjected to critical scrutiny, two features might have emerged. First, the quality of his records might have been observed to be poor. That was certainly the general view of those doctors who subsequently examined his records for the purposes of the Inquiry. I say that the records 'might have been' considered poor because Dr Napier, one of Shipman's colleagues at the Donneybrook practice, was

candid enough to tell the Inquiry that the records of all the doctors at the Donneybrook practice, including his own, were 'fairly terrible, if not pathetic' at the time Shipman left. They had subsequently been greatly improved with the advent of computerisation. It may be, therefore, that the overall quality of Shipman's notes would not have attracted particular attention.

4.57 The other feature would have been the nature of the entries made in connection with the deaths of patients. Sometimes, those entries were extremely sparse and information about the circumstances of deaths, the diagnosis of the cause of death and the basis for the diagnosis was plainly inadequate. Sometimes, the records were much more detailed but revealed unusual circumstances surrounding the death. Many examples of such entries (some dating from the 1980s) are discussed in my First Report. Whether or not the unusual features of the entries would have been noticed would have depended first on whether the RMO had elected to inspect the records of a deceased patient whom Shipman had killed. The chances of that are perhaps small, as most such records would have been sent back to the FPC shortly after the patient's death. Even if they had been returned to Shipman subsequently, they are likely to have been stored at his home, where many records were found after his arrest. It would also have depended on whether the content of the notes was considered critically. If the purpose of the inspection was to ascertain whether the notes were arranged in chronological order, whether proper summaries had been prepared and other matters of that kind, the odd features might have been missed.

The Period from 1990 to 1998: the Tameside Family Health Services Authority and the West Pennine Health Authority

4.58 In 1991, as I have explained, the FPCs were replaced by FHSAs. The FHSAs took over all the responsibilities which had previously lain with the RMS, save for those relating to certification for the purpose of DSS benefits. The independent medical advisers whom the FHSAs were required to employ took over responsibility for monitoring GPs' prescribing and for assisting in the introduction of the new IPAs. From 1990, Dr Archer and Dr David Edwards, both former GPs and RMOs, were co-Medical Advisers to a consortium of the Tameside, Wigan and Stockport FHSAs. They were succeeded, in November 1991, by Dr Freedman, a former GP. In August 1993, he became Medical Director of the Manchester FHSA and his place at Tameside was taken by Dr Banks, another former GP.

4.59 From April 1991, the advisers also took over responsibility for inspecting GPs' CDRs and their stocks of controlled drugs. It seems that, from that time, fewer inspections of CDRs and stocks of controlled drugs took place than previously. Dr Jim Smith, Chief Pharmaceutical Officer for England at the DoH, conceded that that was the case. He said that, in the early 1990s, controlled drugs were not a priority. He thought this was because they were not perceived as a problem. The other systems of control (operated by the Home Office and the police) were thought to be sufficiently robust. He acknowledged that that view had been proved wrong. A team which included Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, undertook a study, the results of which were reported in a paper entitled 'Reducing Leakage of Prescribed Drugs' in January 2002. In the course of the study, the team identified 59 GP practices in Leicestershire and Rutland that kept stocks of controlled

drugs. Thirty one of those practices had undergone no inspection of their CDRs or controlled drug stocks for a period of more than ten years prior to the study. Only six practices had been inspected within the previous 12 months. It appears, however, that the advisers in Tameside did question GPs about their arrangements for keeping controlled drugs. I shall refer to Shipman's responses to such questions later in this Chapter.

4.60 Tameside FHSA also appointed a pharmaceutical adviser. Mrs Rosalyn Anderson was the pharmaceutical adviser to the Tameside FHSA (later the WPHA) from September 1992 until April 1996. Mrs Bernice Abrahams (then Miss Bernice Caden) stood in for a year in early 1993 while Mrs Anderson was on maternity leave. Mr Peter Welsby overlapped with Mrs Anderson for about six months before taking over from her.

Prescribing Data

4.61 By the early 1990s, more informative prescribing data had become available from the PPA. Prescribing analysis and cost (PACT) data was available in paper form. It had certain limitations. The standard eight-page PACT report gave information about prescribing by GP practice, not individual GP, unless the GP practised single-handed. It did not contain information about private prescriptions. It did not identify the patient for whom a drug or appliance had been prescribed. In fact, then – as now – no patient-specific data was collected by the PPA.

4.62 The data was presented by reference to the British National Formulary (BNF). The BNF is divided into chapters, each setting out details of drugs that act on a specific therapeutic area. Each chapter is divided into sections dealing with the types of drug which act on that therapeutic area. The sections are further broken down into paragraphs and sub-paragraphs, providing highly specific details of the drugs of each type. Sub-paragraphs are further broken down into details of drugs, products and individual formulations.

4.63 Using the prescribing of a diamorphine 100mg injection by way of illustration, the information contained within the BNF is as follows:

BNF Chapter 4:	Central nervous system
BNF Section:	Analgesics
BNF Paragraph:	Opioid analgesics
BNF Sub-paragraph:	Opioid analgesics (i.e. the same as the BNF paragraph)
BNF Chemical substance:	Diamorphine
BNF Product:	Diamorphine HCl (systemic)
BNF Presentation:	Diamorphine HCl injection 100mg ampoule

4.64 PACT reports in paper format were available to GP practices and PCOs. Each report covered a period of three months and compared practice data with FHSA/HA national averages. A standard PACT report would show the practice prescribing costs for the BNF section. Using the example of diamorphine, it would show the practice prescribing costs

for analgesics but would not distinguish between the different types of analgesic (still less the chemical substances, products or presentations) prescribed. Thus, it would not be evident from the PACT report that a doctor had prescribed diamorphine. Although the reports identified the 20 leading drugs in the practice by cost and frequency of prescribing, the fact that opiates are inexpensive meant that even large quantities of diamorphine would not have appeared, particularly if a practice was a high cost prescriber in other areas. An exception would be if a number of high dose (100mg or 500mg) ampoules of diamorphine had been prescribed. The high dose ampoules are significantly more expensive than the lower dose ampoules. Usually, the high dose ampoules are prescribed for a terminally ill patient for a short period immediately prior to death. Paper PACT reports have remained essentially the same since they first became available.

4.65 PACT catalogues were also available to PCOs and, on request, to GP practices. In general, they covered a period of three months, although catalogues containing as much as two years' data could be requested. The catalogues were very bulky, anything from 70 to 250 pages for a three-month period. They contained a detailed inventory of every drug prescribed by the practice at BNF presentation level. The catalogue would show the number of times a drug was prescribed, the quantity of the drug prescribed and the total cost. It would not show for how many patients the drug had been prescribed. PACT catalogues contained raw data and offered no means of analysing trends or comparing prescribing between practices.

4.66 Since 1992, electronic PACT systems have been available to PCOs and other NHS bodies. The first of these, PACTLINE, provided data for only the previous year's prescribing. Analysis could be performed down to the level of BNF section (e.g. analgesics) only. Further analysis had to be performed using the paper PACT catalogue. The FEPACT (later known as HAEPACT) system, introduced during 1994 and 1995, enabled PCOs to send requests to the PPA mainframe for analysis of drug and presentation level data. This was used to obtain a more detailed analysis of the information already available from PACTLINE. Theoretically, it would have been possible to request an analysis of Shipman's prescribing of diamorphine injections by means of this system. In practice, however, such a query would not have been made without a prompt suggesting that something was amiss. In general, the FEPACT/HAEPACT systems were used to obtain further data about problem areas identified by PACTLINE. Had the Tameside FHSA/WPHA obtained information from elsewhere that Shipman was misusing diamorphine, it could have interrogated the PPA system to explore that possibility. It would, however, have had to have been alerted to a potential problem in order to make the enquiry in the first place. Only two years' historical data was available on the electronic systems. In April 1997, a new EPACT system replaced PACTLINE and HAEPACT. EPACT permitted more sophisticated analysis and reporting. However, the system was not straightforward and required a degree of expertise.

4.67 In April 1999, a new system, ePACT.net, was introduced. Training in the use of the system was available. Initially, the training course did not cover techniques for analysing the prescribing of controlled drugs. As a result of Shipman's conviction, however, appropriate training was started in May 2000. Since then, many PCOs have instituted a system of

regular monitoring of the prescribing of controlled drugs by GP practices in their area. The ePACT.net system has three significant advantages over its predecessors. First, it is much easier to use. Second, the system permits interrogation of the system on-line, so that the results are available immediately. The third advantage of ePACT.net is that data for the previous three years is available for analysis. This gives a greater opportunity to see the emergence of a pattern.

Shipman's Prescribing

4.68 It is clear that, from at least March 1992, Shipman was identified by the Tameside FHSA as a high cost prescriber. The problem was caused by his tendency to prescribe expensive drugs, in particular lipid-lowering drugs. He favoured branded drugs over the less costly generic variety. In 1993, he was the lowest prescriber of generic drugs in the area. As a high cost prescriber, Shipman received regular visits from the FHSA's medical and pharmaceutical advisers. They tried to persuade him to modify his prescribing habits.

4.69 When challenged about the high cost of his prescribing, Shipman was always able to justify himself, by reference to current research or his own patient data. He would claim to have a low death rate among his asthmatic patients and no suicides among depressive patients, and would cite this as evidence of his successful use of anti-asthmatic and anti-depressant medication. He would explain and justify his belief in the prophylactic effect of lipid-lowering drugs. GPs had clinical freedom to prescribe as they believed appropriate for their patients. Advisers could only encourage and attempt to persuade them to change their prescribing habits. They were powerless to do more unless a GP was guilty of prescribing so excessively as to contravene his/her terms of service. Dr Freedman recalled that, at one time, before he left the Tameside FHSA in August 1993, there was some discussion as to whether it would be appropriate to refer Shipman to a professional committee on the grounds of his expensive, and low generic, prescribing. He believed that the FHSA took advice from one of the regional pharmaceutical advisers. The view was that the new procedures could not be applied to Shipman since his prescribing patterns did not fall into the appropriate categories. It was decided that it was better to pursue an 'educational approach'.

4.70 In 1993, Shipman acquired a computer system with software designed to encourage the use of generic drugs wherever possible. Whether because of that or (as Dr Banks suggested) in response to the introduction by the FHSA of financial incentives for generic prescribing, Shipman increased his generic prescribing markedly. From that time, he became one of the highest prescribers of generic drugs in the FHSA. However, his overall prescribing costs continued to be the highest in the area. In 1995, Shipman joined a fundholding consortium with a shared prescribing budget. The consortium engaged the services of Ms Carol Abdulezer, an independent pharmacy consultant, to prepare a formulary for use by the consortium. In the course of that work, she reviewed the PACT data of all the GPs in that consortium, including Shipman.

4.71 Shipman did not modify his prescribing costs, even when he was subjected to pressure from colleagues within the consortium. In June 1998, three months before his arrest, his prescribing costs exceeded the HA equivalent by 75% and the national equivalent by

88%. Throughout this period, Shipman's prescribing was a matter of real concern to the Tameside FHSA/WPHA and to the North West Regional Office of the NHS Executive. However, that concern did not relate to the quality of his prescribing. It was not felt that he was prescribing inappropriately or inadequately. He was not prescribing drugs which had been superseded by more effective preparations or drugs known to be of limited therapeutic value. On the contrary, he favoured modern, newly developed drugs. The sole reason for concern about Shipman's prescribing habits was their cost.

Shipman's Prescribing of Opiates

4.72 The Inquiry heard oral evidence from Dr Archer, Dr David Edwards, Dr Freedman, Dr Banks, Mrs Abrahams and Mr Welsby, whose joint employment as advisers to the Tameside FHSA/WPHA spanned the period with which I am concerned. The Inquiry also heard evidence from Ms Abdulezer. Mrs Anderson was prevented by family difficulties from attending to give evidence but provided two statements. Notes and letters relating to prescribing visits, some of the prescribing data used to prepare for those visits and other relevant documents were made available to the Inquiry. None of the Tameside FHSA/WPHA advisers had ever had occasion for concern over Shipman's prescribing of diamorphine. Ms Abdulezer had had occasion to speak to him about it once in circumstances which I shall relate shortly.

4.73 As I have explained, the standard paper PACT reports were not sufficiently detailed to show that diamorphine had been prescribed. When the advisers obtained the more detailed PACT catalogues, their attention would have been focussed on the areas of high cost. These would not usually include opiates which, as I have explained, are relatively inexpensive save for the high dose ampoules of diamorphine.

4.74 If an examination of a PACT catalogue had revealed that a large quantity of diamorphine had been prescribed during the period (usually three months) covered by the catalogue, it would be assumed that this was attributable to pain relief prescribed for a terminally ill patient in the last stages of his/her life. Such patients often need very large quantities of diamorphine to relieve their pain. The Inquiry was told that the advisers would not want to appear to be 'penny pinching' in such a sensitive area. Accordingly, they would be reluctant to question the amount of diamorphine prescribed in these circumstances. Mrs Anderson said that she would not have looked at a GP's use of controlled drugs in detail unless she had been alerted to a potential problem.

4.75 In March 1992, Shipman prescribed two 30mg ampoules of diamorphine. He prescribed no more that year. The prescription would have attracted no attention. Between February and August 1993, he prescribed 14 single 30mg ampoules of diamorphine, in the names of 13 different patients. These would not have been evident from the electronic PACTLINE system or the standard paper PACT reports. They would, however, have appeared in the PACT catalogues for the three quarters during which the prescriptions were issued. Prescription of a 30mg ampoule of diamorphine as a 'one-off' means of treating a patient would be unusual. A series of such prescriptions would be even more unusual. If noticed by someone with knowledge about the use of opiates, this pattern of prescribing should have raised questions and concerns. In my Fourth Report, I was critical of the pharmacist

and the CIO who failed to notice the unusual nature of these prescriptions from the entries in the CDR kept at the pharmacy at which the prescriptions were dispensed. However, I am not critical of the FHSA advisers responsible for examining the PACT data for the periods covering these prescriptions. I have already explained that the information contained within the PACT catalogues would not have told a reader how many patients had received the diamorphine. That fact, and the fact that the reader would be examining one quarter's catalogue at a time, would mean that the information, even if noticed, would have had very little impact. The total amount and cost of the diamorphine prescribed over a single quarter would have been relatively small. The information would have appeared in a bulky document containing a great deal of data about the drugs, including high cost drugs, prescribed by Shipman over the same three-month period. It is not surprising that these single 30mg ampoules of diamorphine were not noticed.

4.76 In November 1993, Shipman's method of obtaining diamorphine changed. He took possession of two or three boxes, each containing ten 100mg ampoules of diamorphine, after the death of a patient. He said that he intended to destroy them. The diamorphine had been prescribed for administration by means of a syringe driver to a terminally ill patient who had died at home. Thereafter, Shipman obtained diamorphine in large quantities by prescribing it for cancer patients who did not in reality require it, by removing it from the houses of patients who had died of cancer or by collecting it on behalf of a terminally ill patient and keeping some or all of the drug for himself.

4.77 As I have said, Ms Abdulezer did have occasion to ask Shipman about his prescribing of diamorphine. She told the Inquiry that, when examining the prescribing data of the fundholding consortium of which Shipman was a member, she discovered that his diamorphine prescribing for the quarter had increased. She immediately assumed that the reason for the increase was that Shipman was prescribing for a terminally ill patient. Her purpose in speaking to him was not to investigate the reason for his prescribing or to seek to persuade him to reduce it, but to ascertain for how long the need for the drug was likely to continue. She wanted to know whether she should request the Tameside FHSA/WPHA to take it into account when setting the consortium's prescribing budget. Shipman immediately identified the patient concerned, retrieved his/her medical records and showed Ms Abdulezer a letter from the hospital setting out the dosage of diamorphine to be given. He told Ms Abdulezer that the drug would not be required for long as the patient was in the end stages of a terminal illness. The following quarter, the costs had returned to their previous level so Ms Abdulezer did not query them further. She cannot remember the name of the patient but thought that the incident had occurred in 1995 or early 1996. She had no reason to doubt Shipman's word.

4.78 During those two years, Shipman had several patients who suffered from cancer and were in genuine need of large quantities of diamorphine. In fact, we now know that he diverted some of their diamorphine for his own purposes. That would not have been evident to an adviser, armed only with the PACT data and reliant upon Shipman for any additional information. The PACT data did not identify the patient(s) for whom the drug was prescribed, nor of course did it give any information about what had happened to the drug once it was prescribed and dispensed. It would have been easy for Shipman to convince

an adviser, as he did Ms Abdulezer, that the diamorphine had been legally prescribed to a patient and used by him/her.

4.79 For the reasons I have explained above, I do not find it surprising that the monitoring of prescribing which was carried out by the Tameside FHSA/WPHA advisers did not reveal cause for concern about Shipman's prescribing of diamorphine. Even if it had, I have little doubt that Shipman would have been able to allay any concerns which arose.

4.80 Meanwhile, over the same period, the police CIOs were carrying out inspections of the CDR held by the Norwest Co-op Pharmacy, from where most of Shipman's diamorphine prescriptions were dispensed. They too saw nothing to cause them concern. As I have explained in my Fourth Report, they are not to be criticised on that account save in respect of the records relating to the 30mg ampoules of diamorphine dispensed in 1993. The prescriptions were all made out correctly in the names of real patients who were suffering from cancer. It was not apparent to the CIOs – or indeed to the dispensing pharmacist – that Shipman was prescribing more than the patients actually needed. Nor could they know what a detailed interrogation of the PACT data would have revealed, namely that Shipman was a high prescriber of diamorphine, although not the highest in the area. Nor were the CIOs aware that Shipman sometimes collected the drugs on his patients' behalf. That information was not recorded in the CDR, although if my recommendations are accepted, it will be in future. In the Fourth Report, I have also recommended that a single agency should have the function of inspecting the CDRs and examining the PACT data. In that way, the officers of one body would have a complete picture of a doctor's practice in relation to the prescribing and collecting of controlled drugs.

Enquiries about Shipman's Possession and Prescribing of Controlled Drugs

4.81 I have already said that Dr David Edwards had been told by Shipman that he did not keep controlled drugs and did not have a CDR. That was when Dr Edwards was a RMO. Later, he became one of the Tameside FHSA's first Medical Advisers. Dr Archer, Dr Edwards' co-Adviser, did not say in his statement to the Inquiry whether or not he had discussed the matter with Shipman but, if he had done so, no doubt he would have received the same answer.

4.82 Dr Freedman told the Inquiry that when, on one of his prescribing visits, he asked Shipman whether he had a CDR, Shipman answered that he did not keep controlled drugs. He said that he was afraid they might be stolen. When asked what he would do in an emergency, he told Dr Freedman that it was not his practice to visit patients who telephoned the surgery with the symptoms of a heart attack. He said that, when this happened, he would immediately ring for an ambulance and get them straight into hospital where they could be more promptly treated. As it happens, Shipman frequently claimed that his victims had died of a heart attack after he had failed in an attempt to treat or resuscitate them but Dr Freedman was not to know that. There seems little doubt that Shipman would have given the same answer to anyone who put the question to him. It was not an unusual stance for a GP to take. No adviser would have had any reason to doubt Shipman's word.

4.83 In October 1998, following Shipman's arrest, Dr Banks, then Medical Adviser to the WPHA, asked the PPA to analyse Shipman's prescribing of 100mg diamorphine injections.

Because of the restrictions on the available data (see paragraph 4.66 above), it was possible to look at only the previous two years' data. Two points emerged from this analysis. The first was that Shipman was not, as might have been expected, the highest prescriber of this dosage of diamorphine in the area of the WPHA. In fact, he was the sixth highest prescriber over the two-year period. He might well have been found to be the highest if a longer period could have been examined; he prescribed heavily and stole a very large amount in the first half of 1996. The second point was that, although Shipman's pattern of prescribing 100mg ampoules of diamorphine was unusual (in that there was more frequent relatively low level prescribing than would be expected), the prescribing patterns of the other high prescribing doctors were not all conventional either.

4.84 If this unusual pattern had come to the attention of the authorities and Shipman had been asked about it, he would have been able, on each occasion, to produce evidence of a patient (whether terminally ill or recently dead) for whom the diamorphine had been prescribed. The records of most of those patients would have confirmed that they were in genuine need of large quantities of diamorphine for pain relief. The district nurses who were caring for the patients would, if asked, have confirmed that no more of the drug was being prescribed than was necessary. They would have been unaware of those drugs which Shipman had collected from the pharmacy and diverted for his own ourposes. Even on the occasions when he had prescribed diamorphine for a patient who was not in genuine need of it, Shipman would no doubt have given a plausible reason, associated with the patient's cancer, for prescribing the drug. It would have required an in-depth investigation, of the kind that would be undertaken only if real concerns or suspicions had arisen, to reveal Shipman's practice of collecting and keeping drugs for himself.

Record Keeping

4.85 During the period from 1991 until 1998, no routine inspections of medical records were conducted in Tameside. Dr David Edwards told the Inquiry that, when he was co-Medical Adviser, from 1990 until 1991, he sometimes received requests from patients' relatives to view medical records in connection with a complaint or following the death of a patient. He would seek the permission of the patient's GP and of the LMC before showing the records to the relatives and explaining their contents. If Dr Edwards noticed that records were substandard, he would speak to the GP concerned.

4.86 Dr Banks agreed that individual sets of patient medical records might be examined in connection with the investigation of a complaint against a GP. However if, on examination, the records appeared inadequate, he said this would not lead to any wider inspection of the GP's records.

4.87 The view held by Tameside FHSA/WPHA was that they had no right to inspect records save in the limited circumstances described above. This view is not shared by the DoH. Its view is that, pursuant to paragraph 36 of the 1992 terms of service (which required GPs to keep adequate medical records and to forward them to the FHSA (later the HA) on request as soon as possible), a PCO could request to see the medical records at any time. However, Dr Banks said that any attempt to carry out random inspections of GPs' records would have been resisted by the profession. In the past, there had been problems in

gaining access to records for the purpose of verifying financial claims made by GPs in respect of treatment given to patients. The WPHA had succeeded in reaching an agreement with local GPs that staff should have such access for the limited purpose of financial audit. Not every HA in the country had achieved the same success. Dr Banks said that, if the WPHA had attempted to carry out random inspections of records, 'the BMA (*British Medical Association*) would have been on our backs immediately'. Dr Banks did, of course, examine 15 sets of Shipman's deceased patients' records in the course of the abortive police investigation of March 1998. He thought that the records lacked information but assumed, not that Shipman was a poor record keeper, but that the records must be incomplete.

4.88 The introduction of medical audit revealed problems with the records kept by some GPs in Tameside. Records which were incomplete or disorganised or which lacked a detailed summary card caused difficulty in retrieving information for the purpose of audit. In order to tackle this problem, the Tameside FHSA instituted a scheme (subsequently continued by the WPHA) whereby teams of trained, non-medical staff went into GP practices to summarise and reorganise medical records. There was no compulsion on a practice to accept this service. The work of the team did not involve any clinical assessment of the records and it was in no sense a process of monitoring. Shipman never availed himself of this service.

Other Sources of Information

4.89 In the early 1990s, the Tameside FHSA introduced a system of 'practice profiling'. There was no requirement upon it to do so. The profiling was an additional exercise which it chose to perform. It involved using the available information about list sizes, prescribing and referral activity, chronic disease management and financial matters such as payments for items of service in order to compare the performance of individual GP practices. Each practice was sent a copy of a profile which showed its performance compared with other (anonymised) practices. The profiles became more sophisticated over the years and incorporated a wider range of information.

4.90 Mr Greenwood said that the purpose of the exercise was to identify trends which might assist in planning services in the future. He said that the FHSA was also trying to identify outliers with a view to offering help and support to them and to bringing them more into line with their peer group. The profile also provided a means by which GP practices (which operated to some extent in isolation) could compare their performance with that of other practices. In the early years, senior managers from the FHSA visited all the GP practices in the district annually to discuss their profiles. Over time, it was felt that this did not represent an effective use of resources and the visits were discontinued.

4.91 The Inquiry has the practice profiles compiled in respect of the Market Street practice in March 1996, 1997 and 1998. The profiles show a high level of practice activity in such areas as childhood immunisations and cytology. They also show evidence of Shipman's high prescribing costs. The only additional data which might have been significant related to the low level of hospital activity among his elderly patients (i.e. those over 65). In both 1996 and 1997, Shipman's practice had the lowest level of hospital activity in the district

among patients of that age. In the light of what we know now, this factor has some significance. No figures for hospital activity appeared in the 1998 profile.

4.92 Both Mr Greenwood and Dr Banks explained that the data for hospital activity was regarded as very unreliable. Dr Banks said that, in any event, hospital activity was not a matter within the remit of medical advisers. The use of hospital services tended, he said, to be regarded as a public health issue to be considered in conjunction with those providing the services. Mr Greenwood said that the advisers would look at the correlation between hospital activity and prescribing (e.g. to see whether practices that prescribed a high level of anti-asthmatic medication had fewer admissions to hospital). Otherwise, hospital activity was regarded as a planning and funding issue. Even if it had attracted attention, the low level of hospital activity among Shipman's older patients would no doubt have been attributed to his declared policy of keeping his elderly patients at home for as long as possible.

4.93 The Tameside MAAG was set up in October 1990. It was a sub-committee of the FHSA. It included among its members GPs (some nominated by the LMC), a postgraduate tutor, a representative from secondary care and the FHSA's medical adviser. The FHSA employed a former nurse manager, Ms Heather Harrisson, as audit facilitator, and another member of staff as secretary. The task of the MAAG was to facilitate audit activity by offering advice, education, training and support in audit. GPs were encouraged to participate and the MAAG would suggest suitable topics for audit with a view to obtaining data which could be used to improve patient health. The MAAG co-ordinated district-wide audits which offered a degree of comparative feedback. Every GP practice was offered an annual visit by members of the MAAG. The practice would be invited to make available the written results of its audits for discussion with GP members of the visiting team.

4.94 Audits were carried out by GP practices themselves. They were not obliged to submit their results to the MAAG although most did. If submitted, the reports were discussed at a MAAG meeting at which only GP members (and one member of the staff) were present. The full MAAG would discuss only aggregated and anonymised audit results. The FHSA did not have access to audit results relating to individual practices.

4.95 In April 1996, the Tameside and Oldham MAAGs merged to form the West Pennine Primary Care Clinical Audit Group (WPPCCAG). The Glossop practices joined the WPPCCAG in 1997. At that time, HAs were given specific management responsibilities for clinical audit. It was intended that audit should be closely linked with improvements in the quality of clinical care. The HAs were to have a part in determining what audits should be done. They had to monitor the range and extent of participation in audit by practices and to secure the increasing involvement of patients in the audit process. However, HAs still did not see individual practice audit results and had no opportunity to assess their quality. Nor would they become aware of any signs of substandard practice that the audits might reveal.

4.96 From the time of his entry into single-handed practice, Shipman was an enthusiastic participant in audit. His practice nurse, Sister Gillian Morgan, and practice manager, Mrs Alison Massey, also participated in audit. Shipman submitted to the MAAG (later the WPPCCAG) a number of audits dealing with a wide range of topics. None disclosed any

substandard practice. A few practices in the district had conducted audits of their patient deaths. Shipman never did so although, as I related in my Second Report, he claimed untruthfully to Dr Banks in July 1998 that he and Sister Morgan had carried out an audit into patient deaths that had occurred in the early part of 1998. In November 1997, Mrs Massey conducted an audit of patients who had left the practice in the preceding six months. She discovered at least 29 cases in which the patient had died. This was a high number. The average mortality rate for GP practices is about ten patients per thousand per annum. Given Shipman's practice list of just over 3000, about 15 deaths in six months could have been expected. However, the audit expressed the number as a percentage (27.9%) of patients leaving the practice. The total number of patients leaving was not stated. Those who saw the audit would not have been aware of the underlying number of deaths.

4.97 In general, Shipman's audit activity reinforced the impression of a well-run and enthusiastic practice. In November 1997, a letter from the audit administrator observed that Shipman's practice **'has been identified as one of a number who undertake a high level of audit activity, and are well advanced with practice development'**.

The Arrangements Elsewhere

4.98 I have described the arrangements for monitoring GPs which were in place in Tameside during the period when Shipman practised there. In order to discover how those arrangements compared with those in force elsewhere, the Inquiry sent questionnaires to a number of strategic health authorities in England and Wales, chosen at random, requesting detailed information about the systems which were in place in their areas during the time Shipman was in practice.

4.99 The responses to these questionnaires revealed that the arrangements in Tameside were very typical of those implemented in the majority of areas from which responses were received. The approach to the monitoring of prescribing was similar in most areas. In general, PCOs relied chiefly on patient complaints and expressions of concern to reveal poor practice. Many of the responses referred to the fact that FHSA/HA managers had no access to the audits performed by individual practices. A few managers had developed protocols whereby serious concerns arising out of audit activity would be notified to them. Only one of the PCOs which responded to the questionnaire reported that it had carried out routine inspections of GPs' medical records. Most said that, as in Tameside, records were examined only when a complaint was being investigated. As I have said, most HAs began to operate the new local performance procedures from 1998 onwards.

4.100 A few HAs had developed additional strategies aimed at improving the quality of care and identifying problem GPs. Starting in about 1996, some areas had developed performance indicators against which practices were measured. Some (e.g. Sheffield FHSA/HA) carried out regular audits of chronic disease management, which the Inquiry was told were helpful in identifying doctors who were performing poorly. One PCO reported carrying out examinations of deceased patients' records in order to investigate concerns which had arisen about GPs' performance. One HA monitored the numbers of patients transferring from one GP practice to another while continuing to live at the same address.

Such a move might well indicate dissatisfaction with the patient's original practice. If a spate of such transfers was observed, this would suggest that there was a problem with the practice which required investigation.

4.101 Many of the responses stressed the limitations which were placed on the ability of FHSAs and HAs to monitor and manage GPs as a result of GPs' independent contractor status and the need to prove a breach of the terms of service before any local disciplinary action could be taken.

Conclusions

The Tameside Family Practitioner Committee

4.102 It seems to me that, during the period from 1997 to 1990, Tameside FPC was doing all that it could – within the very limited ambit of activity available to it – to identify and deal with concerns which might arise about the GPs on its list. It had neither the power nor the resources to do more. The information that the Inquiry has obtained from other areas confirms this view.

The Regional Medical Service

4.103 As I have already indicated, I do not consider that any criticism can be made of the RMOs responsible for visiting the Donneybrook practice between 1977 and 1990. There is no reason to believe that they would have been aware of Shipman's prescribing of opiates. Nor can any criticism be attached to their failure to inspect his medical records. The practice of inspecting medical records had fallen into disuse well before Shipman arrived in Hyde. Even if the records had been inspected, it is, on balance, unlikely that they would have revealed anything other than the fact that Shipman was not a particularly diligent record keeper.

The Tameside Family Health Services Authority and the West Pennine Health Authority

4.104 It is clear from the evidence that the Tameside FHSA/WPHA discharged its duties in relation to the control and supervision of GPs conscientiously and properly. I am confident that the members of its staff had a genuine desire to improve the quality of GP practice in its area and made good use of the powers given to them in furtherance of this objective. It seems from the responses to the Inquiry's questionnaire that the performance of the Tameside FHSA/WPHA was typical of that of most PCOs up and down the country. There were areas (South Yorkshire was one) where the HA had taken innovative steps in an attempt to raise standards and identify doctors who were performing poorly. However, the PCOs in Tameside cannot be criticised for not having been in the vanguard. They were doing all that was required of them.

4.105 In many respects, the data collected about Shipman's practice would have given a positive picture of his competence and performance. Only in the area of prescribing was Shipman perceived as an outlier. Even then, the problem arose from his rigid views (which he was able to justify) about the beneficial effects of certain expensive drugs. There was no question of his prescribing being substandard in any way. Unless his prescribing of

diamorphine was high enough to show up amidst his other prescribing (as it plainly was when Ms Abdulezer spoke to him), it would not have been detected in the absence of routine monitoring of the prescribing of controlled drugs. Such routine monitoring was not carried out widely, if at all. It is significant in that context that no training was given nationally on this topic until after Shipman's conviction in 2000.

4.106 Tameside FHSA/WPHA was typical in examining GPs' medical records only in connection with complaints about a GP. Other than that, there would have been no occasion to inspect Shipman's records. Examination of the records of some of Shipman's living patients might have shown little of note, save that the records were of generally poor quality. Careful inspection of his deceased patients' notes might have raised concerns. Tameside FHSA/WPHA was entirely typical in not having a system of examining deceased patients' notes in the absence of specific concerns.

4.107 Tameside FHSA/WPHA appears to have made arrangements for clinical audit which were entirely typical of those of other PCOs. In particular, it had no powers to compel a practice to conduct audits, let alone an audit of any particular activity. An audit of the deaths of Shipman's patients in 1995, 1996 or 1997 would have revealed a real cause for concern and might have led to the discovery of his crimes. However, WPHA is not to be criticised for the fact that this did not happen.

4.108 I have referred to the criticism made of the Tameside FPC and its successors that it failed to unearth and act upon proper and full information as to the true nature and extent of Shipman's criminal past. It is difficult to see how the PCOs could have gone about obtaining this information. First of all, they were unaware that there was anything to find out in Shipman's case. They would therefore have had to institute a system of investigating the past history of every GP on their medical list. This would have been fiercely resisted by the profession and would have been unlikely to have the support of the DHSS/DoH. So far as the Inquiry is aware, this was not an exercise that was undertaken anywhere else. In my view, those responsible for the provision of primary care in Tameside cannot be criticised for failing to undertake it.

4.109 In its written submission to the Inquiry, the Tameside Families Support Group referred to the bewilderment of its members that, during the period when Shipman practised in Hyde, the State should have abdicated its responsibility for monitoring GPs. I can understand that sentiment. Viewed through today's eyes, it seems extraordinary that, until less than a decade ago, the PCOs should have had so few powers to regulate GPs' behaviour.

4.110 The explanation lies, I think, in the historical status of GPs as independent contractors. That status has imposed constraints on attempts by successive PCOs to control and supervise GPs effectively. Until recently, GPs could be compelled to comply with their terms of service but no more. GP practices are small businesses providing services for which the PCOs pay. During the early part of the period with which we are concerned, there was a strong belief, apparently shared by Government, that the profession provided the best (indeed the only) means of imposing high standards of clinical care and professional conduct on doctors and of monitoring those standards. It was believed that it would do so rigorously. Hence, matters of professional concern arising locally were left to be determined by LMCs with the GMC as the ultimate arbiter of fitness to practise. This

belief, which was fostered by the profession, was difficult to challenge in an area involving the need for professional expertise.

4.111 It is clear that, by the 1980s (possibly before), there was a realisation that, if consistency of service and standards among GP practices was to be achieved, some element of management by PCOs must be introduced. The matter could no longer be left to the profession. The process of change began in the mid-1980s and has continued ever since. It has been accompanied by a growing recognition of the importance of tackling poor performance among GPs. As I shall describe in Chapter 5, there have been considerable developments in the arrangements for monitoring GPs since 1998. Until that time, progress was slow and, in retrospect, it is natural to wish that the process of change had started sooner. However, the fact that it did not cannot, in my view, be attributed to fault on the part of any person or organisation.