### Examination-in-chief by MR KARK (continued)

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<td>Wednesday, 28 September 2011</td>
<td>SIR DAVID NICHOLSON (continued)</td>
<td>should be run, which was not part of the way in which the NHS operated at the time. So there was, I think on purpose when it was set up, certainly the way it was set up, a degree where the Department wanted some kind -- certainly ministers wanted some kind of tension in the system, in order -- in that way to get the kind of changes that they wanted. I don't think anyone intended that that tension would mean that they wouldn't communicate with each other over such important issues. But I can perfectly understand in that environment how perhaps the priority of working together was not seen in practice.</td>
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<td>THE CHAIRMAN: Good morning, Sir David.</td>
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<td>A. Morning.</td>
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<td>MR KARK: Sir David, we were looking yesterday at the end of the investigation and the repercussions from the Healthcare Commission investigation, and the point at which Monitor approved this trust for foundation trust status. We also looked at that letter of 28 January, which I won't show on the screen again, to Martin Yeates, and on one view certainly that should have been shown to Monitor -- A. Yes.</td>
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<td>Q. -- at the time.</td>
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<td>What we do now know is that there had been a significant lack of communication between the two major regulatory bodies, namely Monitor and the Healthcare Commission, such that Monitor, at the right level, at least, were not aware that the Healthcare Commission were seriously at least considering an investigation. Do you think that the Department of Health must take a degree of responsibility for that failure, or do you say that that is simply down to the memorandum of understanding which should have been working, but wasn't? A. I think one of the lessons we've learnt from all of this is that over-reliance on formal pieces of paper and arrangements are sometimes not enough. I think what the Department did was what it thought was the right thing at the time, which was to ensure that there was a memorandum of understanding between the organisations. On reflection, I think we had a bigger responsibility, as a department, to bring organisations together, I think, throughout that period. I think it's a big lesson for us and we've absolutely, I think, learnt that.</td>
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It is your exhibit 51, dated 19 October 2007, addressed to you on Monitor headed paper, and it is signed by
Dr Bill Moyes.

The bottom paragraph of the first page he writes:
"What causes me discomfort is the fact that you have written direct to the chief executives of foundation
trusts expressing expectations in terms which will be interpreted as instructions. This approach cuts
straight across the accountability of foundation trusts, which is well illustrated by the National Audit Office
in their report of June 2006 ..."

And then over the page, the third paragraph:
"I am concerned that your letter may have sown in
some minds the seeds of doubt about the precise nature
of accountability for foundation trusts and have been
interpreted as a signal that the independence of
foundation trusts, which is a key to their success, is
in danger of being eroded. I am sure that was not the
intention, but it may be an unintended consequence."

I note that actually when you wrote your 18 March
letter following the HCC report, you very carefully
didn't write directly to foundation trust chief
executives, but you cc'd it to them. Presumably that
was in response to this sensitivity, was it?

A. I would imagine that was the reason I did it. The
Page 5

... quote it from this letter:
"NHS foundation trusts ... are independent of the
Department of Health and are directly accountable to
their local populations and to Parliament. As
a consequence of this independent status, and of this
separate and local route of accountability, I and my
ministerial team will no longer be in a position to
comment on the detail of operational management within
the NHS FTs."

Now, do you agree that that may have been the
intention but that's not actually what came to pass?
Ministers are still accountable and ministers were
standing up in the Houses of Parliament to explain what
had gone wrong with this foundation trust?

A. Well, because, apart from anything else, all of the
resources used by that foundation trust came directly
via the Department of Health to that individual
organisation.

Q. But doesn't that reflect that the original intention,
which was to divorce foundation trusts in the way that
was explained to the Speaker of the House, so that
ministers would no longer be directly accountable for
them, simply has not transpired?

A. Predominantly it has. What we're referring to here is
a particular set of circumstances. On a day-to-day
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Day 128 Mid Staffordshire Inquiry 28 September 2011

| Page | 1 | basis ministers and I don't make comments on detailed operational management of foundation trusts, but when a foundation trust gets into difficulty or potentially affects the quality of services for patients in a detrimental way, I don't think we can stand by and not make comment and try and provide support and help to those organisations when it happens. I don't think that undermines the principle of foundation trusts, which is to give more power to local communities and local hospitals to run their own affairs. |
| Page | 11 | Q. Can I just ask you about performance management in foundation trusts, and we touched upon this yesterday. |
| Page | 13 | A. Yes. |
| Page | 14 | Q. Monitor are not the performance managers of foundation trusts, although I think Andy Burnham, when he gave evidence, thought they were. Who does performance manage foundation trusts? |
| Page | 18 | A. I think we had the conversation yesterday about what was performance management, and I think there isn't a kind of black -- there isn't a black and white sort of one thing is and one thing isn't. It is a matter of degrees. But what I would say, the foundation trusts, themselves, of course, has its own internal governance, through its members, through its board of governors and through its broad, which is responsible for performance managing the organisation as a whole. |
| Page | 19 | The commissioners have a responsibility to set out the kinds of services that they want to commission, to identify the quality standards and the mechanisms for making those happen. That can sometimes stray into what people might describe as performance management but nevertheless it is an important part of what they do, and then Monitor ensures that they comply with the regime. |
| Page | 20 | A. There are elements of that in it, but the relationship is different to the relationship between strategic health authorities and the -- and PCTs as they stand at the moment. There are a -- do you want me to go through this? |
| Page | 21 | There are a series of ways in which that relationship takes place. The first one and the most obvious one is that the NHS Commissioning Board will allocate resources to individual clinical commissioning groups which, of course, as you know, is done by the government at the moment. So -- and that's quite a powerful lever, in terms of that -- in that relationship. So it will allocate resources, based on a formula of some sort, but nevertheless they'll will allocate resources to them. |
| Page | 22 | The NHS Commissioning Board will also be responsible for authorising all of these clinical commissioning groups. So in order for the clinical commissioning group to take-up its commissioning responsibilities, it will have to be authorised. It won't automatically get them on 1 April 2013. |
| Page | 23 | It will also have something which is described as the -- at the moment is the clinical -- let me get it the right way, the commissioning outcomes framework, which is a set of measures based on the outcomes for authorising all of these clinical commissioning groups. |
| Page | 24 | A. Well, we're working on that at the moment, and the only -- and it will look different, I have absolutely no doubt, as we work through all of that. But the slight complication is that for some foundation trusts they've signed up for three-year contracts and so we won't be able to change it all over at the same time. But the commissioning board will design a national contract. |
| Page | 25 | THE CHAIRMAN: But the principle will continue to be the same? |
| Page | 9 | 1. variety of other quality standards for individual organisations to operate, and the clinical commissioning groups can add to those, if they wish. 
2. THE CHAIRMAN: You say there is a national contract, is that something that exists to look at or is -- 
3. A. Yes, there is a national contract in existence at the moment. There has been for a number of years. 
4. THE CHAIRMAN: That I understand, but is that going to be the same national contract when the National Commissioning Board gets up and running? 
5. A. Well, we're working on that at the moment, and the only -- and it will look different, I have absolutely no doubt, as we work through all of that. But the slight complication is that for some foundation trusts they've signed up for three-year contracts and so we won't be able to change it all over at the same time. But the commissioning board will design a national contract. 
6. THE CHAIRMAN: But the principle will continue to be the same? 
7. A. Yes. 
8. MR KARK: And what is the relationship going to be between the NHS Commissioning Board and the local GP commissioning groups? Is the NHS Commissioning Board in effect going to be performance managing the local commissioners? |
| Page | 10 | 1. A. There are elements of that in it, but the relationship is different to the relationship between strategic health authorities and the -- and PCTs as they stand at the moment. There are a -- do you want me to go through this? |
| Page | 15 | A. Yes. |
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<td>framework we have for the NHS as a whole, where we will identify those areas that we need to focus our attention on clinical improvement, and on the back of that the clinical commissioning groups will be allocated extra resources if they achieve more of their outcomes. And the NHS Commissioning Board will appoint all of the accountable officers for the individual -- sorry, will approve the appointment of all the accountable officers of the various clinical commissioning groups that exist. So it's a very -- I think a much clearer kind of set of relationships with the national body than perhaps is the moment -- at the moment.</td>
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<td>framework we have for the NHS as a whole, where we will identify those areas that we need to focus our attention on clinical improvement, and on the back of that the clinical commissioning groups will be allocated extra resources if they achieve more of their outcomes. And the NHS Commissioning Board will appoint all of the accountable officers for the individual -- sorry, will approve the appointment of all the accountable officers of the various clinical commissioning groups that exist. So it's a very -- I think a much clearer kind of set of relationships with the national body than perhaps is the moment -- at the moment.</td>
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<td>2</td>
<td>THE CHAIRMAN: And the accountable officers, will that be a chief executive or will that be the chair of the group, or will it be the local general practitioner?</td>
<td>2</td>
<td>MR KARK: You mentioned as your second point authorising the commissioning groups. Is there going to be some form of test? How are you going to assess whether a commissioning group is ready to start or not?</td>
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<td>3</td>
<td>A. It will be whoever the clinical commissioning group want to put forward. It could be a GP, it could be the chair of the group, or it could be a chief executive. It could be either of those individuals.</td>
<td>3</td>
<td>A. Yeah, we've just published a very large document setting out our approach to authorisation, and I think this is a significantly different way of doing things than we did, for example, when we set up PCTs. As you know, you know, when a PCT was set up from that day it took on the totality of their commissioning responsibilities, and then over time they got -- they kind of developed and all the rest of it.</td>
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<td>place to make sure by the time we've got there we've got a really good set of people who know what the role is.</td>
<td>4</td>
<td>In this environment, we can either partially or wholly authorise a clinical commissioning group or not authorise them at all. And so we -- the process that we've started already is to assess whether we think the organisation is ready to take on the responsibilities of commissioning. And that's as -- you know, we've started that process now. For most organisations it will end on 1 April 2013. But we will take a judgment on each of them as to whether they can take the totality of their responsibilities for commissioning or just part of it.</td>
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<td>5</td>
<td>Q. I was going to ask you if there was a deadline set,</td>
<td>5</td>
<td>Q. I was going to ask you if there was a deadline set, because one of the problems that I think the CQC faced when they had to register providers was that they were given a deadline and it made the registration process difficult, I think one might say. But it seems that this process is going to be differently conducted?</td>
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<td>6</td>
<td>A. Yeah, the shadow NHS Commissioning Board can authorise organisations probably from 1 October 2012, and continue to make judgments about that for as long as it sees fit. So it is perfectly possible not to authorise a clinical commissioning group at all for as long as it take to get a clinical commissioning group into a place where we think that they're capable of commissioning. That's not our intention. Our intention is to get them all up and running and ready around -- as far as we can, around 1 April 2013. But there is no external timetable for the NHS Commissioning Board to force that.</td>
<td>6</td>
<td>A. No, the PCT doesn't continue. What we've agreed is, as you know, as part of the transitional arrangements, trying to manage this huge change that we're trying to do at the moment, we had 152 -- sorry, 151 PCTs. We didn't believe that it was a practical and sustainable thing to keep them running until they are abolished, subject to the legislation, which will be on 31 March 2013. So we've put them into clusters, PCT clusters, we've grouped them together and what we've said is that the NHS Commissioning Board, after 1 April 2013, when those PCTs are abolished, we will keep a local organisation, a local group of people together, on the same footprint, predominantly the same kind of people, I would guess, to do any commissioning that's required that the clinical commissioning group can't do, so we don't lose that knowledge, understanding and expertise.</td>
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<td>7</td>
<td>Q. Forgive me, and in those areas where you have not authorised a commissioning group, the PCT continues?</td>
<td>7</td>
<td>Q. Forgive me, and in those areas where you have not authorised a commissioning group, the PCT continues?</td>
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<td>8</td>
<td>A. It won't be a statutory body. It will be a group of people who have a direct managerial accountable -- sorry, a direct managerial accountability to the commissioning group. It's a transitional arrangement. We think it's -- well, I personally think it's the safest way of moving from the system we have to the new system.</td>
<td>8</td>
<td>A. It won't be a statutory body. It will be a group of people who have a direct managerial accountable -- sorry, a direct managerial accountability to the commissioning group. It's a transitional arrangement. We think it's -- well, I personally think it's the safest way of moving from the system we have to the new system.</td>
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<td>9</td>
<td>Q. Now, you also told us yesterday about a body that I confess I hadn't heard of, but that's my own ignorance, the National Health Service development body, which, as I understood your evidence, was going to performance manage the remaining rump of trusts which had not managed to obtain foundation trust status. Is</td>
<td>9</td>
<td>Q. Now, you also told us yesterday about a body that I confess I hadn't heard of, but that's my own ignorance, the National Health Service development body, which, as I understood your evidence, was going to performance manage the remaining rump of trusts which had not managed to obtain foundation trust status. Is</td>
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Whether it has regional arms or not depends very much on how many organisations are still not foundation trusts when it comes to position. As you know -- or sorry, as you may not know, we've -- because of the slippage of the timetable for the development of the reforms, we've recently taken the decision to bring strategic health authorities together into four clusters, and that pattern -- one cluster for London, which is coterminous to the existing strategic health authority, one for the south of England, one for the Midlands and east, and one for the north, we've said that that will be the -- a subnational arrange -- organisation for the NHS Commissioning Board, and what we've tried to say -- so that's the pattern on which we'll do it. So we've have four regions, and what we've had conversations with all the regulators and organisations about, when they organise themselves, can they do it on the same footprint? And CQC have agreed that they will organise themselves on the same footprint for divisions across the country. The NHS Trust Development Agency, if there are a lot of trusts that have agreed, that they will organise themselves across the four footprints -- what's it called? Public Health England, which is the other body, has agreed to organise itself across those four footprints. We think that will be a better way of organising people and getting communication going at that level as fast as possible in order to help manage the transition.

Q. Is there a significant risk here, once again, of the loss of organisational memory, which we've heard about time and time again as a result of the 2005/2006 changes which occurred?

A. In any organisational change -- and this is a significant -- certainly the biggest I've ever seen in the NHS, there is always that risk. What we've tried to do -- and I have to say that the Inquiry's been particularly helpful in the sense of you've been talking about these issues as we in real time have been trying to build them, so all the stuff around legacy and handover and all of that we're building into the system as we operate.

So, for example, I know that there are -- there's been a whole set of meetings across the country and documents produced by -- when the PCTs cluster together and, similarly, all of the SHAs who are coming together have developed individual handover documents by SHA, which sets out a whole series of clinical, financial and other risks in the system to ensure that when the new bodies are set up that not only do we have face-to-face contact and conversations about all of that, but we do have a written record so that there is real clarity then about what's being handed over. It's one of the ways I think we're trying to mitigate the inherent risk in any kind of organisational change of what you say.

Q. These are the so-called legacy documents, are they, which are meant to reveal the history of --

A. Well, they're not meant to be sort of Domesday books thing. But there are -- yes, they are the -- and people refer to them as legacy documents. Technically, some of them are legacy documents because the organisations are closing down, but some of them are more what I would describe handover documents, because the organisations still exist. But, yes, that's the principle on what we're trying to do.

Q. Can I just come back to the issue of quality monitoring of foundation trusts, and in your exhibit 55, which is the sixth report of the 2007/2008 session of the House of Commons health committee, there's reference, if we could go to page 68642, to this issue.

If we look at four or five lines down, we can see this: "However ..."

Yes, it's the fourth line down: "However, questions remain about whether it is necessary for [foundation trusts] to be subject to fault..."
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<td>1 monitoring by two separate regulators. A further layer</td>
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<td>2 of complexity will be added by the proposed</td>
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<td>3 establishment of a further regulator, the competition</td>
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<td>4 and collaboration commission ...&quot;</td>
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<td>5 Well, I'm not going to concern myself over that at</td>
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<td>6 the moment.</td>
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<td>7 THE CHAIRMAN: Is there any reason, Mr Kark, why in a public</td>
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<td>8 document published by the House of Commons we have</td>
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<td>9 redacted names?</td>
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<td>10 MR KARK: It's a point I've raised back stage.</td>
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<td>11 THE CHAIRMAN: It seems an excess of enthusiasm.</td>
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<td>12 MR KARK: And this is available on the Internet.</td>
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<td>13 THE CHAIRMAN: I notice it includes the committee staff who</td>
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<td>14 have been carefully redacted on the first page.</td>
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<td>15 MR KARK: The one thing I'm not responsible for is redaction</td>
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<td>16 but I nevertheless apologise.</td>
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<td>17 This does raise the issue of the different powers</td>
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<td>18 that each of those organisations have in relation to</td>
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<td>19 foundation trusts. The CQC, of course, have the power</td>
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<td>20 of intervention. Indeed although they don't have the</td>
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<td>21 power to deauthorise foundation trusts, they can stop</td>
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<td>22 any provider providing a particular service. They have</td>
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<td>23 the power to warn and fine and prosecute and all the</td>
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<td>24 rest of it.</td>
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<td>25 Monitor, of course, have the power to intervene in</td>
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<td>1 to Monitor to consider deauthorisation or not? You</td>
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<td>2 don't know?</td>
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<td>3 A. I can't remember. I can't remember.</td>
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<td>4 THE CHAIRMAN: Obviously it has not been acted on, but ...</td>
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<td>5 A. No, it hasn't been acted on. No. No.</td>
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<td>6 MR KARK: My understanding was, and I may be wrong, that</td>
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<td>7 Monitor still does not have the power to deauthorise</td>
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<td>8 because the relevant part of section 15 of the Health</td>
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<td>9 Act 2009, which amends section 52 of the 2006 Act by</td>
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<td>10 adding section 52B, which is the power to deauthorise,</td>
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<td>11 has not been brought into effect. I'll deal with this</td>
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<td>12 with Ms Monaghan.</td>
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<td>13 A. I'm sure you're absolutely right on that. I wouldn't</td>
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<td>14 second-guess that, but the point I was trying to make in</td>
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<td>15 all of this is that in the aftermath of the</td>
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<td>16 Mid Staffordshire report, legislation was put in place</td>
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<td>17 to do. I agree it's never been used. But my position</td>
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<td>18 at that time and subsequently has been that I don't</td>
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<td>19 think it should be up to Monitor to decide. I think it</td>
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<td>20 should be the Secretary of State who decides.</td>
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<td>21 Q. You say at the end of your paragraph 270 that you'd been</td>
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<td>22 asked whether it would have been more satisfactory for</td>
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<td>23 there to be one regulator to avoid the need for these</td>
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<td>24 organisations to become more aligned.</td>
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<td>25 You say:</td>
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<tr>
<td>1 &quot;This would be a practical consideration upon which</td>
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| 2 I do not have a view."
| 3 Some listening to you might find that difficult to |
| 4 believe, frankly, that you don't have a view on it. Is |
| 5 it one that you simply don't wish to express? And if |
| 6 you feel that you would be offending the Civil Service |
| 7 code in doing so, then of course you're entitled not to? |
| 8 A. If you look at the government's proposals in terms of |
| 9 regulation going forward, what you see in that is over |
| 10 time us moving to obviously a quality regulator, CQC, |
| 11 becoming more and more effective in what it does, but |
| 12 Monitor moving from the things it does now around |
| 13 compliance for foundation trusts to becoming an economic |
| 14 regulator, interested in competition, cooperation, the |
| 15 kinds of things that the current competition and |
| 16 collaboration commission do. And it will -- and the |
| 17 plan was, and it is in the legislation, for Monitor to |
| 18 lose its powers over dismissing, removing chairs and |
| 19 boards, and that to be completely the responsibility of |
| 20 the local people through the boards of governors and all |
| 21 the rest of it. |
| 22 So over time the idea was that Monitor would lose |
| 23 all of those compliance powers, and that kind of -- that |
| 24 ability in a sense to do what could be described as |
| 25 performance management of foundation trusts to give them |

6 (Pages 21 to 24)
more freedom and more flexibility locally. So that is  
the kind of long-term plan. So the responsibilities of  
Monitor directly to regulate the way in which foundation  
trusts operate is a temporary phenomenon, and what we've  
agreed in the arrangement is that will go on at least  
till 2006 (sic). So by the time you get to the end of  
this, you do essentially have one quality regulator that  
has the main powers of intervention in individual  
organisations.

Now, the way to bring those two things together --  
because they have to come together at some stage -- is  
to align the licensing for -- sorry -- yes, the  
licensing for foundation trusts with the registration of  
CQC. And I think it's much -- I think it's a much more  
powerful and a much more practical thing to see how we  
can pull those two things together, than it is at this  
stage to get involved in a debate around whether we  
should have one or two organisations. Because, given  
the amount of organisational change we've already got on  
the stocks, it seems to me that's an issue -- whether  
you bring it altogether at some stage, an issue for  
another day, not one for today. So that's what I meant  
in all of that.

Q.  What I don't quite understand is if Monitor  
loses the powers that you say it was intended it should  
Page 25

Q.  Should be the job of the governors of the trust?  
A.  What should be?  
Q.  Well, if a foundation trust is failing --  
A.  Yeah.  
Q.  -- it will be failing because the executives on the  
board are not doing their job properly, presumably, and  
that is I thought what you were just telling us the  
governors were going to be able to change?  
A.  Sorry, that's absolutely right, but even when that  
happens and you've done all of that, the organisation  
may still be failing, and there are then intervention  
powers to deal with a failing organisation. It's called  
the -- I think it's called the continuity of service  
regime, because obviously the priority when that happens  
is the continuity of patient services.

THE CHAIRMAN: And that power will reside with Monitor?  
A.  The power to enact the regime will stay with Monitor,  
yes.

MR KARK: Again, just staying with the Health Select  
Committee sixth report, they said this about governance  
arrangements within foundation trusts. If we could go  
to page 68627, please.

This, I think, is talking about governance in the  
wider context:

"While we saw some examples of good practice in  
Page 28
[foundation trust's] new governance arrangements, in general they seem to be slow to deliver benefits and despite numerous small studies, there remains a lack of robust evidence of their effectiveness. The governance process currently costs circa GBP 200,000 per trust, giving a total of around GBP 20 million per annum. We recommend that the Department of Health make it a priority to evaluate rigorously the [foundation trust] governance system and to give guidance on best practice so that public money as well as members' and governors' time can be used as effectively as possible to improve services.

"We are also surprised and concerned that Monitor did not issue guidance to governors until shortly before our evidence session took place, despite several reports over the last five years having identified the need for this, starting with the health committee which recommended the establishment of a national training system for governors as long ago as 2003."

Now, I don't know if this ties up in any way with your National Leadership Council work, but is there now formal training for foundation trust governors?

A. Not quite yet. We've been working -- I mean, one of the things, of course, when -- when you say that in a period in the future, 2006 or whatever, you're going to give the governors the kinds of powers that Monitor currently have to remove boards, suddenly it has the effect of galvanising the system to start to think about this in a slightly more serious way.

We, through the National Leadership Council have been working with the foundation trust network and we've allocated resources to them to design and deliver a national programme for foundation trust governors. So that is beginning.

Q. Why, may I ask, has it taken so long if it was recommended seven or eight years ago, as it seems to have been?

A. I can't comment on why it has taken so long. All I would say is that it's an -- I mean, it takes me back in a sense to where I was some time yesterday, which is about the purpose of foundation trusts and strengthening local accountability seems to be a really, really important part of it and not always something that people have taken as seriously as perhaps they might.

What has galvanised people in this regard is the fact that the governors in the future may very well have the power of hiring and firing the board, which I think will -- changing the dynamic, I think, in that regard and makes it much more important to take this forward.

THE CHAIRMAN: But they have some of those powers now.

A. Essentially, yes.

MR KARK: And that's in a world where we've been told repeatedly by you and others in fact that the first line of defence is the foundation trust board itself, and their governors?

A. No -- well, I've repeatedly said that, but it is absolutely true that if you look at the quality of the boards of foundation trusts and what they do, there are some very, very significant and important people and organisations set out there. I think NHS -- foundation -- NHS governance overall, with obvious exceptions, but overall, has improved significantly over the last five or six years, because of the way in which foundation trusts are professionalised, particularly the working of boards, supported by Monitor, I have to say.

Q. Can I move on from Monitor to the CQC, who took over, of course, very shortly after the publication of the Healthcare Commission's report in March of 2009. And one of your -- I'm sorry, it's not your exhibit, actually, it's one of Una O'Brien's exhibits, UOB15. This exhibit, which is a response to inform Ben Bradshaw briefing of 27 February 2009, reveals some of the problems when the CQC were about to take on their role.

THE CHAIRMAN: But they have some of those powers now.
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<td>I won't go through what follows.</td>
<td>I suppose, now does with the CQC, there should be</td>
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<td>Does this reveal that, again, the Department of</td>
<td>a single body, whether it's NICE or any other body,</td>
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<td>Health itself might have failed to think through in</td>
<td>driving quality improvement because the danger</td>
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<td>sufficient detail what the practical effects of the</td>
<td>otherwise, I suppose, is that trusts are buried under</td>
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<td>change of regulators would mean, or was this something</td>
<td>a plethora of guidance?</td>
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<td>that the Department was entitled to leave the</td>
<td>A. Yeah, I mean, quality improvement's not driven by</td>
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<td>commissioners, the HCC and the CQC to work out together?</td>
<td>bodies. I mean, it's driven by people. And I don't</td>
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<td>8 A. It was the responsibility of the Department of</td>
<td>know whether this is the right time just to talk</td>
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<td>Health itself might have failed to think through in</td>
<td>about -- when we got out of the position of the deficits</td>
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<td>sufficient detail what the practical effects of the</td>
<td>and we were thinking about how we were going to take the</td>
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<td>change of regulators would mean, or was this something</td>
<td>NHS forward -- and I think I said yesterday that during</td>
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<td>that the Department was entitled to leave the</td>
<td>that period I would not describe quality being the</td>
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<td>commissioners, the HCC and the CQC to work out together?</td>
<td>organising principle of the NHS at that particular time.</td>
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<td>Q. Do you accept that in this changeover period, there was</td>
<td>I was very keen -- we were very keen to make sure</td>
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<td>a significant risk, albeit for a relatively short</td>
<td>that we put quality more and more at the centre of what</td>
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<td>period, in terms of the regulation of the healthcare</td>
<td>we did, and we started on that work. And, as you know,</td>
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<td>system?</td>
<td>after we'd -- about nine or ten months after we'd</td>
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<td>A. Well, it says in the document that there was that</td>
<td>started that work, Lord Darzi was appointed as the</td>
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<td>potential.</td>
<td>minister, and we took forward a whole set of work around</td>
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<td>Q. You discussed the role of the CQC at your paragraph 275.</td>
<td>quality and quality improvement, which involved a whole</td>
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<td>Your view is that the removal of the statutory</td>
<td>series of documents being commissioned, but more</td>
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<td>requirement to improve performance was</td>
<td>importantly than that a huge amount of work being done</td>
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<td>a good thing, and you say the quality improvements</td>
<td>by clinicians on the front line about developing</td>
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<td>should be driven by the Royal colleges, professional</td>
<td>pathways and improving service for patients. So all of</td>
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<td>organisations and commissioners.</td>
<td>that.</td>
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1  I think is going to be a really important thing for us
to do. But I didn't want the -- certainly my view was
that we shouldn't confuse the regulators by getting them
generated in performance -- for quality improvement when
there was such a big job to be done on basic standards.

2  THE CHAIRMAN: Just so I can understand how much of a sea
change or not there was, under the Healthcare Commission
regime there were the two types of standards, one being
the developmental standards that, as I understand it,
nothing ever in reality happened with, but the core
standards and the basic standards, those were intended
to be minimum standards, weren't they?

3  A. Yes, absolutely, they were.

4  THE CHAIRMAN: So the Healthcare Commission in practice
acted as a regulator of minimum standards, rather than
an improvement regulator; would that be fair?

5  A. Well, they tried to do both, but there is an absolute
continuity between the approach around Healthcare
Commission minimum standards and then the regulatory
regime that CQC wants to put in place. It is -- you
know, it's the two sides of the same coin in that sense,
but they are different and they are developed now,
I think, from what the core standards of the Healthcare
Commission were. But the principle, I think, is the
same.

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1  MR KARK: I'm going to come on to High Quality Care for All,
which you discuss in due course, but you also talk about
the new system. The Chairman's just been asking about
the core standards, the basic standards that the HCC
apply, but you talk about the new system adopted by the
CQC which, as we know, are the quality risk profiles.

7  You say at paragraph 90 (sic):
"I have been asked how important physical
inspections are in the field of regulation. The NHS
Confederation conference I recall someone saying that
when running a trust one has between 40 to 50
inspections by various different bodies during the year,
such as Royal colleges, accreditation bodies, the HSE
et cetera. The key issue is bringing all of this
information together, which is where the development of
quality risk profiles is key. The QRPs are all about
ensuring transparency of information and achieving
a lighter touch to regulation."

10  Now, do you agree that the effectiveness of the
CQC's proportionate approach and hoping to develop
a lighter touch of regulation is wholly dependent upon
the quality of the information that they receive? It's
information-based, isn't it?

13  A. Well, there are -- I mean, there are a number of ways in
which CQC carries out its responsibilities. There's
the -- obviously the registration process that it goes
through, which involves directly visiting organisations
and seeing what they're doing and all of that.

14  It still has inspection responsibilities. And
I think they've been particularly effective over the
last three or four months with their short inspections
around nutrition and the care of older people. And they
have the QRP. And you have to do all three of those
things. You can't rely on one to the exclusion of all
the others.

18  Q. You're absolutely right, but the QRPs, which I was
trying to focus on, but I accept my question might have
been wider, but so far as the QRPs are concerned, they
relies on good information and a good analysis of the
data, and I suppose ensuring that there's an appropriate
response where a warning sign is displayed?

19  A. And they also rely on organisations working closely
together. So, you know, risk summits, people coming
together with open minds to think about the quality of
service for patients and what needs to happen. So they
obviously rely on information.

20  Our experience, as you know, is that over time that
information gets better, the more it's used the better
it gets, and we are really, in my view, in the foothills
of all of this, not by any stretch of the imagination at
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1  the end point in relation to the development of quality
and risk profiles.

3  Q. I'm sure that's right, but what you need, of course, is
a consistency of approach across the country, because we
know that CQC have its regional arms and its regional
inspectors.

5  A. You do.

6  Q. They have engagement forms --
A. Yeah.

9  Q. -- and it's critical, I expect you agree, that there's
consistency in respect of the filling in of those
engagement forms and the auditing of the process so that
there's a homogeneous process across the country?

13  A. I think it's -- I mean, my experience on working in the
NHS for many years about getting national consistency is
that's very difficult to do. Clever as we are with the
forms and all the rest of it, you know, you have to work
very hard to get national consistency, but it is so
important if you're going to properly benchmark and
understand what's happening.

16  So I would imagine that that's precisely the journey
that the CQC are on at the moment, of refining and
getting this sort of thing better. They're certainly
not there at the moment in terms to the officers that
I've seen and the way it operates. But you can see
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10 (Pages 37 to 40)
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1. I genuinely don't believe it will only really come of
put into action.
2. Q. What then are your concerns about the QRP's as they
operate at the moment?
3. A. Well, one of the issues about the -- one of the issues
about the QRP is that it's much better at collecting
information that we always collect. So you can see
exactly how all of that goes, and it's very good at
gathering information around what inputs the CQC offices
might get, although I guess there is an issue about
national consistency. The issue for me is how it
collects that, what you my describe, as soft
intelligence about services generally. So, for example,
how does it connect with what patients think about it?

14. How do patients get to use -- to put information on the
QRP? The other area for me is one around local
newspapers, very often very good ways of getting early
signs about things going wrong.

18. And I don't think we've -- they've quite got
a position yet whereby all of that is being brought into
the QRP. Certainly the one I've seen hasn't been. They
may be more advanced in other parts of the world. But
it seems to me as a principle, and as a mechanism for
collecting information, it's a really powerful one.

19. I genuinely don't believe it will only really come of
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1. absolutely the power of this process once it is properly
put into action.
2. Q. What then are your concerns about the QRP's as they
operate at the moment?
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about the QRP is that it's much better at collecting
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collecting information, it's a really powerful one.

19. I genuinely don't believe it will only really come of
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A. Well, it's been an issue since I started in the NHS, to be frank, and it's an issue across the world. This discussion and controversy goes on in most healthcare systems, and most healthcare systems do not have a single set of directions that set out by ward what minimum standards are --

Q. I think --

A. -- because it is so difficult.

Q. I think it has been done in Victoria in Australia, and in New South Wales it has been tried, hasn't it?

A. Certainly the professional organisations have tried it. California tried it, they tried it indeed Germany at a time -- but every time it has fallen into disrepair relatively quickly, because of the complexity underpinning all of the various different kinds of wards and organisations that you have and the way care is organised, but also in terms of the different demands on those services at particular times, and almost as quickly as you set them, someone somewhere is developing an alternative. So it's a very difficult thing to do.

From my view it's a practical issue, not a -- one of principle, really.

Q. Is there any work being done on this by the Department of Health? I think the Royal College of Nursing guidance, issued in December of 2010, asked the DH to undertake work to identify the prevalence and efficacy to planning nursing staff.

A. I think what we focused our attention on is the development of tools and supported tools to enable front-line nurse leaders to make their own judgments locally. We haven't put effort into trying to design a national system in that way.

THE CHAIRMAN: There are, I think, are there not, tools which allow assessments of the nursing needs of individual patients?

A. Yeah, there are.

THE CHAIRMAN: Has any consideration been given to build up from those in any way?

A. There are available about, I think, half a dozen of these tools and they are all slightly different and do depend quite a lot on subjective -- sorry, more subjective analysis of the local needs, and so whilst you can promote one of them -- some of them work really well in some environments and some in others. So there's not been a position where the Department has said, "This is the one that you should use". I think it has been quite difficult to do. But I -- you know -- sorry, I'll shut up.

MR KARK: Where things have gone wrong and appear to have gone wrong in this particular trust was the overuse of healthcare workers, and I certainly don't mean to malign healthcare workers as a body, the majority of whom no doubt do a brilliant job, but it's an easy solution sometimes for trusts to take. And we read yesterday of the call by Professor Dickon Weir-Hughes for the registration of healthcare workers who are used in their hundreds of thousands in the system.

Now, doctors, of course, are regulated and regulated, nurses are registered and regulated, even us lawyers are regulated, as are accountants, the police, and even doormen in London standing outside the clubs. Why can't healthcare --

A. But not chief executives.

Q. Not chief executives, I'll come on to them. We won't miss them off the list, but what about healthcare workers? What is the problem about regulated healthcare workers?

A. I don't know whether there's a problem or not. The issue for all of us is the quality and standards of the people -- sorry, the quality and training of those people and are they equipped to do the jobs that they do. I think it's a quite -- it's a big task to try and regulate such a huge workforce from a standing start.

And they are used in very, very different ways. You've got healthcare assistants who are doing literally everything from housekeeping through to the direct care of patients, right the way through to people who are doing very complicated issues with individual patients.

So I think it's the complexity of that that I think have stopped people doing it. I'm not convince that spending a huge amount of time and effort in doing the registration organisation, as opposed to putting the effort into training and education, might be a better way forward. And, of course, the nursing profession would say all of that, wouldn't they?

Q. But given that some of them do actually care for some of the most vulnerable people in care homes and in hospitals, and as we read the failure to regulate them means that when a healthcare worker misbehaves in some way, they may get the sacked but they often move on to another job, and nurses who get struck off can move very easily into healthcare work. Do you not think that it is an issue that should be given a degree of importance by the Department of Health?

A. I think it's an issue. Whether it's of, you know, top importance in terms of all the other things that we're trying to do at the moment I don't -- I wouldn't like to second-guess, but it's certainly something to take away from the evidence that you've got -- that you've had...
THE CHAIRMAN: Well, how much more by way of top importance is it to ensure that the people who generally speaking are charged with feeding and providing basic care to our most vulnerable patients should be fit and proper people to do that?

A. You're absolutely right, and it seems to me that is an issue much more about training and education than it is about setting up a regulatory framework to cover their work. That it seems to me is the -- and to make sure they have proper nursing and medical supervision in the work that they do, I would have thought that's the effort that we need to place into it. Whether that would result in regulation or not, I think is a separate issue.

THE CHAIRMAN: Well, Mr Kark, you might be coming on to it, but if not, what is being done from the centre about promoting the training and development of healthcare workers in the National Health Service?

A. And that's part of the work we're doing at the moment of developing -- I mean, we spend significant amounts of money on training and education of our workforce, you know. And we expect -- and it's part of in a sense the way in which we might identify whether organisations are taking money out of the right or wrong things at the moment. So we are monitoring very closely the amount of resource that we put into these areas, and we are making sure that we protect that resource as we go through the very difficult times that we have at the moment.

If you're asking me, is there a national initiative at the moment in terms of training and education, the PCT and the SHA who should have been watching over healthcare workers? I'd have to go back and think about that, but I think it's an important point that you make that I do acknowledge.

THE CHAIRMAN: Thank you.

MR KARK: I said earlier, and perhaps we can try and at least start this topic before the break, that I would come to deal with High Quality Care for All, which really is quite closely related to the issue of commissioning. You talk about this document which was published in June 2008, which set out the Seven Steps in the quality framework and which you say at paragraph 318 had at its heart one simple idea, to make quality the organising principle of the NHS.

Now, improving the quality of care had been part of the continual process, hadn't it, since the late 90s? The 1999 Health Act stated: "Each health authority trust and PCT has a duty to put and keep in place arrangements for monitoring and improving the quality of healthcare which it provides to individuals."

So it's not a new concept, is it?

A. No, everyone has always been in favour of quality.

Q. During the period of this particular trust's problems the local PCT were, of course, involved in not only commissioning but should have been involved in increasing the quality of care at the trust. And Geraint Griffiths told us this:

"We were doing the same thing as all the other PCTs in 06/08, but what became apparent was that we were not getting the right answers in relation to identifying care issues at the trust. We will be the first to put our hands up and say we did not pick up on these issues before."

Now, I know we're going back a little bit, but do you accept that that failure is a shared failure both by the PCT and the SHA who should have been watching over them?

A. What -- I said in response to your last question that everyone's in favour of quality and they are. The problem is and the problem was that everyone had a slightly different view about what it was. And if you talked to the Department and ministers and people in the centre, they would have and do talk about quality in terms of access to services and one or two other significant issues, MRSA, health service acquired infection, that sort of thing. That was the definition of what quality was, but of course one of the things that is clear to most people is that quality is a much more wider issue than just those things, but the system was set up to deliver assurance on those things, not the wider set of quality issues. And so although it may sound a small issue, one of the first things that Lord Darzi did was set out a definition of quality, which is now, as you know, being put in the health bill, which covers effectiveness, safety and patient experience. And I think what you can see in the conversations that people had over the period is that sometimes people would take one or perhaps two but almost never three. And quality is all three.

So you will see good work being done around some things in terms of effectiveness, sometimes you see good work in terms of safety, sometimes in terms of patient experience, but the whole point of the definition is it is all three, and that's what health organisations are responsible for delivering all three. And all that's a small point, I think it's a very significant point because the NHS at that stage was not set up to take account of all three of those issues. And bits of them got taken at various times, but we were not organised.
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and we're trying to organise ourselves to deal with all three of those things. So I can perfectly understand how individual organisations responding to national guidance and all the rest of it have found themselves dealing with the issues that they did.

Q. That's a perfectly legitimate answer to the question I asked you, but can I just remind you of what the last part of my question was, which was, do you accept that the failure was a shared failure, the failure which Geraint Griffiths seems to have accepted in his evidence was a shared failure by the PCT and the SHA, who I suggested should have been watching over them?

I mean, should the SHA have been watching over what the PCT were doing?

A. That's their job. I mean, that's their -- fundamentally that's what their responsibilities are. All I am saying in all of that is the way we defined quality at the time and the kind of focus that we put around access and some of the other issues did not give a rounded view about what quality was. So I can perfectly understand why people were in the place that they were. That's why we made the change -- I mean, that why we're trying to make that change.

Q. You wrote the foreword to World Class Commissioning, which you produce at your DN43. And if we go to Page 53, page 8506, you haven't changed very much, Sir David, although this is a black and white, it is a few years ago.

But you say: "World Class Commissioning ... is about improving health outcomes and reducing health inequalities. At the heart of this is the need for PCTs to commission outcomes that deliver high quality healthcare and give value for money."

And then two paragraphs down:

"Clinical leadership and engagement are essential if PCTs are to become world class commissioners. We need to have clinicians from all sectors engaged in care pathway redesign and leading change. PCTs as local leaders of the health system must continue to build on the good work already in hand to develop dynamic partnerships with clinicians, local authorities and communities to deliver high quality services with high levels of productivity." It's obvious from everything you've told us, and it's obvious from this, that you view clinical leadership and engagement as being essential, and World Class Commissioning, as we understand it, has now been formally abandoned but is no doubt still being used by PCTs as a structure for commissioning; is that a fair way of putting the present position?

A. The process to underpin it, the various mechanisms for working with individual PCTs is not -- we removed all of that but the principles, I think, remain.

Q. Is this issue of clinical leadership engagement answered, in your view, by the new drive that GPs should become the central commissioners themselves?

A. Partly, but not wholly. And I think it's worth setting out here the point we're trying to make, is that we've identified GPs as commissioners, not because we particularly like GPs or whatever, although of course we do. That's not the reason. The reason is their position in the healthcare system, in the sense that, as you know, 90 per cent of all contact with the NHS is with primary care. They see the service from a particular place. They're very often navigators of patients through the system. They can see all the various bits of the system. They also -- relatively small changes in primary care in GP activity can make a massive difference to the system as a whole.

So in very simple terms if every GP -- and I'm not suggesting they do this by the way, but if every GP referred one less blood test and referred one less patient to a hospital every week, that would save the NHS half a billion pounds. Now, I'm not suggesting they do that, all I am trying to say in that is relatively small changes in primary care behaviour has a massive impact on the system as a whole. So that's why we thought it's important that GPs engage in the commissioning process. They're also, of course, responsible for a population. So they have a list which is a population. So they're responsible for the health of that population.

But it's not sufficient. GPs on their own are not capable of understanding all of the things that happen in the system as a whole, hence as part of -- when we went through the listening exercise for the development of the bill, hence we added to that the importance of engaging other professionals in the commissioning process, so that you can get a more rounded picture. But even that is not sufficient. You need to engage secondary care clinicians, because the idea that GPs have some kind of complete knowledge of what happens inside NHS organisations, my guess is that you've found this experience as well, some places they have very -- they're very engaged, others they aren't. So just GPs on their own not sufficient.

So we need to build in secondary care clinicians into this system, and that what we've been trying to do by the development of, if you like, moving from GP
consortia, which was the original conception to clinical commissioning. But GPs are at the heart of it, but you have to have those other bits -- other clinicians in the commissioning process, otherwise you simply won't get the improvements that we need for patients.

Q. Given the difficulties that this particular trust has -- and I don't suppose it's unique -- in getting clinicians within a hospital setting to engage with management, is that not going to be a problem with getting clinicians to engage with the commissioning process?

A. Well, at clinical commissioning group level that's not the only way in which we see clinicians engaged in the commissioning process. There are two other ways. One of them is through networks, so a lot of the services that we provide are delivered through networks. If you take cancer services, for example, they're delivered in primary care, they're delivered in your local hospital, they're delivered in radiotherapy units, their delivered in tertiary care. So we've created a series of clinical networks which can oversee the development of those services. And so clinicians need to be engaged at that level but they will be kind of -- they will be about particular disease entities. But even that, in my view, is not enough, and that's why in the -- after the listening exercise we developed the idea of clinical senates, which would cover a broader clinical area. So, for example, there is a clinical senate for London, which engages the variety of clinicians across the whole of the capital, different specialties, different professions, who have a broader view about the pattern of services across the particular geography overall.

Now, London is a very big area to do that in, but East Midlands has got one as well, and we see the country being covered by a pattern of these organisations, not just to -- just for the sake of bringing people together, but because we can use those organisations for intelligence and understanding about what's happening in the service as a whole but will also give us the ability to support interventions when needed when organisations get into trouble.

So this is a commissioning system which has clinicians at every single level of it, not just at the clinical commissioning group, not just at the hospital, but at the clinical network and the broader geography.

Q. It sounds very much as if you're going to have to get the trust, foundation or otherwise, to buy into this system because they will have to be releasing their doctors for a session a week or whatever it is, or a session a month to take part in your clinical senates?
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1. starts its work in this area.
2. Q.  Also this, PCTs now have binding contractual
3. arrangements with foundation trusts, have there been any
4. practical benefits of that?  I mean, are you ever going
5. to find a PCT actually suing a foundation trust for
6. failing to meet its obligations?
7. A.  There are practical -- every day there are -- practical
8. things happen because of it, if you look the way in
9. which the payment mechanism supports delivery of
10. healthcare-associated infection or mixed sex
11. accommodation, all of those sorts of things, money
12. changes hands literally on a monthly basis between
13. foundation trusts and PCTs, depending on where they've
14. set their criteria and thresholds.
15. Q.  We heard last week from Sir Bruce Keogh, and he was
16. talking about quality observatories, and what he said
17. about those was that he was particularly keen on quality
18. observatories, which would provide a service to
19. individual clinicians who wanted to look at their
20. service or didn't know how to measure it so that there
21. would be help.  So quality observatories exist now
22. within the SHAs, and he said that they would supplement
23. the information available.
24.  Now, isn't that something that the SHAs should
25. always in fact have been doing, but haven't?  What's the

1. necessity for setting up a quality observatory?
2. A.  When we started on the process of putting High Quality
3. Care for All together and, can I say, High Quality Care
4. is a document, but underpinning all of that was a huge
5. amount of service improvement work and work that was
6. done at a local level on care pathways and all of those
7. sort of things.  But when we did it, we commissioned
8. Liam Donaldson to do some work on high quality
9. performing -- sorry, high performing -- no, high
10. performing clinical teams, what were they -- the things
11. that made a difference between high performing clinical
12. teams and those who weren't.
13.  And part of that he commissioned work from JCI and
14. IHI and a whole series of people.  And what came out of
15. that was the idea that -- which I guess is obvious at
16. one level -- the distinguishing characteristic of high
17. performing clinical teams is that they measure things.
18. They measure things.  They set themselves goals.  They
19. remeasure.  They set themselves better goals, and that
20. that kind of -- that idea about quality improvement
21. being driven from the bottom was a really important part
22. of what we were trying to do in terms of High Quality
23. Care for All.  But one of the things that they did once
24. they started to do their measuring themselves and
25. setting their goals and then measuring, is they wanted

1. to start to benchmark themselves.  So, where could they
2. look elsewhere to see whether they were doing well
3. compared with somebody else?  And out of that, obviously
4. generates a need for more information, more knowledge,
5. more understanding, and in a sense the quality
6. observatories were put there to enable -- to support
7. that to happen.
8.  Now, as you know, we started off with all of the
9. data that we currently -- I don't know whether Sir Bruce
10. talked about IQI.
11. Q.  He did a bit.
12. A.  This was the -- you know, it's over 300, I think, data
13. items that we collect, which is the kind of basis on
14. which the quality observatories can operate to provide
15. people with benchmarked data about how their service is
16. doing compared with everybody else.  Now, it's not
17. perfect by any means and it's actually pretty distorted
18. that information in terms of the subject areas around
19. some of the work we've already done.  But I think that
20. idea of clinical teams generating a need for information
21. to improve those services, we needed a mechanism to
22. enable them to support them to do that.
23.  Now, there'd been bits of this around the country
24. for a while, but the whole point about quality
25. observatories was to kind of organise ourselves to

1. enable people to use that data, and that's why we did it
2. in the way that we did.
3. Q.  Can I just look at some specific examples from your own
4. career taking you back for the moment to the SHA as it
5. was, to see how these quality observatories and high
6. performance clinical teams might have helped you in
7. a specific example.
8. A.  Okay.
9. Q.  We've now got the benefit of the statement from
10. Mr Martin Yeates, and he talks about meeting you, for
11. instance, on 31 October 2005, and in the minutes of that
12. meeting, there's a record under the finance heading
13. "A reduced workforce and surgical ward reconfiguration",
14. and those seem to be issues that were discussed, and
15. both of those issues had a very negative impact, in
16. fact, on patient care.
17.  Now, first of all, I don't expect you can remember
18. the detail of the meeting now, but would you have picked
19. up then on the significance of a workforce reduction
20. programme and the surgical ward reconfiguration?
21. A.  I'm sorry, I'm struggling to follow the thing.  Is this
22. a document I've seen or not or --
23. Q.  This is a meeting on 31 October 2005 that you had with
24. Martin Yeates.  Do you remember you told us previously
25. about meeting with Martin Yeates?
| Page 65 | | Page 66 | | Page 67 |
|---|---|---|---|
| 1 A. Well, I met with Martin Yeates on a number of occasions. | 1 and that information is used in the observatories, and | 1 wouldn't be what they -- certainly isn't what they do at | 1 Q. What I'm going to do, if you don't mind, is I'm going to |
| 2 I don't -- are you referring to a document -- have | 2 they will do an analysis on that for you and set out how | 2 the moment or most of them do at the moment. | 2 Q. That is what I was going to go on to ask you if a trust |
| 3 I seen this document? I don't -- | 3 you're doing compared with everybody else, and look at | 3 wouldn't be what they -- certainly isn't what they do at | 3 is considering a workforce reduction programme or |
| 4 Q. I can't show you the minute at the moment. We'll try | 4 hospitals like yourselves and how they're doing, and all | 3 the moment or most of them do at the moment. | 3 a surgical ward reconfiguration that's the sort of thing |
| 5 and get you a hard copy, if you need to see it, but can | 5 of that sort of thing, so that when you sit down -- and | 3 that they would trot along to their quality observatory | 3 that they would trot along to their quality observatory |
| 6 we just deal with it at the moment in the abstract. | 6 I've sat down with a group of people trying to improve | 3 and say, "Can you help us out with specific advice on | 3 and say, "Can you help us out with specific advice on |
| 7 Let's assume for a moment that a workforce reduction | 7 stroke services, Wolverhampton, as it happens, and we | 3 this?" | 3 this?"
| 8 programme was discussed during the course of that | 8 sat down and we looked at the information that they'd | 3 A. They could, and the quality observatories are quite | 3 A. They could, and the quality observatories are quite |
| 9 conversation. | 9 got from their Sentinel audit and we looked at the | 3 capable of, you know, getting data of that nature, but | 3 capable of, you know, getting data of that nature, but |
| 10 MR CLARKE: Sir, if I can make an observation, obviously | 10 information that the observatory had produced, which had | 3 that's not normally what they are -- what they are used | 3 that's not normally what they are -- what they are used |
| 11 Sir David hasn't read the statement and he hasn't seen | 11 analysed it by type of hospital, and out of that we | 3 for. | 3 for. |
| 12 the minute. I wonder if the minute could be found | 12 could see that there were some really serious issues | 3 Q. I may have to come back to that meeting but I'll do that | 3 Q. I may have to come back to that meeting but I'll do that |
| 13 before we proceed with this line of questioning because | 13 about the stroke service in that patch that you could | 3 when I've got the documents to hand. | 3 when I've got the documents to hand. |
| 14 it's about a meeting six years ago, and if there is | 14 put right. | 3 I want to come on to the foundation trust programme. | 3 I want to come on to the foundation trust programme. |
| 15 a minute -- | 15 One of the issues was access to CT scanning. So you | 3 We've already looked at the pipeline and the trust's | 3 We've already looked at the pipeline and the trust's |
| 16 THE CHAIRMAN: We will ensure that Sir David has an | 16 can use the -- clinical teams can use that kind of | 3 application, and I'm not going to go back there again, | 3 application, and I'm not going to go back there again, |
| 17 opportunity to see the minute, certainly over the lunch | 17 information to improve their service. It's not | 3 and we've also looked at the possibility that you are | 3 and we've also looked at the possibility that you are |
| 18 adjournment, but at the moment I'm slightly struggling | 18 something you kind of mandate on people nationally but | 3 going to end up with a rump end, as it were, of trusts | 3 going to end up with a rump end, as it were, of trusts |
| 19 to see the connection between this event and quality | 19 you can see how that -- and that's the kind of | 3 which cannot become foundation trusts. And you've told | 3 which cannot become foundation trusts. And you've told |
| 20 observatories, which is where the question started -- | 20 information they have. | 3 us about the organisation which is being developed at | 3 us about the organisation which is being developed at |
| 21 MR KARK: It's a legitimate point -- | 21 To kind of take you to the next bit, the quality | 3 the moment to look after those. | 3 the moment to look after those. |
| 22 THE CHAIRMAN: But it can be put on a hypothetical basis, | 22 observatories don't generally speaking use information | 3 And I wanted to ask you very briefly about the | 3 And I wanted to ask you very briefly about the |
| 23 I would have thought, for the moment, if there is | 23 around inputs. Sometimes they do, so they wouldn't | 3 effect of private finance initiatives on those sort of | 3 effect of private finance initiatives on those sort of |
| 24 a connection. | 24 necessarily have staffing levels from all various | 3 trusts, because inevitably, I suppose, there's going to | 3 trusts, because inevitably, I suppose, there's going to |
| 25 MR KARK: Its a legitimate point, of course, that Mr Clarke | 25 organisations and can compare them with that. That | 3 Page 66 |
| 1 makes and we will get you a copy of the document. | 1 wouldn't be what they -- certainly isn't what they do at | 1 Page 66 |
| 2 What I'm trying to ... (Pause). | 2 the moment or most of them do at the moment. | 1 Q. What I'm going to do, if you don't mind, is I'm going to |
| 3 It's suggested that this may have been the raising | 3 that's not normally what they are -- what they are used | 2 Q. That is what I was going to go on to ask you if a trust |
| 4 standards meeting. Does that ring a bell with you? | 3 for. | 2 is considering a workforce reduction programme or |
| 5 A. It's in my exhibits, if it's a raising standards, | 3 Q. I may have to come back to that meeting but I'll do that | 2 a surgical ward reconfiguration that's the sort of thing |
| 6 I think. | 3 when I've got the documents to hand. | 2 that they would trot along to their quality observatory | 2 that they would trot along to their quality observatory |
| 7 Q. Right. | 3 I want to come on to the foundation trust programme. | 2 and say, "Can you help us out with specific advice on | 2 and say, "Can you help us out with specific advice on |
| 8 A. I don't know which ... | 3 We've already looked at the pipeline and the trust's | 2 this?"
<p>| 9 Q. What I'm going to do, if you don't mind, is I'm going to | 3 application, and I'm not going to go back there again, | 2 A. They could, and the quality observatories are quite | 2 A. They could, and the quality observatories are quite |
| 10 come back to this after lunch so that we can find the | 3 and we've also looked at the possibility that you are | 3 capable of, you know, getting data of that nature, but | 3 capable of, you know, getting data of that nature, but |
| 11 documents, I can put them in front of you and then we | 4 going to end up with a rump end, as it were, of trusts | 3 that's not normally what they are -- what they are used | 3 that's not normally what they are -- what they are used |
| 12 can go through them together because there's a danger | 5 which cannot become foundation trusts. And you've told | 3 for. | 3 for. |
| 13 we're going to waste time doing that, and that's not | 6 us about the organisation which is being developed at | 3 Q. I may have to come back to that meeting but I'll do that | 3 Q. I may have to come back to that meeting but I'll do that |
| 14 your fault, it's entirely mine. | 7 the moment to look after those. | 3 when I've got the documents to hand. | 3 when I've got the documents to hand. |
| 15 I was asking you about quality observatories and | 8 And I wanted to ask you very briefly about the | 3 And I wanted to ask you very briefly about the | 3 And I wanted to ask you very briefly about the |
| 16 I was trying to find specific examples of how those | 9 effect of private finance initiatives on those sort of | 3 effect of private finance initiatives on those sort of | 3 effect of private finance initiatives on those sort of |
| 17 might have changed things -- | 10 trusts, because inevitably, I suppose, there's going to | 3 trusts, because inevitably, I suppose, there's going to | 3 trusts, because inevitably, I suppose, there's going to |
| 18 A. Okay, I can give you -- I mean, if I can give you an | 11 Page 67 |
| 19 example of the way in which you can use the data which | 12 Q. Okay. | 12 Page 66 |
| 20 is real, but not about this particular issue. | 22 A. And that's around stroke services, which obviously is | 23 | 23 |
| 21 Q. Okay. | 24 relevant in this area. There is a stroke Sentinel | 24 | 24 |
| 22 | 25 audit, which you know, which provides information -- | 25 | 25 |
| 23 | 25 which virtually every stroke unit provides nationally, | 25 | 25 |</p>
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<td>be a small number of trusts which will not make it through the pipeline purely for financial reasons; is that right?</td>
<td>but very, very small number of organisations, but it may be necessary to, in a sense, fund them slightly differently, possibly with more resource, in order for them to be financially and clinically sustainable and locally accountable. And that's what we're working through at the moment.</td>
<td>But there are far more than that; yes?</td>
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<td>A. Well, there is a danger -- I can almost hear myself dancing on the edge -- on the end of a pin here. But if you view the take that the purpose of having -- of going through the foundation trust process is that you have to demonstrate that your organisation is financially and clinically viable going forward and sustainable going forward, we have to do that with all services, no matter what organisations that they are in. So we have to come to a conclusion about all of those things, and the foundation trust mechanism is as good a way of forcing those issues, I think, as any that we've got.</td>
<td>A. Well, 2010 has gone.</td>
<td>A. Well, 2010 has gone.</td>
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<td>So undoubtedly there are organisations that will have more difficulties in that regard. And you're referring, I would imagine, to the list that came out last week of organisations with private finance initiatives. What we're doing at the moment is we're looking at all the organisations that are not foundation trusts and trying to do an analysis as to what would need to be done in order to get them there and what specifically we would have to do nationally to enable that to happen. And the outcome of all of this is an agreement signed between the Department, the commissioner and the trust about when they are most likely to become a foundation trust. So all of that work is going on at the moment.</td>
<td>Q. Quite, what I am saying is there are far more than just 20 to 30 being left behind.</td>
<td>Q. Quite, what I am saying is there are far more than just 20 to 30 being left behind.</td>
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<td>Now, there are some things which it's very difficult to deal with locally. Private -- the PFI would be an obvious one, and we've been through -- there are lots of organisations with PFIs, and we're looking at, are some that have a such significant PFI that it would halt their ability to become foundation trusts? And we've drawn up a list of 20-odd. These are not organisations that are in financial difficulty now. They are organisations that to be able to sustain them clinically and financially in the future will the PFI -- the existence of PFI hold them back?</td>
<td>A. Oh, yes. Yes.</td>
<td>A. Oh, yes. Yes.</td>
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<td>Now, I think the -- by the end of this process we'll have a very much smaller group of organisations, probably less than a handful, in my view, that fall into this position.</td>
<td>Q. Then if we go down to 24:</td>
<td>Q. Then if we go down to 24:</td>
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<td>Now, the question then is, how do we then take them forward? Because the important thing is a clinically and financially sustainable organisation, but also an organisation that's locally accountable. So there may be in some circumstances a need to subsidise them from the taxpayer to enable them to take forward their foundation trust application. This will be a very, very small number of organisations, but it may be necessary to, in a sense, fund them slightly differently, possibly with more resource, in order for them to be financially and clinically sustainable and locally accountable. And that's what we're working through at the moment.</td>
<td>&quot;On current projections we expect around 90 per cent of trusts to have become [foundation trusts] or being assessed by Monitor by the end of 2010.&quot;</td>
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<td>Q. This is an issue that was raised back in June 2009 in a note from David Flory to the Secretary of State, and if we could go to your exhibit 57, and then go to page 6897. I want to look at just two paragraphs, if I may. Paragraph 22, first of all. I will wait till you get there. It is exhibit 57 and then it is page 697.</td>
<td>Now, can we take it that we're not there in fact?</td>
<td>Now, can we take it that we're not there in fact?</td>
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<td>A. Yeah.</td>
<td>A. We're not there by a significant margin.</td>
<td>A. We're not there by a significant margin.</td>
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<td>Q. Paragraph 22:</td>
<td>Q. &quot;This leaves some 20 to 30 organisations that will not been a position to submit a credible ... application by the end 2010.&quot;</td>
<td>Q. &quot;This leaves some 20 to 30 organisations that will not been a position to submit a credible ... application by the end 2010.&quot;</td>
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18 (Pages 69 to 72)
support in order to get organisations through.

2. Q. And it's a significant issue, isn't it? Andrew Lansley was on Radio 4 last Thursday, as it happens, (inaudible)
4. typed the document that I'm looking at, and he spoke about 22 trusts having a total GBP 5.5 billion
6. commitment, meaning some, I think he said, 20 billion in
8. interest over 20 years.

A. Yeah.

Q. Is the idea that they are somehow going to be got out of
9. their obligations?
11. A. No, because most of those organisations their PFI's were
13. approved on the back of a service and financial plan, and that service and financial plan can still continue.
14. I mean -- but there are a small number that in the present climate it will be impossible for them to meet the rigours of the foundation trust programme, without having some kind of national support, and that's the process that we're going through at the moment.
15. I don't want to encourage either the 23 or others to think that, you know, there's a huge amount of money available here to do that. But what I'm saying is that
17. what we're saying is that it's more important to get a financially and clinically sustainable organisation locally accountable, and to do that we are prepared to take whatever national action we need to help and

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support that organisation do it, as opposed to leave them to kind of get to their own position in relation to that.

4. Q. Just give me a moment. Sorry. (Pause).
5. Can I turn to the issue of chief executives and doctors and their employment, and particularly chief executives regulation, which you touched upon earlier and I said that I'd come back to it and so I do.
6. First of all, is it your view that chief executives ought to have some form of formal regulatory body?
7. A. I think the present position is not sustainable, that if you sit on a board as a chief executive you're sat next to a doctor, a nurse and an accountant, all of whom have regulatory bodies, who have clear national standards about what's expected, both in terms of behaviour and the way that they carry out their jobs and a view about what training and development they would need in order to carry out their jobs. It isn't the same for chief executives and it seems an anomaly, and it needs to be put right.

Q. How?

22. A. Well, the path we've chosen is one of -- we've consulted widely about the principle of it and there are very, very mixed views around about whether we should do it or not, very mixed, and in management terms it's a pretty controversial set of issues.

25. Monitor, and announced that the CEO had been allowed to resign with all his contractual entitlements despite ministerial concerns about the wider public interest (not rewarding failure ...)."

5. Now, we've heard a lot about this culture within the National Health Service of people moving sideways, never downwards and very rarely getting dismissed. If you have a regulatory structure, will that make it easier to sack chief executives or are the two unrelated?

10. A. It both makes it -- it makes it easier to -- it doesn't make it easier, what it does is it makes it very transparent. It makes it very clear what the terms -- what is expected of a chief executive in terms of performance, and it sets out that -- or potentially sets that in a really kind of helpful way. So it both helps the employer, because it is very clear then whether an individual is satisfying their -- the requirements of being a chief executive, but it also helps the individual chief executive, because it is very clear upfront what is expected of them. So I don't know whether I can say it makes it easier to sack a chief executive or less easier to sack a chief executive.

22. Q. Could you slow down. Sorry. Yes.
24. A. Sorry about that. I don't know whether it makes it easier or less easy to sack a chief executive, but what
it does do, it makes it much more transparent for both parties, and I guess in those circumstances it would enable more rational decisions to be made.

Q. Dealing with Mr Yeates, you're aware --

THE CHAIRMAN: Before we go to Mr Yeates, is the opposition to a regulatory structure largely one of a fear of the resources and bureaucracy that would go with it, or is it wider than that?

A. I think it's threefold. I think it's resources to do it, it, I think it's -- there is a body of opinion that says you simply can't properly describe what a chief executive does and how they do it, because it very much depends on the kind of individual and all the rest of it, and there was a third one which has now completely gone out of my mind -- oh yes, sorry, and the third one is this is seen as sort of top-down interference in the right freedom of boards to decide who they would appoint. So they're the three areas in which the controversy has developed.

20 THE CHAIRMAN: And this isn't meant to be a sceptical comment, but are the second and third of those points largely one's put forward by those who might be regulated?

A. I think all three points are largely put down by people who will be regulated.

Q. Dealing with Mr Yeates, you're aware --

THE CHAIRMAN: Thank you.

MR KARK: We have, perhaps, a good example of this culture. If we could have a look, please, at DH00120000312. This is a note in February 2009, so it's fair to say this is before the final report was published, but there was the draft available.

If we look at the bottom half of the page and the very last two paragraphs:

"In light of the gravity of the situation, leadership will need to be seriously reviewed. Monitor is of the strong view that as a first step the chair should be removed either before or at the time of publication of the report. I agree with this approach."

"The SHA's view is that the chief executive will also leave his post. The SHA is in discussion with him about this. A likely scenario is that he will move to another post in the system."

And it was David Flory, I think, who said:

"This seems reasonable to me in the particular circumstances of this case."

Now, to be fair to him, it may be that the full extent of the problems weren't apparent to him, but this is a good example, is it not, of the culture of being resistant to punish failure? What do you say about the culture now within the NHS, is it any different?
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<td>1 A. Yeah.</td>
<td>1 action taken against them and all the rest of it. The issue is not doing that, it's how complicated and difficult and long-winded and long time it becomes, and I think the reason for that is because of the way -- historically the way this has been dealt with. And as I say, I haven't got a set of plans at the moment as to how I could take that forward.</td>
<td>2 Q. I want to stay, if I may, with the issue of culture within the -- THE CHAIRMAN: Just pausing there and going back to the issue of senior managers. A. Yeah.</td>
<td>21 (Pages 81 to 84)</td>
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<td>2 Q. And the GMC procedure then takes its course, which can be quite slow on occasions, meanwhile the trust is saddled with a doctor that they can't do very much with. In terms of sacking doctors, Antony Sumara described it in this way: &quot;It's like handcuffs on the trust, in terms of dealing with it.&quot; And that's because there are these very specific procedures that have to be gone through, described by the lawyers for the Mid Staffs trust as complicated, time-consuming and difficult to follow. Why is there a necessity for a set of special rules for the employment and the sacking of doctors? Why can't they fall on their sword, as it were, in the way that anybody who fails in the job would have to do? A. Yeah, I mean, this is -- this is undoubtedly an issue that chief executives around the country would say is difficult for them to deal with. I would say we've attempted on two or three occasions to take this forward, make it more streamlined, dare I say it, take the lawyers out of a lot of this kind of work. It has proved almost impossible for us to do it. And I guess there are people in this room who know more about this than I do. But we continue to think about how we might do that. But at the moment we haven't got a set of proposals on the table to discuss with the BMA about how to make it easier to sack doctors. The issue underneath it, of course, though is one of -- one of principle which is around the employment of doctors generally and dates back, as you know, to 1948. Because for most doctors the NHS is the only employer. There is no -- we are a monopoly employer for most doctors in the country, and so the argument for special arrangements for doctors were that if they lost their jobs they lost their jobs. They lost their livelihood. There was no way back, no alternative. So that was why those arrangements were put in the first place. And we are still in that position. We are the monopoly employer of medical staff in this country. There's a tiny number that work outside of the NHS and, in those circumstances, you can see it. I'm not advocating for it, I'm just explaining kind of the understanding of why it is. Q. I'm sure we can all sort of see that argument, but at the same time, of course, they do have a particularly privileged position in society, in the sense of what they do, and they have a particularly responsible position in society? A. And I'm not saying they shouldn't be suspended and</td>
<td>25 A.  And I'm not saying they shouldn't be suspended and</td>
<td>22 THE CHAIRMAN: It wouldn't be fair to say, would it, that they have a monopoly employer in quite the same way. They may well have come up through an NHS system, but someone who is a senior manager of an NHS organisation or even at the level below should be capable of running something less dangerous than healthcare in the private sector. A. Yes.</td>
<td>24 MR KARK: I was going to say on the topic of the culture of the NHS and you mention in your statement at</td>
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And I think that and part of the JCI was very
patient services better.

methodology that IHI provide, in order to get service --
together, using benchmarked data, using improvement
from local organisations, local clinicians working
not come from delivering big national targets, but comes
with the overall analysis of the English healthcare
conclusions of JCI I would agree with, I don't agree
to very similar conclusions in general terms to the IHI
report, which I'm not sure if that was shown to you
during the course of your statement.

A. No, it wasn't.

Q. Do you remember it?

A. I have seen it, yeah.

Q. And that was a report -- the chief executive of IHI is
a man called Don Berwick, who is currently the
administrator for the US Federal Centres for Medicare
Medicaid, and it was based upon the evidence, among
others, of Mark Britnell, who is director general of
commissioning, Sir Nigel Crisp, Bernard Crump,
Sally Davis, Andrew Dillon, Sir Ian Kennedy,
Sir Bruce Keogh and Martin Fletcher. So I don't suppose
you thought that report was insignificant, or did you?

A. Can I -- I mean, in terms of both the JCI and the IHI
reports can I -- I mean, we commissioned them, you know,
first of all. We asked the question and we knew we'd
get a variety of answers to that question. The thing
about JCI and IHI, of course, most of their
experience is in another system, i.e. a system that
hasn't got a system in the sense of it.

I think that the JC -- whilst some of the
conclusions of JCI I would agree with, I don't agree
with the overall analysis of the English healthcare
system that they identify.

With IHI -- and we work with IHI quite a lot in this
country, Don Berwick who actually until recently had
been a member of the National Quality Board, and he had
to resign when he got the job you just described in the
United States, and he has consistently argued -- and in
a sense it underpins what I was saying earlier, he has
consistently argued that real quality improvement does
not come from delivering big national targets, but comes
from local organisations, local clinicians working
together, using benchmarked data, using improvement
methodology that IHI provide, in order to get service --
patient services better.

And I think that and part of the JCI was very
influential in the way in which we took forward High
Quality Care for All. So the way I described to you
quality improvement would be absolutely recognised by
IHI when we set it out in the document and have tried to
take that forward. However, they do both operate in
a very different situation. They operate in a system
where individuals and insurance companies pay for
healthcare, and the government doesn't in that -- in
a comprehensive way, it obviously pays for some
healthcare but the idea of a comprehensive system, free
at the point of use, paid by taxpayers, and the idea
that the government, when it provides that money, should
start to identify priorities for the system is not part
of either of the cultures of those organisations who did
that work. That's why they find it very difficult to
understand this idea that we might have for the country
as a whole three or four major priorities that we want
to take through the system.

Q. To be fair to the authors of the IHI report they
actually recognised that problem. They said, if I can
just read out two sentences to you:
"This report has one particularly serious
limitation, namely that the IHI team that has prepared
this report is made up of outsiders to the NHS and the
UK."

And they say a little later on:
"We are bound to have missed subtleties and
contextual information of potentially great importance
that only people who have grown up in the UK and have
been immersed in the NHS would know."

And for that they apologise in advance. So they
recognise that failing?

A. But in a sense that's why we asked them. Because one of
the criticisms of the NHS that's made -- I think it's
made in one of those documents as well, and I am very
conscious of it, is that we sometimes don't think
outside of our own experience, in terms of what's likely
to make change happen and what isn't, and that was part
of that process.

Q. And I'm just going to take you, if I may, to the
executive summary of the IHI report and ask you to
comment briefly on it. If we could go to PA0002000328.
We can see the introduction and how this report came
about. But can we look at the last paragraph on that
first page, please.
We have to remember that this was published at the
beginning of 2008, wasn't it? They were all published
at the same time:
"Significant barriers to improvement, in the opinion
of the interviewees, included the absence of a coherent
Page 85
| 1 | framework for improvement (leading to contradictory or inconsistent programmes or policies), failure consistently to involve patients and families in improvement activities and designs, absence of a clear and shared definition of 'quality', gaps and conflicts between managers and clinicians, frequent restructuring and changes in leadership, a culture of fear and top-down control rather than shared learning and participative improvement, and lack of emphasis on acquiring and maintaining technical improvement skills among the NHS workforce, clinicians, and leaders." |
| 2 | Day 128 Mid Staffordshire Inquiry 28 September 2011 |
| 3 | A. That's rather a big question. I -- let me take the first bit was -- |
| 4 | Q. Well, I'm asking you specifically about frequent restructuring and changes in leadership? |
| 5 | A. Frequent restructuring. I think I have covered already this real concern that I had at the time, which I think is much less an issue now in the way our acute hospitals, in particular mental health organisations, are managed of this idea that your career -- if you spent more than three years in somewhere that you somehow weren't managing your career properly. I think we've seen big changes in all of that, in this period. |
| 6 | And if you look around at the acute hospitals, even in this region, you will see there's been an amount of stability that we haven't had for a long time. So I think that is -- I think we're moving in the right direction but was an issue, I think, in early 2004/2005. |
| 7 | In terms of restructuring, I agree that restructuring can be a serious problem for developing continuity, for getting consistency of purpose, for agreement that there is still a problem that needs sorting out, is it not? |
| 8 | Now, you've spoken a lot about quality improvement. |
| 9 | A. Well, you know, I see the paragraph, I see what's written in all of that. I can recognise bits of all that in my own experience and knowledge of the NHS. |
| 10 | What I don't believe is that is an adequate summation of the way in which the NHS does quality improvement. |
| 11 | If you think of the enormous improvements that have been made across the country over the last five for six years in particular, they could never have happened had that been the dominant way of doing things. But having said that, I do recognise many of the things that are said, and I've seen aspects of that -- of that kind of culture in organisations as I've gone round. And one of the issues across all healthcare systems is this issue of managers, i.e. non-medically and clinically qualified people and clinicians, and in any healthcare system you want an example, that is there. It is particularly developed in this country because of the way historically, the way in which general management was introduced. |
| 12 | Having said all of that, at least a third of all of those people, who would describe as managers, are actually clinically qualified. I mean, the most obvious group of that is the nursing profession, which provides us with lots and lots of middle and senior managers in the NHS. So it's not quite as they describe, but it brings it back, I think, to a point I made earlier, which is getting alignment between the objectives of the management community and the clinical community in an organisation is critical to taking that organisation forward. Where there are gaps, that is where you get problems. |
| 13 | Q. The second bullet point after "Conflicts between managers and clinicians" is frequent restructuring and changes in leadership, which indeed we're seeing at the moment. Is there any answer to that? Is the only answer to take the politics out of the NHS, and is there any way of doing it? |
| 14 | A. That's a rather big question. I -- let me take the thing about -- let me just take it bit by bit. The first bit was -- |
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| 25 | A. That's a rather big question. I -- let me take the thing about -- let me just take it bit by bit. The first bit was -- |

| 26 | | 27 | understanding why you're trying to do things, all of those -- all of those things, and at the time this was done we'd -- I think it was a couple of years -- two years after Commissioning a Patient-led NHS and we have had in the last -- certainly since I've been the chief executive of the NHS, fewer reorganisations than ever, I guess certainly in my experience since 1989. We, of course, now have the biggest of all, but during my period in that I would say we had more stability then than ever before. |
| 28 | And there's no doubt the NHS benefited from that process. The government have come in with a set of proposals for changing the health service, which is being debated in Parliament at the moment. My job is to make sure that the risks are well understood by people as we take that forward and to make sure we manage the transition. |
| 29 | All I would say about the current set of changes are that for the first time they're going to be legislated for. There's going to be a legislative framework to work on, and one of the things I think -- in my experience working in the NHS is that the NHS -- I know this probably is not a very good legal definition of it, but I apologise, but it's a kind of -- my understanding, is the NHS is essentially what the Secretary of State |
THE CHAIRMAN: I'm really going to the method of --

A. I know.

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A. Absolutely, and I'm trying to think back to the ones that I've been involved in over time, and I would say that there's been more consideration to the risks around this one than there have in the ones that I've been involved in before.

But when the government came into power and the Secretary of State appeared he had a pretty strong view about the way he wanted to do it. We did look at other options. We did look at whether there was a more piecemeal approach that you could take, without a bill.

So we said, if you didn't have a bill, what could you do? And we went -- and we went through that as a set of options and we looked at the kind of various options.

So there was quite a lot of consideration in this time which we didn't have before, but at the end of the day the Secretary of State will make -- the ministers will make their judgments about what they want to do.

But I think on this occasion we did look at what you could do without a bill.

THE CHAIRMAN: Thank you.

MR KARK: Can I come to the last bullet point, which is the top-down culture:

"A culture of fear and top-down control rather than shared learning and participative improvement..."

Now, it's been interesting listening to all of the evidence as we've been here, because it doesn't appear as if anybody who works within the Department of Health recognises the top-down culture or the culture of fear.

Can I give you an example, GP commissioning. This is not meant to be a criticism of what is being proposed, but if that is thought to be a good idea, why not consider -- or maybe it was, why not consider just replacing the existing board of a primary care trust with GPs or whoever you want to do that, rather than abolishing PCTs, abolishing strategic health authorities and starting again? There may be a very good answer to that, and it may be the wrong example, but is there consideration given in an objective, which may be different in policy terms from a previous one?

Another example might be abolishing CHI and producing the Healthcare Commission or abolishing the Healthcare Commission and producing the CQC?

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And that's a bad place for us all to be in. And I've seen that -- I've seen that happen and people will describe that a short cut is made to something which is more important than just the short cut. So I've seen circumstances where people under pressure have said "just do it", and that is a bad place for the NHS to be in. And it's one thing -- it's something we've been trying to move away from significantly.

So if I could give you an example about how we might take that forward, or do you want me to --

Q. No, please do, because I'm going to come on to the issue of targets briefly and it may be that this is related.

A. Well, having said all of that, having said all of that there are things -- I mean, we know how to reduce healthcare-acquired infection. We know what you need to do. We know what the various elements of intervention you need to make to do at a local level in order to deliver a result. We've seen it elsewhere, there is a formula that you can use, and you can make it happen. With organisations that consistently fail to enact all of that, I think it's perfectly reasonable for a central body, an organisation, to make it very clear what your expectations are. Now, that's not to say you run by a climate of fear. But you need to be very clear, I think, when you know that particular actions will improve services for patients that you are unequivocal about what your expectations are as that goes forward. But they're relatively rare. There aren't many things like that and in fact the danger with most of them is the unintended consequences can be worse.

Now, if you take A&E as an example, the A&E target, four-hour targets, 89 per cent of patients seen within four hours, a big -- most people in most A&E departments would say that was a breakthrough for A&E, and it was a breakthrough for A&E because it showed attention, managers had to think about their A&E departments, they had to do something about it in order to deliver the change. But also to deliver it you couldn't just do it in one bit of your organisation. You had to manage the whole of the system.

So it wasn't good enough just to try and get your A&E department to deliver it. It had to be the quality of general practice, how you were avoiding people going to A&E. It had to be the way you organised and managed your A&E department. It had to be the way you managed and/or organised medical admissions when people -- when older people were ill at home, where did they come and how would they -- it involved how you organised your hospital internally, in to order get the right processes in place to take patients through, and it -- you had to organise your discharges -- your discharge policy and arrangements for patients.

So you had to completely redesign the system that you needed to deliver it. And in the best places that's exactly what happened. In fact most places that's what happened. If you go to most hospitals you'll see that redesign in practice. But what tends to happen, of course, is people's experience of that is you've got your four-hour target to deliver, you've got to deliver it.

So what we've tried to do is to move away from that, and what we've developed is a new approach to A&E, which we're not quite there yet but I think we're well on the way to understanding it and to understand that you have to understand the kind of philosophy behind change that was talking about. So we've developed, I think, eight measures now for A&E, eight indicators for A&E.

Now, we didn't developed them in the Department, in the sense of a whole set of boffins sat around thinking about them. It were clinicians across the country had been working on, what are the indicators both nationally and internationally that would indicate whether the service you were providing was a good one or a bad one? And those eight indicators have widespread understanding and knowledge and support from local communities -- from the clinical community and from patient organisations, widespread support.

Now, if you implement them in the way that I described earlier, and what's supposed to happen is that you get your staff together in A&E, you get the staff in, you get your patient representatives together, you get all of those and you say, "Look, these are the measures, this is where we are as a system at the moment, a team at the moment, what improvement goals do we want to get locally?" And you set a set of improvement goals locally, and you measure yourself and then you publish the results, so everyone sees how you're doing.

Now, that's the culture that we want to try and develop in the system.

Now, if you just put that into a culture which is top-down target-driven, what will happen is that people will say, "Oh, we've got eight targets now, not one", and you'll drive people into the ground. And that's why it's so important to get the kind of idea about purpose and why we're doing into the system, because the technical aspects on their own, which you've got -- I'm sure you've got a very thick document there with lots of technical -- the technical documents on their own won't
... that's why implementation in these circumstances is so critical.

Q. I mean, just before we break, I can show you the document I think you're referring to, which is PA0000000307. That's the A&E clinical quality indicators data definitions. And if we go to the third page, those are the eight -- I was going to say targets but eight indicators that you've been referring to.

A. Yes.

Q. Does it follow that trusts are one day going to be checked or somebody's going to audit their results in relation to how they met each of these indicators?

A. What's happening at the moment, that document you've got there the data definitions is setting out how you measure them, because there'll be lots arguments about how you measure all of this stuff, and to get comparison for that organisation -- for one organisation in comparison with another, they need to be assured that they're being measured in the same kind of way. So it is necessary to give people that -- that detail.

What will happen to those measures, they will be published. They will be widely available to the general public and be available to local commissioners and to the organisation itself, and what will happen in those circumstances, the local commissioners will talk to the organisation, they'll engage their local representatives and they will make judgments locally about what progress needs to be made in relation to one, none or all of them over the period. And that is a local discussion and about local accountability, not about somebody at the centre saying, "We want to see, you know, 80 per cent in two, 50 per cent in one", that would be a disaster for this approach, which is built on what I described earlier of clinical teams working together to improve services and measuring and benchmarking.

Q. And when this approach comes into play, the four-hour target, the simple four-hour target goes?

A. Well, already --

Q. Or has it?

A. -- we have moved from 98 to 95 against the background.

Q. You mean 98 per cent to 95 per cent of --

A. Sorry, what did I say? From 98 per cent of patients seen within four hours to 95 patients seen on the basis of clinical advice. We're still reporting that nationally.

We don't want to slip back at the moment in relation to all of that, so we're holding that for the time being because we want to see this system grow and develop and in time this will then be a local template that people can use to drive services locally. And that, I think, is completely in line with the kind of things that IHI were telling us in that document.

MR KARK: I'm going to come on to the issue of the patient voice, and perhaps I can do that after the break.

THE CHAIRMAN: Certainly. We'll start again at five past 2.

(2.05 pm)

(Short adjournment)

(4.05 pm)

MR KARK: Sir David, I said we were going to turn to the public voice and I want to start, please, by looking at a comment which was made in the IHI report, as you remember published in January of 2008, and I'm going to ask for a particular page to put up on the screen.

It is the page we now have on screen, and could we look at the paragraph headed 2, "The patient doesn't seem to be in the picture."

And they say this:

"This second theme reflects something we didn't hear in our interviews, more than something we did hear we were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations, whether we were discussing aims and ambition for improvement, ideas for improvement, measurement of progress, or any other topic relevant to quality. Perhaps this was due to a cultural difference between US/Swedish and the English perspectives, and we simply missed it. But it is our strong impression that the lack of a prominent focus on patients' interests and needs in the centre of these conversations represents a significant barrier to shifting the trajectory of quality improvement in the NHS."

At the time that those words were written, was that a fair criticism?

A. Well, they were reflecting on what they'd heard in their interviews, which was not meant to be, I don't think, an analysis of the totality of activity in the NHS.

Having said that, having said that I -- when I talk to people about that period, one of the things I say, partly I think just to reflect on the history of it so we understand it, but also partly to kind of focus our attention on the future, one of the things I say is that during that time the senior management of the leadership of the NHS did not put -- and I was part of it, did not put sufficient focus on the core purpose of why we were here, for all sorts of reasons.

When you've got senior managers together, team leaders in the system together at that time, to talk about the NHS and what was happening in it, the conversation, we were almost entirely focused around foundation trusts, payment by results, practice-based...
Q. This theme was reflected again in the government's response to the Alberti and Colin-Thome reports, and if we could just look at that, because this is now a year and a half or so on from the document we've got on the screen at the moment. If we could go to your exhibit 49, please, and just to the first page, just to get the heading "Government response to Alberti and Colin-Thome reports".

Then if we could go, please, to page 8580, and we'll find a heading "Patients' views not taken seriously": "Dr Colin-Thome's review found that a significant reason that such poor care at Mid Staffordshire went unchecked for so long was that patients were not listened to. Patients' views need to be a top priority in shaping and guiding the services provided in all NHS organisations. This should not just be the preserve of a small number of organisations exhibiting best practice but should be systematic everywhere."

And then they go on to deal with part of the solution at least: "In foundation trusts, the governors are drawn from patients, the public and the staff and they have statutory powers to influence the trust's plans and call it to account for poor performance, including dismissing the board. Patients, the public and staff should use this opportunity to get involved and make their voices heard."

And then they go on to talk about LINks. Now, having public governors on foundation trust boards is plainly a good idea, but is there evidence at the moment that they have an effective voice? You were talking a bit earlier about this need to empower them, do you think they have an effective voice yet?

A. In some organisations they do. In fact my experience of this, having -- I -- when I visit foundation trusts obviously I meet people in that sphere. I think they do have influence in what the trust does, but is it developed enough of -- or expert enough to be able to do it? I would think there is some way to go, but it is an important part of foundation governance to engage members and governors.

Q. Has any work been done in relation to what the sort of turnover of governors is? Because, of course, one of the problems of this sort of system, which effectively is voluntary, is unless you have people in place for a fairly significant period of time they just don't get the knowledge or the skills to do the job properly.

A. I haven't seen any evidence or documentation around all of that. All I can say, I'm a member of three foundation trusts, as it happens, and the governors have all been pretty consistent over the last three or four years in both.

Q. We heard from Sir Bruce Keogh last Tuesday that there will be a patient representative on the National Commissioning Board, and I just wanted to explore with you briefly, if I could, what that really means and what sort of weight they will have.

How big is the board going to be?

A. I mean, there are two issues here. There's one which is about, how do patients directly get involved in their own care, their own services, the way in which services are delivered for them as individuals? Which is one set of issues, which I think is really, really important. And there's another set of issues about operating as kind of -- people or organisations operating as proxies for patients, patients' representatives, public representatives and all the rest of it, and we're talking now about the second of those things. But they are equally important. In fact I think the first one very often gets missed when we focus on organisational structure. But nevertheless the -- we've already said as part of the listening exercise that there will be patients' representatives on the clinical -- they'll be patients' representatives on the clinical commissioning groups. So we've got it at that level.

What we've said about the commissioning board --
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<td>this is at the most senior level -- there will be a chair, five non-executive directors and five executive directors, and of the non-executive directors we expect at least one to come from a patient representative background. Those are about to be -- we've just advertised for the chair, albeit that's for them. On the executive side, we plan to have an executive director responsible for patients' voice, patients' experience, that sort of thing, and we're currently working through what that will actually mean in practice. We've got some external advice and support. We're working with a whole variety of patient groups to ensure that it's not just about one individual, but it's sort of built into the way in which the organisation operates. So, for example, one of the things that patient groups consistently tell us is that we're not transparent in the way that we operate and it's very important that we get transparency in the way that we work. So from the commissioning board perspective, the commissioning board will meet in public. I would like it to be frank meet -- be broadcast over the Internet. I think the deliberations of the commissioning board should be open to scrutiny for patients and the public, and people will see then the influence or otherwise of the patients both on non-executive side and the executive side in the way the service runs. But that post I talked about is not just about trying to rep -- because how can one individual represent patient views at a national level for the commissioning board as a whole? That individual will be responsible for connecting to the huge networks of patient organisations there are, but also for leading the work in terms of insight to ensure that we have the right kind of poling and patient information that we need to plan services at a national level. So that's the kind of approach that we want to take at a national level. Q. Do you accept this, as a cultural issue, that from what you've just said it might be thought that it sounds as if patients are being included but they're somewhat on the side lines, as opposed to the system being driven by the patients? A. No.</td>
<td>level, where foundation trusts have got patient voices on that level, where you can see absolutely at a local level, so organisations see themselves accountable to patients. So that when I described that example of A&amp;E, of the nurse talking to the doctor about Mrs Smith getting seen within four hours, that those people feel accountable to those patients. That's where we want to get to. Now, one of the things that the IHI thing says is that sometimes this what is described as a top-down culture undermines our ability to do that. So one of the kind of basic building blocks around all of this is to make sure we can support that kind of activity, so we don't get into a position where we're identifying huge numbers of national targets from the centre. And it is -- you're absolute rightly, there is a whole set of cultural issues here, because if you traditionally have got your money from the centre, you know, often follow the money is the answer to all of that. Patients don't directly fund services in that kind of -- Q. I suppose the answer to that is the patients do because the patients are paying the tax. A. Absolutely, but what I'm saying is it's through a middleman. It is through a structure that that happens. In other systems they do it -- that relationship is much more direct, and I'm not advocating that system at all, but we need to mitigate that system. We need to find ways of giving patients more clout. So we need to give patients more budgets, individual budgets, for them to use as they see fit in their local health community. We need to do more of that. We need to make complaints much more part of the general way in which an NHS organisation operates. We want to give incentives to organisations to engage and involve their patients in what they do. That's the kind of direction that we want to take the service. As I say, we're not there yet by any means. Q. I was going to turn to the issues of complaints, because complaints are actually a very important part of the patient voice. And I note in your paragraph 181 that you're in favour of the changes that have been made to the complaints system, so removing the middle tier that the HCC filled. We heard from Ann Abraham about the tiny proportion of -- and that's my expression, not hers, but it was, I think, a tiny proportion of second-stage complaints that actually get through and are fully considered by the whole process. And some might think that seems to be a lost opportunity for discovering problems in the</td>
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A. Okay, can I -- I'll talk about the system but I think there's a bigger issue here than just the way technically you might do it. You know, I've followed the progress of -- there was a Health Select Committee more recently on complaints and I followed the progress of that in some detail.

I've also spent time with Ann Abraham and her team, nationally, I spent a day with them not long after, and it is absolutely, you know, fascinating to see the kind of information and knowledge that they've been able to put together as an ombudsman on, as you describe, a relatively small number, but actually in pretty -- you know, in good depth. They've looked at a whole series of issues, and the learning is absolutely obvious. And it was one of the reasons I think that we had Ann Abraham come to our management board to talk about that. And in her last two reports she has set out some of the themes, but also some of the organisations that seem to have lots and lots of complaints coming through to her, which I think is a signal for issues, and she has named them for the first time. They're now working with those organisations, and we're seeing the benefits of all of that.

You can see directly the benefits of engagement in all of that. So I think the way in which the ombudsman works and what we're beginning to see in terms of the feedback, I think is really important. But underpinning all of this is what -- how do you -- as a chief executive of an organisation, how do you deal with complaints?

Because one of the things that Lord Darzi put in his document that every mistake, every dissatisfied patient, any clinical incident that went wrong should be a learning point. And that's easy to say that. But that, it seems to me, is the thing we need to engender in the NHS.

I can only -- I mean, when I -- when I was a chief executive, in the organisation I was responsible for, we would have a quarterly meeting of the board on complaints where we would have the first complaint letter and the final complaint letter, and I would sit there and have to explain to the board what had happened in each case, and the board would invite three or four of the complainants to the board meeting, in order to reflect back on how effective or whatever that system had been. That was an enormously powerful system and, you know, you learnt a huge amount from all of that directly.

Now, we need to get to a place where perhaps not that particular system, because that was probably would be regarded as old-fashioned or whatever, but that every organisation wants to do it in that way. Now, you can do it by diktat, but actually I'm not sure that -- well, I don't think there's much evidence that saying people need a complaints committee or do anything will actually make it happen.

I think partly it is about transparency, it's about, you know, ensuring people publish all of their complaints in their annual reports or in their regular reports or whatever. As you know, there's an anomaly at the moment around foundation trusts that we're going to sort out in the next planning process. But also it's about organisations meeting in public, and I think it's very important that any organisation that takes money from the NHS should meet in public and be open to public scrutiny in that way. And I think if you build those kinds of things into the system, you're much more likely to engender, I think, the culture that we need about complaints, than some of our interventions so far.

Q. Linked --

THE CHAIRMAN: Sir David, when you say that organisations should publish all their complaints in there annual reports, do you mean in terms of figures, subject matter or the actual story behind the complaint?

A. I think at this stage we're talking about figures that identify particular kinds of complaints, so we can benchmark and compare people. I think that's probably as far as we can go. I think good practice it seems to me would be to also publish some patient stories but I think we're a way from that yet.

THE CHAIRMAN: I mean, my last inquiry was able to publish a lot of stories, unhappily, and it's been said they had a lot of impact. Isn't there any means of publishing stories, not all of them perhaps, to demonstrate to people the impact that their actions or inactions have on real people which doesn't necessarily get conveyed by figures?

A. Yeah, I mean, I have to say I'd not thought of doing that but that's a perfectly possible thing to do. We -- no doubt you'll make some comments about that in your report. We can certainly reflect on that.

I mean, one of the ways I use it, for example -- patient stories is in -- when I'm recruiting strategic health authority chief executives, they -- and we give them a patient story as part of the selection process and we ask them to look at it and explain to us what
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1. they would do in the circumstances as part of -- and
2. I think building those sorts of things starts to bring
3. into people's minds how significant these things are.
4. THE CHAIRMAN: In the old days when it was something called
5. a family practitioner committee, which used to consider
6. complaints about general practitioners, I seem to
7. remember, but you'll tell me if I am right or wrong,
8. that they used to publish in anonymous form the nature
9. of the case.
10. A. I can't remember. It's before my time.
11. THE CHAIRMAN: You're obviously a lot younger than me.
12. MR KARK: Linked to all of this is the issue of transparency
13. of what goes on in hospitals, and what is sometimes
14. referred to as the duty of candour, and I want to look
15. at some of the remarks that were made by the first
16. report in the National Quality Board, which I think you
17. set up in fact.
18. If we could go to WS -- it is one of your exhibits,
19. DN64. This is the review of the early warning systems
20. in the NHS, published in February of 2010. I don't know
21. if you want to comment on the National Quality Board.
22. You've commented on it in your statement.
23. A. Well, only that it came out of the -- it came out of the
24. work around High Quality Care for All and in a sense its
25. work was catalysed by the first inquiry into the

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1. Mid Staffordshire hospital. It is a mechanism by which
2. we can bring together all the various interests,
3. regulatory interests in the NHS into one place. I chair
4. the meeting.
5. So CQC, Monitor, NICE, all of these regulatory
6. bodies all sit -- the chairs of them all sit on the
7. National Quality Board, together with representatives
8. from Royal colleges, representatives from patient
9. groups, representatives from the voluntary sector. And
10. our task in a sense is to ensure that the alignment
11. which in some ways we've seen lacking in some of the --
12. our experience around Mid Staffordshire was brought
13. together, so that organisations could work together and
14. worked effectively for the benefit of patients.
15. So that was the purpose behind the National Quality
16. Board, and one of the things that -- one of the first
17. tasks that it got -- it was given by Alan Johnson as
18. part of the response to the Healthcare Commission report
19. on Mid Staffordshire -- was to look at putting in place,
20. if there wasn't one, an early warning system for the NHS
21. and that's, I think, the document that you are referring
22. to.
23. Q. It is, and I just want to alight, if I may, on a couple
24. of aspects of it. If you go to the internal page 3, 
25. which is 8805, and if we look at the bottom right-hand

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1. paragraph:
2. "To create a self-improving and responsible NHS, we
3. need to aim for a culture of open and honest
4. cooperation. This means individuals and organisations
5. being open and honest about the quality of care being
6. provided to patients and the whole system working
7. collaboratively to address concerns and raise
8. standards."
9. And then if we could go to 8818, I'll just remind
10. you of a few of these, if I may, and then ask you to
11. comment.
12. Then bottom right-hand corner:
13. "But what does a culture of open and honest
14. cooperation look like or mean for the NHS?"
15. And then the first bullet point is:
16. "Healthcare professionals and all NHS front-line
17. staff feel able to raise concerns about the quality of
18. care at an early stage."
19. And then:
20. "Clinical teams understand the quality of service
21. they are providing to patients through routinely
22. measuring and benchmarking [them]."
23. Then it talks about provider boards seeing their
24. fundamental roles as ensuring high quality care.
25. Then system managers sharing information and all

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1. parts of the system actively listening to and engaging
2. with patients.
3. Now, it may be that that last one deals with the
4. duty of candour that I'm trying to get to, but do you
5. think that in all of this talk about transparency there
6. also needs to be a focus upon hospitals being absolutely
7. open with patients (a) when things have gone wrong that
8. have harmed them, and (b) when things that have gone
9. wrong that have not necessarily harmed them but which
10. affect their care? Do you have any views on that as
11. being a duty --
12. A. Well, I have some views on it, although they're not
13. completely formed because this came up as an issue
14. during the listening exercise around the reforms into
15. the NHS. And I know that it was certainly very much
16. supported by members of the future forum, which was a
17. cross-section of people with some caveats about the
18. practicalities of it.
19. Now, I don't really understand some of the
20. practicalities of it, and we are at the moment, as you
21. know, either about to or consulting on this whole issue
22. about a duty of candour. But it seems to me the
23. principle that if the NHS harms you that it actively
24. tells you that it's harmed you, I think seems to me to
25. be a good one. Certainly if I was a patient I would
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<td>122</td>
<td>Q. Well, that's part of it, that's when things have gone wrong and the patient has been harmed and, as you will know, there's a duty of care within the GMC Good Medical Practice that if something's gone wrong, the doctor has to open and honest about it and deal with it immediately. What about where things have gone wrong, but the patient hasn't actually been harmed because there's been a recovery of the problem? And one can understand the view, suppose, where if the patient hasn't been harmed, why should the patient be told? But if you're going to incorporate the patient voice in your system for driving improvements, doesn't the patient have to be told about that sort of incident? A. I don't know. I mean, I don't know enough about how it would work in practice to make a judgment at this stage. Q. And the recent Health Select Committee report on complaints recommended, we're told, and I confess I haven't read it myself, I'm afraid, a duty of candour. It seems to be -- particularly in this area we consistently seem to get it not as right as it should be. And, you know, I was brought -- I mean, I worked for 20 years with community health councils and then suddenly we had four different ways of doing it. In terms of HealthWatch itself, I think it's important that it connects with local government. I think the support to LINks, which has grown up over the period, which I think has got -- certainly in most parts of the country, quite a lot of corporate memory about what's been happening in organisations and we need to make sure that the people are dealt with appropriately there. So if TUPE applies to the changes, we need to make sure that that happens. But, as I say, my main point is that we should do the same with HealthWatch as that we're doing with all the other bits of the system, i.e. we need a proper handover and legacy set up which involves both the handover of the knowledge of that organisation about where the risks and opportunities are in the local health community, and we need face-to-face discussions with however Local HealthWatch ends up being configured, with the people who were in LINks if they're not the same people.</td>
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<td>123</td>
<td>Q. And HealthWatch, presumably, will have to liaise extremely effectively with the local GP consortia for the system to work? A. Yeah, and they're all brought together in the health and well-being boards, which are based -- local authority based. So that will be the forum which you can bring together, commissioners, providers, local authority providers and HealthWatch all in the same place to do it. And at national level, of course, we've got national HealthWatch, which will again we'll need to develop a significant relationship with the NHS Commissioning Board. Q. I turn momentarily there to GP consortia and I meant to ask you earlier, and perhaps I can ask you now in terms of GP consortia, the commissioning board will authorise the individual consortia? A. They're called clinical commissioning groups. Q. Clinical commissioning boards, thank you. Will they be able to deauthorise them? A. The arrangements at the moment, as they're set out, that the NHS Commissioning Board has wide-ranging powers to intervene in clinical commissioning groups. So if the commissioning board feels that they're not commissioning to the standards required, the commissioning board is capable of intervening and taking away those responsibilities.</td>
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"Over the next four years the NHS will make the transition to the new system architecture described in the White Paper resulting in major structural changes to how the NHS is organised and run. Subject to the passage of legislation, by April 2014 ...").

And then I just want to alight on a couple of these, if may:

"Strategic health authorities and [PCTs] will have been abolished (... 2012 ... 2013 respectively).

"All NHS trusts will have become foundation trusts, free from central direction or control but subject to a new system of economic regulation ..."

I know this was only published in March of this year, that timetable has shifted, presumably has it?

Yes, the timetable's shifted in line with the listening exercise, the future forum report, so that the strategic health authorities and primary care trusts are going to be abolished 1 April 2013, both of them. So there's no difference there. GP consortia become clinical commissioning groups. And all NHS trusts will become foundation trusts free from whatever it is, blah, blah, that will be -- we've extended that date now to 2016.

Q. And we better watch that space, I suppose.

A. And, I mean, what will drive that agenda is our ability to make these organisations sustainable, clinically and financially.

and then I'll stop talking and ask you a question. Halfway down the next paragraph:

"To ensure continuity of this important function, priority must be given to placing the NRLS and the responsibility for action that flows from analysis, in an appropriate organisational setting with accountability to the NHS Commissioning Board. The central alerting system that issues patient safety alerts will continue to function and trusts will still be expected to take any actions specified in those alerts to ensure safety issues are dealt with."

Can I just deal with PSAs, first of all, patient safety alerts. Who is taking those over?

A. The accountability for doing it is the NHS Commissioning Board.

Q. When is that going to happen? Start off with the timetable. Is the timetable still as set out there?

A. The timetable I think is as set out there. Q. I mean, patient safety alerts are regarded as being extremely important in the healthcare industry.

A. Yes, absolutely.

Q. Is there a system in place yet for dealing with the transfer of --

A. I think we've just done it. We're either done it or we're just about to do it. But will be done well in...
Q. One of the issues with patient safety alerts has been a fairly long-term failure by a number of organisations, either to comply with PSAs or at least to indicate non-compliance because they're not affected by the patient safety alert.

A. It's an effective system as long as you have that national buy in with all the organisations and they will stand by what happens. What would happen if there was a big disagreement locally about what would happen, I am absolutely sure in the circumstances that the strategic health authority would escalate it to me, and I'm sure the people in it would escalate it to their national bodies, and the NQB is a body that can help us bring all of that together. But I haven't seen that happen yet.

THE CHAIRMAN: I don't quite understand why it is the -- would it inevitably be the SHA or whatever comes after an SHA which would be given the task of ensuring something happened?

A. It wasn't inevitable but you have -- somebody has to take responsibility and given that we -- the strategic health authorities have the capacity and ability to do that, everyone agreed that in the absence of anything else that strategic health authorities should do it.

The next document that comes along, which we're working on at the moment is this for the transition, what's going to happen when the strategic health authority's gone? So what will the equivalent of the early warning system be when the strategic health authorities no longer exist? Then I think there's an issue there about whether it would be the commissioning...
that was an inspection that triggered it. So, I think the information -- the CQC could trigger it, a commissioner could trigger it, another provider could trigger it. There's a whole range of ways in which you could do that.

Q. A completely different topic, I'm afraid, but one you spoke about earlier, and we looked at briefly and I just want to come back to it, if I may, and that was the issue of targets, and you took us with a very helpful explanation through how the A&E target is being refined and developed.

You accept, I think, that there are issues or have been issues of gaming in relation to targets, although you say in your statement you didn't think it was widespread. Are all of the targets going to be altered and refined in the way that you've described in relation to A&E? In other words, they are going to be expanded with a number of different indicators; is that the intention?

A. I would imagine -- I'm just trying to think. I think they're probably all slightly different, I would guess, they're all slightly different. You could see, for example, healthcare-associated infections going in a similar way to A&E, because we know that they're -- MRSA and C.diff are not the only healthcare-associated infections. There may be -- there are seven or eight --

98 Q. And in the structure of the new indicators, as they arrive, even though you personally don't believe that manipulation was widespread, is the danger of gaming being taken into account?

A. Well, there's always that potential. There's always that potential. And whenever we set -- and it's interesting, it's one of the things that we think about quite a lot, because the intent is very important here, as well as the target. And at the end it's very difficult to work out whether the actual intent is being carried out, as opposed to the -- following the number or gaming or whatever. That is much better done at a local level. So if you're accountable to your local patients and you're transparent in the way that you do it, it will be pretty obvious pretty quickly to local people that you're gaming, and it just seems to me that connection and that transparency is much more likely to get us the benefits for patients than me sending out hoards of auditors to second-guess what people have done.

I exaggerate to make a point.

Q. To some extent it's a local cultural issue, isn't it?

A. And that's the kind of culture we want to support and encourage in the future.

Q. When the culture fails, on occasions one has to rely on whistle-blowing, and you know that whistle-blowing has been a theme that we've touched upon in this inquiry.

And we know that there's legislation in place, but it doesn't seem, from some of the evidence that we've heard, to have been particularly effective.

There is still, I think, no central NHS emergency whistle-blowing line, is there?

A. No.

Q. Why not?

A. Well, I mean, we could have one. My guess is that people have not regarded it as being a significant issue, because the -- in terms of whistle-blowing itself, in order to get action put into place you're much more likely get that if you do it locally rather than nationally.

Q. But the whole problem with that document is that whistle-blowers have often exhausted their local remedies, which is why there is the need to blow the whistle which needs to be heard outside the organisation. You don't seem to think it's a particularly serious issue. I don't mean you're taking it lightly.

A. I'm not taking it lightly, because if you look at what our staff think about all of that -- all of this sort of thing, the vast majority of our staff believe they're quite able to make comments and raise issues about quality of service and service at the moment. So there are some high profile cases of whistle-blowers absolutely, but they've found their way through the system well enough as it is.

Q. I want to ask you, finally, before I go to some supplemental questions about public inquiries, and your view, and you can be as critical or uncritical as you would imagine -- I'm just trying to think. I think they're probably all slightly different, I would guess, they're all slightly different. You could see, for example, healthcare-associated infections going in a similar way to A&E, because we know that they're -- MRSA and C.diff are not the only healthcare-associated infections. There may be -- there are seven or eight --
like about the system. But on one view, given the events which have taken place, a full and transparent airing of the issues would have been good for both the public and ultimately for the NHS, rather earlier on.

When all of this blew up, did you yourself have a view about what advice you would give to the Secretary of State if asked about whether to have a public inquiry?

A. This is when the Healthcare Commission report was published?

Q. Yes.

A. I would have been -- I remember very well the conversations that we had at the time, and you always have the dilemma, in these circumstances, about where you put your energy, in terms of the results of the Healthcare Commission report. We thought it was really important to get a view about the organisation itself and what help it needed to take it forward. So we asked -- it will come to me in a minute. Oh, ex-Royal College of Physicians --

Q. The academy.

A. I can't remember his name. George Alberti. Sorry.

Q. I'm going to turn to some questions, if I may, and these certainly my advice at the time.

A. Well, it was certainly not part of the conversations that I had at the time. It was a practical response to where we would put our energy going forward, and I never heard a minister say that we didn't want this inquiry because it would expose a whole load of stuff about the way the system operates, nor did I hear anyone in the Department saying anything of that nature. And certainly it wasn't my view that we shouldn't have a public inquiry for that purpose.

Q. What would your reaction be to that sort of concern?

A. I thought it was one, personally, just of if we had a public inquiry for the Mid Staffordshire on the basis of the Healthcare Commission, every time there's a public inquiry for the Mid Staffordshire we would have a -- we have the clourm for a public inquiry and we would have had a Healthcare Commission in future we would have a -- we might have had a Healthcare Commission in future we would have a -- a Healthcare Commission in future we would have a -- we would have a Healthcare Commission in future we would have a --

organisation internally. And we had David Colin-Thome looking at the external -- the kind of supervisory bit of all of that. We wanted to get in the jargon a quick and dirty assessment as to where we were, and then my priority, in those circumstances, is to put things right, to get the organisation into the right place so it could improve services for its patients.

There was an outstanding issue, though, at the time, and that was how would the patients and the relatives get the opportunity to say their piece and have their story told in this environment. Now, at the time we thought that a public inquiry was not the right thing to do. We thought that if you had a public inquiry every time you had a Healthcare Commission report, it kind of negated the reason for having the Healthcare Commission. So we were naturally reluctant to go down that, but we did believe that the relatives should have some opportunity to be able to set out what had happened, hence we came up with the conclusion of the Francis Inquiry, the first inquiry. That was our -- that was certainly my advice at the time.

Q. I'm going to turn to some questions, if I may, and these are rather out of turn?

THE CHAIRMAN: Just before we leave that, you'll be aware that considerable anger was generated amongst at least some people by the decision not to hold a public inquiry.

A. I know.

THE CHAIRMAN: And not to hold, initially at least, any form of inquiry into what we are now looking at. Some would suggest and suggested to me at the first inquiry that this was due to the government not wishing to be examined about things of that nature or the Department not wishing to be examined about the wider things and not wishing to be examined about them in public.

Q. And what about the Government?

A. I'm sorry, I'm not trying to underestimate the impact that the Healthcare Commission report had on me and the work that we were doing at the time. All I'm saying is that when you added all of those patient stories to it, it -- for me it added a new dimension. You may have
1 I certainly had it at the time. But I can only go back to what I thought at the time, and my focus was to put the hospital right and -- but I acknowledge that we needed some mechanism for the relatives to be able to tell their stories, and I -- my judgment at the time was your first -- the first inquiry could do that. Clearly, it didn't do that in that sense.

2 THE CHAIRMAN: The purpose of my question is not so much to go to the rights and wrongs of having a public inquiry, because me debating that with you is a somewhat circuitous debate, but really what I am seeking to explore is why the first -- the Healthcare Commission report, which has been described by Baroness Young as being florid in its language and, therefore -- you wouldn't agree with that -- but describes matters, why was it that that report didn't bring to the minds of yourself and other officials the impact on individuals that the second report did? Why is that it wouldn't be part of your DNA, if I like -- to put it that way, that a report of that nature doesn't immediately make you think of the enormity of what it was saying.

3 A. No, sorry, I -- I absolutely understand the enormity of what was in the first Healthcare Commission report. I absolutely get that. But in terms of a practical manager -- so what can I do about that? I want to focus my attention on putting the hospital right, and that was where all of my energy went to.

4 I understood that there were still people who wanted to tell their stories about all of that. That's not what I'm not saying is that when we told -- when all those stories were told, that somehow it made it an even worse set of things that needed to be put right. They were still the same things that needed to be put right. I'm just saying that for me personally it made it much more real than even the original report did.

5 THE CHAIRMAN: Thank you.

6 MR KARK: But just on the back of that, do you accept that what you wouldn't have been able to do -- I know you wanted as an NHS manager at a very high level to put things right, what you wouldn't have been able to do is properly to examine why the structures that should have stopped this happening failed and in part that must be because you were part of those structures at the time.

7 You were head of the SHA.

8 A. We were obviously responsible for putting things right for that organisation, and that's what I've said. But in terms of, so how can we take action to make sure that we can put things -- we can make sure it doesn't -- it's unlikely to happen again, what are the kind of -- that's why we did the early warning system with the NQB. So we put something in place there to enable that to happen.

9 Q. Can I move on to the supplemental questions that I wanted to ask you about, and these have come about because we've only very recently got hold of Mr Yeates' statement, literally in the last couple of days. So apologies if these are rather out of turn chronologically, because we have to go back a little bit. The first issue is this, that you and Bernard Crump, I think, interviewed Martin Yeates for a job for -- was it? -- the Telford and Shrewsbury trust? And apparently you said to him: "Keep going and you'll make chief executive in the right hospital."

10 Do you recall any of that?

11 A. I haven't seen the -- I haven't seen the -- Mr Yeates' statement.

12 Q. I understand that. Do you have any recollection?

13 A. I'm just trying to get -- you've just said it to me, I'm just trying to -- I'm trying to wrack my brains now as to what --

14 THE CHAIRMAN: Can I say, please answer the questions as best you can. Of course you'll in due course have an opportunity of seeing the statement, not having done so.

15 If you wish to add or to qualify to what you're now saying, you're free to do so.

16 A. Okay. Okay. This would have been Shrewsbury and Telford where?

17 MR KARK: Well, unfortunately the statement doesn't reveal that. Can I read you the whole paragraph if this helps at all?: "This was at a time of great change in relation to the organisational structures in the NHS. The SHA structure was being simplified. Birmingham and Black Country, Shropshire and Staffordshire and Worcestershire and Warwickshire SHAs were being merged and David Nicholson became the chief executive of the merged West Midlands SHA with three directors who reported into him. I was unsuccessful in my application for the chief executive post at Telford and Shrewsbury. The successful candidate was David's former deputy of the Birmingham Black Country SHA, and was the SHA's financial director. Telford and Shrewsbury had recently discovered severe financial difficulties, so I understood why he was best placed for the job. David was the assessor for the interviews himself along with Bernard Crump, chief executive of Shropshire and Staffordshire SHA, they both told me to keep going, that I would make chief executive at the right hospital."

18 A. I remember assessing at Shrewsbury and Telford trust.
Tom Taylor did get the job. I'm just trying to think.

Well -- who else was on the panel? Okay, well, I've no reason to believe that what he said is not right.

I would have been the assessor for that. I know I was the assessor for that. Tom Taylor was appointed. As the assessor I would normally have fed back to the unsuccessful candidates what the assessment of the panel was, and -- but I genuinely can't remember what the nature of that feedback was and I can't remember how Martin Yeates performed at that particular interview, which was several years ago. But it doesn't seem, you know, on the face of it, quite possibly I could have said that.

Q. What I think is the thrust of the question really is, if it was recognised that he wasn't right for the Telford and Shrewsbury job, why was he thought to be right for the Stafford job, given the large deficit, GBP 3 million deficit and a trust spread across two sites and apparent lack of governance?

A. Yeah, that's why I don't -- I mean, all I can tell you is that in the circumstances Shrewsbury and Telford was a very difficult and complex job. I don't -- I genuinely can't remember whether Martin Yeates was above the line or below the line, and whether it was

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..."Reduce workforce."

And below that: "A surgical ward reconfiguration is planned for April 2006 to increase day care rates."

What would you have done to assure yourself that what was going to be attempted in order to achieve break-even would not damage the quality of patient care?

A. I would have relied on Martin Yeates as the chief exec of the NHS -- as chief executive of Mid Staffordshire hospital to be able to do that. He was referring to a recovery plan that was already in place.

Q. But the purpose of the meeting, presumably, is so that you can have an overview of what is happening at this trust?

A. No, this was a -- sorry, I've explained this before. The day-to-day performance management of that organisation was done by the managing directors and the team within the individual patch. This was a specific set of meetings about how could we improve the standards of the organisation, particularly relating to the way in which the Healthcare Commission was measuring quality at that stage. So that was the main reason for it.

Clearly, while we were talked about finance, because that would be an obvious one for us to do, but it was -- it would be simply in terms of, "Are you delivering your existing plan?" And, "Are you on -- are you in a place where you can reassure us that you can do that?"

The issue about the impact of that on patient safety would be a given, in the sense of this board was responsible for managing that organisation. And there was no indications that I had going into that meeting that there was anything awry.

Q. But as performance manager -- and you are the head of the performance manager of the trust -- where does the buck stop? Does it stop with Martin Yeates, or does it stop with you?

A. The buck stops with the trust. The trust are responsible for delivering those patient services. The SHA was neither set up nor capable of the detailed performance management of individual hospitals. They were never set up with that in mind and that certainly wasn't what we were capable of doing.

THE CHAIRMAN: But does that mean that at the time strategic health authorities were levers of pressure on trusts, albeit alongside some support and help, without there being any responsibility for the result of what was happening?

A. What the strategic health authorities were held accountable for by the centre was the delivery of the government's targets. That's what the strategic health

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...authorities were held accountable for and for developing commissioners to become able to do the full range of their responsibilities, and for supporting and helping NHS trusts to become financially and clinically viable. 

THE CHAIRMAN: So I would be right in taking from that answer that it meant that at the relevant time we're talking about no one was accountable for quality matters, as we're understanding them today, other than the trust?

A. The board --

THE CHAIRMAN: You weren't responsible, the PCT wasn't responsible, the Department of Health wasn't responsible?

A. Well, both the PCT and the SHA had responsibilities for quality, but the way that quality was measured at the time was relating to access and healthcare-associated infections. Those kinds of things that I described earlier. There was no mechanism, either for us to hold them -- the trust to account or for the SHAs to be held to account for the detailed way in which clinical services were managed within an individual organisation.

We were neither skilled nor capable of doing that.

THE CHAIRMAN: So the answer to my question is, yes, no one above the trust board was accountable for quality as we now understand it?

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A. In that sense, and if you think about it, it was only after we set up the High Quality Care for All that strategic health authorities had medical directors.

I mean, as it happens, in Birmingham and the Black Country I had a medical director -- appointed a medical director when I got there, but none of the other SHAs had even medical directors at that stage. But I think that gives you some reflection as to the kind of organisations that they were. It was one of things that we said when we set up High Quality Care for All that all SHAs should have a medical director and should build the capacity to do the kind of quality interventions and wanting that you described.

THE CHAIRMAN: Thank you.

MR KARK: Mr Yeates also says, going back to when he took up the post, that you said to him that Cannock was the biggest challenge in terms of what to do with the trust.

And one reads into that that would have been the biggest financial challenge. Can you remember, first of all, saying that to him and do you remember what the context of it was?

A. I sadly can't remember every -- I mean, this was one of 60 chief executives that I was involved -- you know, involved in discussions with at the time. So forgive me if I can't remember the particular. What I can say is that -- and it comes out of the documentation and my memory at the time, was that Cannock Hospital was a critical issue in relation to the strategy of that trust. As we sat there at the moment only, I think, half of it was being used for clinical work. The other half was being rented out or used for other purposes.

Now, when you have a tariff system, you get paid by the number of patients that you that you treat. If you've got a whole set of estate which no patients are being treated in, you carry the cost but you don't get the income, and that puts pressure on other parts of your organisation.

So he had to sort out Cannock. Either it had to be filled with clinical activity, or it had to find a different mechanism to raise income from it, or it had to shut. We had to do one of those -- it seemed to me one of those things at the time and that was the point I was -- the point I would have made to him in the conversations that we had.

Q. The big problem here, not just for this trust but others, was the CIP and the deficit and what he says is that the sum of 8 per cent CIP, which was the second largest CIP in the West Midlands that year, he says: "The sum involved was dwarfed by the deficit elsewhere and the SHA did not feel able to offer us financial support from the top-sliced funds taken from the PCT."

So that would be the NHS bank that we spoke about yesterday.

And then he says this: "I understand that in his evidence to this inquiry David Nicholson has stated that although all involved in the healthcare community were instructed to break even in 12 months come what may, for those who simply could not more time would have been declared. I think this is a completely disingenuous statement."

Now, it's right you should have the opportunity of dealing with that, because it's a comment directly in relation to something that you have said. Was that a disingenuous statement?

A. No.

Q. Are you saying that if Mr Yeates had come to you and said, "We simply can't manage our deficit, we need more time", that you would have treated that favourably?

A. He did. We offered them GBP 1 million and they never took it up. And the idea that if you look at the -- what happened in reality the first thing is Mid Staffordshire never delivered a CIP of the scale that he described. Secondly, we top-sliced the money and not everybody was in balance in that year. There was a whole set of estate which no patients are treated in, you carry the cost but you don't get the income, and that puts pressure on other parts of your organisation.

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1. were a number of organisations that we gave time to
2. put -- and the record clearly shows that.
3. Q. Forgive me.
4. A. And that's all I really want to say about his comments.
5. Q. You say you offered GBP 1 million. You mean the SHA
6. offered -- how did it of it, in what terms?
7. A. It would have been -- I can't remember the exact detail.
8. I think the paperwork is somewhere in here, but -- that
9. shows that GBP 1 million -- and that would have been
10. a loan, in the sense of all the allocations from the
11. bank were loans, because we had to pay it back to the
12. original PCT at the time. It was much more about giving
13. people more time to get their -- to get them into
14. a place where they could balance, rather than writing
15. off any deficits that they had and that was applicable
16. to all organisations in the West Midlands. And, as
17. I say, if we didn't spend the top slice on giving people
18. more time, what did we spend it on?
19. Q. Finally this --
20. THE CHAIRMAN: Just pausing there, when Mr Yeates came to
21. you, was GBP 1 million the sum that he was after or was
22. he after a greater sum?
23. A. He didn't come to me, sorry. He didn't come to me.
24. THE CHAIRMAN: To you the SHA.
25. A. He came to the SHA. I genuinely don't know. And the
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1. reason I know about the million pounds is I've seen it
2. in the documentation. I wasn't engaged in that direct
3. conversation at that time. They never took it up, as it
4. happens. I do know that.
5. THE CHAIRMAN: There is, I think, some evidence about that.
6. MR KARK: We have that.
7. Finally this, he says that in October of 2008 -- so
8. obviously before the DH had the December draft of the
9. Healthcare Commission report, he says:
10. "I spoke with David and Bill ..."
11. I presume that would be Bill Cash?
12. A. I would think it would be Bill Moyes.
13. Q. Bill Moyes, I'm sorry, of course. Thank you. It's
14. getting late:
15. "When in October 2008 I spoke to David and Bill
16. [Moyes] I offered to resign because I anticipated the
17. report was going to be damaging and what my thoughts
18. were in terms of the nature and scale of the bad news.
19. Both Bill and David stated that they did not want me to
20. go, and that they felt I should stay."
21. Do you have any recollection of that conversation?
22. A. I can genuinely say I've never been in the same room as
23. Martin Yeates and Bill Moyes at the same time. I can
24. remember --
25. Q. Let's imagine it's by telephone --
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1. A. -- that. I can't remember him ever saying that he
2. wanted to resign to me, because why would he? Because
3. I've no leverage or anything in that system, it's
4. entirely a matter for -- my guess is him and Monitor.
5. So I do not remember -- recollect or would have I
6. imagined that I would have had that conversation with
7. those two individuals.
8. Q. And if he had offered to resign at that stage before you
9. had seen the draft HCC report, presumably you would have
10. needed rather more information from him?
11. A. Well, I can't imagine why he would offer to resign to
12. me. I just -- I just can't imagine why he would do
13. that.
14. Q. Can I come --
15. THE CHAIRMAN: Well, I'm sorry, I can't quite leave that
16. there. I appreciate the difficulties of memory and so
17. on, but we have seen a note on which there is
18. a suggestion, albeit not I think from you, and at
19. a later stage, that he could perhaps leave this job and
20. be offered a job somewhere else. Now, in relation to
21. the job somewhere else I imagine you might have expected
22. to have something to say?
23. A. I think I said about that was that when I heard that had
24. been offered I said it was not appropriate.
25. THE CHAIRMAN: Yes, that was much later. All I am seeking
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1. to suggest to you is that there could be context in
2. which there is a conversation about moving from one job
3. to another which might have involved you?
4. A. Unlikely, in the sense that I -- as the NHS chief
5. executive, I don't operate like that and people don't
6. expect that from me. I could perfectly understand that
7. to an SHA chief executive so when I was an SHA chief
8. executive I can see that people would say things like
9. that to me in order for me to help them, because SHA
10. chief executives have much more direct involvement in
11. individual organisations. I don't in the job that I do.
12. THE CHAIRMAN: Thank you.
13. MR KARK: Sir Hugh Taylor -- this is moving on from
14. Martin Yeates, Sir Hugh Taylor said:
15. "It would unwise to place an over-reliance on
16. regulation and supervision in any system where the
17. levels of human interaction are as high as they are in
18. the NHS. No affordable regulatory or supervisory system
19. could guarantee that events such as those at the trust
20. could never occur again. The key safeguard must always
21. lie with professionalism and the values of staff and
22. organisations who take people into their care, the
23. leadership of those organisations and the authentic
24. voice of the people for whom they are caring and their
25. families."
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1. Now, first of all, do you agree with that analysis?
1. year, you can see what a big change that is for
2. A. Yes, I think so. I think so.
2. a developed healthcare system like ourselves.
3. Q. You finish your overview in your statement with an
3. So we've got to deliver over the next four years
4. optimistic view of the NHS, and you produce the various
4. something in the region of GBP 20 billion worth of
5. surveys that have taken place, which point to how well
5. productivity gain in order to reinvest in the NHS to
6. the NHS is regarded by international standards. We can
6. deal with the demand pressures that we know that are
7. find those at your exhibit 4, 5 and 6.
7. coming. That is the biggest challenge affecting the NHS
8. Can we just have a brief look at some of the
8. as we go forward, and that's the kind of focus of my
9. comments made. And if we go to DN14, this is a report in
9. activity at the moment. How are we going to take the
10. December of 2010 by the National Centre for Social
10. NHS through that process?
11. Research.
11. Now, we've done a lot of work around all of this,
12. If we could to page 845 "Recognition for improved
12. and I have to say there is no healthcare system in the
13. health and education services". The first bullet point
13. world that has had a challenge as big this in the way
14. is this:
14. that we're having to deal with it, and most healthcare
15. "With more health service reform on the way,
15. systems in the developed world are now facing this as
16. satisfaction with the NHS is actually at an all time
16. a real test for their future viability.
17. high. When Labour gained power in 1997, only a third of
17. Now, we've been all over the world to find what are
18. people (34 per cent) were satisfied with the NHS, the
18. the sorts of things that we will have to do in order to
19. lowest levels since our survey began in 1983. By 2009,
19. deliver that change? How are we going to manage it as
20. satisfaction had nearly doubled, and stood at
20. we go forward? Where the areas where we think we
21. two-thirds ..."
21. need -- we can make those productivity gains for the
22. That's obviously an improvement, but if Tesco's or
22. benefit of the NHS to reinvest?
23. Sainsbury's had a third of their customers not satisfied
23. We put forward a plan which has been commentated on
24. with their service, they would go out of business,
24. by all the various commentators around the country, all
25. wouldn't they?
25. the experts in the field, as you say, and people broadly

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1. A. Yes, this is not -- I mean, what I was trying to do here
1. think the plan is in the right kind of -- the right kind
2. was to explain that confidence in the NHS by 2009 from
2. of place and I can talk about how we might do that if
3. the general public was at a significant high compared
3. you want me to. At the same time the government has
4. with the rest of the time in which it was measured. If
4. launched its changes into the NHS. So my overriding
5. you look at staff and patient satisfaction across the
5. responsibility in this environment is how can I use
6. NHS, not this but -- most private sector organisations
6. those changes to deliver the productivity gain and at
7. would be very jealous of the results that we get out of
7. the same time improve the quality of service for our
8. both of those, including Tesco and the John Lewis
8. patients?
9. Partnership and all the rest of it.
9. Because one of the things that when we announced in
10. Q. We are facing a period of huge reorganisation or, as one
10. May 2009 that we thought the scale -- that this was the
11. of our expert witnesses would have said,
11. scale of change that was required, we identified
12. redisorganisation and you've been very forthright about
12. a phrase which is not meant to be a kind of -- a slogan
13. the dangers that that poses.
13. but I think is important which was quality, innovation,
14. How can you reassure yourself and those around you
14. productivity and prevention, QIPP, as it's called. And
15. and the patients in hospitals up and down the country
15. the reason for doing that was not to kind of set up some
16. that the service will not suffer by reason of that
16. kind of slogan or some kind of -- or anything of that
17. reorganisation?
17. nature. It was to make sure we never talked about
18. A. Yeah, can I -- I mean, I -- the pressure affecting the
18. productivity without talking about quality, as people
19. NHS at the moment is not about reorganisation, the big
19. lead in the NHS, and we would never talk about quality
20. challenge for the NHS going forward is that because of
20. without talking about productivity and prevention. And
21. the financial circumstances that we find ourselves in,
21. we've attempted to put a programme together to deliver
22. over the next four years we're going to have little or
22. all of that.
23. no growth in health service expenditure, and when you
23. Now, the changes we're trying to make to help that
24. compare that with the position we've had since 1948,
24. happen -- so if I can just explain to you. We -- if you
25. which on average we've had 4.5 per cent growth every
25. look at the GBP 20 billion worth of productivity gains

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And then on top of that the strategic health authorities have to quality assure each of the organisation's cost improvement programmes themselves, and interestingly a lot of the experience that have been got in the West Midlands around this has been used as the core of how we do it. So each SHA is now signing off the cost improvement programmes and the impact on quality for each individual organisation. So that's the kind of where we're starting, as far as that's concerned.

But the other issue for us is how do we mobilise the rest of the staff and patients to enable us to be vigilant while all this is going on? And we're exploring ways of doing that. We have an arrangement with the Royal College of Nursing, who have a process called Frontline First, where they get early information if people are potentially affecting the quality of services, and we talk to them once a quarter about all of that, to be alert so we can make interventions when are required. We're producing written material for patients and staff to enable them to alert organisations or the wider system when they think that the quality of their services are being affected. So we're trying to put a whole set of things in place to make this a reality, but this -- I would -- this is, you know,
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| First. It is absolutely after the event. But we think we need after the event as well as the plans, because a plan on paper can look like one thing, when you put it into practice in an organisation it might look something different. So you have to do both of those things when you do it. Q. But do you not need your cost improvement programmes to be quality assured both by medical directors and nurse directors and have an input at that stage from the patient voice? A. Well, clearly -- all -- organisations have different ways of accessing patient voice. They don't have an executive director called patient voice on it. So there's no one we could point to in order to say that this particular individual should oversee it or whatever. So, you know, we expect the cash releasing cost improvement programmes to be approved by their boards of governors and their members, in the same way that they would do all of the rest of it. We haven't prescribed to that. If you're saying to me, is there an argument for prescribing it? I think there probably is and we're currently working through the operating framework for next year. This was the one for this year, I'm talking about. For next year we're due to publish at the end of this year and we are thinking about how in those circumstances can we engage realistically the patient voice in that process? MR KARK: Sir David, that is all I propose to ask. I'm going to look around to see if anybody would like to have a break so they can discuss anything with me, if I can. I see no notes flying in my direction. There are others who may ask you questions but can I thank you very much indeed. THE CHAIRMAN: I see I think nods of head from Ms Smith and Mr Clarke. MR CLARKE: No questions, sir. MS SMITH: No, I have no questions. THE CHAIRMAN: Thank you. No, Sir David, thank you, that's all I think we have to ask you. Is there anything you want to add? A. I mean, hopefully over the day and a half I've had the opportunity to say most of the things that I wanted to say. If you add that to my statement where I set out my overall views and the apologies that I make on behalf of myself and the NHS as a whole about the appalling events at Mid Staffordshire, I just want to say two or three things, really, if I could in summary. There's no doubt in my mind that when the Healthcare Commission report originally came out I was, like everybody else, shocked and horrified by what I read, but I was kind of -- as a practical manager, my -- I was galvanised to try to do something about it, hence I tried to get the right leadership into the organisation and all the rest of it. But it was when I read the details of the patient stories when the Francis report came out and I spent -- I remember taking them home and, you know, I can't imagine what it must be like having one of your relatives going through that experience. I simply can't imagine what it must be like, and the frustration there must be when you've done that to talk to an organisation that wouldn't respond to your justified -- I just cannot imagine what that must be like. All I can say is what I felt when I saw those stories and they were horrible. But when I think about my job -- I mean when I say -- when I talk to people about my job there's -- you know, every day there are tens of thousands of fantastic things that go on in the NHS, tens of thousands of people whose lives are improved, thousands of people whose lives are saved by the activities of the NHS and the staff and the people who work with them, and I think over the last five or six years we've made some really significant progress across the NHS to make things better for patients and to improve the quality and outcomes of services for our patients. We're certainly not at the end of this journey and as I said earlier the challenges are very significant for us. But I remain determined to take the NHS in that direction. I accept my role in all of this. I think I said yesterday about perhaps a tension being driven by financial problems in the organisation, and I'm learning from all of that all the time. But I think that the NHS has come a long way in the last few years, and we shouldn't lose that in all of this, and I'm, as I say, deeply committed to taking the NHS forward on the next part of its journey, albeit it is very, very challenging. In terms of the experience of Mid Staffordshire for the NHS generally, I think it has had a profound effect. You will have heard people talking about this, I know, sat in this chair and this is not lip service by any stretch of the imagination. Literally hardly a day goes by when I am talking to my colleagues about issues across the NHS, I did so over the weekend, I'll be doing it tomorrow, and the issue of Mid Staffordshire and the dangers of -- for patient care of the kinds of things
that we do as managers is in everyone's DNA. It is absolutely -- that's not to say things won't go wrong and people won't make mistakes and things will happen, I think they will but we need to reduce that. But I can absolutely assure you that the experience of the patients and relatives of Mid Staffordshire has had a profound effect on the management community in the NHS. And the final thing that I would say is that there's no doubt in my mind -- I mean, you, chairman, and the rest of the inquiry team have had a unique insight into the way a complicated, vast healthcare system operates and no one else has had the opportunity that you have and sad that you had to have the events to make it happen. But that experience that you've got over the last 120-odd days is unique in the history of the NHS, so it is vitally important it seems to me that people like myself and senior people in NHS and in the government commit to learn the lessons that you're going to set out for us as part of this process and I'm absolutely committed to taking that forward on behalf of the NHS. We've already set up a unit in the NHS to start to implement the things that you'll be thinking out, so we can plan ourselves and get those lessons learned, because we are absolutely determined to make sure that we learn the lessons out of this ghastly occurrence.

THE CHAIRMAN: Sir David, thank you very much indeed. That concludes today proceedings. We start again on Monday. It is possible there is a slight alteration to the timetable to be announced but I'm not as I sit here in a position to say one way or another, so could I ask those who represent core participants and any interested members of the public perhaps to delay having a cup of tea, or have that cup of tea, as it were, while I try and find out what the position is for Monday. Thank you.

(3.54 pm)

(The inquiry adjourned until 10.30 am on Monday, 3 October 2011)
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