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<td>1 (10.00 am)</td>
<td>1 June 2007.</td>
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<td>THE CHAIRMAN: Good morning, Mr Burnham. Thank you for coming to see us and agree to help us.</td>
<td>Q. You then moved on to the Treasury. In January of 2008 you moved on to become Secretary of State for Culture, Media and Sport. And then again of relevance to us, on 5 June of 2009 you were appointed Secretary of State for Health under Gordon Brown's government.</td>
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<td>You know what the procedure is, I'm sure. You will have an opportunity to add anything in relation to questions you think you ought to have been asked but haven't, and if after you have finished you go away and you have second thoughts, let us know what they are and we will take those into account. Thank you very much.</td>
<td>A. That's right.</td>
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<td>MR KARK: You are the Rt Hon Andy Burnham MP. You made a statement for the inquiry dated 20 July of this year. I haven't been told of any corrections, but can we take it, therefore, that there are no corrections to make to it?</td>
<td>Q. And you remained there until the May election of 2010. So the particularly relevant periods for us would be May 2006 to June 2007, a 13-month period, during the last month of which you authorised this particular trust to go forward for consideration by Monitor for foundation trust status.</td>
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<td>Examination-in-chief by MR KARK</td>
<td>A. Correct.</td>
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<td>RT HON ANDY BURNHAM MP (sworn)</td>
<td>Q. And 5 June 2009 to 11 May 2010, when you were dealing with the fallout of the HCC report in relation to Mid Staffs among your other duties.</td>
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<td>THE CHAIRMAN: You have made one of I don't know how many pages, but ... If you want to make a few introductory remarks, do.</td>
<td>A. Yes.</td>
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<td>MR KARK: Can we begin, please, by looking at your own political background very briefly to see what it was which brought you to the position of Secretary of State. The beginning that I am here to help the inquiry in whatever way I can to understand why these events happened and so that we can all ensure there is no repeat of failure on this scale in the National Health Service.</td>
<td>Q. It follows from the summary that we have just looked at of your political career that you were often in post for relatively brief periods of time. That's not unusual, I suppose, in modern politics, but does that put a great onus upon the departmental civil servants who are advising you and giving you information?</td>
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<td>Q. You were a member of the Health Select Committee between 2001 and 2003, and I think certainly some of the issues that Health Select Committee examined were foundation trusts and inspection and rating thereof.</td>
<td>A. I'm sure it does, but I don't think it's an unhealthy</td>
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<td>A. They will be very brief and literally just to say that these were shocking, terrible events that will forever be etched on -- on my mind. I feel very sorry for what the families have been through, what they continue to go through. I just wanted to make it clear to you, sir, at the beginning that I am here to help the inquiry in whatever way I can to understand why these events happened and so that we can all ensure there is no repeat of failure on this scale in the National Health Service.</td>
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<td>A. That's correct.</td>
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<td>A. There are no corrections.</td>
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<td>A. It was a change of role. In the first six months in the Department, my ministerial duties had mainly focused on issues regarding regulation, inspection, quality, also professional regulation dealing with the aftermath of the Dame Janet Smith inquiry into -- into the Shipman murders. At Christmas 2006 Lord Warner, Norman Warner, left the Department of Health and I moved to his -- his portfolio. So those issues include very much reform of the -- of the National Health Service, foundation trusts, issues to do with finance, and -- and I stayed in that role until I left the Department in</td>
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<td>Q. Do you stand by the content of the statement?</td>
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<td>A. I do.</td>
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<td>With permission, sir, may I make a brief statement to begin? Or --</td>
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<td>Q. You were a member of the Health Select Committee between</td>
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1 thing that there is change, because I always saw it as
my role as a minister to be the voice of the public
in the Department and not to be immersed in the issues
to the extent where you become a part of the -- the
furniture. So our role as ministers, in my judgment,
was to provide challenge, was to look at it with
outsiders' eyes at times. But, having said that, the
roles that I was appointed to in government were always
connected with my experience or my interests. So I did
serve on the Health Select Committee, as you say, but
briefly before I entered Parliament I was employed by
the NHS confederation, so I had a background in the
Health Service, and I was an adviser to Chris Smith at
the Department for Culture, Media and Sport. So the
roles I went into were not unrelated to my -- my
professional experience before entering Parliament.

Q. But in terms of handover, when you take over one of
these ministerial jobs, do you get much of a briefing
from the previous minister?

A. You receive an extensive briefing from the permanent
secretary on arriving in the Department, you know,
a folder not unlike that one, (indicating), full of
background in terms of policy, in terms of where the
Department is up to, but also current issues and issues
that are immediately at the top of the in-tray within
the Department. There is then alongside that a more
formal -- sorry, informal handover between ministerial
colleagues. So when I left the Department in June 2006,
I recall having a meeting with Mr Bradshaw --
Q. 2007.

A. Sorry, 2007. With Mr Bradshaw to give him a more
informal handover. So that is usually what happens,
although I couldn't say it happens in every department.

Q. Six months after you left the post in June 2007, and
18 months or so before you became Secretary of State,
there was a report published by a body called Joint
Commission International. I'm going to show you the
front page of that just to see if it triggers any
memories with you.

If we could have WS5061487, please, on the screen.

Thank you.

This was an independent report during the course of
which they spoke to a fairly large number of those
interested and working with the Department of Health.
They tell us on page 3 that they spent 15 days in
December 2007 and January 2008 conducting in person and
telephone interviews with key public and private sector
leaders and managers in England whose activities relate
to the Department of Health's current and potential
future quality and oversight responsibilities.

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Now, it's fair to tell you that various civil
servants, including Giles Wilmore, appear to have
rejected this report, and in his statement he says:
"The document is not an official Department of
Health document nor was it circulated widely or debated
internally."

And he didn't think it fairly reflected the
Department's culture. Similarly, Sir David Nicholson
doesn't seem to have set much store by it.

Do you remember reading this report at any stage?

A. I don't. I've no recollection of -- of this report. It
seems to have been published in the month where I became
Secretary of State for Culture, Media and Sport. So --
Q. I understand that.

A. -- my focus would have been elsewhere at the time. But
on first sight it's not a report that I recall.

Q. Could I ask you just to look at page 4, which is headed
"Findings and observations".

THE CHAIRMAN: Mr Kark, Mr Burnham's just talked about it
being published. I don't think in fact it was
published. This was a report for the Department.

MR KARK: It wasn't published publicly, no. It was
obviously published but for those in the Department of
Health, as I understand it.

If you just look at the first paragraph, and I very
much take on board what you've just told us, you may not
have seen this, but I'm just going to take it a little
bit further, if I may. We see these words in relation
to the Department of Health and NHS culture:
"A shame and blame culture of fear appears to
pervade the NHS and at least certain elements of the
Department of Health. This culture generally stifles
improvement and the kinds of CEO risk taking behaviours
that are necessary for creating organisation cultures of
quality and safety. This culture is affirmed by
Healthcare Commission leaders who see public humiliation
and CEO fear of job loss as the system's major quality
improvement drivers. This culture appears to be
embedded in and expanded upon by the new regulatory
legislation now in the House of Commons."

If those words had been brought to your attention,
I expect you would remember them?

A. I would. I've no recollection of seeing those findings
presented in that way before.

Q. No civil servant made you aware that this report
existed?

A. To the best of my knowledge, this morning, no. But, as
a minister, you see vast amounts of paperwork. Huge
numbers of reports are written on the National Health
Service every year, and it's just simply not possible to
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<td>1. I have a recollection of every single one. As I say, this report appears to have been related to a time when I was not in the Department.</td>
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<td>2. Q. If you had read those words in this report, they would no doubt have disturbed you?</td>
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| 3. A. They certainly would. I mean, I would have taken issue with them. Point 3 says: "A culture that's being embedded and expanded upon by the new legislation."
| 4. Well, many of the issues we're talking about today and the terms of reference for this inquiry relate to how the NHS was moving to a different world where power and responsibility was being firmly placed at the local level with the foundation trust reform, where organisations were expected to account for themselves to their own local population. And if there had been an overbearing culture in the National Health Service in its first 56/57 years, the foundation trust reform was -- was -- was deliberately trying to break that and move towards a more locally driven accountability system. |
| 5. Q. We've heard a great deal of evidence about this top-down culture within the NHS. Is that a culture which you at least recognise? |
| 6. A. I do. I mean, I spoke many times about it before time in government, there was a very real recognition even though, you know, this was a couple of years on, in NHS terms they are still -- they were still relatively new. So there was a process of -- of -- of ongoing discussion about them. But, yes, I mean, those were -- those were the kind of issues that we would discuss when we met. |
| 7. Q. Does it follow from that that you must have been aware of the widespread concerns about the nature of the core standards? |
| 8. A. I remember at that meeting Sir Ian Kennedy expressing concerns about them, and we had a discussion about them at that time. I mean, the core standards had come out, from memory, in around 2004/2005, so they were still -- |
| 9. "... which were intended to provide a common set of requirements applying across all healthcare organisations to ensure that health services are provided that are both safe and of an acceptable quality."
<p>| 10. You say: &quot;These standards were not driven by ministers; we had quality experts in the Department, [for instance] the [CMO] and the Chief Nursing Officer, who, when designing these standards, were able to say what the best way was to measure quality. These standards were never politically driven. I would say that the AHC was a rigorous assessment, and often organisations were not kindly assessed by the HIC.&quot; |
| 11. Do you accept that the annual health check was, in reality, a very blunt instrument and inaccurate if the... |</p>
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<td>I was a member of the Health Select Committee that looked at the star rating system, and indeed I remember making criticisms of it, very similar to the ones you've just put to me a moment ago. The annual health check was then a -- seemed to be an improvement on the original fairly crude star rating system, and then there was a further move later on, during my time as minister, towards registration with real-time information. So --</td>
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| 15   | Q. That comes much later.  
A. It does, but I want to say to you is that at no point would I say that this was perfection. This was an unfolding journey within the National Health Service where we were using more data, getting better at analysing data, presenting it to the public in a meaningful way and then allowing people to use that data to hold local hospitals to account. |
| 14   | Q. Well, you say it was meaningful. Can I just remind you of a piece of evidence that we have heard. It's an email from Professor David Haslam, writing to Nick Bishop of the HCC, dated 29 October 2008. It's HCC 000000186.  
Sorry, just give me one moment. First of all, this is Heather Wood writing to, as we see, David Haslam:  
"... you share my concerns. I now know that Cynthia has had at least one influential voice telling her that " |
| 13   | The AHC has no clinical credibility.”  
And over the page, please. This is Professor David Haslam, national clinical adviser to the Healthcare Commission, in the second paragraph, saying:  
"I've already discussed this frankly with Cynthia Bower off the record. My particular personal concern remains that on the whole, the AHC is meaningless to clinicians. Those in primary care don't use it and those in secondary care don't recognise it. There are many reasons for this ..."  
And then at the bottom of that email he says:  
"I also think and I hate to say it, that there are some senior members of the HC team who really wouldn't understand what we're talking about and believe their own publicity."  
It sounds as if you did understand that there were severe limitations to the AHC and part of the problem was the way that the core standards were worded. That's what Sir Ian Kennedy tried to get you to change, didn't he?  
A. We had one discussion about -- about that and I was certainly open to having a further discussion with him. I hadn't been involved in the development of the core standards, but they are a detailed set of requirements that are drawn from, as I say, clinical expertise within |
| 12   | A. No, I don't think so. You've got to remember that this was the first time that an independent objective assessment had been placed in the public domain about local -- a local hospital and that people could look at how their hospital was performing in relation to others. I think it's important to put this -- |
| 11   | Q. I'm sorry to interrupt you. Performing in what sense?  
What does that mean? If you accept that it's too blunt an instrument and it can't give an accurate guide to what's going on in a hospital, how does it give people a guide to how a hospital is performing?  
A. I think, sir, I'm recognising the -- the limitations to the -- the system that was introduced. But what I'm trying to say is that you have to see this as a journey. There was something of a quality journey taking place in the NHS at this time. There was no system at all prior to the star rating system, and that was an attempt for the first time to give an independent assessment of each hospital, so that that would be used then as a means by which improvement would be -- would be driven. |
| 10   | A. We had one discussion about -- about that and I was certainly open to having a further discussion with him. I hadn't been involved in the development of the core standards, but they are a detailed set of requirements that are drawn from, as I say, clinical expertise within |
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<td>1. the Department of Health.</td>
<td>1. ways that I -- as we worked through it, and I got more insight into how it worked -- I went and saw the</td>
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<td>2. So my concerns about it were more from a -- the point of view that I don't think they would give a true or detailed enough picture to the public to capture what was going on within their local hospital. Having said that, they were clearly a step forward from the star rating system, which was -- was much cruder, in terms of how it reached those -- those judgments. But I think the -- the thing to say here, that nobody at any time was, say, holding out saying, &quot;This is perfection and we -- we defend it&quot;. That -- that absolutely wasn't the case. There was a -- an iterative journey taking place within the Department discussing things with Healthcare Commission and others as to how best to capture quality within the National Health Service.</td>
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<td>3. Q. That may be right, but Sir Ian Kennedy told us, and this is Day 77, that he had made repeated attempts to have the core standards changed to something more meaningful, but he was unable to do so and the resistance that he was meeting was from the Department of Health.</td>
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<td>4. A. Well, I -- as I've just said, I remember having the discussion with Ian and there was around this time talk about how we were further going to change the way in which the regulators operated, and there was early talk before you took over.</td>
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<td>5. about bringing the regulators together. So this was a -- a moving picture. From my point of view, as a minister, I was never -- had a closed mind when somebody of Ian's stature would bring something to me. But -- but, yes, you are right there -- there was a feeling in the Department that -- that -- that his concerns were not -- were not right. But, you know, as a minister we're there to try and adjudicate between those different points of view.</td>
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<td>6. Q. Yes, but if you listened to his argument and accepted it, then your voice would have had quite a degree of power to it, wouldn't it?</td>
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<td>7. A. It would, yes.</td>
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<td>8. Q. You see, in April of 2009, as we know, the CQC took over from the Healthcare Commission, and shortly thereafter you became Secretary of State for Health in June 2009, taking over, I think, from Alan Johnson.</td>
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<td>10. Q. In that role you became directly responsible for the CQC, and for Monitor. But Baroness Young, then chair of the CQC, which inherited the AHC system, told us this, and it's quite a long passage, I'm afraid, but it's right that you hear it all to put it in context. She said, this is Day 110, page 77: &quot;The annual health check was ... flawed in so many ways that I -- as we worked through it, and I got more insight into how it worked -- I went and saw the Secretary of State and said I wasn't prepared to carry on doing it in this way. It was nonsense ... the data was old, there was too much reliance on self-assessment. There was a very, very complicated methodology that had very little flexibility, so common sense went out of the window on occasions.&quot;</td>
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<td>11. Then she went on a little later: &quot;It just seemed to me nonsensical that not only was it deficient in those ways but it also came out once a year. So by the time the data had been put together and we were getting towards the time for the next health check, it was hugely out of date and ran the risk of being very inaccurate. And having argued that with the Secretary of State and indeed with the chief executive of National Health Service, I was told firmly that we weren't permitted to change it.&quot;</td>
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<td>12. Was that you?</td>
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<td>13. A. I've not read that -- that piece of Baroness Young's evidence. What date is she referring to? Did you say April 2009?</td>
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<td>14. Q. Well, she hasn't given us a specific date. She took over, of course, in April 2009, which is two months before you took over.</td>
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<td>1. A. I recall having a discussion with her about it, and it was the view of the Department at the time that they didn't want more change. One of the things that, again, is something as a minister that you have to wrestle with: do you want to constantly put more change into the system? And there is always a -- a balance to be struck between making further changes and allowing the system stability so it can absorb some of the things that you'd already put -- put into place.</td>
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<td>2. So this was actually a -- a developing discussion that I was having at the time with the CQC and really drawing on also what I was experiencing, in terms of deal with the aftermath of the Healthcare Commission report on Mid Staffordshire. I think it would show that my view wasn't fixed, because in the end I did and became persuaded of the need to introduce and indeed expedite a new system of registration for all NHS providers, which was the -- the then chair and chief executive's of the CQC's preferred -- preferred way forward.</td>
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<td>3. So I can remember having the debate, but I can certainly say to you that my mind wasn't closed and it wasn't the case that that was it, end of discussion.</td>
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<td>4. Q. Your mind was open, wasn't it, by the disaster at Basildon? Because what Baroness Young told us was this,</td>
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and this follows on from the piece of evidence I've just mentioned:
"I was very happy [sic] about that, and lo and behold, about four weeks later ..."

So I think that does put you in post, as it were?

A. Mm-hm.

Q. "... Basildon demonstrated in bucket loads just how unsatisfactory and unreliable a system the health check was. And mercifully at that point the Department decided that perhaps we had been right, rather than wrong. But it took something as dramatic as that to persuade them."

Now, the question for you is really, why does the government need a disaster like Stafford or Basildon for you in government to listen to the concerns of the people who you have put in charge of the system to regulate it? You have Sir Ian Kennedy, Anna Walker, you had Baroness Young, all of whom were trying to change the system, but they didn't manage to do it. Now, why is there that sort of resistance?

A. But we -- we did listen to their concerns over a long period of time. And as I was explaining a moment ago, this was an evolving -- an evolving story about, how do we improve the systems of inspection and regulation in the -- in the NHS?

There is considerable expertise within the Department of Health on these matters, not least the chief medical officer, who was a -- a huge support to me in my time on -- on quality issues, the Chief Nursing Officer. So the Department has a huge reservoir of expertise, and beneath the ministerial gaze there will be regularly discussions going on between the Department and the regulator about -- about these issues.

The judgment that I had to make was, as I said, a second ago, is it right to further change the system and ask the whole system to -- to learn something new, to do something new, or is it better to allow stability?

Now, I had had some concerns about the annual health check. I think I've indicated that to you a moment ago.

I -- when Ian first brought to me his concerns, I understood what he was -- what he was saying. I did not carry those through because I left the job of Minister of State for Delivery and Quality shortly afterwards.

Q. Sorry, does that mean you would have carried them through if you hadn't left the job?

A. Well, inevitably, because I would have had responsibility to respond to what Ian was saying. And you know, the suggestion that Ian would make comments to the Department and we would dismiss them was just not --

So it follows, therefore, that there has to be a real basis of understanding between regulator, department and minister about what statements are being made, on what basis they're being made, and are they something indeed that everybody shares the analysis.

So that is why there is, you know, often disagreement, different perspectives on these things, but ultimately it was because -- so when public statements are made by a regulator, a minister has the confidence and the clarity to be able to stand in a public forum and answer to -- to local people around the safety of their hospital or indeed the safety of the NHS. And, yes, it is a tension, but overall I believe it was one during my time in the Department that was -- that was -- that was managed.

Q. But as long as the Department is the sponsoring department for the regulator, whether it's the HCC, CQC or Monitor, you are never going to escape that problem, are you? It's only if you can separate the regulator entirely from government that you can avoid that particular issue, at which point, I suppose, government can then say, "Well, it's not our problem. That's the regulator falling down".

A. You make an important point and there perhaps would be some merit in going down that path. But
I think, as we may come on to speak about Monitor, there is also, though, a problem where organisations become too separate and not working with the wider NHS family, as it were. Because, ultimately, to use a phrase, there is a -- "we're all in it together spirit" about the National Health Service, and it's not possible for one -- for one bit of it to operate independently from -- from the rest. I think there has to be a reality check brought to bear.

As I say, given the nature of the NHS, unlike other public services, politicians do have to stand up and be held accountable for it, even -- even at a local level because of that way it was created in the -- in the first place, and because of that, there does need to be a basis of understanding and trust between minister and regulator.

Q. Baroness Young described it in this way:

"We constantly faced the issue [she said] of ... who is the Department? You know, is the Department Secretary of State? Is the Department the chief executive of the National Health Service? Is the Department the permanent secretary ... and his team of Civil Service?"

She's told us this:

"I always used to say it was a bit like living through an episode of 'The Thick of It'. Slightly bizarre meetings, where we would go in as regulator ... to say to the chairman and chief executive of the National Health Service, the Secretary of State and the chief executive of the National Health Service, who would be the chairman and the chief executive equivalent of a company, if we were regulating them."

She said:

"... we would discover that halfway through the meeting, it would kind of ... imperceptibly move to being a meeting of the Secretary of State as our boss, as a regulator, being advised by the chief executive of the National Health Service on policy and strategy issues."

Now, do you think that that's a healthy mechanism?

A. I think it is healthy the -- the Department and the independent regulator have full and frank dialogue on a regular basis. Yes, these are complex issues that are being dealt with. There's no doubt about that. They are difficult issues. They have to be debated and got right. But I don't think it would be better to have a regulator that is completely independent that doesn't have -- that accounts to Parliament rather than to -- to the Department of Health. Because statements that that regulator might make immediately have an impact on the ground, in terms of patients' confidence in the NHS or indeed in professional standards.

So these pieces have to be put together and the regulator does have to have regard to those -- to those issues, which are ultimately what the Department deals with. And, you know, the collective aim here is to improve standards in the National Health Service. And I would argue that's better to do it working together with distinct roles, rather than working completely separately.

Q. But when a regulator comes to you -- and I'll move on in a moment, I promise you, but when a regulator comes to you and says, "Look, we really need to change the system", and taking the core standards as an example, "these core standards are not working, they need to be amended", but they are not amended for several years --

A. I think, with respect, you're not really understanding how the process works, because obviously, often, a bill would have to be brought to Parliament to change the regime or indeed a statutory instrument --

Q. Well, not to change the core standards.

A. Well, to -- to change elements of the -- of the regulatory regime, often it will require a detailed process of consultation with the NHS. It will require a lot of change.
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<td>1 A. Yes. Maybe.</td>
<td>1 was that was explained by the move from star ratings to annual health check, and there was concern about how that would be -- how that would be handled and what damage that might do to -- to public confidence.</td>
<td>8 (Pages 29 to 32)</td>
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<td>2 Q. Is that reflective of an attitude which we've heard repeatedly from witnesses that there was a resistance in the Department of Health and among politicians to accept bad news stories?</td>
<td>2 From memory, after the results came out, the first annual health check results, there were a number of complaints that came from individual trusts around the country who felt they had been unfairly rated. And I think that was part of the teething problems that came with the new annual health check and, as we have been discussing, some of its imperfections.</td>
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<td>3 A. No, I don't accept that at all. I mean, it's -- it's not possible with something as large as the NHS to try and have that approach, to say, &quot;Well, we -- you know, we try and stop anything coming out&quot;. I think that's often a caricature that's -- that's used around people like me, ministers in my position, that we were constantly trying to kind of manage things. That just isn't the case. We were trying to ensure that there was a fair reflection of what was taking place in the NHS. Now, on the results you mentioned, the first annual health check, I recall there was a major change between the old results and the annual health check. So lots of organise --</td>
<td>3 A. Yeah. And lots of organisations looked like they had seriously deteriorated in the year between the old star rating moving to the new annual health check. And a senior official in the Department -- I think it's right for me to name him, David Flory -- came to me and said, &quot;We're very worried about this, because it looks as though a whole number of organisations are moving backwards and we don't think that some of the scores that are being given are a fair reflection on where they are up to&quot;. So it wasn't -- you know, I can't stress enough that it wasn't this thing that we were constantly trying to tell them how to do their job. It wasn't. It was simply that information like that entering the public domain can damage confidence in organisations at a local level or indeed the -- the NHS at a national level, and we have a responsibility to ensure that public confidence in the system is maintained.</td>
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<td>5 A. Sorry?</td>
<td>5 A. Not at any cost at all, sir, no. It -- it's -- it's obviously the -- the important thing is that a fair picture, the right picture, is put forward so that people can -- can test that and can make their judgments about it. The concern that came around this time was that a number of organisations appeared to be slipping seriously backwards when the judgment of the Department</td>
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<td>6 THE CHAIRMAN: But doesn't that, if they were right in those concerns and complaints, suggest that there was something wrong with the standards being applied or perhaps the description of those standards and what was meant by them?</td>
<td>6 I have to be honest and say I -- I wouldn't be close enough to the detail of each case and the -- the nature of each complaint that was brought forward to know whether or not it was a complaint about the standards themselves or whether the way in which the regulator had interpreted and applied those -- those standards.</td>
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<td>7 A. I have to be honest and say I -- I wouldn't be close enough to the detail of each case and the -- the nature of each complaint that was brought forward to know whether or not it was a complaint about the standards themselves or whether the way in which the regulator had interpreted and applied those -- those standards.</td>
<td>7 Certainly I became aware of the limitations, the imperfections of the annual health check, having lived through that process. You know, there was a -- a debate with the regulator that was driven by concerns within the Department that the annual health check was not an accurate picture. And then, the -- the fallout from the first results were that these complaints came forward. I wouldn't want to give you the wrong figure but I remember certainly in double figures numbers of complaints from around the country.</td>
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<td>8 And that did bring out to me that there were clearly problems with the annual health check, but, you know, I hope it doesn't sound as though I'm evading the issue to say when you move ministerial jobs you quickly -- it's not your policy responsibility any more, you move on and, you know, you're dealing with a different --</td>
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<td>9 THE CHAIRMAN: Going back to the time you were minister and you were discussing, some of its imperfections.</td>
<td>9 The concern that came around this time was that a number of organisations appeared to be slipping seriously backwards when the judgment of the Department was that was explained by the move from star ratings to annual health check, and there was concern about how that would be -- how that would be handled and what damage that might do to -- to public confidence.</td>
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<td>10 Sir Ian Kennedy was expressing concerns, if your test for action and judgment as a minister is whether you can with the regulator that was driven by concerns within the Department that the annual health check was not an accurate picture. And then, the -- the fallout from the first results were that these complaints came forward. I wouldn't want to give you the wrong figure but I remember certainly in double figures numbers of complaints from around the country.</td>
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stand up in the House of Commons and assure the public as to the safety of parts of the NHS or the whole of it, what were the implications of what he was telling you for your ability to do that?

A. From memory, there was a large number of organisations rated weak on quality that had previously received good ratings. Now, obviously, any local MP will want to know why. You know, why has their organisation moved backwards? So we wanted to be sure that the Healthcare Commission were clear that they had understood why in each case the rating of weak had been given, as opposed to one star or two stars. And that essentially was the discussion that we were -- we were having with them.

I mean, I want to be absolutely clear with the inquiry that this process did bring out the limitations of this whole rating system to me. And the idea that you can put one label on an organisation in terms of the quality of care it provides is a flawed notion. From experience, hospitals are very varied organisations, providing good and bad and indifferent across the whole organisation. So to put one label is in and of itself, you know, a problematic -- a problematic thing to do. But then you've got to say, well, would it be better to have no label put on -- on that organisation? Because if there's nothing, what then do the local public have to use to -- to demand improvements from their local hospital if no authoritative judgment has been placed in the public domain? So really difficult issues to -- to balance.

I tried to balance them as a minister. You -- you have to recall or just imagine, you know, do you have somebody of the stature of Sir Ian Kennedy on -- on one side of the table, you have very, very eminent officials of the Department on the other, often saying different things, and the minister's job is, obviously, to -- to see a way, a course through those -- those opposing views and come forward with something which you believe is in -- is in the public interest.

THE CHAIRMAN: Thank you.

MR KARK: When Department of Health officials said to you, "Well, we feel the overall picture is unduly negative and hospitals have been marked down when they shouldn't be", did you question them on what specific data they were looking at to make that assessment? You obviously know about HSMRs broadly.

A. Mm.

Q. We know now in 2007 there were condition-specific SMRs. They could have been looking at the number of declared SUIs or coroners Rule 43 reports, or an analysis of the complaints, or analysis of staff surveys. How were they forming these judgments that actually things weren't quite as bad as the Healthcare Commission thought they were?

A. I don't know. You'd have to ask them.

Q. Did you ask them? Did you say, "Well, you're telling me one thing. The Healthcare Commission are telling me another, what's your basis --"

A. In advance of -- when we were looking at the -- the early results for the first annual health check, the official advice I had was, as I was saying to the Chairman a moment ago, there had been a huge shift towards what appeared to be slipping back in terms of care standards, and the officials brought to me their concern that that wasn't a fair reflection. How they went to -- to demand improvements from their local hospital if no authoritative judgment has been placed in the public domain? So really difficult issues to -- to balance.

I tried to balance them as a minister. You -- you have to recall or just imagine, you know, do you have somebody of the stature of Sir Ian Kennedy on -- on one side of the table, you have very, very eminent officials of the Department on the other, often saying different things, and the minister's job is, obviously, to -- to see a way, a course through those -- those opposing views and come forward with something which you believe is in -- is in the public interest.

THE CHAIRMAN: Thank you.

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| 1 | had reached those judgments, I do believe that |
| 2 | David Flory and his team at that time did look |
| 3 | organisation by organisation within -- within the |
| 4 | National Health Service. It may not have been David, |
| 5 | actually, I'm trying to remember who -- and I wouldn't |
| 6 | want to, you know, incorrectly give the inquiry the |
| 7 | wrong -- the wrong steer there. |
| 8 | It was -- I think it was David, but it was a senior |
| 9 | official who had a team, who would be looking themselves |
| 10 | at each organisation and its performance. And that led |
| 11 | to them bringing their concerns to me at that level, |
| 12 | saying that, you know, "We have serious reservations |
| 13 | about some of these conclusions". |
| 14 | Q. Might it have been Duncan Selby? |
| 15 | A. It may well have been Duncan Selby. I was beginning to |
| 16 | doubt myself that it was David. David came to the |
| 17 | Department later, from memory now. But I'm afraid it |
| 18 | illustrates the hazards of being a minister in that |
| 19 | a huge numbers of people and information is put before |
| 20 | you at times and it's not possible to recall it all |
| 21 | perfectly. |
| 22 | Q. In a different context, I understand your difficulty. |
| 23 | Could we go to your 14th exhibit, please, AB14. This is |
| 24 | a discussion document. This was when Lord Hunt was -- |
| 25 | is this Minister of State for Quality? Is that what MSQ |

---

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| 1 | means? |
| 2 | A. That's right. If I hadn't moved to Norman Warner's |
| 3 | portfolio, this submission, more likely than not, would |
| 4 | have come to me at that time. |
| 5 | Q. I just want to look, for these purposes, at one aspect |
| 6 | of it. If we could go, please, to page, same prefix, |
| 7 | 3631. |
| 8 | At paragraph 24, this is under the heading "National |
| 9 | investigations": |
| 10 | "In some circumstances, a problem in one service or |
| 11 | organisation may prompt the HC or CSCI [so this is |
| 12 | obviously pre-merger] to conduct a broader review or |
| 13 | investigation to ascertain whether the problem is more |
| 14 | widespread where it has reason to believe that this may |
| 15 | be the case. We assume that you will want the new |
| 16 | regulator [and this isn't to you] to retain such |
| 17 | a power. However, we would appreciate your steer on how |
| 18 | much freedom it should have in deciding when to embark |
| 19 | on these kinds of reviews." |
| 20 | So this might be thought still to be very much |
| 21 | a top-down view. Would you agree with that? |
| 22 | A. Well, it was a top-down view to give them freedom, no? |
| 23 | Q. Yes. |
| 24 | A. It was saying that ministers wanted them to have free |
| 25 | rein. |

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| 1 | Q. Well, how much freedom? |
| 2 | A. I mean, I -- lord Hunt's view probably would have been |
| 3 | mine too, that -- you know, that they shouldn't be |
| 4 | constrained and that they should be able to deploy their |
| 5 | resources in the way they best saw fit. |
| 6 | Q. Let's just have a look at that. Can we look at |
| 7 | paragraph 26. One of the key recommendations of the |
| 8 | Department's 2005 wider regulatory review, chaired by |
| 9 | Lord Currie, was that: |
| 10 | "The new regulator should look to substantially |
| 11 | reduce its activity in this regard [in other words |
| 12 | national investigations]. The HC had proposed that |
| 13 | these improvement reviews should form part of the annual |
| 14 | health check for 06/07. NHS services reacted |
| 15 | unfavourably to the consultation on this proposal. The |
| 16 | Department stance has also been against this." |
| 17 | So not because of the consultation but the |
| 18 | Department's stance is against this: |
| 19 | "Indeed, Minister of State DR ..." |
| 20 | Sorry, DR is development and? |
| 21 | A. Delivery and reform. |
| 22 | Q. I'm sorry, delivery and reform: |
| 23 | "... wrote to Sir Ian Kennedy asking the HC to |
| 24 | reduce the number of improvement reviews scheduled to be |
| 25 | conducted in the current financial year." |
I think the -- the -- the part you quoted a moment ago, which said that their view had come from the NHS in consultation, from memory I think they are referring to that, you know, that there was often the National Institute for Health and Clinical Excellence doing guidelines and -- and thematic reviews, Healthcare Commission doing the same, some of the professional bodies likewise. And the call often from the NHS was, "There's too much here for us to absorb and, therefore, we want a more focused approach to this". And I would -- as I say I -- I read that sentence as meaning that, not as meaning, "We don't want the NH -- the regulator to do in-depth looks at each individual trust".

Q. I'm going to come on to the role of commissioning in due course, but the annual health check and the core standards were, of course, also applicable to the commissioners of services, and particularly to the PCTs. And so they too had to assess themselves against the core standards both as direct providers of the service and in respect of those from whom they were being commissioned services independently. So the same blunt instruments were being used in the very complex world of commissioning.

Did you turn your mind to that particular issue as to whether that was a sensible system or not?

A. I did. There was an enormous amount of focus on commissioning and the quality of commissioning at that particular time. We had an initiative within the Department called World Class Commissioning because, if you --

Q. That came in in 07/08.

A. It did, but we were in the process then of leading towards -- towards that. And obviously it was a period where NHS finances had gone somewhat awry. The role of the PCT as commissioner and provider was very much in our focus. Was it right for them to be both? And indeed, how can we improve how we both regulate them and encourage them to -- to do a better job at commissioning? So yes, we -- the core standards were relevant to PCTs in the respect that they were all providers of community services or nearly -- nearly all.

Q. But, again, do you accept the faults in the system, it was a terribly blunt tool to apply to a very complex piece of machinery?

A. I'm not so sure I accept it was as blunt as you say.

For me, the blunt part of this tool was the label that came with the annual health check. That is the bit where I would agree with you that that was crude and blunt and possibly didn't give a full picture of how a PCT or a hospital was performing.

The core standards themselves, I would take issue with you that they were blunt because they were actually quite a detailed explanation of what basic good care should cover and how basic good care should be also -- should -- should be commissioned. So I think the core standards themselves, while they were clearly not a perfect document, nothing ever is, were a more sophisticated iteration than the Department probably had ever done before of what we expect from all providers and Commissioners in the National Health Service.

Q. I think some might say to you in response to that that what the core standards did wasn't describing what good care should be but what the systems supporting good care should be, and that's one of the difficulties that we have looked at with the core standards, that they were very much system and process based rather than looking at outcomes, and that's an argument I'm sure you recognise.

A. I do recognise that -- that argument. I think the point I was making was that they are -- they're quite broadly drawn, they're quite general, they're not so specific in terms of what the minimum threshold all organisations should reach should be. And just to pick up your -- your wider point -- maybe this is something we can come back to later -- I became clear that some of the ways in which we had measured organisations did focus too much on the process, as you -- as you say, and missed the softer side of -- of healthcare. That's the phrase that Dr David Colin-Thome used in his report on Mid Staffordshire. By that I mean the human side of healthcare.

Q. And the patient's experience, which we'll come on to.

A. Absolutely. And I think that -- you know, that is something that, looking back, I very much see as a flaw. You know, the -- the emphasis when we came into government was very much on access to the system, and I think it's important to remember the climate at the time. It's often easy to forget, you know, the issues that were at the forefront of people's minds. And the issue at the forefront of people's minds was people spending hours on end in A&E, people unable to get into hospital to have their operations, people dying on waiting lists. Those were the issues. So access was very much what drove the early change in NHS reform.

But I became clear, during my time as a junior
minister and then a Secretary of State, that that focus
on process missed the human experience, and what we were
hearing more and more was that, you know, that was --
that was a -- a real problem.
Q. Just before we leave the Healthcare Commission and its
role completely, it had, of course, foisted upon it,
according to those within the Healthcare Commission, the
role of the second tier complaints service. We were
told that those at the HCC had from inception firmly
resisted taking on that role in the complaints system.
We were told by witnesses from the HCC that their
impression was that the Department of Health simply
didn't know where else to put it. And in the first year
or two, the HCC found itself under-equipped and flooded
with complaints.
Do you accept that that demonstrated at the time
a pretty cavalier attitude by government to the public,
many of whom were desperate for some form of proper
redress through the complaints system and it was handed
to a regulator, frankly, that didn't want it?
A. I recognise the final point of what you've said, because
when I had my meeting with the Healthcare Commission,
which was that broad meeting, we discussed this very
issue, and I recall saying to them that I put quite
a large personal store by the good handling of
complaints and I was worried at the time that they had
a huge backlog; long, long delays in processing
complaints. And I remember saying to them as an MP, you
know, "That for me is a really important part of your
work", and I had a feeling at the time that they didn't
like that part of their work very much and didn't
particularly want to focus much time or resource on it.
That was a source of debate between us.
I personally, looking back, think that was the right
place for second-stage complaints to go to, because
those complaints should have informed the broader
picture that the regulator was forming about each
individual trust.
If I may, Mr Kark, just make a broader observation
about complaints. I look back and think, you know, this
is -- this is not an issue that the NHS handled well or
indeed handles well. I was always clear as a minister
that this was an area -- there had to be serious culture
change in this whole area. And indeed I made these
points when putting through the NHS Redress Bill, which
was a bill that I brought forward dealing with NHS
complaints around this time, that we had to see
a complete sea change, that at local level complaints
had to be accepted as part of organisational
improvement, a learning NHS.

What we see instead is that in organisation after
another around the country, there is a shutters down
approach to complaints where the public are pushed away
because it's all too, you know, often -- perhaps it's
all felt to be too difficult and -- and uncomfortable.
And yet this then kind of goes through the system that
nobody really wants to do complaints, and yet it is
fundamental to an organisation that is committed to
improvement that it -- it deals with those complaints in
different, more open way. And I, you know, would
agree with you that, just through the various ways of
trying to do this, this issue was unsatisfactorily dealt
with from local level up to national level.
I know that the Ombudsman now says it's right to
have one-tier complaint straight to final. I have my
doubts about that personally.
Q. Before we break, can I just turn to a discrete topic,
which is the use of language in government or Department
of Health documents.
Back in 2006, you took a job shadowing. I don't
know whether it was within one trust or several trusts.
Presumably, better to inform your role as a minister.
Can we just have a look at the exhibit that you
produce, which is AB1. If we could go to the next page
and look down at "Workforce issues" at the bottom. If
you would rather look at the whole document, you've got
it, of course, in the file on your right.
Just to put this into context, this is part of your
report, as it were --
A. Mm-hm.
Q. -- in relation to your experience working within the
NHS. Where did you go and work, out of interest?
A. I -- I mean, this was very much a decision I made
myself. It was not something that the Department
suggested. It was something I decided to do when I came
in as -- as junior minister in 2006, May 2006. So
I went to a number of trusts around the country.
I shadowed a paramedic in the West Midlands, working
around Dudley hospital, Wolverhampton hospital. I did
overnight at the Queen Elizabeth A&E in Charlton.
Q. So it's a number of different centres?
A. Yes. Tameside in Greater Manchester. So I -- I --
yeah, I spent a number of days at -- at a range of
levels in the NHS.
Q. I want to focus just on the bottom part of this page and
the workforce issues which you mention.
You say:
"In 2006, concerns about the strength of workforce
planning in the NHS came to the fore in response to
financial pressures in parts of the system. In general,
the right direction of travel for the NHS is to take
more decisions at local level. But the important thing
about a National Health Service is knowing where it
makes more sense for regional NHS bodies to act together
and coordinate requirements. Workforce planning and
support falls into this category. Going forward,
we will learn from 2006 by establishing structures for
stronger collaborative action between NHS bodies in
addressing these important issues and creating better
systems of practical support for staff experiencing
change."

Now, we know that in 2006/2007, at this particular
trust, there was a loss of a number of staff, as well as
a reorganisation of the floors and the duties of the
nurses involved, and putting it bluntly, it was
a disaster, and it was approached from top-down from the
senior board level at the trust. And there seems to
have been little or no collaboration with those who were
actually affected, nor was any advice sought from any of
the nursing bodies.

Now, you can't have been aware of that at the time
that you wrote this, but what initiatives arose out of
this recommendation? Did anything actually happen?

A. I like to think it did. I was very instrumental in
setting up and giving more profile to the social
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partnership forum within the Department of Health, which
at national level was a tripartite forum with NHS
employers, trade unions and the Department of Health.
And at local or regional level, we were very clear that
there should be more collaboration between trusts in --
in dealing with workforce issues and indeed
redundancies.

It wasn't this trust, but I think I'm right in
saying north Staffordshire announced at some point in
2006, you know, a huge number of redundancies, I think
something like 1,200 at the time. In the end, I don't
think it made anything like that number of people
redundant. But quite clearly it demoralised the entire
hospital by putting out a figure of that kind and indeed
was trying to take on the pressures of dealing with this
workforce change on its own. My feeling was that
organisations should have been working very much in
partnership to look at if people needed -- if -- if
staffing numbers needed to change, that people were
reallocated to other providers across a particular
region.

There is also the point that I don't bring out
completely there, but is implied, that also the NHS was
undergoing quite a lot of change where hospital-based
staff were beginning to work in community settings, and
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I felt that, you know, it didn't make sense for acute
trusts to be making ward staff redundant only for them
to be re-employed three or four months later by a PCT in
a community capacity. Obviously it made much more sense
for those people to stay within the employ of the NHS
and to have training to help them move towards community
settings. Whereas, at the time, it did not appear that
those issues were being handled in that way.

Q. You make a further comment about this at page 450, about
the top-down culture and the lack of collaboration.

A. You say in the third paragraph:
"It is important to say that I also heard staff talk
of their frustration about the top-down nature of the
NHS system and the inflexibility of its culture. I came
to the conclusion that the NHS is not good at giving its
front line staff a sense of empowerment. People with
good ideas do not feel that they can easily put them
into action; there is a prevailing sense that those
decisions are taken by somebody else."

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Q. Can I just explore that comment you have just made. The sense of disconnect between what happens at national level and how it's felt and interpreted on the ground, and can we just go to your second exhibit, which you say, I think, defined your approach as indirectly you could be right in saying that there is some read across here to the regulator, it's -- it's very much more to what organisation -- culture existed within an individual organisation. And I found it to be, you know, often very deficient.

A. I think often -- yes, that's how they're -- they're called.

Q. All right. We can see that this is presented to Parliament by the Secretary of State for Health in December 2009, if we go to the second page. Thank you very much.

I don't want to spend too long on this. If we go to page 3, we see -- you haven't changed much -- your picture.

Then at the bottom, we see you saying:

"So, as we approach a new decade, it is time to set a new ambition: to take our improving NHS from good to great. For me, this means a new drive towards a more preventative and people-centred service -- better for patients, but also more productive."

And then if we go to page 7 and paragraph 1.3:

"Now our challenge is to accelerate this quality improvement, creating services that are not just good but universally great, increasingly designed around the needs of the individual and accessible to all."

Now, I hope I'm not being overly cyclical, but the use of that sort of phrase might be thought to be unhelpful and even patronising and universally meaningless. How does that relate to people, as you put it, on the ground? What does "universally great" mean?

A. Well, I did try to define it earlier in this document. "Great" would be people centred. It would be care provided according to the individual's needs, not when the system decides where, when, how you'll be treated.

Q. I'm going to come on to the issue of commissioning, but just while we're on this document, can we just look at what you say about commissioning at page 55, or same prefix, 3534.

If we look at the bottom right-hand paragraph:

"Good management, and particularly good commissioning, is absolutely critical to realising our vision of a higher quality and more productive NHS. Commissioners must lead the change from good to great at local level."

Now, we've had quite a lot of evidence about the PCT, the local PCT and commissioning. Going back to the JCI report, they talked about the Department of Health placing unachievable expectations on the commissioning...
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services we commissioned? The answer is no. And I think that's something we cannot argue with."

And a little later it was put to him:

"But from Mr Griffiths' evidence yesterday, is it a fair summary of your view and his that up until 2006/07 the focus of commissioning would have been one of finances and the provision of health services rather than specifically the quality of those services?"

"Answer: I think that's fair, yes."

A. My answer to that would be, you know, we weren't wanting PCTs to wait for us to tell something, you know, it wasn't the case that for them to do something they had to have permission from Whitehall or to be told what to do. As I said, the NHS we were creating was one where we wanted them to move forward, set local priorities, set local challenges for -- for -- for the NHS.

And if you look back, I know the inquiry has drawn heavily on Dr David Colin-Thome's report on commissioning in the -- in the Staffordshire area following the Healthcare Commission report. He, throughout his document, regularly refers to best practice employed by other PCTs around the country. And quite clearly that shows that there were many examples of PCTs that had much better systems for monitoring quality than the one -- than the one that's relevant to...
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1. sense of its -- its core purpose. And as I went round,
   2. I mean, it very much kind of -- I was thinking about how
   3. do you give people on the ground kind of certainty about
   4. what they value? And what they value is the NHS values.
   5. Those are the things that get them out of bed in the
   6. morning, that's what matters to them, that's why they
   7. working for the NHS. And how do you put those beyond
   8. reach -- you know, make them absolutely sacrosanct?
   9. And that was really -- so I picked up the idea from
   10. there, but then thought that one of the ways in which
   11. you give people the confidence to face a changing NHS
   12. was by putting the values very clearly into a -- into
   13. a constitution. And I'm pleased that that was accepted
   14. as a recommendation and then it came into force.

THE CHAIRMAN: Do you see it as a work in progress?
A. Absolutely. I think it would be a very healthy thing
for that constitution to be debated periodically, let's
say every five years, to pick up changing technologies,
also patient preferences. So it would be a healthy
thing for -- for there to be a national debate about the
content of the constitution, and that was very much
what -- what I envisaged. But also that should lay
down the minimum standards I was speaking about before
the break, that all patients should expect indeed that
are their rights. So I very much envisaged that as

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1. treatment within 18 weeks, four hours in A&E, that what
2. were targets should just become permanent patient
3. guarantees within the National Health Service. And I'm
4. pleased that the current government, has
5. committed too to the principle of the constitution, and
6. I think it's a positive thing for the NHS to have some
7. clarity about fundamental values and rights.

THE CHAIRMAN: Thank you.
MR KARK: I want to turn to a fairly large topic, I suppose,
of foundation trusts.
Is it fair to say that certainly part of the reason
for designing the new system was to move away from the
top-down command from the NHS and to provide a degree of
autonomy to trusts?
A. Absolutely right. I made a speech in Parliament on the
foundation trust bill at report stage that said almost
precisely what you have just said. The feeling was that
in NHS organisations there was always a culture of
people looking over their shoulder from the person above
them in the management chain and that kind of went all
the way through right up to the top, and that you would
never build the right culture for self-improvement at
local level in -- in that kind of system.
So it was at the heart of the foundation trust idea
that responsibility, accountability would lie at the

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give you an answer that draws on -- on those -- on those
memories and then indeed from when I was in the
Department.

And it's almost contrary to what people expect of
ministers, indeed people like me. The worry was that
if -- if ministers were signing off these decisions, the
argument or the accusation would be that there was -- it
was too political, that ministers were making it for the
wrong reasons, that one trust was favoured above another
for -- for political reasons.

And actually, if you look at our reform journey
in the NHS, it was very much about placing that
independence of decision-making into the system at all
crucial places. So not just in terms of the Healthcare
Commissions we spoke about earlier, the National
Institute for Clinical Excellence, NICE, was an
incredibly important change in this regard where
ministers didn't want to be telling PCTs which
treatments they should or shouldn't be funding, that
that should be done independently by experts.

And the same idea was then carried forward to the --
to the creation of foundation trusts, that this should
be an independent assessment of their readiness, and
that it shouldn't be driven or be seen to be driven by
other considerations.

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17 (Pages 65 to 68)
Q. We're going to look at the independent assessment of this particular foundation trust, but we have the useful note -- and in fact it's not one of your exhibits, but it's one of Mr Bradshaw's exhibits. It's BB5 and I can give the WS number if we need it. 5069092, which is described as a high level perspective, but it's really a retrospective. If we could go to -- that's it, thank you very much.

It's written by David Flory and Una O'Brien, dated 22 June 2009. It is addressed -- this is at a time when you had just become Secretary of State, I think.

A. Mm-hm.

Q. -- as it were.

If we go to the third paragraph, we can see this:

"Foundation trusts are not a stand-alone policy. They form part of a broader set of interconnected system reform policies. With this in mind, we need a strategic consideration of the future of the whole of the provider"

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A. Yes.

Q. -- as it were.

A. Do you mind if I say a little about that now? Because the question on the -- on the submission is very much getting towards that, what is your broader position on public sector reform?

Q. It's also in the last three lines of paragraph 6, as you can see:

"Failed FTs will need to be deauthorised."

A. I came into the Department and felt strongly that trusts should be brought out of FT status if they were failing, and there was -- this sparked a considerable debate, not least on my own side with some of the people who you might consider our arch reformers, who said, "Oh, that sends out the wrong signal, that we're weakening our response to foundation trusts or our commitment to foundation trust policy". I mean, I just basically didn't see it that way.

When an organisation was failing, there had to be steps taken to restore public confidence, and often the steps that needed to be taken were not within the local -- within the ambit of people at local level. So for -- in this instance, my clear view, arriving back in the Department, was that this trust needed some of the best leadership that we could find in the National Health Service, yet the FT model, as created, didn't allow -- or in theory didn't allow ministers to come in or senior officials in the Department to come in and make those changes. The theory would be that that...
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<td>Q. And if we ignore the argument about deauthorisation, there's a step before that, isn't there, and that is whether you should only be authorising high performing foundations trusts?</td>
<td>A. It does, but I was pretty clear in my view. I mean, lots of people did say when I proposed the deauthorisation clause that this was a signal that I was not a reformer, that I was -- but I didn't care, to be honest, because I believed it would be -- to be the right response to what I was being confronted with in -- in the aftermath of the Healthcare Commission report. It seemed to me to be unsustainable that an organisation could just be -- be left to -- to struggle. And I think that's a flaw, as I say, in some of the models of public sector reform that continue the idea that organisations will just go up and they'll go down and the market will sort it out. Well, I don't see public services like that.</td>
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<td>Q. I didn't ask if it was an ambition. It is clearly an ambition. Is it a reality?</td>
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<td>&quot;We need to decide how to get behind these organisations to accelerate their progress. It is inconceivable that they should be left behind.&quot; So that simply doesn't accept the possibility that any trust will not be able to reach the standard required. Do you think that's a reality?</td>
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Q. Included inevitably the local MPs, who are normally resistant to any sort of closure of the kind --
A. Often they are. I mean, these are difficult issues and nobody likes to see change in local hospital services, but if you look back at more broadly my record as Secretary of State, I did push through some fairly controversial changes to -- to hospital configuration because, as a country, we're going to have to find a way with dealing with this debate, because hospital changes -- hospital services will have to change.

Q. Having looked at that note, which is retrospective, can I now take you to your exhibit 3, which takes us to September of 2006, so it's just before you were going to go forward, and the diagnostic would be a more 360-degree assessment of the organisation at local level, there was never any suggestion at all that this represented a lowering of the bar in terms of quality.
A. Unlikely. Papers that went to the board wouldn't routinely be given to ministers. If I'd have asked for it, I would have expected -- well, I would have been given it. More likely that some of the key conclusions, key parts of the analysis would then have been taken up --

Q. Filtered through to you.
A. -- and come up into ministerial submissions.
Q. I don't want to spend too long on this, but if we could just look at the bottom paragraph 4, please, headed "Existing application process":
"For previous waves of applications, the process can be summarised as: three or two star NHS trusts may apply."
So that's after the change:
"DH developmental support is provided as NHS trusts work up their applications. Secretary of State support is given if the NHS trust applicant can demonstrate that they are: a high quality provider and not presenting any risks to the wider health economy."
First of all, when you were considering these applications which you did, were you still looking for what you would have termed a high quality provider?
A. Yes. Absolutely. The changes that this note, I think, describe were the change to the foundation trust diagnostic process, and very clearly the aim was at that time to not be too prescriptive in setting the criteria by which trusts may aspire to become a foundation trust.

It was obviously to allow more to have that ambition in -- in keeping with the parliamentary -- the

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parliamentary objective.
Just going back to that, it might just be helpful for me to say, I mean, that was very much the view of Parliament when it was considering the foundation trust bill, that Parliament didn't want this bill to lead to two classes of organisation. It wanted all organisations to be able to become foundation trusts.
If these were benefits worth having, that every community should be able to have them, was the basic feeling.
So while this was moving away from perhaps a more rigid approach to assessing the organisations that would go forward, and the diagnostic would be a more 360-degree assessment of the organisation at local level, there was never any suggestion at all that this represented a lowering of the bar in terms of quality.
Q. Well, you say that in your statement, but if you place reliance on the annual health check and you set a bar at one level and then the next year you change the bar, I won't say lower it, but you change it so that a trust that has received a lower grading is now able to apply, why aren't you lowering the bar? It may be a good thing but that's what you're doing.
A. Because the ultimate test that Monitor would apply would be the same. It was just simply that more organisations...
Q.  Isn't the difficulty of that -- and we'll look at this specifically in due course -- that that would require Monitor to have a closer eye on quality than they perhaps had had before?

A.  That does follow, of course, and we can talk more about Monitor in due course. But I think it's important before we get drawn into all of this detail just to think of the bigger picture, if I may, for a second.

Because the decision to go forward is the decision of the trust board and nobody else. Let's be absolutely clear about that. Nobody is -- you know, while there is encouragement, nobody is saying, "You must go forward or else", because that would be completely counter to the spirit of this reform.

So fundamentally, the decision to go forward was a decision of the individual trust board and its management.

Q.  But you're not --

THE CHAIRMAN:  Excuse me.  How does that help you?  I mean, if that was the answer, then you wouldn't need a regulator to consider it, you wouldn't need the Secretary of State's approval because the trust board had to be content that it could stand on its own two feet financially. I mean, that's the effect of what it was doing. So it would be utterly foolhardy for any organisation out of hubris or arrogance to say, "Right, we're going to become an FT", if it didn't feel in its heart of hearts and it had the -- the capacity to do that. And no PCT should have signed it off or supported the application, because ultimately the PCT would have ended up with that problem on its plate if it -- if it was dealing with an organisation that subsequently became financially challenged.

So it is always tempting to go straight to the national level about these processes. But I would argue here, you know, those initial local considerations, I think, in the FT pipeline process are fundamentally important.

THE CHAIRMAN:  What was your understanding, what is your understanding about what is meant by "high quality" in this context?

A.  It would mean meeting all of the core standards.

It would mean meeting all of the national targets that had been set. It would mean providing a good service to the public and that, as we will come on to discuss, I'm sure, was -- was very debatable in respect of this organisation.
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<td>A. There were those debates, absolutely. They preceded my time in the Department slightly because John Reid, as Secretary of State, commissioned a review of the foundation trust application process, and then it was subsequently endorsed by Patricia Hewitt in — just in the period before I arrived. And I think the Department came to the right judgment by introducing the changes to the assessment process that it -- that it did. But you are right, there were always those voices around in the political sphere who were saying that we should be much more gung ho, if you like, about pushing organisations forward.</td>
<td>the — I think it was the note to the management board, or it might be a different one, saying that, you know, they're quite clear that the -- the entry criteria standards haven't been lowered and obviously there needs to be careful explanation to ensure that -- you know, that is more widely -- more widely understood. So, yes, it does imply that, but I take from that that those who were arguing for that didn't win the day.</td>
<td>And then we have some background, which I don't think makes specific reference to Mid Staffs. And then to the bottom of the page, if you would: &quot;The applications committee met on 7 June to consider the applications and now make the following recommendations: that the following two trusts be given ministerial support to proceed to Monitor: North Tees and Mid Staffs.&quot; And then four trusts presented an unacceptable level of risk. Then under &quot;Supported applications&quot;: &quot;There are a couple of issues with the supported trusts.&quot; And it deals with North Tees first, and then paragraph 7: &quot;Mid Staffs business model is marginal in that it does not appear to generate the level of surplus that would stand up to risk assessment. However, there is a strong &quot;can do&quot; attitude at the trust and we can provide them with the additional support ahead of them presenting their model to Monitor.&quot; You've got this as an exhibit, of course, and you're welcome to look through the rest of it. My reading of this is that there are just four lines specifically on Mid Staffordshire. Is that the sum total of the information about this trust which you had?</td>
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<td>Q. Can we turn to the information that you were provided with in relation to this particular foundation trust. If we go to your exhibit 6, please. This is a note in fact from Warren Brown, dated 14 June 2007, to you, I think.</td>
<td>&quot;And the first paragraph reads:</td>
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as your pen hovered over the application?

A. Yes, that was all that was put to me.

Q. And one would expect, if you had been given further
information, for that to have been minuted.

A. Minuted in?

Q. Well, if a civil servant had provided you with
additional information on top of this document, as it
were, you would expect there to be a record of that?

A. Of course, yes. Yes.

Q. And if we look at your comments, if we go back to the
first page:

"Thanks to Warren. Yes, I'm happy to accept these
recommendations ..."

Is that?

A. Yes, it is, yes.

Q. "... provided we give a clear way ahead."

Actually, why don't you read it since it's your
writing?

A. Not quite as bad as a doctor's:

"A clear way ahead to the four and specific advice
on the issues they need to address. However, I'm
conscious that there are growing tensions between the
demands of PFI and the FT regime. It may be that the
two trusts here would never get through without help
from the centre. Could Andrew give me his views on that?

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issue?"

Q. Just to make it clear, the two trusts that you referred
to, and I think this becomes clear from your next
exhibit, which is your exhibit 7, were not the two that
you were being invited to put forward, it was in fact,
that I, think, Bart's and Walsall.

A. Correct --

Q. I'm not going to go into those --

A. -- because Bart's was named in the David
Flory/Una O'Brien note and it was exactly that issue
that I was picking up.

Q. Can we take it that it was upon this recommendation
from -- on the basis of that note, from Warren Brown,
that you acceded to this application in relation to
Mid Staffs?

A. I accepted the official advice that was being presented
to me --

Q. Yes.

A. -- by not Warren Brown, but the applications committee.

Q. You're quite right. You're quite right.

A. And it's important to say that that in itself was
a different level of scrutiny from the ordinary
ministerial submission, the fact that the Department of
Health directors at a senior level had met to discuss
each individual trust, consider the pros and cons of

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had been presented to me, there was no reason for me to stop this trust being put forward for further consideration by Monitor, knowing that the Monitor process was intensive and indeed rigorous.

Q. We keep hearing this expression, you know, trusts are turned upside down in the Monitor process, but did you really think that Monitor was turning trusts upside down in terms of a quality assessment or simply a financial assessment?

A. Both.

Q. Well --

A. Was my expectation.

Q. Okay, what did you think, what skills did you think Monitor had to assess a medium-sized trust's clinical qualities?

A. Monitor had a board that comprises of a number of people with very considerable experience, not just in business, commercial world, but also from the National Health Service. For instance, I remember at the time commercial world, but also from the National Health Service. For instance, I remember at the time

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THE CHAIRMAN: The paragraph which we've looked at, the only paragraph dealing with Mid Staffordshire and its marginal business model, paragraph 7, you appear to be being told that as things stood the trust business model was not one which would withstand Monitor's scrutiny. But, if I can interpret, that because of a strong can-do attitude, there was a good prospect of that position being changed, would that have been your understanding?

A. Yes. It was saying that the trust wasn't financially challenged like many other trusts were at this time. It's important to remember that across the NHS at this moment there were large deficits in a number of not just providers but also primary care trusts. And the fact that this organisation wasn't in that position was relevant in that consideration. But, as I say, there were no guarantees here. This paragraph is essentially saying they could succeed, but it's an open question about whether or not they will be able to convince Monitor that they have got sufficiently robust processes in place.

I mean, in retrospect, re-reading those words, I mean, they are -- in many ways, you know, they bring out the problem, don't they, that the can-do attitude was basically a cavalier attitude to costs, cost management and care quality. But at the time, nothing was put before me to suggest that I should stand in the way of this organisation that was on a path of improvement, and that is essentially, you've got to remember, how this was put to me. I -- we were looking...
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for trusts that wanted to improve themselves, to step forward, to become more accountable, to become more independent. You know, we wanted them to step forward and say, "We -- we want to now take this step as an organisation because we are ready to move into a different era". And it wasn't for me to kind of do the old top-down thing of saying, "No, you can't. We're going to keep you back down in your place".

I was there, as long as reasons were not put before me to stop me putting them forward, to -- to -- to let that process take place. And as I say, I was -- you know, people -- I've seen it reported in -- in some local papers that, you know, I approved -- I gave it official advice to to consider Monitor. And, secondly, I was not presented with a raft of problems. I was not presented with any information about care quality at the trust.

THE CHAIRMAN: Do you think that a safer approach -- and I don't mean that necessarily about Mid Staffordshire, but a safer approach generally would have been to require your officials to be in a position to advise you that the trust had got its ducks in a row so that they, the officials, felt, obviously it will be a matter for the Department of Health scrutiny process.

Monitor, but they, the officials, felt that the business model, for instance, would pass muster along with all other criteria at the time of giving approval, as opposed to the only time it's coming before you, taking responsibility for this, they're still telling you there are things to be done?

A. I think that would be a relevant concern if this was the final moment whereby an irrevocable decision was being taken, but it wasn't. This was the moment when the organisation would be opened up for wider and more detailed scrutiny.

The reference here about not generating sufficient surplus, from memory it was generating very small surplus, but Monitor had, in the wake of the financial difficulties in the NHS, had increased its requirements of trusts in terms of what level of surplus they needed to be making to become a viable, independent prospect.

I think they started to speculate -- to specify that it shouldn't just be a surplus, it should be at least 1 per cent of -- of turnover. So this was a change -- you know, this again was a changing picture, that Monitor were becoming more demanding of organisations because of the difficulties that the NHS had got into. I don't believe -- you know, from my point of view, and I only have to say that from my point of view, dealing with lots of other issues at the time, when presented with this, I don't believe the officials -- the officials -- the official advice to me was to allow it to go forward. They didn't present any reasons to me why it shouldn't. It was financially borderline but, nevertheless, I think making a small surplus. So I don't believe I was presented with any reasons why I should stand in its way.

But I would just ask you to consider that I was only passing it on to a much more forensic level of scrutiny than the departmental layer would ever have -- ever have provided. And Monitor, I don't have the figures, but from memory, many organisations dropped or were deferred at that stage. There was no expectation that trusts then sail through that process.

THE CHAIRMAN: Did you have any expectation that Monitor would place any weight at all on the support given by the Department?

A. Not much, no. Because Monitor were fiercely asserting their independence from the Department.

THE CHAIRMAN: That is contrary to the evidence, I think we have heard from Monitor, which, if I understand it correctly, is that they did place some weight, a degree of weight, on the fact that trusts had passed through the Department of Health scrutiny process.

THE CHAIRMAN: Presumably it was given the gateway -- approval.

A. I find that a little surprising, because at the time Monitor were very much in the position of, "You won't be telling us what to do. We will be -- we will be making this decision, and it's our decision alone".

I guess -- I mean, in any situation the fact that the Department has passed it forward provides a certain degree, but every organisation they were looking at was given that gateway. So no organisation got a different level of Department of Health --

THE CHAIRMAN: I'm sorry to interrupt -- given the gateway by the legislation as a requirement, in order to provide a level of safeguard?

A. Yes, but all organisations coming to Monitor had been through that level of -- of that check, that safety valve, so they couldn't have said that this was more or -- you know, that one organisation had a bigger seal of approval than the other one. So I don't think that they could read that much into that.

I mean, I -- I would certainly be a little surprised by it. I mean, I'm sure it may have given them some reassurance but, normally, the Monitor mindset was, "This is our job. We will do it. Thank you very much, you know, you can now back out of our consideration of

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Page 100
20. 

21. Mr Lavelle, and then Mr Moyes, both say that they relied on others to help them form a view about quality. And "others", I think we're meant to read there to be the Healthcare Commission or Care Quality Commission. And in my judgment, that would be absolutely a sensible thing for Monitor to be doing, to be looking at the financial position alongside that clinical quality picture from other organisations.

22. What surprises me though in this case is that they didn't appear to do that. They didn't appear to do what they have said in evidence to this inquiry. I had left the Department by the time this was taking place, but it has been put to me, since I've looked back at the paperwork, that in the early stages of the consideration of Mid Staffordshire for foundation status at a very junior level, a request was made to the Healthcare Commission to provide care quality clinical information about Mid Staffs that appears not to have been answered satisfactorily, if indeed answered properly at all.

23. Q. There was a failure of communication, we all understand that.

24. A. But it's important, isn't it, because Monitor are saying they relied on others to form that clinical view.

25. And my question would be: to what extent did they rely on others in this case to form that clinical view? There was no question that they have to form a view that their board has to accept as a -- as a view about clinical standards at the trust. What they appear to be saying, it's largely formed by the views of -- of others more expert. My question would be: why in this case that part of the process was not adequately followed through?

26. Q. Mr Burnham, that's an absolutely valid question, and it's one that we have asked, as you understand, in this inquiry. But it doesn't quite square up with what they had said in evidence to us. And that was my point to him -- I'm sorry, this is quite a long question, but it's to inform you, as it were, so that you have the background.

27. He was asked:

28. "Well, it meant that there was less headroom between what we had, which was three or two star hospitals and now in terms of quality care. Equally, I would say that they were meeting a minimum standard, which was fair, but that gave us less wriggle room."

29. He said:

30. "I accept that at that point [so when the bar was changed if not lowered] point we should have stepped back and said, 'Look, you know, do we need to do anything further in relation to quality and quality governance to make up for the fact that we've gone down from three stars down to fair in the diagnostic?'"

31. And then, finally, Bill Moyes told us on Day 93:

32. "I certainly didn't want Monitor to be forming an independent judgment on clinical quality when the Healthcare Commission existed to make assessments of clinical quality and clinical performance. That would seem to me to be entirely contrary to Parliament's intentions and not at all efficient. So de facto what we did was relied on the use of the Healthcare Commission's rating system by the Department as the gateway to give us an indication that the first assessment, the first pair of eyes had concluded that this hospital had quality good enough to be referred to Monitor to be assessed as a foundation trust."

33. Now, if you'd known that that was Monitor's approach, would that have changed your approach?

34. A. Well, I have to say I want to take issue with some of what I've heard there, because the earlier person, Mr Lavelle, and then Mr Moyes, both say that they relied on others to help them form a view about quality. And "others", I think we're meant to read there to be the Healthcare Commission or Care Quality Commission. And in my judgment, that would be absolutely a sensible thing for Monitor to be doing, to be looking at the financial position alongside that clinical quality picture from other organisations.

35. Q. We've heard obviously from a number of witnesses from Monitor, and just to give you a smattering of the evidence, if I may. Mr Lavelle, first of all, on Day 91, page 54 said:

36. "In terms of consideration of quality of care, we relied upon others and the reporting of others to undertake that activity."

37. Giles Wilmore, who's a Department of Health statement tell us:

38. "Monitor did not and does not take a comprehensive overview of the quality of service provision."

39. Stephen Hay of Monitor gave evidence on Day 92. It was put to him -- I'm sorry, this is quite a long question, but it's to inform you, as it were, so that you have the background.

40. He was asked:

41. "If the quality bar was lowered and nothing was put in place to effectively ensure that quality standards were met, can't that have only one impact?"

42. He said:

43. "Well, it meant that there was less headroom between what we had, which was three or two star hospitals and now in terms of quality care. Equally, I would say that they were meeting a minimum standard, which was fair, but that gave us less wriggle room."

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1 told us about what you thought Monitor themselves were doing. When you told us that you thought Monitor was 1 rather longer before you applied your signature? Would you have wanted to know more information from your officials?
2 going to be turning a trust upside down in quality terms, does that mean you thought they were going to go and ask the HCC about the trust, and, I don't know, get a report, or did you think they were going to be performing an independent evaluation of quality?
3 A. Well, it's up to Monitor to decide how to go about their job. Q. What did you think they were doing, I'm sorry?
4 10 A. If I can just -- just answer the question. Q. Can I come back to the question which I asked you approving and what it was not approving.
5 10 Q. Can I come back to the question which I asked you originally, which is: if you had in fact appreciated it had to have a very clear grip on what it was responsible for both. A clinical view, a financial view. And it had to form its own -- it had to decide how best to get the -- the -- the -- the clearest and most accurate judgment on both of those fronts. Because, if I can just finish on this point, when the trust would be through the process, according to the way it was through the process, after I had come back to find out that there was no real communication between HCC and Monitor about this trust, I did find astonishing, and I -- I found that hard to understand or -- or even believe, because it was very much part of the -- the process, that there would be a, "Can this trust operate itself independently, financially, while meeting core standards?" I mean, that is the -- that was the question that Monitor were -- were being asked to answer.
6 13 A. Of course. I mean, always as a minister you look back at things that you've done and you ask, "Could I, should I have done something differently?" I think you have to be realistic about what you can do as a minister. You've got to remember that the NHS is a -- is a huge organisation.
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21 Q. Can I come back to the question which I asked you originally, which is: if you had in fact appreciated that Monitor was not conducting its own independent assessment of the quality of a trust and was relying, in effect, upon the very broad-brush annual health check rating, would that have caused your pen to hover for a report, or did you think they were going to be performing an independent evaluation of quality?
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Merrill Legal Solutions
Day 115 Mid Staffordshire Inquiry 6 September 2011

1 for lunch, if people's patience will still wear it, can
2 we turn to one final document on this issue. That's
3 your exhibit 5, which is the information that the
4 applications committee had before coming to you with its
5 recommendation to support this trust.
6 If we could go to 558, please. Thank you.
7 This is the Department of Health's applicant
8 assessment, and I'm not going to go through every last
9 line of it. We know that when the diagnostic took place
10 back in December 2005 and the letter was sent in January
11 of 2006, we can see this at the bottom of the page, the
12 result was that this trust were told it needed more than
13 two years before it could become a foundation trust.
14 The reason being, as we can see in the right-hand box:
15 "No agreed and costed service strategy in place
16 although being developed. Lack of robust internal
17 controls in place to manage operations and finances to
18 ensure rapid and effective implementation of the plan."
19 That, I suppose, of itself might not have caused you
20 too much concern because it was a diagnostic that had
21 taken place a year and a half before your consideration.
22 But let's go over the page, please.
23 A. Just to say, I mean, I don't believe this document was
24 shared with me. This was shared with the application
25 committee.

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1 Q. I'm not suggesting for a moment it was shared with you.
2 But I presume you've seen this --
3 A. Of course, yes.
4 Q. -- since those events.
5 Then we can see that the quality of service and core
6 standards healthcare rating was fair/fair, which means,
7 as we've had described in this room many months ago,
8 a pass mark.
9 Then we see the SHA support the application. There
10 are no outstanding matters from the FT diagnostic
11 process:
12 "Regarding performance, based upon Monitor's
13 assessment framework, they scored amber as a result of
14 one missed target MRSA and three core standards
15 non-compliant (mandatory training, consent and emergency
16 planning). This is a significant improvement over last
17 year. Whilst the trust did not meet its MRSA target
18 they had an information from the Healthcare Commission
19 in January 2007, which was very positive regarding the
20 trust's adherence to the hygiene code."
21 You wouldn't know, but actually that hygiene visit
22 didn't mean that anybody went on to a ward or indeed
23 into the main body of the hospital itself.
24 Let's just look at the last few lines of this page:
25 "The trust has produced a good IBP [integrated

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1 business plan] based upon reasonably sound agreements
2 with its principal commissioner and the long-term
3 strategy is supportable. Unfortunately, the financial
4 requirements are lacking and the trust had to submit
5 a revised LTFM after the closing date following
6 extensive reworking based upon advice from the
7 Department's lead adviser. The HDD [historic due
8 diligence] also identifies significant improvements that
9 are necessary and taken together it adds up to a less
10 than convincing case that makes the application
difficult to support."
11 Do you wish you'd had that information when you were
12 considering this application?
13 A. Yes, of course. I mean, I didn't see that assessment --
14 Q. No.
15 A. -- at the time that the ministerial submission was put
16 to me. And the question is, of course, whether the
17 debate in the applications committee and this material
18 here was then accurately reflected in the submission
19 that came to me.
20 You were challenging me a moment ago about Monitor
21 and its potentially not sufficiently rigorous approach
to care standards. Well, the feeling was and is,
22 I think, that Monitor did a very forensic job when it
came to -- to finance and that if it was lacking there,

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1 that it quite simply wouldn't get through.
2 So obviously this was the note that was there to
3 inform the application committee's debate. I would have
4 to say that, you know, perhaps you would have to speak
5 to other members of the applications committee as to why
6 they eventually did recommend it to me for approval.
7 But the page you showed me a moment ago, obviously,
8 this -- this commentary here with the difficult to
9 support conclusion relates to finance, it seems to me
10 particularly. Obviously, over the page, the trust had
11 run a surplus, albeit a reasonably small one, although
12 increasing one, for the last three years.
13 So I -- I mean, yes -- I mean, I would -- you know,
14 I was somebody -- the reason why I put the full
15 submission to you with my writing on was to show to the
16 inquiry that I didn't just initial submissions and say,
17 "Fine, you know, it goes through, I just, you know,
ticked them off late at night while I was doing my box".
18 I didn't operate as a minister like that, I was quite
19 hands on as a minister, I read it in detail, I thought
20 about it, I put my comments in handwriting on the
21 outside of it.
22 If there was more information in that submission,
23 the more they gave me, the more likely it is I would
24 have asked questions about it. That was the kind of

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1 28 (Pages 109 to 112)
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<td>A. I don't know the full extent to which actions that the trust then took subsequent to this decision, or was it the actions that they had already taken which put it on this dangerous path towards the appalling care standards that we know about?</td>
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<td>&quot;On balance, recommendation to the applications committee.&quot;</td>
<td>I remain very puzzled why at local level there wasn't noise about this trust, why GPs were not raising concerns. I mean, I don't know how many GPs the inquiry's heard from, but I understand that there wasn't many -- much alarm being raised by the clinical community. You know, I would wonder why more was not said during the public consultation phase.</td>
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<td>And then below that, my understanding is that it incorporates everything above, as it were, so it's a balanced view of all of the information.</td>
<td>A. -- I think it's very -- it's impossible for me to say that. I would have welcomed a more rounded picture of exactly the considerations that they had had, perhaps if there was a marginal decision there in the committee, perhaps some reflection of that. I didn't get that.</td>
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<td>Obviously, the committee decided to support placing the caveat that they did, that, yes, there may be a challenge to the trust on finance. So, as I say, I can't answer for the committee, but I just have to say again that, you know, as a minister it's not possible to unpick every piece of advice that comes to you.</td>
<td>Q. Sorry to cut you off, there are all sorts of other aspects of the evidence that one might look at, but just focusing on what the applications committee knew before they provided you with the advice that they did, do you think now that in fact they were giving you the wrong advice?</td>
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<td>There was no mention of care -- care challenges or issues at the trust in the submission.</td>
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<td>The minister -- that was the way I went about my ministerial duties.</td>
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<td>A. Yes. You're right. I mean, obviously, that is overall -- overall advice, isn't it? It just talks about financial requirements lacking, trusts -- about submitting a revised LTFM. So it highlights finance as the major problem facing this trust and indeed that was then -- that was then flagged up in the submission, the ministerial submission to me. There was no mention of care -- care challenges or issues at the trust in the submission.</td>
<td>Q. But as a health minister, would you not have had an argument, you're not really making an informed decision, are you?</td>
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<td>Q. But, Mr Burnham, unless you're given the contrary argument, you're not really making an informed decision, are you?</td>
<td>A. Yes. And focusing on this one, the submission that I received went on to say that the rigour of the process that these trusts had been through should -- I paraphrase, but should be -- should give me more confidence in the quality of the ones that were going forward. They were the words that were used in recommending the two trusts that were given to me. Now, I -- you know, I hear what you -- you say, but ministers have to act on what is presented to them, which is official advice from public servants. It -- it seemed to me to be balanced, well-argued, reasoned advice, and they didn't present to me any reasons why I shouldn't accept their advice.</td>
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<td>A. No, I mean it was felt that Dr Foster were adding something that they were analysing publicly available information. As I said a moment ago, there was some debate about the extent to which people should rely on those figures for further investigation. I take your point that you might say, well, you know, shouldn't it be formally recorded if it was decided that they were valid things that were the most important things to be looking at? What I would say to you, that wasn't recognised at that time. It was gaining prominence as something that -- partly through the work of Dr Foster.</td>
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score was definitive proof that something was going wrong. It was -- it was a trigger for further investigation, and indeed that is how it was used by the Healthcare Commission. The reason I mentioned patient satisfaction was because I feel at times the NHS does focus on the process, rather than the human experience, and I think often the NHS can miss what it is to be a patient, how it is to be treated, how it is to be spoken to in a hospital. And I think it's very important that those things are -- are brought to the fore. But also, patient satisfaction would be an indirect proxy for also clinical standards and cleanliness and hygiene and all of those kind of issues.

THE CHAIRMAN: Appreciating all you say about patient surveys, but concentrating for an inappropriate on HSMR, if your understanding of the position would have been that a high HSMR was -- you couldn't say from that whether or not there was real cause for concern but it was a trigger for further investigation, then doesn't it follow logically that a high HSMR in the sense of being a demonstrable outlier should have been a trigger for investigation, and regardless of whether a trust was going for foundation trust status or not, should have been something that, if known to the Department, should have led to someone saying, "Why isn't this being investigated, or is it, and if what's being done about it?"

A. I think that's a reasonable question. But it was principally one for the regulator rather than the Department. That is the regulator's role, to analyse data that comes in from a whole range of sources, matches it up with other information it knows about the organisation, and then takes a rounded judgment on whether or not that organisation requires further investigation. I think for the Department always to be second-guessing the system in that way wouldn't -- wouldn't be right, I don't think. Because --

THE CHAIRMAN: Except that at the time we're now focusing on, Mid Staffordshire was not a foundation trust and, therefore, was the direct line responsibility of the National Health Service, ending up in offices not far from your own, and indeed we know that the strategic health authority was taking an interest in this. That being so, what's your comment on that aspect of it not being drawn to your attention in the context of approving this foundation trust application?

A. It would be that any data of this kind wasn't routinely drawn to the attention of ministers at that time, so the question is: should it have been? It was still seen as experiment-- "experimental" might be the wrong word, but new and contested. It wasn't seen as a -- you know, a very established measure of clinical standards and safety. It was developing, and I think there was a growing currency around that data, but it wasn't yet at that point.

And the answer would be that it was acted upon insufficient -- you know, very badly, it would seem, in that the trust concerned challenged the coding and the way in which -- tried to present -- say it was all an issue of coding. But there was action taken on the numbers. You know, I think there was action within the trust, the PCT/SHA commissioned Birmingham University. So that process of inquiry had begun, triggered by the -- the -- the score -- the large score, and then subsequently followed up by the Healthcare Commission on -- when alerts came in on a service-by-service basis.

So the system began to pick it up. Did that happen quickly enough, or was that given sufficient prominence? I think it probably didn't happen quickly enough. Certainly the local inquiry into the issue doesn't seem to have been satisfactory. Certainly the trust's wasn't. To claim it was all coding seems to be a convenient way of explaining it away.

Should it have been more quickly picked up by the national regulator and then indeed flagged up to the Department? I think that's a bit -- it's a big leap to say that, because this data I think only came out in April 2007, and it -- in an organisation the size and scale of the NHS I don't think at that point it would have leapt immediately up to the national -- to the national level.

There is a question as whether -- should it have done, but I think it's just recognising where the -- where this whole business of the -- of the analysis of data was up at the time and it wasn't as sophisticated as it -- as it now is today.

THE CHAIRMAN: Well, if my memory serves me correctly, the figures have been published in the Daily Telegraph, which might not have been everyday reading for every minister, I suppose, but it might have been everyday reading for your communications department and, therefore, one would wonder slightly whether a league table, whatever criticism could be made of it, wouldn't find its way to interest ministers, if only in the sense that the public might begin to ask you about it.

A. Of course it did. You know, we -- we were aware of the growing prominence that the data was acquiring, we were interested in it. I think there was various pieces of work under way in the Department to look at it, to -- to -- to be more confident about whether or not the...
| Page 125 | With the trust receiving a fair/fair rating in the AHC, marginal financially on the information your civil servants had, difficult to support on that information, they thought, and being one of the ten worst performing trusts in the country on the Foster figures, which, as you rightly say, should be a trigger at least for investigation, isn't it difficult to accept what you say at the end of paragraph 66 -- and can I just read it to you to save you leaving through:

"Therefore, by the time I received the submission [you say], I would have known that any trust I was being advised to support were considered to be high performers, who could handle financial autonomy and everything that FT status brings."

Now, are you telling us that in the light of that background you would still say that this trust could be considered as a high performer?

A. Well, it wasn't the considered view of the Department the trust was difficult to support. The team had put that paper to the applications committee, but clearly the applications committee hadn't accepted that advice, and the Department's view became that it was possible to support with the caveats they placed in terms of the marginality of their -- of their financial case.

But there is a broader picture, isn't there? This trust itself had to decide to go forward. It had to ultimately had to decide: could it stand on its own two feet financially? And clearly, they had decided that they could, hence their decision to go forward.

Now, the PCT clearly had concerns about that decision, and I think the implication of what you've just read out is that they were putting a marker down with the SHA to say that if the organisation gets into trouble, "don't expect all of the bailout to come from us".

Q. Right.

A. So they were, if you like, putting the ball into the SHA's court to say, you know, "Are you absolutely sure that this organisation has a sound business case?"

I would say again, the context would be here that the organisation had run a surplus, a small one, but a surplus nonetheless, in those three years before it was considered, when many organisations in the NHS were -- were severely financially challenged at that point.

Q. I just want to explore what your signature on the document actually meant. Could we go, please, to JH26?

This is ex post facto, as it were, in relation to your document.

It's an email dated 20 April 2009 when, in light of the HCC's report, this decision was being, as

| Page 126 | Page 127 |
1 I understand it, reviewed.
2 The writer says:
3 "Dear all ..."
4 And this is an internal Department of Health email.
5 And it's headed "Briefing for Ben Bradshaw meeting":
6 "The Act is silent on what [Secretary of State]
7 support means or on what it should be based. Are we
8 looking at something like saying that in considering
9 whether to support an FT application, SOS should consult
10 with the regulator, this would be consistent
11 with the recommendations in the paper."
12 Now, I only mention that because it does raise the
13 issue of what Secretary of State support really did mean
14 and what you thought you were doing other than simply
15 handing this on to another regulator.
16 A. I mean, this email relates to a time when I wasn't
17 in the Department, so it's hard to know what it -- what
document it's commenting on.
18 Q. You're right, but the question is raises is the same
19 one you have asked yourself.
20 A. Yes, so I go back to what I said earlier in the day.
21 When I accepted the advice put to me by the applications
22 committee to allow the trust to go forward, I -- it was
23 simply that and no more. I was essentially saying, as
24 the minister, the effect of my decision that no reason
25 can you be asking trusts to get a grip on infection when
26 many of them are facing, you know, financial
27 challenges?"
28 Well, the answer to that was the best quality care
29 is the most cost-effective care. If you are not having
30 long length of stay of patients because they are
31 acquiring hospital-acquired infections, or if they're
32 not being readmitted subsequently because of poor care,
33 you know -- you know, that is the way to lose control of
34 your finances. If you're delivering poor quality care, you
35 will often find that those are the most financially
36 challenged organisations.
37 So it's not the case to say that the Department's
38 language at the time was, you know, overly focused on
39 finance to the exclusion of quality. It would often
40 make the argument that safe and effective care is also
41 cost-effective care.
42 Q. In light of that, could we just look at a note created
44 This is addressed to MS(H), Minister of State for
45 Health, which was not you at this time, was it?
46 A. No. It's about two or three weeks before I came --
47 Q. Yes. Because you came in on 5 June. But I think it is
48 worth looking at this note, and it is the foundation of
49 the question that I've just asked you:
50 "At our meeting on 27 April, we discussed options
51 [he writes] to strengthen the quality assurance of FT
52 applicants. You also asked for a paper to consider the
53 tension between the drive to achieve NHS FT status for
54 all trusts, and the increasing pressures facing FT
55 applicants due to the financial climate and renewed
56 emphasis on quality. This submission outlines the
57 quality measure, which will be used for the Department
58 of Health applications committee in reviewing future FT
59 applicants."
60 Over the page, please. Heading, "Effect on flow of
61 applicants":
62 "The FT trajectory has slowed for three main
63 reasons. (a) greater focus on quality, which has been
64 formalised as a result of the fallout from
65 Mid Staffordshire NHS FT."
66 And then if we go to 10, focusing on quality, but
67 obviously you can look at the whole document if you'd
68 like to:
69 "Renewed focus on quality (and more exacting
70 financial standards) is likely to compromise our ability
71 to deliver the NSR recommendation to accelerate the flow
72 of FT applicants."
73 And then the very last line of that paragraph:
74 "Secretary of State has recently indicated that
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<td>So really, that was the premise for my question,</td>
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<td>that in fact there had been, perhaps, a loss of focus</td>
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I was taken aback by what they told me, they were just so condemnatory of the current culture within the trust that I left and immediately picked up the phone and asked my office to instigate some action. So I include those examples and I include the Mike O'Brien example just to say that where we have information, as ministers, where something happens that people bring us information that gives us cause for concern, we do act, and the public interest is in our mind. I think, you know, frustration for us sometimes is that the media expectation is we're not like that, that, you know, to use Barbara Young's phrase, The Thick of It caricature is that we're all just kind of being run rings round by these sort of -- and it's all just being nodded through. Well, it's not like that, and, you know, we can't go out delving down into every -- the NHS is too vast and too large for -- for that, but where we do know of a problem we should intervene, and I think those two are relevant examples of where ministers take initiative on their own to -- to challenge the Department.

Q. Can I move on to the time when the Healthcare Commission investigation report is published. Three months later, you come into your post, and so you, in effect, had to deal with the aftermath of this pretty explosive report.

A. Of course.

Q. Bill Moyes of Monitor -- and I appreciate you may have had your disagreements with him, but this is part of his evidence, that he gave us on Day 93: "The politicians, Andy Burnham and Mike O'Brien, Alan Johnson before them, had taken on a degree of accountability that wasn't really there, but in reality they were behaving as if they were accountable. But as they then discovered, they didn't have any statutory basis for that accountability. There was no action that they could be seen to take. We were in the fervent atmosphere of the pre-election and that was not irrelevant, and they were desperate to be seen to be doing something."

Is that an exaggeration of the position?

A. I think it's an unfair description of the position. I came into the Department in June 2009, and I was disappointed, to say the least, to discover that this trust still had interim leadership, an interim chief executive and interim chair. And I didn't believe that three months or so after the Healthcare Commission report that that was an acceptable state of affairs.

Q. What, you felt they should have been able to find

A. Without senior management present, which I did. And...
a permanent chief exec immediately?
A. Correct.
Q. How do they do that? Martin Yeates stands aside, where are they going to conjure up a permanent chief executive immediately?
A. There are hundreds of chief executives or senior level managers across the National Health Service, or indeed across health services more generally, some of whom who have extensive experience of turning round failing organisations and dealing with the complex range of -- of public confidence issues and media issues that that entails.

And I say again, I -- I was disappointed to find that -- that permanent leadership had not been put in place at the trust. So it wasn't a case of being seen to be doing something, I did something, I asked the NHS chief executive to find for me people who would go into that trust and who were the best people we could find to go into that trust. And he did.

Q. You saw hand back as the way through for this trust, didn't you?
A. Deauthorisation, you mean?
Q. Yes, deauthorisation, take it back under the control of the SHA and, therefore, the direct responsibility of the Department; is that fair?
A. I did, because I believe that you can't have a system that only deals with improving organisations, you have to have a regime that deals with an organisation that goes the other way. And that's why I announced, it probably would have been six weeks after coming in as health secretary, that I wanted to amend the bill that was then before Parliament to introduce a deauthorisation clause into that bill.

I did discuss it with the incoming chief executive and chair of that trust, that that was my intention, and we asked them whether they felt that would be something that the trust would want, and subsequently a letter was sent from the chair, Sir Stephen Moss, saying that the trust board had considered it and wanted to be deauthorised so that it could -- could receive more support in -- in improving the state of the organisation.

Q. I'm just trying to find it, but that was quite a lot later, wasn't it? I think that was in March of 2010 that letter --
A. I think it was after the first independent inquiry where, indeed, one of the conclusions of that was to both have a power of deauthorisation and for Mid Staffordshire to be considered for deauthorisation.

THE CHAIRMAN: When you initially came in and you wanted to have extensive experience of turning round failing organisations and dealing with the complex range of -- of public confidence issues and media issues that that entails.

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<td>Q. This, I suppose, comes down to the fundamental issue, which you have discussed before lunch, as to whether we should have or you should be aiming for an entirely foundation trust system or whether it has to be a two-way event, and no doubt there are a number of politicians who agree with you and a number who disagree with you.</td>
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<td>A. I think that's true, yes. I mean, my system would be that if a trust was a foundation trust and it was deauthorised, the expectation would be at the earliest opportunity you would get it back into foundation trust status, but there will be occasions where it will call for more rigorous intervention because, and I think this perhaps might be a flaw in the way the system was created, at local level -- if an organisation is failing, at local level all the expertise doesn't exist about where the best chief executives are to bring in quickly. You know, people don't have all of that knowledge at local level. So there still is an important role either for the Department or Monitor in supporting trusts in that position.</td>
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<td>Q. But does the real issue -- ignoring whether you've got a power of deauthorisation or not, the purpose of deauthorisation is to get the trust back under DH direct control. But if you have a system where the trust, whether it's a foundation trust or a non-foundation trust, is going to be effectively performance managed, why does it matter under whose control it is? If Monitor were able to effect appropriate performance management, doesn't that solve the problem?</td>
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<td>A. I think it would, but that's the question, isn't it, if? And my judgment when I came back to the Department was that they weren't. And so the question is: what do you do in that situation?</td>
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<td>Q. I'm going to look at that in a moment, but just on the issue of performance management, I think the House of Commons Select Committee Patient Safety Report, published in June 2009, came to this conclusion. We can put it on the screen if we need to. I think it's either 01 or OI. OI0002000548.</td>
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<td>If we just go to the very last paragraph, they say: &quot;We are also concerned about Monitor's role in regulating foundation trusts following authorisation. We are told that Monitor does not re-indicate the performance management role played by SHAs in respect of trusts, but it is unclear by exactly which means foundation trusts are intended to be performance managed or whether they are supposed to be performance managed at all. In Monitor's defence, it could be said that too many SHAs have also done no effective performance management.&quot;</td>
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<td>Well, perhaps as the ex-secretary of state you could answer that question for us. Who does performance manage foundation trusts?</td>
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<td>A. Monitor. It should have been Monitor. I mean, that was their role, and indeed it was a role they quite fiercely protected. If the Department contacted trusts directly, it often didn't take particularly kindly to that.</td>
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<td>My reading of what happened here, though, was that Monitor, itself a relatively new organisation, found itself overwhelmed by the situation it was in, and wasn't able quickly enough to put in place the measures needed to get the trust moving in the right direction and hence the need to speed that up.</td>
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<td>I mean, as I say -- I mean, you know, everybody needs to look back and accept what could have been done better, could have been done differently, and Monitor had a huge amount of work to do at the time, it had very clear focus on authorisation and perhaps less on performance management. But I think this did expose some shortcomings in how it was monitoring trusts after they'd been authorised, and that's partly because there was no deauthorisation clause.</td>
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<td>In a sense, the job was done, you know, there was nothing else that could happen. And, you know, that's why I felt it was right to rebalance the whole system by saying, &quot;No, trusts should come in -- should be able to come out as well as go in&quot;, and to my surprise, Monitor didn't support that recommendation when I put it forward.</td>
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Q. In terms of the recommendations for chief executives, and, if I may say so, and I don't mean this discourteously to you, you may have glossed over some of the tension, I think, that there was between Monitor and the Department of Health. If we could have a look at an email, it's WM98, WS0000040357.

If we could look at the bottom half first, this is Ed Lavelle. It's an internal email going to Bill Moyes, among others.

If we look at the very last paragraph, he writes as follows, and the date is 9 July, so it's right in the middle of this discussion about who should be appointed:

"I am speaking to David Flory again in the morning. When we spoke today, he said that some calls were being made to chairs today and he would have a name of one which 'they would expect Monitor to appoint'. They also expected to have some names of potential CEOs who they would look to put into some sort of process ..."  

Is that how the system was working? Monitor had to appoint the chair and CEO, but you in the Department of Health were going to tell them who it was?

A. Yes, I mean, I'd never seen this before, but that pretty much, I think, is a good summary of where we had got to with them.

You will see the final sentence on that page says, "You will see the final sentence on that page says,"

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Q. -- when this hits your desk. It's quite a long note, which I'm obviously not going to go through, discussing the difficulties and the benefits of foundation trust status.

Could we go, please, to page 3663 -- sorry, on the DH pages, 0233. If we look at the top paragraph:

"Recent events at Mid Staffs highlighted the nature of the relationship between the regulator and the Department of Health and have provided grist to opponents of the FT model. Questions were asked as to how trusts could have been authorised as an FT when an investigation into patient safety was about to be launched and Monitor has since revised its processes. On the sensitive issue of disciplinary action against the outgoing chief executive, the FT made its own decision in close consultation with Monitor and"

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announced that the CEO had been allowed to resign with all his contractual entitlements despite ministerial concerns about the wider public interest."

Can we just focus on that issue for a moment. We've heard frequently in this inquiry about how senior members of the NHS very rarely lose their jobs, they might get shifted sideways, they often get shifted upwards, but the nuclear button, as it were, of the CEO losing his or her job and not being rewarded for failure is very rarely pressed. Why is that?

A. I don't know. And I think it was a very real weakness -- has been a very real weakness in the NHS.

And the first -- the chairman's first independent inquiry that I commissioned recommended some big changes in this area, that, you know, you could have a hospital board where the medical director can be struck off by the GMC, where the nursing director can be struck off by the NMC, but the NHS managers around that table don't live with any such ultimate accountability.

For me, you know, why had that never been properly addressed over the years? I must say I really don't know. To have a proper, you know -- at a senior level in an organisation, a manager is capable of causing real damage to patient care. And it seems though that the regulatory system, as it applies to senior professionals..."
in the health service, doesn't adequately reflect that. So I accepted that recommendation in the first independent inquiry because, quite frankly, it's well and truly overdue. I think it owes itself -- it owes itself to a world, doesn't it, where people were moved around from trust to trust and, you know, people perhaps were always on a kind of certain career path and, you know, they were moved to one trust, moved to another, where there wasn't sufficient accountability, I think, of of performance. But when you're living in a world when you want to judge individual organisations on their own performance, it follows that you have to have the nuclear button, as you describe it, of anybody in a position of seniority in an organisation who has the potential to cause harm to patients should be subject to a stringent professional -- a professional regulatory regime that would include disqualification from serving in the health service.

Q. And at the time that you were Secretary of State, did you think to have a consultation or at least discussions within the Department of Health as to what practically could be done to bring that about?

A. I did. I mean, on the back of the first -- the first inquiry, I was minded immediately to accept that recommendation. We held a discussion within the Department. I don't remember any serious disagreement amongst the senior management team in the Department. I think there was a general recognition that this reform was overdue. I think, to be fair to the Department, it had been through a whole period when professional regulation of the -- of the clinical professions was -- was in the fore, you know, was the issue. Post-Shipman, that was the big issue. And certainly as a junior minister, that consumed probably as -- more of my time than any other single issue, when I was MS(DQ), to use the -- the jargon, you know, we were reforming the GMC. We were reforming all of the professional regulators. We were reforming death certification. And that point I don't think it had ever been -- you know, we were dealing with those issues first, but really it should have been quite clear that we were going to come on to managerial -- you know, regulation of NHS managers, and probably it should have been put in train much earlier than it was, but the -- the Chairman's recommendation certainly was enough for me.

Q. But at the end of the day, in fact that is still the position, (a) you can't deauthorise foundation trusts --

I'm sorry, you're not in government any more. The government, the Department can't deauthorise foundation trusts, that's still not in place. And there's still no power to dismiss chief executives without pay, without going through the usual employment difficulties that that will attract.

A. Personally -- and I'm not making a political point -- I'm surprised that the government hasn't continued some of the things that I put in place. Deauthorisation, it seems to me, is just a sensible step to take because it means that all organisations constantly have to have an eye to their performance, and that they need to know they can lose the freedoms they've gained if that performance isn't good enough.

So I -- in some ways, the government -- current government are back to a position that we were in after we passed the original foundation trust legislation that we should just work to a very quick timetable to make everybody FTs. It doesn't seem to have the nuances that we -- you know, they seem to have got rid again of the nuances that we had brought in, learning from what happened at Mid Staffordshire and -- and the original Francis inquiry. Because -- I don't know where they're up to with the regulation of managers, but it would disappoint me greatly if that's on the back-burner. I think it's a tremendously important reform and it needs to happen.
Q. And you talk also about the skill-mix review, which was part of that headcount issue. You say that the skill-mix review should have picked up that staffing levels was an issue. Well, the skill-mix review was actually an answer, in one sense, to the staffing issues, it did pick up that problem, and that's why it was instituted, but not until after the foundation trust status was obtained, after which they started recruiting urgently.

But do you think that the regulator or the Department were capable of examining staffing levels?

A. I don't think that is realistic or right. We had been through a period, a year or two before, where trusts were making large numbers of redundancies and, you know, there was political pressure at the time, people saying, "We're making so many nurses redundant, can't ministers jump in and stop this?" And I just think it would be completely to go against the grain of what was trying to be achieved if we were trying to tell every organisation in the NHS how many physiotherapists it should employ, how many nurses it should employ. You know -- I mean, that just would not be -- you know, it is for local decision where organisations decide to put their -- their -- their money into -- into staff.

I mean, when I received the Chairman's first inquiry, that figure, it was shocking obviously on many, many levels, but that figure leapt out at me, you know, that the trust was short of 120 whole-time equivalents. I just found that almost unbelievable. And to me, that -- when you said we started to establish where -- where things had really gone wrong, I felt it was in that -- in that statistic you could see a lot of the -- the problem, that they just didn't have acceptable workforce to -- to deal with the pressures that were upon the trust.

And, as you say, independent -- a new -- I think a new nursing director came into the trust and review was commissioned, but as you rightly say, it appears that sufficient action wasn't taken upon the findings of that review.

Q. I think it took a long time for that to resolve itself, if it ever did.

Could I ask you to look at another exhibit, please, and I'm sorry, but I'm going back to an issue that we have already discussed, which is the question of step-in rights, but it's a document I should have shown you before. It's WM96, Options for Further Action.

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Q. Following our recent meetings on Mid Staffs, MSH asked for careful consideration to be given to a package of five measures with a view to an announcement before Parliament rises on 21 July.

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A. Yes.
say the system we had put in place was tested severely
by what we had been through and -- I mean, I can't make
any bones about it. I mean, I was clear that it was not
acceptable, that the situation I was being presented
with was not good enough, you know, that we had to have
quick change at the trust so that it could move on.
You see, at the time, the call that -- you know,
I was -- I'd inherited and was discussing with the MPs
affected, with the chair of the Health Select Committee,
who had recently done a report, was an inquiry. I mean,
the call was for a public inquiry, but the select
committee had called for an independent inquiry.
I think the RCN had called for an independent inquiry.
So that was the main thing that I was-- the call
that I was facing when I came into this job in this
period. But I knew that, I felt that my -- prior to all
of that, my primary goal was to get in place good
leadership at the trust because, without that, if we'd
had a public inquiry without having shored things up
at the trust, I felt that that could have had a very,
very dangerous and damaging effect on the quality of
local healthcare services if we'd left the trust in
a fairly fragile position and a new form of inquiry had
begun that potentially was going to put real stress on
relationships and the operational capacity of the trust.

Q. You say this was a one-off, but can I just mention
Basildon and Thurrock to you. In July of 2009 they were
written to with a list of concerns. There were various
meetings with the SHA, et cetera. And then a report was
published, part of which appears -- I think it wasn't
leaked to the press, there was a press release, and in
a letter to you from Barbara Young dated
2 December 2009, and it's exhibit BY10 -- perhaps just
to be fair to you, it's probably easier if you have it
in front of you rather than me read it out. It's
O100070000001.
It is just to test this contention of yours that

Stafford, as it were, and the Department's behaviour was
a one-off. You were very concerned, weren't you, by the
nature of the press release? And you complained, didn't
you, about the use of what was termed "florid material
and graphic language"? Do you remember this discussion
with Baroness Young?
A. I remember a discussion with her about Basildon NHS
Trust, and my concern -- there were probably more than
one discussion about it. My concern about it was that
there was seemingly a press release or press statement
made about the hospital before any prior notification
had been given to the Department, and our concern was
that it put into the public domain, without warning,
some fairly dire warnings about the state of the
hospital without officials in the Department ever really
having got to the bottom of what was going on.
I think that's what's being referred to. I might be
wrong.
Q. Just to be fair to the CQC, they'd say that they did
actually alert the Department but there were officials
in the Department who didn't let you know and they say
that there was a lack of information within the
Department.
What Baroness Young told us was this, because she
resigned the day of the press release. Do you remember

So I would just want to encourage you to see things
in the round. I mean, I inherited a difficult set of --
difficult set of issues where the relationship with
Monitor had deteriorated in my time away from the
Department. I took the view that Monitor hadn't got
a grip of this situation. And, yes, you might say that
this was the NHS reverting to its old, old style command
and control roots. And I would probably answer you by
saying, yes, it was, but it was only in respect of this
one organisation. You know, there were many others that
were now existing quite -- quite successfully as
foundation trusts and there were many other
organisations doing quite well.

Q. You say this was a one-off, but can I just mention
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with government, accountable to government, but
responsible really to the public, with less resource to
discharge effectively, and services being more at risk
... to be honest, the whole thing was getting so
fraught, in terms of the role of the regulator and how
we were regarded, and having now been a regulator in
three different departments, three different government
departments ... the relationship with the health
department was by far the worst by an order of
magnitude. And I didn't see any way that it was going
to resolve itself. So despite the fact that I'm not
a quitter, I quit."

And she told us that she resolved never to work for
government, any government, again.

Do you take some responsibility for that?

A. No, I don't. I'm afraid, because at that time I was told
that there had been a breakdown in relations between CQC
and Monitor, that even within the CQC there'd been
various breakdowns in relations. I think it is my job
as a minister to hold those regulators to account for
the public. I cannot sit back and just say to any
regulator they are absolutely free to do whatever they
like. It has to be within a context of agreement and
mutual support, because when you're dealing with health
services, they are interdependent, there's not -- if you
government criticism is actually misplaced, to be
honest, because in this case, particularly in relation
to Basildon, there was a reputational issue at stake for
the regulator itself because, you know, the annual
health check had been done and then all of a sudden this
new information was about to be put into the public
domain, which seemingly contradicted that, and it
appeared that Dr Foster were about to make public
information that the regulator hadn't picked up or
wasn't aware of. So in these situations it was often
a case of intervening to ensure that there was public
confidence both in the regulator and in the safety of
services more generally.

And, you know, I can never get away from the fact
that, you know, whenever one of these stories landed,
if -- if -- if any regulator put a trust name into the
public domain, it would be ministers in Parliament or on
the media who were immediately asked to account for the
safety of services at that particular hospital. And,
you know, to be able to do that you have to have
absolute clarity and -- and a detailed understanding of
what the regulator is saying.

Q. And you don't think that even if you let go of the
reins, as it were, completely, and you really did ensure
that regulators were entirely independent, both Monitor
and the CQC, you still don't think that that would save
the government, as it were, from criticism when things
go wrong?

A. I don't think it's -- I mean, I think the point about
the National Health Service, and to be accountable to
the minister, who's therefore vulnerable in those
circumstances, makes for a difficulty of regulation?

A. I think that's a fair point. But it was a relationship
that was very well managed. The tension was managed
with other organisations, an example being NICE, who
often said things that were difficult to handle, in
terms of the public debate, treatments denied, things
like that. But at all times, at all times as
a minister, I completely respected the independence of
NICE and never sought to overturn one of their
decisions.

I think in this case, when I came back as
Secretary of State, concerns had begun to be aired about
how the CQC was doing its job and how Monitor had been
doing its job and how they had both been working
together, and I inherited quite a difficult set of
relationships on that front, where it would appear to me
there wasn't proper communication between the two and
where there had been relationship issues in terms of
people not talking to each other, communicating
properly. And the question is in that situation: what

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1 do you do as a minister? and it's not about managing
2 news because, as i said, the news comes out, it's not
3 about that. people always want to say it's about that,
4 it's not about that.
5 the question is: what do you do? do you just allow
6 regulators to fall out and perhaps lose their focus, or
7 ultimately, do you think, well, i have got ultimate
8 responsibility for the quality and safety of healthcare
9 services in this country, as i believed i did have as
10 secretary of state, and then take the action necessary
11 to uphold that responsibility? so that -- i think
12 i inherited quite a difficult situation that had --
13 because of what had gone before and the way in which
14 these organisations had been tested, and as best
15 i could, i tried to find a way through it.
16 the chairman: does that suggest, on one view, that you were
17 provided with too many regulators?
18 a. possibly. i did think very carefully about whether or
19 not it was right to bring monitor and cqc into one
20 organisation and, in fact, that was an unresolved issue
21 in my mind at the time of the general election. faced
22 with what was coming, i think with any government there
23 was going to have to be change and savings made on the
24 costs of -- of government arm's length
25 organisations. inevitably those questions started to

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1 arise. and i think there was a good argument to say
2 that they probably should have been brought together
3 into a single organisation. but i would not want to say
4 that i'd reached a firm conclusion about that.
5 i would -- just wanted to be upfront with you and say
6 that that was certainly something that i had begun to
7 give quite serious thought to.
8 the chairman: thank you.
9 mr kark: i wonder if that's a convenient moment.
10 the chairman: i think it is.
11 mr kark: can i just say on the record i'm very close to
12 finishing and i would welcome the approach of any cp's
13 who were still interested in me asking further
14 questions.
15 the chairman: in that case, we will take 20 minutes rather
16 than 15.
17 (3.35 pm)
18 (a short break)
19 (3.55 pm)
20 the chairman: are we on a final lap, mr kark?
21 mr kark: we are, and i hope it's going to be slightly
22 shorter than the previous lapse.
23 the chairman: never believe anything a barrister says about
24 time.
25 mr kark: mr burnham, i wanted to turn very briefly to the

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1 cqc. we've looked already, of course, at the
2 resignation of baroness young, but the budget of the cqc
3 was set prior to its coming into existence, and we know
4 that it had to deliver its role at a substantially
5 reduced budget.
6 i'm not going to ask you about the details of that
7 because, again, you were not minister at the time
8 responsible, but did you ever form a view as to the
9 necessity for physical inspections as part of an
10 effective regulatory system?
11 a. yes, i thought they were a very important part of an
12 effective system. we've mentioned basildon today, not
13 long after that members of parliament in the tameside
14 area brought to me concerns about their trust. and,
15 again, it shows how mps cannot divorce themselves from
16 these issues. even though tameside was
17 a foundation trust, concerns were brought to me about
18 standards at the trust. so i asked for there to be an
19 unannounced inspection of -- of that trust on the back
20 of concerns brought. so i was always very clear that i
21 think they play a very important part in a -- in a range
22 of measures that any regulator has at its disposal, and
23 i think, you know, i would certainly expect them to
24 continue.
25 q. one significant issue in relation to the cqc, which came

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1 out of the evidence relatively recently, is that the
2 health and safety executive and the cqc have still not
3 come to any form of sensible agreement in relation to
4 which of those two bodies should investigate accidents
5 or failures in hospital leading to patient deaths.
6 is that an issue, first of all, of which you were aware
7 and, if you were aware of it, should you not have
8 grappled with it?
9 a. i became aware of it because i believe it was an issue
10 which cure the nhs raised with the department in respect
11 of mid staffordshire. and then in the case of basildon,
12 i hope my memory serves me well, in saying that
13 i believe there was an outbreak of legionnaire's disease
14 at the hospital that was linked to cooling or air
15 conditioning machinery or something. and, again, that
16 had brought into focus this issue about the divide
17 between the cqc on the one hand and the health and
18 safety executive on the other. so i'd certainly looked
19 into the issue. whether i -- i mean, obviously not from
20 what you say, has it been -- did i satisfactorily
21 resolve it or has it yet been satisfactorily resolved.
22 q. who should be knocking those two heads together,
23 rhetorically, perhaps? whose role is it to say to such
24 august bodies, "look, you've got to get this sorted out
25 within a limited timeframe"? should that come down from

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1. the Department of Health?

2. A. The way an issue like that would normally be resolved
3. would be via the two relevant ministers, probably
4. cabinet ministers. So obviously the Health and Safety
5. Executive reports directly to Work and Pensions,
6. I think, or maybe BIS, I think it's Work and Pensions,
7. and obviously that would have to be some agreement
8. reached where the two ministers concerned probably would
9. have to reach that agreement rather than probably the
10. two organisations.
11. But it is quite clear to me that there are elements
12. of what goes on on a large and complicated hospital site
13. that would be better inspected by the Health and Safety
14. Executive, issues to do with maintenance of plant and
15. machinery and building safety. So, yes, I mean, that
16. seems to me as something that has to be resolved.

17. Q. You just mentioned it as being an issue that Cure raised
18. with you, and I think Cure wrote to you back
19. in June 2009 and you received something like 100 letters
20. from patients and relatives. Did you read those
21. letters?
22. A. I read some of those letters, and I devoted a lot of my
23. time to this whole issue. I wouldn't want to say to you
24. today that I read all of those letters. The difficult
25. thing at times about being a minister is that the

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1. Department tends to shield direct enquiries from the
2. public to ministers, either they be by correspondence or
3. by phone. I mean, they try and erect something of a --
4. of a wall around ministers. But I do remember the MPs
5. concerned raising individual cases with me that I then
6. looked at, particularly David Kidney at the time and
7. then -- and Bill Cash. So, yes, I did look at some of
8. the letters that were sent to me.
9. Q. You were not an advocate of holding a public inquiry,
10. and obviously I hope we are proving that you were wrong
11. in that view. Was that purely because of the political
12. fallout that would ensue?
13. A. Not at all. I mean, I hope you'll permit me a moment
14. just to -- to explain this -- this in detail. I came
15. into -- into the Department when there was a -- this
16. issue was a very live issue and there was a clear call
17. being made for a public inquiry. Although others were
18. saying there should be an independent inquiry, the
19. Health Select Committee perhaps most notable amongst
20. them, the RCN as well. And I was clear when I came into
21. the Department that there needed to be a further process
22. of inquiry, that while the George Alberti and
23. Dr David Colin-Thome reports had been helpful, they were
24. by no means the end story, that such was the
25. enormity of the failure and such was the sheer awfulness

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1. of what people had suffered and been through, that that
2. wasn't and couldn't be it, and there had to be a further
3. process of really understanding how this happened.
4. So I was clear that there needed to be a further
5. process of inquiry. What I hadn't resolved in my mind
6. was how best to do that, reconciling it with my
7. overriding objective to improve healthcare in
8. Staffordshire as quickly as possible.
9. Now, I believed that to be the most immediate
10. priority that I had. That was the main responsibility
11. I had to the public here, was that they'd had a hospital
12. that had gone through a complete and utter crisis and
13. breakdown. Public confidence in local healthcare
14. services clearly would have been severely damaged by
15. that, and that my immediate job was to improve services
16. now and begin to restore trust in healthcare services.
17. I had to reconcile that with my recognition that there
18. needed to be a further process of inquiry.
19. Now, the judgment I reached was that there should be
20. a further process of inquiry, that that should be an
21. inquiry under the NHS Act. But as I said to the then
22. chairman, "Now your chairman of this inquiry, that
23. should further powers be needed to compel people to
24. appear, that they should be asked for and they would be
25. given".

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1. I remember having some discussion -- I shouldn't
2. really be talking about the Chairman with him sitting in
3. front.
4. THE CHAIRMAN: I'm listening.
5. A. But talk about whether or not, if that was in public,
6. would that be helpful or unhelpful in terms of helping
7. people come forward and tell their story both in terms
8. of public and staff. And, again, there was a debate to
9. be had about that. But I remember very well the words
10. in the first report, whereby the Chairman felt that more
11. people had been able to come forward and tell their
12. story frankly because of the nature of the inquiry that
13. was created.
14. Now, in my judgment, to conduct that first stage
15. in that way, I think still was the right thing to do
16. because I believe a full public inquiry at that point
17. could have put huge pressure on the trust, it could have
18. distracted the trust from its main job, and it could
19. have made improving services more difficult.
20. Now, I know people will not agree with that view,
21. but what I want to get over to you, Mr Kark, and to the
22. inquiry is that that wasn't, you know, me going with the
23. line, if you like, the departmental line. If you read
24. a submission from David Flory to me, which I think comes
25. after the Mike O'Brien note, where I think a meeting had

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A. Yes, of course. I mean, at the first stage it was very much that it would be the stories of patients affected and their families, it would be a chance for that to be told in -- in detail, and essentially looking at what went wrong at a local level. But I can remember, I think -- I wouldn't want to misquote one of our conversations, but speaking to the Chairman about what would come after and that there would have to be a process of looking at the other bodies involved at
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a more regional, national level. And I was always clear that that also would have to -- would have to follow.

Q. How did you see that taking place? By a public inquiry or by some other method?

A. Well, when we announced -- when the report was published and the -- the -- the statement was made to Parliament, I made a statement in February 2010, I said that we were accepting all of the recommendations that -- that -- I think I said then that my expectation would be that Robert Francis QC would chair the second-stage inquiry.

I don't have the Hansard to hand, but -- and that would then look at the role of regulatory bodies.

Now, there remains the question of, you know, what kind of inquiry? Would that be a full public inquiry?

Would that be an inquiry under the NHS Act? I mean.

I was always quite clear that if in the Chairman's view sufficient powers weren't in place to get to the bottom of what happened, why it happened and to put all the relevant information in the public domain, that those powers should be asked for and would be given.

And I took the view that that was the best way to handle it.

And I would come back to the argument that if we'd gone straight to a full public inquiry in the middle of 2009, I don't think I could say now that that wouldn't have distracted the trust from its main job of improving standards immediately.

Q. Can I just ask --

A. Can I just say a very last thing on that point. For one of the reasons being that the very nature of it -- if individual local members of staff were coming to a setting like this, you know, putting one person against another within the trust and in a public forum, I was quite clear in my mind that that wasn't going (a) to help get to the bottom of the story, and (b) potentially would distract the trust.

Now, I can only say that they were my reasons, but I can also point to the fact that I was being asked to have no inquiry at all, and in the end I went with the recommendation that was being put forward by the Health Select Committee, and I think one of the MPs at least locally had called for something similar.

Q. When this sort of disaster happens, as we've seen, and I'm not going to go back to them, there was immediately tension between the Department of Health and Monitor, and there was an understandable reaction by yourself and other ministers to want effectively to take charge. Is there a need, do you think, for some form of central protocol or guidelines about measures that should be put in place when there is a large-scale Health Service scandal? Perhaps they already exist, but just in the same way as there's the Cobra committee for terrorist offences, do you think that there should be a standing committee within the Department of Health to deal with just this sort of problem so that it's not dealing with things on the hoof?

A. I think that would be a good suggestion as a natural evolution of the relationship between the different bodies. I think perhaps what we underestimate in this consideration is how new some of these organisations were, both Monitor and the CQC in its various guises before. I mean, in public sector terms, you know, four/five years old is not particularly old really, and I think, you know, the period of transition clearly tested those organisations and, yes, perhaps there would be a need for that. But I think that comes with a maturity of the relationship between the two.

I think the Department still had a direct relationship to both of those bodies to help build the -- the public confidence in their capacity to regulate. Because I don't think you can just say, you know -- as I say, flick a switch and say, "Overnight all of those trusts are now completely out of our view, this new regulator is completely responsible for everything that they do and we will never -- you know, I think certainly members of Parliament found that hard to
1. I think what I'm just indicating to you it's not
2. system.
3. to create independence and local accountability in the
4. reform journey was putting in place the building blocks
5. public services can be run by ministers. So part of our
6. to be changed. It couldn't be the case that modern
7. in the decision-making process.
8. Q. Is there an argument for pulling Monitor back within the
9. Department of Health? If they are in effect to be
10. a financial assessor of applicant trusts and then
11. a performance manager, and a mere performance manager,
12. is there any reason for them to remain independent of
13. the Department when, as we've seen, as soon as a wheel
14. comes off the system, the Department takes over anyway?
15. Why does Monitor need to be independent?
16. A. Because I think there does need to be independence
17. in the decision-making process.
18. Q. Unless things go wrong?
19. A. I think the NHS culture of ministers -- you know, back
20. to "the echoing bedpan", in Aneurin Bevan's phrase, had
21. to be changed. It couldn't be the case that modern
22. public services can be run by ministers. So part of our
23. reform journey was putting in place the building blocks
24. to create independence and local accountability in the
25. system.

Grasp, you know, that if there were real concerns they
would come straight to ministers rather than going
to Monitor. So there was a period of transition taking place in
terms of the relationship between the Department and
these organisations.

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to create independence and local accountability in the
system.

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trust, and I accept it was early days, the FT governors were treated by the then chair as someone to address and to hand out news to, rather than to be a body to whom there was a serious sense of reporting and accounting to. And as the board itself of governors doesn't seem to have, in the short time it had available during the events we've been concerned with, to have asserted itself.

How does that fit in with the concept that you at the centre are in effect seeking to surrender accountability to local people, who, of course, might make a good job of it or might make a bad job of it?

A. I mean, you've put your finger on a very real problem, which was that the Parliamentary intention when this legislation was passed was that hospitals would have less interference from the Department and regulators, but it wasn't just that they were then free, that had to be replaced by more interference, if you like, or more scrutiny, more power for people locally to change their decisions, to hold them to account.

And I think that you could look at many examples -- and this trust would certainly be one of them -- where they took the freedoms but not the new responsibilities of foundation trust status. So they in many ways misused those freedoms, more meetings in private, not

MR KARK: Mr Burnham, those are all the questions that I ask, thank you very much indeed.

Questions from THE CHAIRMAN

THE CHAIRMAN: While Mr Clarke thinks whether he has any question to ask you, can I ask you this. Quite a lot has been said by you and others about quality and about standards, and obviously the role of the regulator in relation to those. Do you see there being any valid distinction between standards in the sense of a minimum requirement that every trust must meet in providing any particular service and quality in the sense of going over and above such standards and producing something rather better in terms of competition, perhaps, with others?

A. I do. I think it's a very good distinction to draw. Standards can be met in name, but the point can be missed, if you like, you know, "that you meet the target but miss the point", was a phrase I often heard, that you might be to the bureaucrats be doing everything that was meant has to be done but actually providing poor quality care to the -- to the public. And, you know, what I was struck by in your first report was just the, you know, sheer failure on a human level to provide decent care, and that came out on every page. And, you know, it's not unique to this trust. You hear it about other trusts as well, that, you know, perhaps as the demands have grown on the health service
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<td>year on year and, you know, the pressure of 1  operating a modern health service, that the care for 2 people has diminished over that time. And, you know, 3 we've lost something along the way. 4  And, you know, as I say, I was very struck by that 5 and still am, and it's why it's not a, you know, 6 technocratic point to say that I was very convinced that 7 patient satisfaction was the thing that was a good thing 8 to look at on a routine basis, not hospital by hospital 9 but, you know, individual ward or service by service 10 within a hospital. And alongside that, staff 11 satisfaction. Because in my experience of being 12 a health minister, those two things will tell you quite 13 quickly whether or not you have a problem within an 14 organisation and whether or not it's doing all of those 15 other things well, looking after people properly, 16 speaking to people properly, feeding people properly, 17 providing a safe and clean environment for them. And, 18 you know, somewhere along the line some organisations 19 lost sight of those things and indeed lost sight of 20 dealing with people's complaints properly. And, you 21 know, that -- that is and was, you know, a huge, huge 22 preoccupation of mine. And if we're going to have the 23 health service I think we all want, then it has to be 24 there, it has to be a priority for chief executives that 25</td>
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| people treat people as people when they come through the doors. You've got to find a way of getting that 2 absolutely at the forefront of people's minds. 3 The danger is if we're always saying it's this 4 clinical standard or that one or the other, you miss the 5 totality of people's care, and I think that's a very 6 real -- real issue for the National Health Service. 7 THE CHAIRMAN: Is part of that problem anything to do with 8 the way in which standards are defined and in the way in 9 which regulators or others are encouraged to look at 10 performance? 11 A. Yes. I think that's absolutely the case. People can 12 meet standards, basic standards in theory, but if you're 13 meeting the A&E target by moving people to a medical 14 assessment unit, and leaving them there for a while, 15 that's not -- that's missing the point, isn't it, rather 16 than -- that's meeting the target, missing the point. 17 And, you know, that was very much a story that came 18 out to me time and again when I did the work shadowing 19 experience that I did. I mean, I became very conscious 20 in that period, the middle point of our government, if 21 you like, that there was a "growing disconnect", was 22 a phrase I used to Mr Kark earlier, that, you know, 23 we were doing all this frenetic activity at a national 24 level, all of these initiatives, things happening, new 25 statements, new policies, and yet we weren't taking 26 enough time to go down to the ground and say, "Well, 27 what -- how does this feel to be there -- you know, 28 we're throwing so much change at this health service, we 29 want it to be better". You know, any of the things that 30 we did was not because we were vindictive, we just 31 wanted the health service to be better and to be better 32 as quickly as we could possibly make it to be better. 33 Okay, we didn't always get things right but that was 34 what we were trying to do. 35 And so that is why, you know, I did that, and I -- 36 I still feel that the culture in the NHS is too -- 37 doesn't do that enough, chief executives don't go out on 38 to the wards enough, they don't go out and listen to 39 people, to speak to -- to speak to staff. So when I put 40 forward that document, the Good to Great document, 41 I explicitly made a recommendation. And, you know, the 42 events at Mid Staffordshire were in my mind when I did 43 this, that we should link payment to patient 44 satisfaction, because how else do you get an 45 organisation to concentrate on the human side of 46 healthcare unless it's very directly linked to -- to 47 their financial position? 48 So those are the conclusions I reached. I hope I'm 49 not going off the point in putting them before you, but 50
to them. I mean, I would say fundamentally targets are about people, it's about the basic minimum that every single person should be able to expect when they arrive at the doors of the NHS, four hours and 18 -- 18 weeks if in you're an inpatient. So it's not prescriptive everything else, it's just saying as a basic minimum you should be able to provide that level of service to everybody. So, you know, targets were not about political or bureaucratic imperatives, they're basically trying to guarantee for every independent patient a decent level of service, and if you take those targets away -- as I said before, I wanted to make them right in the NHS constitution. If you take that right away, the 18-week target, it means the system can start messing around patients again, it can stop -- people can start saying, "Oh, well, it's fine if you wait six months, nine months a year", and people have no comeback to being told that. And, you know, I was clear we can never go back to those kind of days.

THE CHAIRMAN: If a target is being met, as we know it was kind of days.

And, you know, I was clear we can never go back to those kind of days.

I often heard from professional bodies as well was that while nobody would go out and champion them, they nevertheless were quite important in ensuring a basic standard of service for all patients.

THE CHAIRMAN: Thank you. Then just one final question following up some of the questions that have been asked about accountability and responsibility. A complaint is often made in the context of what's happened to date in relation to Mid Staffordshire that no individuals -- and I use the word plurally -- have been satisfactorily held to account, or indeed, some would say, held to account at all.

Firstly, do you consider it necessary, in these circumstances, for someone to be held to account or not? And, secondly, do you consider that process has happened or will need to happen further?

A. I would say I think those are judgments for this inquiry. If that needs to be done, then that -- that's important. I think what we've heard today is that there were so many people involved at so many levels where people have an influence but not overall control that that is a complicated picture that we're -- that we're dealing with. I remain of the view that the failing was ultimately a local failing by the trust, its board, its senior management, that decisions were taken that were just unsupportable and left clinicians and nursing staff in an impossible position on the ward in that they were just simply understaffed and were being asked to do things without sufficient support. There simply wasn't the capacity in place to run the hospital safely and efficiently.

So, as far as I can see, that -- those decisions were taken at that level, and I would say that personally is where primary accountability rests.

That's not to say that I don't accept that there are lots of other people then that have had a role and that perhaps should have, as I said before to Mr Kark, done things differently, done more. Of course, like anybody, I -- I -- I look back at the submission I received. I wonder to myself: could I have done more, should I have done more? I looked at it at the time and -- and acted on the information that was presented to me by -- by civil servants.

So I think that, ultimately -- to answer your question, it is ultimately a decision for -- for the inquiry. The important thing is that clearly we don't see failure on this scale ever again in the National Health Service and we also have to have a health service where accountability is accepted and people are -- are
Q. It's actually in the statement of Sir Hugh Taylor, but it's just point of detail.

You were shown this morning the JCI report, which is a report of a firm of external consultants that was sent to the NHS. The reference is WS0000061487, page 4 of that report, please. Thank you. You made some comments about the culture. You took issue with point 3, the culture appears to be embedded. Do you have any

A. Yes. To say on that, of course, I ultimately accepted what was being said, that the CQC needed to move quickly to a new system of regulation. That was what Barbara Young had asked me to do and, as I said to Mr Kark, I can't immediately just agree whenever a regulator brings something like that to me. I can't just say, "Right, Fine, we'll do it".

Q. But ultimately, I became persuaded that we shouldn't delay, that we should move more quickly to a new system of registration for all NHS providers, and that was very much the effect of a statement I made to the House of Commons in response to the events at Basildon Hospital.

Q. And on the old system did you have advice from the Department which countered the criticisms that were made to you on the same kind as they were made later by Baroness Young or was it just the more focused requests for amendments?

A. No, it was different, obviously, because Baroness Young was talking about moving to a new system altogether, which would be a system of realtime information gathering about trusts as part of registration and whether or not the CQC would register them as an acceptable NHS provider, the point being that if at any point the CQC had concerns, it could remove registration. So that was a new system, it wasn't the snapshot judgment on an annual basis provided by the annual health check.

Q. And so what kind of emails were sent to the Department which countered the criticisms that were made by -- externally by [sic] the core standards?

A. Sorry?

Q. Did you have advice to sort of -- did you -- were you able to balance what was being said to criticise the

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<td>core standards against advice from the Department as to whether those core standards should be maintained? A. Well, it's important to say that the Department isn't a kind of single entity that always speaks with one voice. There are very eminent individuals within the Department who often are of a clinical background, who were national directors, particularly in certain areas. George Alberti would be one, for instance, who was regularly involved in discussions at the top of the Department and, of course, always I had a very close working relationship with Professor Sir Liam Donaldson and listened to his advice very carefully. It was often the case that Sir Liam would send me a side note on a submission he'd seen and was worried about. And I think that -- we've not touched on it much today, but the role of the Chief Medical Officer, I think, is an important safeguard in these issues because I think it's a role that comes with independence of mind and of action and was regularly a source of support and advice to me when I was seeking to challenge perhaps something that had been put to me by the Department. So in some ways it kind of plays back to that image, the thing of too many people involved, too many cooks, too many people chipping in with their two penn'orth.</td>
<td>reducing that activity. So are paragraph 24 and paragraph 26 talking about the same type of investigations? A. I mean, it's hard to say without having the full document before me. If you look in paragraph 24, the investigation that's referred to is one on learning disability services, and I think when they're talking certainly about thematic reviews, that is absolutely what they mean; they mean a review that is across the NHS into a certain service or disease area. So I think they mean both, basically. They're talking about focused pieces of work that might draw a large amount of resource away from other day-to-day functions of regulation, is the way I read that. But I also read Lord Hunt's conclusion very clearly, that he wanted them to have freedom, that they should decide, and I think that would have been the view of all ministers at the time.</td>
<td>Q. On exhibit 2, you were asked some questions about that document, which is the &quot;great to good document&quot;, the policy initiative. It was suggested that the language is rather broad and difficult to define what you mean by &quot;great to good&quot;. That was, presumably, a document that was a public statement of policy issued to the public; is that right? A. Yes, of course, yes. Q. Would that be supplemented by more detailed, more technical documents that would be issued to NHS bodies? A. Yes. The 2009/10 operating framework -- or 10/11, sorry, I should say, operating framework followed not along after this document. So what this document was seeking to do was to put forward an overarching vision, direction, for the National Health Service in this period. The operating framework, as you may know, dealt with matters year to year, and it was often the case that, you know, just to receive those annual documents may never -- you know, it may be not giving a clear enough picture about how the health service might develop in the next medium-term period. So that's why I -- we brought together this document and it overlaid the operating framework that I think followed, from memory, a week or two later. Q. Talking about -- moving to the subject of foundation trusts, and there's been discussion about lowering or changing the bar. Was there ever any change to the test that Monitor was expected to apply in [inaudible]? A. No, not to my knowledge, and, from memory, I think the Andrew Cash note makes that clear. And I do come back</td>
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to the letter that he sent to the chief executive of
Mid Staffordshire, where he talks of the process testing
them to the limit. I don't think there was ever any
suggestion that there was a weakening or a general kind
of lowering of standards. None at all. And indeed, the
decision of the applications committee to withhold the
applications of four trusts -- bear in mind, four quite
eminent organisations, certainly Bart's, these were
clearly not decisions taken lightly. But nevertheless
the fact that they were -- that, of six, four didn't go
through, two did, I think shows that there was a fairly
serious job of work being done at that level to consider
who was ready to go forward. And you know, if there was
an unrealistic drive on, you would have, I think, had
a recommendation that all six should have gone forward,
and that wasn't the recommendation.

Q. You described your role in looking at the application
and deciding whether it should go to the next stage and
be considered by Monitor. What role did you expect the
applications committee to perform before it got to you?

A. Well, essentially they were giving me a judgment on
whether or not the organisation was ready to proceed to
that stage. And I can -- as I say, I can only act on
the information that's put before me by -- and the
advice by civil servants, and their advice was that it
should.

The decision I was taking, as I said to Mr Kark, was
very clear to me. I was essentially allowing it to be
put through a fairly rigorous assessment process for
which it would have to decide whether or not it was
ready to do it or not. It wasn't -- you know, my job
essentially -- again, the effect of my decision was
I had not been given a reason why I should stop that
organisation from going into that process that it had
determined -- it had initiated in the first place.

Q. And turning to the aftermath of the Healthcare
Commission's report and the question of the management
of the trust. On Day 93 in the evidence of Bill Moyes
at page 195, he said this:

"The question was how to secure the appointment of
a capable, permanent chief executive. And I acknowledge
that we were not -- the trust was not managing that and
we were not managing that, although it really was the
trust board's responsibility at this point."

And he went on to say:

"And you are perfectly correct, that if a provider
were manifestly failing, completely failing, the
Secretary of State is bound to have some role. But it's
not a detailed operational role."

Now, looking back to your intervention or your
involvement at that time, would you agree with what
Mr Moyes said about what was happening at that time when
he said, "The trust was not managing that and we,
Monitor, were not managing that"?

A. Well, yes, I would, and I think Mr Moyes has put it well
and probably fairly. I mean, the Department, in wanting
to expedite matters, wasn't seeking to, as I say, ride
roughshod over Monitor. As one of the exhibits showed
this afternoon, there was discussion between David Flory
and -- was it Mr Lavelle of Monitor? So clearly this
was being done in discussion rather than being imposed
on them. But I think the intervention of the Department
was important in speeding up the appointment of capable
and senior management, permanent management at the trust
and --

Q. Was that something that would routinely happen any time
something went wrong in a foundation trust?

A. No, no, absolutely not. I think we're dealing with
exceptional circumstances here that were really -- the
enormity of the events was beyond anything we'd seen
before and I think, you know, a different level of
action was required to restore public confidence and,
you know, people can say rightly or wrongly -- I mean,
I took the view that we had to do what we did. Yes, it
probably trampled on some of the constitutional
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arrangements that had been put in place, but, you know,
I felt that was necessary in these circumstances.

Q. Lastly, paragraph 141 of your statement. You refer to
a failure of what you've called a failure of the
management of the trust, and these organisations are
called trusts. Did you as a minister repose trust in
hospital boards to manage the hospitals and balance the
books?

A. Well, yes. You know, the -- I said to Mr Kark before
that you wouldn't want it to become so onerous that
nobody came forward. But when you do serve on the board
of a hospital, it's a very -- you're taking on very
clear responsibilities to patients to act in the public
interest.

I think the role of boards has been underplayed down
the years. We probably should have put more emphasis on
helping them hold trust management to account. The
decision of this trust back in 2003 to stop putting
detailed complaints data to the board, I mean, you know,
an unbelievable, really, unbelievable decision that
could have no justification. And yet somebody on that
board should have been saying, "No, we want to see more
detailed information", and perhaps they should have been
able to draw on some national guidelines that say,
"These are the kind of things you should be doing", and
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we should have been perhaps empowering board members
in that way. But that -- as I said to the Chairman,
this, in my view, was fundamentally a local failing by
management, but the trust board didn't sufficiently hold
them to account.

MR CLARKE: Thank you. Those are all my questions.

THE CHAIRMAN: Thank you, Mr Clarke.

Mr Burnham, thank you. That concludes your evidence
unless there's anything you want to add at the end of
it.

A. Not at great length. Just, if I may, one final thought.

I know that the issues we're dealing with here are huge
and they've caused enormous distress on many levels.
I just wanted to say that when your report was
published, your first report, that came to me, that did
send shock waves through the Department and through the
National Health Service, and I think the NHS began to
face up to some of the fundamental challenges it faced
in providing decent, good quality care to all people.

I know people will still say I should have made it
a public inquiry then. But I want to just say in
closing that for those who might make a criticism of me
and other ministers that we were in the business of
managing news and managing things and closing things
down and not letting the full facts come out, I would
want to argue in closing that the very fact that
I didn't accept the departmental advice, that I set up
your initial inquiry and then allowed that report to
come out and tell that story would show that I wanted
the full enormity of what went wrong here to be felt and
be felt across the NHS, and I think the chain of events
still has been ever since helpful for the NHS.

So I want to say again that I feel dreadfully sorry
for what the families locally have been through.

I think it's unimaginable, some of the situations people
found themselves in, as I think you described, and
I hope what I've said today has shed some further light
on these issues for the inquiry and I'm sure your work
will help us all prevent this happening again.

THE CHAIRMAN: Thank you very much. That concludes today.

(5.00 pm)

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