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1 Tuesday, 21 June 2011
2 (10.00 am)
3 (Proceedings delayed)
4 (10.07 am)
5 THE CHAIRMAN: Good morning, Professor Paton.
6 **A. Morning.**
7 THE CHAIRMAN: Have you been following our proceedings?
8 **A. Within reason. I've been in Scotland.**
9 THE CHAIRMAN: I'm not sure what --
10 **A. I mean, I've been in Scotland looking after my aged**
11 **parents, so I've missing recent stuff but I've been**
12 **looking on the Internet.**
13 THE CHAIRMAN: Thank you. So you'll have some idea of our
14 procedure.
15 **A. Absolutely.**
16 THE CHAIRMAN: Obviously we will ask you some questions, but
17 if at the end of that you feel there's something you
18 want to add, please feel free to do so, so long as it's
19 within our terms of reference.
20 **A. Thank you very much.**
21 THE CHAIRMAN: And if on consideration after you've left,
22 there's anything you feel you should have added but
23 hadn't, let us know and we will seek to take that into
24 account as well.
25 **A. Thank you.**

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1 THE CHAIRMAN: Finally, as I've said to every single
2 witness, could you please try to speak slowly so that
3 this lady can keep up with you.
4 **A. I will indeed.**
5 THE CHAIRMAN: Thank you very much.
6 **A. And do remind me if necessary.**
7 THE CHAIRMAN: I will. So will others.
8 PROFESSOR CALUM PATON (affirmed)
9 Examination-in-chief by MS HUGHES
10 MS HUGHES: You are Professor Calum Paton?
11 **A. Yes.**
12 Q. You are currently professor of health policy at
13 Keele University.
14 **A. Correct.**
15 Q. Professor Paton, you made a statement in preparation for
16 attending the inquiry today.
17 **A. Yes.**
18 Q. That statement is dated 4 February 2011, and it runs to
19 51 paragraphs. Do you have a copy of that statement --
20 **A. I do.**
21 Q. -- with you?
22 **A. I do.**
23 Q. Do you adopt that statement for the purposes of giving
24 your evidence today?
25 **A. Yes.**

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1 Q. Professor Paton, I'm going to asking you questions based
2 around, firstly, that statement and also around the
3 first exhibit to that statement, which is a written
4 submission that you submitted to the inquiry.
5 **A. Yes.**
6 Q. This won't come as a surprise to you, because I've
7 explained to you that it's important that we remain
8 within the terms of reference in respect of your
9 evidence today. Your statement does cover in particular
10 events that happened at the University Hospital of North
11 Staffordshire and, as far as possible, I'm going to try
12 and achieve it so that the evidence that you give is as
13 relevant as possible to our terms of reference.
14 **A. Absolutely. I understand.**
15 THE CHAIRMAN: I'm sure you understand that as much as
16 I would like to investigate north Staffordshire, I've
17 got enough to do in south Staffordshire.
18 **A. I fully I appreciate that.**
19 MS HUGHES: Following from that, it's important that
20 I acknowledge publicly that in particular the strategic
21 health authority, who naturally have an interest in much
22 of what you say, do not accept some of the views that
23 you express about particular events and individuals, but
24 they do not wish me to make any specific challenge in
25 relation to some of that evidence. But I'm publicly

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1 stating that on their behalf.
2 **A. Okay.**
3 Q. You, of course, have some local experience because of
4 having worked within the local health economy of the
5 West Midlands, having been the non-executive chairman of
6 the University Hospital of North Staffordshire from,
7 I think, 1 November of the year 2000 until
8 1 January 2006?
9 **A. Absolutely, yes, that's correct.**
10 Q. One aspect of your evidence that you deal with fairly
11 early on in your statement is to do with the way in
12 which the NHS is structured and the various
13 restructurings that have taken place over time.
14 **A. Yes.**
15 Q. You start by -- at paragraph 5 -- expressing a view that
16 things were more manageable under the old structure, and
17 I think by the old structure you are referring to the
18 position before 2001, where there were, I think, 100
19 health authorities.
20 **A. Correct.**
21 Q. And you say in your statement that, with hindsight, you
22 thought that things were more manageable under that
23 structure. Can you explain in what way it was more
24 manageable, what the advantage of that arrangement was?
25 **A. Yes. Yes, I will do that.**

1 THE CHAIRMAN: Sorry if I interrupt, when you talk about
2 health authorities, do you mean the old area health
3 authorities or the district --
4 A. **Well, they were actually -- the health authorities that**
5 **were created they were known as local health**
6 **authorities. They were, if anything, district health**
7 **authorities. The areas -- it's -- it's a typical NHS**
8 **evolution or redisorganisation as -- as I say later.**
9 **But the area health authorities were abolished some**
10 **considerable time earlier. Until 2001/2002 --**
11 THE CHAIRMAN: Just slow down slightly.
12 A. **-- there were 100 health authorities simply known as**
13 **health authorities in England and, in a sense, the point**
14 **I -- you know, I was driving at primarily is that that**
15 **was -- it's a qualitative judgment -- a manageable and**
16 **sensible number.**
17 **What happened with the reorganisation of 2001, which**
18 **started really to have serious effects in the NHS in**
19 **2002 onwards, it was known as Shifting the Balance of**
20 **Power, you know, it's one of these acronyms that the NHS**
21 **is fond of, S-T-B-O-P, StBOP, Shifting the Balance of**
22 **Power. What it did was abolish these health**
23 **authorities. It also abolished the, I believe, eight**
24 **regional offices that existed at the time, which were,**
25 **if you like, the regional organisations for England, and**

1 **replaced the regional offices with nearly 30 strategic**
2 **health authorities, of which the Shropshire and**
3 **Staffordshire health authority was one, and replaced, if**
4 **you like, the 100 health authorities with approximately**
5 **350 primary care trusts. Up until then, the Labour**
6 **government, as it then was, the new Labour government**
7 **had encouraged the formation of primary care groups and**
8 **allowed them to be trusts, i.e. self-governing up to**
9 **a point, if -- if they wanted to be but. But this was**
10 **the reorganisation which made that a mandatory model**
11 **throughout the whole of the English NHS.**
12 **And my point, really, is that I think it got -- it**
13 **put -- in the management consultancy jargon, it put form**
14 **before function. Because, if I may coin a phrase, the**
15 **strategic health authorities were too small to be**
16 **strategic and too big to be local. They were neither**
17 **fish nor fowl. This is a judgment I make, of course.**
18 **It's my opinion. And, of course, that varied across the**
19 **country, as to the truth of that statement. But I think**
20 **it was particularly true in -- in the -- in this area.**
21 **And, secondly, when it came to the primary care**
22 **trusts, while I could speak either as an academic or as**
23 **I was at the time as chairman -- chairman of the trust**
24 **in the north of Staffordshire, taking -- taking the**
25 **latter position first, what we found overnight was that**

1 **instead of planning our future for our local services,**
2 **if you like, with one health authority, we were planning**
3 **our future with four primary care trusts. And I would**
4 **submit, although, you know, I know one might say, "He**
5 **would say this, wouldn't he?", as the trust chairman,**
6 **that was rather anarchic because the primary care trusts**
7 **didn't have a coherent vision, in my opinion, shared**
8 **with each other, and I believe that that was true, not**
9 **just in North Staffordshire but in other areas of the**
10 **NHS.**
11 **Speaking as an academic, I think that the problem**
12 **was that earlier judgments, perhaps as well as research**
13 **on the NHS changes in the 1990s, had suggested that if**
14 **you were going to plan or commission or strategically**
15 **commission, in the jargon, non-local services, then to**
16 **abolish strategic organisations with a direct**
17 **responsibility for commissioning, in other words, health**
18 **authorities, was a mistake. So it's not just the**
19 **judgment of -- you know, of an ex-trust chairman, it's**
20 **also the judgment of my -- my academic person, if I can**
21 **put it that way.**
22 Q. In your statement you say that looking back in hindsight
23 that structure was more manageable. In fact it sounds
24 from the answer that you've given that at the time your
25 perception was in fact that this reorganisation was

1 going to make life more difficult.
2 A. **I -- I will -- looking back as best I can to -- to the**
3 **way I was feeling at that time, I had gone to be**
4 **chairman of a -- of a what was actually one -- is one of**
5 **the biggest trusts in England, and I suspended my**
6 **academic theories and -- and whatever else, as much as**
7 **I could, and got into the role, as much as I could, of**
8 **working within the health economy. So I'll be blunt, in**
9 **the year before all this happened, or the year and**
10 **a half before the new redisorganisation came about, I --**
11 **I was not pontificating as an academic, so much as**
12 **working my way into the trust and seeking to make the**
13 **health service work as well as I could, insofar as that**
14 **was my responsibility.**
15 **So I wasn't looking out for trouble, and I was --**
16 **I had a relatively open mind as to what, for example,**
17 **would happen in terms of governing the local health**
18 **economy. If you'd asked me, if you'd taken me aside in**
19 **those days and said, "Do you think this is a sensible**
20 **thing to do, to have this reorganisation?", my answer**
21 **would have been, "No, I don't". And with hindsight --**
22 **when I say with hindsight, I'm in a sense not wishing to**
23 **exaggerate or over -- overdo the point, and one could**
24 **even argue that that's a very gentle way of putting it**
25 **with hindsight.**

Q. In that last answer you used the term "redisorganisation", which is a term I don't think we see in your statement, but we do see in some of your other writing that's been submitted to the inquiry. Presumably, that term is not coined specifically in relation to this particular reorganisation, and so I wonder if you might, please, unpack for us what that term "redisorganisation" is intended to convey?

A. I will try my best to do that. You're quite right, it's not a term derived for or applied only to the locality, nor, I should add, is it a term coined by me, much as I would like to have coined it; coined by another academic colleague.

What it refers to in a nutshell is the persistent top-down reorganisations of the form and structure of the NHS, which happened with increasing frequency throughout the 1990s, but even more so throughout the 2000s. For example, if you want -- this is where you might have to say, you know, "Don't tell us any more", but, for example, when New Labour came in in 1997 it -- it -- it allegedly abolished the previous government's so-called internal market in the NHS. I could comment on that but I'll just state that as a bald fact. Between roughly 1997 and 2000/2001, they were developing institutions organically.

In 2001, they had a major reorganisation, with or without the "dis", the one I've just described. The following year they published a paper, which is -- was thought to herald the new -- the new market in the NHS. This was New Labour going back on its belief in abolishing market forces within the National Health Service.

In 2005, they published a paper, if I -- a White Paper, if I remember rightly, called Commissioning a Patient-led NHS, which sought to, ironically, undo the reorganisation of only three years -- three and a half years before, because they had actually discovered, in my opinion, although they didn't announce it as such, that in fact they had made a dysfunctional reorganisation in 2001/2.

We've subsequently had many other re -- reorganisations, of one -- at one level or another, and it's not something I don't think you want to get to just now, but, of course, the phrase "top-down reorganisation" became a boo phrase, so much so that in the last election campaign, you know, one of the -- one of the parties that now -- now in the coalition government made -- made a pledge not have any more top-down reorganisations of the NHS.

One could add the rest is history but, you know, you

might want to ask me about that later. So it -- it's this constant structural change, and I would -- I would argue putting form before function. In other words, acting on the belief that moving the deckchairs can make substantive differences when there might not be much evidence to suggest that the particular forms of moving the deckchairs did any such thing.

THE CHAIRMAN: Do you have any concept or understanding of why it was thought necessary to make these changes? Whether they were the right changes or not is another issue, but what was the perceived need for changes with this degree of frequency?

A. Unequivocally I'd be wearing my academic hat on this --

THE CHAIRMAN: That's why I'm asking you.

A. -- on this one. And absolutely, it's just so -- so -- so you're aware of that, rather than talking about, you know, the -- the -- the local health economy.

Well, as a political scientist, politicians like to make grand symbolic statements. Reorganisations based on what is an apparent philosophy can seem like decisive action. The particular 2001/2002 reorganisation, keeping in mind that that laid the groundwork for most of my time, actually in the health service as a non-executive admittedly, that particular reorganisation came from the then Secretary of State,

Alan Milburn's belief that devolution to the front line, which was the phrase coined at the time, was the aim, the objective, if you like, and this reorganisation was a means of achieving it. So to be fair to Mr Milburn, that -- if he were sitting here, I believe that is what he would say.

I, on the other hand, without wanting to sound grandiose, believe that because it devolved inappropriately to agencies, for example, small primary care trusts, which had neither enough strategic back up or in some cases capacity to do what they were allegedly going to be doing, that in fact it led to back-door centralisation because, as a result of a lack of capacity at Mr Milburn's front line, decisions had to be made, strings had to be pulled, things had to be managed at a higher level. But, of course, because this was no longer allegedly legitimate in -- in -- in quote marks if I can put "legitimate" in quote marks. This was no longer legitimate, it had to be done covertly.

So my criticism, if you like, of the 2001/2002 reorganisation would include the claim that under the guise of a lot of fancy rhetoric about devolving to the front line, there was actually, out of necessity, quite a lot of covert informal centralisation.

MS HUGHES: Where do you say that decisions were then being

made? I think what you've just expressed, you also deal with in your statement at paragraph 7, where you say that there were too many organisations, too small to make a difference, unable or unwilling to make decisions --

A. **Yes.**

Q. -- independently. Independently of whom?

A. **Independently of authorisation from further up, the hierarchy or food chain in the National Health Service. If I unpick that statement, unable or unwilling, there would be some primary care trusts that would actually want, quite rightly in terms of legitimacy, to do what the reforms was allegedly created to enable them to do to be quite -- to be relatively autonomous in their action, on behalf of the local communities, that they -- you know, the local populations that were theirs.**

So some were able -- sorry, some were willing but unable, because, for example, if -- I mean, we get into difficult minutiae here potentially, but if take, just for illustrative purposes, because I know it's -- you know, not the focus of this inquiry, the North Staffordshire health economy, if one of the four primary care trusts wanted to do X for the future, then it might require, to use a bit of jargon, a critical mass of more than one primary care trust to do that and if the others

were unwilling, et cetera, et cetera.

So it was the un -- the inability to mobilise a strategy for the future. I can put it quite tangible terms. As a hospital, as, you know, the primary care trust would have called us, this big beast on the patch, this big hospital, we needed to know -- it wasn't our job to commission services, but we needed to know, for example, if we were going to be financed for new cardiac surgeons or new cardiologists to do X rather than Y, and quite often there -- there was absolutely no decision forthcoming in our -- in our health economies. That's an example.

So if I was being -- I wouldn't want to be cynical but -- but if you ask who made the decisions, the problem often was that decisions simply were not made, there was drift, and then at the end of the day, of course, somebody had to knock heads together. But my point about the covert centralisation to the strategic health authority, or in some cases higher up to -- to the Department of Health, the covert centralisation came about out of necessity.

So in a sense, there would be organisations which welcomed it. My point would be that that's not the best way to run a National Health Service, to avoid decisions and then deal with the consequences hastily and in what

I might call semi-panic. That's my -- my stance on that one.

Q. If we could stick, please, with your experience of interaction with primary care trusts, you deal with this at paragraph 17 of your witness statement.

A. **Right.**

Q. You talk there about an impression, a perception, that commissioning was about money, rather than quality. Is that something that you would like to expand on, please?

A. **I -- I would to some extent, and I would affirm, you know, that these are my -- my judgments based on my experience and not -- I don't have typed empirical evidence that, you know, quality was not important. I don't this there's anybody in the NHS who -- who would argue that -- that quality wasn't important. And I'm not attributing bad faith to the people responsible for writing contracts doing what was in my case -- in -- in my view, euphemistically called commissioning, but the diktats of the day, and I'm talking about this particular time in the NHS, were very much about government targets, which included, of course, financial targets, quite -- quite rightly, to -- to break-even, for example, if you're an NHS trust or an organisation generally. And I believe that quality didn't have the -- perhaps it's a -- a -- a statement of the**

bleeding obvious, that quality did not have the priority that rightly it -- it has today following a number of very unfortunate events, of which -- of which this inquiry is -- is dealing with were.

But, no, it was money -- money -- money and targets were the must-dos, in terms of the regime run from the centre at this time, and it would be wrong of me to argue that none of the targets indirectly or directly involved quality. But quality in the way that we have, I think, come to consider it in an improved form more recently was not at the centre. That's the least I -- the least I would say.

THE CHAIRMAN: Do you agree that with all their apparent imperfections, for instance the A&E waiting time target and other targets of that nature were at least intended to --

A. **Yes.**

THE CHAIRMAN: -- address quality issues?

A. **I do indeed. We obviously in the -- in a big acute hospital, the A&E target was one of our core targets, and I used to say, quite sincerely, and I say today, that it is an aspect of quality that people should not pitch up in an accident and emergency department and wait for an indefinite amount of time so that, for example, if there's a target that most people -- you**

1 know, it went from 94 per cent to 98 per cent and back
2 again a little bit now, most people are seen within
3 four hours, that is an honest and well-intentioned
4 attempt to improve an aspect of quality.
5 No doubt there were some perverse effects as
6 a result of that target, and one could argue the
7 technical details of that target. Funnily enough,
8 I would personally think that if set at an appropriate
9 level, and not policed inappropriately, then that is
10 actually one of the better targets. Not to say that
11 98 per cent of patients have to -- have to go within
12 four hours, but -- but in fact, it's a judgment, isn't
13 it? How long is a piece of string? But there were some
14 informal studies done, which I can't quote now I'm
15 afraid, by health economists which suggested that, in
16 the jargon, the opportunity cost of raising the target
17 from 94 per cent of patients having to be seen within
18 four hours to 98 per cent, the opportunity cost of that,
19 in other words the money you spend on that, what could
20 you do with that money if it was applied to something
21 else, rather than getting 94 patients comply --
22 94 per cent of patients complying rather than 98, that
23 the opportunity cost meant that that was an inefficient
24 strengthening of the target.
25 So there's all sorts of technical debates about

1 targets, and one of my regrets about that is it's been
2 polarised, you know, for example, in the last election
3 campaign New Labour defending its target, the
4 Conservative Party saying, "We don't believe in
5 targets", you know, silly black and white stances. And
6 this things are shades of grey. Perhaps what I would
7 draw your attention to is not that I don't believe in
8 target at all, because I do, but the culture of the NHS
9 and the manner in which targets were policed, was often,
10 in my view, faint -- frankly ludicrous, and I try and
11 give one example -- one or two examples, you know, in --
12 in the -- in -- in -- in the statements.
13 Q. All right. Well, that is a topic that I'm intending to
14 come back to. Just sticking for the moment with the
15 primary care trust and your interaction with them.
16 Another comment that you make about commissioning is
17 that what made logistical sense to service provision ran
18 contrary to the contracting culture, and again, I'd like
19 to give you the opportunity to explain what you mean in
20 that statement.
21 A. I'll try and do that as pithily as possible. I give
22 a little example there. Let -- let me say a hospital is
23 filling the time of an operating theatre session. The
24 consultants and the surgeons might say -- let me make
25 this almost Mickey Mouse, my apologies -- "We've got so

1 many hours, we can -- you know, we have scheduled two
2 big operations, we can use the capacity of the hospital
3 efficiently to schedule a few small operations around
4 the edges of these big operations. So we can actually
5 use the assets more efficiently". Now, that might run
6 foul of a primary care trust saying, "We've contracted
7 a priori at the beginning of the year", if that's when
8 it were done, "We've contracted to do X but not Y, so
9 you're not allowed to do that". I could be a little bit
10 facetious and say, "You've got to ring up and ask us".
11 I used to think that was facetious, although rather more
12 recently, you know, that has often become the reality
13 that the efficiency of operating a provider is
14 a different agenda from the commissioning culture, if
15 I can put it that way.
16 Q. In that sort of environment, to what extent are trusts
17 as providers able to determine how they provide their
18 services?
19 A. In theory -- the theory of the split between the
20 commissioner, or what used to be called the purchaser,
21 more accurate still I think to call it the purchaser,
22 the purchase or commissioner the split between that
23 institution, the primary care trust and the hospital, or
24 the mental health trust, the idea is that the
25 commissioner decides what will be done, bluntly volume,

1 within their available money, and the provider will go
2 away and do that, but it's -- it's not the
3 commissioner's business to tell them how to provide the
4 services. But they do have to provide the services that
5 have been allegedly prospectively rather than
6 retrospectively bought. That's purchasing.
7 Commissioning is supposedly about doing more.
8 Commissioning's supposed to be about determining
9 population needs and meeting them within available
10 resources and then, in order to do that, going on to
11 what's called the purchasing.
12 So in theory, and -- and the more you have a market
13 approach, such that the purchaser or commissioner on the
14 one hand and provider on the other hand are separate
15 entities making contracts in a so-called marketplace,
16 it's not the provider's job to do commissioning
17 obviously. It's a truism.
18 Now, we in the -- in our health economy, and this is
19 me, you know, being completely honest from memory, as
20 far as I can remember, we were quite often, I think,
21 behind -- you know, behind our backs and sometimes to
22 our faces said, you know, "This hospital's making
23 decisions about which services, you know, for the future
24 and that's our job". To which my response tended to be,
25 "Well, you know, if you would do your job, we wouldn't

have to make these decisions which we're actually rather uncomfortable making."

What hospitals would also find -- and I don't want to stray on to the North Staffs territory here -- is that often, for example, the contract for emergency appearances, patients coming to A&E, would be unrealistic. It would not include, bluntly, enough -- enough headcount and enough money.

And, of course, as -- as a hospital, in that situation, we would say, "You are the primary care trust, it's your general practitioners that are either not doing something or whatever, and so people are coming to our hospital so can you, please, sort it?" That's the nature of the haggle. And to my view -- as I say, I was not an executive, I was not a chief executive, I was a non-executive chairman, but to my subjective but what I think accurate impression, a huge amount of senior executive and management time was spent in those days on very nitty-gritty haggling about matters such as these. And when the North Staffordshire trust, for example, came -- the University Hospital came into financial problems at the end of my tenure, having had good financial record, the nub of the argument was hospital says to primary care trust, "You haven't paid us for what we've had to do". Primary care trust says,

"Tough, we ain't got the money, you should have turned patients away even" -- you know, but then, "What, turn patients away from A&E? You think the Secretary of State would have liked that?" This is the culture of the NHS.

So that's -- I should stop there because otherwise I will -- I will go on too much.

Q. If we perhaps go back to the example that you gave about the scheduling of short operations between the big operations with that example, how was the tension there resolved?

A. I will be completely honest and say on -- on the particular example there, which comes to mind literally from my memory, how that particular one was resolved, I don't recall. I suspect it wasn't resolved. I suspect it went into the pot and then at -- towards the end of the financial year, I think I give another example, which is actually backed up by some of the additional letters from the time that I -- that I released to you.

A lot of end of year haggling about how much the hospital should treat patients without getting paid, or how much if the hospital's not to be paid the patients go back to their GPs, to the PCT, for the next financial year, and the role of the strategic health authority in

that -- in the North Staffs, you see, so -- I don't want to bog you down with -- with the North Staffs but as -- in terms of the culture of the NHS I don't think we were atypical. We may by the end of my tenure have become an extreme example of it or -- or one of the more extreme examples of it, but the culture was very much around that.

What I will say is the strategic health authority at the time, and I'm talking about up to 2005, summer, was -- so -- so in some ways before the years that -- you're inquiry's crucial years, nevertheless the culture -- the strategic health authority in those days was, I -- I -- I would defend my statement that it was inert. It was unwilling to get involved, and my chief executive and I called the -- coined the phrase, I think, that they were into performance monitoring rather than performance management.

Q. You've mentioned in that last answer quite a lot of individual points that you make in the course of your statement, and I do want to take you through them, if I may, one by one and clarify them.

So just focusing on the strategic health authority, and going back to the days of SASSHA.

A. Yes.

Q. You've already made the comment earlier in your evidence

that your perception was that the problem with SASSHA was that it was too big to be local and too small to be strategic, and in the same paragraph you then go on to say that you perceived it to be one of the weakest SHAs nationally.

A. Mmm-hmm.

Q. Can I start by asking what your basis is for saying that it was one of the weakest SHAs.

A. Yes. First of all, may I ask you which of my own paragraphs you're on at the moment?

Q. This is your paragraph 9.

A. 9. Go back -- that's fine. Okay. My basis is partly subjective. Wearing my academic hat, at the time in the early 2000s up to the -- the mid-2000s, I experienced as an academic, you know, on visits and research and so forth other strategic health authorities. So while I don't have a quantitative basis for my judgment, I found the approach to governance of the SHA, the SASSHA, to be inert by comparison with some others.

In terms of poor performance, what I've characterised as a sense of drift produced a situation -- and I don't have the figures before me -- whereby the strategic health authority's overall financial deficit, by which I mean the financial deficit of its constituent organisations, primary care trusts,

1 hospital trusts and others, became for a small strategic
2 health authority, one of the smallest, one of the
3 largest deficits by 2005/6. Now, I don't have the
4 figures to hand but these figures are easily -- easily
5 available, obviously.
6 So there -- you know, that's not what
7 a mathematician or even an academic like me in political
8 science and public policy would call proof. But it's --
9 it's a suggestion. So that's my personal judgment.
10 I have another reason for making that personal
11 judgment. I have the view that when SASSHA was not
12 abolished but was ready to be abolished, in other words,
13 between summer 2005 and summer 2006, when it was
14 formally abolished in summer 2006 and became part of the
15 West Midlands strategic health authority, between 2005
16 and 2006, for about a year, there was de facto a West
17 Midlands strategic health authority, but because the
18 legislation, et cetera had not -- had not yet taken
19 effect, there were still constitutionally three separate
20 health authorities in the West Midlands -- strategic
21 health authorities of which SASSHA was one.
22 What I noticed was when SASSHA, as we'd known it,
23 yielded in summer 2005 and new personnel came in, the
24 approach -- this is my personal characterisation, was
25 "Good God, look at the drift there's been. We've got to

1 do something about it". That's a coined phrase, not
2 a quote. Coined phrase from me. Is it's not a quote
3 from anybody. That is my understanding. And we saw
4 a very, very different approach, you know, which was we
5 are realising belatedly that we are facing local and
6 national deficits in the National Health Service. This
7 was the -- the year of deficits and the so-called
8 deficit crisis that took up the attention of the
9 Secretary of State, Patricia Hewitt and Blair --
10 Mr Blair, the Prime Minister himself, as -- as a major
11 political crisis if not an economic one.
12 "My God we've got to do something here". And, of
13 course, we had a new regime coming in to -- to SASSHA,
14 part of the West Midlands regime now, if I can put it
15 that way. Acting not only on a more activist agenda in
16 itself quite appropriate, I would quarrel with some of
17 the details of their activism but the idea being of
18 activist I wouldn't quarrel with. And also, of course,
19 a national regime, very, very concerned with the
20 political embarrassment that we spent more money than
21 ever before on the National Health Service and we're
22 facing large deficits, you know, not everywhere, but
23 spread across England.
24 So that was the culture, you know, and I couldn't
25 help but compare before and after, and so that no doubt

1 accentuates my view that the before regime was -- was
2 rather inert.
3 Q. In terms of the before regime, you, if we can call it
4 that, draw a distinction in your evidence between
5 performance management and performance monitoring. What
6 is the distinction --
7 A. Okay.
8 Q. -- between the two?
9 A. Performance monitoring is something that we experienced
10 as -- as trusts and as chairs and chief execs at our
11 quarterly meetings, for example, with the strategic
12 health authority.
13 Most of these meetings were about the targets and
14 who was meeting them and who wasn't. It wasn't about
15 strategic threats and opportunities, to use that jargon,
16 for the future. It wasn't about reasons for health
17 economies being unable to cooperate or unwilling to
18 cooperate or whatever. It was about, "Here are the
19 targets, you're not meeting this and that, what are you
20 going to do about it?" Cue and individual agencies,
21 such as our trust, "Well, in the current climate --
22 sorry, in the current year it's not possible to do, A,
23 B, C, D, and E. It's only possible to do A, B, D and E,
24 or A, B, C and E. It's not possible to do everything,
25 let's work through what we can do". Response, "No, no,

1 you've got to do everything". So it's -- it's -- "We
2 are the strategic health authority. We are responsible
3 for the data, i.e. targets in our patch, and we need you
4 too do everything". That's what -- that's what I call
5 performance monitoring.
6 Performance management, would be saying things
7 like -- saying something like the following. There are
8 three levels in the strategic health authority. There's
9 us, the strategic health authority, there are the local
10 health economies, for example, North Staffordshire, Mid
11 Staffordshire and South Staffordshire, and Shropshire.
12 And below that there are individual organisations.
13 There are primary care trusts, there are hospitals and
14 so on. And it's about working together at the three
15 different levels about what needs to change if finances
16 are going to be managed appropriately, and yet at the
17 same time quality as well as government targets and so
18 on can be addressed.
19 So that, for example, as a hospital it would be our
20 job to seek to be more efficient where we needed to be.
21 As a primary care trust, it would be their job to say,
22 "If we can't afford something, we say so and we don't
23 leave it up to the hospital and the GPs to have a fight
24 about it". And the strategic health authority, it would
25 be up to them to manage their patch and say, "Well,

1 actually there are too -- too many primary care trusts,
2 and while we can't go against government legislation, we
3 have to find informal ways of ensuring that these
4 primary care trusts act as one, when it's necessary for
5 the future planning of services that they do, and so on
6 and so forth".
7 And that's what I -- that's not a textbook
8 definition, it's my pragmatic illustration of what
9 I might mean by "performance management", rather than
10 merely "performance monitoring", and the latter in the
11 early -- the years up to 2005, to my way of thinking
12 was -- well, it wasn't wholly unaddressed, but it was
13 inadequately addressed.
14 I can give one -- one, you know -- one example from
15 memory, which I didn't mention in the -- in the -- my
16 written submissions. For a matter of years, in the
17 early 2000s, in -- almost immediately after the 2001/2
18 reorganisation, I think the strategic health authority
19 was aware there were probably too many primary care
20 trusts. They were also aware that they couldn't merge
21 them, because that was not within their fiat. But
22 instead of being quite strong in setting a strategy or
23 trying to get agreement around a strategy, they -- they
24 set up long-running committees to deal with these
25 issues. One -- one was infamously call, if I remember,

1 the three strands review. Now, I can't remember why it
2 was called the three strands review, because it was
3 dealing with three strands, I dare say, one of which was
4 the behaviour of the primary care trusts, one of which
5 was the configuration.
6 Q. You're speeding up again. Can I just ask you to take a
7 breath --
8 A. One of which was the behaviour of the primary care
9 trusts and whether they were coordinated or not. One of
10 which was the configuration of mental health trusts in
11 SASSHA's area, and I can't remember what the third
12 strand -- it may have been elderly services. But from
13 my personal experience, what -- what's the old joke?
14 You know, you -- you take minutes and you waste years.
15 Now, to my way of thinking, this three strands review
16 pootled along without effective leadership for two or
17 thee years and laboured to produce a mouse at the end of
18 it.
19 So that's the sort of thing I mean that by
20 comparison with some other strategic health authorities
21 it was -- it didn't -- you know, it was weak by my way
22 of thinking. To be fair they would defend themselves as
23 saying, you know, the 2001 reform was allegedly about
24 creating facilitative organisation rather than
25 a directive organisation at the SHA level. So they

1 could find some chapter and verse from the legislation
2 that created them to justify their approach, and in
3 the -- in the interests of being utterly fair, I -- you
4 know, I would wish to say that.
5 Nevertheless, in terms of these hard choices and
6 looming financial crises, you know, which we and others
7 were trying to get them to pay attention to from 2003
8 and 4 onwards, it didn't -- it didn't pass muster, in my
9 opinion, in my personal opinion.
10 Q. Would it be right to infer from particularly I'm looking
11 at your paragraph 12 and all the answer you've just
12 given, that in fact in some ways you considered it
13 impossible to meet all of the targets that your
14 organisation was set.
15 A. I think we found it very difficult. And latterly, you
16 know, the proof of the pudding was in the eating. We --
17 we did find it impossible. Whether -- whether or not,
18 you know, you could argue we should have found it
19 possible it or not, you know, somebody else might beg to
20 differ on that. What we did find was that meeting all
21 the targets, adding to that, you know an important --
22 including an important target of financial balance, in
23 other words, financial break-even of the organisation at
24 the end of the financial year, and adding to that the
25 national pressures that came at the time, pay large --

1 pay settlements for all branches of the medical
2 profession, in our case in the North Staffordshire
3 the -- the costs of planning for a private financial
4 initiative, the fact that, in my opinion, money was
5 wasted locally and nationally by having too many
6 organisations, primary care trusts, for example, and so
7 on and so forth. Yes, it got, you know, never say
8 never, never say impossible, but if we take the word
9 pragmatically, yes, it was sometimes impossible. What
10 I would say is it was quite often impossible in the very
11 short-term, by which I mean within or covering one
12 financial year.
13 And yet the regime, and I would have to say
14 primarily a national regime, didn't take account of
15 these facts. And I think they -- you know, the national
16 level got -- got, which it -- what it had, you know, set
17 in train, with the deficit crisis of 2005/6. That was
18 a manifestation at the national level of the sort of
19 thing I'm -- I'm talking about.
20 When the NHS, you know -- you know, was officially
21 half a billion in -- in the red, I think the accurate
22 figure is estimated by the King's Fund in London was
23 more like 1.2 billion, and it could have been even
24 higher. But that's -- that's the sort of thing I'm
25 referring to.

1 THE CHAIRMAN: Just going back to what you said about
2 strategic health authorities and perhaps primary care
3 trusts as well, did you have any sense of certainty as
4 chairman of a provider trust what the actual functions
5 of either the SHA or the PCTs were, as between each
6 other?
7 **A. Yes, well, the money, with some exceptions, was held by**
8 **the PCTs. It was -- you know, it came directly from the**
9 **Department of Health's allocation formula to primary**
10 **care trusts against England -- across England. Some**
11 **money was -- was top-sliced by strategic health**
12 **authorities for specific purposes. But the basic**
13 **distinction in -- in plain language, was the PCTs had**
14 **the money, increasingly after 2002 the ideology, I would**
15 **use the word, was that the NHS was reentering a market**
16 **relation -- a market environment and the strategic**
17 **health authority's role, if we must use the language of**
18 **the market, was to -- to manage the market to ensure**
19 **that perverse results didn't -- didn't flow and so on**
20 **and so forth.**
21 **So that wouldn't be what the legislation said, but**
22 **the legislation, if I remember rightly, and I'm**
23 **suffering from, you know, this being almost ten years**
24 **ago when they started, in 2001/2, if I remember rightly,**
25 **there were three prime -- primary objectives or -- or**

1 **strategic functions of -- attributed to the new SHAs in**
2 **2001, in the Shifting the Balance of Power legislation.**
3 **Now, one of them was about promoting good services.**
4 **One of them was about management. And I can't remember**
5 **the third. But what I would say is that the words were**
6 **essentially contested. They weren't a tight definition**
7 **of what the SHA would be. And to be fair to SHA people,**
8 **it was up to them to create their own -- their own**
9 **culture. And there may have been good faith involved in**
10 **saying, "Well, we'll let these organisations below us**
11 **get on with it, except in extreme cases".**
12 **But that runs into, you know, my -- your -- your**
13 **first question to me this morning. That would only work**
14 **if the -- if the organisations were fit for purpose and**
15 **if the structure to which they fitted in, you know,**
16 **were -- were -- were fit for purpose. And I think**
17 **perhaps my phrase with hindsight, while an attempt not**
18 **to over-egg the pudding is perhaps appropriate because**
19 **it took some time, I think for the SHA to realise, "Hang**
20 **on, you know, things -- we thought -- we think things**
21 **are pretty okay, well, maybe they're not".**
22 THE CHAIRMAN: Thank you.
23 MS HUGHES: Can I ask you, please, about paragraph 14 of
24 your statement.
25 In the latter part of that paragraph you refer to an

1 occasion where your trust was in a degree of conflict
2 with the PCT about the treatment of a particular group
3 of patients, and in the statement you describe in the
4 SHA as procrastinating and as brokering last minute
5 stitch-ups. And that expression clearly has a negative
6 connotation attached to your perception of what the
7 strategic health authority was doing. And my question
8 is why you would see it in that way, rather than having
9 seen the SHA as being facilitating or brokering
10 a compromise in those circumstances?
11 **A. That's a very fair -- a very fair point. I think what's**
12 **probably not in the -- in the paragraph there is it's**
13 **simply a matter of time. We would have asked the --**
14 **there were some ground rules about how uncompensated**
15 **care, by which I mean care that the hospital felt it had**
16 **no alternative but to provide, as opposed to, for**
17 **example, my -- I've already given my example of turning**
18 **patients away from -- from A&E, care the hospital felt**
19 **it -- it had to provide, that the PCTs said they weren't**
20 **going to pay for. It's a matter of time. The SHA,**
21 **I feel, should have had some ground rules about these**
22 **things.**
23 **Now, the stitch-ups -- a stitch-up is a pejorative**
24 **term, you're quite right. It could be considered**
25 **a pejorative term, and I probably am using it in**

1 **a pejorative way. Had these things been handled evenly**
2 **throughout the financial year, I might have been less --**
3 **less inclined to use the phrase. What happened, of**
4 **course, was my chief executive or somebody else would**
5 **say, "Look, we really want you to adjudicate on this",**
6 **and it would only be when backs were really against the**
7 **wall that any adjudication would come, in those days.**
8 **And perhaps, as I say, not in -- not in other SHAs.**
9 **I don't know, obviously. Because this not, as is**
10 **obvious, you know, a piece of academic research. These**
11 **are my true examples from -- from a particular area at**
12 **a particular time. But, yes, too little, too late**
13 **I think is -- is what "stitch-up" implies. And the fact**
14 **that we -- we can move this and move that and get as**
15 **much near break-even as we can if, you, hospital do this**
16 **and, you, PCT do that".**
17 **Now, I don't want to be a purist, because if you're**
18 **in public life things aren't pure but, you know, what**
19 **I would often think and what we would often say,**
20 **"There's got to be a better way of doing it than this".**
21 Q. You have already, I think, given your description of the
22 SHA as being supine until the summer of 2005, and we've
23 touched on the 05/06 reform and the merger of the
24 strategic health authorities. Given what you said at
25 the start of your evidence about the previous

1 restructuring having been a mistake in terms of the
2 plurality of organisations it created, does it follow
3 that at this point in time you had a degree of optimism
4 about this set of reforms, please, and if not why not?
5 A. **Ah, that's an interesting one. I thought that the**
6 **2005/6 reforms, you know, were not earth shattering, or**
7 **restructurings were not earth shattering, but they**
8 **pushed it back in the right direction rather than the**
9 **wrong direction, if you ask me my subjective opinion.**
10 **Not unfortunately in my -- in my view, in terms of**
11 **decisions made about the trust I was chairing at the**
12 **time, but if I was taking the national view, and indeed,**
13 **perhaps, the West Midlands view, it made more sense to**
14 **have a West Midlands strategic health authority than**
15 **a SASSHA and the other two strategic health authorities**
16 **that operated between 2001 and 5 on the patch, which had**
17 **previously been the West Midlands regional office and**
18 **before that the West Midlands regional health authority.**
19 **So what -- what I found was, yes, this -- this is**
20 **sensible but I found it almost embarrassing, you know,**
21 **that ministers were conducting an ill-informed**
22 **experiment with their own extra money for the NHS. I --**
23 **I found it frustrating that they were actually saying,**
24 **"Oh goodness, we got this a bit wrong, we better sort it**
25 **out again". And, of course, on the hoof -- and I don't**

1 **mean particularly in North Staffordshire or -- or -- or**
2 **Mid Staffordshire or anywhere in the country, on the**
3 **hoof what sounded like, you know, a -- a recoordination**
4 **of the NHS often was a little bit less than that.**
5 **Now, I ceased to be chairman on 1 January 2006,**
6 **although inevitably, because of the circumstances in**
7 **which I did cease to be chairman, I was still interested**
8 **in -- in what was going on locally for a year or two**
9 **after that. Are things better or worse today than they**
10 **were at the height of Shifting the Balance of Power**
11 **between 2001 and 2005? In this -- I'm not talking about**
12 **quality now and the really important things, but in**
13 **terms of the organisational structure of the NHS,**
14 **I think things are, you know, passe Mr Lansley's reform,**
15 **before we get into the next round, you know, as of**
16 **2007, 8, 9 were things a bit better or a bit worse?**
17 **A bit better, in my humble opinion.**
18 Q. Your impression, I think, was that in particular
19 David Nicholson and Antony Sumara had been tasked with
20 doing a specific turnaround job in the West Midlands
21 region, I think that's something you've already alluded
22 to.
23 A. **I -- I mean, can I just qualify that a little bit?**
24 Q. Certainly. Please do.
25 A. **I think, you know, they were creating new larger SHAs**

1 **because they thought we created was it 29, was it 30?**
2 **It was one of these two, in 2001, and this was my point,**
3 **you know, they were too -- too small to be strategic,**
4 **too big to be local. They went in effect back to**
5 **regional health authorities. They still call them**
6 **strategic health authorities now. But what -- what --**
7 **what the NHS has in England now is regional health**
8 **authorities, like it did before 2001.**
9 Q. You're going very fast.
10 THE CHAIRMAN: Just slow down.
11 A. **I do apologise, these are at the anoraky bits that I'm**
12 **trying to spit out so I can get to the interesting bit.**
13 **I do apologise.**
14 **The regional authorities have been reinvented by the**
15 **2005/6 restructuring in slightly different form in some**
16 **cases. In the case of the West Midlands in exactly the**
17 **same form, covering the same area.**
18 **Now, David Nicholson was simply -- he wasn't brought**
19 **in to -- overtly to do a turnaround job, he was brought**
20 **in to be chief executive designate of the West Midlands**
21 **strategic health authority designate. Now, because it**
22 **was designate and hadn't yet been formally approved, the**
23 **NHS is very good at getting on with it before**
24 **legislation or statutory instruments have -- have**
25 **actually been passed. And that's what happened there.**

1 **David came in as overall patch de facto chief**
2 **executive, but the way they handled that, given that the**
3 **three SHAs had not yet become the West Midlands single**
4 **SHA, was that he became chief executive of each of the**
5 **three and, of course, he couldn't be in three places at**
6 **once, and so a managing director, in the case of the**
7 **SASSHA, was put in, so that technically David Nicholson,**
8 **between 2005 and when he left the patch to go elsewhere,**
9 **was chief executive of SASSHA, as well as chief**
10 **executive of two others, and the managing director of**
11 **SASSHA was -- was Antony Sumara, working, of course, to**
12 **Nicholson and very closely with Nicholson.**
13 **So he was brought in at that stage not to do**
14 **a turnaround job. He was brought in just to do a job**
15 **that the restructuring necessitated. I think -- I think**
16 **if you asked -- as no doubt you have and will, if you**
17 **ask Antony Sumara, did he find everything in good**
18 **health? The answer would clearly be no. And so he then**
19 **later, wearing different hats, became chief executive of**
20 **the trust I had been chairman of, only later. I didn't**
21 **overlap with him. And then, of course, more recently**
22 **having been in London, I believe in the interim, he has**
23 **come back to be -- to be chief executive of -- of the**
24 **Mid Staffordshire trust.**
25 MS HUGHES: Can I just explore with you the question of the

1 manner generally in which government policy was fed down
2 through the hierarchy and implemented, and this is
3 something that you touch on at paragraph 16 of your
4 statement, where you express --
5 A. **Yeah.**
6 Q. -- a view that the government of the day did not seem to
7 understand how its orders were being implemented by the
8 SHA. And I wonder if you could just put some meat on
9 the bones of that statement, please?
10 A. **Yes, it's -- the phrase is not -- is not original to me**
11 **but it's -- the phrase that, you know, a few of us used,**
12 **you know, about the NHS, and perhaps -- perhaps still**
13 **would, I'm not quite sure, is in terms of culture, the**
14 **kiss-up kick-down culture. I think it's**
15 **a transatlantic -- I think it's an American phrase by**
16 **origin and, of course, it's sometimes used whimsically,**
17 **but kiss-up kick-down means that your middle level**
18 **people will kiss-up, they will please their masters,**
19 **political or otherwise, and they will kick-down to blame**
20 **somebody else when things go wrong.**
21 **Now, you may say, is that a pejorative**
22 **characterisation? I guess so. Does it always apply?**
23 **No. Is it, in my opinion, too prevalent a feature of**
24 **the NHS culture at this time, and perhaps to this day?**
25 **Yes, in my opinion. So that's -- that's really what**

1 **I mean.**
2 **It's always an open question, if you take one**
3 **example, Secretary of State, Alan Milburn with his**
4 **targets in the -- in the early 2000s. To me, it's**
5 **a waste of time and expensive resource of top executives**
6 **that if there's one breach of one target -- that's**
7 **jargon for, for example, one patient missing the A&E**
8 **four-hour wait target -- that that chief executive is**
9 **summoned to regional head office, SHA head office or in**
10 **some extreme examples national head office, the**
11 **Department of Health, to explain.**
12 **Now, I don't know if that -- I used the phrase**
13 **earlier this morning, the targets are not necessarily**
14 **bad, some of them were bad, some of them were good. But**
15 **the implementation of targets in a particular culture**
16 **can be, I think I used the phrase, "ludicrous", the word**
17 **"ludicrous". That I experienced -- and I can't give you**
18 **chapter and verse, but I experienced specific examples**
19 **of people running around, you know, like headless**
20 **chickens explaining individual breaches because**
21 **strategic health authority people were frightened of**
22 **what ministers were going to say to them and so on and**
23 **so forth.**
24 **Now, I assume, perhaps -- perhaps -- I don't know,**
25 **perhaps wrongly, I assume that if you're Mr Milburn or**

1 **you're Patricia Hewitt who whoever the Secretary of**
2 **State was, knew about that, they'd say, "Oh, don't be**
3 **silly". You know, the alternative hypothesis is that**
4 **they were running, you know, a top-down control**
5 **organisation, you know, that would be rather ludicrous,**
6 **in my view. That -- but the culture, it's -- I think**
7 **I do use the phrase, "overenthusiastic to please" and**
8 **that's what kiss-up kick-down isn't -- isn't, you know,**
9 **you centralise credit and you devolve blame, et cetera.**
10 THE CHAIRMAN: You describe this in your paragraph 16 as
11 micromanagement of data.
12 A. **Yes.**
13 THE CHAIRMAN: Is there not something of a political
14 imperative, whichever party is in power, to be able to
15 deliver positive statistics, figures to the public --
16 A. **Yeah.**
17 THE CHAIRMAN: -- as being a result?
18 A. **Yes, and I -- I -- I should correct --**
19 THE CHAIRMAN: Is that what you mean by that?
20 A. **Yeah. I think so. I -- I think it is, and I -- I --**
21 **I wouldn't -- you know, I wouldn't say that this**
22 **suddenly appeared in 2001 and disappeared in 2005.**
23 **I'm -- in my opinion, and this is the -- the academic in**
24 **me, the NHS, despite rhetoric about different phases,**
25 **for example, the internal market as opposed to alleged**

1 **hierarchies before that, and something else after that,**
2 **we've been on a fairly steady line of increased central**
3 **control from 1948 to 2011. And, you know, I'm not**
4 **pontificating about what happens after 2011, obviously,**
5 **but, yes. I mean, you could argue, well, what's wrong**
6 **with that? The more you've got to do with limited**
7 **public money, the more tight accountability there has to**
8 **be. Yes, there should be accountability for objectives**
9 **but the devil's going to be in the detail and also the**
10 **culture's going to be important.**
11 **If it's, you know, "We'll give you three years to**
12 **get it right and then if you got it wrong you're out",**
13 **fair enough. But if it's, "We'll give you three years**
14 **to get it right and then on Monday morning, by the way**
15 **you've got do this, we've just heard about this from --**
16 **from the Department of Health", or, "We've realised**
17 **that, you know, that what we're going to have to do with**
18 **payment by results is going to X rather than Y", so**
19 **suddenly three-quarters of the way through the financial**
20 **year you've got 3 million less than you thought you had.**
21 **It's that kind of stuff that's the culture, absolutely,**
22 **of the NHS, until hitherto.**
23 **Now, I should make it clear, because these remarks**
24 **can be misinterpreted, I am a great believer in the NHS**
25 **and a great believer in public -- publicly funded,**

1 **publicly provided health services. I'm not criticising**
2 **that model. I'm criticising an inappropriate culture,**
3 **which can apply in any system, whether public, market,**
4 **private, you name it.**
5 MS HUGHES: What you describe in terms of the inappropriate
6 culture, does that manifest itself in terms of direct
7 instruction coming down the hierarchy or is the pressure
8 more covert? Is this done by sort of late evening phone
9 calls and that sort of --
10 **A. Yeah. I mean, there are late evening phone calls and**
11 **there are -- there are letters. I gave you an example,**
12 **I think, of a letter from Antony Sumara, managing**
13 **director of the SHA, just in the last month or two when**
14 **I was chairman of the trust, a letter to my then acting**
15 **chief executive, saying, "Dear Peter, we have done so**
16 **and so, we have looked at so and so, here's what**
17 **I expect you to do by", whatever, year end, next week,**
18 **whatever it happened to be, a list of things, "If you**
19 **have any problem or anticipate any problems in meeting**
20 **these, please" -- I'm paraphrasing, you've got -- you've**
21 **got it in front of you.**
22 Q. It's because you have speeded up, that's why I'm looking
23 at you like that.
24 **A. Sorry. "If you have any" -- I'm paraphrasing, "If you**
25 **have any quibble with any of that, give me a ring.**

1 **Yours, Antony". Now, that's very much the culture. So**
2 **that's there, you know.**
3 Q. That would be a direct --
4 **A. That's a direct --**
5 Q. -- instruction?
6 **A. If you had Antony here, he would say, "Well, of course,**
7 **it's my job, because these are national targets as well**
8 **as the -- the rules governing the NHS about financial**
9 **break-even and so on so, of course, I'm telling you to**
10 **do it". I just think that if it's that plus the phone**
11 **call, plus something else, and that's the main means of**
12 **engaging, then, you know, there needs to be more.**
13 **Now, I'm not criticising that particular individual.**
14 **I'm just saying that's an example of a letter which**
15 **I provided in terms of, you know, the must-dos, do them.**
16 **Now, if I was sitting here from a strategic health**
17 **authority at that time or indeed today, I would say,**
18 **"Well, you know, the Department of Health tells us to do**
19 **that. The government's elected, it's the only part of**
20 **the government -- governance of the NHS which is**
21 **elected, the national government at Westminster. They**
22 **tell us to do that, so we've no option but to tell you**
23 **to do that". It's a question of how these things are**
24 **done. Okay?**
25 THE CHAIRMAN: But just to take your example, surely for

1 better or for worse, what Mr Sumara or someone like him
2 is doing in such circumstances is performance managing
3 what you do?
4 **A. Yeah. Now -- I mean, we've got on to --**
5 THE CHAIRMAN: The reason I ask is, in your paragraph you
6 distinguish between micromanagement of data as being the
7 preoccupation from what you say they ought to have been
8 doing --
9 **A. Yes.**
10 THE CHAIRMAN: -- which was performance management.
11 **A. Now, what I would like to say immediately here is**
12 **that -- you know, we -- we've given, and I know it's**
13 **only an example, of, you know, Antony at that time.**
14 **Now, since I barely overlapped with Antony at -- when he**
15 **was at the SHA and didn't overlap with him at all at the**
16 **trust, I'm not criticising his approach to these**
17 **matters, because I haven't worked with him enough to do**
18 **that. I'm saying that in the years I experienced**
19 **things, yes, of course, there has to be a statement, "We**
20 **expect you to do this", but there has to be more than**
21 **that as well, in other words, "Now, if you as a trust**
22 **have views about the -- you know, why there are factors**
23 **impeding your ability to do that, then let's sit down**
24 **with you, the PCTs and others and not just have our**
25 **monthly or weekly performing management meeting or**

1 **performance monitoring meeting, but let's talk about,**
2 **you know, ways of working and so on".**
3 **Now, that's what in my tenure was -- was missing.**
4 **Partly a national problem, because, for example, if the**
5 **North Staffs is an actual health economy, then what you**
6 **have was a health economy, a local health economy, with**
7 **lots of different agencies, but no head office. This is**
8 **my point, the SHA too small to be strategic but too big**
9 **to be the head office of a local health economy, and so**
10 **on and so forth.**
11 **Partly, I think that -- how can I say? My -- this**
12 **is subjective, but my view is that if the strategic**
13 **health authority was confronted with, you know, "We**
14 **can't agree with the PCTs for the following reasons,**
15 **based on the structure", you know, that would be seen as**
16 **whingeing. Now, you know, I mean, David Nicholson, for**
17 **example, and not about the West Midlands or about**
18 **SASSHA, but, you know, he's often been quoted or has**
19 **been quoted in national interviews about people**
20 **whingeing about other organisations. Now, I would draw**
21 **a distinction between whingeing about other**
22 **organisations on the one hand and making diagnoses of**
23 **dysfunctional structures and so forth. And so I think,**
24 **you know, there's -- there was -- there probably is an**
25 **element in the kiss-up kick-down culture, as I call it,**

1 **of yours's -- yours's not to reason why, you know, if**
2 **I could put it that way.**
3 MS HUGHES: Sir, I'm about to move on to another topic but
4 I wonder if that's a convenient moment?
5 THE CHAIRMAN: Yes, I agree with you, and we'll take 15
6 minutes and I'll be back at 25 to or thereabouts.
7 (11.22 am)
8 (A short break)
9 (11.35 am)
10 (Proceedings delayed)
11 (11.40 am)
12 MS HUGHES: Professor Paton, can I move on now to asking you
13 about foundation trust status, and looking at it,
14 firstly, in terms of an example of the way in which
15 national government policy is implemented.
16 Just to orientate you, I'm going to have a look at
17 in particular paragraph 8 of your written submission to
18 the inquiry --
19 **A. Oh yes.**
20 Q. -- which is exhibited --
21 **A. Yes.**
22 Q. -- to your statement as your exhibit 1.
23 **A. Yes, I understand.**
24 Q. One of the things that you say there is that national
25 policy fads drove the agenda locally and absorbed huge

1 amounts of management time and non-trivial amounts of
2 non-executive time.
3 And if we can just explore that, so that we can
4 understand the criticism, if it is a criticism that
5 you're making there, because on one view it might be
6 asked, how else national policy can be implemented,
7 other than by driving the agenda locally?
8 **A. Yes. I mean, in -- in a sense you've -- you've cut to**
9 **the -- the nub of the NHS dilemma, in my view, which is**
10 **if the reality, despite the rhetoric, is central**
11 **political control, then it's highly inefficient to have**
12 **a structure in the NHS which pretends the opposite. For**
13 **example, foundation trusts being created on the grounds**
14 **that they will allegedly be fairly autonomous, for**
15 **example, that the model of -- what is it? -- the**
16 **Britannia Building Society mutual -- all the -- how can**
17 **I call it? -- optimistic theory or anticipation of a new**
18 **NHS, if the reality, however, is different, then the**
19 **danger is you have central control but a structure**
20 **pretending something different. I guess I'm saying it's**
21 **better to be honest, and if it's going to be central**
22 **control, then set up a hierarchy to recognise that and**
23 **efficiently transmit instructions from the centre.**
24 **What's the phrase which is sometimes used**
25 **pejoratively but not -- not in the -- in the military,**

1 **of course, "command and control". "Command and control"**
2 **isn't a term of abuse in the military, it's a functional**
3 **necessity under certain circumstances. In the NHS, it**
4 **tends to have become a term of abuse, by those who want**
5 **to persuade the public or the media or whoever that they**
6 **are not -- what is it? -- old style planners. In**
7 **Tony Blair's case, very keen to sell the message to the**
8 **media, and therefore the public, that I'm not old**
9 **Labour, I'm New Labour. I don't do things by state**
10 **control and hierarchy.**
11 **Hence, foundation trusts is something that fits very**
12 **nicely into that. So what I'm in effect saying is if**
13 **that is the latest policy must-do, or so -- or something**
14 **like that, then it is a distraction. It's a -- it's**
15 **only not a distraction if the benefits of all that**
16 **management time and preoccupation are borne out by the**
17 **transformation of the NHS as a result of foundation**
18 **trust status applying widely, let's say. As far as I'm**
19 **aware --**
20 THE CHAIRMAN: Aren't you painting it slightly black and
21 white, in the sense that if there's a genuine political
22 intent to localise, make things more independent, and so
23 on, there has to be a transition during which, while you
24 aspire to that, you still need to retain central
25 control?

1 **A. I -- I do accept that, and I don't want to divert the**
2 **issue but maybe later, very briefly, that's exactly the**
3 **debate they're having right now. The National**
4 **Commissioning Board will have to run things, where**
5 **groups of GPs or groups of clinicians, as it's now to**
6 **be, are not willing or able to do so. It's when**
7 **temporary -- you know, this -- I don't want to be**
8 **facetious, but -- but this is Lenin, Lenin said you've**
9 **got to centralise to decentralise. It's very easy to**
10 **forget the second bit of that.**
11 **Now, my view is that foundation trust status is --**
12 **was and is very, very much about process, as it was**
13 **administered, rather than outcome at that time.**
14 **I totally take the chairman's point that if this is**
15 **a policy which for better or for worse is believed in,**
16 **even you could argue if it's not believed in, if it's**
17 **a must-do it's a must-do, and therefore you have to**
18 **spend management time doing it, preparing for it, and**
19 **you also have to check that the -- the ship doesn't sink**
20 **while you're remaking it. You know -- what is it? --**
21 **mending the boat while sailing it, and that is exactly**
22 **where the same David Nicholson find himself today,**
23 **trying to hold the NHS together, et cetera, et cetera.**
24 **My view, however, I can't prove it with -- with data**
25 **here today, but my view or my -- my judgment is that**

1 foundation trust status at this time was a way that
2 strategic health authority chiefs could win political
3 favour by demonstrating that they had organisations in
4 their patch ripe or fit for foundation status. So while
5 at this stage, and even now to this day, I think,
6 almost, it's a voluntary procedure, what is the famous
7 phrase from Sir Humphrey Appleby to the Prime Minister
8 in "Yes Prime Minister," "Yes, well, of course, you
9 can -- you can decide not to be a foundation trust if we
10 fingered you to be one, but, of course, it would be
11 a very brave decision". It's that kind of culture in
12 the NHS.
13 Now, they haven't, to be fair, done with foundation
14 trust status what they've done with some previous
15 initiatives. They haven't rolled things out, in that
16 phrase, as mechanistically as in the past. Witness the
17 fact today that there are many trusts in the NHS which
18 are not -- many hospitals or mental health trusts,
19 whatever, which are not foundation trusts. So they
20 haven't said, "Right, you've all got to do it by next
21 Christmas". They have a process, and it's a very, very
22 rigorous process in some ways, but I think at this time
23 you would have to ask the -- legitimately the question,
24 what is the opportunity cost, in terms of time, not in
25 terms of conspiracy, of setting, for example, the Mid

1 Staffordshire hospital trust on the road to being
2 a foundation trust?
3 There's always a danger with ministerial
4 predilections that they become an end in themselves.
5 That's, I guess, part of my point there.
6 Q. How feasible do you think it is for a trust to adopt
7 a strategy that is at odds with that centralised agenda
8 of foundation trust status?
9 A. It's not easy. I mean, when I was chairman of the
10 University Hospital trust we had a two-star status. We
11 went up from one or, you know, what would have been one
12 to two stars in the -- in the latter years of my -- my
13 time there.
14 Now, we, as a trust, corporately wanted to be three
15 stars. As an academic I could say, if I wanted, either
16 to myself or to whoever I could get to listen, "Hang on,
17 what does three-star status actually mean?" But
18 I thought that would have been illegitimate of me
19 because in perhaps tangible or intangible way, which
20 I can't -- you know, I probably won't say more about
21 that at the moment, I would probably have been
22 disadvantaging the trust. Because if the game being
23 played is, stars on the one hand and then subsequently
24 foundation trust following on from that, I -- I think,
25 really, you know, one cannot put ones own views, you

1 know, at the expense of the organisation. That's the
2 compromise one makes -- makes in public life. For
3 example, the private finance initiative, to me that's
4 a rotten deal financially, was, is and will be, as far
5 as I can see, but when I was chairman of the trust the
6 choice in the University Hospital of North Staffordshire
7 was keep your Victorian buildings in the 21st century or
8 get a PFI. So you have to -- you know, you have to put
9 your views on the side on some occasions. And -- and we
10 were asked if we were willing to be diagnosed to be
11 a foundation trust in the University Hospital, and our
12 answer was yes. That didn't prevent us having
13 conversations as individuals and human beings, saying,
14 "We could actually do without this, but we will -- we
15 may disadvantage the trust, not in terms of managers'
16 jobs, in terms of money for the health economy and for
17 patients.if we don't play the game". That's that kind
18 of thing.
19 Q. I think you said in your statement that your immediate
20 reaction to the proposal that your trust should go
21 through the foundation trust application process was
22 that it would be a distraction from the trust's real
23 agenda. So is it right that you saw it as being at odds
24 with the trust's -- was there no way in which the two
25 could work together, as it were?

1 A. A very -- very pragmatic answer would be I was proved --
2 proved hideously right, in that for two -- between
3 2003/2004, never mind later years, the then chief
4 executive at the trust, Mr Crowley and my -- and myself
5 were constantly saying to anyone who'd listen, and the
6 SHA included, "If things don't change, because of the
7 way this health economy is in North Staffs we'll be
8 heading for a deficit", although, you know, we avoided
9 that until 2005/6, and so on and so forth.
10 So it's pure how much can you -- can you handle? We
11 had a major PFI for a major new hospital, rationalising
12 it on to one site. We had very many other -- we had
13 just become a University Hospital. We an increasingly
14 difficult financial environment. You know, I can list
15 all the -- all the things, that, you know, that trusts
16 like ours had and that we did indeed have like, you
17 know, massive new information management and technology
18 strategy and implementation and so on.
19 It wasn't -- if it's the game that must be played,
20 then you have to find management time. But, you know,
21 you can eventually create a situation whereby, however
22 good they are, there just aren't enough strategic or
23 chief type managers to do -- to do all this. And that's
24 the sense in which it was a distraction.
25 Now, I could have my own views that it was also

1 something which was going to take a lot of resource
2 without commensurate benefit for the whole NHS, and
3 I stand by that. But that wasn't so much the point.
4 The point locally was, it didn't take eyes off the ball,
5 but it had so many -- you know, it was yet another ball
6 bouncing around.
7 THE CHAIRMAN: There are trusts, I think, round the country
8 who took the view, including some who had big PFI
9 commitments, that they wouldn't go for foundation trust
10 status and didn't. Why didn't you join that gang,
11 rather than the other?
12 A. Well, I -- well, with -- I've used, I've been credited
13 with the phrase with hindsight already. Given the
14 peculiarities of North Staffordshire and the fact that
15 we were eventually given our initial assessment under
16 the so-called diagnostic process -- the initial
17 diagnostic process as -- given that that hit at exactly
18 the time our own local financial problems hit, with
19 hindsight very simple. You know, it would have been
20 sensible to say, "Too much of a distraction, we'd rather
21 not, thank you very much".
22 I mean, our trust in the North Staffs -- and this
23 isn't about the North Staffs, I know -- had a bit of
24 a reputation as being willing to -- what's that
25 grandiose and perhaps arrogant phrase? -- speaking to

1 truth to power. In other words, saying, "Look, you
2 can't do this, you'll just have to tell the minister".
3 And ironically enough, I didn't think we wanted to be
4 seen as the awkward squad, you know, on every issue.
5 But -- but these -- you know, that -- that is with the
6 benefit of hindsight. At the time, it was a pragmatic,
7 unquantitative judgment, it was a qualitative judgment
8 that in the round, you know, it was worth doing it for
9 the sake of the local health service.
10 Now, if we'd known what was known even a few months
11 later about the national financial crisis, the fact that
12 we were going to be a part of that, plus the fact that
13 foundation trust status was actually going to be
14 problematic in some very specific cases, I think, with
15 hindsight, it would have been better to say, "Just,
16 look, leave us alone to do other things at the moment".
17 MS HUGHES: Just following from the question the chairman
18 asked you, in terms of that decision, one of the points
19 you also make in your written submission at paragraph 10
20 is that senior NHS executives are forced or moulded into
21 addressing the must-dos of the day. My question is, to
22 what extent your own senior executive team at your own
23 trust was under the influence of the sort of pressure
24 you describe in respect of the decision --
25 A. To be -- I think I'd have to be -- be absolutely clear

1 and say that before summer 2005, when the issue was
2 becoming one -- you know, formally of charge for our
3 board, shall we -- shall we continue down -- shall we go
4 down the road of this or not? We -- nobody was bringing
5 pressure on us at that stage. It was more a question of
6 us looking at the lie of the land.
7 Ironically enough, by autumn of 2005 onwards, when
8 we'd just -- you know, ticked the initial box and say,
9 "Yes, we'll go down the beginning of this road", events
10 were taking over, to the extent that the pressure,
11 ironically, would have probably been the other way,
12 "Look, you know, the health economy is going into
13 a financial tailspin, and you -- you know, you shouldn't
14 be doing this".
15 So in our particular case, I've -- I've no claim to
16 make about, you know, somebody twisting my arm
17 personally, "You must become an FT". I would say, of
18 course, that we were an atypical -- we're not
19 necessarily typical of the story of FTs, because, you
20 know, this -- this inquiry isn't -- isn't about the
21 University Hospital. And the University Hospital,
22 ironically, you know, went -- went from hero to zero in
23 the opinion of the -- the government at the time,
24 because we'd -- we'd been, you know, we'd been the
25 shining star of the SASSHA patch for many years and then

1 suddenly we weren't. And so I think the question is
2 much more about -- well, the Mid Staffordshire trust,
3 you know, and others, perhaps, in a position like the
4 Mid Staffordshire trust, which judging by star ratings,
5 and I -- I've made it extremely clear, I've no internal
6 connection with the Mid Staffordshire hospital trust,
7 but in terms of star ratings, which, of course, you
8 know, were the government's own chosen means of
9 indication, I'd have to say, how on earth can a trust
10 which goes in four consecutive years from two to three
11 to zero to one star be considered a suitable candidate
12 to, you know, assess through the diagnostic process
13 for -- for foundation trust? It's that kind of thing
14 I'm pointing to.
15 I mean, if you were whoever at the strategic health
16 authority or the Secretary of State or whoever, you
17 could -- you could at that time have looked at the
18 University Hospital and said, "You've gone from middling
19 one star to middling two star to top of the league at
20 two star and just missing three star in 2004, so you are
21 likely, if you want to want to go beyond three star
22 trusts".
23 Now, already you see we're into stars and twos and
24 threes and, what does all that mean? As an academic
25 I've got to keep reminding myself of that. But these

1 **things after extremely powerful and I -- I say this**
2 **perhaps, you know, absolutely just from my impressions**
3 **in the trust, these things are extremely powerful, not**
4 **just around the boardroom table, in terms of the**
5 **self-perception of an organisation. I don't want to**
6 **over-egg this pudding but, you know, when you go from**
7 **three star to zero star from one year to another, as**
8 **I believe this Mid Staffordshire trust did, you know,**
9 **that has a desperate effect on the morale well beyond**
10 **the boardroom.**
11 **There's a phrase that my academic colleague**
12 **Carol Propper and Julian Le Grand use "targets and**
13 **terror". Well, the NHS in this day, it's a coined**
14 **phrase, was being run through an academically coined**
15 **phrase of "targets and terror", if you like and, you**
16 **know, these things are -- are -- the terror, of course,**
17 **is -- is, you know, the then -- what was it? -- the then**
18 **chief executive of the Mid Staffordshire trust way back**
19 **whenever they had the zero star after having been three**
20 **star, he was named and shamed on the front page of one**
21 **of the tabloids as, you know -- what was it? -- the nine**
22 **potatoes or whatever it was, the nine chief execs**
23 **earning more than 100 grand, you know, who -- who got**
24 **zero stars. So that's -- that's what I think the**
25 **academics mean by "the terror", you know, it's naming**

1 **and shaming and it's, you know -- it -- it's part of the**
2 **culture and it may be -- I mean, at the end of the day**
3 **the board of a trust is always responsible. You know,**
4 **in the last resort it can resign or in the intermediate**
5 **resort it can refuse to do X, Y, Z. So people are not**
6 **in a direct hierarchical line of command and control, so**
7 **they do bear responsibility at board level.**
8 **But the environment of success and promotion for**
9 **executives, not non-executives, is extremely heavily, at**
10 **this time, bound up with the political agenda of the**
11 **day. No question about that. Anyone who denied that,**
12 **I would -- you know, I would really be surprised to find**
13 **them doing so, even if they were to do so publicly, if**
14 **I may say.**
15 Q. I'm going to ask you now about the diagnostic meeting
16 that your trust was involved in in December of 2005.
17 It's not a topic on which I want to spend a large amount
18 of time, because as we've said, we're not concerned with
19 the specifics of North Staffs.
20 Before I ask my questions, there's just a point of
21 clarification, in terms of your paragraph 33 of your
22 statement.
23 **A. Of my oral statement, yes, yes.**
24 Q. Of your full statement --
25 **A. Yes.**

1 Q. -- rather than the exhibit. I'm asked to remind you
2 that the region-wide diagnostic meetings were initiated
3 by the strategic health authority as a pilot development
4 programme, and that they had the support of the
5 Department of Health and Monitor, but that Monitor were
6 not directly involved and that the pilot was designed to
7 identify areas where the trust needed to develop in
8 order to reach the standard required for foundation
9 trust status.
10 **A. Yes. Yes.**
11 Q. Do you accept that characterisation of the process,
12 first of all?
13 **A. Well, it depends. The thing that I would possibly**
14 **quibble with there is that Monitor were not directly**
15 **involved. I can only speak for the diagnostic meeting**
16 **that we had in the -- in the North Staffordshire**
17 **University Hospital. Nicholson -- David Nicholson**
18 **chaired -- chaired the meeting. Monitor were there.**
19 **Since foundation trust status is at the behest of**
20 **Monitor's recommendation to the Secretary of State, it**
21 **would have been bizarre if Monitor weren't there. And,**
22 **indeed, they were there in the form of Ruth Carnall,**
23 **a former -- at that time a former NHS senior executive,**
24 **and again subsequently an NHS senior executive, more**
25 **recently chief executive of -- of the London strategic**

1 **health authority. Now, she was there, in her -- one**
2 **of -- a temporary period out of the NHS formally,**
3 **representing Monitor.**
4 **Now, my paragraph 33 is not intended to be**
5 **facetious, but I would say it's intended to be wry.**
6 **What I'm really saying there is that this is all part of**
7 **the fact that the Department of Health, its**
8 **representatives in the provinces, the strategic health**
9 **authorities, and Monitor are together working on an**
10 **agenda. And so the idea that, you know, foundation**
11 **trust status is something which is going to be radically**
12 **new in terms of absence of control, political or**
13 **otherwise, was always to me, with -- if I may sound**
14 **pompous, an academic's nose for the history of the NHS,**
15 **was always to me highly unlikely. That's -- you know --**
16 **so -- so I feel, that, you know, yes, it was the**
17 **strategic health authority's job, so my comment about**
18 **why was David Nicholson chairing it? Is an -- I'm being**
19 **slightly wry but I'm saying if one was having a stiff**
20 **upper lip and saying it's Monitor's job to go with**
21 **trusts to assess them from beginning to end and then**
22 **recommend to the Secretary of State, then, you know, it**
23 **really should be a different -- a different arrangement.**
24 **And I think -- you know, I -- I can't have it both**
25 **ways. I, you know, I cannot (inaudible). I can't have**

1 it both ways. I can't on the one hand say, what?
2 I can't on the one hand say SHAs don't get involved
3 enough and they're too inert, 2001 to 2005, and on the
4 one hand, why was Nicholson there? You know. Well, of
5 course -- you know, of course he should be there. But
6 I'm just making a point that there's a very tight agenda
7 and it's all managed. It's chess pieces. It's -- it's,
8 you know, "We'll move that there and we'll make this an
9 FT, and we'll do this and we'll do that". And that may
10 be fine but if it is fine, let's drop the silly rhetoric
11 about, you know, autonomous foundation trusts. Okay?
12 THE CHAIRMAN: Well, if I may say so, I don't know that one
13 part of your answer follows from the other, because
14 surely a process of some care would have to be taken in
15 launching a trust as a foundation trust if in truth it
16 were to have a genuine degree of independence in the
17 control of its finances --
18 A. Yes.
19 THE CHAIRMAN: -- in that the government would be entitled,
20 and indeed under a duty, to ensure that it wasn't losing
21 control over a large portion of taxpayers' money --
22 A. Yeah.
23 THE CHAIRMAN: -- without some assurance it was going to be
24 properly looked after?
25 A. Yeah, I mean --

1 THE CHAIRMAN: So why would a process like this import lack
2 of intent to allow independence at the end of the
3 process?
4 A. I do take that point. I'll just go back to -- you know,
5 my very brief paragraph 33, is intended to be a wry
6 comment on the culture of the, NHS rather than
7 a naive --
8 THE CHAIRMAN: Yes, but you've just said, if I understood
9 you correctly, that this wasn't a genuine attempt to
10 produce greater autonomy at the front line.
11 A. Yeah. Right. Let me give my honest view on this.
12 I honestly believe that the originators of the
13 foundation trust process -- sorry, foundation trust
14 policy, you know, the Secretary of State, Milburn,
15 I haven't spoken to him, I don't know him personally,
16 his chief adviser in those day, Paul Corrigan, they
17 believed sincerely in it. You know, I think they
18 believed, talking to Mr Corrigan, Professor Corrigan,
19 that this was actually an attempt to make a new NHS.
20 My point isn't that, you know, forget about
21 paragraph 33, as I've said for -- for one reason, in
22 terms of what that's trying to say. My wider point is
23 not that ministers are fiendishly trying to centralise
24 while selling the story to the Daily Mail that they're
25 not, so they can persuade people they are New Labour not

1 old Labour. I'm not -- I'm not saying that. I'm saying
2 that the logic of what they set in train results in much
3 less autonomy for constituent parts of the NHS than they
4 think for ironical reasons, some of which I think
5 you're -- you're pointing to that, you know, they have
6 to hold on -- or David Nicholson or whoever it happens
7 to be. Sorry, has to hold on, and it's then a question
8 of, well, you know, does the holding on set the culture?
9 Now, I cannot say that financial autonomy of any
10 sort is not available to foundation trusts. But, of
11 course, we'd had from 1991 to 93 the Conservative
12 government's policy of the internal market, creating
13 self-governing trusts. Every single hospital in the
14 country, by the time -- in England, by the time Labour
15 came in in 1997 was a self-governing trust. So when
16 I read, you know, the prospectus, if you like, for what
17 an FT, a foundation trust was to be, I thought, "Well,
18 90 per cent of this is -- is -- was there, in
19 Ken Clarke's reforms at the end of the 80s, beginning of
20 the 90s. That gradually got taken back, under
21 a Conservative government. By which I mean real
22 autonomy was found to be a little bit of an illusion.
23 And maybe I was cynical, maybe not, but I didn't see
24 this being in the long run massively different. And the
25 reason it's not because of the bad faith of Alan Milburn

1 or Professor Corrigan, it's because of a point
2 somebody's made earlier, it's taxpayers' money. And at
3 the end of the day, however it's routed, that taxpayers'
4 money goes into the foundation trust, even if it's via
5 a commissioning PCT or a commissioning group of -- what
6 is it going to be? Clinical commissioning groups under
7 this new government's recently reannounced reforms.
8 At the end of the day, my view is -- is quite
9 a simple one. It's public money in what, despite the
10 rhetoric, is a public organisation, so that's -- that's
11 my point, really. It's a bit of a rigmarole to go
12 through, given that reality at the end of the day.
13 I think that's what I'm trying to get at. I maybe --
14 I am -- I mean, I -- I was aware of the danger of
15 inconsistency here, not least when I said about the SHA.
16 I can't carp about everything an SHA does or doesn't do.
17 I can't say, "It's not doing enough. Oh, by the way,
18 it's now doing too much". I do understand your point.
19 THE CHAIRMAN: Thank you.
20 MS HUGHES: In terms of the meeting itself, I think it's
21 fair to say that you are critical of the manner in which
22 the meeting was conducted, at least to the extent that
23 your recollection is that it was dominated by finance
24 and in your statement you use the term "hijacked".
25 Now, presumably you would accept that sound

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1 financial governance is an essential component of
2 providing high quality care?
3 A. **Yes, I do.**
4 Q. And so do you want to explain why you use the term
5 "hijacked"?
6 A. **Yes. The danger, of course, here is that we're into the**
7 **minutiae of the complex North Staffordshire University**
8 **Hospital story. But, yes, it's perfectly legitimate for**
9 **a diagnostic meeting to be about the financial -- the**
10 **underlying financial status and future of the trust.**
11 **It's less legitimate that three-quarters of the meeting**
12 **is about an in-year financial crisis, unless that's**
13 **believed to be indicative of the trust's underlying**
14 **status past, present and future in the absence of**
15 **action. And, of course, it's legitimate to talk about**
16 **finance.**
17 **Given where we were in the health economy by that**
18 **stage, it would have been quite sensible, you know, to**
19 **have said, "Okay, we'll -- we'll leave this foundation**
20 **trust thing". It's just simply a question of form, and**
21 **I don't want to sound precious or -- or, you know,**
22 **speaking with a stiff upper lip, but what's the point of**
23 **pretending it's, you know, the whole agenda of**
24 **foundation trust status when the meetings -- well, as**
25 **I say, a little bit of a -- a hatchet job, what's the**

1 **point of not doing that in -- what's -- why do we do**
2 **that in a different forum and then either cancel the**
3 **meeting or ...**
4 **So it's a question of -- maybe as an academic I'm**
5 **too willing to put myself into other people's shoes.**
6 **What would David Nicholson say? He would say, "Well,**
7 **when I go to a new patch in the health service" -- in my**
8 **humble opinion this is what David would say -- "When**
9 **I go to a new patch in the health service I take it by**
10 **the scruff of the neck, I shake it, I find out**
11 **everything I can about it, I, you know, challenge people**
12 **in any direction", and he would probably justify what he**
13 **did at that meeting on that basis.**
14 **But what I think -- of course, I would say this**
15 **wouldn't I? -- that my own view of what happened at that**
16 **meeting was that the underlying reasons for the trust's**
17 **deficit, financial deficit in that year were not**
18 **explored at all. It was seen as here's an -- here's an**
19 **organisation which has a problem, we've got to clobber**
20 **it with a mallet and sort it out. That's about that**
21 **meeting.**
22 **But, of course, I don't know what happened at the**
23 **Mid Staffordshire because I'm very conscious that you**
24 **want to focus on that. But the culture of these**
25 **meetings was around financial solvency, the need for job**

1 **cuts and so on and so on and so on.**
2 **Now, if you believe in patient safety and quality,**
3 **as hopefully we all do, it's not the case that every job**
4 **cut endangers patient safety, because clearly it**
5 **doesn't. You'll find some management gurus who even**
6 **tell you that economy and quality go together. I'm one**
7 **of those who's a pragmatist on these matters. You know,**
8 **they may, they may not. You've got to look at the case**
9 **in point. But what I do believe is that the combination**
10 **of the financial crisis plus the foundation trust agenda**
11 **was bound, without extreme care, to push -- to push what**
12 **we now know as the -- the full quality agenda further**
13 **away from the centre than it should have been.**
14 Q. Just in terms of the meeting, a couple of brief points
15 to put to you.
16 Do you recall that during the meeting there was an
17 open altercation between members of your board?
18 A. **No, I don't believe there was an open altercation**
19 **between members of our board. I maybe recall -- miss --**
20 **failing to remember that. What I -- what did surprise**
21 **me, and this is getting into real detail about the**
22 **University Hospital event, what I -- what did surprise**
23 **me is despite the conversations we'd had in the weeks,**
24 **days and hours leading up to that and other meetings,**
25 **was the fact that my -- most of my executives just --**

1 **just didn't put up a defence of the trust's record in**
2 **the round over the previous years. I -- I mean,**
3 **I wouldn't like to single out too much more than that,**
4 **although I could if you really pushed me. But -- but**
5 **I think that's really what I'm saying. It wasn't what**
6 **was said, it was what was not said. And I found myself**
7 **thinking we were -- you know, as to my astonishment**
8 **despite conversations earlier in the week and in the**
9 **day, I found myself hearing about a trust I didn't**
10 **recognise at that meeting, both from the SHA side and**
11 **from some of my executive colleagues at the -- at the**
12 **time. That's all I would care to say about that. Well,**
13 **I mean, I will say whatever you want me to, but I think**
14 **that's the nub of it. That's the nub of it, I think.**
15 THE CHAIRMAN: Well, you can say this or not as you wish,
16 but did you feel hung to dry yourself at the end of the
17 meeting?
18 A. **In the meeting itself, you know, I was chairman of a big**
19 **trust and, you know, if you -- you know, you've got to**
20 **take -- take stuff and take stuff on the chin and take**
21 **the good and the bad. I felt a little bit hung out to**
22 **dry in subsequent weeks, when I -- when I pieced**
23 **together some of the things that I thought may -- may**
24 **have happened, yes. Yes.**
25 MS HUGHES: Do you recall at that meeting that

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1 David Nicholson expressed concern about a lack of
2 strategy and governance, and about the overall
3 dysfunctional nature of the board?
4 A. **Well, he didn't -- he didn't express to my knowledge --**
5 **to my memory -- I'll tell you what I do remember, he**
6 **didn't express anything at that meeting about the -- the**
7 **board's dysfunctionality or the governance. He did say**
8 **at the very end of the meeting -- and this is as much of**
9 **a direct quote as my poor old memory will give me,**
10 **drawing it to a close, his final words and nobody**
11 **else -- you know, got in afterwards, were, "Well,**
12 **anyway, whatever, you've no strategy, merry Christmas".**
13 **That was his final words. It was on 21 December or**
14 **something like that, if I remember rightly. So he did**
15 **indeed say, "you've no strategy", and, of course, I did**
16 **find that very ironical, given that, you know, we've**
17 **been telling his predecessor SHA up to, you know, the**
18 **summer, a few months before that, that, you know, we**
19 **were having to make our own strategy on the hoof in the**
20 **absence of leadership, either in the local or SHA health**
21 **economy.**
22 **So I guess it just shows you, doesn't it, that**
23 **a week -- a week is a long time in -- in politics.**
24 **Yeah.**
25 Q. Now, it's fair to point out, I think, that this meeting

1 appears to have set in motion the chain of events which
2 led to the involvement of the Appointments Commission
3 and ultimately culminated in your resignation from your
4 position. And it may be that we've touched upon that in
5 terms of your feeling of having been hung out to dry.
6 Before coming on to talk about that in more detail,
7 you do go on in your statement to describe what you call
8 "controlled panic" setting in, and of NHS managers
9 acting like frightened children. Does that relate
10 specifically to the diagnostic meeting and what
11 followed, or is that something separate?
12 A. **No, it's -- it's primarily that is. Primarily -- okay,**
13 **a couple of things there. Just without being**
14 **pernickety, the involvement of the Appointments**
15 **Commission -- Appointments Commission, to my knowledge,**
16 **the only involvement of the Appointments Commission**
17 **was -- was after we'd resigned. We communicated to them**
18 **that we had resigned. You know, I had no contact with**
19 **anyone from the Appointments Commission.**
20 **Clearly, what we had to weigh -- weigh up, you know,**
21 **when we resigned was -- you know, was it the right thing**
22 **to do? I can say more about that if you want. We -- we**
23 **didn't actually resign initially. We offered to resign**
24 **subject to a new board being available.**
25 **Now, the then chairman of the -- of the SASSHA,**

1 **Mike Brereton, told the -- the Stoke -- the North**
2 **Staffordshire Sentinel newspaper that there was a new**
3 **board waiting in the wings, and in effect he told us**
4 **that too. There was -- there was no such thing, as far**
5 **as I'm aware. And we were -- we felt -- in the short**
6 **term we felt we had been misled on that and we'd laid**
7 **ourselves open to criticism because we didn't see**
8 **ourselves as quitters. My non-executives, you know,**
9 **had -- three of them had been there for nearly ten**
10 **years, you know, reappointed twice, the maximum**
11 **allowable. I'd been there for five and a bit years. We**
12 **didn't see ourselves as quitters, but what we didn't**
13 **want to do was just disappear without there being a new**
14 **board.**
15 **Now, it turns out that there wasn't really a new**
16 **board. I can substantiate what I mean by that if you**
17 **want. So we felt misled and we felt we wouldn't have**
18 **chosen to go, you know, pending, you know, as of**
19 **1 January had we -- had we known that. So the**
20 **Appointments Commission, you know, were holiday for**
21 **Christmas. You know, we -- we -- we had no contact with**
22 **them. The first they heard of it was when they heard**
23 **about our -- our resignations, which formally, of**
24 **course, went to them because that's who formally**
25 **appoints us. So it wasn't one of these cases where the**

1 **Appointments Commission twists your arm and says,**
2 **"You've got to go".**
3 **Now, what was your second point about -- sorry, that**
4 **was my point about the Appointments Commission, but were**
5 **you asking was my point about frightened -- frightened**
6 **school children or whatever, is that it?**
7 Q. The first part of my question was about whether the
8 controlled panic, as you term it, that ensued was the
9 fallout from that meeting. So that was just really
10 a point of clarification.
11 A. **It was -- it was more than the fallout of that meeting.**
12 **In pure historic -- I mean, in the -- in the historical**
13 **facts, we lost an excellent chief executive, who -- who**
14 **retired from that job for personal reasons and genuinely**
15 **personal reasons I can say in the summer of 2005,**
16 **Mr Crowley. We sought to appoint, didn't find**
17 **a candidate we thought we could appoint, and asked the**
18 **deputy chief executive to act in the post. The SHA, you**
19 **know, chaired the appointments panel, where we -- sorry,**
20 **I chaired the appointments panel with the involvement**
21 **with the SHA when we failed to appoint, and at the time**
22 **that wasn't a controversial thing.**
23 **With hindsight, and I do make some comments in**
24 **there, since you're asking me about the specifics, with**
25 **hindsight, when Mr Crowley went, he took quite a bit of**

1 the -- the culture of the executive team with him, which
2 was can do and be honest, and if you don't get money
3 from the PCTs don't just accept it, go and talk to the
4 SHA and -- and all that.
5 I, perhaps wrongly, assumed that that culture would
6 continue under, you know, the man who'd been Dave's
7 number 2 for a long time, and -- and I don't think with
8 hindsight that it did. But I don't have -- I'm not
9 suggesting very specific conspiracies, I'm talking about
10 people's ways of handling things and so on and so forth.
11 So I -- the -- the -- I may be, you know, maybe
12 these vivid metaphors about -- about, you know,
13 controlled panic and frightened people and all that, you
14 know, I'm seeking to paint a picture there and -- and
15 I do -- I do substan -- I do stand by that picture,
16 which is that it comes to a point at which people say,
17 "You know, we've got to fit in with what they've got
18 planned for us because these are our futures and these
19 are our careers", and things like that. And I was
20 outside of that. I -- I had the luxury of -- you
21 know -- I mean, of being a non-executive chairman with
22 a -- with a day job. So I do understand people's --
23 people's positions, and I do understand the fact that
24 people have mortgages. That's -- that's what I'd say
25 about that.

1 Q. In terms of your own decision to resign, you say at
2 paragraph 44 of your statement that you recognise that
3 you weren't going to be able to buck the policy that was
4 being enforced on a national level. Just as
5 clarification, which policy are you referring to there?
6 A. I'm referring to deep financial cuts in particular
7 trusts, as part of Patricia Hewitt's national turnaround
8 team initiative to deal -- you know, her -- her means of
9 Secretary of State for Health of dealing with either the
10 deficit crisis or the perception that she was dealing
11 effectively with the deficit crisis. That's what
12 I mean.
13 My own view was not just about the need to make
14 financial savings, which, you know, we'd recognised and
15 we had a three-year financial turnaround plan from four
16 months before. My view was about -- sorry, where --
17 I've lost my thread. Financial -- yes, the need -- my
18 view was about the extent of the cuts, given that the
19 projections for one year down the line there was
20 actually going to be more money again coming to the --
21 the Stoke-on-Trent commissioners in particular, which
22 would lead to, you know, not a restoration of the status
23 quo ante, but made it, in my view, inappropriate to
24 do -- to do swinging cuts. And -- and inappropriate,
25 I think, to announce things to the media, you know,

1 about -- you know, like Antony did about 1,000 job cuts
2 being necessary, which of course never -- never happened
3 on that scale, one can -- you know, understand the
4 management philosophy of you know, pour encourager les
5 autres, but I think it was irresponsible, personally, at
6 the time to talk like that. And I -- and I think, you
7 know, we wouldn't -- we weren't happy with that.
8 We also weren't happy with the fact that the scale
9 of the private finance initiative was to be pared back.
10 When I say the private financial initiative, what I mean
11 is the scale of the new hospital to be funded through
12 the new finance initiative was to be pared back because
13 we didn't believe that the facilities in the community
14 allowed the hospital to be as small as the new version
15 was making it. And dare I say, I take no pleasure in
16 saying, that in recent years I think that view has been
17 substantiated, with severe worry internally at the
18 hospital in recent years about whether or not there will
19 be, in the jargon, enough post-acute community or
20 intermediate care and, indeed, whether or not there will
21 be avoidance of admissions on a scale to that.
22 So we have serious worries. I would be dissembling
23 if I didn't say also we were under pressure to go and we
24 felt we were being made scapegoats. And all things
25 together, I didn't feel like, you know, being a frontman

1 for what the -- what this next year was going to -- was
2 gonna hold. My non-executives came to that decision
3 extremely reluctantly, as -- you know, as I did.
4 Q. To what extent do you say that there was a culture of
5 blame that was pervasive across the West Midlands local
6 health economy at this point in time?
7 A. Well, across the whole health economy at that point in
8 time, I'd have to say I just don't know. Other than my
9 surmising or guessing.
10 THE CHAIRMAN: Don't guess, please.
11 A. No, I won't guess. That's what I'm saying. I'm not
12 gonna guess. In terms of our own hospital, I would say
13 this, wouldn't I, but I stand by it, you know, with data
14 in that longer submission I gave to you the -- you know,
15 the article I've written on the whole event, which is
16 just about to be published ironically this summer as
17 a case study of how decision-making happens in the NHS.
18 What I think we saw in that episode is that -- well, how
19 can I say? Sorry, I've lost my -- sugar levels, I've
20 lost my thread again. I was talking about -- remind me
21 of your exact question.
22 MS HUGHES: My question was, to what extent there was
23 a blame culture pervasive --
24 A. Yes. Yes. In our organisation I feel that -- I'm not
25 talking about my personal position now. I was -- that's

1 trivial compared to what I'm now going to say.
2 The trust had -- had, you know -- was being
3 scapegoated for the failures of the North Staffordshire
4 health economy as a whole, in particular, and the
5 strategic health authority as a whole in general. No
6 doubt we had our part to play. It would be a bit -- how
7 can I say? It would be a bit off if I were to say that,
8 you know, everyone -- what's the Scot saying? Everyone
9 is out of step but our jock. You know, the trust was
10 wonderful and everyone else was rotten. That wouldn't
11 be very plausible. But I think the trust was -- was
12 scapegoated, not because somebody said, "We're going to
13 scapegoat this trust", but because it was easy to -- to
14 say, "Well, there's a financial deficit there, the
15 reasons for that financial deficit, i.e. not being paid
16 for work --
17 Q. Can you slow down, please?
18 A. Sorry. The reasons for the financial deficit were --
19 were of no interest at the time it seemed to me. So
20 I don't know about a culture of blame at that moment in
21 the health authority -- in the strategic area as
22 a whole, the strategic health authority's area as
23 a whole, but I do know that I remember saying ruefully
24 to somebody, "Well, we've been complaining about an SHA
25 that doesn't do enough, and now one has come in and done

1 tons, only it's acted too simplistically", that was
2 my -- my view.
3 Q. Just sticking with the question of the culture of the
4 environment in which this took place, one of the things
5 that the Bristol Inquiry identified was a club culture
6 within the management, where those who fitted in
7 progressed rapidly, but for others who were willing to
8 challenge that was treated as disloyalty. Is that
9 a feature that you recognise in terms of the environment
10 that you were operating in?
11 A. I would have to say, between 2000 -- when I took over,
12 in summer 2005, absolutely and categorically not. In
13 the very short period of difficulty, from the autumn to
14 the period at the end of which I resigned at the end of
15 December/beginning of January 2006, with hindsight, in
16 an extremely short period of time, there may have been
17 an element of that.
18 Unfortunately, as well as our chief executive
19 leaving in the summer, we had a serious personal illness
20 and problems of our director of finance, and the SHA
21 found for us, it's fair to say, somebody we interviewed
22 and -- and thought suitable, a person who came in and
23 did a temporary job, as interim director of finance.
24 And I think we lost -- we lost a lot from the top of the
25 executive team, and the culture within the finance

1 department, I think under that -- I believe, and I can't
2 substantiate this in every detail, but I have -- I have
3 some -- some reasons for believing that -- that there
4 was a punitive culture, which I was unaware of at the
5 time and wasn't brought to my attention. And, you know,
6 I don't want to sound as if I'm protesting too much but
7 I wasn't the sort of person who was inaccessible.
8 I think a lot happened in a terrific amount of --
9 a very, very short period of time.
10 But in terms of the overall characterisation of
11 a trust, of course, the Bristol Inquiry, the Kennedy
12 Inquiry and so on, is looking at, as you say, the
13 culture which allowed, well, not just poor quality
14 but -- but inappropriate patient safety and death to
15 occur. I think the University Hospital of North
16 Staffordshire is such a large trust, it is bound to have
17 had its quality issues. There's one in the media at the
18 present time, I believe. But our issue was finance, not
19 quality. In fact under Mr Crowley, he and I were
20 absolutely adamant under -- under his insistence I would
21 say, that he was a previous director of finance but when
22 it came to a direct trade off between finance and
23 quality, quality won and Dave didn't say that lightly
24 because he had a superb record at the trust in financial
25 break-even, and indeed financial recovery in the early

1 years, from the -- from an earlier period of -- of
2 deficit.
3 So, the club culture leads to poor quality. I know
4 the sort of thing you're saying, as it were, from --
5 from Kennedy and other comments on Bristol. You know,
6 we were a very different -- different -- very different
7 kettle of fish. Our -- our issue wasn't quality. In
8 fact part of our issue was arguably a deficit worsened
9 by looking at quality targets that the government was
10 insisting we follow up to 2005. For example,
11 appallingly inhumane length of time for waits for
12 diagnostic tests that we actually did something about.
13 And later on we were told, "Well, you didn't have the
14 money to do that". You know, we disputed that, in terms
15 of negotiations. But we were -- if anything -- if we
16 erred -- if there was a trade-off between quality and
17 financial economy, or financial cuts, to be blunt, then
18 we erred in the pro quality direction at that time, up
19 until the period at which I -- you know, I resigned.
20 Q. If I can I'd like to try and draw out some comparative
21 evidence in terms of your experience at North Staffs
22 compared to Mid Staffs. Really, the first point to make
23 is that it doesn't appear from your statement that you
24 had any conception of the idea that poor care was being
25 provided at Mid Staffs during this period; is that

1 right?
2 A. **That I personally?**
3 Q. Yes.
4 A. **Well, I would have to say absolutely not. I mean, I had**
5 **nothing to do with the -- you know, the Mid Staffs**
6 **trust, and so I was aware that the trust had been on**
7 **a roller coaster ride, in terms of its reputation. Most**
8 **of that, but not all of it, I was made aware, you know,**
9 **was about money. But I would expressly say I had no**
10 **inside information, you know, about the Mid Staffs**
11 **trust. I knew some individuals, you know, who worked**
12 **there. A couple of people who'd done an MBA with me at**
13 **Keele University in previous years or decades,**
14 **embarrassingly. I'd, you know, worked there. I have no**
15 **knowledge about what became the -- the crisis,**
16 **obviously, you know, that was -- you know, I couldn't**
17 **have really.**
18 Q. One aspect of the culture of management at Mid Staffs
19 that the inquiry has heard about is that the medical
20 staff were somewhat divorced from the management of the
21 hospital. So my question is, to what extent were
22 medical staff incorporated into the management at
23 North Staffs?
24 A. **You saw my -- my additional wry comment, didn't you?**
25 **I keep using this word wry about David Nicholson, away**

1 **back in 2001/2002. In fact when he -- when**
2 **David Nicholson chaired the appointments panel for -- to**
3 **confirm Mr Crowley in his substantive post as chief**
4 **executive in 2002, in a perfectly amicable throwaway**
5 **comment to me over a bowl of soup or whatever it was,**
6 **you know, before the appointment committee he said to**
7 **me, "Now, come on, the doctors run this place, don't**
8 **they?" Now, you know, one's response there is, yes --**
9 **yes or no. Is that a good thing or a bad thing? And --**
10 **and I knew what he was driving at. He was saying, "You**
11 **know what the doctors want, don't you?", rather than**
12 **stand up as managers against them.**
13 **I can't remember how I answered it. It really was**
14 **quite jocular, although it was coming, I suspect from --**
15 **you know, I wouldn't read too much into it, except that**
16 **there's medical leadership and there's medical**
17 **leadership. I think -- I've no reason to think that,**
18 **you know, our -- at the University Hospital our record**
19 **of involvement of doctors in leadership and management**
20 **was brilliant or -- or even great. I've no reason to**
21 **think that. What I do think though is that serious**
22 **important things didn't happen on financial grounds over**
23 **the -- over the wish of senior doctors.**
24 **Now, there's medical leadership, which involves**
25 **thinking of the hospital, as a -- as a clinical**

1 **cooperative responsible for running itself. And there's**
2 **medical leadership which basically means doctors buying**
3 **into the managerialist agenda and selling it to their**
4 **colleagues.**
5 **Now, far be it from me to put words into**
6 **Mr Nicholson's mouth, but my personal view is, although**
7 **he would not put it in these terms, he has more of the**
8 **latter in mind than the former. Now, I could be wrong**
9 **about that. I have to be careful here, and I think**
10 **David's quite sincere about involving doctors, to the**
11 **extent I know anything about his views on these matters.**
12 **But, you know, phrases like, "Are the doctors involved**
13 **or not?", have to be unpicked very carefully.**
14 **I've no idea about Mid Staffs. I know what I've**
15 **read, you know, from these three inquiries that took**
16 **place before the independent inquiry, by which I mean**
17 **the CH -- sorry, not the inquiry, the investigations,**
18 **the special investigation by, you know, what became the**
19 **Care Quality Commission, and then there was the**
20 **David Colin-Thome and the George Alberti things. Now,**
21 **they -- they've all got comments to make along the line**
22 **of what -- what you've said, I think, haven't they?**
23 **All I could I say is that if we tried to do that at**
24 **the University Hospital to, you know, keep the doctors**
25 **out and have them disenfranchised, we wouldn't have got**

1 **away with it. And I think it's right that we wouldn't**
2 **have got away with it. That's my opinion and that**
3 **doesn't mean that there's been no desperate quality**
4 **issues from time to time, maybe ones I don't know about,**
5 **because, you know, the big question is, what -- how do**
6 **you know what you don't know? And that's the -- that's**
7 **the million dollar question for a board, how do you find**
8 **out what you don't know? But, you know, these -- these**
9 **things come and go in the NHS, you know, with -- with**
10 **frightening regularity, I guess.**
11 Q. Just on that point of how do you find out what you don't
12 know, another aspect of the Mid Staffs experience about
13 which the inquiry has heard evidence is the fact that
14 the board was somewhat disengaged with what the staff
15 and patients experiences were and so, again, is that an
16 area in which you can shed any light in terms of how the
17 board at UHNS remained engaged with the staff and the
18 patients?
19 A. **Well, that's -- that's a difficult one. I -- I think,**
20 **now that I know all I know about Mid Staffs, as an**
21 **outsider to the trust, and other trusts in the NHS,**
22 **I think I -- I think nearly everyone, you know, at board**
23 **level in the NHS and at ministerial level has probably**
24 **not got right how to involve patients and the public.**
25 **And I wouldn't -- I wouldn't claim that we -- we got it**

right in my time there.

I was quoted by a friend of mine, Ken -- Ken Lownds, as saying that I -- I didn't believe in it. But I think -- I think, you know, he subsequently realised what I meant was I was a bit sceptical that the mechanisms being used at that time for patient and public involvement were actually all that -- up to much. Now, that's not my deeply substantiated opinion, but, just for the record, what I would say is I passionately believe in, you know -- in patient involvement and I now -- that now that I see, you know, elsewhere, not in University Hospital, what can happen, I think we have to, you know, have -- I'm not an expert in that field, but I think we have to, you know, really be serious about that for the future.

So I believe in it passionately and -- and at that time I probably thought that what's become, ironically, a redisorganisation of that was also getting a bit dysfunctional. Community health councils. Patient and public involvement. LINks. Local involvement networks HealthWatch, and wherever we're going.

Again, it's institutional and structural tinkering. And this is what academics dryly call "voice", as opposed to "choice". If you are not happy, what do you do? Do you go somewhere else? Choice. Or do you use

your voice? And how do you use your voice?

Now, I think, whether or not you have choice, you have to have voice, and I don't think the NHS has got it right. But I'm not a -- I'm not an expert on how to get that right. I wish -- you know, I wish I were.

Q. Professor Paton, the final topic I want to ask you about is in relation to the proposed reforms that are now coming forward under the coalition government's agenda. It's apparent from your statement that you have concerns about this going forward. So can I give you the opportunity to just expand on what you think the issues are there.

A. Okay. Just to be absolutely clear, of course, my statement was written before the NHS Future Forum reported last week, and David Cameron accepted the recommendations almost by grabbing the sheet out of their hands and saying, "I accept this".

What I saw before that stage, what I'll call the reform -- the White Paper -- sorry, not the White Paper, the NHS Bill, mark 1. You know, we're going to get another one or an amended one. What I saw there was, in very blunt terms, PCTs to go, SHAs to go. So no internal performance management officially. Therefore, who does it?

Care Quality Commission does quality. Monitor,

instead of just being a -- an enforcer for foundation trusts, enforcing good practice to allow them to be trusts and enforcing the maintenance of good practice, instead of just being an enforcer, Monitor becomes the regulator of what is unashamedly the marketplace or ... So that's Lansley's reform. That's White Paper leads to Health Bill.

Severe worries on my part about that. Without being pompous or patronising, sympathy for Mr Lansley in one way. If he's heard that PCTs have not really justified the huge investment in them, would be the polite way of putting it. He's read the House of Commons Select Committee report on the management costs of the NHS in recent years. He's read other reports from York University and so on. So he thinks PCTs really haven't done what we could have expected of them. Maybe he thinks this.

He thinks, "SHAs, oh, you know, we don't want them either for one reason or another." Maybe some of his diagnosis is correct, but I think his prognosis is -- you know, was very dangerous because it said, "Therefore, we can scrub that and just have a national level, plus some local GP consortia." And who will be responsible for quality in that system? Well, the external regulator or regulators.

Now, that's worrying. What is the track record -- and it's not for me to come here and knock organisations, but what is the track record of regulators in getting ahead of the game? I'd have to say not a great one. And I don't just mean, you know, the various incarcerations of what's now become the Care Quality Permission -- Commission, I mean, things like the Audit Commission as well.

Monitor didn't see quality primarily as part of its role, I believe, informally. I may be wrong about that. But, you know, the old Monitor, you know -- we've heard in the various and, you know, reports about Mid Staffs in particular, as well as elsewhere, you know, Monitor and the CQC, as it became, weren't necessarily on the same wavelength and so forth.

So, in a nutshell, severe worries that, you know, there isn't a real, pragmatic, behavioural, appropriate, culturally appropriate model for ensuring patient safety in the new -- the new NHS.

Now, reforms part 2. New reforms, the re-reforms. What have we got? We've got a wider forum for commissioning services, not just GPs. We've got Monitor taken out of its -- what shall I say? -- Ofgas/Ofwat role as regulator of a market.

We've got a few things, which I think are right.

1 But what I will say about quality in the future is there
2 will be patches where local clinical commissioning
3 groups hold the ring on that and do a good job, and
4 there will be parts where they don't.
5 So whose responsibility at the end of the day is it
6 to assure -- either to assure that organisations do
7 appropriate work on patient safety and quality and
8 achieve things, or ensure that where they don't there's
9 somebody else to do it? Now, who is that somebody else?
10 It's the National Commissioning Board.
11 So the new system -- whether reforms mark 1 or
12 mark 2 -- under the coalition, are putting a terrific
13 amount in the centre, and the devil's gonna be in the
14 detail. The National Commissioning Board is going to
15 have to, for the reasons I've said, take quality as
16 its -- and I don't just mean that glibly, I mean patient
17 safety, appropriateness of care, all these things, not
18 just jargon about integrated care pathways and stuff
19 like that.
20 All of that is going to have to be done -- either
21 overseen very effectively or done by the National
22 Commissioning Board. The Care Quality Commission will
23 get better and better as time goes on, I -- I hope and
24 have a major role to play as an external -- what is it
25 then? You see, is it an inspector or a regulator? Can

1 it be both? I don't even know.
2 So I think there's a lot unanswered in the future.
3 The initial danger was just torching organisations and
4 being either complacent or a little bit unknowing about
5 what would take their place.
6 And just perhaps finally, I'd say, you could say to
7 me, "Okay, you've had a pop at PCTs and SHAs in
8 different -- in different form". I've had a -- if
9 I have, I've honestly made a critique of what I've seen
10 in practice. That does not deny to me -- sorry, I do
11 not deny, therefore, that there must be appropriate
12 internal performance management. And I just don't see
13 enough of that in the -- in the new reforms.
14 MS HUGHES: Professor Paton, thank you very much. I've come
15 to the end of my questions.
16 Sir, I'm going to look around to see if anyone else
17 has anything to pass to me. (Pause).
18 They don't appear to.
19 THE CHAIRMAN: Well, I don't think I can quite let you go,
20 having, as it were, criticised -- and I see what you say
21 about the new reforms and the gap you perceive. How
22 would you fill that gap?
23 A. All right. I mean, I -- I actually believe that we
24 need, not separate foundation trusts and purchaser or
25 commissioner/provider splits. I actually believe we

1 should -- we ought to have integrated health
2 organisations for health economies, for local health
3 economies.
4 I don't think it's helpful, to be honest, to have in
5 the North Staffordshire, for example, PCTs still arguing
6 with the hospital -- okay, there's two of them now, not
7 four. But the dilemma is how to have an integrated
8 organisation which isn't just reinventing, as Tony Blair
9 would say, the 1940s, 50s, 60s old Labour.
10 Well, maybe there was nothing wrong with that in
11 some ways. But I think we have moved beyond that,
12 because that system didn't have proper involvement of
13 clinicians in planning decisions or strategic
14 commissioning decisions, whatever you want to call it.
15 So by an "integrated organisation" I don't mean
16 putting the clock back to before 1991, I mean
17 a differently configured organisation.
18 Now, I think we need regional health authorities.
19 Maybe the number we've got. So we've got a good start.
20 And I think they need to ensure that services are --
21 they need to do internal performance management.
22 And we need to have an external regulator, but I do
23 think that there's been -- you know, the theory for
24 having a commissioner/provider split or
25 a purchaser/provider split is market theory, or what

1 academics call sometimes public choice theory, that
2 providers will only do their best if they've got to sell
3 themselves to somebody. Either, you know -- it's either
4 Smith's invisible hand or Tony Blair's NHS market was
5 supposed to be about quality. You regulate the price,
6 everyone gets the same income for providing the same
7 service, so hospitals will compete on grounds of
8 quality.
9 Now, without boring you, I think there are lots of
10 technical reasons why it doesn't actually work like
11 that. And I think, warts and all, integrated
12 organisations, overseen by a key number of strategic
13 performance managers, is not the orthodoxy of the age.
14 But at the same time, ironically enough, if the
15 coalition, through all its compromises of recent weeks,
16 is coming to say, "We need clinical commissioning groups
17 involving hospital doctors, as well as GPs, and
18 involving nurses as well and all the rest of it", if
19 that works, because it says you don't have to have
20 a tender for every service. You work with your local
21 hospital to improve quality, because you're part of the
22 same organisation -- funnily enough, you know, what was
23 supposedly the coalition's market reforms could actually
24 go a little bit in the direction I'm suggesting.
25 I do believe in patient choice, but I don't think

1 **it's the same thing as market competition. And**
2 **I believe GPs as individuals ought to have an absolute**
3 **right to refer anywhere in the NHS, and that integrated**
4 **organisations can be funded according, over time, to the**
5 **amount of work they're -- they're doing in the system.**
6 **I just think that a lot of the reforms and**
7 **structural reforms have been sledgehammers to -- to**
8 **crack a nut. But, at the end of the day, ironically,**
9 **the nut maybe hasn't even been cracked, it's just rolled**
10 **off the table.**
11 **So I think there's no -- there's no structural**
12 **answer to a cultural issue. You know, that if the**
13 **cultural issue is, "How do you get people to take**
14 **quality seriously?" You can have any structure and if**
15 **they don't take quality seriously, you know, it won't**
16 **guarantee good quality.**
17 **So the sort of structural thing I'm talking about is**
18 **a -- is necessary but not sufficient, in my view. You**
19 **need people working together in health economies in**
20 **a public service. But you also need -- you need some**
21 **performance management. You need some targets. We need**
22 **a small number of core targets, which are fundamentally**
23 **about quality and patient safety, as well as money and**
24 **waiting times.**
25 THE CHAIRMAN: Well, thank you very much for that.

1 **A. Thank you.**
2 THE CHAIRMAN: That's all I want to ask. Is there anything
3 you want to add after what you've just added?
4 **A. I think probably not at this stage. You know, we've**
5 **covered quite a lot, I think. So I shall leave it**
6 **there. Thank you, chairman.**
7 THE CHAIRMAN: Professor, thank you very much indeed for
8 your help today. As I have said, if you have some
9 afterthoughts, write to us --
10 **A. Thank you very much indeed.**
11 THE CHAIRMAN: -- and we'll seek to take those into account.
12 **A. Thank you. Yes, I will certainly take that seriously.**
13 **Thank you for that.**
14 THE CHAIRMAN: Thank you very much. Well, that concludes
15 today's proceedings and we meet again at 10 o'clock
16 tomorrow morning.
17 (12.57 pm)
18 (The inquiry adjourned until 10.00 am
19 on Wednesday, 22 June 2011)
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