Tuesday, 21 June 2011

(10.00 am)

(Proceedings delayed)

(10.07 am)

THE CHAIRMAN: Good morning, Professor Paton.

A. Morning.

THE CHAIRMAN: Have you been following our proceedings?

A. Within reason. I've been in Scotland.

THE CHAIRMAN: I'm not sure what --

A. I mean, I've been in Scotland looking after my aged parents, so I've missing recent stuff but I've been looking on the Internet.

THE CHAIRMAN: Thank you. So you'll have some idea of our procedure.

A. Absolutely.

THE CHAIRMAN: Thank you. So you'll have some idea of our procedure.

A. Absolutely.

THE CHAIRMAN: Obviously we will ask you some questions, but if at the end of that you feel there's something you want to add, please feel free to do so, as long as it's within our terms of reference.

A. Thank you very much.

THE CHAIRMAN: And if on consideration after you've left, there's anything you feel you should have added but hadn't, let us know and we will seek to take that into account as well.

A. Thank you.

THE CHAIRMAN: Finally, as I've said to every single witness, could you please try to speak slowly so that this lady can keep up with you.

A. I will indeed.

THE CHAIRMAN: Thank you very much.

A. And do remind me if necessary.

THE CHAIRMAN: I will. So will others.

PROFESSOR CALUM PATON (affirmed) Examination-in-chief by MS HUGHES

MS HUGHES: You are Professor Calum Paton?

A. Yes.

Q. You are currently professor of health policy at Keele University.

A. Correct.

Q. Professor Paton, you made a statement in preparation for attending the inquiry today.

A. Yes.

Q. That statement is dated 4 February 2011, and it runs to 51 paragraphs. Do you have a copy of that statement?

A. I do.

Q. -- with you?

A. I do.

Q. Do you adopt that statement for the purposes of giving your evidence today?

A. Yes.

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#### THE CHAIRMAN: Sorry if I interrupt, when you talk about health authorities, do you mean the old area health authorities or the district --

A. Well, they were actually -- the health authorities that were created they were known as local health authorities. They were, if anything, district health authorities. The areas -- it's -- it's a typical NHS evolution or reorganisation as -- as I say later.

But the area health authorities were abolished some considerable time earlier. Until 2001/2002 --

THE CHAIRMAN: Just slow down slightly.

A. -- there were 100 health authorities simply known as health authorities in England and, in a sense, the point I -- you know, I was driving at primarily is that that was -- it's a qualitative judgment -- a manageable and sensible number.

What happened with the reorganisation of 2001, which started really to have serious effects in the NHS in 2002 onwards, it was known as Shifting the Balance of Power, you know, it's one of these acronyms that the NHS is fond of, S-T-B-O-P. Shifting the Balance of Power. What it did was abolish these health authorities. It also abolished the, I believe, eight regional offices that existed at the time, which were, if you like, the regional organisations for England, and

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Instead of planning our future for our local services, if you like, with one health authority, we were planning our future with four primary care trusts. And I would submit, although, you know, I know one might say, "He would say this, wouldn't he?", as the trust chairman, that was rather anarchic because the primary care trusts didn't have a coherent vision, in my opinion, shared with each other, and I believe that that was true, not just in North Staffordshire but in other areas of the NHS.

Speaking as an academic, I think that the problem was that earlier judgments, perhaps as well as research on the NHS changes in the 1990s, had suggested that if you were going to plan or commission or strategically commission, in the jargon, non-local services, then to abolish strategic organisations with a direct responsibility for commissioning, in other words, health authorities, was a mistake. So it's not just the judgment of -- you know, of an ex-trust chairman, it's also the judgment of my -- my academic person, if I can put it that way.

Q. In your statement you say that looking back in hindsight that structure was more manageable. In fact it sounds from the answer that you've given that at the time your perception was in fact that this reorganisation was going to make life more difficult.

A. I -- I will -- looking back as best I can to -- to the way I was feeling at that time, I had gone to be chairman of a -- of a what was actually one -- is one of the biggest trusts in England, and I suspended my academic theories and -- and whatever else, as much as I could, and got into the role, as much as I could, of working within the health economy. So I'll be blunt, in the year before all this happened, or the year and a half before the new reorganisation came about, I -- I was not pontificating as an academic, so much as working my way into the trust and seeking to make the health service work as well as I could, insofar as that was my responsibility.

So I wasn't looking out for trouble, and I was -- I had a relatively open mind as to what, for example, would happen in terms of governing the local health economy. If you'd asked me, if you'd taken me aside in those days and said, "Do you think this is a sensible thing to do, to have this reorganisation?", my answer would have been, "No, I don’t". And with hindsight -- when I say with hindsight, I'm in a sense not wishing to exaggerate or over -- overdo the point, and one could even argue that that's a very gentle way of putting it 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 already 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. I would like to have coined it; coined by another academic colleague.

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 booo 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 -- 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?

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 a lot of covert informal centralisation.
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

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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

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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
know, it went from 94 per cent to 98 per cent and back again a little bit now, most people are seen within four hours, that is an honest and well-intentioned attempt to improve an aspect of quality.

No doubt there were some perverse effects as a result of that target, and one could argue the technical details of that target. Funnily enough, I would personally think that if set at an appropriate level, and not policed inappropriately, then that is actually one of the better targets. Not to say that 98 per cent of patients have to have to go within four hours, but -- but in fact, it's a judgment, isn't it? How long is a piece of string? But there were some informal studies done, which I can't quote now I'm afraid, by health economists which suggested that, in the jargon, the opportunity cost of raising the target from 94 per cent of patients having to be seen within four hours to 98 per cent, the opportunity cost of that, in other words the money you spend on that, what could you do with that money if it was applied to something else, rather than getting 94 patients comply -- 94 per cent of patients complying rather than 98, that the opportunity cost meant that that was an inefficient strengthening of the target.

So there's all sorts of technical debates about targets, and one of my regrets about that is it's been polarised, you know, for example, in the last election campaign New Labour defending its target, the Conservative Party saying, "We don't believe in targets", you know, silly black and white stances. And this things are shades of grey. Perhaps what I would draw your attention to is not that I don't believe in target at all, because I do, but the culture of the NHS and the manner in which targets were policed, was often, in my view, faint -- frankly ludicrous, and I try and give one example -- one or two examples, you know, in -- in -- in the statements.

Q. All right. Well, that is a topic that I'm intending to come back to. Just sticking for the moment with the primary care trust and your interaction with them. Another comment that you make about commissioning is that what made logistical sense to service provision ran contrary to the contracting culture, and again, I'd like to give you the opportunity to explain what you mean in that statement.

A. I'll try and do that as pithily as possible. I give a little example there. Let -- let me say a hospital is filling the time of an operating theatre session. The consultants and the surgeons might say -- let me make this almost Mickey Mouse, my apologies -- "We've got so many hours, we can -- you know, we have scheduled two big operations, we can use the capacity of the hospital efficiently to schedule a few small operations around the edges of these big operations. So we can actually use the assets more efficiently". Now, that might run foul of a primary care trust saying, "We've contracted a priori at the beginning of the year", if that's when it were done, "We've contracted to do X but not Y, so you're not allowed to do that". I could be a little bit facetious and say, "You've got to ring up and ask us".

I used to think that was facetious, although rather more recently, you know, that has often become the reality that the efficiency of operating a provider is a different agenda from the commissioning culture, if I can put it that way.

Q. In that sort of environment, to what extent are trusts as providers able to determine how they provide their services?

A. In theory -- the theory of the split between the commissioner, or what used to be called the purchaser, more accurate still I think to call it the purchaser, the purchase or commissioner the split between that institution, the primary care trust and the hospital, or the mental health trust, the idea is that the commissioner decides what will be done, bluntly volume, within their available money, and the provider will go away and do that, but it's -- it's not the commissioner's business to tell them how to provide the services. But they do have to provide the services that have been allegedly prospectively rather than retrospectively bought. That's purchasing.

Commissioning is supposedly about doing more. Commissioning's supposed to be about determining population needs and meeting them within available resources and then, in order to do that, going on to what's called the purchasing.

So in theory, and -- and the more you have a market approach, such that the purchaser or commissioner on the one hand and provider on the other hand are separate entities making contracts in a so-called marketplace, it's not the provider's job to do commissioning obviously. It's a truism.

Now, we in the -- in our health economy, and this is me, you know, being completely honest from memory, as far as I can remember, we were quite often, I think, behind -- you know, behind our backs and sometimes to our faces said, you know, "This hospital's making decisions about which services, you know, for the future and that's our job". To which my response tended to be, "Well, you know, if you would do your job, we wouldn't".
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A. I will be completely honest and say on -- on the
12 particular example there, which comes to mind literally
13 from my memory, how that particular one was resolved.
14 I don't recall. I suspect it wasn't resolved.
15 I suspect it went into the pot and then at -- towards
16 the end of the financial year, I think I give another
17 example, which is actually backed up by some of the
18 additional letters from the time that I -- that
19 I released to you.
20 A lot of end of year haggling about how much the
21 hospital should treat patients without getting paid, or
22 how much if the hospital's not to be paid the patients
23 go back to their GPs, to the PCT, for the next financial
24 year, and the role of the strategic health authority in
25 resolving 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
5 culture -- the strategic health authority in those days
6 was, I -- I would defend my statement that it was
7 inert. It was unwilling to get involved, and my chief
8 executive and I called the -- coined the phrase,
9 I think, that they were into performance monitoring
10 rather than performance management.

Q. You've already made the comment earlier in your evidence
11 that your perception was that the problem with SASSHA
12 was that it was too big to be local and too small to be
13 strategic, and in the same paragraph you then go on to
14 say that you perceived it to be one of the weakest SHAs
15 nationally.

A. Mmm-hmm.

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

A. Yes. First of all, may I ask you which of my own
17 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
18 subjective. Wearing my academic hat, at the time in the
19 early 2000s up to the -- the mid-2000s, I experienced as
20 an academic, you know, on visits and research and so
21 forth other strategic health authorities. So while
22 I don't have a quantitative basis for my judgment,
23 I found the approach to governance of the SHA, the
24 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
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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
24. So that was the culture, you know, and I couldn't
25. help but compare before and after, and so that no doubt
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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 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,
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7 (Pages 25 to 28)
One -- one was infamously called, if I remember, trying to get agreement around a strategy, they -- they instead of being quite strong in setting a strategy or them, because that was not within their fiat. But
they were also aware that they couldn't merge trusts. They were also aware that there were probably too many primary care reorganisation, I think the strategic health authority early 2000s, in -- almost immediately after the 2001/2
memory, which I didn't mention in the -- in my written submissions. For a matter of years, in the
early years up to 2005, to my way of thinking it was -- well, it wasn't wholly unaddressed, but it was inadequately addressed.
I can give one -- one example from memory, which I didn't mention in the -- in my written submissions. For a matter of years, in the early 2000s, in -- almost immediately after the 2001/2 reorganisation, I think the strategic health authority was aware there were probably too many primary care trusts. They were also aware that they couldn't merge them, because that was not within their flat. But instead of being quite strong in setting a strategy or trying to get agreement around a strategy, they -- they set up long-running committees to deal with these issues. One -- one was infamously call, if I remember, one of which was the behaviour of the primary care trusts, one of which was the configuration of mental health trusts in SASSHA's area, and I can't remember what the third strand -- it may have been elderly services. But from my personal experience, what's the old joke?
You know, you -- you take minutes and you waste years. Now, to my way of thinking, this three strands review poottled along without effective leadership for two or thee years and laboured to produce a mouse at the end of it.
So that's the sort of thing I mean that by comparison with some other strategic health authorities it was -- it didn't -- you know, it was weak by my way of thinking. To be fair they would defend themselves as saying, you know, the 2001 reform was allegedly about creating facilitative organisation rather than a directive organisation at the SHA level. So they could find some chapter and verse from the legislation that created them to justify their approach, and in the -- in the interests of being utterly fair, I -- you know, I would wish to say that.
Nevertheless, in terms of these hard choices and looming financial crises, you know, which we and others were trying to get them to pay attention to from 2003 and 4 onwards, it didn't -- it didn't pass muster, in my opinion, in my personal opinion.
Would it be right to infer from particularly I'm looking at your paragraph 12 and all the answer you've just given, that in fact in some ways you considered it impossible to meet all of the targets that your organisation was set.
A. I think we found it very difficult. And latterly, you know, the proof of the pudding was in the eating. We -- we did find it impossible. Whether -- whether or not, you know, you could argue we should have found it possible it or not, you know, somebody else might beg to differ on that. What we did find was that meeting all the targets, adding to that, you know an important including an important target of financial balance, in other words, financial break-even of the organisation at the end of the financial year, and adding to that the national pressures that came at the time, pay large --
The Chairman: Just going back to what you said about strategic health authorities and perhaps primary care trusts as well, did you have any sense of certainty as chairman of a provider trust what the actual functions of either the SHA or the PCTs were, as between each other?

A. Yes, well, the money, with some exceptions, was held by the PCTs. It was -- you know, it came directly from the Department of Health's allocation formula to primary care trusts against England -- across England. Some money was -- was top-sliced by strategic health authorities for specific purposes. But the basic distinction in -- in plain language, was the PCTs had the money, increasingly after 2002 the ideology, I would use the word, was that the NHS was reentering a market relation -- a market environment and the strategic health authority's role, if we must use the language of the market, was to -- to manage the market to ensure that perverse results didn't -- didn't flow and so on and so forth.

So that wouldn't be what the legislation said, but the legislation, if I remember rightly, and I'm suffering from, you know, this being almost ten years ago when they started, in 2001/2, if I remember rightly, there were three prime -- primary objectives or -- or

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A. That's a very fair -- a very fair point. I think what's probably not in the -- in the paragraph there is it's simply a matter of time. We would have asked the -- there were some ground rules about how uncompensated care, by which I mean care that the hospital felt it had no alternative but to provide, as opposed to, for example, my -- I've already given my example of turning patients away from -- from A&E, care the hospital felt it -- it had to provide, that the PCTs said they weren't going to pay for. It's a matter of time. The SHA, I feel, should have had some ground rules about these things.

Now, the stitch-ups -- a stitch-up is a pejorative term, you're quite right. It could be considered a pejorative term, and I probably am using it in a pejorative way. Had these things been handled evenly throughout the financial year, I might have been less -- less inclined to use the phrase. What happened, of course, was my chief executive or somebody else would say, "Look, we really want you to adjudicate on this", and it would only be when backs were really against the wall that any adjudication would come, in those days. And perhaps, as I say, not in -- not in other SHAs. I don't know, obviously. Because this not, as is obvious, you know, a piece of academic research. These are my true examples from -- from a particular area at a particular time. But, yes, too little, too late I think is -- is what "stitch-up" implies. And the fact that we -- we can move this and move that and get as much near break-even as we can if, you, hospital do this and, you, PCT do that".

Now, I don't want to be a purist, because if you're in public life things aren't pure but, you know, what I would often think and what we would often say, "There's got to be a better way of doing it than this".

Q. You have already, I think, given your description of the SHA as being supine until the summer of 2005, and we've touched on the 05/06 reform and the merger of the strategic health authorities. Given what you said at the start of your evidence about the previous occasion where your trust was in a degree of conflict with the PCT about the treatment of a particular group of patients, and in the statement you describe in the SHA as procrastinating and as brokering last minute stitch-ups. And that expression clearly has a negative connotation attached to your perception of what the strategic health authority was doing. And my question is why you would see it in that way, rather than having seen the SHA as being facilitating or brokering a compromise in those circumstances?
restructuring having been a mistake in terms of the plurality of organisations it created, does it follow that at this point in time you had a degree of optimism about this set of reforms, please, and if not why not?

A. Ah, that's an interesting one. I thought that the 2005/6 reforms, you know, were not earth shattering, or restructurings were not earth shattering, but they pushed it back in the right direction rather than the wrong direction, if you ask me my subjective opinion.

Not unfortunately in my -- in my view, in terms of decisions made about the trust I was chairing at the time, but if I was taking the national view, and indeed, perhaps, the West Midlands view, it made more sense to have a West Midlands strategic health authority than a SASSHA and the other two strategic health authorities that operated between 2001 and 5 on the patch, which had previously been the West Midlands regional office and before that the West Midlands regional health authority.

So what -- what I found was, yes, this -- this is sensible but I found it almost embarrassing, you know, that ministers were conducting an ill-informed experiment with their own extra money for the NHS. I -- I found it frustrating that they were actually saying, "Oh goodness, we got this a bit wrong, we better sort it out again". And, of course, on the hoof -- and I don't

mean particularly in North Staffordshire or -- or -- or Mid Staffordshire or anywhere in the country, on the hoof what sounds like, you know, a -- a recoordination of the NHS often was a little bit less than that.

Now, I ceased to be chairman on 1 January 2006, although inevitably, because of the circumstances in which I did cease to be chairman, I was still interested in -- in what was going on locally for a year or two after that. Are things better or worse today than they were at the height of Shifting the Balance of Power between 2001 and 2005? In this -- I'm not talking about quality now and the really important things, but in terms of the organisational structure of the NHS, I think things are, you know, passe Mr Lansley's reform, before we get into the next round, you know, as of 2007, 8, 9 were things a bit better or a bit worse?

A bit better, in my humble opinion.

Q. Your impression, I think, was that in particular David Nicholson and Antony Sumara had been tasked with doing a specific turnaround job in the West Midlands region, I think that's something you've already alluded to.

A. I -- I mean, can I just qualify that a little bit?

Q. Certainly. Please do.

A. I think, you know, they were creating new larger SHAs because they thought we created was it 29, was it 30?

It was one of these two, in 2001, and this was my point, you know, they were too -- too small to be strategic, too big to be local. They went in effect back to regional health authorities. They still call them strategic health authorities now. But what -- what -- what the NHS has in England now is regional health authorities, like it did before 2001.

Q. You're going very fast.

THE CHAIRMAN: Just slow down.

A. I do apologise, these are at the anoraky bits that I'm trying to spit out so I can get to the interesting bit.

I do apologise.

The regional authorities have been reinvented by the 2005/6 restructuring in slightly different form in some cases. In the case of the West Midlands in exactly the same form, covering the same area.

Now, David Nicholson was simply -- he wasn't brought in to -- overly to do a turnaround job, he was brought in to be chief executive designate of the West Midlands strategic health authority designate. Now, because it was designate and hadn't yet been formally approved, the NHS is very good at getting on with it before legislation or statutory instruments have -- have actually been passed. And that's what happened there.

David came in as overall patch de facto chief executive, but the way they handled that, given that the three SHAs had not yet become the West Midlands single SHA, was that he became chief executive of each of the three and, of course, he couldn't be in three places at once, and so a managing director, in the case of the SASSHA, was put in, so that technically David Nicholson, between 2005 and when he left the patch to go elsewhere, was chief executive of SASSHA, as well as chief executive of two others, and the managing director of SASSHA was -- was Antony Sumara, working, of course, to Nicholson and very closely with Nicholson.

So he was brought in at that stage not to do a turnaround job. He was brought in just to do a job that the restructuring necessitated. I think -- I think if you asked -- as no doubt you have and will, if you ask Antony Sumara, did he find everything in good health? The answer would clearly be no. And so he then later, wearing different hats, became chief executive of the trust I had been chairman of, only later. I didn't overlap with him. And then, of course, more recently having been in London, I believe in the interim, he has come back to be -- to be chief executive of -- of the Mid Staffordshire trust.

MS HUGHES: Can I just explore with you the question of the
manner generally in which government policy was fed down through the hierarchy and implemented, and this is something that you touch on at paragraph 16 of your statement, where you express --

A. Yeah.

Q. -- a view that the government of the day did not seem to understand how its orders were being implemented by the SHA. And I wonder if you could just put some meat on the bones of that statement, please?

A. Yes, it's -- the phrase is not -- is not original to me but it's -- the phrase that, you know, a few of us used, you know, about the NHS, and perhaps -- perhaps still would, I'm not quite sure, is in terms of culture, the kiss-up kick-down culture. I think it's a transatlantic -- I think it's an American phrase by origin and, of course, it's sometimes used whimsically, but kiss-up kick-down means that your middle level people will kiss-up, they will please their masters, political or otherwise, and they will kick-down to blame somebody else when things go wrong.

Now, you may say, is that a pejorative characterisation? I guess so. Does it always apply?

No. Is it, in my opinion, too prevalent a feature of the NHS culture at this time, and perhaps to this day?

Yes, in my opinion. So that's -- that's really what I mean.

It's always an open question, if you take one example, Secretary of State, Alan Milburn with his targets in the -- in the early 2000s. To me, it's a waste of time and expensive resource of top executives that if there's one breach of one target -- that's jargon for, for example, one patient missing the A&E four-hour wait target -- that that chief executive is summoned to regional head office, SHA head office or in some extreme examples national head office, the Department of Health, to explain.

Now, I don't know if that -- I used the phrase earlier this morning, the targets are not necessarily bad, some of them were bad, some of them were good. But the implementation of targets in a particular culture can be, I think I used the phrase, "ludicrous", the word "ludicrous". That I experienced -- and I can't give you chapter and verse, but I experienced specific examples of people running around, you know, like headless chickens explaining individual breaches because strategic health authority people were frightened of what ministers were going to say to them and so on and so forth.

Now, I assume, perhaps -- perhaps I don't know, perhaps wrongly, I assume that if you're Mr Milburn or you're Patricia Hewitt who ever the Secretary of State was, knew about that, they'd say, "Oh, don't be silly". You know, the alternative hypothesis is that they were running, you know, a top-down control organisation, you know, that would be rather ludicrous, in my view. That -- but the culture, it's -- I think I do use the phrase, "overenthusiastic to please" and that's what kiss-up kick-down isn't -- isn't, you know, you centralise credit and you devolve blame, et cetera.

THE CHAIRMAN: You describe this in your paragraph 16 as micromanagement of data.

A. Yes.

THE CHAIRMAN: Is there not something of a political imperative, whichever party is in power, to be able to deliver positive statistics, figures to the public --

A. Yeah.

THE CHAIRMAN: -- as being a result?

A. Yes, and I -- I -- I should correct --

THE CHAIRMAN: Is that what you mean by that?

A. Yeah. I think so. I -- I think it is, and I -- I --

I wouldn't -- you know, I wouldn't say that this suddenly appeared in 2001 and disappeared in 2005. I'm -- in my opinion, and this is the -- the academic in me, the NHS, despite rhetoric about different phases, for example, the internal market as opposed to alleged hierarchies before that, and something else after that, we've been on a fairly steady line of increased central control from 1948 to 2011. And, you know, I'm not pontificating about what happens after 2011, obviously, but, yes. I mean, you could argue, well, what's wrong with that? The more you've got to do with limited public money, the more tight accountability there has to be. Yes, there should be accountability for objectives but the devil's going to be in the detail and also the culture's going to be important.

If it's, you know, "We'll give you three years to get it right and then if you got it wrong you're out", fair enough. But if it's, "We'll give you three years to get it right and then on Monday morning, by the way you've got this, we've just heard about this from -- from the Department of Health", or, "We've realised that, you know, that what we're going to have to do with payment by results is going to X rather than Y", so suddenly three-quarters of the way through the financial year you've got 3 million less than you thought you had. It's that kind of stuff that's the culture, absolutely, of the NHS, until hitherto.

Now, I should make it clear, because these remarks can be misinterpreted, I am a great believer in the NHS and a great believer in public -- publicly funded,
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<td>1</td>
<td>publicly provided health services. I'm not criticising that model. I'm criticising an inappropriate culture, which can apply in any system, whether public, market, private, you name it.</td>
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<td>MS HUGHES: What you describe in terms of the inappropriate culture, does that manifest itself in terms of direct instruction coming down the hierarchy or is the pressure more covert? Is this done by sort of late evening phone calls and that sort of --</td>
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<td>A. Yeah. I mean, there are late evening phone calls and there are -- there are letters. I gave you an example, I think, of a letter from Antony Sumara, managing director of the SHA, just in the last month or two when I was chairman of the trust, a letter to my then acting chief executive, saying, &quot;Dear Peter, we have done so and so, we have looked at so and so, here's what I expect you to do by&quot;, whatever, year end, next week, whatever it happened to be, a list of things, &quot;If you have any problem or anticipate any problems in meeting these, please&quot; -- I'm paraphrasing, you've got -- you've got it in front of you.</td>
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<td>Q. It's because you have speeded up, that's why I'm looking at you like that.</td>
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<td>5</td>
<td>A. It's because you have speeded up, that's why I'm looking at you like that.</td>
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| 6       | Q. Sorry. "If you have any" -- I'm paraphrasing, "If you have any quibble with any of that, give me a ring."

| Page 47 | Yours, Antony". Now, that's very much the culture. So that's there, you know. |
|---------| Q. That would be a direct -- |
| 8       | A. That's a direct -- |
| 9       | Q. -- instruction? |
| 10      | A. If you had Antony here, he would say, "Well, of course, it's my job, because these are national targets as well as the -- the rules governing the NHS about financial break-even and so on so, of course, I'm telling you to do it". I just think that if it's that plus the phone call, plus something else, and that's the main means of engaging, then, you know, there needs to be more. |
| 11      | Now, I'm not criticising that particular individual. |
| 12      | I'm just saying that's an example of a letter which I provided in terms of, you know, the must-dos, do them. |
| 13      | Now, if I was sitting here from a strategic health authority at that time or indeed today, I would say, "Well, you know, the Department of Health tells us to do that. The government's elected, it's the only part of the government -- governance of the NHS which is elected, the national government at Westminster. They tell us to do that, so we've no option but to tell you to do that". It's a question of how these things are done. Okay? |
| 14      | THE CHAIRMAN: But just to take your example, surely for Page 46 |
| 15      | better or for worse, what Mr Sumara or someone like him is doing in such circumstances is performance managing what you do? |
| 16      | A. Yeah. Now -- I mean, we've got on to -- |
| 17      | THE CHAIRMAN: The reason I ask is, in your paragraph you distinguish between micromanagement of data as being the preoccupation from what you say they ought to have been doing -- |
| 18      | A. Yes. |
| 19      | THE CHAIRMAN: -- which was performance management. |
| 20      | A. Now, what I would like to say immediately here is that -- you know, we -- we've given, and I know it's only an example, of, you know, Antony at that time. |
| 21      | Now, since I rarely overlapped with Antony at -- when he was at the SHA and didn't overlap with him at all at the trust, I'm not criticising his approach to these matters, because I haven't worked with him enough to do that. I'm saying that in the years I experienced things, yes, of course, there has to be a statement, "We expect you to do this", but there has to be more than that as well, in other words, "Now, if you as a trust have views about the -- you know, why there are factors impeding your ability to do that, then let's sit down with you, the PCT's and others and not just have our monthly or weekly performing management meeting or performance monitoring meeting, but let's talk about, you know, ways of working and so on". |
| 22      | Now, that's what in my tenure was -- was missing. Partly a national problem, because, for example, if the North Staffs is an actual health economy, then what you have was a health economy, a local health economy, with lots of different agencies, but no head office. This is my point, the SHA too small to be strategic but too big to be the head office of a local health economy, and so on and so forth. |
| 23      | Partly, I think that -- how can I say? My -- this is subjective, but my view is that if the strategic health authority was confronted with, you know, "We can't agree with the PCTs for the following reasons, based on the structure!", you know, that would be seen as whingeing. Now, you know, I mean, David Nicholson, for example, and not about the West Midlands or about SASSHA, but, you know, he's often been quoted or has been quoted in national interviews about people whingeing about other organisations. Now, I would draw a distinction between whingeing about other organisations on the one hand and making diagnoses of dysfunctional structures and so forth. And so I think, you know, there's -- there was -- there probably is an element in the kiss-up kick-down culture, as I call it, |

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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 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 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 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. I
14 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

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13 (Pages 49 to 52)
foundation trust status at this time was a way that
strategic health authority chiefs could win political
favour by demonstrating that they had organisations in
their patch ripe or fit for foundation status. So while
at this stage, and even now to this day, I think,
almost, it's a voluntary procedure, what is the famous
phrase from Sir Humphrey Appleby to the Prime Minister
in "Yes Prime Minister," "Yes, well, of course, you
can -- you can decide not to be a foundation trust if we
fingered you to be one, but, of course, it would be
a very brave decision". That's it kind of culture in
the NHS.

Now, they haven't, to be fair, done with foundation
trust status what they've done with some previous
initiatives. They haven't rolled things out, in that
phrase, as mechanistically as in the past. Witness the
today that there are many trusts in the NHS which
are not -- many hospitals or mental health trusts,
whatever, which are not foundation trusts. So they
haven't said, "Right, you've all got to do it by next
Christmas". They have a process, and it's a very, very
rigorous process in some ways, but I think at this time
you would have to ask the -- legitimately the question,
what is the opportunity cost, in terms of time, not in
terms of conspiracy, of setting, for example, the Mid
Staffordshire hospital trust on the road to being
a foundation trust?

There's always a danger with ministerial
predilections that they become an end in themselves.
That's, I guess, part of my point there.

Q. How feasible do you think it is for a trust to adopt
a strategy that is at odds with that centralised agenda
of foundation trust status?

A. It's not easy. I mean, when I was chairman of the
University Hospital trust we had a two-star status. We
went up from one or, you know, what would have been one
to two stars in the -- in the latter years of my -- my
time there.

Now, we, as a trust, corporately wanted to be three
stars. As an academic I could say, if I wanted, either
to myself or to whoever I could get to listen, "Hang on,
what does three-star status actually mean?" But
I thought that would have been illegitimate of me
because in perhaps tangible or intangible way, which
I can't -- you know, I probably won't say more about
that at the moment, I would probably have been
disadvantaging the trust. Because if the game being
played is, stars on the one hand and then subsequently
foundation trust following on from that, I -- I think,
really, you know, one cannot put ones own views, you
know, at the expense of the organisation. That's the
compromise one makes -- makes in public life. For
example, the private finance initiative, to me that's
a rotten deal financially, was, is and will be, as far
as I can see, but when I was chairman of the trust the
choice in the University Hospital of North Staffordshire
was keep your Victorian buildings in the 21st century or
get a PFI. So you have to -- you know, you have to put
your views on the side on some occasions. And -- and we
were asked if we were willing to be diagnosed to be
a foundation trust in the University Hospital, and our
answer was yes. That didn't prevent us having
conversations as individuals and human beings, saying,
"We could actually do without this, but we will -- we
may disadvantage the trust, not in terms of managers'
jobs, in terms of money for the health economy and for
patients, if we don't play the game". That's that kind
of thing.

Q. I think you said in your statement that your immediate
reaction to the proposal that your trust should go
through the foundation trust application process was
that it would be a distraction from the trust's real
agenda. So is it right that you saw it as being at odds
with the trust's -- was there no way in which the two
could work together, as it were?

Staffordshire hospital trust on the road to being
a foundation trust?

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A. Very -- very pragmatic answer would be I was proved --
proved hideously right, in that for two -- between
2003/2004, never mind later years, the then chief
executive at the trust, Mr Crowley and my -- and myself
were constantly saying to anyone who'd listen, and the
SHA included, "If things don't change, because of the
way this health economy is in North Staffs we'll be
heading for a deficit", although, you know, we avoided
that until 2005/6, and so on and so forth.

So it's pure how much can you -- can you handle? We
had a major PFI for a major new hospital, rationalising
it on to one site. We had very many other -- we had
just become a University Hospital. We an increasingly
difficult financial environment. You know, I can list
all the -- all the things, that, you know, that trusts
like ours had and that we did indeed have like, you
know, massive new information management and technology
strategy and implementation and so on.

It wasn't -- if it's the game that must be played,
then you have to find management time. But, you know,
you can eventually create a situation whereby, however
good they are, there just aren't enough strategic or
chief type managers to do -- to do all this. And that's
the sense in which it was a distraction.

Now, I could have my own views that it was also

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<td>something which was going to take a lot of resource</td>
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<td>without commensurate benefit for the whole NHS, and</td>
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<td>I stand by that. But that wasn't so much the point.</td>
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<td>The point locally was, it didn't take eyes off the ball,</td>
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<td>but it had so many -- you know, it was yet another ball</td>
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<td>bouncing around.</td>
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<td>THE CHAIRMAN: There are trusts, I think, round the country</td>
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<td>who took the view, including some who had big PFI</td>
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<td>commitments, that they wouldn't go for foundation trust</td>
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<td>status and didn't. Why didn't you join that gang,</td>
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<td>rather than the other?</td>
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<td>A. Well, I -- well, with -- I've used, I've been credited</td>
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<td>with the phrase with hindsight already. Given the</td>
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<td>peculiarities of North Staffordshire and the fact that</td>
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<td>we were eventually given our initial assessment under</td>
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<td>the time our own local financial problems hit, with</td>
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<td>hindsight very simple. You know, it would have been</td>
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<td>sensible to say, &quot;Too much of a distraction, we'd rather</td>
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<td>not, thank you very much&quot;.</td>
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<td>I mean, our trust in the North Staffs -- and this</td>
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<td>isn't about the North Staffs, I know -- had a bit of</td>
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<td>a reputation as being willing to -- what's that</td>
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<td>grandiose and perhaps arrogant phrase? -- speaking to</td>
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<td>truth to power. In other words, saying, &quot;Look, you</td>
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<td>can't do this, you'll just have to tell the minister&quot;.</td>
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<td>And ironically enough, I didn't think we wanted to be</td>
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<td>seen as the awkward squad, you know, on every issue.</td>
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<td>But -- but these -- you know, that -- that is with the</td>
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<td>benefit of hindsight. At the time, it was a pragmatic,</td>
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<td>unquantitative judgment, it was a qualitative judgment</td>
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<td>that in the round, you know, it was worth doing it for</td>
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<td>the sake of the local health service.</td>
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<td>Now, if we'd known what was known even a few months</td>
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<td>later about the national financial crisis, the fact that</td>
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<td>we were going to be a part of that, plus the fact that</td>
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<td>foundation trust status was actually going to be</td>
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<td>problematic in some very specific cases, I think, with</td>
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<td>hindsight, it would have been better to say, &quot;Just,</td>
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<td>look, leave us alone to do other things at the moment&quot;.</td>
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<td>MS HUGHES: Just following from the question the chairman</td>
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<td>asked you, in terms of that decision, one of the points</td>
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<td>you also make in your written submission at paragraph 10</td>
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<td>is that senior NHS executives are forced or moulded into</td>
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<td>addressing the must-dos of the day. My question is, to</td>
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<td>what extent your own senior executive team at your own</td>
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<td>trust was under the influence of the sort of pressure</td>
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<td>you describe in respect of the decision --</td>
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<td>A. To be -- I think I'd have to be -- be absolutely clear</td>
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<td>suddenly we weren't. And so I think the question is</td>
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<td>much more about -- well, the Mid Staffordshire trust,</td>
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<td>you know, and others, perhaps, in a position like the</td>
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<td>Mid Staffordshire trust, which judging by star ratings,</td>
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<td>and I -- I've made it extremely clear, I've no internal</td>
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<td>connection with the Mid Staffordshire hospital trust,</td>
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<td>but in terms of star ratings, which, of course, you</td>
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<td>know, were the government's own chosen means of</td>
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<td>indication, I'd have to say, how on earth can a trust</td>
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<td>which goes in four consecutive years from two to three</td>
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<td>to zero one star be considered a suitable candidate</td>
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<td>to, you know, assess through the diagnostic process</td>
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<td>for -- for foundation trust? It's that kind of thing</td>
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<td>I'm pointing to.</td>
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<td>I mean, if you were whoever at the strategic health</td>
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<td>authority or the Secretary of State or whoever, you</td>
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<td>could -- you could at that time have looked at the</td>
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<td>University Hospital and said, &quot;You've gone from middling</td>
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<td>one star to middling two star to top of the league at</td>
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<td>two star and just missing three star in 2004, so you are</td>
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<td>likely, if you want to want to go beyond three star</td>
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<td>trusts&quot;.</td>
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<td>Now, already you see we're into stars and twos and</td>
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<td>threes and, what does all that mean? As an academic</td>
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<td>I've got to keep reminding myself of that. But these</td>
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things after extremely powerful and I -- I say this
perhaps, you know, absolutely just from my impressions
in the trust, these things are extremely powerful, not
just around the boardroom table, in terms of the
self-perception of an organisation. I don't want to
over-egg this pudding but, you know, when you go from
three star to zero star from one year to another, as
I believe this Mid Staffordshire trust did, you know,
that has a desperate effect on the morale well beyond
the boardroom.

There's a phrase that my academic colleague
Carol Propper and Julian Le Grand use "targets and
terror". Well, the NHS in this day, it's a coined
phrase, was being run through an academically coined
phrase of "targets and terror", if you like and, you
know, these things are -- are -- the terror, of course,
is -- is, you know, the then -- what was it? -- the then
chief executive of the Mid Staffordshire trust way back
whenever they had the zero star after having been three
star, he was named and shamed on the front page of one
of the tabloids as, you know -- what was it? -- the nine
potatoes or whatever it was, the nine chief execs
earning more than 100 grand, you know, who -- who got
zero stars. So that's -- that's what I think the
academies mean by "the terror", you know, it's naming

and shaming it's, you know -- it -- it's part of the
culture and it may be -- I mean, at the end of the day
the board of a trust is always responsible. You know,
in the last resort it can resign or in the intermediate
resort it can refuse to do X, Y, Z. So people are not
in a direct hierarchical line of command and control, so
they do bear responsibility at board level.

But the environment of success and promotion for
executives, not non-executives, is extremely heavily, at
this time, bound up with the political agenda of the
day. No question about that. Anyone who denied that,
I would -- you know, I would really be surprised to find
them doing so, even if they were to do so publicly, if
I may say.

Q. I'm going to ask you now about the diagnostic meeting
that your trust was involved in in December of 2005.
It's not a topic on which I want to spend a large amount
of time, because as we've said, we're not concerned with
the specifics of North Staffs.

Before I ask my questions, there's just a point of
clarification, in terms of your paragraph 33 of your
statement.

A. Of my oral statement, yes, yes.
Q. Of your full statement --
A. Yes.

A. Well, it depends. The thing that I would possibly
quibble with there is that Monitor were not directly
involved. I can only speak for the diagnostic meeting
that we had in the -- in the North Staffordshire
University Hospital. Nicholson -- David Nicholson
chaired -- chaired the meeting. Monitor were there.
Since foundation trust status is at the behest of
Monitor's recommendation to the Secretary of State, it
would have been bizarre if Monitor weren't there. And,
indeed, they were there in the form of Ruth Carnall,
a former -- at that time a former NHS senior executive,
and again subsequently an NHS senior executive, more
recently chief executive of -- of the London strategic
health authority. Now, she was there, in her -- one
of -- a temporary period out of the NHS formally,
representing Monitor.

Now, my paragraph 33 is not intended to be
facetious, but I would say it's intended to be wry.
What I'm really saying there is that this is all part of
the fact that the Department of Health, its
representatives in the provinces, the strategic health
authorities, and Monitor are together working on an
agenda. And so the idea that, you know, foundation
trust status is something which is going to be radically
new in terms of absence of control, political or
otherwise, was always to me, with -- if I may sound
pompous, an academic's nose for the history of the NHS,
was always to me highly unlikely. That's -- you know --
so -- so I feel, that, you know, yes, it was the
strategic health authority's job, so my comment about
why was David Nicholson chairing it? Is an -- I'm being
slightly wry but I'm saying if one was having a stiff
upper lip and saying it's Monitor's job to go with
trusts to assess them from beginning to end and then
recommend to the Secretary of State, then, you know, it
really should be a different -- a different arrangement.

And I think -- you know, I -- I can't have it both
ways. I, you know, I cannot (inaudible). I can't have

Q. -- rather than the exhibit. I'm asked to remind you
that the region-wide diagnostic meetings were initiated
by the strategic health authority as a pilot development
programme, and that they had the support of the
Department of Health and Monitor, but that Monitor were
not directly involved and that the pilot was designed to
identify areas where the trust needed to develop in
order to reach the standard required for foundation
trust status.
A. Yes. Yes.
Q. Do you accept that characterisation of the process,
first of all?
A. Well, it depends. The thing that I would possibly
quibble with there is that Monitor were not directly
involved. I can only speak for the diagnostic meeting
that we had in the -- in the North Staffordshire
University Hospital. Nicholson -- David Nicholson
chaired -- chaired the meeting. Monitor were there.
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indeed, they were there in the form of Ruth Carnall,
a former -- at that time a former NHS senior executive,
and again subsequently an NHS senior executive, more
recently chief executive of -- of the London strategic
THE CHAIRMAN: Well, if I may say so, I don't know that one part of your answer follows from the other, because surely a process of some care would have to be taken in launching a trust as a foundation trust if in truth it were to have a genuine degree of independence in the control of its finances --

A. Yes.

THE CHAIRMAN: -- in that the government would be entitled, and indeed under a duty, to ensure that it wasn't losing control of its finances --

A. Yeah.

THE CHAIRMAN: -- without some assurance it was going to be properly looked after?

A. Yeah, I mean --

THE CHAIRMAN: So why would a process like this import lack of intent to allow independence at the end of the process?

A. I do take that point. I'll just go back to -- you know, my very brief paragraph 33, is intended to be a wry comment on the culture of the, NHS rather than a naive --

THE CHAIRMAN: Yes, but you've just said, if I understood you correctly, that this wasn't a genuine attempt to produce greater autonomy at the front line.

A. Yeah. Right. Let me give my honest view on this.

I honestly believe that the originators of the foundation trust process -- sorry, foundation trust policy, you know, the Secretary of State, Milburn, I haven't spoken to him, I don't know him personally, his chief adviser in those day, Paul Corrigan, they believed sincerely in it. You know, I think they believed, talking to Mr Corrigan, Professor Corrigan, that this was actually an attempt to make a new NHS.

My point isn't that, you know, forget about paragraph 33, as I've said for -- for one reason, in terms of what that's trying to say. My wider point is not that ministers are fiendishly trying to centralise while selling the story to the Daily Mail that they're not, so they can persuade people they are New Labour not old Labour. I'm not -- I'm not saying that. I'm saying that the logic of what they set in train results in much less autonomy for constituent parts of the NHS than they think for ironical reasons, some of which I think you're -- you're pointing to that, you know, they have to hold on -- or David Nicholson or whoever it happens to be. Sorry, has to hold on, and it's then a question of, well, you know, does the holding on set the culture?

Now, I cannot say that financial autonomy of any sort is not available to foundation trusts. But, of course, we'd had from 1991 to 93 the Conservative government's policy of the internal market, creating self-governing trusts. Every single hospital in the country, by the time -- in England, by the time Labour came in in 1997 was a self-governing trust. So when I read, you know, the prospectus, if you like, for what an FT, a foundation trust was to be, I thought, "Well, 90 per cent of this is -- is -- was there, in Ken Clarke's reforms at the end of the 80s, beginning of the 90s. That gradually got taken back, under a Conservative government. By which I mean real autonomy was found to be a little bit of an illusion.

And maybe I was cynical, maybe not, but I didn't see this being in the long run massively different. And the reason it's not because of the bad faith of Alan Milburn
I say, a little bit of a -- a hatchet job, what's the foundation trust status when the meetings -- well, as pretending it's, you know, the whole agenda of speaking with a stiff upper lip, but what's the point of I don't want to sound precious or -- or, you know, trust thing'. It's just simply a question of form, and I have said, "Okay, we'll -- we'll leave this foundation stage, it would have been quite sensible, you know, to have said, "Okay, we'll -- we'll leave this foundation trust thing". It's just simply a question of form, and I believe to be indicative of the trust's underlying status past, present and future in the absence of action. And, of course, it's legitimate to talk about finance.

Given where we were in the health economy by that stage, it would have been quite sensible, you know, to have said, "Okay, we'll -- we'll leave this foundation trust thing". It's just simply a question of form, and I don't want to sound precious or -- or, you know, speaking with a stiff upper lip, but what's the point of pretending it's, you know, the whole agenda of foundation trust status when the meetings -- well, as I say, a little bit of a -- a hatchet job, what's the financial governance is an essential component of providing high quality care?

point of not doing that in -- what's -- why do we do that in a different forum and then either cancel the meeting or...

So it's a question of -- maybe as an academic I'm too willing to put myself into other people's shoes.

What would David Nicholson say? He would say, "Well, when I go to a new patch in the health service" -- in my humble opinion this is what David would say -- "When I go to a new patch in the health service I take it by the scruff of the neck, I shake it, I find out everything I can about it, I, you know, challenge people in any direction", and he would probably justify what he did at that meeting on that basis.

But what I think -- of course, I would say this wouldn't I? -- that my own view of what happened at that meeting was that the underlying reasons for the trust's deficit, financial deficit in that year were not explored at all. It was seen as here's an -- here's an organisation which has a problem, we've got to clobber it with a mallet and sort it out. That's about that action. And, of course, it's legitimate to talk about financial solvency, the need for job.

just didn't put up a defence of the trust's record in the round over the previous years. I -- I mean, I wouldn't like to single out too much more than that, although I could if you really pushed me. But -- but I think that's really what I'm saying. It wasn't what was said, it was what was not said. And I found myself thinking we were -- you know, as to my astonishment despite conversations earlier in the week and in the day, I found myself hearing about a trust I didn't recognise at that meeting, both from the SHA side and from some of my executive colleagues at the -- at the time. That's all I would care to say about that. Well, I mean, I will say whatever you want me to, but I think that's the nub of it. That's the nub of it, I think.

THE CHAIRMAN: Well, you can say this or not as you wish, but did you feel hung to dry yourself at the end of the meeting?

A. In the meeting itself, you know, I was chairman of a big trust and, you know, if you -- you know, you've got to take -- take stuff and take stuff on the chin and take the good and the bad. I felt a little bit hung out to dry in subsequent weeks, when I -- when I pieced together some of the things that I thought may -- may have happened, yes. Yes.

MS HUGHES: Do you recall at that meeting that...
David Nicholson expressed concern about a lack of strategy and governance, and about the overall dysfunctional nature of the board?

A. Well, he didn't -- he didn't express to my knowledge -- to my memory -- I'll tell you what I do remember, he didn't express anything at that meeting about the -- the board's dysfunctionality or the governance. He did say at the very end of the meeting -- and this is as much of a direct quote as my poor old memory will give me, drawing it to a close, his final words and nobody else -- you know, got in afterwards, were, "Well, anyway, whatever, you've no strategy, merry Christmas".

That was his final words. It was on 21 December or something like that, if I remember rightly. So he did indeed say, "you've no strategy", and, of course, I did find that very ironical, given that, you know, we've been telling his predecessor SHA up to, you know, the summer, a few months before that, that, you know, we were having to make our own strategy on the hoof in the absence of leadership, either in the local or SHA health economy.

So I guess it just shows you, doesn't it, that a week -- a week is a long time in -- in politics.

Yeah.

Q. Now, it's fair to point out, I think, that this meeting appears to have set in motion the chain of events which led to the involvement of the Appointments Commission and ultimately culminated in your resignation from your position. And it may be that we've touched upon that in terms of your feeling of having been hung out to dry. Before coming on to talk about that in more detail, you do go on in your statement to describe what you call "controlled panic" setting in, and of NHS managers acting like frightened children. Does that relate specifically to the diagnostic meeting and what followed, or is that something separate?

A. No, it's -- it's primarily that. Primarily -- okay, a couple of things there. Just without being pernickety, the involvement of the Appointments Commission -- Appointments Commission, to my knowledge, the only involvement of the Appointments Commission was -- was after we'd resigned. We communicated to them that we had resigned. You know, I had no contact with anyone from the Appointments Commission.

Clearly, what we had to weigh -- weigh up, you know, when we resigned was -- you know, was it the right thing to do? I can say more about that if you want. We -- we didn't actually resign initially. We offered to resign subject to a new board being available.

Now, the then chairman of the -- of the SASSHA, Mike Brereton, told the -- the Stoke -- the North Staffordshire Sentinel newspaper that there was a new board waiting in the wings, and in effect he told us that too. There was -- there was no such thing, as far as I'm aware. And we were -- we felt -- in the short term we felt we had been misled on that and we'd laid ourselves open to criticism because we didn't see ourselves as quitters. My non-executives, you know, had -- three of them had been there for nearly ten years, you know, reappointed twice, the maximum allowable. I'd been there for five and a bit years. We didn't see ourselves as quitters, but what we didn't want to do was just disappear without there being a new board.

Now, it turns out that there wasn't really a new board. I can substantiate what I mean by that if you want. So we felt misled and we felt we wouldn't have chosen to go, you know, pending, you know, as of 1 January we -- had we known that. So the Appointments Commission, you know, were holiday for Christmas. You know, we -- we -- we had no contact with them. The first they heard of it was when they heard about our -- our resignations, which formally, of course, went to them because that's who formally appoints us. So it wasn't one of these cases where the Appointments Commission twists your arm and says, "You've got to go".

Now, what was your second point about -- sorry, that was my point about the Appointments Commission, but were you asking was my point about frightened -- frightened school children or whatever, is that it?

Q. The first part of my question was about whether the controlled panic, as you term it, that ensued was the fallout from that meeting. So that was just really a point of clarification.

A. It was -- it was more than the fallout of that meeting. In pure historic -- I mean, in the -- in the historical facts, we lost an excellent chief executive, who -- who retired from that job for personal reasons and genuinely personal reasons I can say in the summer of 2005, Mr Crowley. We sought to appoint, didn't find a candidate we thought we could appoint, and asked the deputy chief executive to act in the post. The SHA, you know, chaired the appointments panel, where we -- sorry, I chaired the appointments panel with the involvement with the SHA when we failed to appoint, and at the time that wasn't a controversial thing.

With hindsight, and I do make some comments in there, since you're asking me about the specifics, with hindsight, when Mr Crowley went, he took quite a bit of
the -- the culture of the executive team with him, which
was can do and be honest, and if you don't get money
from the PCTs don't just accept it, go and talk to the
SHA and -- and all that.

I, perhaps wrongly, assumed that that culture would
continue under, you know, the man who'd been Dave's
number 2 for a long time, and -- and I don't think with
hindsight that it did. But I don't have -- I'm not
suggesting very specific conspiracies, I'm talking about
people's ways of handling things and so on and so forth.

So I -- the -- the -- I may be, you know, maybe
these vivid metaphors about -- about, you know,
controlled panic and frightened people and all that, you
know, I'm seeking to paint a picture there and -- and
I do -- I do stand by that picture, which is that it comes to a point at which people say,
"You know, we've got to fit in with what they've got
planned for us because these are our futures and these
are our careers", and things like that. And I was
outside of that. I -- I had the luxury of -- you
know -- I mean, of being a non-executive chairman with
a -- with a day job. So I do understand people's --
people's positions, and I do understand the fact that
people have mortgages. That's -- that's what I'd say
about that.

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**Q.** In terms of your own decision to resign, you say at
paragraph 44 of your statement that you recognise that
you weren't going to be able to buck the policy that was
being enforced on a national level. Just as
clarification, which policy are you referring to there?

**A.** I'm referring to deep financial cuts in particular
trusts, as part of Patricia Hewitt's national turnaround
team initiative to deal -- you know, her -- her means of
Secretary of State for Health of dealing with either the
deficit crisis or the perception that she was dealing
effectively with the deficit crisis. That's what
I mean.

My own view was not just about the need to make
financial savings, which, you know, we'd recognised and
we had a three-year financial turnaround plan from four
months before. My view was about -- sorry, where --
I've lost my thread. Financial -- yes, the need -- my
view was about the extent of the cuts, given that the
projections for one year down the line there was
actually going to be more money again coming to the --
the Stoke-on-Trent commissioners in particular, which
would lead to, you know, not a restoration of the status
quo ante, but made it, in my view, inappropriate to
do -- to do swinging cuts. And -- and inappropriate,
I think, to announce things to the media, you know,

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**Q.** To what extent do you say that there was a culture of
blame that was pervasive across the West Midlands local
health economy at that point in time?

**A.** Well, across the whole health economy at that point in
time, I'd have to say I just don't know. Other than my
surmising or guessing.

**THE CHAIRMAN:** Don't guess, please.

**A.** No, I won't guess. That's what I'm saying. I'm not
gonna guess. In terms of our own hospital, I would say
this, wouldn't I, but I stand by it, you know, with data
in that longer submission I gave to you the -- you know,
the article I've written on the whole event, which is
just about to be published ironically this summer as
a case study of how decision-making happens in the NHS
What I think we saw in that episode is that -- well, how
can I say? Sorry, I've lost my -- sugar levels, I've
lost my thread again. I was talking about -- remind me
of your exact question.

**MS HUGHES:** My question was, to what extent there was
a blame culture pervasive --

**A.** Yes. Yes. In our organisation I feel that -- I'm not
talking about my personal position now. I was -- that's

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trivial compared to what I'm now going to say.

The trust had -- had, you know -- was being scapegoated for the failures of the North Staffordshire health economy as a whole, in particular, and the strategic health authority as a whole in general. No doubt we had our part to play. It would be a bit -- how can I say? It would be a bit off if I were to say that, you know, everyone -- what's the Scot saying? Everyone is out of step but our jock. You know, the trust was wonderful and everyone else was rotten. That wouldn't be very plausible. But I think the trust was -- was scapegoated, not because somebody said, "We're going to scapegoat this trust!", but because it was easy to -- to say, "Well, there's a financial deficit there, the reasons for that financial deficit, i.e. not being paid for work --

Q. Can you slow down, please?

A. Sorry. The reasons for the financial deficit were -- were of no interest at the time it seemed to me. So I don't know about a culture of blame at that moment in time. As we've learned, the University Hospital of North Staffordshire is such a large trust, it is bound to have had its quality issues. There's one in the media at the present time, I believe. But our issue was finance, not quality. In fact under Mr Crowley, he and I were absolutely adamant under -- under his insistence I would say, that he was a previous director of finance but when it came to a direct trade off between finance and quality, quality won and Dave didn't say that lightly because he had a superb record at the trust in financial break-even, and indeed financial recovery in the early years, from the -- from an earlier period of -- of deficit.

So, the club culture leads to poor quality. I know the sort of thing you're saying, as it were, from -- from Kennedy and other comments on Bristol. You know, we were a very different -- different -- very different kettle of fish. Our -- our issue wasn't quality. In fact part of our issue was arguably a deficit worsened by looking at quality targets that the government was insisting we follow up to 2005. For example, appallingly inhumane length of time for waits for diagnostic tests that we actually did something about. And later on we were told, "Well, you didn't have the money to do that!". You know, we disputed that, in terms of negotiations. But we were -- if anything -- if we erred -- if there was a trade-off between quality and financial economy, or financial cuts, to be blunt, then we erred in the pro quality direction at that time, up until the period at which I -- you know, I resigned.

Q. If I can I'd like to try and draw out some comparative evidence in terms of your experience at North Staffs compared to Mid Staffs. Really, the first point to make is that it doesn't appear from your statement that you had any conception of the idea that poor care was being provided at Mid Staffs during this period; is that...
right?
A. That I personally?
Q. Yes.
A. Well, I would have to say absolutely not. I mean, I had nothing to do with the -- you know, the Mid Staffs trust, and so I was aware that the trust had been on a roller coaster ride, in terms of its reputation. Most of that, but not all of it, I was made aware, you know, was about money. But I would expressly say I had no inside information, you know, about the Mid Staffs trust. I knew some individuals, you know, who worked there. A couple of people who'd done an MBA with me at Keele University in previous years or decades, embarrassingly. I'd, you know, worked there. I have no knowledge about what became the -- the crisis, obviously, you know, that was -- you know, I couldn't have really.
Q. One aspect of the culture of management at Mid Staffs that the inquiry has heard about is that the medical staff were somewhat divorced from the management of the hospital. So my question is, to what extent were medical staff incorporated into the management at North Staffs?
A. You saw my -- my additional wry comment, didn't you?
I keep using this word wry about David Nicholson, away back in 2001/2002. In fact when he -- when David Nicholson chaired the appointments panel for -- to confirm Mr Crowley in his substantive post as chief executive in 2002, in a perfectly amicable throwaway comment to me over a bowl of soup or whatever it was, you know, before the appointment committee he said to me, "Now, come on, the doctors run this place, don't they?" Now, you know, one's response there is, yes -- yes or no. Is that a good thing or a bad thing? And -- and I knew what he was driving at. He was saying, "You know what the doctors want, don't you?", rather than stand up as managers against them.
I can't remember how I answered it. It really was quite jocular, although it was coming, I suspect from -- you know, I wouldn't read too much into it, except that there's medical leadership and there's medical leadership. I think -- I've no reason to think that, you know, our -- at the University Hospital our record of involvement of doctors in leadership and management was brilliant or -- or even great. I've no reason to think that. What I do think though is that serious important things didn't happen on financial grounds over the -- over the wish of senior doctors. Now, there's medical leadership, which involves thinking of the hospital, as a -- as a clinical cooperative responsible for running itself. And there's medical leadership which basically means doctors buying into the managerialist agenda and selling it to their colleagues.
Now, far be it from me to put words into Mr Nicholson's mouth, but my personal view is, although he would not put it in these terms, he has more of the latter in mind than the former. Now, I could be wrong about that. I have to be careful here, and I think David's quite sincere about involving doctors, to the extent I know anything about his views on these matters. But, you know, phrases like, "Are the doctors involved or not?", have to be unpicked very carefully.
I've no idea about Mid Staffs. I know what I've read, you know, from these three inquiries that took place before the independent inquiry, by which I mean the CH -- sorry, not the inquiry, the investigations, the special investigation by, you know, what became the Care Quality Commission, and then there was the David Colin-Thome and the George Alberti things. Now, they -- they've all got comments to make along the line of what -- what you've said, I think, haven't they?
All I could I say is that if we tried to do that at the University Hospital to, you know, keep the doctors out and have them disenfranchised, we wouldn't have got away with it. And I think it's right that we wouldn't have got away with it. That's my opinion and that doesn't mean that there's been no desperate quality issues from time to time, maybe ones I don't know about because, you know, the big question is, what -- how do you know what you don't know? And that's the -- that's the million dollar question for a board, how do you find out what you don't know? But, you know, these -- these things come and go in the NHS, you know, with -- with frightening regularity, I guess.
Q. Just on that point of how do you find out what you don't know, another aspect of the Mid Staffs experience about which the inquiry has heard evidence is the fact that the board was somewhat disengaged with what the staff and patients experiences were and so, again, is that an area in which you can shed any light in terms of how the board at UHNS remained engaged with the staff and the patients?
A. Well, that's -- that's a difficult one. I -- I think, now that I know all I know about Mid Staffs, as an outsider to the trust, and other trusts in the NHS, I think I -- I think nearly everyone, you know, at board level in the NHS and at ministerial level has probably not got right how to involve patients and the public. And I wouldn't -- I wouldn't claim that we -- we got it away with it.
right in my time there.

I was quoted by a friend of mine, Ken -- Ken Lowndes, 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 coming forward under the coalition government's agenda. What is in relation to the proposed reforms that are now coming forward under the coalition government's agenda. What have we got? We've got a wider forum for external regulator or regulators.

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.
But what I will say about quality in the future is there will be patches where local clinical commissioning groups hold the ring on that and do a good job, and there will be parts where they don't.

So whose responsibility at the end of the day is it to assure -- either to assure that organisations do appropriate work on patient safety and quality and achieve things, or ensure that where they don't there's somebody else to do it? Now, who is that somebody else?

It's the National Commissioning Board.

So the new system -- whether reforms mark 1 or mark 2 -- under the coalition, are putting a terrific amount in the centre, and the devil's gonna be in the detail. The National Commissioning Board is going to have to, for the reasons I've said, take quality as its -- and I don't just mean that glitzy, I mean patient safety, appropriateness of care, all these things, not just jargon about integrated care pathways and stuff like that.

All of that is going to have to be done -- either overseen very effectively or done by the National Commissioning Board. The Care Quality Commission will get better and better as time goes on, I -- I hope and have a major role to play as an external -- what is it then? You see, is it an inspector or a regulator? Can it be both? I don't even know.

So I think there's a lot unanswered in the future. The initial danger was just torching organisations and being either complacent or a little bit unknowing about what would take their place.

And just perhaps finally, I'd say, you could say to me, "Okay, you've had a pop at PCTs and SHAs in different -- in different form". I've had a -- if I have, I've honestly made a critique of what I've seen in practice. That does not deny to me -- sorry, I do believe we need, not separate foundation trusts and purchaser or commissioner/provider splits. I actually believe we should -- we ought to have integrated health organisations for health economies, for local health economies.

I don't think it's helpful, to be honest, to have in the North Staffordshire, for example, PCTs still arguing with the hospital -- okay, there's two of them now, not four. But the dilemma is how to have an integrated organisation which isn't just reinventing, as Tony Blair would say, the 1940s, 50s, 60s old Labour.

Well, maybe there was nothing wrong with that in some ways. But I think we have moved beyond that, because that system didn't have proper involvement of clinicians in planning decisions or strategic commissioning decisions, whatever you want to call it.

So by an "integrated organisation" I don't mean putting the clock back to before 1991, I mean a differently configured organisation.

Now, I think we need regional health authorities. Maybe the number we've got. So we've got a good start in that way.

And I think they need to ensure that services are -- they need to do internal performance management.

And we need to have an external regulator, but I do think that there's been -- you know, the theory for having a commissioner/provider split or a purchaser/provider split is market theory, or what academics call sometimes public choice theory, that providers will only do their best if they've got to sell themselves to somebody. Either, you know -- it's either Smith's invisible hand or Tony Blair's NHS market was supposed to be about quality. You regulate the price, everyone gets the same income for providing the same service, so hospitals will compete on grounds of quality.

Now, without boring you, I think there are lots of technical reasons why it doesn't actually work like that. And I think, warts and all, integrated organisations, overseen by a key number of strategic performance managers, is not the orthodoxy of the age. But at the same time, ironically enough, if the coalition, through all its compromises of recent weeks, is coming to say, "We need clinical commissioning groups involving hospital doctors, as well as GPs, and involving nurses as well and all the rest of it", if that works, because it says you don't have to have a tender for every service. You work with your local hospital to improve quality, because you're part of the same organisation -- funnily enough, you know, what was supposedly the coalition's market reforms could actually go a little bit in the direction I'm suggesting.

I do believe in patient choice, but I don't think it
it's the same thing as market competition. And I believe GPs as individuals ought to have an absolute right to refer anywhere in the NHS, and that integrated organisations can be funded according, over time, to the amount of work they're -- they're doing in the system.

I just think that a lot of the reforms and structural reforms have been sledgehammers to -- to crack a nut. But, at the end of the day, ironically, the nut maybe hasn't even been cracked, it's just rolled off the table.

So I think there's no -- there's no structural answer to a cultural issue. You know, that if the cultural issue is, "How do you get people to take quality seriously?" You can have any structure and if they don't take quality seriously, you know, it won't guarantee good quality.

So the sort of structural thing I'm talking about is a -- is necessary but not sufficient, in my view. You need people working together in health economies in a public service. But you also need -- you need some performance management. You need some targets. We need a small number of core targets, which are fundamentally about quality and patient safety, as well as money and waiting times.

THE CHAIRMAN: Well, thank you very much for that. A. Thank you.

THE CHAIRMAN: That's all I want to ask. Is there anything you want to add after what you've just added?

A. I think probably not at this stage. You know, we've covered quite a lot, I think. So I shall leave it there. Thank you, chairman.

THE CHAIRMAN: Professor, thank you very much indeed for your help today. As I have said, if you have some afterthoughts, write to us --

A. Thank you very much indeed.

THE CHAIRMAN: -- and we'll seek to take those into account.

A. Thank you. Yes, I will certainly take that seriously.

Thank you for that.

THE CHAIRMAN: Thank you very much. Well, that concludes today's proceedings and we meet again at 10 o'clock tomorrow morning.

(12.57 pm)

(The inquiry adjourned until 10.00 am on Wednesday, 22 June 2011)
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