Day 93  
Mid Staffordshire Inquiry  
1 June 2011

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<th>Page 1</th>
<th>Wednesday, 1 June 2011</th>
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<td>1</td>
<td>(10.00 am)</td>
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<tr>
<td>2</td>
<td>(Proceedings delayed)</td>
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<td>3</td>
<td>DR WILLIAM MOYES (continued)</td>
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<td>4</td>
<td>Examination-in-chief by MR KARK (continued)</td>
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<td>5</td>
<td>THE CHAIRMAN: Ready for the second innings?</td>
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<td>6</td>
<td>A. I don't play cricket, but yes, sort of.</td>
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<td>7</td>
<td>MR KARK: Dr Moyes, nor do I.</td>
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<td>8</td>
<td>THE CHAIRMAN: Whichever.</td>
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<td>9</td>
<td>A. I'm Scottish.</td>
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<td>THE CHAIRMAN: It can't help that, I'm sorry.</td>
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<td>MR KARK: Sir, can I just mention that we've had some recent</td>
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<td>disclosure from Monitor. I'm not making any complaint</td>
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<td>13</td>
<td>about it, it's as a result of us suggesting to them</td>
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<td>certain further search terms and it's resulted in quite</td>
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<td>15</td>
<td>a lot of material.</td>
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<td>16</td>
<td>Just to let CPs know that that is going up on</td>
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<td>LextraNet. We hope it will not result in the recall of</td>
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<td>any witnesses, but it's just to alert all those who sit</td>
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<td>behind me that they may want to look out for that</td>
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<td>material.</td>
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<td>21</td>
<td>THE CHAIRMAN: Is your hope of the devout kind or based on</td>
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<td>information? How much material is there?</td>
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<td>23</td>
<td>MR KARK: Well, Monitor have just told me that it's a large</td>
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<td>number of emails, but in fact the material that's come</td>
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<td>through to us on CDs has translated itself into</td>
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<td>something like seven lever arch files. But a lot of</td>
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<td>that is material, having had a very brief look at it</td>
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<td>myself, which is not going to concern people at all.</td>
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<td></td>
<td>Whereas the emails may be more interesting.</td>
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<td>THE CHAIRMAN: Very well, and thank you for that. I'll</td>
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<td>restrain my concern for the moment.</td>
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<td>MR KARK: Dr Moyes, in fact perhaps we could start with</td>
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<td>that, because we have from that material found one</td>
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<td>matter that I think I probably would have put to you</td>
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<td>yesterday if I'd had it in front of me, and that's an</td>
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<td>email that's going to come up on the screen. It is</td>
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<td>dated 10 March 2006 from yourself to Adrian Masters.</td>
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<td>Do you remember yesterday we were discussing the</td>
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<td>issue of whether there was pressure from the Department</td>
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<td>of Health to push foundation trusts through, rather</td>
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<td>early on in your evidence?</td>
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<td>MR KARK: Yes, it's a reflection of fear than anything else.</td>
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<td>Being an FT is not being in a club -- it's a key</td>
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<td>element of coping with PBR, choice, competition,</td>
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<td></td>
<td>et cetera. Being performance managed by the SHAs is</td>
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<td>actually a very comfortable life. They take the</td>
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<td>decisions ... and the blame.</td>
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<td>&quot;But this raises the question of who should be</td>
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<td>setting this policy -- us or DH?&quot;</td>
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<td>Now, there are a couple of questions I want to ask</td>
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<td>you about that.</td>
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<td>First of all, was it your view that the award of</td>
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<td>foundation trust status wasn't so much a mark that</td>
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<td>a trust had got to a certain point, but it was an</td>
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<td>encouragement to them to do better? I say that because</td>
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<td>of the second line in this paragraph &quot;being an FT</td>
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<td>sharpened up et cetera&quot;.</td>
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<td>A. I think when we started in 2004 there were a good number</td>
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<td>of applicants at that stage who thought it was simply</td>
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<td>another badge. The minister wanted the hospital to be</td>
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<td>an FT, so they'd become an FT, and -- and that was fine.</td>
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<td>And I don't think that they had really internalised or</td>
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<td>thought about the real proposition, which was instead of</td>
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<td>doing what the minister wanted they would be running</td>
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<td>a very complex organisation under contract to a number</td>
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<td>of commissioners, but they would then be responsible.</td>
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<td>And -- and I think it -- it took -- I mean, this is</td>
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<td>2006. So this is just after, I guess, the Healthcare</td>
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<td>Commission's report following their review of the</td>
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<td>lessons to be learnt from the first two waves. So there</td>
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<td>has at this stage been a year pretty much when there has</td>
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<td>been almost no authorisation work done, if I am</td>
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<td>remembering correctly, because of the hiatus caused by</td>
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<td>that review, and I think some hospitals probably felt</td>
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<td>the policy would slowly grind to a halt. I think there</td>
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<td>were some hospitals -- I would characterise Bradford,</td>
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<td>for example, that when they first applied they just</td>
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<td>thought this was a -- a mark that had to be got. And</td>
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<td>I think that it dawned on people after Bradford and then</td>
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<td>Royal Devon and Exeter and then Peterborough when</td>
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<td>Monitor intervened that we did mean what we said, that</td>
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<td>we expected hospitals to reach a certain stage to become</td>
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<td>foundation trust but beyond that we expected them at</td>
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<td>least to maintain that, but actually to continue to</td>
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1 (Pages 1 to 4)
improve, so that they were constantly compliant with the
terms of their authorisation, and that if they were not
compliant, then we could and would intervene.

Q. What led to this email -- we ought to have looked
perhaps at the second paragraph of the email written to
you from David McArtney:

"On another topic [he says] I am picking up a number
of funny (peculiar) comments from trusts including wave
2a applicants regarding the logic of becoming FTs --
including if it is a club that includes everybody why do
we want to be in it, it isn't very good for finances
look at UCLH ...

Was that one of the difficulties, that you and the
government faced, really persuading trusts that it was
making the application?

A. Yes, I think so, and I think it still is the case.
I mean, the policy slipped almost imperceptibly from
Alan Milburn saying, "This is about identifying a cadre
of elite hospitals, maybe 20/25, something like that,
who will be extra special, and they will be foundation
trusts and then we'll have the rest". And then -- and
this is just me from reading the papers, I wasn't
involved at all at this stage, but --
Q. Can you slow down a little bit.
A. Sorry, forgive me. I'll calm down in a second.

And then Alan Milburn came under great pressure, as
I remember it, to recognise that this would be in effect
a two-tier system. So he then declared in the House of
Commons, if I remember correctly -- or John Hutton
perhaps on his behalf -- that the possibility of
becoming a foundation trust would become open to
everyone, the possibility. And then imperceptibly,
I would say, overtime, the Department's stance became,
"Well, we would like all the system to be foundation
trusts".

But I don't think -- sorry, I'll -- I'll finish in
a second, but I don't think that anyone at any point
really sat down with the hospital system to argue the
case why this was actually a good thing for hospitals,
for patients, for the entire healthcare system. So,
therefore, there were a good number of hospitals,
I think -- and I think there are still some -- whose
view was, "Why go through all the pain? Why take the
risk of being a foundation trust? Why not just stay as
we are?"

Q. In the first email, I also want to ask you about the
last line, because it seems a very odd comment from
a wholly independent regulator, which is what you were.
You say:

"But this raises the question of who should be

 selling this policy -- us or [the Department of
Health]?"

Why on earth should Monitor be selling a government
policy?

A. Well, that's a good question, I agree. That was the
very question I was posing. Why is it the case that if
the government wants this policy it isn't really putting
effort into promoting the positive benefits of becoming
a foundation trust, and leaving Monitor to get on with
the operation of authorisation and then compliance where
necessary?

But, in my experience, throughout my time at
Monitor, there was very appetite to sell the policy.
The government, in my characterisation, having passed
the legislation, thought it had done its job. But it
hadn't.

Q. But do you agree that, as an independent regulator, your
job is to regulate in terms of authorisation, first of
all, foundation trusts and then to regulate them when
they are foundation trusts, but you as an independent
regulator should have absolutely nothing to do with
pushing through a particular policy of government?

A. Well, I don't think it's that clear-cut in any context.
There are lots of examples around government where
quangos find themselves part of the process of saying to
people, "This particular policy is a good thing, here is
the evidence". Quite often the evidence, for example,
rests in the quangos, rather than in the government.
I mean, the Office of Fair Trading, where I sit on the
board, is quite happy to sell to the public and to
industry the benefits of competitive consumer markets,
although that is a government policy.

Q. With respect, that's different, isn't it --
A. Yeah, it is, up to a point.

Q. -- because in this circumstance you have the power to
authorise the trust that you're going to push into the
system?

A. We have the power to authorise the trusts that the
Secretary of State brings to us and says, "We think this
bunch of trusts are now capable of being authorised".
But selling the policy, saying to the healthcare system,
"Being a foundation trust has benefits and it has
benefits to the wider system, as well as to the
organisation", I don't think in any sense compromises
our independence. But I would have much preferred,
absolutely, the main focus of selling the policy to have
been in Richmond House than in Matthew Parker Street.

THE CHAIRMAN: When you say it doesn't compromise your
independence, I'm sure that would obviously be an
intention, but if whether willingly or unwillingly

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A. Well, if that were the case, I don't think we would have rejected one in three at the first attempt, and I don't think we would have intervened so regularly as we did.

30 cases, 30 different times, 30 organisations, or multiply -- or multiple times some organisations,

Moorfields, for example. No, I don't -- I wouldn't accept for a second that by saying on the one hand,
"Actually this is a good policy, the way it is being implemented, it has real benefits to you as an organisation, you will be a better organisation, it has real benefits to patients across the piece", I don't think that, saying it about the system and about the policy, implies in any sense that we would just let hospitals slip through, and I think the facts speak for same themselves on that.

MR KARK: Can I come back to the issue of self-certification, we were discussing yesterday the importance of self-certification and the importance of the honesty of the self-certification. You mentioned that there'd been a review, and we've managed to uncover a review. In fact, we're grateful to Cure for finding

"Some boards have declared anticipated compliance with their terms of authorisation but then rated their trust as high risk on their risk registers for the achievement of individual healthcare targets. In some instances, annual plans also highlighted the risk of not achieving certain targets, but the board then chose to self-certify full compliance."

Now, weren't these fairly obvious dangers of self-certification, and did it not cause you concern about placing too much reliance upon them?

A. Well, it is an obvious danger. I mean, the culture of the NHS is a danger to this approach, let me be quite clear about that. The culture of the NHS, particularly the hospital sector, I would say, is not to embarrass the minister. That -- that's a big pressure and has been on managers in the NHS almost since its creation. Don't do anything to embarrass the minister. And what Monitor was saying, which was a completely different approach, was, "Be honest, acknowledge where things are going wrong, or might go wrong, and give us some comfort that you're doing something about it". And every so often, we had to take steps to remind people that we would rather have honesty, than good spin, if I can put it that way. And I think what happened here was that Stephen Hay and his team identified a number of trusts where they began to think, "These self-certifications don't really match the reality of the evidence, and we're not happy about that". And I think Stephen got me or the board to agree that we would commission an external study, and that's this study, by I think one -- I guess one of the major accounting firms to go and look at how was self-certification actually happening in this sample, which was chosen to be a sample of hospitals where we suspected that self-certification was not accurately reflecting the circumstances of the trust. This is not a representative sample of hospitals, good and bad. It's -- it's weighted to be at the bad end, as we thought about it. And -- and I think it is to our credit that we did this work and put it in the public
1. domain. And I think it had an impact.
2. Q. But Monitor still relies on self-certification, doesn't it?
3. A. As do many industries.
4. Q. I understand many industries do --
5. A. Yes.
6. Q. -- but Monitor does --
7. A. And Monitor -- well, at -- at the point where I left
9. Q. What was the penalty where a trust was found to have
10. self-certified inappropriately or even negligently as
11. some of these, frankly, seem to have been, because there
12. was a recognised risk, what was the penalty for those
13. chief executives who'd taken that course?
14. A. Well, not necessarily of the chief executives, because
15. we did focus on the board chair very much.
16. Q. Yes.
17. A. I think I'm right in saying that in our compliance
18. documents, from an early stage in their development, we
19. said that, "If we ever uncover deliberate false
20. information, or a board that is clearly being negligent
21. in the way it assembles information, then, in the most
22. extreme circumstances we will intervene and we can
23. remove you for that". So that's the ultimate penalty.
24. Most of these hospitals were identified publicly by
25. 17 Q. Yes.
18. A. In Mid Staffs -- sorry, put the question again, if
19. you -- I may, let me understand it properly.
20. Q. In relation to Mid Staffs, you discovered by 2008 that
21. they had been sitting on information which had not been
22. revealed to your assessors, they had self-certified in
23. circumstances where you must have come to the view they
24. should not have self-certified, and as you then came to
25. know, they were under active consideration by the HCC at
26. the time that they were authorised, but you didn't
27. intervene.
28. A. Well, if I remember the sequence properly, we authorised
29. them formally in February 2008.
30. Q. On 1 February, yes.
31. A. At which point the Healthcare Commission and the SHA
32. knew that an investigation was likely to be imminently
33. launched but no one troubled to tell us.
34. Q. Yes. Well, we'll look at that.
35. A. That happening, we then had a foundation trust
36. that was about to be investigated. Gradually over time
37. the Healthcare Commission assembled powerful evidence,
38. but to reach conclusions on the basis of the evidence
39. they had, and come to us with them, was that I did, at
40. some point in 2008, come to the conclusion myself, and
41. I think my board subsequently, that intervention was
42. appropriate here. But I think it's -- no doubt we'll
43. talk about this later on today, but I think it is
44. extremely difficult for a regulator to intervene when
45. another body is undergoing -- undertaking a detailed
46. investigation.
47. Q. We looked at what Monitor did know yesterday, and
48. I don't want to retread old ground, and I am sure nor do
49. you. But one of the issues we were looking at was the
50. HSMR. You told us that you were aware that the trust
51. had commissioned research by a company called CHKS.
52. A. That's right.
53. Q. Were you aware that the research that was commissioned
54. by CHKS was actually commissioned before and indeed
55. reported four months before the Dr Foster figures came
56. out?
57. A. I'm not -- I can't remember now if I was aware or not.
58. I'm sorry.
59. Q. Because the CHKS were instructed, and we can look if
60. necessary at their report, I'm not sure it's going to be
61. on the system but I'll have a go, Cure 0001000206.
62. No. I'll try one other. HCC 0017001219.
63. That's all of I've got to offer. I'm afraid I'll
64. simply have to read the first paragraph to you. The
65. introduction of the report reads:
66. "The trust has expressed some concerns that recovery
67. introduction of the report reads:
68. "If we ... [uncovered] deliberate false information,
69. or a board that is clearly being negligent in the way it
70. assembles information, then, in the most extreme
71. circumstances, we will intervene and we can ..."
people who understood this better than we did thought that the trust had offered a credible explanation and were taking credible steps to rectify the problems that they faced. They had CHKS. They had set up a mortality group. They were strengthening their coding. So there was a number of things that taken together seemed on the face of it at the time to be a credible response.

Q. The figures that Dr Foster were using -- and I'm just using part of the Dr Foster report -- was, if I can just read the first paragraph, "Data explained": "The hospital standardised mortality ratios in this report are based on the routinely collected administrative data for England for the year ending March 2006 and combined with the hospital episode statistics for the three years ending March 2006." So it was relatively old data by the time that it was published. But can we take it that, understandably perhaps, you didn't perform a personal close examination of the figures, but if you realised that the CHKS report and the Dr Foster report were looking at different periods, would that have caused you greater concern than perhaps you had?

A. It might have done. I mean, I think the -- the main thing that I was looking to get comfort on was, first of all, did the hospital at the board level understand that

of income for clinical activity has decreased over the first two quarters of the 06/07 financial year."

And that was the period, in fact, that CHKS examined, and they say they did an audit of clinical coding. The first audit of case notes was performed on the discharges, which occurred during April to September 2006, with focus on the surgical specialties.

Now, how much focus did you give to these mortality figures if you were deriving comfort from a report which bore almost no relation to the period that Dr Foster was looking at?

A. Well, in the pack that came to me -- I mean, I -- I didn't direct the assessment and I -- not for any assessment would I expect to see all the detailed papers. The assessment team do the assessment and it was never the case that I got involved in detail after the very early ones. So in the board pack that came to me and to my colleagues on the board for the board-to-board meeting and then for the final decision there was an explanation of the Dr Foster figures and there was an explanation of what we understood the trust to be doing, and I think also of the views of the SHA, who were involved.

And overall, the assurance I was given, and my colleagues were given, by the assessment team was that

it appeared to have a problem from the data that was coming from different organisations? And irrespective of what had happened in the past, did the hospital now have a credible programme to put things right? And based on the material that I had in front of me, I and my colleagues -- and I think I'm -- I'm right in saying the SHA and other people -- were persuaded that what the hospital was doing was all going in the right direction.

Now, with the benefit of hindsight, that clearly isn't the case. But at the time it seemed a credible explanation.

THE CHAIRMAN: Would you have expected your assessors to have examined the underlying reports, or would they have taken a description of those reports from trust directors?

A. Well, I probably would have expected them to examine the underlying reports up to a point, anyway. I mean, I -- I suspect probably what I would have expected them to do would have been to -- asked people who really did understand this kind of data, "Is there anything here that I should be worried about?" Or, "Do you find this is a credible explanation?" And I think the team made some efforts to try and do that.

THE CHAIRMAN: Do you know whether they in fact did get outside expert help on the mortality --
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<th>Q.</th>
<th>I understand. What I want to do is just examine it briefly with you and then ask you whether you think that this sort of information would in fact so late in the day have stopped your authorisation, if you'd had it.</th>
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<td>A.</td>
<td>This is two days before we authorised it; is that correct?</td>
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<td>Q.</td>
<td>Yes.</td>
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<td>A.</td>
<td>Yes.</td>
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<th>Q.</th>
<th>On one view, and you must tell us, the dye is cast by that stage and perhaps no amount of information would have stopped the process, or alternatively perhaps you would have been affected by information?</th>
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<td>A.</td>
<td>Well, I think my general view would be that until I sign the authorisation document, it was always possible to reconvene Monitor’s board in some way, even by an email and say, &quot;Fresh information's come to light and I think we should pause&quot;.</td>
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| Q. | Okay, well, let's have a look at this letter then: "Dear Mr Yeates. "As you are aware the Healthcare Commission has been alerted to the fact that mortality data held by Imperial College indicates significantly high mortality rates for some diagnoses/procedures ..." And then they are listed, four separate procedures. And then if we go down to the bottom of the page: "In addition to receiving copies of mortality alerts sent to Imperial College, the Commission conducts its own data analysis of mortality rates. This analysis has identified [Mid Staffs] as having significantly high mortality rates for ..." And then there are a further three conditions. And then over the page: "We have also conducted some additional mortality analysis further to the alerts generated internally and those we have seen from Imperial college. This analysis identified an above average mortality rate for all emergency admissions with an increasing trend from 2005 to early 2007." I'll read on, if I may. Next paragraph but one: "One of the functions of the Healthcare Commission is to conduct investigations into the provision of healthcare by or for NHS bodies. The Commission is not conducting a formal investigation at this stage but is making preliminary enquiries in order to decide the appropriate course of action." And you'll remember yesterday that I picked you up on whether the HCC had actually decided to investigate or not. |
| A. | Mmm. |

| Q. | But then at the bottom of the page they say they'd like to conduct a visit. So let's assume for a moment that information had come to you at Monitor, and it had filtered itself through the various levels up to your desk. What view would you have taken? |
| A. | Oh, I would have taken the view that this is a clear indication that the Healthcare Commission plans to do an investigation. They -- they may say they haven't made up their mind, and that would be formally the case, I've no doubt. But it's a bit like saying, "We're minded to do X or Y", and giving people an opportunity to explain why that action shouldn't happen. |

I think if -- if I'd seen it or Stephen Hay had seen it or Miranda Carter had seen it, any of us would have said right in the way, "In the light of this, we should stop". And -- and I don't mean reject, I just mean stop and say to the trust, "Until this is clarified, we will put your application on hold, and then once we know the outcome of this, we will reactivate the application and take a decision". |

Q. | Under the new system that we looked at yesterday, when you would only defer for three months, would that have meant effectively knocking this trust out of that wave of applicants? |
| A. | Well, not necessarily. We -- we always gave ourselves the opportunity to say there are special circumstances. My guess is that in the light of this, and here I am changing my arm, but my guess is that my board would have said, "Let's reject the application and tell the trust to come back once this matter is sorted, one or other". It depends on whether we were advised that the Healthcare Commission's investigation looked like to be extremely serious, or was something that could have been taken ... |

6 (Pages 21 to 24)
A. Yes.

Q. -- which when he sits across a desk from you he doesn't mention you?

A. No, that's a perfectly fair point. He clearly, with the benefit of hindsight, was not open and honest with us.

And had he been open and honest with us, or his medical director been open and honest with us, then the authorisation process would have taken a completely different course.

Q. Could I ask you on a different topic in relation to the authorisation in relation to your knowledge of the CIP, because we've heard a lot about this CIP of 10 million that the trust had strived for.

A. Yeah.

Q. It would be obvious to you, presumably, with your background, that a GBP 10 million CIP for a relatively small trust would require particular attention. You deal with this, if it helps, in your paragraph 66.

A. Mmm.

Q. Or thereabouts.

A. Well, the thing about the cost improvement programme now is that it wasn't actually GBP 10 million of cost improvements. It was a mixture of cost reductions and income generation, if I recall it correctly. But you're absolutely right, it was still, on the face of it, a pretty testing level of reduction, even if one eliminates the income generation, which I never liked being mixed up with cost improvements because it's a completely different set of risks to the trust. So, yes, it was.

But I -- I wouldn't say it was by any means unique.

We -- we did meet a good number of smallish hospitals that in the run-up to becoming a foundation trust found it possible to cut the cost basis substantially, without the kind of effects we saw at Mid Staffordshire.

Q. But it required somebody in your organisation to consider what the effects of that GBP 10 million CIP might be on the trust, surely?

A. Well, up to a point. I mean, the first responsibility for considering those kind of things is the trust itself, and the board of the trust. At this stage, the trust is still a trust, subject to detailed performance management by the SHA. So I would have expected someone in that system to be asking the question, "Is this being done appropriately? Is this being done safely? How does it benchmark with comparable trusts, and so on?"

But you're absolutely right, as part of the authorisation I would have expected my team, and I hope my team did, just ask the question, "Do you know how this has been achieved?" But as I say, you've got to unpick, if I remember correctly, Mid Staffordshire's cost improvement programme, because it was a mixture of reductions in cost, including things like procurement.

It was a mixture of planned income generation. It wasn't a straightforward slashing costs.

Q. By the time of the trust's authorisation, you at Monitor weren't a straightforward slashing costs.

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It was a mixture of planned income generation. It wasn't a straightforward slashing costs.
The sequence of that now.

Q. Were all of those interventions as a result of financial
failures?

A. No, not all. Moorfields, for example, I think, was
a mixture of financial failure and failure to deliver
targets, and something else, I forget.

Q. But I think Bradford was financial. Devon and Exeter
was financial.

A. Those were primarily financial, yes.

Q. UCLH was financial.

A. Yes, primarily, yes.

Q. Do you think you had a lower bar for intervention when
the finances of a trust looked ropey, rather than when
the healthcare of a trust looked ropey?

A. No, I don't. I mean, the healthcare looked ropey is --
is -- is not sufficiently precise a phrase for this
classification, if I may say so. We -- we had to judge
information --

THE CHAIRMAN: Just pausing there, data in the sense of
figures in a table, but if you want data about patients
who have had bad experiences, which indicate bad care,

A. Well, there is -- there's data in the complaints they
make, yes. But there isn't on any scale systematic data
that I'm aware of in the system about the performance of
clinical teams and hospitals in relation to specific
illnesses or categories of patient. It's something that
the new Secretary of State, Andrew Lansley, looks to put
right. But I think he's realising it's going to take
many years to get to that stage. It has happened,
I think, for cardiac surgery now. But even then,
I think some of that data when you interrogate it is

THE CHAIRMAN: Well, as the objective of medical treatment
is to make people better or prevent them getting worse

A. My knee replacement last year was a great success, but
I am still in considerable discomfort. But my surgeon
regards it as a great success, and he's told me that,
and he and I have discussed it. So perception as to
success and failure often vary as between clinician and
patient.

THE CHAIRMAN: And that includes patients left in
excrement-stained sheets.

A. Oh no, no. I mean, I'm -- I'm not -- sorry, don't --
don't misunderstand me. I'm not for a moment condoning
the kind of lapses in care that went on in Mid
Staffordshire, and I think there are big questions about
why it was that clinical staff allowed that to happen

THE CHAIRMAN: Well, that's a different issue --

A. And we'll come perhaps --

THE CHAIRMAN: -- but the point is that if you have
information of that nature from patients, then you don't
probably need an orthopaedic expert or a geriatrician to
tell you that there's something wrong.
### Day 93

#### Mid Staffordshire Inquiry

1. **A.** If there is information like that and it's well attested and it's representative of what's happening in the hospital, then you're absolutely correct. And there is data up to a point of that kind available around the system. But it's a small fraction of the information that would be needed to make regulatory judgments about interventions on the basis of clinical quality and service quality. And I think one of the things that the new government is trying to do that ought to be applauded is trying to put that right but it's a -- a much bigger task than perhaps people realise.

2. **MR KARK:** Does your own experience, since you've raised it, not persuade you that patient surveys ought to be higher up the register.

3. **A.** I think patient surveys should be higher up the register. I think patient-reported outcomes should be mandatory, and I think the data from them should be available both to commissioners, to patients, to GPs when they're guiding patients making choices, and obviously to regulators, and I think performance data on clinical outcomes, deaths, readmissions, hospital-acquired infections, those kind of things, those should all be available across the system, and I think there are big questions as to why it's not the case.

### Questions and Answers

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<tr>
<td>Q. Well, it's a question you might have answered when you were chief executive of Monitor, because you didn't pay any regard to patient surveys at that stage, did you?</td>
<td>A. Oh, I have really no idea.</td>
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<td>Q. What you might have said, I suppose, is, &quot;Anna, we've got something of a problem here. We've just authorised a trust that Monitor literally just authorised as a foundation trust was coming under the Healthcare Commission's spotlight, surely, if your organisation was working properly, would have reached your desk pretty fast?&quot;</td>
<td>A. Mmm.</td>
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<td>Q. Therefore, if the Healthcare Commission had decided to launch an investigation into Mid Staffordshire, I'm sure that was the case.</td>
<td>A. Yeah.</td>
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| Q. -- the rest of that, and indeed it reflects the letter, pretty much, that we saw of 28 January. Do you think someone at Monitor should have been asking for further information about what these outliers were from the HCC itself? | A. Well, I'm not sure about that, because -- I mean, this is telling us that the Healthcare Commission are now about to investigate data, and -- I mean, I think at this stage it would surely have been right for Monitor to say, "Well, if the Healthcare Commission are now getting involved, we obviously want to know what they're doing and why they're doing it. But we certainly don't want to have our own line of questioning to the trust about something that the quality inspectorate is now actively looking at."

### References

- **A.** Well -- well, I expect so. But I -- I don't know that for sure. I don't ever recall seeing this, for example.
- **A.** But that doesn't mean to say I didn't.
- **Q.** I understand that. I'm not suggesting you would have been copied in on every email. But the fact that a trust Monitor literally just authorised as a foundation trust was coming under the Healthcare Commission's spotlight, surely, if your organisation was working properly, would have reached your desk pretty fast?
- **A.** Well, I think I was told pretty quickly. I don't remember exactly when and in what detail, but I think I was told pretty quickly by my team that the Healthcare Commission had decided to launch an investigation into Mid Staffordshire. I'm sure that was the case.
- **Q.** How quickly did you get on the phone to Anna Walker?
- **A.** Oh, I have really no idea.
- **Q.** Did you get on the phone to Anna Walker?
- **A.** I've really no idea. I mean, I simply cannot remember at that level of detail after this lapse of time.
- **Q.** Wouldn't that be a fairly obvious thing for you to have done?
- **A.** What would I have said? I mean, there's all the danger of being misunderstood that you're trying to persuade them not to investigate. So...
1 a trust and your commission is investigating it, we need
2 to know everything there is to know about the trust so
3 that I can go and have a word with the chief executive,
4 find out what he hasn't been telling me". That would be
5 one conversation, wouldn't it?
6 A. Well, I think that conversation would have been much
7 misunderstood at the time.
8 Q. By whom?
9 A. By Anna, amongst others. The Healthcare Commission,
10 using their own powers, were now deciding to
11 investigate. I think if I'd said, "I'm going to go and
12 tell the hospital to pull its socks up or question them
13 or intervene or anything", I just don't feel even now,
14 and I'm sure I would have felt this at the time, that
15 that would have been appropriate. I -- I cannot
16 remember if I had a conversation with Anna to register
17 that I was disappointed to find this out, or to find out
18 what was happening. I think at this stage quite a lot
19 of the contact with the Healthcare Commission was
20 between Stephanie and her opposite number, and perhaps
21 between Edward Lavelle and his opposite number. But
22 I think -- I think I would have been quite hesitant in
23 saying to Anna, "I want to go and talk to the trust
24 now".
25 Q. But even if you, for some reason of protocol, didn't

1 want to contact Anna Walker directly, surely your
2 instructions to your team would have been, "Find out
3 everything there is to know from the Healthcare
4 Commission to reveal to us, to let us know what's gone
5 wrong, if anything, with our authorisation process and
6 what this board has not been telling us"?
7 A. Well, I think my instructions to my team at the time
8 were, certainly hope they were, "Be completely
9 cooperative with the Healthcare Commission. So if they
10 want to know things from us, by all means give them
11 access to information". I'm sure I would have said to
12 the team, "Keep close to the Healthcare Commission and
13 find out what it is that is emerging from this". And
14 I know from my preparation for this inquiry that
15 I consistently said to the trust, "You must cooperate
16 with the Healthcare Commission. You must be honest with
17 them. And you mustn't also wait. You must get on and
18 rectify things as they emerge".
19 Q. Can we have a look, please, at some emails that passed
20 within Monitor, and it's part of your exhibit 12.
21 If we could go to the second page, please. This is
22 you being alerted, one doesn't know whether it's for the
23 first time or not, to what was going on.
24 It's to yourself and to Stephen Hay:
25 "Yvonne and I had a call yesterday with Heather Wood
Page 37

1 who is heading the HCC's investigation team at
2 Mid Staffs."
3 And they set out a summary of the conversation --
4 sorry, it's your exhibit 12. Do you have it?
5 A. I have found it. Thank you very much.
6 Q. Then the third bullet point, which must have caused you
7 some concern immediately, perhaps:
8 "Overall the process is expected to take around
9 a year from the start of the investigation to
10 publication of the final report. The investigation is
11 likely to start early April with trust visits planned
12 for the second half of April."
13 Q. You're now aware that the trust board hasn't told you
14 everything that you would have liked the trust board to
15 have told you. Isn't this the point at which Monitor
16 would want to get extremely active with this trust to
17 find out exactly what was going on to ensure patient
18 care?
19 A. Well, I think I did ask the question of my team, in my
20 memory, "Is there any chance that this investigation can
21 be done in two stages, so that there can be a quick
Page 38

1 investigation as to whether prima facie there is
2 evidence of a serious problem, or whether this is
3 something that in fact the trust is already aware of and
4 is rectifying?" Because, yes, you're right, from the
5 very start I felt that 12 months was a very long time
6 for the Healthcare Commission to spend on this
7 investigation. Not because I thought it wasn't serious,
8 but because it just seemed to me to be a very
9 considerable use of resources that could have been
10 directed at putting things right.
11 Q. But if at any stage you're of the view that
12 a significant breach of authorisation has occurred, or
13 was occurring, you had the power to intervene.
14 A. Yes.
15 Q. How did you decide what the level was of a significant
16 breach?
17 A. Can I just clarify by the way, "you" means Monitor?
18 Q. I beg your pardon --
19 A. Not me personally --
20 Q. -- yes.
21 A. -- five of us --
22 Q. Yes --
23 A. -- the board of Monitor --
24 Q. -- your board.
25 A. Correct, that's the "you", and that's how I interpret
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<td>1</td>
<td>&quot;you&quot;. How do we decide a significant breach? Well, as</td>
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<td>I think emerged in the course of evidence yesterday,</td>
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<td>there were no hard and fast rules. There were</td>
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<td>indicators of what significant breach might be. I think</td>
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<td>in this case, no doubt you will suggest to me that</td>
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<td>a failure to be open and honest with Monitor might have</td>
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<td>been one, and —</td>
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<td>8</td>
<td>Q. That's just about where I was going. But you carry on</td>
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<td>9</td>
<td>first.</td>
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<td>10</td>
<td>A. I could -- I could see that direction of travel. And</td>
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<td>11</td>
<td>you're right, that is a possible significant breach</td>
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<td>12</td>
<td>requiring action. I was focused at the time, and</td>
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<td>13</td>
<td>I think my board colleagues were focused at the time, on</td>
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<td>14</td>
<td>a recommendation from the Healthcare Commission that</td>
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<td>special measures were necessary or, failing that,</td>
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<td>evidence from the Healthcare Commission that there was</td>
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<td>a significant lapse in the quality of care in the</td>
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<td>hospital.</td>
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<td>19</td>
<td>Q. Did you think, given what you now knew in March, and</td>
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<td>then we'll look at a letter in May, that this board had,</td>
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<td>in the words of your own document, cooperated with</td>
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<td>Monitor?</td>
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<td>A. Well, initially they appeared to be cooperating with</td>
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<td>Monitor, but then --</td>
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<td>25</td>
<td>Q. No, I'm sorry, can I ask you to pause.</td>
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<td>1</td>
<td>A. Mmm.</td>
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<td>2</td>
<td>Q. Did you think they had cooperated. Not now, not at the</td>
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<td>time that you were then dealing. Do you think that they</td>
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<td>had cooperated with you in --</td>
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<td>5</td>
<td>A. Do you mean in February --</td>
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<td>6</td>
<td>Q. Yes, in a true sense --</td>
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<td>7</td>
<td>A. -- 2008.</td>
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<td>8</td>
<td>Q. -- during the assessment period.</td>
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<td>A. Well, in February 2008, yes. My sense at that stage was</td>
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<td>that they had been cooperative.</td>
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<td>Q. Short of replacing the chief executive and the</td>
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<td>governors, what did you consider the main regulatory</td>
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<td>intervention powers to be?</td>
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<td>14</td>
<td>A. Depending on the issue, Monitor's normal approach was</td>
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<td>not to replace the chief executive but to replace the</td>
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<td>chair.</td>
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<td>17</td>
<td>Q. All right. But short of that rather nuclear option,</td>
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<td>what else could Monitor do?</td>
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<td>A. Well, in -- in a case like this it -- I mean, this is</td>
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<td>one of the reasons why I was keen that the Healthcare</td>
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<td>Commission made specific recommendations as the report</td>
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<td>evolved. We could have, for example, required the</td>
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<td>hospital to bring in clinical experts to review things.</td>
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<td>We could have required the hospital to replace the</td>
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<td>medical director, for example, or to take certain steps</td>
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<td>to change clinical practice. But those are the kind of</td>
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<td>things where we needed expert advice.</td>
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<td>Q. But you didn't have to wait for the HCC to give that to</td>
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<td>you, did you?</td>
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<td>A. Well, I think we did. And this is something that</td>
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<td>I think was discussed on a number of occasions in</td>
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<td>Monitor. I -- I think, and I speak for myself here</td>
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<td>rather than for the board, but I -- I would have been</td>
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<td>quite reluctant to have launched a formal intervention</td>
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<td>by Monitor, when the Healthcare Commission was</td>
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<td>investigating but had reached no conclusion and made no</td>
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<td>recommendation. And at a later point in the year,</td>
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<td>having raised this more than once with Anna, she wrote</td>
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<td>to me in those terms, if you recall, saying, &quot;We haven't</td>
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<td>reached conclusion&quot;. So I -- I -- I felt at the time --</td>
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<td>maybe with hindsight it's the wrong judgment, but I felt</td>
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<td>at the time very inhibited about using Monitor's powers</td>
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<td>of intervention when the Healthcare Commission was in</td>
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<td>the course of an investigation.</td>
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<td>Q. But the effect of that, if you follow that line, is that</td>
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<td>Monitor is almost effectively supine until the HCC</td>
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<td>reports?</td>
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<td>23</td>
<td>A. Well, what we were doing was pressing the HCC to get on</td>
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<td>with it.</td>
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<td>25</td>
<td>Q. Well, yes. But it comes to the same thing. Until the</td>
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| you — it's — it's a very serious thing to do. We had been threatened with judicial review at Bradford. Counsel were instructed. Counsel sat alongside the trust. Listened to all the phone calls. It was only at the very last minute that, as I understand it, although I've never seen documentation, counsel advised his client there really was no prospect of a judicial review. But public meant was spent lining up lawyers to threaten us, and it was something that I was very alive to. Q. But if you live permanently in fear of judicial review, when what you're being asked is to make a reasonable judgment, and that's all you're being asked to do, it is difficult to ever to act, isn't it? A. Well, when you run a public body you always have to balance the need for immediate action with the risk of judicial review, and you make a judgment at the time in the circumstances. And the judgment I came to at the time, and my board did not press me to take any other view, was that, certainly in the early stages, for Monitor to intervene while an investigation by the Healthcare Commission was continuing would not have been appropriate. And I still think, although I can see the arguments, but I still think that the better outcome would have been for the Healthcare Commission to bring its investigation to a more rapid conclusion, and to have given us a basis then for intervention. Q. You met with the chair, Toni Brisby, on 14 April. We have a note of that meeting. If we could go to your exhibit 13, please. We can see that Toni Brisby had requested a meeting to discuss the current investigation by the HCC into mortality rates and care on the wards: "Key points discussed: "Toni wanted to make sure that Monitor was aware of what the issues are and also take any advice Monitor might have on what the trust ..." And then: "... [??]." You outlined that this meeting would mainly be: "About us [Monitor] listening and that we might request the board to come down and present to us what they are doing over the next couple of months." You highlighted the role of the HCC and Monitor in the investigation and encouraged the trust to do as much to rectify any issue they themselves had identified as quickly as possible: "[And] Toni set out the sequence of events leading up to the investigation and noted that there was probably substance in some of the complaints about care on the wards and that the trust were looking to rectify these issues." Now, just focusing on that information, she was telling you that there had been a sequence of events leading up to the investigation, so that must have been prior to authorisation. A. Mmm-hmm. Q. Yes? And that there was substance in some of the complaints about care on her wards; yes? A. Yes. Q. None of which she had revealed in any way to you when she'd been sitting across the table from you at the board-to-board meeting of 5 December. A. Mmm-hmm. Q. Did you still have faith in her? A. At this stage, I was prepared to, I think, give her the benefit of the doubt, if I remember correctly. I mean, what we don't know, because this is just key points, we don't really know the substance of this conversation. I don't know whether she said, "Look, the hospital is a shambles and it's terrible", or whether she said, "Yes, some of these complaints can be justified, but in the main the hospital is well run". So I really don't remember the substance of this meeting at all. Q. But how can it be well run if vital information isn't being given to the lead regulator? A. Well, in any hospital on any day there will be something going wrong. It's a question of scale. I don't know at this stage whether what is behind this email is Toni saying to me, "Actually, the scale of this is quite substantial and the depth of it is quite serious", or whether she was saying, "Yes, there are -- these complaints are not wholly without foundation but we think we're on top of it". Q. But whatever she was saying, you knew things were serious, didn't you? A. Well, I wouldn't say at this stage yet that we knew things were as serious as it later emerged from the Healthcare Commission's investigation. I think the first time that I began to feel that the hospital really was in a seriously bad way was when I saw the Healthcare Commission's letter about A&E. Q. All right. Well, we'll come to that. I'm trying to deal with it, obviously, as far I can, chronologically. A. Mmm. THE CHAIRMAN: Can I ask, was this meeting on 14 April the first face-to-face meeting Monitor had with the chair of the trust, following the email at the beginning of February? A. I don't know the answer to that.
THE CHAIRMAN: Was it your -- you think it was --

A. I have no recollection of the precise sequence of meetings. This was April. It probably was the first, but I'm -- you know, I can't be sure.

THE CHAIRMAN: And if full-blown investigations by the HCC were a rarity, was not the occurrence of such an investigation itself some indication of the gravity of the situation?

A. Well, I think at the time the Healthcare Commission were saying, "We are planning an investigation to see if there are grounds for concern". Initially, the Healthcare Commission's investigation was focused on certain mortality outliers. Later on, of course, that was not the focus of the investigation. It was quality of care in certain departments. So given that was in touch with the Healthcare Commission and my team was in touch with the trust, I'm not sure I felt it necessary for me to be summoning the chair at this stage.

THE CHAIRMAN: Would you have known by 14 April of the Healthcare Commission mortality outliers and the fact that you at Monitor had not been told about them prior to authorisation by the trust?

A. Probably, yes, but I'm not sure whether I personally would have known or not.

THE CHAIRMAN: That at least must have raised a question mark as to whether the disclosure in the authorisation process had been open and honest, wouldn't it?

A. It -- it might have done. My memory at this stage of the process, and it is only a memory, is that our focus was not so much on what happened in the authorisation, as whether the trust was now -- whether the Healthcare Commission was going to uncover serious defects in the trust or whether the Healthcare Commission would come back and say, "Actually, there is not a lot to investigate here". That is what we wanted to know, was there problem or not. I was less focused on the process.

THE CHAIRMAN: But it would have been particularly relevant to whether or not you could continue to have confidence in what the chair of the trust was telling you, wouldn't it?

A. Well, it would have been of some relevance, but I'm not sure that the minute some information comes in to say, "This trust has got a problem that you didn't know about", that we immediately jump to the conclusion that there is a lack of trust.

THE CHAIRMAN: No, I'm not asking whether you jumped to conclusions, but whether you would feel it right to compete urgently to the pretty rare event of a trust being subjected to a formal investigation by the HCC within almost minutes of you having authorised it?

A. Well, we took it very seriously. We were in touch with the Healthcare Commission at senior level through the team, and we were in touch with the trust. So we weren't saying, "Well, you know, you get on with the Healthcare Commission and tell us the answer". We -- we made it very clear we wanted to be very close to this and to understand it. But I don't think at the time that we were in a position, certainly not in April, to say to ourselves, "It looks as if we've been seriously consistently lied to, or information has been concealed from us and that we are going to have to intervene on grounds of process".

THE CHAIRMAN: But at the very least -- I appreciate that no responsible regulator jumps to conclusions and will always need evidence, but you only get to that stage if you conduct an inquiry. Would there not have been a case for Monitor, not treading on the HCC's toes but to at least have some sort of consideration of whether it could continue to have confidence in the board of this trust, bearing in mind what you had or had not been told?

A. Well, I don't think at this stage, from -- from my recollection of events, that -- that I would have been in a position to have gone to my board and said, "In parallel with the Healthcare Commission's investigation I think we should launch our own investigation into this trust about the extent to which they disclosed information to us". Quite early on, but not in April, I think I did say to my board, "Clearly, we're going to have to learn lessons from this about the authorisation process and about how it operated in this case and about what lessons we should take to the future". That came, I think, a month or two later on when the Healthcare Commission's evidence began to become very solid indeed. But that was evidence about poor care, not about outliers. So --

THE CHAIRMAN: Could I just ask what is a hypothetical question, but if a trust, having been authorised, Monitor discovered that the information that led to that authorisation was incorrect, false, misleading, whatever, would that past event of its being capable of being considered a significant breach of the authorisation?

A. It's -- it's not a hypothetical question. It happened at Bradford, and the chairman went.

THE CHAIRMAN: So the fact that something precedes authorisation doesn't mean that it can't lead to recollection by the pretty rare event of a trust being subjected to a formal investigation by the HCC within almost minutes of you having authorised it?
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23 Q. -- they weren't what the investigation was all about.
22 A. Yes, that's right.
21 Q. -- they weren't what the investigation was all about.
20 A. Well, usually if it precedes authorisation, it's effects
19 are felt post-authorisation. So one way or the other we
18 can find a way. And at Bradford, the prime grounds for
17 dismissing the chairman and putting our own chairman in
16 and for -- asking him then to replace the entire
15 executive team, pretty much was that in effect they lied
14 to us, in my judgment. Certainly they concealed
13 important information.
12 A. Eventually, but not in April. No, I wouldn't say -- at
11 least that's my memory of the time. I don't think at
10 this stage I'd yet come to the conclusion that this
9 trust had systematically and consistently and seriously
8 withheld information from us.
7 Q. You've said on a number of occasions that your
6 understanding was that the Healthcare Commission's
5 investigation was focused on certain mortality outliers.
4 Later on, of course, that was not the focus of the
3 investigation. But I think it may be important to look
2 at the terms of reference, which were published for the
1 investigation.

WS0000028159.

1 Q. Before we take the break, can we just look at one other
2 topic and that is the communication you had with the
1 SHA.

4 A. Well, I think -- I think I'm right in saying that the
3 correspondence you showed me earlier on from the
2 Healthcare Commission focused on them, on mortality
1 rates for certain conditions.

5 Q. But those were the triggers for the investigation --
4 A. Yes, that's right.
3 Q. -- they weren't what the investigation was all about.
2 A. Well, they were the initial triggers for the
1 investigation, that's correct.

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Page 53
I was in an SHA, which I've never been, but if I'd been in that position, I think I would have been, yes, I wanted to know what was going on, but I -- I equally would have been keen to have seen the process, not extenuated --
Q. Sure.
A. -- I mean, as quick a result as we can reasonably get that's consistent with good information on which we can act.
Q. If we go to your exhibit 15, which is a minute of a Monitor meeting with Peter Shanahan.
THE CHAIRMAN: We have been going about an hour and a quarter. Do you want to deal with this and have a break?
MR KARK: That's what I was going to do, but if anybody needs a break earlier --
THE CHAIRMAN: No, certainly.
MR KARK: -- I was going to deal with this one note. Mid Staffordshire hospital:

"The SHA is behind the trust on the current HCC review and feels that there are suitable explanations for the mortality variances which have been identified. The SHA feels the HCC investigation is vindictive and they are looking for evidence to support a predetermined outcome."

A. I -- I couldn't have any sense of it. I mean, this is April. I know that from time to time, over the course of the investigation, Martin Yeates and Toni Brizzy complained mildly to me or less mildly sometimes to me. But my attitude was always the same, that the investigation is being done by a body set up by Parliament to investigate, "And whether you like it or not, you've got to cooperate with them". Monitor was regularly accused of being overly aggressive or unnecessarily aggressive, so perhaps I felt some sympathy with the Healthcare Commission on this.
Q. Your paragraph 77, which deals with this note, is, I think, perhaps, inconsistent with what the note actually says, and perhaps I could ask you to expand on what you've said.

You say in your paragraph 77:

"I have been asked for my recommendations on the following statement ..."

It's the statement I've just read out:

"I suspect this note reflects Peter Shanahan's distillation of what he had heard from Martin Yeates and Toni Brizzy, but I have no way of knowing definitively. I recall that Martin Yeates and Toni Brissy were complaining mildly."

As you've just told us.

Well, with respect, Dr Moyes, that's actually not what the note says, because the note reads:

"The SHA feels that the investigation is vindictive."

A. Yes, and that raises the question, how did the SHA know?

And I have no idea how the SHA could come to a judgment.

I mean, this is, what, a month or so after the investigation started?
Q. Yes.
A. I'm making in my statement the assumption that their information came from Martin Yeates and Toni Brizzy, but as I say in my statement I've absolutely no way of knowing, I'm guessing.

MR KARK: I'm going to come on to the letter of 23 May, but as I say in my statement I've absolutely no way of knowing, I'm guessing.
THE CHAIRMAN: Certainly. We'll start again at 20 to 11.

(11.26 am)
(A short break)

(11.40 am)
MR KARK: Dr Moyes, I keep holding out the prospect of the 23 May letter in a sort of tantalising way. Just before we get there, can we go, please, to EL26, and this is an email of 7 May to Stephen Hay and to you from Mr Lavelle.
I appreciate you probably don't remember the email.
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<td>now, but perhaps we can just refresh your memory:</td>
<td>Q. And what really shines out from this note is the</td>
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<td>&quot;Please see the attached briefing paper for</td>
<td>importance of you as an organisation being able to trust</td>
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<td>Mid Staffs...&quot;</td>
<td>the board of the trust to deliver, as it's put here,</td>
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<td>This is for a meeting on the 8th:</td>
<td>a broad and demanding agenda. Do they have the</td>
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<td>&quot;The main objectives of the meeting are:</td>
<td>capabilities of doing that? And that was central to</td>
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<td>&quot;To receive an update from trust as to progress of</td>
<td>your concerns, presumably?</td>
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<td>current investigation.</td>
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<td>&quot;To assess whether Monitor should be taking any</td>
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<td>further action at this stage.</td>
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<td>&quot;To identify matters which Monitor may wish to</td>
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<td>discuss with HCC...</td>
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<td>&quot;The main queries we have mirror in part the</td>
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<td>findings at Maidstone. Our focus is as much on what</td>
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<td>they are doing (and have been doing) to rectify</td>
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<td>standards of care concerns (and not just to wait until</td>
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<td>the outcome of the...report). The impression I get</td>
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<td>(having not been involved) is that they need to</td>
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<td>demonstrate to us that they have the energy and to</td>
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<td>consider fairly seriously whether they have the people</td>
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<td>on the board to deliver a fairly broad and demanding</td>
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<td>agenda. Not just to panic and all hold hands together.</td>
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<td>&quot;If we aren't satisfied that this is the case</td>
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<td>I think we need to consider whether we need to encourage</td>
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<td>them to act before we do.&quot;</td>
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<td>Obviously a number of points made in that email, and</td>
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<td>16 (Pages 61 to 64)</td>
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the agreement of our legal adviser. I mean, obviously, I reserved the right to say to the board, "You've heard what Kate has said, but for other reasons we take a different view". But in something like this we're using formal powers under statute, I would definitely have wanted Kate, and Kate personally, to have had a chance to explore all the aspects of the issue, and she would be given the opportunity in the board to say to the board, "My advice is either you can use your powers", or "You can't use your powers", or, "You need to gather further information". So another aspect to these meetings would have been, after I saw the trust, making sure that Kate had the chance to familiarise herself with how the issue was developing.

THE CHAIRMAN: An issue like this, clearly you'd want to keep your lawyers fully informed of developments as they happen, but you would be putting a proposition to lawyers, wouldn't you, to advise you whether that was justifiable in law or not?

A. Yes. I mean, Kate didn't have a veto in that sense. As I say, she was clear and I was clear that there might be situations where I would say to the board, "Notwithstanding that advice, I think there are wider considerations and we'll -- we'll take a risk". And there one or two times when that happened.

THE CHAIRMAN: So your method of working was obviously, by the sound of it, very much one of a team effort with a search for consensus, but a team which you on issues like this would be taking a personal lead --

A. Or --

THE CHAIRMAN: -- would that be fair?

A. Yes. I mean, if there was any danger that Monitor might want to use its formal powers, I always felt that I needed to be pretty close at the time of the issues. It wasn't always possible for me to be completely familiar with every aspect of every issue. But I certainly didn't want to learn about a proposal to use our powers for the first time in a board meeting, if I can put it that way.

THE CHAIRMAN: No, I can see that.

MR KARK: Just before you received the 23 May letter, you had a so-called heads-up about it, I think, by email, which is your exhibit 17, which reads:

"Bill ..."

It's an email to you from Kate Moore.

A. From Kate, yeah.

Q. "Anna Walker may have contacted you already (as was her intention), to say that Nigel Ellis and I spoke yesterday. The HCC is imminently to write to Mid Staffs with its concerns re the trust's A&E services in a number of fundamental respects (e.g. level of cover, organisation, inadequate audit and leadership). The [chief exec] is aware of this."

Then if we can go to the letter which you were sent, which is exhibit 18.

Now, we've looked at this letter many times and so I turn to it almost apologetically, but I don't apologise because it's so important and important for your consideration.

The Healthcare Commission were highlighting a series of concerns which they had, which they believed needed addressing immediately. The first concern that they raise was staffing, and this relates, as you properly said previously, to the emergency medicine department.

Over the page:

"There is a single-handed emergency consultant in A&E despite the fact that the College of Emergency Medicine recommend that there should be a minimum of four."

That consultant was not providing leadership. I'm going to try and take a short cut, as it were, through it.

There were insufficient middle grade doctors to provide adequate cover.

One long-term locum doctor works only at night, and sometimes works a long sequence of more than ten consecutive nights.

The lack of sufficient senior and middle grade cover means that junior doctors in training don't get sufficient support and advice.

And there was an inadequate number of nurses, with evidence that the current recruitment drive may not only not increase staffing levels as intended, but not compensate for those leaving or intending to leave. So, in other words, a danger that actually the staffing is going to get lower, worse, rather than better.

Then "The structure and operation of the department", the recent refurbishment appeared to be a missed opportunity.

I'm not going to go through the detail of that. But over the page, right at the top:

"Effective initial assessment of patients is not in place. Although nurses have been trained in triage, the staffing situation means that they frequently cannot be released to triage patients. Receptionists are undertaking this function, placing patients who walk into the department, in the major or minor category." Now, just pausing there for a moment. When you read that, did that not that make the hairs on the back of your neck stand up, frankly? Was that not of huge Page 65
A. Yes, it was. I mean, this, I would say -- this correspondence and -- and discussions that took place around this time, were certainly the tipping point at which my confidence in the trust began to diminish extremely rapidly. And I was quite clear that the Healthcare Commission, although this might not have been the trigger for their investigation, were certainly going to be identifying -- had identified serious failings in care, and certainly serious enough for, I think, anyone reading that letter to be very alarmed by it.

Q. And reading on: “The four-bedded area originally described as CDU ... is used for a number of different types of patient. The staff we spoke to are not clear about the existence of a protocol for placing patients in the CDU.”

And then the next paragraph: “There is no clear system to move patients through the Department, and when the four-hour limit is approaching, junior doctors can be put under undue pressure to make quick decisions. This is particularly undesirable given that there is often insufficient support from more senior doctors.”

Now, this trust you knew had had problems meeting its targets, and there are fans of targets and those who are not so much a fan of targets. But this is one of the potential problems of an A&E waiting time target which you must have been alert to?

A. Well, as you say, there are fans of targets and there are people who criticise targets. As I went round foundation trusts I probably met more A&E specialists who were broadly in favour of the target than who were against the target. So I -- I wouldn't wish to be drawn into criticising the target per se. The way it was being operate here was clearly wholly undesirable.

Q. Then "Governance": “There are few protocols or pathways in use in the Department, and when the four-hour limit is approached, junior doctors can be put under undue pressure to make quick decisions. This is particularly undesirable given that there is often insufficient support from more senior doctors.”

A. All I needed at this stage was for the Healthcare Commission, I thought, to say to us, "We think this hospital needs special measures".

Q. Why didn't you think they needed special measures?

A. With due respect, in -- in the legislation I don't think that it is my judgment or Monitor's judgment to say this hospital needs special measures. I think the way the legislation was set up, as I understood it at the time, was that the Healthcare Commission could have come to us at this point, and said, "We have done enough work to conclude that special measures are needed and we invite..."
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<td>you to get the trust to do the following things”.</td>
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<td>2</td>
<td>Q. Well, they could have done but if they don't, was</td>
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<td>3 Monitor powerless?</td>
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<td>4 A. Well, I felt at the time, and you may say now that</td>
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<td>5 I took the wrong decision and that I didn't advise my</td>
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<td>6 board properly, but I did feel at the time that with</td>
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<td>7 a Healthcare Commission investigation that was</td>
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<td>8 continuing, that had not reached conclusions, we didn't</td>
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<td>9 have a formal conclusion from the Commission itself,</td>
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<td>10 that it was very difficult for Monitor to use its formal</td>
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<td>11 powers of intervention. And at some point in the not --</td>
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<td>12 not short -- not very much longer after that, when I had</td>
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<td>13 written to Anna Walker, she came back, if I remember</td>
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<td>14 rightly, and said in writing, &quot;We haven't reached any</td>
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<td>15 conclusions&quot;.</td>
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<td>16 So as I say, with the benefit of hindsight, I might</td>
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<td>17 agree with you that it would have been better if I'd</td>
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<td>18 said to the board, &quot;Let's take our courage in our hands</td>
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<td>19 and intervene, and if we're criticised for intervening</td>
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<td>20 while an investigation is ongoing, we'll deal with it&quot;.</td>
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<td>21 But at the time, it just did not feel the appropriate</td>
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<td>22 thing to do.</td>
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<td>23 Q. What would you have done, if you'd intervened? Let's</td>
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<td>24 focus on that letter. What would you have done?</td>
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<td>25 A. Well, we would have -- first of all, had to established,</td>
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<td>26 were there grounds in the authorisation to intervene?</td>
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<td>27 Now, I think there were, from memory, although it's</td>
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<td>28 a long time since I read and authorisation, but I think</td>
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<td>29 there are statements about providing good quality safe</td>
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<td>30 care and so on that would have given us a basis to the</td>
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<td>31 say to the trust, &quot;We think you are in significant</td>
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<td>32 breach of your authorisation&quot;. We would have asked the</td>
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<td>33 trust quite quickly to demonstrate to us either that we</td>
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<td>34 were wrong or that they were rectifying it. Assuming</td>
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<td>35 that they couldn't do that or couldn't do it</td>
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<td>36 satisfactorily and we probably would have had -- have</td>
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<td>37 asked the Healthcare Commission to advise us on how</td>
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<td>38 satisfactory their response was, one end result might</td>
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<td>39 have been a decision to remove Toni Brisby and put</td>
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<td>40 someone else in. But there might have been other</td>
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<td>41 results here. We might, for example, have instructed</td>
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<td>42 the trust to increase the staffing of its A&amp;E</td>
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<td>43 department, for example. There's a range of things we</td>
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<td>44 could have done.</td>
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<td>20 Q. If you'd done that, how immediate an effect would you</td>
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<td>21 have expected that to have had?</td>
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<td>22 A. Well, I don't know. I mean, it -- I'm not sure that the</td>
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<td>23 trust necessarily could have just found three consultant</td>
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<td>24 A&amp;E doctors and so on right at way. I just don't know.</td>
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<td>25 I've no idea whether it would have had an immediate</td>
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<td>26 effect or whether it would have taken several months.</td>
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<td>27 Q. Can you remember having that conversation internally</td>
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<td>28 within Monitor, &quot;Look, if we intervene, actually what</td>
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<td>29 can we do about this?&quot;</td>
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<td>28 A. No, I don't, but that doesn't mean to say it didn't</td>
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<td>29 happen. I just do not remember that conversation.</td>
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<td>29 THE CHAIRMAN: Did you, in the broadest sense, believe the</td>
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<td>30 contents of this letter, or did you share what I think</td>
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<td>31 was probably the position of the trust chair, chief</td>
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<td>32 executive, that the HCC had been unfair and was lacking</td>
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<td>33 in objectivity?</td>
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<td>32 A. No. I mean, I might have, if you'd pressed me at the</td>
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<td>33 time, said, &quot;Perhaps some of this is a little bit</td>
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<td>34 strong, I'd like to see some of the evidence&quot;. But, no,</td>
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<td>35 I'm -- I'm fairly confident in saying to you that at the</td>
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<td>36 time, when I saw this letter, that was the point where</td>
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<td>37 I was saying to myself that this trust has a major</td>
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<td>38 problem. And I don't think for a second I really</td>
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<td>39 thought that this letter was so overstated as to be of</td>
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<td>40 no value.</td>
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<td>40 THE CHAIRMAN: Thank you.</td>
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<td>41 MR KARK: What would have been, presumably, of great concern</td>
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<td>42 to you is whether the chief executive recognised these</td>
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<td>43 problems or whether he was in denial and whether he was</td>
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<td>44 capable of dealing with them?</td>
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<td>20 A. Yes, and the board and -- and the senior team. It's not</td>
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<td>21 just the chief executive.</td>
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<td>22 Q. Could we go to EL28, please, which is an email actually</td>
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<td>23 of the same day as this to you, from Mr Lavelle:</td>
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<td>24 &quot;Bill.</td>
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<td>25 &quot;Yvonne has just spoken to the [chief exec] and the</td>
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<td>26 A&amp;E HCC findings appear to be very poor -- he said he</td>
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<td>27 knew some of the problems but wasn't aware of others --</td>
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<td>28 which is fairly concerning. I understand the trust has</td>
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<td>29 already appointed an A&amp;E turnaround specialist.</td>
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<td>30 &quot;Yvonne will give you a fuller briefing ...</td>
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<td>31 Stephanie will join you on the call with Anna this</td>
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<td>32 afternoon, and I have asked her to think whether we</td>
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<td>33 should be doing anything else which would be useful at</td>
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<td>34 this stage (we are meeting HCC in early June).&quot;</td>
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<td>35 You were in the position of actually being able to</td>
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<td>36 do something about this trust. The SHA were no longer</td>
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<td>37 performance managers. I suppose the SHA might have</td>
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<td>38 taken action, and we'll look at a letter from them to</td>
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<td>39 you in due course. But do you accept that you were at</td>
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<td>40 the forefront of the fight outside the trust, in terms</td>
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<td>41 of those with power to do something?</td>
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<td>42 A. I think we were one of several. Monitor certainly had</td>
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<td>43 powers of intervention that might have been relevant</td>
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<td>44 here. As you say, the PCT had a contract with the trust</td>
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19 (Pages 73 to 76)
and was entitled to have some point of view as to
whether the trust was fulfilling that contract, and the
professional regulatory bodies, and the Royal colleges
had points of view on this. So I wouldn't accept for
a second that Monitor was alone in having the ability to
influence it, but we were certainly one of the main
actors.
Q. Was it not a particular concern to you that the chief
executive seemed to be admitting that he was in fact
unaware of some of these very central issues?
A. As Edward says, it is concerning, and Edward also
acknowledges that the chief executive appears to have
taken some action by appointing a turnaround specialist.
I'm afraid I don't recall who that was.
Q. Did that flag up to you the fact that he was unaware of
these issues? Did that flag up to you issues of
competence?
A. Well, you can read it two ways. You can say, yes, that
it was concerning. And it was concerning that Martin
didn't appear to know that the Healthcare Commission,
without doing a huge amount of work, would uncover very,
very serious failings in one of his major departments.
You can also say that he was apparently taking remedial
action very quickly.
Q. In your paragraph 84 you say this:
"The HCC's provisional findings on A&E were very
critical but they were provisional views, rather than
a final report and they didn't include a recommendation
that Monitor take special measures to intervene. It
would have been helpful to Monitor's process of deciding
on how to act if the HCC had made such a recommendation,
which I think it inconceivable that Monitor would have
resisted in light of the evidence contained in the ...
letter. As I recall, the HCC did not make any
recommendations to Monitor at that stage, but continued
with its investigation to its original timetable, and as
a result seven to eight months were lost before Monitor
could intervene at the trust."
Now, with respect, Dr Moyes, isn't that simply
misstating it, to say that, in effect, seven to eight
months were lost before Monitor could intervene because
the HCC hadn't given you any recommendations?
A. Well, I still think that the way Parliament intended the
system to work in a case like this was for the
Healthcare Commission to make a clear recommendation to
Monitor that special measures were needed and to be
specific as to what those were, and then for Monitor to
use its powers of intervention. I do believe that that
was the intention.
Q. But you agreed with me yesterday, I think, that you did
not have to wait for recommendations from the HCC for
Monitor to act.
A. No. I mean, I -- I accept that legally we could have
probably acted at this stage, but I felt at the time,
and as I say, with the benefit of hindsight you may tell
me that I made the wrong judgment, but I felt at the
time, and my colleagues felt at the time, that the right
ting to do was to ask the Healthcare Commission to
bring their investigation to a rapid conclusion, give us
clear recommendations and then to intervene.
THE CHAIRMAN: Did you at that stage ask the Healthcare
Commission whether it was prepared to make
recommendations?
A. Well, I think there were a number of phone calls and
letters from me to Anna Walker and others in the
Healthcare Commission over the next few weeks, if
I recall the timetable correctly, in which I did raise
quite explicitly, "Can you not speed up this
investigation? Do you have to go through each
department in the hospital?"
THE CHAIRMAN: That's, if I may say so, a slightly different
issue. Did you ask them whether they, in relation to
the findings they'd already made, evidenced in this
letter, they could or were intending to make
recommendations?
THE CHAIRMAN: I don't recall now.
A. Well, I -- I'm not saying I didn't. What I'm saying is
I just do not recall. I do recall writing to
Anna Walker, and I do recall talking to her, and I do
recall, I think, copying that correspondence to
Cynthia Bower at one stage. But whether we followed up
on the 23rd of -- the letter of 23 May asking the
Healthcare Commission to give us specific
recommendations, I really can't remember.
THE CHAIRMAN: Would a wish on their part to continue their
investigation in other parts of the hospital have
prevented them making recommendations about what they'd
found so far?
A. Well, I -- I'm not that familiar with their legislation.
But I wouldn't have thought so. I mean, I would have
thought it was open to them to write to us and say, "In
relation to A&E special measures are need and we think
you should intervene and we are going to continue".
I can't see any reason why they couldn't have done that,
but they didn't.
MR KARK: You see, much later on, in October of 2009, you
described this period in a -- I think it's an email in
fact to John Stewart at the Department of Health, copied
into Barbara Young, Ian Carruthers, Una O'Brien, among

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others. It is your exhibit 104.

Could we go to the last -- it is not the last page, sorry. It is 056.

I'm just going to pick up from the first full sentence on the top of the page:

"Once the Healthcare Commission launched its investigation into Mid Staffs we had regular and close dialogue with them and had ample opportunity to understand the analysis they were developing and think about the action that we might take. The main problem at that stage, in my view, was the Healthcare Commission's process. The investigation took too long and was too geared to establishing evidence to secure 'a conviction'. I repeatedly pressed Anna Walker to bring the investigation to a much earlier conclusion once it was clear that there was enough evidence to justify intervention and changes at board and senior management level, but this wasn't something the Healthcare Commission was prepared to do. And we felt very inhibited about using our formal powers of intervention before the Healthcare Commission had concluded its investigation and produced its report."

Now, a number of issues perhaps arise from that. You speak about it being clear that there was enough evidence to justify intervention. When did you come to that view?

A. Well, I think the letter about A&E, assuming that there was good data behind it or hard evidence, because the letter itself is a summary, rather than a -- a detailed line-by-line explanation, but making the assumption that the Healthcare Commission had all the evidence it needed to back up what it says, which I'm sure it did, I am sure that if we had said at that stage, "We think we should intervene", we probably, probably, could have made that stick as an intervention in the face of challenge. But it would have been a much stronger intervention if it had been supported by a recommendation from the Healthcare Commission for special measures. That was my concern at the time.

Q. Well, I understand that, but you were being told that -- and we'll look at it, if we have to, but you were being told on more than one occasion the Healthcare Commission wasn't going to shorten its process. You'd been told right at the beginning of the process, as we saw yesterday, it was going to take a year. It seems, certainly from what we've been looking at so far, that you felt that there was almost nothing else you could do until the Healthcare Commission actually reported.

A. I mean, is that a fair description of your thinking?

That was your inhibition was?

A. Yes, at the time I think all of us in Monitor felt inhibited about launching a formal intervention to use our powers when a Healthcare Commission investigation remained extant and -- and had not formally reported in any sense. And there is correspondence, if I remember correctly, from Anna Walker later on that says, "We've reached no conclusions".

Q. Just picking up this evidence, and bringing it into the modern day -- and I know you're not at Monitor now and I expect you've been thinking about other things, but the CQC has powers of intervention, in the sense that it can suspend services, it can stop services --

A. That's right.

Q. -- it can fine. Is there any reason now for Monitor to have any intervention powers at all, which are not related to finance?

A. Well, the CQC, as I understand it, and you are right, I'm not very familiar with their legislation, but they have powers of registration, and they can register with conditions and they can deregister, if I remember correctly. So I would expect in a case like this, if -- if this were to happen within -- if this had happened within the CQC's regime, that much earlier on they would have been either attaching conditions to their registration for A&E service, or deregistering it, or threatening to at least.

What I don't think the CQC can do is intervene to change personnel. I don't think they can. I think that would be stretching conditions of registration pretty far.

So I think there is still the need for someone to be able to look at an organisation, look at a foundation trust, and say, "This isn't just a problem with the service, this is a more fundamental problem that needs change of people".

Q. Isn't the answer to that to give the CQC that power?

A. Well, that's one option. I've always felt myself it's a bit -- that there are difficulties in having two bodies that can intervene to change personnel. But, you know, it is an option, and if Andrew Lansley wants to legislate in that sense, I think an argument can be made.

Q. You say at paragraph 84, dealing with this period, that you were increasingly concerned. And that, presumably, was because at the back of your mind, at least, you had the plight of the patients, who were still receiving treatment, which might not only not be very good in parts but potentially positively dangerous.

A. Did you not think, bearing those patients in mind, that you were duty-bound to act and take the...
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Q. You took comfort, you say, or a degree of comfort, perhaps, in the patient survey that the trust had prepared. I don't want to spend too long on that, but it's your 20th exhibit.
A. Well, I think what I said to the trust was, you know, "You can show this to the Healthcare Commission if you want, but you still have to cooperate with them".
Q. In fact, I'm sorry, I've misstated your position and I should correct it. I apologise. It's your paragraph 85.
A. Yes. Yes, I certainly hadn't seen that.
Q. So it is wrong to say you took comfort from it.
A. I did have the concerns of patients, and towards the end, you were as cautious about necessarily judicial review than being able to pressurise them to respond to the Healthcare Commission's emerging findings. And I'm not sure that tying up the trust in a judicial review would have done anything for patients either.
Q. Well, it's a matter for the trust if they decide to judicially review you. It's not a requirement.
A. No, but I had to, and Monitor had to, have some regard to the possibility. And as I say, I think at this stage in the executive team, certainly, there was a sense it was possible. We'd faced it before.
Q. Do you think, as things moved on at your time at Monitor, and towards the end, you were as cautious about judicial review as you were during this period? In Page 85

A. Again, with the benefit of hindsight, it is possible to reach that view. It -- it's certainly the case that later on, I think I'm right in saying, that we intervened formally slightly more frequently, and we did face more challenge, considerably more challenge, for example, in the case of Colchester, than we had done in 2008, in the period up to 2008. So, yes, if -- looking back on it, you might say that we were overcautious at this stage.
Q. The fact is that Monitor has never been successfully judicially reviewed, has it?
A. Yes, but not on intervention. We lost the case on the private patient income cap.
Q. Right. You're quite right to correct me on the issue of intervention.
A. I did remember that.
Q. On the issue of intervention, you've never been successfully judicially reviewed.
A. No, but we -- we had had, in Bradford, as I say, a pretty serious attempt, and we knew that we had to tie down all four corners, any intervention, we couldn't take chances, at least I didn't feel, and I still feel that very strongly.

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A. No, I think that's -- that's right.
Q. Then on 25 June you had a meeting with Anna Walker, which I think is reflected in an email of Ed Lavelle's at your exhibit 22.
A. I had been referred to a research study conducted by the trust which evaluates the services provided.
Q. Suffice to say that there was nothing in this meeting which would have provided you with any cause to doubt what the HCC had been telling you back in May.
A. Yes. And we're presuming that which has been redacted is in relation to a different trust?
Q. "Mid Staffs -- real concern that if the HCC just keep bashing on with their reviews ... the good bits of the hospital will decline as there is a firefighting focus on the bad/findings -- enough evidence already that material action is required and there is a need for an operational and strategic review (including viability of services provided -- this would ... include discussions with SHA) -- HCC is open to a meeting ... to agree way forward on this which may not entail an extension of current investigation process. Meeting to be arranged. Monitor will need to play fairly significant role in crafting this."
A. Again, there's the use of the expression "enough evidence already that material action is required", and I'm not going to ask you to keep on repeating your line -- I beg your pardon, your -- the view, as you've Page 88
expressed it to be, which is that you, all the way through this period, really were waiting for the end of the investigation and for hard evidence.  
A. Yes. I mean, I -- I was -- Monitor was waiting for -- or would have felt much more comfortable to act on the basis of a clear recommendation, as statute envisaged.  
Q. But you see, what you were trying to do -- THE CHAIRMAN: Sorry, could I -- I'll let you finish your line of questioning. I want to go back to the previous exhibit.  
MR KARK: What you were trying to do was to get the HCC to curtail this investigation. We see this more clearly, as we move on, to shorten their investigation; yes?  
A. Well, you use the term "curtail", which could be read pejoratively. As I've said in response to the chairman a few minutes ago, I don't see any reason why the Healthcare Commission could not have recommended special measures to us on the basis of the work they'd done in A&E, and if they thought it right to continue in other departments that was a choice open to them. I wasn't asking them to stop uncovering things. What I was saying was, "I am not sure that continuing to pile up evidence is of itself necessary to give us a basis for intervention. I think if you tell us now that, yes, you have concluded as a commission that special measures are necessary and if you're able to describe those special measures, then we can make sure those special measures are taken";  
Q. But then wasn't the answer to that to ask through Anna Walker for Heather Wood to provide you, not in letter form, but a brief report setting out her findings which justified the 23 May letter?  
A. And I think indeed that's what I did with Anna Walker at various points. I said, "Look, you know, can you not give us the basis?" But it didn't happen. I mean, my memory is, and perhaps we'll come to it, that Anna wrote to me and said, because I'd raised the matter with her more formally, that the Commission had reached no conclusion. Well, in the face of that, you know, I think it's very difficult for Monitor then to intervene.  
Q. I'm going to move on through the correspondence, so if the chairman -- THE CHAIRMAN: Can we just go back to your previous exhibit, 21. And the bottom bullet point. And if you -- I won't read it out aloud, but if you go over the page, there seems to be the discussion about the HCC's intention to consider the need for external intervention, if not satisfied with the trust's response. And there's a discussion about the nature of what that intervention was, it being pointed out that the Department of Health, the SHA had no locus in this.  
Q. To what extent was it your understanding that the HCC was, in effect, actively asking you not to intervene, or recommending that you don't, or just being silent on the issue, where was the balance in what was happening?  
A. It's quite hard to answer that question, actually. I mean, I think -- I think they were probably being silent on that. I don't think it would be fair to say that they were acting -- they were actively asking us not to intervene.  
THE CHAIRMAN: But if you look at this top paragraph here, there's concern about loss of knowledge, which Mr Lavelle seeks to explain would not be the case. And I would understand that to be a reference to the possible disadvantages of an intervention.  
A. I wonder if it's possible for me to see the preceding paragraph --  
THE CHAIRMAN: Yes.  
A. -- if I may. Yes, I think my interpretation of that exchange would be that the Healthcare Commission's assumption -- or Nigel Ellis and Heather Wood's assumption was that it would be for the SHA to force the trust to take measures, and Edward is saying, "Well, actually, no, it is now for Monitor". And Heather Wood is saying, "But the SHA knows a bit more than you do about this kind of thing". I think that's the exchange that's going on there. And that simply portrays, I think, that there wasn't complete clarity in the investigations team about what it meant to be a foundation trust and what Monitor's role was and so on. I wouldn't read more into it than that, myself.  
THE CHAIRMAN: So your understanding would be that the HCC's position on intervention was one of silence, but lying behind that an uncertainty about what the intervention would be if there was going to be one?  
A. I think that's correct. Yes, I think that's how I would read it.  
MR KARK: Way back in paragraph 20 of your statement you say that your powers were drafted to enable intervention to be used in circumstances of clinical failure. Is it fair to say that by this stage of the discussions you cannot have been in any doubt that there were circumstances of serious clinical failure at the trust?  
A. Absolutely. I mean, I think we've -- we've been over this quite a lot, and I think I have acknowledged at various points in the conversation this morning that there is no doubt that the Healthcare Commission did uncover successively evidence that the quality of
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Q. That is reflected in your email of that date, which is it to intervene?
A. Yes, I do accept that.

Q. But, Dr Moyes, sorry, just coming back to the question that I asked you, do you accept that by 8 July Monitor had taken a view that enough evidence existed to allow that I asked you, do you accept that by 8 July Monitor had taken a view that enough evidence existed to allow to intervene?
A. Possibly. I mean, I -- I cannot remember, having gone through all the papers in preparation for this, myself having much involvement with that. I think Edward very largely handled that aspect of the -- the dealings with the trust. So I suspect Edward did positively encourage the trust to look to external help, to try and bring together all the various strands of activity that had to happen.

Q. Have you read it? Did you ever read that report?
A. No, I can't. I'm sorry.

Q. Have you read it? Did you ever read that report?
A. I may have done at the time. I certainly don't recollect it now.

Q. Have you read it? Did you ever read that report?
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Q. Have you read it? Did you ever read that report?
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| 1 Q.  This can't have given you any belief that they were able to do that?  
2 A.  Well, I wouldn't put it that strongly.  What it said was that, you know, you have got people who are  
3 well-intentioned but they need to be more challenging and they need to be more focused.  
4 Q.  You also say in your own statement at paragraph 98 that by this time -- I'll just confirm that we're dealing with the same period.  
5 Yes, September, beginning of September, you say by this time you'd understood that clinical performance was not being discussed at the trust at board level.  That's rather fundamental to the operation of a hospital, isn't it?  
6 A.  Well, you might think so, but I don't think that Mid Staffordshire was unique in that by any means.  In fact, I think a good number of foundation trusts, in fact the reason that Edward Palfrey, to whom I refer in paragraph 98, was involved is that we'd had a discussion in Monitor with a group of medical directors that we'd brought together from time to time to have informal discussions, and one of the topics I think we talked about was, "Well, how do you involve your boards in looking at cases where death has occurred and on one argument that death might have been avoidable?"  And  
7 A.  More or less, yes.  
8 Q.  When you say:  
9 "I am keen to use Monitor's intervention arrangements to get an agreed action plan and to focus on ensuring effective implementation.  I believe this is urgently needed to achieve our common objectives of a well governed trust delivering high quality care."  
10 Again, I don't want myself to sound like a stuck record, nor force you into the position, but if you were keen to use Monitor's intervention arrangements, you could have done so, couldn't you?  
11 A.  We had, as you've said before and I've acknowledged, probably enough evidence to use our powers.  The question remained whether we could safely use our powers.  That was still the issue.  And I was here trying to make my best pitch to Anna.  
12 Q.  Whose safety were you considering when you say:  
13 "We could safely use our powers."  
14 What does that mean?  
15 A.  Well, if we got tangled up in a judicial review with the trust, that would have impact on the way the hospital was run.  I was trying to get to the fastest way of using our powers to make sure the hospital was taking action to rectify the failings that the Healthcare Commission had uncovered.  And I didn't think that  
16 Edward Palfrey had talked to us and to his colleagues about the steps he was taking at Frimley Park to talk his board through, not just high level figures but specific cases, to illustrate to them some of the things that he thought in his hospital, which we regarded as a pretty good foundation trust, still needed to happen.  
17 So I thought it was useful at that stage to say to Martin Yeates, "Why don't you talk to Edward Palfrey and see how he does it?"  But although you're absolutely right about this being part of running a hospital, I would still say that there were many perfectly good foundation trusts where those kind of conversations didn't take place in-depth.  
18 Q.  The fact that something is widely done badly does not mean that you, the regulator, should not take action when you are focusing upon a particular trust.  
19 A.  Oh no, I accept that.  
20 Q.  And the relevance of it not being done well is particularly acute, isn't it?  
21 A.  Yes, and that's why we said to Martin Yeates, "We think that Edward Palfrey could help you with, why don't you go and talk to him?"  And I believe Martin did.  
22 Q.  On 15 September you wrote to Anna Walker, and this is the diminishing benefits letter.  It is your exhibit 29.  
23 I expect you do remember this.  
24 | 1 | 25 |
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<td>getting tangled up in a judicial review, which I still think was a possibility, would have helped us with that.</td>
<td>it does seem to me that that letter -- well, I wish --</td>
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<td>So I was making my best pitch here to Anna, to say, &quot;Look, it is in everyone's interests, including the patients, not least the patients, for us to try and come to a conclusion and move to a point where we can use the power we have, which is what Parliament intended&quot;.</td>
<td>1 I wish with the benefit of hindsight the Healthcare Commission had said, &quot;You are perfectly right, we have enough on A&amp;E to say to you 'special measures are needed' and you should act, and now we're going to go and look at the rest of the hospital.&quot;</td>
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<td>Q. Do you accept, Dr Moyes, that for relatives and patients listening to this, that your marginal worries about judicial review must be extremely frustrating when they had people in that hospital throughout this period?</td>
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<td>A. Well, you say marginal, but I'm not sure I accept marginal. And I think if we had tried to use our powers and got stuck in the courts with judicial review, with all the cost and delay and management time and effort that would have been a involved in that, someone might have said to me, &quot;It wasn't wise to have used your powers before the Healthcare Commission gave you a basis?&quot; So at the time I made my best judgment. As I say, with the benefit of hindsight it might not look as good as it did at the time.</td>
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<td>Q. Then on 6 October Anna Walker wrote back to you. It is your exhibit 30. We don't need to spend much time on it, perhaps it was quite clear that Anna Walker did not intend to instruct her investigation team to shorten the investigation.</td>
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<td>A. I wonder, forgive me for interrupting, but before you leave the first page --</td>
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<td>Q. Yes, of course.</td>
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<td>A. -- would you mind -- the bottom -- the bottom paragraph: &quot;As yet the Commission does not have substantive findings.&quot; That seemed to me to be an important statement, and forgive me for interrupting you.</td>
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<td>Q. No, you're quite right to point that out. Let's just read that through: &quot;It is not the case that 'the substantive findings from [our] investigation have been considered by the trust'. As yet the Commission does not have substantive findings. Specific issues relating to the [A&amp;E] department were thought to pose an immediate threat to the safety of patients, and were therefore reported to the trust in order that it could take urgent action. Other judgments have still to be made.&quot; Well, that makes it look very much as if they have come to a judgment on A&amp;E, doesn't it?</td>
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<td>A. Well, yes, it does. But what she's saying to us is, &quot;The Commission does not have substantive findings&quot;, and</td>
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<td>point I have ever tried to say to the Healthcare Commission, &quot;You are not justified in investigating&quot;. What I'm trying to do, in this letter, but this letter was -- was not particularly helpful, I didn't think to use it, because it says that they're not in a position to offer fair conclusions. Well, again, for us to try and intervene with that letter on the record I think would have been to risk successful challenge. I was trying to get the Healthcare Commission to say, &quot;On the basis of this evidence, we are formally recommending that you take special measures&quot;.</td>
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<td>Q. You see, it may sound to people listening as if your entire focus was on your worries about judicial review, which might or might not happen, as opposed to concerns about the patients in the hospital?</td>
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<td>A. But you have to think about what happens in the face of a judicial review. Management gets completely distracted in trying to defend their position. Huge amounts of time and effort and money and energy go into that. And it's not that the threat of judicial review was a theoretical threat. As I say, before we had faced that in Bradford, and I was quite thoughtful about whether opening up that issue was -- was a risk that we should take.</td>
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<td>Q. But the question that would have been asked would be,</td>
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Merrill Legal Solutions  www.merrillcorp/mls.com  8th Floor 165 Fleet Street  London EC4A 2DY
1. was your decision based on reasonable evidence? Was it reasonably taken? Did you go through proper processes and was it irrational? Was that so much of a fear for you?

2. A. Well, Parliament had created the structure on which an expert body, a body expert in clinical quality, was meant to report and recommend special measures, and then a regulator was meant to intervene in -- and make sure those special measures were taken. And I still think that if the body charged with doing the initial analysis is saying, "Well, we're not in a position to make recommendations to you", it is a risk, maybe a risk we should have taken, but it is a risk to say, "Well, damn the consequences, we're going to do it anyway". But I have acknowledged at several points that perhaps with the benefit of hindsight we were too cautious.

3. THE CHAIRMAN: This passage that you refer to about fair conclusions, refers to the emergency care pathway that may have and may still be posing a risk to patients. So what Mrs Walker seems to be saying is, "We are collecting evidence about something that we have reasonable cause to suspect", if one uses a more legal phrase, "is and has been causing a risk to patients. On any view, therefore, a serious issue". You'd agree with that?

4. 15 October. The only reason I don't go through it is that to act at the moment -- to draw conclusions at the moment would not be fair.

5. A. Yes, but I think fair conclusions says, does it not, that to act at the moment -- to draw conclusions at the moment would not be fair.

6. THE CHAIRMAN: But you also had information from PWC, who had been appointed by the trust, albeit with your encouragement, that the chair of the board didn't appear to reflect the seriousness of the situation.

7. A. Yes, but PWC are also saying they're doing the right things but not fast enough. I mean, you know, the picture was that -- I think it's not that they completely lacked the competence or the will but the trust is just not quite driven enough yet to get on with it.

8. THE CHAIRMAN: Well, if they weren't being driven enough to get on with it by August/September, bearing in mind what had been going on since January, when were they going to be?

9. A. Well, I don't know the answer to that question. I mean, I -- you know, I'll stop there. I don't know the answer to that question.

10. MR KARK: But you actually deal with this in your paragraph 102, if I could just remind you, which deals with -- there's another letter, which I'm not going to go through, from the Healthcare Commission of 15 October. The only reason I don't go through it is because I think your answer is likely to be the same about why you didn't respond to it.

11. But let's just see what you say in your letter -- sorry, in your statement at paragraph 102:

12. "During this period ..."

13. So we're into October:

14. " ... I felt that problems at the trust were piling up. The trust had already called in PWC to help and Monitor was trying to get the trust board to consolidate all its various action plans and prioritise their implementation. By this stage I perceived the HCC's evidence of poor practice to be mounting. The focus of the HCC's investigation seemed to be on quality and care and I understood they were uncovering some very unpleasant things which needed to be tackled."

15. So that's during the period they are uncovering unpleasant things at the trust:

16. "I was expecting the HCC's report to be critical and I had the sense that the trust's board was losing control of what it needed to do and in what order of priority."

17. Surely this was the stage, if that was your genuine concern, and you had plenty of evidence to support it, to have the conversation with Toni Brisby that you had in March of the following year?

18. A. I had conversations at this stage, in my recollection, with both Martin and Toni separately to say, you know, "We could well use our powers of intervention and if we do, you could well be the focus of them, and we need to see some real evidence that you are not just being reactive so that whatever is the latest problem you are rushing to fight that fire, but that you have some proper prioritised plan of action to tackle fundamental things and then less important things and then minor things". So I don't think they were in any doubt by this stage that the possibility of Monitor intervening was a real possibility that they should take seriously.

19. Q. And you had a meeting with Toni Brisby on 17 November 2008. It's your exhibit 37, just to remind you.

20. What we have here is an outline for a meeting on Monday. We can see the various issues that were raised, and if you'll forgive me I wasn't going to go through them all. But if we focus on paragraph 2 towards the bottom:

21. "Board governance and leadership: we will focus on the governance issues raised by PWC, in particular their report indicates concerns in the following areas:

22. "Leadership;"

23. "The effectiveness of the board;"

24. "The benefit of hindsight we were too cautious."
"The structure of the committees; and
"The effectiveness of the risk and performance
management systems.
"And expect the board to rectify the issues raised
in a timely manner."
Wasn't it just far too late for this?
A. Well, the preamble to that is the fifth bullet point,
which was saying, "We haven't determined if you're in
significant breach, but", and my guess is that this note
was drafted for me by either the legal team or the
compliance team with Kate Moore's involvement, and it
was now a fairly formal script that I would have stuck
to, saying to them, "You're now very much in the firing
line and we are starting to assemble the evidence that
will give us a basis for intervention". I think that's
correct.
Q. Over the page, just to remind you, the last bullet
point:
"A failure to meet these requirements is likely to
give rise ..."
A. Yes.
Q. "... to us considering whether or not the trust is in
significant breach of its authorisation."
Do you recall that meeting?
A. Not really, no.

Q. Was there any indication before the call you made in
March from Toni Brisby that she felt that really she
ought to resign and let somebody take over?
A. I don't recall any.
Q. Martin Yeates, was he on top of it?
A. I don't recall any indication from Martin that he was
planning to resign at that stage. Perhaps later on.
Perhaps as the Healthcare Commission's report -- as the
drafting progressed to a conclusion, I think Martin then
began to signal that he didn't feel he could continue.
But I don't have any specific recollection of either
Toni or Martin in the last quarter of 2008 saying to me,
"We're going to step down".
Q. Given your requirement, as it were, for the HCC to
report and hopefully to give you recommendations upon
which you could act, does it follow that reports
provided on the basis of responsive and planned reviews
by the CQC are still an essential to Monitor's
functions?
A. I don't know what view Monitor takes now.
Q. You left in 2009.
Q. I beg your pardon. January of 2010. At that time, when
the CQC had obviously been up and running for almost
a year, what view did you take as to whether you were
Going to get the sort of report that eventually you got
from the Healthcare Commission, from the CQC, which
would allow you to intervene?
A. I don't really know the answer to that question. It --
I think it was a debate, as I recall, in the National Quality
Board's work on dealing with serious incidents, or
whatever the title is. And my recollection is that
Barbara Young said quite explicitly on many occasions
that she did not see the CQC conducting this kind -- the
kind of investigation that the Healthcare Commission had
conducted at Mid Staffordshire that she saw it operating
faster and with a greater emphasis on identifying
problems and identifying solutions. However, those
solutions were to be enacted, rather than piling up
evidence. Those are my words not hers.
So my recollection, which is not very precise, is
that CQC were telling the Department and us and others
in the context of the National Quality Board that they
saw themselves operating in a different and by
implication faster way than had happened at Mid
Staffordshire.
Q. And that would inevitably have an effect on the sort of
material that you were likely to receive, which would
allow you, Monitor, to exercise your powers of
intervention under section 52?

THE CHAIRMAN: Can I ask you another hypothetical question.
If during the course of this story in 2008, in addition
to your hats as chairman and chief executive of Monitor,
you'd been the chairman and chief executive of a joint
organisation having the powers of Monitor and the powers
of the Healthcare Commission, would you have required
the -- and I won't use the word "curtailment", but the
ending of the investigation to enable you to use your
powers of intervention?
A. As you say, it's a hypothetical question. I think
1 I would have done because I -- I think I would have
2 taken the view, wearing the Healthcare Commission hat,
3 so to speak, that it wasn't necessary to assemble every
4 possible piece of evidence, that there came a point
5 where there was enough evidence to justify to any
6 reasonable person action, and that that should be the
7 main focus. I might have, as -- as has been suggested
8 in the course of this conversation this morning, have
9 suggested an interim report or a report focused purely
10 on the A&E department, with special measures as the
11 recommendation and so on, and then a continuation of
12 work. I mean, there are a number of options, I think,
13 that one could have followed.
14
15 THE CHAIRMAN: Which leads me to my next question, which is
16 hypothetically, do you think there may have been a case
17 for having the sorts of powers that the Healthcare
18 Commission had, CQC now, albeit different powers, and
19 the sorts of powers that Monitor had residing in the
20 same body?
21 A. Well, that's been debated extensively over the years
22 I've been in Monitor, and Patricia Hewitt, when she was
23 Secretary of State, had a long period of exploring that.
24 You can make the argument, but the problem is that, in
25 my experience, whenever a foundation trust gets into
1
2 a financial problem, for example, there's always
3 a temptation to solve a financial problem at the expense
4 of quality. You've got to be careful that that -- that
5 that situation doesn't arise.
6 
7 Now, when we intervened at Bradford, and part of
8 Bradford's problem, as I said I think earlier, was that
9 they had taken on several hundred additional clinical
10 staff, they had created theatre capacity which the local
11 PCTs did not want and were not prepared to send patients
12 to and, therefore, there was no income. So Bradford got
13 itself into a position where it had a substantial
14 deficit, instead of a small surplus, and one of the
15 things they had to do was to get rid of that capacity or
16 find a different way to use it. So they had to cut
17 their costs in effect.
18 
19 I thought at that stage it was a real comfort, not
20 just to me but to patients and users of the service, and
21 to local GPs and so on, that there was a completely
22 independent organisation that could look at the quality
23 consequences of the financial decisions that we were
24 requiring the trust to take. So if the argument had
25 been made in Bradford that, well, this cost-cutting has
26 reduced quality materially, I, the Secretary of State,
27 the commissioners could have turned to the Healthcare
28
Could you not be accused of asking the Healthcare Commission really to do everything for you, as it were? A. I don't accept this is critical at all. That was never the intention of this letter.

And I say towards the end of the letter, in the penultimate paragraph:

"None of the above is intended to undermine or diminish the importance of what is clearly very detailed analysis."

I was simply saying to the Healthcare Commission,

"Give us as much firm information as you can, because obviously your report is going to be vital to us". No, I wasn't asking them to do our job for us at all, but I was simply saying to them, "Wherever you can substantiate clearly and precisely the conclusions you draw, it would be very helpful if you included that substantiation. And wherever you have recommendations to make, it would be very helpful (a) if you could make the recommendations, and (b) if you could give some inkling of the logic that took you to those recommendations, of the rationale for them. So that's all I was trying to do. This letter was not in any sense meant to say to the Healthcare Commission, "This is an inadequate piece of work". It was a first draft, as I recall, at least the first draft that we saw --

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I saw, and it was simply highlighting the kind of things that if the Healthcare Commission could elaborate, it would be useful to us.

Q. Could we just have look, please, at paragraph 8 and test that for a moment, and test your attitude to the complaints that had been received from patients. You say:

"Throughout the report, and particularly in the section dealing with complaints, the Healthcare Commission places a lot of reliance on its conversations with patients and relatives. However, this was a group of people who responded to an invitation from the Healthcare Commission and therefore was a self-selecting group. We and the Healthcare Commission would have to exercise great care in any conclusions we may draw from the comments made by a group which may not provide a fair representation of patients."

Now, just picking that up by way of example, you may have 90 per cent of patients happy with their care, but 10 per cent of patients have received dreadful care.

That doesn't mean you can't act on the basis of what you describe as that "self-selecting group" of 10 per cent, can you?

A. No, and I'm not making that point. By this stage we were getting from Martin Yeates, certainly, and I think from Toni Brisby, in my recollection, quite a lot of --

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to the HCC that there is a lack of balance."

But he wasn't undermining or attaching the fundamentals of the report, was he?

A. No, and I'm not suggesting in my letter to Heather Woods that he was. I'm simply saying to Heather, "As you develop this draft into a final report, where there are points that you can anticipate the kind of responses that we'll get, if you can deal with those points deal with them". My letter to Heather was genuinely not in any sense meant to undermine the report. It was to give her pointers of how it could be strengthened from our perspective.

Q. Could we go to an email --

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THE CHAIRMAN: Just pausing there. At the bottom of your letter.

I'm sorry, if we could go back to that, please, and page 4 of it, and you say:

"With the evidence assembled in this way ..."

By which I think you mean assembled in the way that you've suggested above:

" ... Monitor will be able to decide at its discretion whether the failings amount to a significant breach ..."

Does that not carry the implication that as things stood on the basis of the draft report, you weren't able
A. No, I -- I think the point here and later on is that by this stage Kate Moore would be saying to me at every opportunity, "You mustn't give the trust any sense that you've made up your mind. Monitor has to appear to have an open mind and to be open to argument", and that was a constant refrain, for reasons you will understand better than I, of our legal advisers. So that is simply making sure that at no point in the future could the trust say, "Well, of course, Monitor made up its mind. We didn't get a chance to respond to the report." So that's all that was.

THE CHAIRMAN: So it was a matter of legal nicety rather than in fact you having not made up your mind, if I can put it that way? In other words, there's a difficulty in your answer, if I may say so.

A. Well, I don't think there is. I mean, if you had asked me and my colleagues on that day, at that time, were we convinced, the answer is, we probably were convinced, and we were heading in the right direction. But inevitably, in cases where we're thinking of intervening, Kate Moore's prime concern, quite properly, is to make sure that our intervention is as proof against challenge as possible. And she will have, I am sure -- or Yvonne Mowlds on her advice, because this letter was drafted for me, but based on my own -- a lot of my own material, she will have said, "Look, make sure that he doesn't give any impression that he's made up his mind".

THE CHAIRMAN: Thank you.

MR KARK: Did you think that the advice you were receiving was actually a bit too careful?

A. Well, no, I don't think so. I think Kate was quite properly saying, "The more you can proof this against challenge, the better". And that's a legitimate point of view for her to take. And it was one to which Monitor -- Monitor's board and I personally paid quite a lot of attention. I mean, I have acknowledged in the course of this session that with the benefit of hindsight one might say that Monitor could have and should have intervened earlier. And I accept that there is a case to be made for that. But all I'm saying in explanation for this letter that we're looking at now is that that phrase there was simply put in, in my view, to make sure that we could not be accused of having made up our mind prematurely.
a report and presented it, and Monitor said, "Well, we'll read this carefully and in a month's time our board will meet and decide to act". David was perfectly properly, I think, keen to say, "If you are going to act, then can you get the timing so that when the report is published you can tell the world what your action is". I think that's what was behind that set of exchanges.

A. Well, I don't know whether David was saying to me -- because I really can't remember, "I hope that you're going to intervene", or whether David was simply saying, and this is my recollection, "If you are going to intervene", and the expectation, I think, was all round the place that we would, "then can you get the timing right". But, you know, I'm not sure that I can really construct after all this time precisely what these words meant.

Q. And what was this about:

"Perhaps we should resurrect the idea of writing to ministers or David"?

A. Well, at one point, early on, we had adopted a course of writing to either the Secretary of State or maybe the Minister of State or the chief executive, if we thought we might intervene. I think in Bradford, for example, I wrote to John Hutton, or I might have written to John Reid, saying, "I should warn you that we're planning to use our powers."

Over time, when we had not formally used our powers but had regularly said to trusts we might use our powers, we hadn't particularly told ministers that.

I think what I'm saying here is maybe this is a case where we ought to tell ministers or David Nicholson, because I assume that's the David I'm referring to there, that we are planning to act and what we're planning to do.

Q. That doesn't quite, with respect, seem to follow, does it:

"Perhaps we should resurrect the idea of writing to ministers or David"?

If you're about to take intervention action, obviously you may want to let the Department and ministers know that that's about to hit the press, because it would hit the press, wouldn't it?

A. Yes, and it did.

Q. But this is talking about resurrecting an idea of speaking -- of writing to ministers, as if you are hoping to get some response from ministers; is that not a --

A. No, I don't think so. No. I mean, I think all I was saying is perhaps we talked earlier on about writing to ministers, perhaps we'd decided at that point, well, there's nothing we can say usefully, or we shouldn't do it, and I think I'm saying to Yvonne maybe with the benefit of reflection we ought to write to ministers and tell them what we're up to. But I don't have a precise recollection of what was behind those words.

Q. You were certainly getting very close to the point of intervention, and you wrote to Toni Brisby on 20 February, and that's your exhibit 51.

"Going to the bottom of the page, obviously draw our attention to anything else you want to:

"If the Monitor board concludes that the trust is in significant breach of its authorisation, or that it was and risks being so again, in determining whether to use its formal powers we will consider the following ..."

And then there are a number of bullet points, the last of which is:

"Does the trust board have the skills, management capacity and governance arrangements in place to demonstrate that it is likely to deliver the rectification plans within an acceptable time frame?"

In reality, you were beyond this point, weren't you?

A. Well, in -- as I go on to say, we'll -- we will take into account the findings of the Healthcare Commission and what it recommends, and PWC's report. So I'm saying to the trust, "If you're going to argue that you have done a lot, you're going to have to have extremely convincing arguments". I mean, you are correct, by this stage I think we were probably pretty clear that we knew the answers to these questions, but I think the advice we would have got is, "You have to give people an opportunity to respond before you take a decision".

Q. Although in a conversation with Martin Yeates, which we've got a note of at your exhibit 53:

"Martin noted the pressure on both himself, the chair and the trust was increasing."

There were a lot of politics going on.

And then third bullet point:

"Martin noted that he had heard that there was a lot of ministerial interest in this and the view was that if he resigned in advance of the report they could offer him another post somewhere but that if he didn't and was forced to go after the report is published they would not be able to 'save him'."

And let's finish this note, and then we'll come back to that, if we may.
A few bullet points further down:

- "Bill took Martin through the discussion that Monitor's board had on Wednesday and in particular noted:
  - "At the moment the trust is probably in significant breach although no decision would be made until after the receipt of the final HCC report, PWC report and response from the trust."
  - "Board's current feeling is that Monitor should use statutory powers to intervene."
  - Can we just break that up.
  - The question of Martin Yeates being saved begs the question, I suppose, what for? Why is there this attitude in the Department of Health that people who are thought to have failed or who are shown to have failed should simply be shifted sideways instead of being sacked?
  - A. Well, I'm afraid you'll have to ask the Department that.
  - It's not a policy that I liked. But I think in practice, my recollection is that Peter Shanahan had said to me in a telephone call at one stage, roundabout this time, that this was the proposition being put to Martin by the SHA, but I suppose on behalf of the Department, that if he stepped down then, some role would be found for him, but if he hung on and didn't step down, then he was on his own, so to speak.

THE CHAIRMAN: Before we leave the note, though, at the bottom of the page we have -- you are recorded as noting that:
- "Monitor was not currently thinking of replacing the [chief executive]."

THE CHAIRMAN: Does that mean that at that time you still retained confidence in Mr Yeates?

A. No, that's correct.

THE CHAIRMAN: Does that mean that at that time you still retained confidence in Mr Yeates?

A. No, I wouldn't say that. But what I was anxious about was they had recruited a new medical director but he had not yet taken up post. And although I didn't know the gentleman at all at that time, people said to me that he was good news and that he would have a really good effect on the clinical culture in the trust. And that was important, I felt.

My apprehension was that if he woke up one morning to discover that both chair and chief executive had been removed simultaneously, he might decide not to turn up, and that would have been pretty catastrophic, I felt.

So my thinking at that stage was that we would try, if Martin were willing, to get him to stay for a bit so that we could bring in a new chair, the chair could

THE CHAIRMAN: Thank you.

MR KARK: But what actually happened was in fact not satisfactory at all, was it, because you didn't intervene to suspend or dismiss Martin Yeates, did you?

A. We told Toni Brisby that it was likely that we would intervene and initially we would dismiss her.

Q. Yes.

A. Having reflected on it --

Q. I'm asking, sorry, about Mr Yeates.

A. No, but what I'm saying is that was our initial focus, and that was always Monitor's approach that we initially would question whether the chair could continue in a -- in circumstances where a trust was experiencing a serious failure.

Q. Yes. But you did not intervene to dismiss or suspend Martin Yeates, did you?

A. We didn't have to because he decided to resign.

Q. Well, he actually stepped aside. If we look at paragraph 64, we can see the sort of problem that arose -- exhibit 64. I beg your pardon.

This is a couple of weeks on, 9 March 2009. It's a note to Yvonne Mowlds. And if we could have a look at the fourth paragraph:

"The one thing that concerns me is the position of Eric Morton. We issued a notice appointing him last week as interim chief executive. But when I spoke to David Stone on Friday he told me that, although

Martin Yeates is no longer on the premises and is no
longer functioning as chief executive, he has still not
resigned. I think the sticking point remains Martin's
desire to have the guarantee of future employment in
some form, which the SHA as I understood it was planning
to arrange."

Because of Monitor's lack of desire to exercise its
functions to dismiss Martin Yeates, the trust was left
in something of a mess, so far as the chief executive is
concerned, wasn't it?

A. No, I don't think that's fair or correct. By this stage
we had engineered the departure of the chair and we had
appointed an interim chair and an interim chief
executive. Martin had chosen to, as you say, step
aside, although initially he presented it as
a resignation. But because the SHA had dangled the
possibility in front of Martin of a role somewhere else,
not entirely surprisingly he was now negotiating behind
the scenes and not within my visibility for some kind of
role. And it was a great pity that that possibility was
ever dangled in front of him.

Q. Do you know of your own knowledge what the possibilities
were that were, as you put it, "dangled in front of"
Martin Yeates?

A. No, I've no idea whatsoever.

Q. I mean --

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THE CHAIRMAN: Did you at that stage have your own views
about the proper process of accountability for chief
executives or for that matter chairs of trusts which had
been found as deficient, as this one had been?

A. When you say "accountability of chairs", do you mean
Toni Brisby, or do you mean --

THE CHAIRMAN: Yes, I mean Toni Brisby as chair and
Martin Yeates as chief executive.

A. Well, Toni Brisby as chair had -- she had resigned
before she was dismissed and that was well known. So
I think it was pretty clear what had happened to her.

I think in the case of a chief executive, like
Martin, who has manifestly failed, it's a mistake for
the healthcare system to offer them the possibility of
an alternative employment elsewhere. I mean, they're
free to apply for jobs if they want to. When we
intervened at Bradford, for example, the chair was
dismissed. He wasn't found another role in the
healthcare system. The chief executive was dismissed by
the acting chair that we put in. He wasn't found
another role in the healthcare system. They just simply
retired, and that seems to me to be the appropriate
course, that it should be seen to bite.

MR KARK: What actually caused you to speak to Toni Brisby,
which effectively prompted, I think, her resignation,
was the fact that the HCC indicated in February that it
would make a recommendation that Monitor took special
measures.

A. Well, I don't think, in my memory now, that there was
a causal link there. I -- I was simply clear that my
board and I were clear that we would intervene formally
and that our first intervention certainly would be to
dismiss Toni Brisby and I -- I was giving her that
indication, in memory.

Q. Can I just remind you of what you said in paragraph 136?

A. Sorry, could you remind me which exhibit we're on.

Q. We're actually on your statement.

A. Statement.

Q. It is paragraph 136, where you say:
"In late February 2009 the HCC indicated for the
first time that it would make a recommendation that
Monitor take special measures in relation to the trust.
Taking this into account, together with the other
information Monitor had received by this stage "
Presumably the draft reports.

A. Mmm.

Q. "... and its view of the situation in the trust I spoke
to Toni Brisby."

And then it is exhibit 54 is the note which we can
have look at, perhaps.
Day 93 Mid Staffordshire Inquiry 1 June 2011

1. had a second reading debate in Monitor's board. The conclusion was quite clear. It was almost inconceivable that anything would emerge to change Monitor's mind, so at the board meeting, which I think was planned for the following week or a few days later, anyway, what I was saying to Toni was, "I think it is only reasonable to warn you that it's now likely, very likely, that Monitor will intervene formally and that the outcome will be to ask you or to tell you to step down".

THE CHAIRMAN: So is this the equivalent of giving her the revolver and a bottle of whisky?

A. Possibly. You might put it that way, yes.

MR KARK: I was going to put it another way, but if we go over the page -- I might get a chance yet -- if we go over the page, third paragraph down, you acknowledged -- sorry, she acknowledged your statement of the issues and then raised an issue around the quality of the HCC report. She said essentially that she thought it was: "Rubbish, poorly constructed, inadequately triangulated and queried ['where' I think it should be] that left Monitor's decision."

And you say, and some might think it's almost apologetic, that the HCC report as published would be treated as fact.

A. That's correct.

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Q. Now, was that almost apologetic?

A. No, no. I mean, you can see what she was doing. She was lining up the possibility of challenge. This report's rubbish. It's not based on anything. A lot of tittle-tattle, there's no substance to it. And if I'd blinked at that point and said, "Well, yes, it's not a great piece of work, Toni, but you've got to take it for granted".

What I was saying to her, was, "Look, you may have your opinion about the report. We are not going to be swayed by your opinion on the report. We are not going to engage in discussion about the content of the report. The report, once it is published, will be the facts and we will act on the basis of the published report". So I was discouraging her heavily from having any -- making any attempt to say to Monitor, "I want to negotiate about this", about the content of the report, "I want to challenge it".

Q. We can see in the final paragraph she thanked you for the clarification given around the issues she had raised and agreed she would go away and reflect on her position, no doubt with the bottle of whisky, et cetera, over the weekend, and that she would call you on Monday, 2 March, which presumably is what happened?

A. Indeed. And -- and in my recollection, she emerged from that phone call in no doubt that the Healthcare Commission's report was the Healthcare Commission's report and we would act on it.

Q. Some might ask why you focused your attention on the chair, rather the chief executive. One perhaps understands why you didn't want both to go at the same time, although they did. But why was the focus of your attention on the chair, rather than the person who had actually been managing this trust?

A. Well, I think our developing view in Monitor was that where there is a significant failure in the organisation, you expect the chair and the board to have enough information and to be challenging enough to spot that failure and to tackle it. So one can obviously make different arguments, but the view we had come to was that the first deficiency in any organisation that's in any kind of serious situation is a deficiency in the board. Either they haven't known or they haven't asked the right questions or they haven't taken the right action.

So to revert to Bradford, we sacked the chair. It wasn't the chair who misled us, but we felt that the organisation's leadership in the chair had been inappropriate. The board there had simply not challenged the chief executive and the finance director properly. And then we put in our own interim chairman and I invited the interim chairman to make his own judgments about the board and executive team. And, broadly speaking, that was what we were planning to do here.

Q. By this stage, did you think that Martin Yeates had misled Monitor?

A. Yes, probably. But as I've explained, I was trying very hard to make sure that the medical director would turn up and get started, and I wasn't envisaging Martin staying. I was envisaging Martin not departing at the same time as Toni Brisby. That's all.

Q. Your annual report for 2008/2009, which is published on your website, makes the following claim. I say your -- I beg your pardon, Monitor's.

A. Monitor, thank you.

Q. "We do not hesitate to use our formal powers where needed. Monitor used its formal powers at Mid Staffordshire NHS Foundation Trust in early March 2009, prior to the publication of the Healthcare Commission's investigation report into emergency care at the trust in order to stabilise the trust and ensure that it had a board capable of turning around the trust to deliver a good quality of care. We appointed a new interim chair and required the appointment of an interim chief executive."

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35 (Pages 137 to 140)
 myself, we hesitated only to make sure that when we did come to use our formal powers, that we could do so safely.

Q. But it's right to say that what triggered intervention was the expected resignation of Toni Brisby?

A. Only in the most technical sense. I mean, the intervention technically is the appointment of David Stone and then Eric Morton. That's the intervention notices.

Q. But by doing it in the way which you did, which is a telephone call -- and I won't repeat the phrase that the chairman used -- you avoided the danger, didn't you, of judicial review; is that what you were still frightened about?

A. No, no. By this stage I just thought it was a matter of courtesy to Toni to say to her, "My board has got to the point where, within a few days, we will have the material we need to intervene and we will intervene, and it's pretty clear from the debate we've had that you will be the focus of intervention and you ought to be aware of that".

Q. Now, before the HCC report was published, you had a meeting with Alan Johnson, Secretary of State, on 16 March, I think. You deal with this in your paragraph 152, if that helps you.

\[1,400\text{ over a period of time that I don't recall knowing. This estimate to be included in the report was based on simple arithmetic, multiplying standardised mortality rate for the trust by the number of patients it had treated, rather than an analysis of individual cases, and I believed it was inappropriate to include such a calculation in the report. There was a row about this during the meeting with Alan Johnson. In the end, the Secretary of State instructed Anna Walker not to include the statistic in the report, which was the correct decision in my view."

\[Now, can we just look at that for a moment. First of all, so far as you were concerned, did the Secretary of State have that power to instruct the chief executive of an independent regulator to include anything in their report or not include anything in their report?\]

A. Well, I think the Secretary of State did have a power of direction over the Healthcare Commission. I am reasonably confident that that was the legal position.

Q. Who was the row between?

A. Well, in my memory, because this text wasn't in the report, it was produced as, "We're going to put this text in the report!", and none of us had seen it before the meeting. I saw it in the waiting room, minutes before we were ushered in to see Alan Johnson and his colleagues produced a draft text for insertion into the report. The text included an extrapolation of the potential number of avoidable deaths at the trust, which as I recall it estimated to be somewhere between 400 and 1,400 over a period of time that I don't recall knowing. This estimate to be included in the report was based on simple arithmetic, multiplying standardised mortality rate for the trust by the number of patients it had treated, rather than an analysis of individual cases, and I believed it was inappropriate to include such a calculation in the report. There was a row about this during the meeting with Alan Johnson. In the end, the Secretary of State instructed Anna Walker not to include the statistic in the report, which was the correct decision in my view."

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is one whereby I don't respond to such pressure.

I think what I would like to say, as regards what you've
just read me, is that if the conversation was of the
order that the figures or the methodology or the notion
of avoidable or excess deaths was being attacked,
I would have resisted that on the grounds that we were
pretty confident that the methodology and the analytical
method was sound. There were those who would wish, as
ever, to criticise either the method or the data, so as
to avoid what the message was.

"So if it was being put to me that the methodology
or the [conclusion] as to what might be described as
[excessive] deaths were wrong, I wouldn't have accepted
that. If you are seeking to draw a conclusion from
that, that I was put under pressure from the Department,
or others, to remove any information, the answer is
categorically I was not put under that pressure, and if
I had been put under that pressure, I would have said,
"We do what we always do, we tell the truth".

It sounds from your description of the meeting as if
there certainly was pressure placed upon the Healthcare
Commission to remove those figures.

A. Well, let me say this, it's probably not appropriate for
me to say in my statement the Secretary of State
instructed Anna Walker. If that gives the impression
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that he issued a formal direction, because that
certainly wouldn't be the case. But my recollection is
that after some debate, and me having asked the
question, "Are we sure that it is wise to put in figures
that are not supported by case note reviews?", the
debate was then between the Secretary of State, his
colleagues, David Nicholson, Anna and Ian, I think, and
at the end of, in my memory, ten or 15 minutes of
debate, I recall the Secretary of State expressing
himself quite bluntly that he didn't think that this
should go in the report. What happened after that
meeting I've no way of knowing, because this was not
a matter for Monitor.

Q. Was the concern about the reliability of the figures or
was the concern about the impact upon the public
perception of the Department of Health, or the way that
the -- or the effect that the publicity was going to
have generally? What was the Secretary of State's
concern, as far as you could glean it?

A. Gosh, it's very, very hard at this time to -- you know,
this distance of time to answer that question. If I may
answer it from a slightly different perspective, if
you'll indulge that. David Nicholson would always,
I think, in circumstances like this, say that he would
be concerned not gratuitously to undermine public
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confidence in healthcare. And -- and that is a point of
view. And, therefore, if you're -- if one is going to
say, "Large numbers of people who have died who need not
have died", it's not unreasonable to ask the question,
"How confident are you in saying that? Is that based on
very reliable evidence or is that a broad assessment
that might not be very accurate?"

Whether the Secretary of State took that
perspective, or whether he took a perspective that, you
know, "This is politically very difficult for us", or
what, I really can't speak for him. I'm sorry.

Q. What you say in paragraph 153, and we may need to get
some timing from you on this, is:

"Following this meeting, I briefed Yvonne Mowlds and
Edward Lavelle and said that the HCC had said that it
would remove the indication of possible numbers of
avoidable deaths. I noted that the discussion on this
issue at the meeting on 16 March focused on the fact
that there was no medical evidence to support the
estimated number of avoidable deaths included in the
draft report, and that in particular to date no case
note reviews had been carried out. Yvonne Mowlds
subsequently instructed those Monitor staff with a copy
of the latest draft HCC report at that date to delete
and destroy it. This was to ensure the draft was not
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made public."

Q. How were you able to brief Yvonne Mowlds and Edward Lavelle after that meeting when, according to you, the decision hadn't yet been made by the HCC?

A. Well, my recollection is that in the meeting with Alan Johnson -- and one of the other people present was Bruce Keogh, who was the medical director of the NHS, that there wasn't any support that I can recall around that table for these figures to be included in the published report. That's my recollection. And what I took out of the meeting was that Anna had accepted, in the discussion, that it was not appropriate to put those figures in the report. But, as I say, after I left the room, I am sure many other conversations took place, but I'm not privy to them.

Q. Did you personally think that the figures should be removed or not be put into the report?

A. Given that Ian Kennedy acknowledged and Anna acknowledged that -- that they weren't based on a review of cases, they were -- I think I am right in what say in my statement, they applied the SMR and the -- the ranges of uncertainty of the SMR data to activity and derived numbers. If that was the case, that seemed to me to be not a satisfactory basis for the numbers. And if the numbers couldn't be better substantiated, then it didn't seem to me to be right to include them in the report.

Q. In fact what happened was that in advance of the Healthcare Commission publishing its report, somebody leaked, it seems, the version of the report with the figures in.

A. The figures certainly got into the public domain.

Q. You say this, and perhaps this needs a correction:

"Subsequently, the trust agreed to a request from the Secretary of State to commission an independent review of the case notes of patients who had died in the hospital in those cases where relatives suspected that the death may have been avoidable."

And I'm asked to correct you, in fact the ICNR was a review open to any patient or relative and was not confined to the notes who died.

A. Forgive me.

Q. And I'm sure you'll accept that.

There is one question I meant to ask you about this meeting, I'm sorry. Do you remember any of the words -- specifically the words that the Secretary of State used when he spoke to Anna Walker and expressed his views about including the statistics or not?

A. No, I don't. I mean, I -- no, it would be quite wrong of me to pretend I did.

Q. You say in paragraph 155 that Anna Walker had told you...
THE CHAIRMAN: Can we look at your meeting with the PCT, please, and --
Q. Can we look at your meeting with the PCT, please, and --
THE CHAIRMAN: Sorry, in the authorisation process, did
Monitor undertake any assessment of the ability of the
governors as a board analogous to the process undertaken
with the directors?
THE CHAIRMAN: But if the governors are meant to be,
I suppose, the second line of defence for a trust,
a foundation trust, doesn't the authorisation process
need to do a bit more than merely confirm as a matter of
fact that there is a board of governors duly
constituted?
A. Yes, a mixture of all of those things. The governors --
I mean, the -- the governors are a mixture of staff,
patients and public, and the staff governors were quite
angry, and I got a lot of criticism for having
authorised the trust in the first place. I wasn't
to believe that now. But what I was saying to them at
the time was, you know, "You do have quite a lot of
powers. You can appoint the chair, appoint the
non-executives, confirm the chief executive, put in the
auditors and all those kind of things, but -- but you
are not doing much about it".
Q. Can you remember which came first, was it -- I think
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powers. You can appoint the chair, appoint the
non-executives, confirm the chief executive, put in the
auditors and all those kind of things, but -- but you
are not doing much about it".
Q. Can you remember which came first, was it -- I think
to their appointment or their operation.

THE CHAIRMAN: But in a case such as Mid Staffordshire, which is undergoing the crisis that it was for a prolonged period of time, if it had been thought that governors generally had a duty to fulfil and a role to play, one might have thought that you would have engaged with them in the way that you've described happening with another trust later?

A. Yes, you could be right. But I'm not sure it would have made any difference in this case, frankly, and I think at the time we felt that we had enough on our plate and we had lots of people to engage with in relation to this trust quite properly. I think the governors are a difficult part of the system, frankly.

THE CHAIRMAN: Well, I was going to ask whether it might suggest that the lack of interaction and the lack of any visible activity by them that really the governors are not a very effective mechanism?

A. I think it varies tremendously. I mean, I have met governors of established foundation trusts who were extremely effective, who had replaced chairs, for example. They'd run a recruitment process and they'd said to the existing chair, "You've been interviewed but you're not going to be appointed". And some governors are very good. I'm not sure I agree with Andrew Lansley

that it's safe or sensible to place entirely in the hands of governors the responsibility for intervening in the case of a foundation trust that is getting into trouble, and on the face of it that's Andrew's proposal.

THE CHAIRMAN: Thank you.

MR KARK: You deal with the meeting with the chief executive of South Staffordshire PCT in a single line. You say: "I also met with the chief executive ...

Do you have any recollection of that conversation?

A. Not really, no.

Q. Can I tell you what Alex Fox told us about that in his statement, and I don't know if we can bring this up on trial Director. It is WS0000013027:

"I do recall a meeting with Monitor that took place on 2 April 2009 to discuss the issues at the trust. I recall that Monitor, the trust board, and the PCT were present at this meeting. I recall that Dr Moyes of Monitor had called the PCT in late to the meeting. Dr Moyes then put Stuart Poynor and I firmly in our place by making it clear that the PCT had no role in monitoring the trust's quality assurance and it was for the trust to provide the PCT with that assurance. I refused to accept this and I told Dr Moyes so. I said that the trust still had issues with patients that Monitor was simply not addressing. At this point of the meeting Dr Moyes had to leave."

Ms Monaghan for reminding me of this, that actually paragraph 216 you do comment on this meeting --

A. That's right.

Q. -- and apologies for having misled you.

A. My recollection is that before the meeting David Stone and Eric Morton said to me that they felt that the PCT was concerned that they were open to criticism. That the Secretary of State had launched two inquiries, one was George Alberti's inquiry, which was formally jointly with Monitor, and the other was David Colin-Thome's inquiry, which was about the commissioning side, and I think quite reasonably the PCT was perhaps a little apprehensive that their operation of their oversight of the contract with the trust would be subject to some criticism.

Q. But they were also concerned, is this fair, that they were concerned about the pace of change at the trust and they wanted reassurance that somebody was going to be hands-on, as it were?

A. Well, my recollection is that on that day the issue was not so much that, that -- that what I was told by David Stone and Eric Morton was that the PCT had begun to adopt a very, very intense scrutiny of very, very detailed operational levels in the hospital, and that David and Eric felt that this was inappropriate and
A. No. Yes. Not greeted with enthusiasm, I wouldn't have thought that I would really have played much part in that kind of discussion. I mean, perhaps it was, but -- perhaps it was me, but I don't recall it.

Q. "SP stated that the PCT needed 'hands on' assurance and quoted the inadequacies of the 'mortality review group' as an example of where assurance appeared to be in place but was not effective."

A. And you reverted back to the contract argument:

"AF [Alex Fox] stepped in and said: "Patients and politicians would not be too impressed if we said all solutions rested in the contract."

"We need/want: Close dialogue between the board -- work in partnership."

"Close attention to patient stories ... Clear understanding that culture/clinical supervision is in place and an open public dialogue and transparency."

Was it still your attitude that the board, with its new chair or interim chair and new interim chief executive had to be left alone to sort the problems out?

A. Not left alone, and -- and absolutely not ignored or -- or -- I mean, the PCT has, I am absolutely clear, in any circumstances, whether crisis or not, a legitimate requirement for information to support the fact that they're getting what they desire under the contract. But I think the point I was trying to make was that there had to be a little degree of realism. You know, David Stone and Eric Morton were having to do a huge number of things simultaneously. David Stone was reviewing the board. He was trying to bring new people in there. They were trying to sort out an action plan for the trust, for Monitor. We had George Alberti monitoring that on our behalf.

There was an awful lot of activity going on. And what I was trying, I think, to convey to the PCT was that there had to be some accommodation between David and Eric and Mr Fox and Mr Poynor about not just how much information, but how it was collected, how much the PCT was prepared to rely on the information that the trust provided, and how much the PCT felt obliged to go and collect their own data. But in the end, this had to be a negotiation between the four of them. I wasn't going to get too deeply involved in that.

Q. Well, we'll look in a moment at another letter that the PCT wrote to you. But can we have a look --

THE CHAIRMAN: You would have to forgive the PCT for wishing to exercise extreme caution about how well a brand new trust board was getting on, given the background that had happened to date.

A. Absolutely. I mean, I'm not saying the PCT was wrong in principle at all. I mean, at this stage there wasn't a brand new board. David Stone was in the process of one of many things he was trying to do --

THE CHAIRMAN: I'm sorry, a brand new chair and --

A. There's a new chairman chair, new chief executive. And David Stone as a high priority was reviewing the capability of the board, he had one vacancy, and was trying to identify good candidates to fill the vacancies, and was also asking himself the question, "Should the other non-executive directors remain or not?" He was also looking at executive team and asking himself questions there, quite a legitimately. He was trying to manage the Martin Yeates situation. Of course, everyone was focused on the trust. Monitor was certainly asking lots of questions. George Alberti was involved. Forgive me.

The PCT had a legitimate right to information. It was simply a question of how that information was collected. That was a simple point I was trying to convey to them. My recollection is it wasn't a huge part of our conversation, but I may be wrong about that.

MR KARK: You wrote to the chairs of all foundation trusts on 5 May 2009, and it is your exhibit 83. I just want...
to deal with this quite shortly, if I can.

On the second page of that exhibit, you set out
a series of issues which you were pointing out to the
chairs of foundation trusts, and which you wanted them
to take on board.

Just looking at the headings, it now seems clear
that the board of directors at Mid Staffs agreed to
reductions in expenditure, which led to significant
reductions particularly in nurse staffing levels,
without a clear understanding of the likely operational
impact on patients.

Then the board didn't appear to have sufficient
information about complaints.

Then 3:
"The governors of the hospital appear not to have
called the board to account ...

4:
"Clinicians at [Mid Staffs] do not appear to have
spoken out sufficiently frequently and strongly and, if
they did, they appear not to have been able to ensure
that their voices were heard by the board of
directors ...

Just looking at that list, are you able to give us
any insight now as to what it was about your
authorisation process that didn't pick up on these

points? Why these points weren't recognised until the
HCC investigation.

A. Well, the point about governors wouldn't arise in the
authorisation. The other points, I mean, quite clearly
we didn't ask enough questions and deep enough probing,
we didn't do enough probing about how the board
understood clinical governance and quality. And that
was one of the recommendations that came out of the work
that KPMG did for us on the lessons to be learned, and
I think Monitor has subsequently -- I recall in my last
couple of months kicking off work on, "Well, can we
develop a framework within which we can ask these
questions and give boards some guidance on the kind of
things that they should be looking at?" And that work
was done, I believe.

Q. Before we take the afternoon break, perhaps I can just
deal with two more letters from the PCT. If we go to
your exhibit 84. It is, first of all, the letter sent
on 12 May 2009, via email.

For the sake of brevity, I'm not going to go through
the contents, except the second paragraph which reads:
"We are extremely concerned that after two months
there remains no agreed action plan that has been shared
with all parties."

The letter also points out, which may be of

importance that over a nine-day period there'd been no
less than four serious untoward incidents and in each
case the patient had died.

Do you recognise that these were legitimate concerns
by the PCT to raise with the central regulator for
foundation trusts?

A. Yes, it was quite reasonable for the PCT to be pressing
us hard to satisfy itself that the right things were
being done in the trust in the right way, and to draw to
our attention aspects of the work of the trust that they
were not themselves satisfied with. But that said,
I think that -- to say that there was no agreed action
plan is not quite right. There was no well-prioritised
action plan that I think the trust had shared with all
its stakeholders, but I think it is correct to say that
the trust was putting a lot of effort into trying to
make sure that it had a pretty clear and prioritised
idea of all the things that had to be done.

Q. The central concern of the PCT, as we'll see in the next
letter, I think was the management of the trust. That
was, obviously, a concern of yours --

A. Mmm.

Q. -- as well.

If we go to your exhibit 87, this is

Mr Stuart Poynor writing to you, on 20 May 2009, saying,
Day 93 Mid Staffordshire Inquiry 1 June 2011

"Eric Morton said the trust and PCT need to work more closely together. He said that we must agree on numbers ..."  
"Bill Moyes asked Stuart Poynor to clarify the management capacity issue and his concerns. 

"Stuart Poynor responded by saying that he feels the trust needs a full-time transformation director to lead this programme. He could not say that the current way of working was wrong or failing as there had not been enough time to make such an assessment."

And over the page:  
"Stuart Poynor welcomed ..."  

This is two-thirds of the way down:  
"Stuart Poynor welcomed the communications plan and expressed disappointment at the lack of appointment of a chief executive."

Does this highlight to you a fundamental difference in approach between the regulator and the commissioner?  

A. Well, I think that this is the commissioner getting too deep into the organisation of the trust.

Q. Given the background and in the circumstances of what had happened with this particular trust, it's difficult to criticise them for that, isn't it?

A. Well, I don't know. I mean, I -- I think they have absolutely the legitimate concerns to express about the performance of the trust. I think they're entitled to ask, "Do you have plans? Are those plans well prioritised, well resourced? Can you give us assurance that the trust will manage to deliver good quality services?" I think they can express points of view about, "We don't think you have enough of X or Y". But I think there comes a point when you have to say to the chief executive of the trust and the chairman of the board, "You've heard our concerns. It's up to you what you do about them". I would be quite resistant, in any circumstance, not just here, to commissioners starting to dictate to providers the detail of their staffing levels, management structures and so on.

Q. I'm going to move on from the PCT to other topics and, sir, I wonder if that would be a convenient moment for the mid-afternoon break?

THE CHAIRMAN: Just finishing off on this topic before we break, a PCT, if doing its job properly, it might be thought to someone, a body close enough to a trust, to have insight into how the senior management is actually working, and whether it needs reinforcement in some way; do you not agree with that?

A. I think it's quite legitimate for a commissioner to ask questions about capacity and capability in a supplier.  

But I think you do have to at some point say, "It's the..."
| 1  | job of the board and the chief executive of the  |
| 2  | organisation to make those final decisions". |
| 3  | I -- I'm reluctant to accept that the PCT should |
| 4  | get into the fine detail about, "Do you have enough |
| 5  | management capacity? Do you have enough people? Are |
| 6  | you doing enough of X and Y?" So I think there's  |
| 7  | a point that one comes to where you say, "Well, you've |
| 8  | heard that I'm concerned, but it's up to you as to  |
| 9  | whether you're listening to that or not". |
| 10 | THE CHAIRMAN: Well, were the PCT at this meeting and |
| 11 | previously doing anything other than expressing quite |
| 12 | strongly their views and concerns, in the context of an |
| 13 | acknowledged failing trust at this stage? |
| 14 | A. In the meetings, as I can recall them, yes, the PCT |
| 15 | continued to press for the trust to increase its |
| 16 | resource, and I think that's fair enough. But the final |
| 17 | decision on priorities and on what -- where resource |
| 18 | should be increased and by how much and so on, had to |
| 19 | rest with the trust board. It couldn't be the PCT |
| 20 | dictating. But I'm not suggesting that the PCT wasn't |
| 21 | entitled to ask questions. |
| 22 | THE CHAIRMAN: But they weren't purporting to dictate, were |
| 23 | they? |
| 24 | A. Well, I don't know. I think there were times when the |
| 25 | PCT probably was pressing rather hard, and the SHA. But |

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| 1  | in the circumstances of the time, perhaps that's  |
| 2  | understandable. |
| 3  | THE CHAIRMAN: Thank you. Well, we'll pause now and we'll |
| 4  | start again at about quarter to. |
| 5  | (3.27 pm) |
| 6  | (A short break) |
| 7  | (3.45 pm) |
| 8  | MR KARK: Dr Moyes, this really is the last stretch, or |
| 9  | innings, as the chairman would have. |
| 10 | A. Whatever that is. |
| 11 | Q. The two sort of main issues I want to deal with, first |
| 12 | of all, very briefly a couple of points in relation to |
| 13 | the strategic health authority. |
| 14 | You deal with this in your paragraph 185, and you |
| 15 | say: |
| 16 | "The trust had done a lot of work on SMR data and |
| 17 | Monitor did not accept what the trust was saying about |
| 18 | mortality at face value." |
| 19 | So we're going back quite a few steps: |
| 20 | "Instead we were persuaded, as was the SHA, that it |
| 21 | was a coding issue." |
| 22 | Well, the SHA I think would say, well, they weren't |
| 23 | simply persuaded that it was an issue of coding because |
| 24 | we know they also undertook a structured clinical case |
| 25 | note review of two particular conditions, and you may |

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| 1  | have been aware of that, I don't know. |
| 2  | A. No, I wasn't. |
| 3  | Q. You also deal with the money that the SHA injected into |
| 4  | the trust, and I'm not going to go to the Lavelle letter |
| 5  | in relation to this, but we know that the SHA agreed to |
| 6  | provide GBP 4.5 million non-recurrent funding. |
| 7  | You're not suggesting, are you, that this was as |
| 8  | a result of pressure from Monitor to do so? |
| 9  | A. I really was not much involved in this question of the |
| 10 | money. I mean, I probably signed one or two letters, but |
| 11 | by this stage I think I'm coming to the end of my |
| 12 | time in Monitor, if I remember correctly, and I don't |
| 13 | really recall having much personal involvement. I think |
| 14 | Stephen Hay now was beginning to pick up the reins and |
| 15 | Edward Lavelle. |
| 16 | Q. Does the fact that Monitor -- I beg your pardon, that |
| 17 | the strategic health authority did have to come up with |
| 18 | this reasonably large sum of money demonstrate that the |
| 19 | initial assessment by Monitor of the trust's finances |
| 20 | were sufficiently sound for it to gain foundation trust |
| 21 | status was in fact flawed, because it wasn't looking at |
| 22 | what the trust really needed to provide quality care? |
| 23 | A. Well, I really don't know the background to the |
| 24 | 4.5 million. I don't know whether this was additional |
| 25 | staff being brought in. I don't know whether it was |

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| 1  | a decision that certain services that might have been |
| 2  | located elsewhere were to be located in the trust. |
| 3  | I just wasn't really very closely involved in that set |
| 4  | of conversations at all, and I -- I certainly can't |
| 5  | construct them in my mind now, I'm afraid. |
| 6  | Q. And a point that the SHA has been keen to establish, and |
| 7  | perhaps you'll accept, is that the basis of the |
| 8  | provision of the money was not that the trust should |
| 9  | break-even but that the trust could meet its monthly |
| 10 | outgoings from its monthly income. In other words, that |
| 11 | it's underlying financial position shouldn't be allowed |
| 12 | to deteriorate as result of the feeding in of this |
| 13 | additional resource. |
| 14 | A. Well, I'm sure Monitor would be supportive of that |
| 15 | general position but, as I say, the detail of this I'm |
| 16 | afraid I'm not master of at all. |
| 17 | Q. I want to turn, if I may, please, to politicians and |
| 18 | Monitor and Monitor's relationship with the CQC. |
| 19 | You discuss in paragraph 183 this issue. If we can |
| 20 | go to the second -- sorry, middle of paragraph 183, it's |
| 21 | page 72 of the statement. |
| 22 | You say: |
| 23 | "An NHS trust has a non-legally binding agreement |
| 24 | with the PCT and responsibility lies with the SHA to |
| 25 | make sure the trust delivers on the contract. |

Page 176
A. Oh, yes, the -- the analogy with companies was not meant to be a precise analogy in any sense. And you are perfectly right, companies have shareholders, which foundation trusts don't in the true sense.

Q. Can we have a look at a document that we've been provided with recently, which is headed -- it's on Monitor headed paper, and it is headed "Introductory meeting with Ben Bradshaw", and it is dated 28 August 2007. It will have to be put up on the screen.

A. I think this is your note, isn't it?

Q. It's a note of a meeting --

A. I think so.
in some senses to divorce central government from the
management of foundation trusts and, therefore, the
problems that trusts might have in the future. But here
there seems to be concern that ministers are having to
answer Parliamentary questions about the performance of
foundation trusts, but not actually having any control
over the trusts that they're being asked to account for?

A. Well, when the policy -- when Monitor was first set up
in 2004, the then Secretary of State, John Reid, wrote
to the Speaker and made a statement in Parliament to the
effect that he and his ministerial colleagues would not
answer questions on -- I forget the precise language,
but the sense, I think, is the operations of foundation
trusts. So that they would answer questions about the
policy, but they wouldn't go into operational issues.

Q. We've got that letter, if you want. I think it was
dated 25 March 2004 to the Speaker, who was then
Michael Martin.

A. That's correct. That's correct. And initially I would
say, in 2004 and 2005, ministers stuck pretty rigidly to
that stance. So, for example, our interventions in
Bradford and UCLH were naturally accompanied by MPs
wanting to know more. And John Hutton told the MPs for
Bradford and the associated constituencies that they
should come and talk to Monitor, which they did. We
had, I think, three meetings with local MPs. And John,
I think, was pretty robust in -- in not answering
detailed questions about foundation trusts. But over
time I think that that philosophy in the Department had
become much diluted and ministers had started to assume
an accountability, which in law they didn't have. They
had started to behave as if they were once again
accountable for foundation trusts.

Q. That issue is directly related perhaps to the second
part of this paragraph, which reads as follows:
"This in turn led to a discussion about how we had
managed problems in foundation trusts. He was not
aware, for example, that there had been a serious
problem in his own local foundation trust -- Royal Devon
and Exeter -- which we had sorted out without drama.
That made a good impression. We also talked a little
about Bradford and about UCLH, where he was very
impressed at the speed of turnaround and the lack of
political noise. This was what he focused on: our
ability to spot problems and to sort them out without
the process of rectification causing major political
difficulty either with backbenchers or with trade
unions. So when we come to publish our material on our
approach to turnaround, he will be a very receptive
audience."

A. No, I think the way the system is designed is that
the -- the political input is through the commissioning
line, but ministers don't get involved -- shouldn't get
involved in the operations of providers. Prior to
foundation trusts, when a hospital like UCLH, for
example, got into trouble, the chief executive would
simply say to the Department that someone had to sign
a cheque, and a cheque would have been signed. Whereas
the way we operated that didn't have to happen. The
hospital was perfectly capable, over a two-year period,
of sorting itself out and going on to be very
successful. So I think that the system is designed to
make it clearer where political influence is legitimate
and where really managers and boards should get on with
running their providers.

Q. You had -- I'm sorry, it wasn't your meeting with
Lord Darzi, but there's reference to a meeting with
Lord Darzi in an email to you from -- well, perhaps
I can show it to you. Sorry, from Stephen Thornton.
It's an email dated 9 June 2009. I just want to ask
you a couple of matters about it, and to seek your
assistance:
"Bill.
"I met Ara."
Is that Lord Darzi?
A. Yes, Ara Darzi, that's right.

Q. "... today for a briefing."

A. I'm sorry, Stephen Thornton was who?

A. Stephen Thornton was one of the non-executive directors on Monitor's board and was also the chief executive -- is the chief executive of the Health Foundation.

Q. "Lord Darzi said very positive things about Monitor's work on quality accounts."

And if we go to the next paragraph:

"In contrast he was vehement in his comments about the CQC, not least what he describes as Barbara's desire for organisational mission creep into quality improvement and her intemperate round robin letter re the NQB.

"On the Mid Staffs issue he was again very critical of the HCC and what he feared might be repeat failures by CQC. I thought that rather unfair as the department of Health] and SHA had some part in all of this but I said nothing."

There's a sense that one might get from some of this correspondence and others that there was something of a turf war between Monitor and, as it became, the CQC, for organisational mission creep into quality improvement and her intemperate round robin letter re the CQC.

A. I think absolutely. I think the PCTs are meant to be, if you like, the patients' friend, they're -- they're job is to, in my view, say to providers, not just foundation trusts but all providers, "Here are areas where we would like improvements in quality". They have to work within the national framework, the operating framework, the national targets and standards, whatever.

They can't just ignore that I don't think. But I think it is the case that the drive for improvement ought to come primarily from the PCT, rather than from other organisations. It doesn't mean to say other organisations can't have a view, but I think the PCT should be in the driving seat.

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And the CQC?

A. Well, may I make one preliminary observation? This Stephen Thornton seeing Ara in his Health Foundation capacity, not in any sense on behalf of Monitor, and I'm not necessarily accepting either the tone or the content of this email as reflecting Monitor's views. This is Stephen feeding back to us.

I don't think there was a turf war with CQC and I think we went -- we in Monitor went out of our way to try and form better initial working relationship with CQC than we had managed with the Healthcare Commission.

And I've acknowledged, I think in my statement, that with the benefit of hindsight, we should have done more with the Healthcare Commission in the early days.

I think the area of concern was we just wanted to be sure that registration operated -- was meshed in with what we did rather than being a completely separate exercise in cases where a foundation trust had a problem. So there were discussions about that between the two organisations. But no, I don't recognise the proposition that there was a turf war.

I think Barbara Young -- and I should be very careful about speaking for her, but I shall. I think Barbara Young would say that she often felt that the Care Quality Commission was actually intended to be the

Q. I want to look briefly at your relationship with the Department of Health, again I'm not speaking about you personally, Dr Moyes. But if we could to your exhibit 96, please.

I think this is a briefing note. No, it isn't, I'm sorry. It's a note from David Flory to the Secretary of State, dated 7 July 2009.

Headed "Mid Staffordshire -- option for further action":

"Following our recent meeting on Mid Staffs MS(H)..."

That is presumably Minister of State for Health?

A. Yes.

Q. '"... asked for careful consideration to be given to a package of five measures with the view to an announcement before Parliament rises on 21 July "..." And then the measures are:

"The possibilities of trying to remove foundation trust status from Mid Staffs." Well, you knew at this stage that couldn't be done, or --

A. That's right.

Q. -- there was no power to do so.

A. No.

Q. "Proposals to put in place new, full-time leadership at
Day 93
Mid Staffordshire Inquiry
1 June 2011

1 Q. Over the page, to paragraph 11 at the bottom, please -- sorry, another page on:
2 "We believe that there is still a pragmatic route
3 towards achieving our twin goals of installing new
4 leadership and sending a tough message on FTs. Hugh has
5 had a preliminary conversation with Bill Moyes following
6 our conversation last week ... he appeared to be
7 generally cooperative. He has ... written to you ...
8 Although this is a useful update and he suggests they
9 are close to a permanent chair appointment, on the
10 whole, the scale and urgency of the actions he sets out
11 do not satisfy the urgency of your concerns."
12 Now, first of all, you didn't actually have the
13 power to appoint a permanent chair, did you?
14 A. No, we didn't, and that's not entirely recognised there.
15 But what I think I was saying to David Flory at this
16 stage was that Sir Stephen Moss, who had joined the
17 board as a non-executive director, had made it pretty
18 clear that he was willing to become chair, and I think
19 there was a lot of support for Stephen's appointment.
20 So my own assessment, I think at this stage, was
21 that the chair vacancy would be satisfactorily filled
22 relatively quickly. The issue was chief executive, that
23 the board of the trust had had one round of trying to
24 recruit someone. They used Saxon Bampfyde. They'd had
25

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1 to what extent it was realised.  
2 At the bottom of the page:  
3 "With that in mind, this submission sets out three 
4 principal recommendations."  
5 And "that in mind" is establishing new leadership at 
6 Mid Staffs?
7 A. Yes.
8 Q. " ... that we act quickly to secure the future of the 
9 trust by increasing the pressure on Monitor to put in 
10 place full-time leadership who we agree are capable of 
11 delivering the rapid improvements -- both in services 
12 and in engaging the local population -- that are 
13 necessary for this trust to move on. This would be 
14 likely to receive wide support, including from Cure the 
15 NHS."  
16 How would the Department of Health or how would 
17 ministers put pressure on Monitor to put in place 
18 full-time leadership?
19 A. Well, I don't really know. I've never seen this until 
20 I was preparing for this inquiry. But, I mean, 
21 I suppose they might have said things publicly. 
22 David Flory had certainly made it clear to me that 
23 ministers were anxious. He wasn't alone in that. 
24 Monitor was anxious. And I can quite understand why 
25 this conversation is taking place in the Department. 

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1 the trust? 
2 "Ensuring the work on clinical records review is 
3 well known ... 
4 "Further work on the options for a form of further 
5 inquiry ..." 
6 And then 5:  
7 "Options for changes in legislation, in particular 
8 around the current Bill and the possibilities of 
9 a narrow amendment that might be able to be consulted on 
10 over the summer to give ministers step-in rights on 
11 Mid Staffs and failing foundation trusts more 
12 generally." 
13 We take it that, so far as you at Monitor were 
14 concerned, ministers certainly did not have step-in 
15 rights in relation to foundation trusts? 
16 A. No, they didn't. They had no power of direction over 
17 either individual foundation trusts or, in my 
18 recollection, over Monitor, and that was a deliberate 
19 drafting of legislation.
20 Q. Because the whole purpose of the change was to make 
21 foundation trusts independent?
22 A. Yes. I mean, Alan Milburn's phrase, as I recall, was to 
23 "cut off the hands of the Secretary of State". 
24 Q. But can we look at the sort of pressure that was being 
25 considered being put on Monitor, and then I want to ask

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1 a set of interviews, but they hadn't made an 
2 appointment, and that was understandably an anxiety for 
3 the Department and certainly for us too. 
4 Q. At the end of the day, the Department of Health had no 
5 power whatever to direct you at Monitor to take any 
6 steps whatever. 
7 A. No, they had no statutory power. But in a sense they 
8 didn't need it. I mean, it wasn't that we didn't want 
9 to see a chief executive in post, but as I think I say 
10 in my statement, when Monitor intervenes there are two 
11 constraints. We cannot appoint a permanent chief 
12 executive. We have to make interim appointments. And 
13 we cannot require, in my understanding, anyone to be 
14 released by their trust to be appointed. We simply have 
15 to call in favours, which I did. 
16 Q. Do you think you should have -- I'm sorry, do you think 
17 Monitor should have the power to appoint permanent -- in 
18 other words, in certain circumstances to appoint 
19 a permanent chief executive and take that out of the 
20 hands of the governors? 
21 A. On balance, probably not. I mean, I think it's better 
22 for the appointment to be made -- the chief executive 
23 appointment is technically made by the board and the 
24 governors ratify it, they don't technically make the 
25 appointment. And on the whole, I think that's better. 

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| Page 193 | I mean, Mid Staffordshire was an entirely, in my experience, unique situation, and I had never known a foundation trust, even though some of them had had serious problems, to fail after an extensive search to make a reasonable appointment of a chief executive. Question 25: Just sticking with this theme of potential pressure being placed on an independent regulator, could we go to page 4. Paragraph 12 and 13: "Our advice therefore would be to try to work with Monitor but to raise the stakes in threatening serious consequences if they do not cooperate/deliver. Our immediate next step could therefore be to call Monitor to see [the Minister of State] who ..." And then we can see what is set out there. And then 13: "The explicit underlying threat could be that in the event they failed to cooperate and/or deliver all this, ministers would be forced to publicly declare a lack of confidence in Monitor." First of all, did you ever receive such a threat? A. Well, I was on holiday at this stage in Spain and Portugal, although it didn't feel like it. And in the event, as I recall, Mr O'Brien, whom I'd never met, who was the Minister of State, had a meeting with...  

| Page 194 | Stephen Thornton and with Edward Lavelle, and there may have been one other, I think Adrian Masters may have been there, and by all accounts it was a robust meeting. But I don't think it went as far -- at least from the account I had from my colleagues, as I recall it, I don't think it went quite as far as this note suggests it could have gone. Question 28: It was a robust meeting, presumably, because the politicians were trying to persuade Monitor to do something that it was disinclined to do or what? A. It wasn't disinclination. The politicians, Andy Burnham and Mike O'Brien, had taken on -- Alan Johnson before them had taken on a degree of accountability that -- that wasn't really there, but in reality they were behaving as if they were accountable. But as they then discovered, of course, they didn't have any statutory basis for that accountability. There was no action that they could be seen to take. We are in the fervent atmosphere of the pre-election, and that's not irrelevant. They were desperate to be seen to be doing something. Eric Morton was keen to back get to his trust. His trust was keen to get him back full-time. Monitor were keen to see a permanent chief executive appointment made. So although we came at this issue from slightly different perspectives, there was a lot of congruence of interest here. The question was how to secure the appointment of a capable, permanent chief executive. And I acknowledge that we were not -- the trust was not managing that and we were not managing that, although it really was the trust board's responsibility at this point. Question 29: And I'm going to avoid, if I can, going through all of the emails, but there came a point when it became pretty clear that the Department of Health were going to provide you with some names that they would expect you to appoint and there was a degree of resistance to that, perhaps understandably, within Monitor? A. Yes and no. I wish the Department had provided us with some names. I do recall having more than one telephone conversation with David Flory, including from Spain, from Salamanca, if I remember correctly, in which I said to him, "Have you got suggestions?" And suggestions there came none, initially. It wasn't as if David was sitting with a list of names saying, "You could try X or Y". One or two names I think did bubble up, but the only name that bubbled up with any conviction was Antony Sumara's. Question 30: Well, I'm not sure there's much purpose in going through all of the emails. There's some fairly florid language used in some of them, not by you, I don't think.  

| Page 195 | The end result was that Antony Sumara was appointed, and you say that wasn't because of any pressure by the Department of Health? A. I'm not going to say it wasn't -- that there wasn't pressure. There manifestly was pressure. We agreed with the Department, wholeheartedly, that a chief executive had to be appointed. And we didn't have a better suggestion than Antony Sumara in the end, and David Stone was happy with Antony, having met him, I think, and the trust board were content. It was the trust board's decision. It wasn't something that I wished to discourage them from doing, so therefore it happened. The CHAIRMAN: The dilemma that ministers have faced, I have no doubt in due course I might hear a bit about it, was surely that even though in principle independence of foundation trusts divorced from the Secretary of State seems like a good idea to encourage innovation and efficiency, the Secretary of State still remains accountable to Parliament for the efficient delivery of the National Health Service, and if there is a fundamental failure in provision, it's not entirely surprising if he tries to put it right? A. No, you're right. The Secretary of State has a slightly ill-defined accountability to Parliament, which in the...
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<td>Alan Milburn, wanted to exercise through pressure on</td>
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<td>providers. And it's not entirely clear-cut yet. We</td>
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<td>haven't got to that stage. It will never be clear-cut</td>
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<td>until we have an all foundation trust system, and then</td>
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<td>I think accountabilities can be redefined much more</td>
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<td>sharply.</td>
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<td>And you are perfectly correct, that if a provider</td>
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<td>were manifestly failing, fully failing, the</td>
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<td>Secretary of State is bound to have some role. But it's</td>
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<td>not a detailed operational role. I mean, what we were</td>
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<td>trying to get ministers out of was having lots of very</td>
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<td>detailed points of view on lots of issues in a trust.</td>
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<td>THE CHAIRMAN: But if his only means of exercising leverage</td>
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<td>is via commissioning, that is of potentially small</td>
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<td>comfort to the inhabitants of a place like Stafford, if</td>
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<td>the commissioners in reality have nowhere else to turn</td>
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<td>to commission for their services?</td>
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<td>A. I mean, you are correct, that you are in a health</td>
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<td>economy where there is in effect no alternative, and</td>
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<td>that, I think, could be debated, though. But if that's</td>
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<td>the assessment made, then it is quite difficult,</td>
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<td>I think, for the Secretary of State to operate purely</td>
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<td>through the commissioning line. At the same time my own</td>
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<td>view is that it's much, much better -- when you look at</td>
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<td>the system as a whole, and not just Mid Staffordshire,</td>
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<td>it has proved to be much better for ministers not to be</td>
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<td>involved and not to be called to account for the</td>
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<td>operation of hospitals. I do not believe that we would</td>
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<td>have sorted out some of the problems that we have sorted</td>
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<td>out in places like UCLH if there had been the remotest</td>
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<td>prospect of pressurising ministers into providing</td>
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<td>subsidies or taking other steps.</td>
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<td>THE CHAIRMAN: Because that's what would have happened?</td>
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<td>A. Oh, undoubtedly.</td>
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<td>THE CHAIRMAN: Doesn't the current system still end up with</td>
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<td>ministers signing cheques, I mean that metaphorically,</td>
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<td>I hope, for trusts that are in deep financial trouble?</td>
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<td>A. Well, I think there's only one case that I'm aware of,</td>
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<td>apart from Mid Staffordshire but, of course, I'm well</td>
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<td>out of date, but towards the end of my time I wrote to</td>
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<td>David Flory and said that in the case of Dorset County</td>
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<td>Hospital, I think it's called, the costs of</td>
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<td>restructuring -- because this was a hospital that had to</td>
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<td>lose a significant volume of staff, and it had a lot of</td>
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<td>staff of very long service and, therefore, very high</td>
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<td>redundancy payments, my memory is that the cost of that</td>
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<td>was something like GBP 10 million, and this was a small</td>
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<td>trust and it simply could not manage to generate that</td>
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<td>level of free cash to pay those bills. So it was a bit</td>
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<td>stuck. And my proposal to David, which I think after</td>
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<td>I retired was implemented, was that the Department</td>
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<td>should make a loan to the trust but a loan not a grant,</td>
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<td>on commercial terms, repayable, to enable it to fund its</td>
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<td>transitional obligations, reduce its staffing level, pay</td>
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<td>the redundancy payments and then in time generate</td>
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<td>sufficient surpluses to repay the loan. And I think</td>
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<td>that has happened there. But across my time in Monitor,</td>
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<td>that was the only hospital that I can immediately think</td>
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<td>of where there appeared to be a financial problem that</td>
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<td>simply could not be resolved.</td>
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<td>THE CHAIRMAN: Thank you.</td>
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<td>MR KARK: And something like that sort of system is going to</td>
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<td>have to continue, because however good Monitor's</td>
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<td>authorisation process gets, there are always going to be</td>
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<td>foundation trusts that at one time or another run into</td>
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<td>financial trouble?</td>
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<td>A. Mmm. Yes. But to repeat myself, in most cases, in my</td>
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<td>experience -- I mean, even if you take UCLH where my</td>
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<td>memory is the deficit grew to 50 million before we</td>
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<td>really understood what was causing it and could start</td>
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Day 93 Mid Staffordshire Inquiry 1 June 2011

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<td>putting huge pressure on the hospitals in the region?</td>
<td>happened to our recommendations?&quot; There is -- a degree</td>
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<td>A. I’m not necessarily saying close, but you might have</td>
<td>of that goes on, but I think I’m right in saying it’s</td>
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<td>a reduction in the scale of intensity of patient that</td>
<td>a paper process rather than a proper investigation.</td>
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<td>comes to A&amp;E, for example. You’re perfectly right, you</td>
<td>Q. With an annual budget of about, I think,</td>
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<td>have to look at the system in the round.</td>
<td>GBP 14.5 million, and this is Monitor, 55 per cent or</td>
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<td>Q. Can I turn to another short topic, which is your</td>
<td>so, according to your accounts, goes on staff, and</td>
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<td>criticism of the Parliamentary Health Select Committee,</td>
<td>I think you had in 08/09 about 95 staff -- 94 staff.</td>
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<td>which you really criticise for not seeking to draw</td>
<td>A. Probably about that, yes.</td>
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<td>lessons from Monitor's experience, and I'm sure you</td>
<td>Q. 1.5 million goes on office costs, apparently, and</td>
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<td>could speak at some length on that issue.</td>
<td>GBP 1.9 million on consultants. What does Monitor bring</td>
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<td>But the Parliamentary Health Select Committee</td>
<td>finance, then Monitor would have the ability to</td>
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<td>identifies its own topics, obviously, to scrutinise.</td>
<td>intervene and commission whatever assessment it needed</td>
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<td>One of the issues which has been raised in this inquiry,</td>
<td>from auditors or whoever else. And if there were</td>
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<td>particularly in fact by the evidence of Sir Ian Kennedy</td>
<td>a quality issue that went beyond just the registration</td>
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<td>but also others, is the failure of the National Health</td>
<td>of a particular service but required changes in the</td>
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<td>Service to learn from experience.</td>
<td>organisation, then acting on CQC’s advice Monitor would</td>
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<td>Is there an argument that there should be</td>
<td>intervene to do that.</td>
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<td>a permanent Select Committee to review the activity rate</td>
<td>MR KARK: Dr Moyses, that brings me to the conclusion of my</td>
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<td>in respect of previous recommendations by either reports</td>
<td>questions. I'm going to look around. I know that the</td>
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<td>or inquiries such as these, to see what the activity</td>
<td>chairman may have some matters for you. But I'm going</td>
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<td>level is like?</td>
<td>to look around to see if anybody is sending me any notes</td>
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<td>A. I think there is certainly a case that Select Committees</td>
<td>in the meantime. Thank you.</td>
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<td>should go back to the reports that they've done and --</td>
<td>Questions from THE CHAIRMAN</td>
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<td>and question departments carefully, a bit like an audit</td>
<td>THE CHAIRMAN: I know we've covered this to some extent</td>
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<td>committee does with management, about, &quot;What has</td>
<td>already, but if a foundation trust is financially</td>
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<td>happened to our recommendations?&quot; There is -- a degree</td>
<td>failing, leaving aside the quality for the moment, every</td>
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<td>of that goes on, but I think I’m right in saying it's</td>
<td>effort is made to keep it afloat, and to date I don't</td>
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<td>a paper process rather than a proper investigation.</td>
<td>think any have gone under, as it were, but the</td>
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<td>Q. With an annual budget of about, I think,</td>
<td>possibility, presumably, is there that they could be</td>
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<td>GBP 14.5 million, and this is Monitor, 55 per cent or</td>
<td>allowed to do so?</td>
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<td>so, according to your accounts, goes on staff, and</td>
<td>A. Mmm.</td>
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<td>I think you had in 08/09 about 95 staff -- 94 staff.</td>
<td>THE CHAIRMAN: Were that to be allowed to happen, what would</td>
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<td>A. Probably about that, yes.</td>
<td>happen to the assets, if there were any remaining, of</td>
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<td>Q. 1.5 million goes on office costs, apparently, and</td>
<td>the foundation trust?</td>
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<td>GBP 1.9 million on consultants. What does Monitor bring</td>
<td>A. They revert to the consolidated fund, as I recall.</td>
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<td>to the health service that a good firm of auditors and</td>
<td>THE CHAIRMAN: So they don’t get lost to the public purse?</td>
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<td>some increased powers of the CQC could not?</td>
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<td>A. Well, I -- I think Monitor has done a lot of things that</td>
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<td>a good firm of auditors wouldn't do. There are things</td>
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<td>like quality accounts, for example, where Monitor</td>
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<td>pioneered that in foundation trusts and required</td>
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<td>foundation trusts to draw up and publish quality</td>
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<td>accounts and have them audited, and the Department were</td>
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<td>very happy to come alongside that. But that's an</td>
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<td>example of the kind of innovation we’ve put in place.</td>
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<td>I don't think a good firm of auditors would</td>
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<td>necessarily intervene in boards in the way that Monitor</td>
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<td>has done. I don't think that they would have put on the</td>
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<td>programme for finance directors that’s been so popular.</td>
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<td>I don't think they would have published the guide to</td>
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51 (Pages 201 to 204)
| 1 | A. No. |
| 2 | THE CHAIRMAN: Monitor has no powers, does it, to direct a trust to dissolve itself or to merge with another one? |
| 3 | A. No, Monitor can't do that. I don't think anyway, and I'm -- I'm now straining at my recollection of the legislation. But if -- if a trust wishes to be dissolved, it has to consult, and then I think the dissolution order is one that is made technically by the Secretary of State, but perhaps on Monitor's advice. |
| 4 | THE CHAIRMAN: I mean, during your time at Monitor, were there any schemes whereby foundation trusts got together and in effect merged? |
| 5 | A. Yes, there were -- there were several cases. In two or three cases I think south Staffordshire was one, a mental health trust took on the mental health community services of the PCT, for example. Heart of England hospital took over -- merged with technically -- Good Hope Hospital in Birmingham, and there were one or two other, I think, proposals around for similar merges. But there -- they're very complicated, and not many have proceeded. |
| 6 | THE CHAIRMAN: I mean, is there a case for somehow or another introducing into the foundation trust system, if it's to survive, given everything is apparently to become one, a greater degree of flexibility around that? |

| 1 | A. Yes, there is. |
| 2 | THE CHAIRMAN: With appropriate safeguards, obviously. |
| 3 | A. There is. The acquisition of community services by mental health trusts, Oxleas would be another example, with Greenwich and Lewisham and Bromley and Bexley, is relatively straightforward, because it's not the whole PCT that's dissolving, it's simply disposing of an arm, transferring it. |
| 4 | In the case of the Heart of England/Good Hope, it was extremely complicated, because consultation had to take place on the dissolution of Good Hope and on the creation of this effectively new foundation trust from the two parties. It was not at all clear -- we tried to treat it as an acquisition in the commercial sense. It wasn't at all clear who the vendor was, and that was quite a difficult issue. Who was disposing of this trust and who could look after the interests of the trusts, so to speak, and its clinicians and patients and so on? So the system to permit merges and acquisitions on the commercial model has not remotely, I think, been brought into existence in the foundation trust system as it stands at the moment. Nor do we have the kind of special administration system that you have in other utilities. |
| 5 | THE CHAIRMAN: That's an administrator appointed by the regulator taking over? |

| 1 | A. Correct, yes. Where the trust is in danger of becoming insolvent. |
| 2 | THE CHAIRMAN: Do you know why there isn't such a power? |
| 3 | A. Well, in the 2003 Act, as I remember, there was provision for part B of the Insolvency Act to apply to foundation trusts, subject to regulations. But the Department, despite considerable efforts, never managed to come up with regulations that worked, and in the end, at some point, and I can't remember when, that provision was repealed. I am aware that more generally -- not just in the case of healthcare but across public services, some ministers are giving some thought to the question of having a public service failure regime, with safeguards and so on. But I don't think it's made much progress because I don't think politically there is yet a willingness on the part of the public, perhaps, to acknowledge the possibility that public services can fail in some areas. There are some areas where it's inconceivable that a service would be allowed to fail in the sense of just closing up. So you then have to find a mechanism to sort out whatever problems that service is having. In other cases there might well be possible (sic) for public services simply to fail because there are so many providers. It's -- it's not a threat to the public. |
| 4 | THE CHAIRMAN: Monitor has no powers, does it, to direct a trust to dissolve itself or to merge with another one? |
| 5 | A. No. |
| 6 | THE CHAIRMAN: But the ability to appoint an administrator doesn't necessarily mean that the organisation is allowed to dissolve or it can be a means of keeping the business of the organisation going? |
| 7 | A. Well, that would be precisely the intention. In Monitor, we commission quite a lot of work in an effort to help the Department to try and develop a special administration regime that would work for foundation trusts, and we had legal advisers that helped us take what existed in railways, for example, and map it across to the hospital system. Trying to think of the hospital system as a bit like a utility. And I think we came up with something that was broadly workable but it in the end didn't make progress. |
| 8 | THE CHAIRMAN: I mean, do you think that powers of intervention of that nature would assist at all where there were quality concerns of the type exemplified by Mid Staffordshire, if you have a board that's not functioning properly, a really serious crisis, and a need to keep the show on the road as best one can? |
| 9 | A. It's possible. I don't know. I haven't given it much thought, I have to admit, but it's possible. |
| 10 | THE CHAIRMAN: Thank you. |
| 11 | Any further in inspiration. |

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Further examination by MR KARK

MR KARK: I'm afraid there is. It comes entirely from me having missed something, and it is really assist you, Dr Moyes, to correct something. You gave us the impression, perhaps, that at the meeting with the Secretary of State of 16 March the issue of figures was really an addendum to the report and raised on that day, and I think you -- I haven't got the comment you made, but it sounds as if you were surprised.

On 9 March 2009 there's an email from Yvonne Mowlds to you. Can I just read out the relevant paragraph. This is a document that's come to us recently:

"I spoke to Heather this afternoon and she noted that there would be one major change to the executive summary. They intend to include an estimate of the level of deaths that exceeded the expected level. This will be based on statistics and will be a range similar to what they did in the Maidstone report. They have not finalised the wording or numbers yet, so she would not share with me. Likely to be finalised over the next couple of days. It's very late at this stage for them to be introducing this analysis and I think it might be worth you having a conversation with Anna about the impact this will have on public confidence and how we can discuss this tomorrow if you want."

A. I have to admit I had forgotten that. But I think it is still the case that as we were waiting to go into the Secretary of State, recognising now that we had been told that there would be something in the report about a range of possible avoidable deaths, it was only as we went in or just before we went in the text was produced and figures were produced. So I think it is still the case, I don't think I'm misleading you, that it was only minutes before we met the Secretary of State that I became aware of what the text would say. And I'm not sure the Secretary of State and his officials had had any more warning than I did.

Q. But it's fair to say that it wasn't, as it were, sprung on you at the last minute, in terms of the point that was being made?

A. No, the -- the fact that there would be something in the report, you are perfectly correct, was not clearly sprung on us, but the -- the numbers and some of the text round the numbers I think we had no preparation on.

MR KARK: Dr Moyes, thank you very much.

THE CHAIRMAN: Ms Monaghan. I'm afraid you're on to the Day 93 Mid Staffordshire Inquiry 1 June 2011
that the trust engage with external experts ..."

There was then a response to the HCC by Mr Yeates, dated 3 June, as anticipated. Do you recall seeing that letter?

A. I must have done but I don't recall it in detail.

Q. I wonder if I bring that up, please, if I give you the MON number. It is MON00030026961.

I should say, Dr Moyes, that this letter doesn't appear to be copied into Monitor, but the response from the HCC to it is copied to Monitor. So from that we suspect, I think probably reasonably, that Monitor received this at some point too.

And on the second page of that letter, just wait until it is brought up.

It is 3 June 2008, it's the second page. And perhaps I can just -- do you have that, Mr Kark? It's the letter from Mr Yeates to Heather Wood. It is actually exhibited to the Monitor documents. If you just bear with me one moment, Dr Moyes. I can perhaps read out the relevant paragraph but let Mr Kark find it so he has it.

You haven't got it.

I wonder if I could read the paragraph just in the hope of refreshing your memory about questions concerning expert advice and A&E. This is a letter, as I say, dated 3 June 2008 to Heather Wood from Martin Yeates.

The second page for those who have found it or might want to refresh their memory, later reads:

"In order to ensure that all matters are identified and appropriate workforce numbers, standards, pathways of care and monitoring arrangements are agreed, we are being supported by the Heart of England NHS Foundation Trust, a nationally recognised team will lead this piece of work. The clinical team consists of ..."

And then four people are identified.

Does that ring any bells with you --

A. It does ring a faint bell, yes.

Q. -- Dr Moyes. And were those matters, that is the appointment of external expert advice, material so far as Monitor was concerned?

A. Yes, I think it would be, because if the trust were doing that and were bringing in people of national reputation to do relevant work, then it's not obvious that there's anything additional that Monitor could require them to do using our powers of intervention at that stage.

MS MONAGHAN: Thank you. No further questions.

THE CHAIRMAN: Thank you. Well, Dr Moyes, is there anything you'd wish to add?

A. I think the only point that I would, if I may, just add very briefly is to reinforce a point I've made at various points in my evidence is that I still find it surprising, to put it no higher, that apparently at no point before the trust became a foundation trust, or afterwards, did clinical staff draw to the attention of their professional organisations or their Royal colleges concerns about quality. And I think that does raise a number of questions, which I'm sure the inquiry will be pursuing. But it just seems to me to be concerning, to put it no higher. Otherwise, thank you very much.

A. Thank you.

THE CHAIRMAN: That concludes our evidence for today and we start again at 10 o'clock tomorrow morning. Thank you.

(4.45 pm)

(The inquiry adjourned until 10.00 am on Thursday, 2 June 2011)

A. Thank you.

THE CHAIRMAN: Thank you very much indeed, Dr Moyes, for a long day and a half.

A. Thank you.
| Yvonne Yeates | 18:15 |
| Yvonne Yeates | 07-08 |
| Yvonne Yeates | 10:24 |
| Yvonne Yeates | 0017001219 |

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| 0010000026 | 209:11 |
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