

viewpoint

Changing of the guard:
lessons for the new
NHS from departing
health leaders

Edited by Nicholas Timmins

About this Viewpoint

Nuffield Trust Viewpoints provide a platform for UK and international health leaders to explore, discuss and debate critical health care reform issues.

Our latest offering comes at a critical time in the reform of the NHS, with the new structures introduced by the Coalition Government about to go live in April 2013.

To mark this moment, Nuffield Trust Senior Associate Nick Timmins has interviewed some of the most experienced NHS leaders of the past decade and more to gather their personal experiences and lessons for the new generation of leaders that are about to take the reins.

The 12 interviews feature leaders from across the NHS landscape: those leading strategic health authorities and primary care trusts, which are about to be abolished; hospital trusts; and from health regulators.

They offer widespread reflections on what it is like to work in the NHS at a senior level, and their collective wisdom offers insights into the challenges faced by NHS leaders during the last decade and into the future.

This Viewpoint forms part of the Nuffield Trust's work programme on NHS reform.

Our award-winning website brings together our research and analysis in this area at

www.nuffieldtrust.org.uk/our-work/nhs-reform

Visit the publication webpage for additional materials related to this Viewpoint, including videos and blogs from the interviewees: **www.nuffieldtrust.org.uk/publications/changing-of-the-guard**

The views expressed are the authors' own, and do not necessarily represent those of the Nuffield Trust.

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Above all, we are grateful to Nick Timmins for his skill, insight and tenacity in drawing these reflections together in trademark swiftness to ensure they could be published ahead of the implementation of the new NHS structures. His work will ensure this publication is timely reading for all those involved in leading the new NHS.

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Foreword



Dr Judith Smith,
Director of Policy,
Nuffield Trust

As any politician or preacher will tell you, you can't beat a good story for conveying what you are really trying to say. An account of direct personal experience will stay with the listener long after the carefully researched facts and clever analysis have faded into obscurity.

NHS managers are a group whose story is rarely heard. They are the 'faceless bureaucrats' or dispensable 'pen-pushers' detracting from those highly-valued doctors and nurses. During the past three years of seemingly endless and polarised debate about NHS reform, managers have been demonised and denigrated to a greater extent than ever before.

When Robert Creighton approached the Nuffield Trust and asked if he could share his reflections on a decade of being a primary care trust chief executive, we quickly realised that his story, and that of his peer group, needed and deserved to be heard. This was not just about putting the record straight, but ensuring that the collective wisdom of a generation of senior NHS managers could be passed on to those charged with making the latest NHS reforms work.

The stories gathered and explored skilfully by Nick Timmins are a testimony to the complexity of the health management task, and the integrity and dedication with which many managers approach their apparently impossible role.

Indeed, as the NHS contemplates dealing with a decade of financial austerity, and assuring safe and high-quality care in the wake of the Francis Inquiry Report, we can be reassured by these managers' concern for patient care, supporting their staff, and working in a climate of transparency.

The biggest challenge presented by these 'changing of the guard' stories is not, however, to the next generation of health managers; it is the NHS Commissioning Board and the Department of Health that have to persuade ministers to resist the temptation to reorganise the NHS every few years. There is no time for further reorganisation – scarce management talent has to be focused on assuring safe and affordable NHS care.

Foreword



Alastair McLellan,
Editor, *Health Service
Journal*

Something very significant is happening to the leadership of the NHS, and the Nuffield Trust is to be applauded for recognising it. An entire generation of senior leaders are taking the opportunity of attractive redundancy packages or pension arrangements and leaving the service. They should not be criticised for this – they have done their time – but it presents the service with a wicked problem.

Across the country around one in ten senior leadership posts lie vacant, the NHS is suffering a major loss of ‘corporate knowledge’ at a dangerous time of change and there appear to be few volunteers to step into the breach.

This is not surprising – the job of an NHS chief executive is a punishing one. True, the rewards are good – but the job security is not. The pressure is unrelenting and the criticism, very often, non-stop and impossible to avoid. No wonder many potential chief executives – especially clinicians – opt for less high-profile jobs, which, over the course of a career, can deliver even higher rewards with a tenth of the stress.

The collected wisdom winnowed out from departing leaders with trademark precision by Nick Timmins offers many clues as to how leading NHS organisations can be made more attractive and sustainable. It also, of course, contains myriad dire warnings about what can happen if the denigration of NHS management continues.

The NHS Management Training Scheme remains one of the most over-subscribed executive training courses in the country – so we are not short of talent. But, as these interviews demonstrate, if that talent is to flower, much has got to change.

Executive summary



Nicholas Timmins,
Senior Associate,
Nuffield Trust

Time. Time and transparency, and clinical engagement. These are the three issues that come roaring out of these interviews with ‘the dear departed’ – a clutch of recent NHS chief executives and other health leaders who were asked what advice they would deliver to their successors as the new NHS structures go live in April 2013.

The time it takes to do reconfigurations – to use the NHS jargon for the reorganisation of NHS services from the most specialised all the way through to primary care. The time that is oh-so-destructively swallowed by the endless reorganisations of the NHS superstructure: known these days as commissioning. The time it takes reporting and accounting back up the system.

Not, you will note, the time it takes consulting inside and outside the service, or winning friends for constructive change, or making cases.

Little of that was resented. Indeed in a tax-funded service, where managers recognise that they are unelected and it is politicians who provide the funding, that was seen as an essential and indeed a proper form of accountability.

What was bitterly resented was the bureaucracy of all that, the frequent extreme politicisation of it – and with plenty of people suspecting that the current round of changes will make that worse, not better.

Time, and the lack of it. Too little available to do the day job, which is improving services for patients – something which almost everyone who was interviewed for this project volunteered, unprompted, to be what the job is actually all about.

Time, and the fact that everything takes so long – sometimes offered up by interviewees almost as a scream of frustration, sometimes as an almost resigned, sobered, judgement that is simply the brute reality of trying to change health systems.

And it is clear from these interviews – which are, to be fair, anything but a random sample – that NHS chief executives live, conceptually, in an entirely different world to the one inhabited by those health ministers and MPs who were so recently deriding those who worked in primary care trusts (PCTs) and health authorities as “pen pushers”.

It was the pen pushing that drove them up the wall. And there was a total acknowledgement, repeatedly volunteered, from hospital chief executives to those in strategic health authorities (SHAs) that it was the engagement of clinicians, whether consultants or GPs or the other professions, that was the key to almost all advance – the facilitation of clinicians to themselves improve services. The opposite of the commonly perceived culture – and perhaps of the too-frequent practice – of managers trying to order doctors around.

As Ruth Carnall, Chief Executive of the London SHA put it, “if you want to have an influence on outcomes for patients and experience for patients, then what you need around you is the best, most diverse group of clinical leaders that you can possibly muster”. In different words, that was said time and again. The gulf between the public portrayal of NHS managers and what these interviewees see the job as being about was profound. How it arose is worth a study in itself. However it arose, it is clearly deeply damaging.

“We have gone the way of estate agents and politicians themselves in terms of public esteem,” Robert Creighton, Chief Executive of Ealing PCT, said. “The belittlement of managers and management by politicians in recent years made it very easy to become defensive, and hard to be self-justificatory. That sense of being constantly told that anything we did was irrelevant and, if not irrelevant, then positively harmful. It is terribly counter-productive. There was the comfort that it is not a view shared by the more thoughtful clinicians. They didn’t share this crap, and they knew that their success depended on the mutuality of good management. But it was dispiriting.”

Through all this was the central piece of advice that NHS managers and chief executives need to be clear what their core job is and stick to it, through all these other distractions. Cling to it, almost as an agenda of their own, regardless of the latest set of marching orders from on high.

That, of course, raises an interesting and difficult tension between political and managerial accountability in a tax-funded system. Is that an unresolvable tension or a manageable one? After all, these people came into health care to make it better, sometimes in spite of the environment in which they work. Being able to do that, they say, is the joy of the job. But they recognise that the service is politically accountable. And all of them recognised that leading

“Norman Warner, the Labour former health minister, asked if we had interviewed past health ministers on these subjects. We would have got, he said, a powerful feeling that the service, when viewed from Whitehall and Westminster, was very unresponsive; both to what patients wanted and to the goals set for it by ministers.”

the NHS these days is a job that, critically, involves building alliances with many others, both inside and outside health. It is not just about what goes on inside the NHS or your own NHS organisation.

The tension between central direction and local responsibility twangs throughout these interviews. There was a strong sense that people felt they would be able to do better if, within the broad goals that ministers set for the NHS, they were rather more left alone to get on with the job. However, at a session on the preliminary findings from this at the Nuffield Trust’s Health Policy Summit in March 2013, Norman Warner, the Labour former health minister, asked if we had interviewed past health ministers on these subjects. We would have got, he said, a powerful feeling that the service, when viewed from Whitehall and Westminster, was very unresponsive; both to what patients wanted and to the goals set for it by ministers. His point is well made. We didn’t interview health ministers this time round. But we did interview all the living former health secretaries in 2008 for the 60th anniversary of the NHS and they pretty much all said that in pretty much the same words.¹ The conflict between central and local, between political timescales and service deliverable ones, has been there since 1948. It is unlikely to go away.

The interviewees were not all chief executives. There is one chair in this sample, and a regulator, for want of a better word, who was not a chief executive. But, while recognising that the dozen interviews are in no way a representative sample, merely those who we identified and who were generous enough to find time to be interviewed, we did want to try to get views from, so to speak, every level of the NHS. So there are PCT, SHA and acute trust chief executives here, plus a more regulatory view, although not, we regret, a view from a former chief executive of a purely mental health or community trust. It is important to note that not all of the interviewees have left the service or retired. Some are in a different role but would like, as would some of those who have left, to return to a chief executive type job.

It is also important to note that these interviews have been heavily edited – down to a couple of thousand words in most cases when

¹ Timmins N, ed (2008). *Rejuvenate or Retire? Views of the NHS at 60*. Nuffield Trust.

“It is worth remembering that it is now 20 years since Virginia Bottomley first promised extensive publication of clinical outcome data, and the service is still struggling to achieve that.”

the transcripts ran from 12,000 to 20,000. So where a point is picked up as being made by most people in this introduction, it is not necessarily reflected as frequently in the edited interviews. That does not mean an interviewee did not make it. We wanted to maintain the variety of views about what was important, as well as pick out common themes. And we wanted to keep the tone conversational.

The interviews were about lessons for successors. But the personal, career type advice of the conversations rapidly became about policy, about the structure and the environment.

When it came to what might most improve the NHS, a repeated theme was transparency. Transparency around safety, quality and clinical outcomes; published into the public domain. Not so much as an aid to choice and competition. More as something that will create peer pressure across and within NHS organisations and NHS clinicians to improve; or provide the evidence for restructuring when the data show that quality and financial sustainability – two deeply inter-related issues – will best be achieved elsewhere.

Such transparency is, of course, the current fashion. That doesn't make it wrong. But it is worth remembering that it is now 20 years since Virginia Bottomley first promised extensive publication of clinical outcome data, and the service is still struggling to achieve that.

The annual planning cycle also emerged as a deep frustration. This is not an easy problem to crack, as Labour's period of government demonstrated. Then, at least conceptually in Whitehall, there was an attempt made to do something about it. The current financial position will not make breaking the cycle any easier. But the view was strong that annual spending rounds, and the near absolute requirement to break even each year, frustrate much sensible longer-term change.

Most of these interviews were conducted just ahead of the Francis Inquiry Report,² published in February 2013, which nevertheless hovered like a harbinger of doom over them. So there is little direct comment on his recommendations, although every word of what

² Francis R (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery Office.

Anna Walker has to say about them is worth reading. She has the advantage not just of having been chief executive of the Healthcare Commission, but she is now chair of the Office of Rail Regulation, having previously worked on the regulation of utilities.

Perhaps the most arresting interview is that with Andy McKeon. He, of course, technically has no successor, the health functions of the Audit Commission having been abolished. But he was one of the key group of civil servants who first devised the internal market and the purchaser–provider split back in 1988 and 1989, and he has been involved in and around the use of incentives in the NHS ever since.

“I am a disappointed man,” Andy says. That when it comes to hospitals, “the incentives we have got so far don’t really work and, if they work, they certainly don’t work on their own.” His key lesson is “don’t put your faith in incentives and clever policy,” at least in the hospital sector.

It is highly questionable, he says, whether all the effort put into choice and competition has been worth the results. Rather, he recommends, work directly on problems, ideally with the tools you have got. Reorganisation and legislation eat time, cause disruption and achieve less than was hoped. It is a sobering analysis from someone who, from a helicopter view, has seen and been involved in so much of that.

Repeated reorganisations came out as everyone’s top bugbear. When it was pointed out to the one interviewee who didn’t volunteer that as a big problem, he said: “Oh, I just took that as an absolute given.”

Structures usually get changed before they have had the chance to prove themselves or otherwise. Indeed, one of the ironies of the Lansley legislation is that PCTs and SHAs, having been disruptively reorganised at least twice from the days of primary care groups, were abolished just at the point when there was at least some evidence emerging that they were getting better at the job.

Interviewees were specifically asked if the NHS has a bullying culture; a common complaint and a feature of the Francis Inquiry. Views were highly mixed. Some felt so strongly. Others firmly denied it. No-one of course felt that described their

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own management style. But there was a sense that performance management can too easily tip over into that, and plenty of interviewees said they had seen people being bullied. The answer may be that the NHS is anything but one organisation and that the picture is very mixed. Certainly people believed that the culture of the best organisations was around transparency of performance, and clinical involvement and responsibility at all levels in the running of the organisation, rather than one driven by a purely myopic set of targets, which people were bullied to achieve at any cost.

As with so much else in these interviews, a nuanced picture of the value of targets, choice and competition emerge in terms of their value as a tool for improvement.

There was a lot of concern about general practice. The sense that it remained potentially the ‘jewel in the crown’ but one that needs re-setting if it is to sparkle – to fulfil the role it has now been given and to drive the changes to the pattern of care that most people believe are needed. There were considerable doubts as to whether the tools are there to tackle poor-quality general practice. There was a strong sense that it needs to be more organised, more corporate.

Tim Richardson, a pioneer of fundholding and total purchasing, and someone who moved day surgery, diabetes and much else out of hospital, was utterly convinced that the only way to achieve that is to create GP-led integrated care organisations from which patients can choose – using them, effectively, to destroy sub-optimal and unsafe district general hospitals, while the specialist care that has to be in hospital is provided from fewer but high-quality centres of excellence.

Scattered across these interviews are many insights and lessons for future chief executives. They include the central reliance on clinicians, data and evidence to drive change. And there are others that are deeply practical – Mike Rawlins’ advice, for instance, that if you ever get to chair one of these organisations, cultivate the opposition and rising backbenchers, not just the government of the day. It won’t always be there. And his advice that if you ever get invited on to the *Today* programme, go into the studio, not the radio car, however inconvenient that is. It is far harder for John Humphrys to bully and berate you eye-to-eye than on a phone line.

The collective view of the future was far from entirely optimistic.

In contrast to the 1991 reforms – which were in fact far more controversial, although that is hard to believe given the time that has passed – relatively few people saw this set of changes being stuffed with opportunity.

It may be the background of the people interviewed here, but there was much worry about the absence of a system manager. People were sure something would move into the vacuum. But it won't be statutory. And no-one was entirely sure quite how that would play out, though some tried to guess.

There was a lot of worry about fragmentation, which was less (with some exceptions) about markets, and more about divided responsibilities for service, research and education, and a profound worry about how many organisations and bodies now have to be consulted to achieve change. Some feared that the way the reforms have emerged, they may push more of the more difficult decisions about service change up the line, rather than the issues being resolved more locally – an outcome that would be the opposite of the reform's intention. Few saw markets and competition as providing much of the answer, though one or two did. Not that, again with one or two exceptions, they wanted choice and competition to be abandoned.

The view of the future, however, was a long way from being an entirely depressing one, even though everyone worried about the money.

If the former chief executives had lots of concerns about how the brave new world will work, they did still see some real opportunities – though chiefly as long as the principles of the Lansley reforms around transparency, choice and clinical engagement are adhered to, as opposed to the legislative practice and detail. Many of those who have been closest to the nascent clinical commissioning groups (CCGs) were decidedly impressed by the vision of the future that many of them have, even as they worried about whether CCGs will have the resources – resources being very broadly defined – to achieve that.

The sense was strong that the government could have got – and the service would have, at least up to a point, delivered – the bulk of what Andrew Lansley wanted without the legislation and the massive concomitant reorganisation. As Lansley himself once said,

“Amongst some of the interviewees there was a sense that the torch did indeed need to be handed to a new generation of NHS managers, both clinical and lay.”

“I could have done most of this without the legislation.”³

And among some of interviewees there was a sense that the torch did indeed need to be handed to a new generation of NHS managers, both clinical and lay, even if that was combined with a far from self-centred belief that too much experience and expertise are being cast overboard.

Preparation for being a chief executive – and the lack of succession planning – came through in some interviews. That the NHS Management Training Scheme is good, but that it is there only at the start of a career. That much more could be done, as their career progresses, to prepare people for these top jobs – both to build the next generation of managerial leaders and to support clinicians who take on managerial responsibility.

That seems to be an important lesson at a time when – after the denigration NHS management has faced over the past few years, and in the wake of the Francis Inquiry Report – there is a need for NHS management to rediscover itself as a profession.

There was a powerful belief that somehow – for good or ill and sometimes both – the NHS usually seems to muddle through, whatever the latest set of ministers is trying to do to it. Muddling through, however, is not what these interviewees wanted.

My final, highly personal, reflection on all this is to re-call the words of Roy Griffiths, the Sainsbury’s boss whose 1983 report⁴ introduced general management into the NHS – thus, in a sense, creating the jobs that almost all of these interviewees now hold: “Reorganisation,” Sir Roy said – and I think he meant reorganisation of structures rather than the restructuring of services – “is the thing that you absolutely should do. But only when everything else has failed.”

Whether that can hold this time round, when so much of the reorganisation has – in many ways for the first time – been laid down in legislation with profound new duties given to external rather than internal bodies such as the Office of Fair Trading and the Competition Commission, remains to be seen.

3 Timmins N (2012). *Never Again? The story of the Health and Social Care Act 2012*. The King’s Fund and the Institute for Government.

4 Griffiths R (1983). *NHS Management Inquiry*. Department of Health and Social Security.

The strategic health authority viewpoint

Dame Ruth Carnall



Dame Ruth Carnall has been Chief Executive of NHS London since 2007

My key lessons for a successor would be first that if you want to have an influence on outcomes for patients and experience for patients, then what you need around you is the best, most diverse group of clinical leaders that you can possibly muster.

The notion that you can take forward change in the NHS without ambitious, enthusiastic, brave doctors, nurses and others is nonsense. You can't do it without them. Finding ways to nurture that clinical leadership, not just from senior clinicians, but from emerging clinical leaders as well, so junior doctors, junior nurses, is essential. It's not the only thing which matters, but it is vital.

The second, again about leading change in the NHS, would be – be really careful about giving in, compromising solely in the face of political pressure. It's very, very tempting when put under a load of pressure from above to say, "Well ... we can at least get this agreed. We can at least get that done. Why don't we just go for that, put the rest on the backburner, and then come back and have another go later?"

My experience has been that compromising solely in the face of political pressure is a mistake. I've done too much of that, and I wish I hadn't.

Take south east London. When I came here, the original proposal, with a good amount of clinical support and backup, was to tackle the whole of south east London. So there would probably have been two trusts: Bromley and Queen Mary's Sidcup together, and Greenwich and Lewisham, along with big changes and investment in primary and community care. The Lewisham part of that was immensely controversial, and there was a lot of political and other pressure that we did not need to do it. And we gave in and put only Greenwich, Bromley and St Mary's into the South London Trust. Mortality dropped and their quality improved, but their financial position was a disaster. It didn't deliver something that was viable in the long run. And so we ended up with the worst of all worlds.

In the end we had to use the unsustainable provider regime, and as a result Lewisham now feels completely victimised because they feel they are being used to solve a problem that is only in the South London Trust. But it was obvious when you looked at the numbers

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first time round that you could not solve all the problems in south London simply by tackling one part of it. You had to look at the whole system, and I just wish that at the time we’d said no, “it’s all of south London or nothing”.

It would have fallen over very quickly and that would potentially have given us a burning platform that would have allowed us to tackle the whole of south east London, rather than now, four years on, after we have spent all this money and put people through a nightmare of process.

There’s a number of examples in London where we have stood up to the pressure and have seen the benefits. People now say the stroke changes were easy and everyone was on board. But that’s complete nonsense. The prime minister himself (Gordon Brown) was lobbied about it. Andrew Lansley phoned single-handed consultants and small departments in Barnet and Croydon to tell them that if they wanted to keep stroke, they should ignore the health authority and the market would sort it out.

But that was an example of where we absolutely stuck rigidly to what the evidence said a good model of care would be, and everyone now says, “It’s wonderful”.

It’s not easy. And I don’t want to sound arrogant or dismissive about the political process, but I sometimes think that rather than compromise, it would have been better to say, “We won’t do this at all because there is so little support for it.” Because when you only do half of it, everyone still hates it. The politicians still hate it. Everyone hated what we did in south London first time round anyway and it was a dog’s dinner in the end.

There is no silver bullet, but if I had only one thing I could change in the NHS, it would be publish and be damned on the information that we’ve got about quality and safety. Be much more assertive about putting information into the public domain about the safety and quality of health care services, at the level of the individual clinical provider, and make that as accessible as possible. Information drives change, and we have been really poor at it until very recently.

The best thing about working in the NHS is knowing that if you’re doing a good job, you’re having a positive impact on something

“This is the fifth time I’ve led an organisation that’s been abolished. The cost of it – not just the financial cost – is huge.”

that is at the centre of everybody’s life, something that is profoundly important to the entire nation, and profoundly important to the individual. The idea that you can be involved in something as part of a team that includes some of the brightest, best and most committed people in the country, and that you can see a positive impact on people’s lives as a result, what could anybody want more than that?

The worst is the constant reorganisation. The despair you have when another group of politicians come round with another set of ideas about structure. This is the ninth major national reorganisation in my career. I think in NHS London, I probably had the best team of people I’ve ever worked with. They understood each others’ strengths and weaknesses. They worked to capitalise on those strengths. That took time to build. And I think we could have delivered more or less what Andrew Lansley wanted. We could have put GPs much more in the leadership position. We could have dealt with some of the other things he wanted to do in principle in a different way, and had some continuity and maintained some momentum.

Instead of that, he arrives in May 2010 and says he’s going to abolish everything in April 2011. He doesn’t actually manage to get it done until April 2013. We’ve had two and a half years of trying to shore up a waning level of authority, and yet, continue to take responsibility for performance and finance and all of that, and try and maintain a commitment to deliver strategic change.

It’s hard to do that when you’ve got a declining level of authority. And I’ve experienced a version of that nine times over. This is the fifth time I’ve led an organisation that’s been abolished. The cost of it – not just the financial cost – is huge. That’s the fifth time, how stupid is that?

I like to think if he had turned up and said, “This is what I want to achieve – GPs in the frame, transparency, choice for patients, a market,” that we could have thought about how to deliver what he wanted. In many ways, it wasn’t in principle a long way from the direction of travel that we were going in anyway, certainly around quality, clinical leadership, patient involvement and transparency.

We would have more quickly got to integrated care by putting GPs in leadership positions, with us still here to support them, than we

are going to do with them left in the isolated position they're now going to be in.

I've been to visit most CCGs in London, and they're fantastic. There's some fantastic people there, with great ideas about what to do locally. But the capability and capacity they've got in terms of resources and support is woeful, frankly.

Things do get easier as you get more experience. When you are leading big, controversial change earlier in your career, the risk you are taking is huge. Without the right support it is very difficult.

The older you get, the more you can think, "Well, OK. If they can find somebody better to do this, let them get on with it."

I do think the complexity of the whole process of trying to deliver change has got worse. This may be rose-tinted spectacles, looking back. But the process that has to be gone through now and the complexity of it, the limitations on the power that you have to do things, the complexity of partnership working – all of that just makes it feel like swimming through treacle and you can run out of energy.

It is right that the NHS is more accountable than it was. But there so much of it. Overview and scrutiny committees – I've got 33 of them – the Greater London Authority, the Major Projects Authority if you are doing anything big, the National Audit Office, the Public Accounts Committee and the Health Select Committee, the Care Quality Commission, Independent Reconfiguration Panels, National Clinical Assessment Team. The potential for judicial review. The complexity and exposure of it do feel different. And if you are sitting in an acute trust there are hundreds of people who can come in and investigate what you are doing in one way, shape or form.

The other thing is that you can do these jobs, like mine, just by keeping the balls in the air. It is possible to survive and even succeed, if success is staying with the job, by just keeping everything going and not changing anything. So if you do want to actually do something and make changes happen, it feels like pushing a massive boulder up a hill.

You've got to have really good people around you in order to remain enthusiastic. You've got to have, as I said at the beginning,

a fantastic bunch of clinicians, particularly doctors, saying, “We’ve got to do this. It’s the right thing for the patients.” You’ve got to have all of that to shore up your own energy to do it. Otherwise, it’s impossible. And given that it is possible to do strategic leadership jobs in the NHS by not actually doing anything, it’s quite easy to fall back to that if you’re not determined.

As for the reforms, I think they will cause conflict to go up the system. There is the question of who is going to hold the system to account. You have got the Commissioning Board responsible for the CCGs and for some direct commissioning themselves. Then you’ve got the Trust Development Authority responsible for NHS trusts. Those two are going to have to work together and I think that in London, that will work well because of the people. The people who are in those jobs have worked together for a long time and are incredibly able individuals. But even so, I think there will be occasions where the conflict between them, just because of the pressures in the system, will be such that those problems will have to go upwards.

One of the things we tried to do in London, and I think successfully, is not allow problems to just go up – to manage them in London. But if you are sitting there in your CCG and you can’t agree with your local trust, where is the pressure to sort it out? So I think problems will go to the regional office of the Commissioning Board and then the Board itself and the Trust Development Authority, because the fragmentation will encourage problems to go up the system rather than to be managed down. Which is the exact opposite of the intention. We’ve now got 33 local authorities, and health and wellbeing boards, 32 CCGs and three commissioning support units; and we couldn’t make 31 PCTs work. And we have now got three local education and training boards instead of one deanery, and regional offices of Public Health England, the Commissioning Board, the Trust Development Authority and so on. I can’t see how problems at the system level will be managed other than them going upwards.

From a London perspective, I’m very worried about the impact on research, specialist services and teaching from national silos, because I believe in the synergy that comes from having the three together. I think it’s a vital synergy for the country as a whole that exists mostly, but not exclusively, in London.

“The whole environment of 100 per cent targets whereby failure was 99.9 per cent ridiculously distorted behaviours around the 0.1 per cent.”

Somebody needs to look at those three things together because if you degrade one of the three, then your ability to do the other two is immediately affected. I think that is a big problem for London. There is nowhere at all in the new system where those things come together.

You ask whether the management culture has changed over time. I think it has. I'm surprised post-Francis that there's been no real discussion of the Milburn era. Because when I look back, that was the point at which the 'targets above all else' environment was created.

There have been a lot of benefits from targets. But the whole environment of 100 per cent targets whereby failure was 99.9 per cent ridiculously distorted behaviours around the 0.1 per cent – and the money and everything being thrown at the 0.1 per cent. All of that started then, and it was very distorting, and sometimes that felt like bullying.

If you bully somebody who is weak, they will then do it in turn. I can think of lots and lots of people who don't do that. I like to think that I fall into that category, that you have a proper discussion with people about what needs to be done. It's not to say you don't take tough decisions about people. I've done enough of that. But you handle it in a way that is respectful to them, their teams and their function.

And if it is because a job is just too difficult for this person, or the circumstances mean they no longer carry confidence, you handle it in a way that allows them to recover, to take their career forward – unless it's gross misconduct and all that. They don't have to be bullied. They don't have to be gagged.

The first time I ever met Alan Milburn, the very first time, he said, “Why is everything in this region so f*****g crap?” He didn't say hello. Why would anybody behave like that? I found it absolutely astonishing. And, of course, some of the people who were around him soaked all that up and transmitted it. Not all of them. NHS management is not all the same.

And I do think it has changed since then, from Ara Darzi's time. *High Quality Care for All* preceded by *Healthcare for London* and other work that was done around then substantially shifted the

focus towards quality and outcomes. I think some of the work that Sir Liam Donaldson did created a focus on safety that hadn't been there before. Ara and others managed to get quality far more at the forefront of people's mind. In London we had people like Steve Smith, David Fish and Robert Lechler talking about the synergy between research, specialist provision and teaching, and how that would generate improvement across the system and produce high-quality services. Ara wanted to take service change forward on the basis of evidence. His line was to centralise where necessary and localise where possible. And later, Cyril Chantler always having a mantra about quality, safety and integrated care. All this provided a platform for our leadership of change in London.

I'm not saying that it did away with the target culture. It didn't. But I think it created a counter to it.

What would make the job easier? Well, getting rid of some of the mountain of process we've talked about. And if we could pull everyone together, including the politicians, and make an absolute commitment to putting information about safety and quality into the public domain – and not bottling it when it actually shows up some difficult things.

There is still a problem when you say you want to change services on safety and quality grounds. When you do that, good people start to leave, so services can get even worse. There's no easy solution to this.⁵

But if it's a choice between having the public clamouring for you to do this quickly because the service is not good enough, or battling, day in and day out, through a minefield of bureaucratic process that's designed to stop you doing stuff – and in the end getting only a compromise – if those are the choices, then I'd go for everybody clamouring for it to be done tomorrow and have to explain why it's going to take six months, a year, or whatever, because quite often you can put something in place in the meantime to mitigate risk – if it's temporary.

⁵ Also see: 'Ruth Carnall: take the shakes out of the shake-ups'. *Health Service Journal*, 5 July 2012. www.hsj.co.uk/opinion/columnists/ruth-carnall-take-the-shakes-out-of-the-shake-ups/5046480.article

“So, no money, and loss of public confidence post-Francis. The environment is hostile. The organisational structures we have set up won’t work. They will need to be simplified.”

The challenges post April? They include the money getting more difficult. So the productivity agenda is very significant. That will force people to look more seriously at how we use expensive hospitals, capital and equipment. There will be a lot of pressure to create more integrated care pathways for patients, because that’s both good quality and efficient – although the organisational structures that we’ve now got don’t facilitate any of that, not really.

I think the challenge will be creating effective means of working across the boundaries, which have now been created, without always having to go upwards to solve things. So that’s about networks. But networks are weak organisations, aren’t they? Networks are great when everybody agrees. It’s difficult when they don’t because no-one is in charge.

I think that the three Academic Health Science Networks that we’ve created, working together, can fill some of the strategic vacuum. But they are voluntary bodies. They’ll be dependent upon the personal leadership qualities of the people in charge.

And I think the structures we will have are incredibly complex, incredibly difficult to understand. The complexity is too great and will have to be simplified. But if you look at the underlying principles – this is the sad aspect – of what Andrew Lansley wanted to do, I think that those are absolutely right and can succeed. GPs in leadership positions. Transparency around information. Choice for patients. All of the principles underlying it are absolutely right. But when he got such massive opposition that he had to pause, we ended up with the most amended bill in history and organisational forms that are too complex to deliver the change needed in an environment that is not benign. In my view, it’s the structured change part which is so wrong and so wasteful.

So, no money, and loss of public confidence post-Francis. The environment is hostile. The organisational structures we have set up won’t work. They will need to be simplified.

Candy Morris



Candy Morris is the former Chief Executive of the South East Coast Strategic Health Authority

Advice for my successors? First, keep a relentless focus on what you're there for. A real focus on high-quality health and care. Don't get sidetracked. Second, humility. Keep listening. Keep learning. Keep an open mind. Seek out others' views. Don't think you know it all.

Recognise what you can't control. Be absolutely superb at what is within your influence and authority or your connections. Don't spend time and energy agonising on what absolutely you can't fix, and I guess that applies particularly to some of the political environment.

You can get distracted by focusing on only one element of the job. You might say that is what happened at Mid-Staffs. People lost sight of the core and focused on some elements to the detriment of others.

I've been a chief executive of one sort or another for nearly 20 years, and I am a bit of a change junkie. This may sound really odd, but I love the way the environment changes around you all the time. Whether that's because of new technologies, political changes, increasing societal expectations, greater transparency and all those sorts of things. It is never a dull moment. I just love that. I guess it is important to me that I'm doing something which I believe in. I have a fundamental belief in the NHS and what we're doing as servants of the people.

Among the biggest frustrations? Well, things can be slow. As I've got higher up, and as I've been more part of the DH [Department of Health] environment and so on, you begin to understand why things seem to take a long time. You can understand all the machinations that go on, and the very careful positioning, and the way people have to be aligned and so on. But when you're out in the field, it can actually feel bureaucratic and frustrating.

You need to have your systems and processes and structures and so on. But they should be there to serve the purpose, to make it easier to fulfil the purpose, not sometimes to appear to get in the way – and at times of big transition, not just this particular set of reforms. But if it is a trust merger, for example, people who are part of the current regime don't necessarily want to commit to the future, and the people of the future either aren't known or don't want to take it on yet.

So you can lose pace, and it can feel very bureaucratic and frustrating. It is not through ill will. It is just a consequence of transition. And part of your job is to try to compress and mitigate all that as much as you can.

When it comes to trust re-configurations, much of that lies within leadership, and with the trust boards. There is much more within your own power than sometimes people recognise. Sometimes people seek permission rather than simply getting on with it.

We have to live within employment legislation, and all those sorts of things. We just need to be smart about operating within the system. Again, if you go back to the humility point, you need to learn the lessons from others rigorously – What went well for them? What tips can they pass on? If we don't do something very well, what are the lessons learned? What do we do next time around?

And I'd say, be optimistic. Surround yourself with optimists! You need people who are realistic, but there's nothing worse than having people who only and always see the problems.

Amongst other things, I am senior responsible officer for the southern programme for IT. Some of the business case and approval processes for that have been confused, duplicating, slow, unwieldy, over-administered and under-managed. But there have in fact been a lot of successes from the IT programme. More than most people give it credit for. Prison health care, digital imaging, the national spine which enables information from everywhere around the country to join the Christmas tree and be analysed and used for commissioning, surveillance and planning, and for virtual wards and all that. It has been first class.

The electronic care record, which is the bit that everybody thinks about, hasn't been so successful, although in London and the south, with BT, it is now finally progressing rather well. I think none of us – including the companies that got the contracts, the NHS itself and the Department of Health – realised the scale of the endeavour. How hard it would be to develop a UK-friendly version of the software so that it would actually do the business. We were all culpable of that.

Things we have gained and lost? Some things have become almost cyclical. I have been in the NHS since 1977. In my early

days as a trust chief executive, clinical leadership, clinical general management, developing first-class information systems, developing patient-centred service management, including cost performance and things like that – all that was very much to the fore. It's what we did. I had a director of clinical effectiveness and a director of research. All my divisional general managers were clinicians. Then that died away across the country. I don't mean completely, but it slipped back in too many places. You might still have clinical directors or clinical leaders, but they weren't held to account, or weren't given the authority that was needed.

But that is coming back. And we probably saw some of the nursing standards go backwards as well. Things that we took for granted in my initial time. Of course, over the last few years, that's all come to the fore again, which is absolutely right. I'm not quite sure why we lost the absolute focus on those things.

You ask how I would describe the NHS management culture. Well, I'm not sure there is a single culture. Even within a single NHS organisation, different trusts will have different cultures within particular departments, or teams, or specialisms. What, I think, trust leadership needs to do is work to develop a prevailing contextual culture. Recognise that there will be legitimate differences, but that you must have prevailing core values and approaches.

Some people will describe the NHS culture as 'command and control', or even 'bullying'. I think that there are elements of command and control, particularly around the access promises and finance.

People talk about 'hitting the target and missing the point', and I think that's completely possible. You stick to a bunch of processes to provide an outcome while delivering a really awful service.

The four-hour A&E target might be an example. Rather than focus on, "we're going to have a really good arrangement, so patients really are seen, and they really get the right attention, and really have the right tests, and then we can make the decision – and, by the way, gosh! we've done it within four hours." Instead people focus on how they can use processes to meet four hours, even if that's not necessarily the best care for the patients. Some people focus on the wrong end of things.

“Do I think the reforms will succeed or fail? Oh, I think they’ll succeed. The NHS leadership, managers, clinicians, all have an extraordinary track record of making anything work.”

I doubt the NHS is different from any enterprise in terms of management culture. There will be as many different managerial styles and leadership styles in the NHS as elsewhere. Part of your job is to protect people from what can feel like a command and control culture at times, and there can rightly be absolute intolerance of poor performance. But I certainly don’t agree that somehow the NHS as a whole has a bullying culture. I absolutely don’t agree with that.

You ask what big change I would like to see? I’d like to really speed up getting the right digital environment everywhere, so that we genuinely have got a seamless record, and so that there is real transparency on data for the service and for patients. So patients have access easily, not just to their own record, but in a way that lets them be a co-producer. They can’t just book their appointments online, but they can talk to consultants, or whomever, in a way which is easy. The digital environment, and all the opportunities that offers, is something that we just need to get done.

I am also one of Sally Davies’ research champions and I would really like to get that triple helix of service, research and learning working properly. Adopting the best evidence, but also pushing the boundaries – putting patients into trials, and seeing that as part of the normal clinical mainstream conversation and one that patients are involved in. And facilitating that by social media and the digital age, so that we are all part of the same endeavour.

And I am very much in favour of the transparency agenda. Publishing clinical outcomes, and so on; although I think there are considerable professional challenges in that, in having your performance or your unit’s performance put in the public domain for all to see. It is something we can use as a positive lever, but some people will find that quite hard.

Do I think the reforms will succeed or fail? Oh, I think they’ll succeed. The NHS leadership, managers, clinicians, all have an extraordinary track record of making anything work.

Part of that, I’m quite sure, is fuelled by this fundamental belief in what we’re here to do, which is improve care. It is really important that we have a safe landing, and a safe handover. And I am sure some people will find they have been appointed into roles which aren’t quite what they thought they were going to be, and there will

“There is a lot of very complex work to be done, and across organisations. But sometimes, when you are under real pressure financially, that can sharpen up and catalyse thinking and action.”

be some churn. Equally, building relationships across all the new bodies when power and accountability has been distributed will be harder. And I suspect some of the new organisations will evolve over time. Not necessarily mergers, but things coming together under an umbrella network.

My view is that the health and wellbeing boards and the Academic Health Science Networks will play critical, glue-like, roles. The Academic Health Science Networks bringing together providers, commissioners, industry, education and research and so on with a real focus on improving diabetic care for Mrs Smith, or whatever. And the health and wellbeing boards for the strategic commissioning.

The money does feel hard, even though the NHS has done well compared to other sectors. We do need an enormous amount of change, for example re-engineering care for and with frail elderly people. There is a lot of very complex work to be done, and across organisations. But sometimes, when you are under real pressure financially, that can sharpen up and catalyse thinking and action. The money will be hard. But I remain an optimist.

The acute sector viewpoint

Dr Chris Gordon



Dr Chris Gordon is the former Chief Executive of Winchester and Eastleigh NHS Trust

It is all about the patient, isn't it? We're going to get this post-Francis chorus around, "It's all about the patient." Well, it is. It absolutely is. But, to deliver care for your patients you also have to pay attention to your staff, who actually do the work. I was chief executive for two years of a small and pretty challenged trust and I had 2,500 members of staff.

If you've got 2,500 people, at any time of day, there's a fairly good chance that one of them is either at risk of doing something wrong or is struggling to do it right. Everybody has their Friday afternoon moment. So it is about people, and understanding the staff, and trying to make sure they are working in an environment and culture that supports them in doing what the patient wants and needs.

In management speak, that boils down to risk. It's how you limit or mitigate risk, and very importantly how you respond to error, because you can't ever remove it completely.

People talk about hospitals and they like to compare them to widget factories. But very little about health care is actually widget activity. It's more like a garage under the arches really. You're trying to repair and refurbish a huge range of pre-used models, some of great antiquity, rather than manufacturing new ones, and you have every conceivable make to work on, and most of what you do has no spare parts at all. You can carry that analogy too far. But it is an incredibly complex task.

People also say a hospital's turnover is equivalent to a FTSE 250 company. But most of those organisations, maybe they've got a couple of hundred lines or products. You've got thousands. And you have lots of staff, some of whom are the most skilled and trained people on the planet, and some of whom are being paid not much above the minimum wage, and some of those are delivering a large portion of bedside care.

In many parts of the country, for some people, you're comparing the opportunity to come and work in my hospital to getting a job behind the tills at one of the major supermarkets. The pay is not much different, and the hassle factors are going to be different.

I used to have the luxury of doing the induction talk for staff. I'd say, "I need you to be coming to work here because you want to

“Unlike Sainsbury’s or Tesco, people do not choose to come here. They are either in pain or suffering some kind of a problem; they’re scared for themselves, or they’re scared for somebody else, or worried about the future.”

work in this hospital, not because you just want a job. You must want to provide care and compassion or you might be here for the wrong job. Never forget that the person you’re dealing with is somebody’s grandmother, mother, son, father, daughter, uncle, aunt, whatever.”

And unlike Sainsbury’s or Tesco, people do not choose to come here. They are either in pain or suffering some kind of a problem; they’re scared for themselves, or they’re scared for somebody else, or worried about the future. They’re perhaps very worried because they understand too much about the future.

So they’re usually going to be in some kind of a situation, and so not always in a particularly good frame of mind. You are providing personal care to people who might be in a difficult emotional state, and you have to give something of yourself to work well in that environment.

So how do you get that message across to two and a half thousand, or in a large trust, nine, ten, eleven thousand people? You have to tell it around personal stories and get them to do the same. Sometimes very simple anecdotes. Like a lot of hospitals, mine – and I still work there as a doctor one day a week – is built on a funny site and is a bit of a rabbit warren. I used to tell people that when I first arrived for an interview some years ago I had to get someone to show me to the interview room. And I am very proud of the fact that almost every time I walked down that corridor I could see some member of staff helping someone, saying, “Do you know where you are going? Can I help?” Concerned about people’s welfare and carrying that all the way through to bedside care.

As a chief executive you must ensure you concentrate your drive absolutely on the core business, which is patient care. A lot of hospital management teams risk diversion from that towards money making schemes or balancing the books by ham slicing. That was part of Francis. There are always external relation issues, challenges, negotiations. And some of the transactions you have with your commissioner, and your conversations with the SHA are pretty hardball. There’s not a lot of love lost sometimes.

But those conversations have to be separated to some extent from the care that you’re delivering because you have to focus on providing that care safely. If those conversations get particularly

difficult, I think it's extremely easy to get your priorities mixed up.

You have got to have a clinical strategy. I have been around a lot of organisations in the last year providing a confidential advisory service for trusts on strategy and delivery. And very few can pull down something from the shelf that is jointly owned by the clinical staff and the senior management as to what services they know they should and can provide at a high quality, and how they're going to develop those services over the next three to five years, what they need to do, for instance around partnerships, and how they're going to do that.

High-performing organisations have those strategies. And you wonder how people can really run an organisation with assurance if they don't have that.

You have to have the clinicians involved. We've still, in a lot of places, got this difficult relationship between doctors and management. There is a long history behind it. Medicine is an unusual profession in that you get to the age of 35 before you assume any responsibility that might be outside your usual job. You go into a civil engineering firm, you are going to have some kind of budget to manage by the time you're 25. But in hospital medicine you are in training until you are 35. And then we say to them, "We'd like you to be divisional director for this or that" and give them 10 minutes with a junior HR person about the HR rules and "off you go". So no wonder they feel unskilled, or not ready to do it.

Management is much more hierarchically structured. And there is mutual suspicion. Managers have heard these tales of surgeons throwing scalpels around the operating theatre all the time. Or they believe the doctors are obsessed with their private practice. And the chief executive worries about how he or she can be sure about performance and accountability if they delegate more responsibility. After all, "I am the one who takes the hit, whether it is clinical, or organisational or finance," or all of those things.

It's not a matter of fault. Or, if there is a fault, it is on both sides. Because I am now 'bilingual' so to speak, a fair bit of what I have been doing this past year has been brokering those conversations. Going in and talking to doctors who say, "Well, we would quite like to be taking more accountable control of the organisation.

We don't like the way it's run. We'd like to be more involved, but they won't let us." So we brokered a conversation, or a programme of management development, and we help give them some tools.

It is changing. There are doctors at all levels who are more willing to do this than 20 years ago and more managers who recognise the need. So there are grounds for hope. But there are still too many places where this does not happen.

What else? Well you absolutely cannot let quality go. I do think there is evidence that if you do things right the first time, if you avoid avoidable harm and you focus on delivering quality, then you will get efficiency.

Then I think that if I was running a hospital again, which who knows maybe one day I will, I would fill the place with mystery shoppers, also known as patients. I was just about to stop being a chief executive when Winterbourne View came out. I wanted to speak to Channel 4 and say, "Can you bring your secret cameras into my hospital, because if there is something less than good in my trust, I want to know?" Instead I assured myself we had enough to be confident of the quality of our care by more conventional means.

Because there is a big question about how do we get an accurate picture of what the patient experience actually is? So that we know, not just from when we ask them a week, or a month or six months down the line, and when and what to ask, as it is so easy for responses to be distorted by their desire to please the doctor, or the nurse.

One of the most difficult things about being a chief executive was dealing with the emotion. Making really difficult decisions while taking the emotion out of it. Mine, but mostly other people's, who were emotional about their futures or the services they provided.

At Winchester we went through a merger with Basingstoke – well an acquisition, technically, as they were the foundation trust. I spent a good deal of time helping people see that this is a really good idea, an opportunity, and that they had to seek the positives, the wins. Let's think together dispassionately about what's the right thing to do for the people who live and work in central Hampshire. What should be the model of care to provide that best service?

There was a story to be told around size, and critical mass and clinical efficiency, and providing local care for local people in a better way.

We were quite challenged financially, and we had to deliver a massive savings programme without loss of quality, whilst improving service performance. We managed to do that and I'm very proud of my team for the achievement, although it was extremely challenging.

During that time there was some additional risk and uncertainty. People start to think of leaving, alternative options. People might start to worry about their own futures rather than the job at hand. And even if you say, "Your job is going to be there but some of the service might move to here, or to here", they worry about how they will get the kids to school, the practical day-to-day.

It comes immediately to the person. That's human. You expect that. You have to describe the story in a hundred different ways to thousands of different people on a regular basis and keep some consistency about it. To encourage them to be where they needed to be mentally and emotionally to cope with the change and uncertainty.

The best thing about working in management was being able to do that. As a doctor, you get a one-to-one reaction with the patient. I still do it and it can be addictive, an instant hit, very rewarding. You get a direct response. You deliver good care, you give a good opinion, you get an immediate reaction. That's hard to beat.

But in executive leadership or management, you get a little further away from the patients and lose some of that immediacy, but by influencing the way that a clinical service runs, you can be excited by influencing the future, or the outcomes, or the experiences of thousands of people. That's where doctors running services get their rewards.

One of the frustrations is complexity, and conflicts of agenda. We were trying to create an integrated care service that crossed the lines between the acute, primary and community sectors. And as stakeholders we all said, "We are here for the patients." But we were here in different ways. Each of us had a primary responsibility to

“One change I would like to see would be the ability to have a more long-term planning relationship with commissioners... the 12-month planning cycle is very destructive.”

deliver for our organisations, our own financial bottom lines, targets and outcomes.

When you are appointed as chief exec, you get an Accountable Officer letter from David Nicholson that puts up your heart rate. It just reminds you very clearly and unambiguously of your personal accountability, kind of thing. You get it wrong, you can be up before the public accounts committee. It's pretty scary, as clear as a letter from the GMC! A chief exec's responsibility is to 'deliver' the trust.

So you have three organisations each talking the same language. But you stand still. There is a lack of progress because the priorities of the organisations are not aligned.

However, we did successfully do some integrated care work around discharge planning, length of stay for the frail elderly, for instance. And that worked really well because we had trust. We made some pretty good alliances and that worked because senior people in the partner organisations built up trust and were signed up at a personal level to do it.

One change I would like to see would be the ability to have a more long-term planning relationship with commissioners. To be able to say, “This is what we'd like to do over the next three, five years to ten years.” The 12-month planning cycle is very destructive. We need some new contracts and approaches that allow that – including the ability to break even over a number of years rather than just the one year. The arcane management accounting process that trusts go through is complicated and inflexible. We need to write a new set of rules that reflect what we are actually doing and trying to do.

Among the good things? Oddly, payment by results was a good change. It is much knocked. But it does relate activity to income as at least the start of a conversation. It allows people inside the organisation to do the maths around service line reporting, and that allows individuals to benchmark themselves on performance and quality and those sorts of things.

Constant reorganisational change is a massive distraction. I don't know whether it's going to end up having been a good thing or not. But, from the outside looking in, commissioning has been in a state

“The reforms will succeed if CCGs retain a strong clinical commissioning difference from PCTs. There is a real risk that CCGs will turn into PCTs in the future, in which case, we will have done a huge amount of change for no great benefit.”

almost of paralysis over the last couple of years. I feel for the people in the PCTs. They have had a really rough time.

The main challenge for delivery organisations is going to be having a commissioning relationship with the CCGs. Some trusts will have one CCG, and if the CCG is big enough, they’ll be able to have a reasonable relationship with them. Other trusts will have four or five or six CCGs. It is more difficult to do collaborative working with five or six organisations. That’s going to be one of the biggest challenges.

The reforms will succeed if CCGs retain a strong clinical commissioning difference from PCTs. There is a real risk that CCGs will turn into PCTs in the future, in which case, we will have done a huge amount of change for no great benefit. But having said that, I’ve seen a CCG in an area with real challenges, which has got a live clinical strategy. They have big structural problems, with two hospitals that are not big enough, and a population which isn’t big enough and the politicians causing hell.

But we helped them organise a big joint session with the acute hospital consultants and executives in the room, the CCG and the local authority and patient representatives, and there was this light bulb moment with the doctors towards the end of the day when they said, “We have kind of sorted out the orthopaedics, and the general surgery. We know about stroke. We are getting there.” Working together.

And there are some really, really good CCG leads who get it. But they need to be encouraged and supported and not allowed to burn out 12 months from now.

Brian James



Brian James was Chief Executive of the Rotherham NHS Foundation Trust from 2004 to 2012

My first key lesson for my successor would be to understand what you can and can't control as chief executive of an acute trust, because there is a surprising amount that you can't control.

What 'business' do you know of that cannot control its wages or its staff's terms and conditions of service? Cannot control its prices, or most of its costs? Only has one 'buyer' and cannot really negotiate terms with them? Cannot refuse to deal with its customers? Is required by law to deliver services even if they are unaffordable? And whose board is held to account for every failure of national policy? That's us!

Secondly, when the latest policy or directive comes down the line, you need to concentrate on how you translate that into a language that makes sense to the staff, and to find a way to implement it without losing sight of your core purpose – which is delivering improving services to patients and the public. And third I would stress the importance of collaborating with your clinicians and developing clinical leadership. You have to choose the people carefully, but recognise that they are key and that you need to develop both clinical and managerial talent, both for now and as your successors.

The best bit about being an NHS chief executive is that it is the most satisfying job that you could ever aspire to. The diversity of it, the complexity of it, the interest and the sense that you are doing a public service, that you are working for the public good. All of that is immensely rewarding. And when I've employed people from outside the health service at quite senior levels, some of whom stayed and some of whom didn't, all of them still said that, in those sorts of terms.

The worst thing about working in the NHS has got to be that it undergoes politically driven reorganisation every three years. The difficulty of continuing to develop the service when everything around you is constantly being reorganised. All those crucial relationships you have built up with individuals being broken. And especially when you can't understand the purpose behind the changes, and how the newest set of reforms is meant to translate into benefits for patients. Running alongside that, a close second or even a draw, is the sheer bureaucracy. The volume of top-down stuff

“The huge number of regulators and the amount of information they demand, often the same information in different forms, and the massive amount of money being spent to feed that beast.”

that is dumped on a chief executive’s desk is phenomenal. And it all has to be dealt with, when the real job is about patient care.

I also think it is very difficult to be innovative in the NHS, and steer your own course, because the whole system drives the need for conformity. If you move too far out of the pack, people above you start to get exercised. I’ve done it a few times, and I am not sure it has done me much good. You come under pressure to conform. Take the National Programme for IT, which in my view was a disaster from day one and has consumed vast amounts of money for little benefit, and which has now left many trusts with systems that are more than 20 years old, at a time when there is no money to pay for new ones. The pressure to conform, to take part in it, was enormous, with the threat of ‘consequences’ for not for doing so.

And another example. We needed to plan two or three years ahead – to 2015 – how are we were going to deal with the £20 billion Nicholson Challenge? We were talking to the unions about what it would mean for staffing. That the trust would have to operate with some 750 fewer posts by 2015, and how changing some terms and conditions could help reduce that figure. This issue was then hijacked by regional union officers and the next thing was headlines in the local press to the effect that 750 staff were to be made redundant imminently, with a call for strike action – even though we made it clear that forward planning would mean that the majority of losses would have been perfectly manageable through natural turnover. Subsequently, a national agreement was reached about changes to the terms and conditions. So in a sense it would have been better to have waited. To ‘hope’ that something would be done nationally to help deal with this. But to be passive, and behave as a victim of circumstance, and wait for something to happen – well that’s simply not me. My approach – to lead the organisation through such challenges – seemed the only logical thing to do in the apparent absence of any national strategy. So being innovative and setting your own course, trying to manage your own destiny, is difficult and, as I have learned, sometimes counter-productive.

The bureaucracy includes the targets and all the reporting up the line of endless key performance indicators. The micro-management from the centre. The huge number of regulators and the amount of information they demand, often the same information in different forms, and the massive amount of money being spent to feed

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that beast. It is very expensive. Every now and then we have an outbreak of common sense – I remember Korner who rationalised information collection around only that needed to manage services effectively. But it just grows back again, and most of it is just a huge distraction from getting the day job, the core job, done. We are now asking every patient did they feel better after their operation. Surely that could be done by some sort of sampling? It just gets translated into a massive bureaucracy.

Things are easiest to achieve when clinicians and managers at all levels are lined up behind what you all want to do to improve the service. So when we talked to our patients they told us that their biggest concerns were first the waiting – the wait to see the specialist and then the wait from seeing the specialist to get treatment – and second their worry about getting a hospital acquired infection. And when we got everyone to accept that this was what was most important to our patients, then we got clinicians and managers all working on it so that in 2009, I think, Rotherham was reported through the National Patient Survey as having the shortest waits in the UK. We also pretty much eradicated MRSA as an issue and went for three years without a single case. But it wasn't the result of government targets. You get people to do that when they truly believe that you are motivated by what is in the best interests of patients, not because you have been told to do this in order to meet political objectives. Another example is when we started discussing with consultants the need to move to seven-day working, not because we were being told to, but because of the benefit to patient care; that it would be good for patients.

What I wish I had known before I became a chief executive is how lonely it is. There is very little support, and there is no real training for it. Indeed, you can't really be prepared for it. It is very different to being a director. I was a director for nearly 20 years before I became a chief executive, and it is just completely different. The way people treat you. The way they see your role. And it takes time to grow into the job and develop the skills, and build the relationships and networks that you need – with the PCT, regional officials, the council and the chief executives of other public sector bodies. The relationships that are crucial to doing the job. Learning how to manage the consultant body. You can talk to people about it, what it is like – and I have to those of my directors who have gone on themselves to be chief executives. And they all agree – there is

nothing that can prepare you effectively for how different this role is to any other.

The most productive change in my time in the NHS has been the elimination of waiting. That has been fantastic. The least productive has been the direction of travel of successive governments over two decades with the market reforms. I am not a believer in them. I think they have done a lot of damage. And I worry about where they are leading us. Payment by results and all of that is taking us to a point where small and medium hospitals will be seen as non-viable. They will be bankrupted by the market and more and more will be pulled into the big teaching hospitals. But for people in Rotherham or Doncaster, that will mean Sheffield and that is going to mean a huge amount of travelling for poor people – and Rotherham is full of poor people – who will need to get three buses and a taxi to go and see their loved ones in hospital. I think it is very questionable where it is all leading us.

Does the NHS have a bullying culture? Well, I certainly hope not in the organisation that I ran. But what comes down the line is very oppressive, and yes I would call it bullying. It is not overt. It is more subtle than that. But those higher up are under huge pressure to achieve political objectives and their careers are at risk if they do not achieve them and that pressure comes down. And you know that if you don't perform you are finished. You are really finished. And the NHS is very unforgiving if you are in somewhere that hits real problems. If you have been anywhere near somewhere like Mid-Staffs, regardless of what role you may have played in it, the rest of the service almost conspires to shun you. The idea that you can be a whistleblower without being finished is ridiculous. Those in influential positions will make sure that you never get another job in the service.

You asked about me inviting the television cameras and Gerry Robinson in for the *Can Gerry Robinson Fix the NHS?* series. Well, it was personally bruising. But the impact on, and benefit to, the organisation was considerable. I was a new chief executive at the time, having taken over a hospital that needed to change the way it was thinking. I knew what I wanted to do and I saw Gerry as a way of helping us think about delivering high-quality care in a business-like way. At the time, the consultants thought that managers were only motivated by targets, not patient care, characterised by the

“There has been, and there still is, huge uncertainty and lack of clarity about the new system on a scale that I’ve never seen in my 37 years in the service.”

scene where the consultants were talking in derogatory terms about managers only having three O-levels. And that Friday afternoon in the operating theatre, which he said was like walking onto the “Marie Celeste”, it was just awful. But it was a mirror. And it had a cathartic effect. Within a year the situation had been transformed. Consultants, other clinicians, managers and staff agreed that what was shown on television was simply not acceptable. So it absolutely moved things on, which I hope viewers recognised from the follow-up programme. As he said when he returned, “the place was humming”.

Am I optimistic about the reforms? No, I’m afraid I’m not. The last two years have been quite awful. The rhetoric about no fundamental change from the incoming Government followed by the biggest reorganisation we’ve ever seen. There has been, and there still is, huge uncertainty and lack of clarity about the new system on a scale that I’ve never seen in my 37 years in the service. There are still many people out there who don’t know what, if anything, they will be doing a month from now. It’s chaos, really. And now we have the Mid-Staffs report on top of it all. And the £20 billion savings is going to make things incredibly difficult over the next two years. It is only in the next year or two that we will start to see the full effects. But it effectively means in my hospital that we would need to operate on £50 million less than we had two years ago. I think something will have to give on that.

And I do worry that if the market puts small and medium sized hospitals at risk, which it will, I fear it will become increasingly difficult to attract leaders who want to be chief executives to those hospitals because of the sense that, ultimately, if you take one of those jobs, you will end up having to resign or getting fired.

I do wish the reforms luck. No-one wants to see the NHS get into real difficulties. But I am not optimistic. The creation of a market in acute care has not worked, and it feels increasingly at odds with what the NHS needs to deliver in the future.

Dr Lucy Moore



Dr Lucy Moore is the former Chief Executive of Whipps Cross University Hospital Trust

Key lesson? Keep thinking about patients. Because a lot of the things we have to deal with can be potentially very distracting and diverting. You can always bring yourself back to your core purpose by thinking about patients and being very clear about what you're doing that's going to make a difference today, tomorrow, the day after that.

One of the privileges of running a hospital is that you're actually pretty close to patients. You can see, feel, breath them just by walking down the corridor. Although much of your time might be taken up with the next set of questions from the competition panel or the strategic health authority or something like that, which may seem very remote from patients.

You've also got to enjoy yourself – which I have. It's a hugely enjoyable environment, and very rewarding – despite some of the challenges and the coverage you get in the media which is particularly difficult at the moment. Actually, I don't think anything beats being an acute trust CEO.

The other lesson is about resilience. The ability to keep going despite things that are mad, odd, impossible, don't make sense...

One of the best things about being an NHS chief executive is the complexity of it. All these multi-dimensional things that move and getting them to work for the benefit of patients. I get a buzz out of it.

The worst job I have had was as a junior doctor. I started out in paediatrics before moving into public health, and I've been in management for the last 15 years. I was doing a neonatal job, which required you to work from 8 in the morning until 10 the following morning and you literally usually did not get to sit down in that 26 hours. This was looking after very sick, very premature babies. The particular unit I worked in, they had no understanding of the human side. One example that sticks in my mind was that when they moved the unit because they were refurbishing it to the floor below, they forgot to move the doctor's bed – used when we did get a chance to take a breather. The solution was to hook up an intercom from the old (bed)room to the new neonatal unit. You could hear the baby's heart rates going down, which meant that

“Part of the problem is that NHS doesn’t operate its leadership development at scale and never has done.”

there was a crisis and you needed to hot foot up a floor to take action. It was just surreal.

It was part of what drove me into management and leadership. The sense that surely we can do better than this for both patients and staff, and why is someone not grasping it?

My last job was running Whipps Cross Hospital in East London and I led the merger with Barts and the London Hospital and Newham Hospital. When they merged, my job became redundant.

I really didn’t want to leave the NHS – I felt I had more to offer – everybody said I had done a good job. But I didn’t manage to find a suitable role, and instead took redundancy. Now I’m working for one of the ‘Big Four’, supporting their work in the NHS. It does seem crazy, really. I’m one of many with expertise and experience leaving, when everyone says, “Oh, well there’s a real shortage of x, y and z.”

Part of the problem is that NHS doesn’t operate its leadership development at scale and never has done. It’s noticeable in my time in consulting that firms such as Deloitte invest in leadership development in a different way – operating their graduate entry as part of a much bigger leadership scheme.

The NHS Management Training Scheme is fantastic. But it is small scale, and there is nothing else really. We describe it as a National Health Service, but as far as that sort of leadership training and succession planning is concerned, it’s not at all. I’ve been very struck by that in my new life, where that is taken much more seriously.

And a linked effect from that is that when you get a trust that is really challenged, you tend not to get the best people there. They are all sitting in the big teaching trusts like UCLH [University College London Hospitals] or King’s – there’s less risk to your future career.

One of the bigger frustrations of being a manager is the way the bureaucracy gets in the way. I’d probably divide that into two chunks. If you’re thinking about it from the perspective of running a trust, then some of the employment contracts and workforce approaches we have seem to make change very difficult.

When I was at Whipps Cross, the trust went through a turnaround. I had a private sector turnaround director brought in. This guy was good for about a month. After that he found the complexity of having to talk to the trade unions, work within a set of employment frameworks, and so forth, really difficult. He said: “Why can’t you just give everyone a plastic bag and tell them to go?” That was because he came from a very different environment.

And then there are all the rules about achieving change in the way clinical services are configured. We spend a huge amount of public money and time and effort working through all that. If you look at London, there has been huge change made with some really fantastic improvements in outcomes. But the time it takes and the amount of really strong leadership, and challenge and persistence that has been required, is huge.

It may be that the special administrator regime will help. That it will cut through some of that stuff, although doubtless there will still be significant challenge via judicial reviews.

I was at Barnet and Chase Farm back in 1999. And it was pretty obvious back then that Chase Farm needed to close. But it took something like 17 years from the original proposal to get agreement to close its A&E.

I was involved with the closure of the A&E at Mount Vernon, which actually we did with the support of the CHC at the time. It’s an example of how you can do these things. But I think the odds are stacked against it. We should speed it up.

And of course every time you have another reorganisation, every time you change the people or change the system, you lose the momentum for some of that.

One of the changes for the better has been that hospitals are now run in a much more business-like way, and another is the engagement of clinicians in leadership and management. If I go back to the beginning of my career, the involvement of clinicians, and doctors in particular, was pretty tokenistic.

Certainly my experience at Whipps Cross was that if you put clinicians in the driving seat, you get the results you need. Coming through the system – and it is a generational issue – there are some

“The commissioning structure to me looks even more complicated than I’ve ever seen it, with more layers and more people and more interfaces. And every time you change something, you lose the relationships and the partnerships, which count for so much.”

extremely able and willing medical leaders, which will make a massive difference to patient experience, quality and the efficiency of the way we do things.

In the past it was tokenistic because many clinicians didn’t want to do it, and – particularly at middle level – managers didn’t want them to either, perhaps because it was too intellectually challenging, and managers might have to do something differently. But there’s been a massive change in that regard.

And there has been a sea change in how quickly we treat patients. The whole attitude to that’s completely changed.

The NHS management culture? There’s quite a strong view, if you talk to a lot of people, that it’s very bullying, and that a lot of it comes from Sir David Nicholson. I take a different view.

I hadn’t been at Whipps Cross very long when we went from a balanced financial position at the end of the year to minus £16 million. In his brief time in London, I was summoned to see David Nicholson. He gave me a chance. I believe that he did that because there was a story around improving patient care and quality, as well as action being taken to turn the financial position around.

These are high profile roles, with a huge amount of responsibility invested in individuals, with large amounts of money and people’s lives at stake. You have to be able to give as good as you get. That’s my response to the bullying issue.

I do think the creation of foundation trusts has been a good thing. It has helped people move on and look out not up. It gives a sense of local autonomy and responsibility, and having to run a sound organisation in terms of governance and finance – taking the best from business, and understanding how you manage risk.

I suspect the biggest problem with the Lansley reforms is the inability to answer the question, “Where does the strategic change leadership come from?” It might come from the Commissioning Board. It might come from the Academic Health Science Networks, although I don’t think they are really equipped to do it.

The commissioning structure to me looks even more complicated than I’ve ever seen it, with more layers and more people and more

interfaces. And every time you change something, you lose the relationships and the partnerships, which count for so much.

There is so much evidence that it is strong organisations with stable leadership teams, ones that build trusting relationships and partnerships, that are the ones who are the most successful. We're just making the job more difficult for ourselves by chucking it up in the air.

I haven't counted how many reorganisations I've been through. But this is one of the bigger ones where the amount of continuity of people is much more limited than I've seen before.

The primary care trust/ commissioner viewpoint

Sophia Christie



Sophia Christie was Chief Executive of NHS Birmingham East and North from 2002 to 2012

First point: be very clear about what purpose you are here for. That has got two elements. Know thyself. And be clear about the purpose of the organisation.

It is really very easy over time to get pulled in different directions. We had a very clear and very explicitly stated local purpose, a health improvement purpose, which was an important compass for us when other things happened.

Immediately after our launch in 2002, the waiting time targets followed – access and the four-hour wait in A&E and so on, which is not what you would prioritise if your purpose is to improve the health of the local population. It raised the question of how much did we devote our entire lives to the A&E at Heartlands, versus the other stuff we thought mattered, and which was our direct responsibility rather than a third party's?

That meant being able – when we were later told, at six week's notice that we had to reduce costs by £26 million the following year – to have a conversation internally about our core purpose. And that then meant that we delivered most of that challenge but were absolutely confident that we hadn't compromised on our core goals.

My second lesson is 'don't confuse policy and strategy'. We've had the decade in which the centre makes the policy, and then performance manages us to deliver it, and the only role of the service is to do what government tells them.

People have been appointed to jobs who look like a safe pair of hands, who'll do what they're told by the government to deliver. Rather than people who might be thinking about what might be needed in five years' time,

I think that plays out most starkly in some of the Mid-Staffs stuff. There it looks like one of the things that happened was that the board got completely confused between the policy statements – which were all about becoming a foundation trust and delivering the access and financial targets – at the expense of an organisational strategy. If they had been a bit more thoughtful about it, they would almost certainly have paid more attention to patient experience and the effectiveness of care.

My third lesson, as a PCT chief executive, is never make assumptions that you understand the population that you serve. If I

had to pick only one thing of what we learned in the ten years, then I think that was probably the one that came as the greatest shock to our collective system, and then provided the strongest basis for really being able to do things differently and better.

Some years in, we realised that we needed much better insight into who our community really was. We had huge amounts of academic public health data, which told us all about the issues. But in terms of how to engage with people it wasn't useful at all.

We'd established that it was cardiovascular disease in men that drove much of our premature mortality – specifically cardiovascular disease in men aged 45 to 65. The initial approach was to pay the GPs extra money for additional chronic disease management, and they sent letters out to their patients and got an absolutely minimal response, other than from people who came to see them anyway.

So we did some focus group work. We looked at different groups within the category of men aged 45 to 65. For five of the six groups, one of the clearest things that came out was that they never darkened the door of their GP, and they regarded it as an absolute matter of pride that they didn't.

If you were a real man, then you lived with discomfort on a spectrum which went from indigestion to mid-STEMI [heart attack] intense pain without seeking any help whatsoever. And they placed very little value on the length of their own lives. All of the traditional messaging around, “Well, you need to do good coronary disease management because otherwise you will die younger” was, “Yeah, we know that. It doesn't particularly bother us.”

What did bother them was being fit and healthy enough now to engage with their grandchildren. They weren't particularly bothered about their kids. They'd missed that one. But they had got to an age when, “well, if I get out of breath if I take him to the park and I can't really play football with him,” or, “I worry that the rate I'm going, I'll never make it to her wedding”

We also tested out with them ideas of what sorts of services they would consider using. What we ended up with was a van that parked up at football grounds and supermarket car parks where they could get their health check, or they were able to just call into the local pharmacist and have it done there. We had a really simple system of phoning them up and letting them book into wherever

The primary care trust/commissioner viewpoint: Sophia Christie

“The worst thing, in some ways, was the invisibility of much of our most important work to the rest of the NHS system.”

and whenever was most convenient. We did a deal with Lloyds Pharmacy and we had the bus. And they had a choice of 70 venues across the PCT. They could book it at a time convenient to them as well. Early evenings and weekends as well as during the day.

I can't remember exactly what the take up was, but I think it was over 80 per cent. We found 50 per cent of those who participated had demonstrable disease, and 20 per cent were in the actively symptomatic and dangerous category. And we did the message of 'if you want to be around for your grandkids you need to go to see the doctor.' And the majority did – when most of them remembered previous letters from the doctor to which they had no intention of responding.

The sixth group was really interesting. Bangladeshi men who liked to go to the doctor 'at least once a week'. They had the opposite problem. They went so often and they wittered on about so many different things that actually their doctors just filtered them out. They'd got to the point where they couldn't really distinguish when there was something that really did need attention. It always drives me mad when people use South Asian as a generic category because it is meaningless. The strategy that we needed for the Pakistani population was different from the one we needed for the Bangladeshi population and very different from that for the white working class men.

The best thing was having the real accountability for the health, outcomes and experiences of a defined population. It felt like a real civic role. It was very scary, disappointing and frustrating at times, but it was a huge privilege. Having the authority, and finding ways to deliver services differently and better.

The worst thing, in some ways, was the invisibility of much of our most important work to the rest of the NHS system.

The only thing I ever got beaten up about in performance management terms was the four-hour wait in A&E or the money, or the cancer drugs fund. They could have had a four-day wait and it would not have made much difference to the population health status.

I once said in a meeting with the SHA: “I think it's interesting that you've never told me off about having a health status equal

to the Yemen in my infant mortality.” Apparently that’s far more acceptable than happening to have a hospital on your patch that can’t manage its own A&E. So the tension between investing in population health or palliative cancer drugs, most of which made very little difference, was a very uncomfortable tension at times.

I think it got harder to be innovative and radical over time. But that was not particularly about the culture changing. In the first three years, when we were just Eastern Birmingham, before North Birmingham got added, we felt we could more or less do what we wanted and nobody was that interested.

In any reform, as in 2002 when PCTs were created – and I suppose now – there is a moment when there are no rules. There is a short period where you have the huge challenge of getting a new organisation up and running, where you have freedom to do what you like – just go away and do it. So we were able to do all sorts of things without anyone really asking questions or making us jump through hoops.

As we got better known for doing stuff that was different and making a difference, we came under more scrutiny. And there were people who wanted us to fail. I won’t be popular for saying this, but there is an attitude that the dominant culture is to blame the victim. That if you work in a disadvantaged community, that’s an excuse for poor standards, because they’re poor people.

There is a difficult line to walk, because you are a public servant, so by definition part of your role is to do the will of the state. But then again, you are a public servant, so by definition part of your role is to do what is right for the public.

From the NHS Plan in 2000, we lived in an environment where the government not only knew what needed doing, but, increasingly, how it needed doing. That may not sit comfortably locally with what you can see happening for the population and the public.

There were some huge benefits to that clarity. It did drive focus on some very important things. It wasn’t acceptable that people spent 12 hours on a trolley in A&E. But people did lose sight of the balance between the spirit and letter of the law – queuing up ambulances outside or moving people into rooms that were not A&E, etc.

“It made you very, very conscious of a job that was about best value health investment, which for me is what lies at the heart of commissioning.”

And it did re-emphasise the focus on the hospital as being the NHS, just at a point when we needed to be de-emphasising that. And, perversely, it escalated the number of people who used A&E as first point of care because four hours was the longest you wait, so why bother to ring up and make an appointment and wait two days for something completely minor?

There were also some other good targets – for infant mortality and premature adult mortality and smoking cessation, etc, alongside the access targets. But there was a two tier application of performance management to them. So long as your access targets were OK, nobody beat you up about the others.

I am not sure that I can comment on whether the NHS does or does not have a bullying culture because I've never worked for any other organisation to make the comparison.

But I do think there is a problem in the NHS being full of lovely, well-meaning, highly-paid, professional double graduates living on decent incomes. Increasingly, many of them have been to private school, been educated in settings in which the only other people they speak to are other people who got four A-stars at A-level. Then we let them loose on the rest of the population. Particularly the elderly, most of whom left school at 14, have had unbelievably challenging lives and grew up in a completely different culture and set of expectations. Then we rant on about, “Why don't they do things the way that we think they ought to?” Well, because they don't think like us, for a start.

The most productive change I've seen in the NHS? Well, this is going to be a really difficult one, given what has happened. But the most productive change in my experience, was the original move to PCTs. Creating organisations that brought GPs to the party, but had a shared managerial and clinical responsibility at the heart. Bringing together the commissioning and the provision of some services in a way that allowed for research and development, and innovation, and rapid delivery. All that was hugely powerful when put alongside the responsibility for the total health of a defined local community.

It made you very, very conscious of a job that was about best value health investment, which for me is what lies at the heart of commissioning. It's very difficult to do that if you're only

“Will the reforms succeed? ... I suspect they have already failed... But one bit that has survived is all the stuff around transparency and responsiveness to patients and the public. If we are able to maintain a critical mass of people really excited about that, it could make a very big difference.”

responsible for one bit of the system, because you get caught up in all the perverse incentives of making that bit of the system work – if necessary, at the expense of the other bits of the system. I do think that has got lost in the current changes.

So why did PCTs get such a bad name? Well, they are implicitly a challenge to the traditional power structure and to the teaching hospitals and the consultants who work in them. The better you were at doing your job as a commissioner, the more likely you would be upsetting some of the traditional power balance. And the PCT tended to get coverage only when it was making decisions about a perceived limit on services, either changes to a local hospital or denial of a drug or whatever.

PCTs are NHS bureaucrats. We're there to be excellent administrators and wise investors of public money. But that does make us managers and bureaucrats, and whenever has the public ever stood up and said, “what we need is more bureaucrats?” And most PCTs had only been in existence for three years before they were being reorganised again.

If you take an organisation from scratch, it takes two years to get it to the level of a decent, safe, functioning organisation. They had one year to change the world before they were changed again, which then meant another two years diversion and loss of competence.

I would be the first person to say that most of us needed to do better most of the time, and the way of getting us to do that would have been through reviewing some of the metrics and processes rather than the structure.

We did have GPs involved in the commissioning. There was no shortage of structural clinical leadership. And I have massive respect for GPs. But if they had wanted to be involved in managing the system, any of them could have done it at any time, but very few of them did. They are actually qualified in, and most of them are interested in, other things.

Will the reforms succeed? Given their declared aims I suspect they have already failed. There is not much harnessing of the creativity of the population of GPs that I can see. But one bit that has survived is all the stuff around transparency and responsiveness to patients and the public.

“Some of the brutality of the language about managers over the last couple of years has had a very powerful negative effect on people trying to do their jobs.”

If we are able to maintain a critical mass of people really excited about that, it could make a very big difference. Transparency about clinical outcomes, about patient experience, and all that goes with that.

It could be pretty powerful and might make up for the loss of two years of improvement and the loss of huge numbers of people with capability and experience, including some of the GPs who were most involved with PCTs. GPs who objected to the notion that something they had given 10 years of their life to was a complete waste of space, and who are sceptical about how far their colleagues will want to be involved in the day-to-day graft of commissioning.

I do think something has been lost in the separation of health improvement from the procurement of treatment. And some of the brutality of the language about managers over the last couple of years has had a very powerful negative effect on people trying to do their jobs. I remember on the day after *Liberating the NHS* was published, I went into the head office and the three executive secretaries – to the board, the chairman and my PA – were in a huddle. Two of them were in tears. One who had been a secretary in the NHS for over 30 years said: “I never realised that what we were engaged in was slavery. Why does he think that we’re so evil that people have to be liberated from us?” Some of that may take a long time to heal.

But if I had to make one major change, I think it is that wherever we have ended up structurally, it is what we have got. We now need a minimum of five years to let it play through. I would allow any structural change which emerges at the local level to happen. Give organisations at the front line the freedom to merge and acquire. But ban any central top down redefinition. Just give people the time and space to make the most of what they now have.

It is that old quote from Sir Roy Griffiths: “Reorganisation is the thing you absolutely should do, but only when everything else has failed.”

And I do hope that what we do not get from Francis is even more burdensome regulation and checking. If Mid-Staffs tells us one thing, it is that there is no substitute for the personal professional responsibility of the person at the bedside and the manager on site. There is no substitute.

Robert Creighton



Robert Creighton was Chief Executive of Ealing PCT from 2002 to 2011

Never underestimate the complexity that you have to go through to engineer change. It may sound trite, but there are no simple solutions. Take the whole business of trying to make strategic change in hospitals in West London. I worked out there for ten years. Repeatedly we tried, and it had been tried before. They're still trying, and it looks like at last there is some success.

So do not expect easy and quick solutions. Be content with small triumphs. If you take an incremental view of what you can do, rather than a revolutionary view, you can probably bring about something that will last.

But if you try to be too sweeping, the risks are of course very high, and many things run into sand, and often not of your fault at all. If you take *Healthcare for London* [Lord Darzi's review before he was health minister], I thought that was excellent. And you might say that 20 per cent of that, at the most, has been successful. It was the grand gesture, and you get 20 per cent. And that may be a fair return. I don't know. It is worth talking about.

I agree that doesn't sound very ambitious, and may be it is a counsel of despair. We did have ambitions but we found them hard to achieve. Do I think that, therefore, I or the organisation failed? No, we didn't fail. But we didn't achieve our ambitions.

It may be, now that there is going to be much less money around, that might enable something more radical. For the whole of the period from when the PCT was founded in 2002, right until the end really, there was plenty of money around. That was meant to lubricate change. But of course that encourages sloppiness because people don't see the need to change. They just see the need to do more of what they are doing.

Every year, with the hospital, we tried to reduce the growth in the hospital to less than the overall growth in the budget. And every year we failed. One year we went to arbitration and were told by the SHA that for the safety, as it were, for the stability of the local health economy, it was not appropriate for us to "penalise the local hospital". So there was less to spend in the community than we would have liked.

“It is the really difficult balance between localism and centralism. I totally accept there needs to be some degree of central drive. And in a national service there needs to be national standards. But it felt very top heavy.”

Maybe all of that changes when the money gets really tight. We’ll see. If it does engender radical change, then I won’t be bitter about it.

The best thing about working in NHS management, as someone at a PCT, was working with the local community and the local council to make a difference for the people – particularly those of Southall where the needs were greatest. Making the PCT a genuinely local organisation, able to lead health and social care across the community. Engaging with the council, the local voluntary and community groups and being able to bring about some real improvements. That was really very rewarding.

The worst was the constant sense that you could never do enough of the right thing for the system. The business of meeting the requirements of the regime, from above, was always very irksome. You could play that game. But there was the feeling that you never felt you were fully trusted.

It is the really difficult balance between localism and centralism. I totally accept there needs to be some degree of central drive. And in a national service there needs to be national standards. But it felt very top heavy. The number of hours, and the number of people and the amount of effort that went into feeding the beast was depressing. And not productive. And, from that, having less time to put into the things that you think are really important.

I do, though, resist the idea that the NHS has a bullying management culture. I don’t subscribe to the view that is pervasive. Of course there are some people who can be bullies. And if you work in the bit between ministers and the real world – at the top of the NHS and in the department – it is very hard not to do what ministers tell you. And you haven’t got many shots in your locker other than to tell people what is expected. So there is certainly some very tough performance management, and I’ve been on the receiving end of it. But I didn’t feel it was bullying.

As a chief executive you have to act as a buffer, a shock absorber, between all that and the real world, and find ways of converting it into something that makes sense for the people in your organisation.

For the first two years, we were zero-rated under the star system that the Commission for Health Improvement ran. The first year we got away with it. The second year, I spent the whole of that period dealing with the consequences. Just about hanging on, personally, by the skin of my teeth. The organisation just about hanging on. Then we made this great leap from being zero-starred to being two-starred. Of course, everybody thought that was a wonderful triumph. But it wasn't really.

It was just that we'd manipulated the system a bit better. But it bought us the breathing space. For the first year or two I said, "Look, if we do the right thing, it will come good." But it didn't.

Each measure had a certain number of points attached to it. So we identified the measures where we could improve the score with the least amount of effort, regardless of whether we thought those were the most important things we wanted to achieve. That got us the points.

What do I wish I had known when I started? I've two answers to that. One when I was chief executive at Great Ormond Street, which was very resistant to change. There were some very lively clinical leaders. But it became very difficult at the end for them to hold together their consultant body, which felt very threatened by change. You can do that if you have unanimity in the leadership team. But if you have an insecure relationship between the chair and the chief executive, you are doomed. We got a new chair in 1997 with the change to the Labour Government, and the relationship between us became poisonous, and we were on the road to disaster. In the end she had to go, and I had to go. It was very instructive, in terms of what you might call human politics.

I think that I wish I'd known that was likely to happen, if you see what I mean, so that instead of being as devastated as I was, I would have ridden with it a bit more.

I think, in relation to Ealing, what I wish I'd known is how incredibly hard it is to bring about change in primary care. It's not a part of the system with which I was at all familiar. It is obviously the part of the system that needed – still needs – to move into the 21st century, in places like Southall.

I hadn't appreciated just how few, or how weak, the levers would be. Would knowing that have made any difference? I don't know. But at least I would have felt less frustrated.

I don't remember the precise figures, but I think when we started 40 per cent of the general practices in Ealing were single handed, and something like 60 per cent were one or two handed. Over time, we reduced that a bit, but not radically. In a population of 300,000, there were precisely two things that you might call 'clinics', when we arrived. By the time we were finished ten years later, there were five or six – six really. So we had increased the capacity in the system, but it took a long time. Getting GPs to move from their crappy, crappy terraces, into these beautiful places was bloody hard. Crazy hard. Ridiculously hard.

And then there's the psychological part, of persuading the population that they don't need to go to hospital. That it is actually better for them to be looked after in the community. That they can be looked after at home. Certainly, in some parts of our communities, those that were recently arrived in Ealing, and quite traditional, they didn't recognise the idea that a GP was a good idea. They just pottered along to the hospital for anything.

And all that did was make it harder to hold on to what I call the myth that, 'by definition', life was going to be better if you could keep people out of hospital.

It became very, very difficult, over time, to see how the broader care system was going to be able to absorb whatever it needed to absorb, and reduce the inexorable flow – for all sorts of good and bad reasons – into hospital care.

That doesn't mean that it's not the right policy intent. But after a number of years in which we said we were going to do demand management, and that meant fewer people would flow into Ealing Hospital or North West London or Imperial – well it never happened.

That was partly because of things beyond our control. But it was partly because however cynical you are about GPs, they do absorb a lot of pressure and, without very radical changes to the way they work, they can't absorb much more. Without very much better

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facilities in the community, they can't absorb much more, and they take a very long time to create.

One of the interesting questions is whether CCGs might do a better job than we were able to in sorting out the poorer-performing GPs. Because under-performance will be a peer-to-peer conversation, not one between managers and doctors. If there is real leadership from innovative GPs, that could be an advantage. But it is not easy. Even some of the worst-performing GPs we had were consistently sending me letters from their patients telling me how wonderful their GP was – because he gave them what they wanted; handed out sick notes or prescriptions, or whatever, or spoke to them in their own language. This may all sound a bit negative.

Primary care did improve over the PCT's nine years, if measured by access and availability, by the quality of facilities in some areas, by the range of services offered, by QOF [Quality and Outcomes Framework] points, and by addressing – laboriously – the practice of the poorest individual practitioners.

Such improvements were particularly marked in Southall, where the quality of primary care inherited by the PCT was weakest, and in the needy parts of Acton. By focusing efforts in these areas the PCT made some profound and acknowledged improvements where they were needed. They went some way towards reducing the variation in quality across the borough. But we were a long way from removing the inverse care law. That would have required many more incentives and penalties, with much greater investment of resources over a much longer period. It does sometimes make me wonder whether we should not have more central control over general practice.

And these improvements we achieved were all improvements to inputs. It is not clear whether they have led to improvements in outcomes or in health status. The measures of this are essentially complex and long term. It would be difficult to disentangle the effects of different interventions. And there is no composite measure of the performance of primary care.

There is evidence that some chronic illnesses – diabetes and musculoskeletal pain for example – are better managed without the need for hospital attention. But in general, the demand for specialised care, largely provided through hospitals, has continued

to grow. This is not in itself inconsistent with improvements in primary care – the growth in demand may be due to genuine unmet need or the system responding to higher expectations, both of which may be revealed by better access to better primary care.

Other good things were that because we did engage with the community and the local council – we had the portfolio leader for health and social care on our board, for example – we got through changes such as Ealing Hospital losing its stroke services. There was a massive campaign against that. But we managed to handle it in such a way that the council didn't take its resistance to the final resort, unlike in other places such as Barnet.

That was based on years of investment of time and energy, so things like that became easier.

Among the most productive changes I have seen has been the development of stronger organisational independence, so NHS trusts, foundation trusts and PCTs at their best. It gives the opportunity for local pride – which wasn't there in an entirely hierarchical system, when you had the area health authority, district health authority, and all the units within it. Where it works well, that organisational independence has made a huge difference. It gives the opportunity to create organisations with their own cultures, with their own loyalties, with their own ... well, you could even use the word 'brand'.

Among the least was constant reorganisation. That goes without saying. We were lucky in that by the standards of the rest of the country, the PCT was not constantly reorganised and we built over time a very stable, very committed team. And we were co-terminous with the borough, which was really important.

But if you look at the other PCTs around us, they didn't get reorganised, but people were constantly moving. Chairs were being kicked out, chief executives were falling by the wayside, directors were moving on. There was a lot of churn. And I do think that having 33 PCTs in London was a real challenge to the leadership capacity. Having 33 people who could really do good, local leadership. It sounds a small number. But in 2002 they made some shocking appointments and it took an awful long time for some organisations to recover. And that is a worry when we are going to have 211 CCGs.

“It made it very easy to become defensive and hard not to be self-justificatory. That sense of being constantly told that anything we did was irrelevant, and if not irrelevant then positively harmful.”

What do I think of the prospects for the reforms? Well, there was a time when I thought they were doomed to disaster, and there was no prospect of them succeeding. But that was a reaction, really, to the way I felt that we were being treated; the belittlement of managers and management by politicians in recent years.

It made it very easy to become defensive and hard not to be self-justificatory. That sense of being constantly told that anything we did was irrelevant, and if not irrelevant then positively harmful. It is terribly counter-productive. There was the comfort that it is not a view shared by the more thoughtful clinicians. They didn't share this crap, and they knew that their success depended on the mutuality of good management. But it was dispiriting. We have gone the way of estate agents and politicians themselves in terms of public esteem.

But it is possible that health and wellbeing boards will have a positive impact over time, although again you face the problem, or risk, of the politicians and chief officers there constantly changing.

If you want to see lots of little local initiatives doing lots of good things for people in small numbers, then CCGs probably will have the opportunity to do something quite interesting, and maybe they can change the way in which general practice works. That would be great. But I fear it will be much more difficult to effect strategic change in the acute sector. I do feel there's the absence of a strategic health authority, so to speak. I suspect the Commissioning Board will move into that vacuum. But it is a worry. And there is this enormous inertia in something as complex as the NHS.

Kathy Doran



Kathy Doran was the Chief Executive of Cheshire Warrington Wirral PCT cluster until March 2013

The key lesson is that it is all about working with clinicians. Managers cannot be successful in the NHS on their own and neither can clinicians. It's about joint effort. I think the most successful organisations that I've seen are where that happens.

I spent part of my early days at Guy's setting up clinical budgeting and clinical directorates back in 1983, working with Cyril Chantler and Peter Griffiths. They were my role models. And I guess I took that into the health authority and primary care arena, and when PCTs were established, that was the theory behind them. And the better PCTs did that, and significant numbers of them did.

But clearly not enough, or we would not have the current reforms, or that fairly damning report on PCTs from the House of Commons Health Select Committee at the end of Labour's time. Though I thought that report was very unfair.

One of the problems you face as a chief executive is that the system is so complex, with so many pressures, that it is easy to get pulled off in different directions. Ones that take you away from your core purpose of improving services for patients.

The best thing about working for the NHS has been about seeing services change and outcomes improve. I've been lucky in that I've been in the Mersey region and on the Wirral for the better part of 20 years.

I started as a civil service fast track trainee, then I was at Guy's, back to the department and then out again before moving north in 1989. And I've seen these huge improvements in mortality rates and outcomes as we, with the clinicians, have changed the services in both primary and secondary care.

I've seen primary care develop from almost the corner shop approach to much, much larger networked practices, working together with a whole range of backup services. We have seen patient outcomes improve and we've seen patient satisfaction improve. We've seen the primary care estate develop hugely. So those have been the best bits.

Out-of-hours, for example. We changed that in 1996, so that instead of having 30 doctors wandering around every night in their

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cars on the Wirral doing home visits, we have a call centre with five or six doctors on call. And that has survived. It is still run by the community trust, and it is still the local GPs who work in it, by and large.

The worst bits have been some of the low financial times, and dealing with difficult individual cases of misbehaviour. We do that quite well once we get to it. But we are not always good at spotting it sufficiently early in advance to nip it in the bud. I am assuming post-Francis we will get more into that territory.

On the finances, you would think that having resources to invest would be the easiest time. But it is not always. Once we weren’t trying to save money all the time, we were really trying to make sure that we targeted it in a cost-effective way. But that could be quite tricky. The nature of the annual spend cycle doesn’t lend itself to sensible, strategic application of funding. So, ironically, sometimes having money was more difficult than not having money, because when there was a large financial problem everybody understood the need to change. Mind you, given the choice, I’d always choose to have resources.

One of the worst things of my 35-year career has been constant structural reorganisation. If I added up the number of years that I’ve lost personally and with colleagues in terms of doing the work associated with reorganisation, and I had put that effort into developing quality services, I think our services would be of a higher quality.

The political reaction is always to change the structure, because that’s what politicians can do. It’s very difficult for them to affect quality. If we had been able to convert all of that managerial and clinical time into actually planning to improve quality locally, then maybe we would have been more successful.

And these attacks on managers as pen pushers have made life difficult. There’s almost a starting point, if you’re dealing with a member of the public, that they’re suspicious of that. You’ve become one of the disrespected professions, if you like.

I don’t enjoy that and I don’t enjoy it on behalf of my staff because I think they’re all there because they want to contribute to the success of the NHS. And constantly being criticised, or having that cut away from under them, is not at all helpful.

What do I wish I'd known when I started? I think there's something about the scope that people look at the world through being so different, depending on where they're sitting. I don't think as a junior manager, or a junior anything, that you understand that. So, I came with my civil service management training, such as it was. I had one view of the world. But I didn't really grasp how a medic, or a senior medic, and a junior medic, and a GP, and a consultant, and a nurse, and a therapist looked at it.

They all have a slightly different take on the world, on how they interpret their role in it, and how they serve their patients. I think that's one of the biggest challenges in running any service. How you deploy all the different legitimate professional inputs – you can add finance, you can add HR, the managerial and social care ones to that as well – into something that produces the best service that we can for a patient, which is what we're all there for. It took me a long time to work it out.

Over time, with experience, one is able to do things intuitively that you might have had to plan, or worry about, or not have confidence about, when you started out. There's something that experience does for you that you can't get in any other way.

But there is an obverse of that, which is that you become so conscious of all the bits of the jigsaw and the different influences that you can't see the wood for the trees. That, in a funny way, the more you understand, the harder it can become to navigate through it. You can just become subsumed by the next email, or the next phone call, or the next person that walks through the door. It's keeping on mission, and having your mission, and not becoming distracted.

It is a bit like that much-mocked Rumsfeld quote about the unknown unknowns. The naivety associated with that. You can sometimes actually be quite successful without really understanding why. Sometimes, at the other end, you can get too reflective.

The growth of governance, as a conscious movement aimed at keeping things safe, has been good. But it has become much more burdensome and bureaucratic as time has gone by. It is another opportunity cost issue.

“All [the CCGs] had a really enthusiastic group of local clinicians who really wanted to change things for patients.”

Things have been made much easier because of the internet, IT, powerful databases, digital X-rays, all of that. When I started, we didn't even have word processors or personal access to photocopiers. We had to take them to a photocopying room. It has made the work much more fast and furious than it was. Think of being a minister's private secretary. It would have taken you a day to get a document over to somebody and a day to get their response back. The world was just much slower.

So that is an additional pressure. People's expectations are for a very quick turnaround. And I think some of the impatience on the part of politicians, how quickly they expect things to change, is almost a spin-off from that – when in the health service many of the indicators such as mortality from heart disease really only demonstrate change over years.

As for the future, it feels a bit confused. I actually think CCGs are the least confused part of the system and I think they're ready to roll. I've been involved with the authorisation process, looking at some 18 of them. I think that has added clarity for them as to what it takes to be ready. I think that, in a sense, they have the legacy of their PCTs rolling forward and they know, by and large, clinically, what they want to do with local services. All of them had a really enthusiastic group of local clinicians who really wanted to change things for patients.

For me, I think the confusion is the rest of the system. The Commissioning Board has a huge recruitment job still. There are still a lot of vacancies. Its primary care responsibilities and the specialised commissioning responsibilities are risky. Because I think the boundary issues between specialised commissioning and local commissioning, and the boundary issues between primary care contracts and CCG commissioning are – almost inevitably – ill defined.

I don't think the money's clear between the three, and we're very near the first of April. There's a huge amount of work to be done, even though the Board and David have tried really, really hard. But he is right. This is a change you can see from space.

Up until now, PCT clusters have held the ring between all of these bits of the system. But now they won't be there from the first of

“All the stuff about GP commissioning was fine, because we were doing it. And if we could have been left to get on with it on a local basis, that would have been fine.”

April. I suppose in as much as anybody’s holding the ring, the Board is holding the ring. But it doesn’t have quite the same role.

Ever since I have worked in the NHS, there has been this pendulum between central and local control. Primary care is essentially a very local service with local contractors. Having that commissioned at 27 points across the country, doesn’t, I think, feel right. Maybe the Board will use the CCGs as an intermediary for that. But I don’t think it is at all clear how it is going to work.

What was so attractive about Andrew Lansley’s original “no more top down reorganisations” was precisely that. All the stuff about GP commissioning was fine, because we were doing it. And if we could have been left to get on with it on a local basis, that would have been fine. But we may have ended up with a structure that is not fit for purpose.

I think that probably the most important reorganisation of my time was the Griffiths Report. But he didn’t play with the structures. His report was all about relationships. Not just bringing in managers, but bringing in doctors and nurses and working with them.

I actually do think that there’s an enormous enthusiasm amongst the members of CCGs. They do want to really make changes for their patients and I wish them well. I think they’re doing that at a tremendously difficult time in terms of the money.

And there is a major risk of fragmentation with all these new bodies that have to coordinate and work together. There isn’t really a controlling hand. Some might say that the reforms are designed not to have a guiding hand. But my experience would be that there will be occasions when that won’t work. When you are trying to reorganise a specialist service, or move it, you have different competing interests, and people will misbehave.

When you get a big conflict I think it will end up going up to the Secretary of State, which is exactly the position that Mr Lansley wanted to get away from. Money and fragmentation are the two big challenges going forward.

Dr Tim Richardson



Dr Tim Richardson was lead and chair of a local practice-based commissioning group in Surrey from 2004 to 2012

My advice to my successor if I was chair of a CCG would be to be absolutely clear what they want to achieve and how they plan to do so. In particular, the CCG needs to deliver better local services, less variation and better clinical outcomes. And it is going to have to do that within ever tighter resources. I would advise against short-term salami slicing of all services to achieve financial balance. That simply makes them all vulnerable.

Instead we need to transform services by moving more care from acute hospitals to primary, community and mental health care – but very quickly.

This requires a strategic overview, which must not be destabilised by local politicians, whether MPs or councillors, who support inefficient and potentially unsafe acute DGH [district general hospital] services, propped up with subsidies that add to total public spending and waste precious patient resources.

We can only deliver more appropriate care by better managing the increasing burden of chronic long-term conditions through integrated services in the community – which means diverting resources from already unsustainable district general hospitals and closing them, or turning them into non-acute community-based facilities or polyclinics.

Patients with very serious acute illness need to be rapidly triaged through GP, ambulance or 111 to centralised critical care hospitals that have seven-day consultant cover in all major specialties. That will provide safe care with better outcomes.

For the larger number of patients with chronic long-term problems who currently end up in acute care at full tariff, we must invest in better detection and management in the community and not keep paying for unnecessary episodes of acute admission. This applies particularly to mental health, where conditions such as dementia are not well managed.

This is in line with both national and international reviews, which recognise that the changes that commissioners need to make will lead to fewer, but better-staffed and safer, acute hospitals, supported by speedy transport to the most appropriate service.

To ensure access for urgent but non-acute care, urgent care centres need to be staffed by experienced GPs and redundant A&E staff, not just nurses. The experience of NHS Direct and the current walk-in centres has been that they have added steps to the process of care, and directed more minor problems into A&Es.

So GPs need to go back to organising out-of-hours themselves in a way that incentivises them to develop this model. One option would be to work out the national spend on all A&E, urgent care and out-of-hours services, and add the capitated cost of that per patient to GP contracts. That would make the GP with a registered list financially responsible for the cost of every first attendance.

Once GPs work out that seeing the walk-in patients in extended GP services, or in GP-staffed urgent care centres, costs them less than £40, versus a cost of £70 to £90 in A&E, they will take responsibility for all first contacts and will thus create this new model.

In turn, that will begin to address the unexplained and unwarranted variation in services provided by GPs, and the consequent huge variation in practices' use of other more expensive services.

Those providing the best total access to their own services would be rewarded, while those practices where A&E attendance is highest will be penalised as their contract will be paying for the high A&E attendance rates.

This concept could, and in my view should, be extended to GP-prescribed medication, GP-ordered tests, to long-term conditions and even to all elective care.

This package is very similar to the Integrated Care Organisation proposed in Ara Darzi's *Next Stage Review*. Were it to be offered, I believe the most forward-thinking and efficient practices would take this up and rapidly develop better access to non-acute services.

This could be made compulsory. But if it was not, those practices that were less willing would risk losing patients to the practices that would be delivering swifter, more local and better care – something that patients would soon get to know about locally. As a result, we would get more innovation and competition in primary care, something that appears to have been completely lost in the latest set of turgid reforms.

“Once patients know they can access more primary and secondary care through their local practice, they will support the reconfiguration of acute services which is required.”

By extending GP provision in this way, giving it a fair share of spending to control rather than just its historic levels of funding, longer-term investment in local facilities such as polyclinics would be facilitated. Integrated services would start becoming the norm.

This is what my practice, the Integrated Care Partnership, did when we acquired the Old Cottage Hospital in Epsom in 1991. We developed a polyclinic with the first free-standing community day surgery facility, and then, using our 1998 PMS [Personal Medical Service] contract, directly provided a much wider range of services than most other practices. These included consultant specialist clinics, near-site imaging and endoscopy, a wide range of consultant-delivered day case surgery, palliative care, and community-based support for long-term conditions that was led by specialists.

We delivered better care at demonstrably significant savings against the cost of similar practices covering the same local population.

Once patients know they can access more primary and secondary care through their local practice, they will support the reconfiguration of acute services which is required, as they will become less frightened by the downgrading of their small acute hospital.

Hopefully, even local politicians would eventually see the benefits of such service developments, and call a halt to their support of campaigns to try to maintain unsafe and financially unsustainable acute hospitals.

I think that list holders – whether GPs or in due course other providers – taking over practices or setting up new, more modern, facilities, must take full financial responsibility for their registered populations, acting as integrated, or managed care providers rather than as part provider and part commissioner. We will only see primary care take on more services and offer clear choice through extended provider contracts.

So I would want the new CCG boards to be lobbying DH, Number 10 through Paul Bate [David Cameron’s Special Adviser] and Norman Lamb [the Liberal Democrat Health and Care Minister] to be allowed to offer extended provider contracts.

The safeguard around all this would be that there would be choice and competition between practices or groups, rather than us just having the local monopolies, which CCGs risk becoming.

You asked about whether there is a bullying culture, and about the Francis Report. Having been involved in commissioning with the Surrey PCTs, I did see open bullying occurring under pressure from the NHS Board and the DH for the PCT to achieve financial balance and hit the New Labour political targets. This created awful tensions and open recrimination within the PCT, especially as the year-end drew near and deficits loomed.

Whose fault was this when managers were forced only to look up the line and avoid bad news for ministers rather than down the line at the service user and funder? I have no doubt the greatest blame lies with politicians. But too many senior managers lost their bearings, serving the conflicting demands of their political masters, and they did undoubtedly lean far too heavily on more junior managers and so on down the line.

I believe very senior managers such as Sir David Nicholson, and especially Dame Barbara Hakin, missed many opportunities to support primary care providers who were willing and able to take on extended provider ICO contracts – something that ministerial advisers did support in 2011. Instead they forced practice-based commissioning groups into geographic arrangements, rather than allowing like-minded CCGs to emerge. The new CCGs have spent most of the last year achieving form – setting themselves up for authorisation – rather than delivering their function; commissioning or service development.

On top of that was the forced merger of very efficient with very inefficient practices, and the use of the savings achieved by the former to bail out the latter's deficits. This has had a major adverse effect on efficient practices.

Even worse is to see subverted the supposed independence of CCGs to get commissioning support from any provider. Instead it is coming almost exclusively from former PCT staff in CSUs [Commissioning Support Units], without any tendering. My experience in Surrey was that it was only in the final year that data flowed back to practices on performance, but little real or comparative intelligence was ever provided. Why should we expect

“I will be very surprised to see real change taking place in the timeframe required.”

the new CSUs to do any better than the PCTs, especially as they are now being staffed by the same people?

Sadly I think financial balance and targets will still be major top-down pressures, especially with the dire state of both national and NHS finances.

I will be very surprised to see real change taking place in the timeframe required. No doubt there will be another whole-system management reorganisation by the next incoming government in just over two years' time. With that uncertainty, do we really expect CCGs to be able or motivated to deliver better care at lower cost within those two years?

I have recently retired as a GP. Yet my old practice demonstrated that significant savings can be achieved whilst services are localised and improved. Examples of good practice, however, are rarely recognised if they clash with other political priorities such as saving the local acute provider!

The regulator viewpoint

Andy McKeon



Andy McKeon was
Managing Director,
Health, at the Audit
Commission from 2003
to 2012

Lessons for my successors? One is don't put your faith in incentives, for the hospital sector. Don't put your faith in incentives and clever policy. The ones we have got so far don't really work and, if they work, they certainly don't work on their own. The second thing – and this is closely related – is don't think your policy will be implemented. Because as it emerges from the department, it will probably be 'subverted' by the people locally – to fit what they want to do.

I was going to say the pace of change is very slow. But if you think that the service is inadequate in any particular way, tackle that inadequacy directly, and don't think that a restructuring, changing the incentives and so on, is actually going to change it in any quick way – or even in the medium term or perhaps even long term.

I don't think financial incentives in hospitals have really worked at all. You might say that they've perhaps never been given a chance to work properly. But after ten years of payment by results – I suppose eight years to be absolutely fair, as it was thought of in 2002 but not introduced until 2004 – it's hard to see that it has had any real impact, other than improving coding and maybe sharpening bits of financial management.

I think that goes, so far, for best practice tariffs. It's hard to see what CQUIN [Commissioning for Quality and Innovation] has done other than if we had simply concentrated on the quality standards. And I think that is probably true of the larger incentives that were introduced over 1989/90 with the purchaser-provider split.

I think that's largely because of two reasons. One is in most cases – in most places – the hospital service and the purchaser are probably doomed to work together. Therefore, affordability rather than incentives becomes a more critical factor in our cash constrained system.

It is true that you can give purchasers a different set of tools which they may use. They can tender a service or something like that. And it is good that they have that. They do that quite often in desperation, however, because it's a very time consuming and long process to go through. And therefore, they can't do that on any kind of scale.

“Don’t put your faith in incentives and clever policy. The ones we have got so far don’t really work and, if they work, they certainly don’t work on their own.”

Providers have more in terms of incentives for themselves in the way in which they may outsource or deal with particular services or activities. But we’ve always thought the commissioners were going to do this. So having been a great fan of incentives and the like, I’m a disappointed man.

This is not true in primary care, where clearly the financial incentives impact directly on people’s pockets. People will do what they need to do in order to make their money – the Quality and Outcomes Framework illustrated this.

That has its own dangers, doesn’t it, about whether we’re overpaying, if the incentives aren’t right? I mean QOF is not the first time we’ve done this. In the 1989 GP contract there were payments for health education classes and they mushroomed. There were a lot of them and they were probably of little value. And more importantly, they threatened to destabilise the entire payment structure for GPs because while they could earn more for health education classes the total amount was capped. Too much was going into the health education classes.

It may be that the financial incentives on hospitals, payment by results and the like, do not impact directly on the consultant’s pocket as they do for GPs.

But it strikes me that consultants are concerned about their service and its quality. Therefore, if there’s a failure there, it’s a failure of the organisation, for whatever reason, to articulate sufficiently the impact of financial incentives on the individual services they are providing. That’s probably a failure of the way in which hospitals haven’t had to adapt their financing systems and the way in which they organise themselves. Total affordability of the hospital budget is a more critical factor than individual payments for commissioners and providers.

So if you are in Worcestershire, for example, they’ve got one trust, three sites, and therefore, they’re pretty well doomed, as I say, to work together – and affordability for both the commissioner and the provider is a critical issue.

There is some evidence from work at the LSE and Bristol and here [the Nuffield Trust] that choice and competition does have an impact. But you have to ask yourself whether that impact is sufficient in order to justify the effort that’s gone into producing

“Having been a great fan of incentives and the like, I’m a disappointed man.”

it. A system driven mainly by choice and competition might well produce greater innovation and improved quality, but it would take a long time to get there – see progress in the former nationalised industries – and the effort would be great.

Where we’ve wanted to upgrade services or safety in a particular hospital, we’ve had more success in tackling those things directly than we have by trying to introduce choice and competition. So actually, if you think that venous thromboembolism [VTE] assessments are the right thing to do... well, they have had a meteoric rise. And hardly any of that has been to do with financial incentives, and none of it to do with choice or competition.

Now you could argue that if you pick on VTE, there’ll be something else that’s falling away, so therefore choice and competition is a way that would drive improvements in overall quality. But actually other developments have pointed in the other direction. The Francis Report actually is rather about standards, regulation and so on. Not about, “Well, let’s change the system in order to drive up quality.”

Having got this far I wouldn’t scrap financial incentives or choice and competition. That seems the wrong thing to do. But I would think very carefully about whether I wanted to put my future faith in really trying to develop those further, rather than going for some other approaches such as clearer requirements on measurement, and transparency on outcomes and performance, and providing more information publicly. That is, of course, grist for choice and competition. But actually, the main effect will probably be on the providers themselves, on the consultants and clinicians as they see their results in the public domain.

A lot of thought and effort has gone into the restructuring of incentives. But we might be better off putting the policy resources into developing other things, rather than continually trying to introduce new incentives, or fine tune them. As I say, I am a disappointed man.

When I say departmental policy will be ‘subverted’, I don’t mean malignly in the sense of people saying, “I’m against what the government is doing and therefore, I am not going to do this.” It’s more that people have their own agendas and see how they can pragmatically improve or advance their own service.

“There are some basic principles that are worthwhile working towards, including getting the clinicians more involved in the direct management and direct development of the service.”

In 1989 when we were developing Working for Patients, there was an argument about whether family health service authorities [FHSAs] should be brought together with the new health authorities to form a single purchaser, bringing prescribing and everything else into a single budget. I can't remember the details. But the Treasury was firmly opposed and we specifically wrote into the White Paper that it would not happen. The legislation wasn't provided.

Lo and behold, a few months after the White Paper was issued, people locally had got together to invent their own structure, which effectively brought together FHSAs and health authorities – because that seemed to make the most sense.

And I remember talking to people at Torbay, and asking, “How have you managed to keep this going through these various restructurings?” The reply was, “Oh well, in any kind of policy statement, you always look for the bit you can use and look for the way you can apply it.”

Do the endless reorganisations have merit? Well, they've all got a logic of their own, haven't they? But very rarely do they have the results envisaged. There are some basic principles that probably seem right, although other countries may be able to show differences. So giving hospital management greater freedom to operate seems a worthwhile thing. Getting them more managed than administered, which was the Griffiths Report. That also seemed like a worthwhile thing.

Whether there's been any merit in swapping between health authorities to bigger health authorities to smaller health authorities to PCTs, smaller PCTs, back to larger PCTs and on to CCGs is, I think, probably 'no'. Well, it's not probably. The answer is 'no', given the level of destruction and what's been produced as a result.

So there are some basic principles, as I said, that are worthwhile working towards, including getting the clinicians more involved in the direct management and direct development of the service. That is a good thing, and a lot of the reorganisations have been geared to that end. But we didn't need a reorganisation to achieve that, as opposed to different approaches and different cultures being introduced.

Getting clinicians more involved in management means giving them more constructive power through allocation of budgets, better structures in hospital, clinical governance. It is giving clinicians, and consultants in particular, a more constructive way of being professional. Not that they sometimes see it like that.

Of course think tanks argue that we haven't tried the incentives and competition hard enough; that we haven't really got any new providers. And if we'd been more bold and said, "Right, we'll have a system of chambers for consultants, and allowed various other people to come in" – it might all look different. Arguably in other industries that has worked over a long time. But in other industries the government doesn't carry the bill and the can for any failure, which makes it potentially a very expensive financial and political route to go down where it does. The difficulty of introducing an adequate failure regime demonstrates the problem.

What has become harder to do? I think it has become more difficult to introduce new approaches. Ten or 15 years ago it was quite straightforward for a minister and a few civil servants to get together and decide what's going to be done by way of policy and to introduce that. Maybe you say, "Well, that's part of the problem, isn't it, Andy?" But when you were trying to do things, you might have been bogged down locally in terms of the attitudes of the local managers and a few of the consultants. But now there's a more institutionalised bureaucracy. The number of people who have to be talked to, discussed with, squared, must make it very difficult to make progress except through some really concerted effort.

If you're sitting in a CCG, and you've got the health and wellbeing board, the local authority, the clinical senate, the NHS Commissioning Board, the Trust Development Authority, the Academic Health Science Networks all around you, it's a kind of institutionalised bureaucracy. So whereas before you had to tackle a few people who did not want to make change, now it is all getting more complicated in terms of the number of organisations that have to be dealt with. It is quite difficult to find out where power is in the system.

There are more people who can argue for doing nothing, because it's always easier to do nothing than to do something.

“Whatever one thought of PCTs and health authorities, there was at least a single organisation that was responsible. I keep coming back to the fact that there are now four or five organisations that are concerned with my care.”

In terms of the challenges as the reforms come in, responsibility is the first one. So ‘who is responsible for what?’ – I think that is increasingly unclear. So whatever one thought of PCTs and health authorities, there was at least a single organisation that was responsible. I keep coming back to the fact that there are now four or five organisations that are concerned with my care. And the opportunity in any system for buck-passing will be exploited.

The Commissioning Board is responsible for the primary care contracts and, therefore, I think, for the monitoring and management for poor performance in general practice, but actually that seems to be delegated more to CCGs, and how they will operate. I think it is confusing. And also there is formally no system manager as there was in the past with SHAs, although one is clearly emerging.

So it’s interesting that Bruce Keogh, who is from the Commissioning Board, is looking at 14 hospitals to ensure they’re adequate. And you might say that is reasonable as he is a commissioner. But maybe there are other people like CCGs who might have some responsibility for that in their own locality?

And we’ve now got Sir David Nicholson as the person who’s going to oversee the changes in south east London. So we’re going back to a system manager. But the way the responsibilities are set out in the legislation, it seems extremely unclear how they are actually going to be operated.

And there are obviously things like the sheer variability of 211 CCGs and how their performance is going to be made universally better. We didn’t really crack this with PCTs, or we sort of cracked it in a very crude kind of way through minimum standards and targets and things like that. But it’s hard to see what the levers are for improvement.

And what are we going to do about poorly performing practices? If we think that the variability of general practice has been a major source of health care inequality, it’s hard to see anything in the last 20 years that has directly tried to affect that. Ken Clarke introduced a contract in ’88 or ’89, which had some good things and tried to generate more competition between GP services.

But that failed because the public wasn't given the information about the quality of practices and nor did it have the inclination to move practice. It's hard to see what the approach is that will address that. That comes back to my very first comment – that if we think variability is a significant issue in general practice, then we need something that directly addresses variability rather than, “Well, let's have a system of incentives.”

We will have some measures being published about individual practices. But I'm not sure whether these are sufficient, and how they then translate into what would be done about a poorly performing practice and who would be responsible for this?

We can hope that peer pressure and peer review through the CCGs might help. The Commissioning Board has a role through holding the contract. But I doubt they have the means to deliver on that. Truly, I don't know what the answer is.

The money is a challenge, but I don't think that's as big a challenge as has been made out. I think the £20 billion is overstated, and the Nuffield Trust's work on the 'Decade of Austerity' illustrates that.⁶ But we do need a more authoritative government and departmental analysis of what the pressures are and what the real funding requirements are. That is fundamental to having a solid NHS that we know is capable of delivering.

My one major change that would make a difference to the NHS would be a steady growth in resources. Not the big increases of the 2000s variety, where 15 years of three per cent real would have been better than five years of seven per cent. That, and better access to capital, but there is little prospect of that.

My other one would be information – in terms of interoperability, the patient record, and all the data about clinical performance being more readily accessible, interpreted, and available for public and professionals. That I think would make a difference.

And for ministers? Try to find a way of avoiding restructuring and primary legislation. Ministers always think the pace of change is

⁶ Roberts A, Marshall L and Charlesworth A (2012). *A Decade of Austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*. Nuffield Trust.

“If more thought was given to the tools, much more could be achieved in terms of improvement in services in a five-year parliament than usually is.”

going to be a lot quicker than it is. But from their idea to actually starting to implement it on the ground is probably about two years, and can be more if legislation is needed.

But if a way was found of going with what already existed, two years might be cut from the implementation. So Andrew Lansley achieved nothing on the ground, despite all the effort centrally over two and a half years.

But if he had said, “I do want more clinical involvement and here’s an approach to do that. I want to see more focus on outcomes and we’ll start with these outcome measures” – that would have had much more immediate impact. But it’s been dissipated. The tools that are chosen are important to the timescales. If more thought was given to the tools, much more could be achieved in terms of improvement in services in a five-year parliament than usually is.

Sir Michael Rawlins



Sir Michael Rawlins has been Chairman of the National Institute for Health and Clinical Excellence (NICE) since its formation in 1999

You have to remember I'm the chair of an organisation rather than a former chief executive, like most of your interviewees. But my key lessons include keeping in touch with the stakeholders, which in my case meant the professions and the pharmaceutical industry, and the NHS Commissioning Board, in particular its chairman.

Secondly, keep in touch with parliamentarians, particularly those in government and supporting the government, and those who are in opposition. You need to do that because politicians can make the weather. And if they understand what we're doing they're less likely to criticise us. And if you stay in touch with the opposition they sometimes become the government and you have already developed a relationship with them. Also, try to spot up-and-coming backbenchers with a health interest. I did that with Andy Burnham, for instance, when he was just a backbencher, and then he eventually became secretary of state.

My third lesson is that when you or your organisation fouls up, don't get on the defensive. Put your hands up and put it right. And that, of course, applies to anyone doing anything like this in the NHS. It's not rocket science, is it?

In NICE's case, sometimes our guidelines go off course in the course of the development, and when that happens, we talk to the people involved and admit it and put it right. And when we were assessing mifamurtide, which is a drug for osteosarcoma in children, the appraisal committee was thinking of saying no because the Treasury discount rate we were using showed no benefit by the time they reached 50 or so. And I said that didn't sound right, so we changed it, and indeed the Treasury said we were right to.

The best thing for me about working in the NHS has been the privilege of being a doctor. And sharing with patients and their families the good times and the bad, and even the bad times are a privilege. And I think people should never forget that.

I loved teaching medical students. I still do a bit, but it's the one thing I really miss. Bedside teaching, the Socratic approach, letting them work out for themselves what's wrong from the first principles of anatomy, physiology, biochemistry, and all that sort of stuff. And you can do unusual things if you have a bit of imagination.

On one occasion I had a patient on the ward who had fought at Passchendaele. And I had three students who were going to be doing a ward round with me. I got the guy's permission before I did it, and said, "I'm not going to teach you this morning. You're going to speak to a man who fought at Passchendaele. And you will learn more medicine from two hours with him than you ever will with me." And the three of them, two boys and a girl, they all came out weeping.

On another occasion I had a man on my ward who was dying from lung cancer. He was a bachelor, ex-policeman. One day I saw him and said, "You are looking a bit glum" and there had been some scandal associated with the royal protection squad. And he said, "I didn't tell you before, but I was in the royal protection squad, and I looked after the Queen Mother for ten years." And he talked about it a bit. And that evening I just happened to mention it to a friend of mine, and he said, "Well I hope you've told the Queen Mother." And I said, "Well, I'm not exactly on those sort of terms ... How do I do that?" And he said, "Don't be such a fool. Write to her private secretary, tell him this gentleman is on your ward and you understood he knew her very well, and you thought she should know." And five days later I went on the ward and he was a changed man. He said, "I don't know how she has heard about it, but I've had a letter from the Queen Mother." And he showed it to me. And he died a happy man about a fortnight later. And I did more for him doing that than I ever did for him with any drugs or anything else.

Amongst the worst things about my time in the NHS is that we have messed up junior doctors' training big time.

I used to feel responsible for the young doctors who were under my care, as it were. But now there aren't any doctors under your care. Different ones come on every time. I used to take pride in their development and their successes. And we have lost the apprenticeship bit of it, so to speak. We don't have that responsibility for a group of young doctors that we did.

And I think we have messed up nursing big time. When I was a student and a young doctor, sisters ruled the ward. And they were marvellous. And that's gone. That's lost. They don't have that sort of role any longer, and that's bad. And I think that lies behind the

“I would have liked a mentor when I started as chairman of NICE. Somebody I could call up.”

Mid-Staffs stuff. When I was a young houseman at Thomas’s, the ward sisters used to teach me, and I relied on them.

I’m not sure why it has gone wrong. Nursing training now is nine months in lecture theatres and three months on the ward. In the old days, it was the other way around. And somehow along the line, the authority of the ward sisters has been lost. And their confidence too. I used to say to my ward sisters, “Why didn’t you tell Doctor X not to do it like that?” And they’d say, “Oh, I can’t tell a doctor what to do.” And I’d say, “Come off it, you’ve been ward sister for 30 years, and he’s been a doctor for two weeks!” They’ve lost the confidence somehow.

I would have liked a mentor when I started as chairman of NICE. Somebody I could call up. We sort of had that with the Appointments Commission. And the commissioners were sort of father figures to trust chairmen, and to people like me. And I think we’ve lost that.

Sometimes, new arm’s length body chairmen have got in touch with me and asked me for advice, and bits and pieces, and I’ve been more than happy to do that. It’s a pity we can’t formalise it, in a way.

What became easier over the years? The pharmaceutical industry became easier. At the beginning it was very hostile. But we made a great effort to go out to the States and Japan and talk to them. And they got used to us and realised we weren’t quite the ogre they thought.

And the *Today* programme became easier. I learnt that the trick was to go to the studio, however inconvenient it was. John Humphrys finds it more difficult to be rude to you when you’re sitting the other side of the table, and he’s got eye contact with you!

You asked about NHS management. I’ve been very, very lucky, in that I’ve had a superb chief exec in Andrew Dillon. We keep each other out of trouble. Or if we’re getting into trouble, we help each other out. Andrew – and it’s really him – has made NICE a can-do organisation. He drives a hard bargain with the department, and if they want us to do something, he drives a hard bargain to make sure we get the resources. But they’ve discovered over time that if

The regulator viewpoint: Sir Michael Rawlins

“One big change for the better would be to do service configurations quicker. Service configurations are very, very painful.”

we say we’ll do something, we do it. And up in Newcastle I had the famous Len Fenwick. I’ve been privileged to have worked with the crème de la crème, I suppose.

One big change for the better would be to do service configurations quicker. Service configurations are very, very painful. I’ve been involved in them, and I know how painful they are.

I very much agree with Bruce Keogh when he was recently talking about this, when he said MPs must not just join marches to save whatever hospital it is that’s threatened with closure, or the maternity unit, or the A&E, or something like that.

Many reconfigurations, or most, actually, are concerned with improving the quality of care as well as saving money. They need to be done quicker. We are still faffing around with children’s heart surgery and that is a relatively minor issue in the scheme of things.

I do worry under the new reforms about who is in charge. There are so many different bodies and it is not entirely clear where responsibility lies. But a former chief executive of the NHS said to me once during an earlier set of reforms, “The great thing about the NHS is that whatever we do in Richmond House, the doctors and nurses get on and do the job.” And I hope that culture will remain.

Anna Walker



Anna Walker was Chief Executive of the Healthcare Commission from 2004 to 2009

Key lessons? Well, if you're a regulator, then first of all you have to recognise the limitations on the changes that you can bring about. That's really important. You always need to think about that. Because that helps you position what you and the organisation is doing in the right way.

The second is, as a regulator, you need to be very clear on what methodology or methodologies you are using to get at whatever it is that you think you should be checking. We had a lot of debate on that in the Healthcare Commission. Ultimately we ended up with a number of different approaches to understand what was happening in a trust. Doing rail safety regulation, exactly the same is true here. We have a basic inspection approach but we also analyse an awful lot of information. We carry out inspections and, where we have a concern on a particular issue, we go to look specifically at that.

Whatever sector you are looking at, you need to use sophisticated information, which helps you understand the safety trends over a period of time. Ideally you need leading and you need lagging indicators. How many broken rails have you got? That's a lagging indicator. The mortality rates are a lagging indicator.

But the real question is can you get anything which would give you a forewarning of problems? Interestingly, I think there has been more work done to pull together risk models in rail safety than in health care. The reason, I think, is that people have been very conscious of the rail safety issues. Whereas in health, people tend to talk about the quality of care. And of course you must talk about quality of care. But if it is poor, it's actually safety of care. I think that's really quite an important point.

Then this debate which actually opened up on the back of the Healthcare Commission's report [on Mid-Staffs] and then subsequently the Francis Report, on what is the information that really tells you something about whether too many people are dying?

There is the argument that the mortality rate figures weren't good enough. That is true. But I have sympathy with the view that they tell you something, because all information tells you something.

I think this question of what the methodology is to get at what it is that you're looking at, and what information you use, are a big set of issues. Methodology requires both the looking and seeing, and the statistics.

Something else, I think, that we learnt in spades at the Healthcare Commission was how you need to use different sorts of information. The quantitative, which is the death rate or whatever, and then the qualitative, which is what the patient may tell you.

The challenge on the qualitative is how do you brigade that so that it is actually useful to you? We tried to do that, but it is quite hard. There are some very interesting issues. What numbers of complaints do you have? How do you tell if they are real? What are you going to do about them? The Francis Report brings that out. And then go and check how a trust is handling complaints, which we did do.

Do they handle complaints in such a way that they, at the end of it, genuinely try and take learning away? We did a study into that, whereby we discovered that even well-performing trusts, in handling individual complaints, found the learning from it quite demanding.

And trusts may encourage complaints or discourage them, so that a low figure, or a high figure, can be misleading. That's entirely true. We once put out a press release on the staff survey and said we were concerned about those trusts where there were very few staff expressing concerns. You could see why some of the trusts were worried about that. But we were trying to make a fundamental point.

You make the point that we have only been inspecting hospitals for a decade, and so we are still learning how to go about it. I think that is absolutely right. That's where some of the learning from Francis needs to be very sophisticated.

Because what we know is that it is not easy. It's not easy if a trust itself isn't facing up to the problems. You can go and walk around a ward, but you may not see the problems that are going on. Because they may be about quality of clinical results, or the unseen distribution of infections. You've actually got to use a number of different methodologies to get there. We need to get better at it over time, so it tells you more.

“Regulation is complex and it needs time to evolve and ensure lessons are learnt on what works best.”

I do think it's incredibly important that it is crystal clear that the trust and the trust board has prime responsibility for the service. Francis has moved that on quite considerably. Because both his reports are clear that you have to start with the trust and its board.

But what Francis seems to have picked up on in his recommendations is the criminal sanctions bit of our health and safety at work legislation – new criminal sanctions for board members and staff. But he has not, in the recommendations, picked up on the front-end of that legislation, which does make it crystal clear that it's the provider of the service that has the duty to think about the risk and have a plan for dealing with the risk.

This is important, because it gets the provider of the service to think about it. Only the provider of the service knows when they are changing the service and whether that brings risks that have actually changed.

We worked very hard to get a methodology which would require the trust and the board to think about the provision of its own service, because we believe that was absolutely crucial.

Regulation is complex and it needs time to evolve and ensure lessons are learnt on what works best. The first thing that happened after Ian's report into Bristol [Sir Ian Kennedy's report on paediatric cardiac deaths there] was the Commission for Health Improvement [CHI]. They went in to look in depth at trusts every four years. That was an improvement on what went before. But it also had certain problems. We worked hard to deal with those problems. And the Francis Report actually says that what the Healthcare Commission did was an improvement on what went on before. I'm actually really trying to make a very, very profound point about regulation – which is that these things are complicated because the organisations that you're dealing with are complicated.

You have to learn over time what works in terms of regulation to really get under the skin of things. That means you have to have a learning culture and not be defensive. It also means that it cannot be right to serially pull these regulatory organisations up and reorganise them. Because we [the Healthcare Commission] weren't the first that that happened to. We were the third. I think the National Care Standards Commission lasted 17 days before

“I think that Francis himself became personally very convinced that it was extremely important that responsibility began with those providing the service.”

they were told they were being abolished. We lasted a glorious 11 months before our abolition was announced – although it was a further four years before we were actually abolished. I think it was about three years that CHI lasted. It may have been four. But it was happening serially.

You’ve asked if we expect too much of regulation and inspection. Unequivocally there is that danger. I think the regulator can do something about that by making it clear what they think their role is and what it isn’t.

It’s in that context, actually, that the general health and safety law helps by being crystal clear. It is the provider of services that has to assess the risk. When the Francis Inquiry started, the first draft of the terms of reference we saw made it clear that the thinking was that the regulator was responsible for the quality of service. We pointed out that there was a real issue about that. And the Inquiry very fairly took that point on board.

Indeed, I think that Francis himself became personally very convinced that it was extremely important that responsibility began with those providing the service.

EDF (the power company) came and talked to the Inquiry team and I understand that when it was put to them that the regulator needed to be the one that spotted problems in the nuclear sector, EDF was absolutely crystal clear that the responsibility began with them. Because there is a level at which believing in inspection and regulation can give you a huge sense of false comfort. As you put it, “I’ve passed my inspection, so I don’t have a problem. So I don’t address the things that the regulation didn’t spot.” That’s absolutely right.

But that doesn’t let the regulator off the hook. The regulator has to ask themselves a rather different set of questions. They have to ask themselves what are the indicators in this sector which might tell me the way things are going? Am I looking at those systematically and professionally? Am I then ensuring that I am following them up? What am I doing to check that the organisation that owns the risk is checking – are they really doing what they need to do in relation to the risk? That’s something you can check about those that you’re actually regulating.

There is another issue. In any sector that is complex – and that tends to be all sectors but particularly those, I think, which are providing public services – what you find is a number of organisations which have responsibility for part of this jigsaw of safety. In health care you've got Monitor, you've got the CQC, you've got the GMC, you've got the Royal Colleges, you've got the BMA and the Royal College of Nursing and so on. You've got lots of them. They have to cooperate. Clearly that didn't happen as well as it could have at Mid-Staffs, although the Healthcare Commission always put a lot of effort into joint working. But I have plenty of examples of where joint working does occur. You can require people to cooperate. But the requirement in legislation, which we actually had at the Healthcare Commission, is not enough.

We are back to the culture issue. It needs to become a professional ethic. Then I think it's a very exciting story.

That is what happened in Cornwall. I don't want to mention the name of the trust, but what happened is that the Health and Safety Executive had some information, and we had some information – as, I recall, did the then Audit Commission. And they sat around the table and they shared all this information. And they said, "This story, as a whole, is a real worry and concern." What they then did was take it to Sir Ian Carruthers, as the then chief executive of the SHA. And he acted. There was an in-depth look into what was going on there.

Now you contrast that with the SHA in the case of Mid-Staffs. One of the questions you ask is what surprised me? One of the things that really surprised me was the extent to which the trust and the SHA, and it was both of them, went on arguing, even after Heather Woods' draft investigation report, that we should not be using those sophisticated mortality statistics.

I couldn't believe that. The reason I couldn't believe it was that I had said, "Look, these statistics don't, of themselves, condemn. They raise questions. On the back of that, we've gone into the trust with an investigation asking these questions. We have now got an evidential story. And that evidential story is deeply worrying. Don't argue about those statistics. Turn and help us sort the issue out."

“There was absolutely no doubt that we saw quite a lot of bullying management culture in one way or another. It came through the staff surveys, it came through in the patient surveys and through those trusts where we carried out investigations.”

Our annual ratings suggested that there were a third or so of trusts which needed attention. There were about a third that had got stuck in terms of not improving, and they were a worry to us. And there were a third which were either good in the first place or took the messages and acted on them.

You asked about the management culture. I think you’ve got both extremes. There was absolutely no doubt that we saw quite a lot of bullying management culture in one way or another. It came through the staff surveys, it came through in the patient surveys and through those trusts where we carried out investigations.

Equally, however, going around the country and visiting a lot of hospitals, I was also aware that if you went into a hospital and the statistics told you it was pretty well performing and the atmosphere was positive, on the whole what you found was that the clinicians and the management were working well together. So you could find some extremely good practice as well.

But there is another important point in all this, which is what are you asking your regulator to do? Are you asking your regulator to ensure simply that minimum standards are met? Or are you asking your regulator to encourage improvement? Not just the safety net for minimum standards. Or do you want to leave improvement – stretch – only to the commissioners?

I think, if my assessment is broadly right, that there are two-thirds of trusts who are either stuck or you have concerns about, you want to find some way of the regulator providing a framework for national stretch.

Now you can do that working with the commissioners. You can work in partnership with each other. One thing I am very attracted by in the Francis Report is this emphasis on the recommendations that standards should be discussed with the Royal Colleges, should come from NICE, be endorsed by the Commissioning Board. In other words, they are not the creature of the government or the regulator. They are owned by the sector as a whole. Sir Ian Kennedy always stressed the importance of standards which reflected the key concerns on quality of care of the relevant doctors.

But I do not believe that Ofsted would have the national confidence which by and large it commands if all it was actually doing was checking the basics in schools. Its aim is to encourage improvement, as is the requirement for regulators (HSE [Health and Safety Executive], the Office of Rail Regulation) under general health and safety law.

The question of improvement is a deeply, deeply fundamental question. And it's one that Ian [Sir Ian Kennedy, chair of the former Healthcare Commission] feels passionately about. And it is not being discussed enough.

Let me give you a very brief description on the ground. I chair a charity for young people who have very severe epilepsy. We provide a school and a health centre and residential care, all of which we hope is cutting edge, for these children, some of whom are severely disabled. We are inspected and regulated both by the Care Quality Commission and by Ofsted. We react very, very positively, given the interests of the children, to the stretch which goes into the Ofsted approach. They come, they look at us, they tell us they're moving the goalposts on. They judge us against that. We gear ourselves up to ensure that we get into their top two categories, if we possibly can.

The Care Quality Commission come and they tell us that our health care centre is outstanding. But all we get is this report, which describes some standards, which mean almost nothing to anybody, and whether we've met the basics or not. It is no help either to us in trying to improve for the next stage or to the parent who is thinking, "Do I put my child into Lingfield or do I take them to some centre up in the north of England?" Although I note that the CQC is proposing to expand their reports.

And that leads me into the whole question of information. I'm a regulator who would like to see less regulation. I want it to be effective. But I'd like there to be less of it. I do think the provision of information is very, very powerful in achieving this.

You can have regulation in all sorts of ways. You can compare and contrast organisations, and actually that's what we were doing at the Healthcare Commission. That's what we're trying to do with

“I strongly believe regulation has to be about more than just minimum standards. If you are asking people to come and just do the basic policeman act, you are going to get a lot of inspectors who want to trip people up.”

Network Rail, by the way, now. Let’s break it down into units and compare and contrast, which allows probing questions to be asked.

You can then provide information as a regulator about your regulatory conclusions on organisations. When we began to publish that in an effective way, some organisations which we used to have difficulty with suddenly began putting things right.

And there is another set of things which people really want. That’s the publication of generic information which will tell you how good or not services are across the hospital, or certain aspects of the service.

In other words, that is information which may not be generated by a regulatory inspection. But it actually does tell you something about the quality of care. For example, the C. diff rates and the MRSA rates.

And you need it broken down within a hospital. And then you want something that a patient can push a button and get. But over a period of time, our technology is going to allow all of that to be done. And of course the NHS is trying to do just that already. But I do think the amount that you can gain through transparency of information is really worth working at.

We began working with Brian Jarman’s unit [at Imperial College] which gave us all the outlier statistics they were getting when looking at different conditions in hospitals. The statistics people we had, who were very good, analysed those and where there were concerns took them up with the trust. In, I think, something like 90 per cent of the cases where we raised concerns, the trust took on board the issues and moved to do something about it. You’ve then got a whole system which becomes more focused on, “What information can I use which will be helpful to me and the patients I am serving?”

I strongly believe regulation has to be about more than just minimum standards. If you are asking people to come and just do the basic policeman act, you are going to get a lot of inspectors who want to trip people up. Over a period time, you get a culture which is very unattractive. That’s not an over-riding argument, but I think

it is quite an important one. I cannot tell you how different the feel is of an Ofsted and CQC report at the moment.

There is a very important balance to be achieved between pulling together information, visiting and the patient voice. All are needed. And I think it is very important not just to criminalise activity. I have some real anxieties over criminal sanctions, particularly if these were to be introduced without the other elements of health and safety legislation in this country, which makes it clear that the duty of assessing safety risks lies with the service provider and they must act on this.

Biographies

Dame Ruth Carnall DBE

Dame Ruth Carnall DBE was appointed as Chief Executive of NHS London in April 2007. Prior to that, from 2004, Ruth worked as a freelance consultant in NHS London and government departments including the Prime Minister's Delivery Unit and the Home Office. Ruth was a Non-Executive Director at the Cabinet Office until 2010 and, until April 2007, was a Non-Executive Director at Care UK plc and Chair of Verita, a small private company that undertakes investigations and inquiries in the public sector.

Prior to 2004, Ruth worked in the NHS for over 25 years. During this time, she undertook senior leadership positions at local, regional and national levels. Her career began in finance, holding various posts in a number of NHS organisations before taking the position of Finance Director at Hastings Health Authority in 1987. In 1992 Ruth became Chief Executive at Hastings and Rother NHS Trust. She was Chief Executive of the West Kent Health Authority for six years before she moved to the civil service to take the position of Regional Director, South East and then Director of Health and Social Care for the South. From April 2003 until the end of September 2004, Ruth served as Director of the Departmental Change Programme at the Department of Health.

Ruth lives with her husband and two teenage sons. She was awarded her CBE for services to the NHS in 2004 and later received a DBE in 2011.

Sophia Christie

Sophia Christie was Chief Executive of Eastern Birmingham PCT from 2002, leading a merger with North Birmingham to create NHS Birmingham East and North from 2006. With an international reputation for innovation and health improvement, in its first year of operation it achieved top decile performance in governance and assurance and went on to become the highest-performing PCT in world class commissioning and one of only five health systems internationally identified in Canada's Quality by Design initiative.

She now works independently supporting organisations, and the systems in which they operate, to develop, align and enact strategy,

performance and delivery. A member of the Vista Network, and founder member of the European Organisation Design Forum, she also works independently on public policy analysis and development, building on her role as a regular columnist with the *Health Service Journal* from 2006 to 2010.

Robert Creighton

Following nine years as a PCT Chief Executive, Robert Creighton is now Director of Public Health Transition at NHS London, responsible for leading the transfer of public health functions from the NHS to local government and Public Health England. The transition is being taken forward as a joint programme between the NHS and the 33 councils in London. Robert also has a role as an Honorary Senior Lecturer at the London School of Hygiene and Tropical Medicine. From April 2013 he will oversee the legacy programme of the NHS in London.

Between 2002 and 2011, Robert was Chief Executive of Ealing PCT, and in 2010 took on additional responsibility for the PCTs in Hillingdon and Hounslow. He created Ealing PCT from its inception and led it through its whole period of existence, until the formation of PCT clusters in 2011. Initially the PCT was a large provider of community services, and Robert oversaw its evolution into a commissioning-only organisation; in the process he led the creation of a pioneering integrated care organisation, joining the community services of Brent, Ealing and Harrow with Ealing Hospital.

From 1995 to 2000, Robert was Chief Executive of Great Ormond Street Hospital NHS Trust, the country's leading children's hospital, where he led the organisation through extensive strategic change, securing investment in a major rebuilding programme and strengthening research links with the Institute of Child Health.

Before joining the NHS, Robert was a senior civil servant in the Department of Health (1988 to 1995), where he was for two years the Department's Principal Private Secretary, while Virginia Bottomley was Secretary of State. His early career was in teaching and international development, first as a teacher and for ten years Deputy Director in the head office of an international educational charity, United World Colleges.

Kathy Doran

Kathy Doran has worked in the public sector for 35 years, as a civil servant and as an NHS manager. Her most recent post, from which she retires on 31 March 2013, is as Chief Executive of Cheshire Warrington Wirral PCT cluster, comprising four PCTs. Before this she was Chief Executive of Wirral PCT from 2006 to 2011, and of Birkenhead and Wallasey PCT from 2002 to 2006. She was Head of Primary Care at the Department of Health from 2001 to 2002. She also worked at the former Wirral Health Authority from 1995 to 2001 and Wirral Community Trust from 1993 to 1995.

Before working in Merseyside, Kathy worked in a range of posts in the Department of Health and the NHS in London, working variously on a number of NHS reorganisations, in ministerial and Chief Medical Officer private offices, acting as secretary to reviews of public health in England and primary care in inner London and the introduction of clinical budgeting in Guy's Hospital in the early 1980s.

Dr Chris Gordon

Dr Chris Gordon is the Programme Director for QIPP at the NHS Leadership Academy, leading an innovative confidential support programme for executive teams of NHS organisations; helping them to refine strategy and procure support to ensure effective implementation.

He was Chief Executive of Winchester and Eastleigh NHS Trust from 2010 to 2012, leading it through a complex merger process while maintaining quality of care and performance. Prior to this he was the Medical Director for the trust. He is a consultant physician specialising in movement disorders. His most recent publications are on falls in older people, Parkinson's disease and clinical leadership.

Brian James

Brian James retired as Chief Executive of the Rotherham NHS Foundation Trust after eight years in post, and after a 37-year career in the NHS, of which he loved (nearly) every minute. He has held a wide range of executive and director posts during his working

References

life, including responsibility for strategy, business development, operational management and information management and technology, at both hospital and SHA levels, but is perhaps most noted for his involvement in the TV programme *Can Gerry Robinson Fix the NHS?*.

Andy McKeon

Formerly a career civil servant at the Department of Health, Andy McKeon led on several major White Papers reshaping the NHS. He also had responsibility for primary care and all pharmaceutical matters.

He joined the Audit Commission in 2003, where he was responsible for all the Commission's work in the NHS and on wider health matters. During his time at the Commission, he undertook a review for the Secretary of State on the NHS's financial management and accounting regime, and produced a number of major studies on the NHS and public health issues more generally.

Andy is a Trustee of the Nuffield Trust and an Adjunct Professor at the Centre for Health Policy in the Institute for Global Health Innovation at Imperial College London. He is also a Non-Executive Member of NICE and a Non-Executive Director of Egton Medical Information Systems.

Dr Lucy Moore

Dr Lucy Moore is an Associate Director at Deloitte corporate finance, supporting Deloitte national NHS restructuring practice.

As an acute trust Chief Executive for seven years, Lucy turned around the patient experience, operational and financial performance of Whipps Cross University Hospital Trust in East London. As Integration Director, Lucy led the merger, transaction and integration of Whipps Cross, Newham Hospital and Barts and the London to create Barts Health which has a turnover of £1 billion and is the largest acute trust integration in the country and formed on 1 April 2012.

Lucy played a key role in delivering strategic change within the health economy, including changes to local emergency care, stroke, cancer and vascular services.

Lucy is a doctor by training, has worked in public health, workforce development and education and has a track record and reputation of achieving significant and transformational change in difficult and complex circumstances.

Candy Morris CBE

Candy Morris CBE is NHS Research Champion and was most recently Senior Responsible Owner for the establishment of the Health Research Authority. Candy is also Senior Responsible Owner for Southern Programme for IT. She was previously the Chief Executive of South East Coast Strategic Health Authority, covering Kent, Surrey and Sussex, where she was also the SHA Chief Executive lead for Europe.

Candy earned a degree in biochemistry at Oxford University, joining the NHS as a National Trainee upon graduation.

She has worked in all sectors of the NHS in the North West and Trent, serving as Chief Executive of Scunthorpe and Goole Hospitals Trust for eight years before moving south, initially as Chief Executive of West Sussex Health Authority in October 2000.

Until September 2012, she was Chair of the National Institute for Health Research Advisory Board, which provides strategic direction for research and development in the NHS, a flagship priority for the NHS whose research and development work has won international recognition.

She is now Interim Shadow Chair of the Health and Social Care Information Centre, a non-departmental public body being established on 1 April 2013 under the Health and Social Care Act 2012.

Sir Michael Rawlins

Sir Michael Rawlins has been Chairman of the National Institute for Health and Clinical Excellence (NICE) since its formation in 1999. He is also an Honorary Professor at the London School of Hygiene and Tropical Medicine, University of London, and Emeritus Professor at the University of Newcastle upon Tyne.

He was the Ruth and Lionel Jacobson Professor of Clinical Pharmacology at the University of Newcastle upon Tyne from 1973 to 2006. At the same time he held the position of Consultant Physician and Consultant Clinical Pharmacologist to the Newcastle Hospitals NHS Trust. He was Vice-chairman (1987 to 1992) and Chairman (1993 to 1998) of the Committee on Safety of Medicines; and Chairman of the Advisory Council on the Misuse of Drugs (1998 to 2008).

Dr Tim Richardson

Dr Tim Richardson entered medicine as a mature student having had an initial career as a merchant navy navigation officer.

After medical school (St Bartholomew's London) and training jobs, he became a GP partner in Epsom in 1983.

He was the lead partner for fundholding, total purchasing (1991 to 1999) and the extended PMS integrated (primary, community and secondary care) provider contract (from 1998 to present) having set up the first community outpatient/day surgery polyclinic in the Old Cottage Hospital Epsom.

He was the lead and Chair of the local practice-based commissioning group covering the 160,000 population in Surrey from 2004, until retirement from general practice and commissioning in 2012.

Tim is currently Medical Director of Epsomedical Ltd, which operates two-day surgery polyclinics in Surrey.

Nicholas Timmins

Nick Timmins is a Senior Associate at the Nuffield Trust, and a Senior Fellow at the Institute for Government and The King's Fund. Between 1996 and 2011, he was Public Policy Editor of the *Financial Times*. Nick is also a Visiting Professor in Public Management at King's College London, and in Social Policy at the London School of Economics.


Previously he worked for the science journal *Nature*, The Press Association and *The Times*. He was a founder member of *The Independent*. He is also an honorary fellow of the Royal College of Physicians and author of *The Five Giants: A biography of the welfare state*, which tells its story from 1942 to 2001.

Anna Walker

Anna Walker is Chair of the Office of Rail Regulation. She was Chief Executive of the Healthcare Commission from 2004 to 2009. She has wide-ranging experience in regulation and performance improvement. Anna was Director General responsible for rural policy at the Department for Environment, Food and Rural Affairs from 2001 to 2004, Director General of Energy at the Department of Trade and Industry from 1998 to 2001 and Deputy Director General, Office of Telecommunications from 1995 to 1998. In 2008/09 she led an independent review for the government into water charging.

She is also Chair of Young Epilepsy (a charity providing health, education and residential support for young people with epilepsy) and is on the Board of Welsh Water.

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