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Oral Evidence

Taken before the Health Committee

on Tuesday 5 March 2013

Members present:

Mr Stephen Dorrell (Chair)
Andrew George
Barbara Keeley
Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Sir David Nicholson KCB CBE, Chief Executive, English National Health Service, Professor Sir Bruce Keogh KBE, NHS Medical Director, and Liz Redfern CBE, Director of Nursing, NHS South of England, gave evidence.

Q86 Chair: Good morning and welcome to the Committee. The first thing I have to do this morning is to present apologies on behalf of four of our colleagues on the Committee who have been detained elsewhere and have asked that their apologies be presented. Chris Skidmore, Grahame Morris, Rosie Cooper and Andrew Percy are all unable to be with us. We are grateful to you for joining us this morning.

I would like to say a word about the background and the purpose of this morning’s session before we start. The background is, sadly, very familiar to all of us—a scandalous failure of care in an NHS foundation trust that was supposed to serve the people of Mid Staffordshire. I think we all agree that it is deeply shaming for the national health service as an institution that these events should have happened. It is shaming for the NHS as an institution and also for those individuals who are implicated in that failure of care—so shaming, in fact, that it prompted an apology by the Prime Minister to the House of Commons following the publication of the second Francis report. That is the background.

The purpose this morning is to hear from our witnesses how these circumstances came to be and what now needs to change as a matter of urgency within the health service to ensure that nobody needs to sit on an equivalent Committee one, two, three or five years hence, answering questions about similar circumstances having arisen again.

The report by Robert Francis attempts to address those questions. He builds his 290 recommendations around a core requirement for a change of culture in the way care is delivered in the health service. I would like to open the questioning by asking our witnesses what they understand by this phrase “change of culture”. What does it mean, and, perhaps even more importantly, how is it going to be brought about?

Sir David Nicholson: Thank you. One of the things that Francis says in his report and has said subsequently is that everybody who was involved—everybody who was in the NHS at the time—needs to reflect on the report and the sorts of things that you described, and work out for themselves what they need to do, both in terms of changing the way they are and what they need to do going forward. That is a really important bit of thinking about culture.
If I reflect back on the report—and I have to say that I reflect back on both reports because there was, obviously, the first one that particularly dealt with the hospital. I remember the time that I sat down and went through those patient stories. There is a great big pile of patient stories that were published at the time, and I spent the whole weekend going through them. Like anybody, any human being—particularly someone who has spent almost all their professional life in the NHS trying to improve services for patients—it was a deeply, deeply saddening process. Out of that, I wrote to all the chairs and chief executives saying that every board should read those patient stories. They were not statistics or targets; they were patient stories. In terms of understanding the way a culture operates, understanding those stories is really important.

All I could do in those circumstances, as you know, was to apologise to those people, because not only did they get really poor, appalling care, but also, when they faced the NHS with these issues, the NHS denied it had happened, which was absolutely appalling. In response to that, I decided to redouble my efforts to improve quality and services in the NHS, and that is what, hopefully, people will say I have been doing over the last few years.

When I particularly reflect on the culture at that time in 2005-2006, I was responsible, as members know, for 10 months for one particular strategic health authority; there were three that I was responsible for. Essentially, the Government had announced their abolition or merger together, so I was running them down. The NHS at that time was neither equipped nor capable of monitoring the quality of those organisations. Not only that, but the strategic health authority that I was responsible for neither had the capability nor the capacity to do it. On top of that, there was no sharing of information across the system as a whole, whether it was regulators or whatever.

In a sense, that analysis led me to apply for the job of chief executive of the NHS. This is not something I am saying now; I actually said it at the time—that I felt at that particular moment that the leadership of the NHS had lost focus on what was really important for patients, which was patient safety and the improvement of services. So that is what I started to do right from the beginning as chief executive of the NHS, whether it was focusing attention on improving services for stroke, coronary heart disease or cancer patients, or attacking infection in our hospitals, or whether it was making sure that when patients were diagnosed they were treated as fast as possible.

At the moment—and this is why the culture point is so important—the NHS is facing its greatest challenge. In the next few days, we will abolish over 160 organisations and set up another 211 local organisations and a whole myriad of national ones. We will completely change the way in which we allocate resources and incentivise the NHS. At the same time, we are losing—well, we have already lost—13,500 administrative and management staff, who have all that corporate memory in them. It is at maximum risk over the next few days.

I said two years ago that I would take the responsibility of leading the NHS through this enormously complex set of changes. I promised both the Government and the NHS that I would see that through. I am absolutely determined to do that over the next period.

On top of that, of course, the Francis review gives us a huge opportunity to accelerate some of the changes that certainly I have been advocating for some time, but which Francis sets out really well in his document, around getting patients at the centre, zero tolerance of patient safety incidents, tackling a whole series of issues with the way hospitals are run, and transparency. We have a real opportunity to do all of those things over the next period, and I am really looking forward to making that happen.

**Q87 Chair:** Can I bring you back to this concept of culture change and my question about what is at the heart of the change of culture required? If you had to put three bullet points on a sheet of paper as a circular round to the NHS, what are you looking for, and how,
when you go to a trust in April or May 2013, are you going to make yourself confident that they get it—that they understand the need for change?

Sir David Nicholson: The first thing—you can see it absolutely played out in Mid Staffordshire and in parts of the NHS where there is poor care—is that motivated, supported staff provide great outcomes for patients. That connection seems to have been lost in a whole set of discussions about systems and processes. It is that basic fundamental thing. What you do when you go to a hospital is you talk to the staff, look at their results, see what they are doing, and you make an assessment as to whether they are supported and whether they feel that they can provide the best care for their patients. That gives you a really good opportunity to judge whether outcomes are better.

The second thing is that one of the things that came out of the report “High quality care for all” was that what really high-performing clinical teams do is measure things. It is the distinctive characteristic. As well as having the compassion, they measure things. If I think about 2005, there were probably 20 or 30 indicators around that you could measure. As we sit here today, we publish for most hospitals—in fact, all hospitals—over 600 various measures, such as stroke audits and all of that. So it is measuring things. What they do is they measure things, set themselves goals and deliver improvement for patients. Then they benchmark themselves against other clinical teams. That is the way they drive improvement. So you would look in a hospital at the way in which improvement for patients is driven.

The third thing is this thing about patient focus, and it is very interesting. One of the things I often see when I go round to hospitals is that most of them have in their strap-line or mission, “We love patients,” or “The patients are at the centre of all we do,” and all the rest of it, but they sometimes find it quite difficult to explain how they put that into action. But that is a really important question. They are the three things I would say about hospitals.

Q88 Chair: I will have one more shot and then I will pass it to Valerie. Two linked words that I was listening for in what you said, which I think reinforce what you have described as your three bullet points but which you did not use, are “accountability” and “openness”. Both words feature strongly in the Francis report. Do you not think that needs to be an important part of what we understand by “culture change”?

Sir David Nicholson: Absolutely. I did not mention those words particularly, but, if you think about what I was saying there, particularly this issue about measurement and transparency in what we do—I am sure we will get on to hospital standardised mortality and all that sort of thing at some stage during the conversation—that kind of data is really important to get out among the population so that we can have really transparent discussions about it. It is the thing that will drive change in the system—clear accountability; accountability at every level, from the accountability of individual professionals to their patients, through to the accountability of the chief executive of the commissioning board and the Secretary of State.

Q89 Valerie Vaz: Good morning, Sir David. Please do not feel that this is a trial; this is trying to elicit some information, as not all of us could be at the Francis inquiry. I have before me your statement, and I hope one of your officials is going to give you a copy of the statement because I do want to refer to it. Earlier you said you sat down and read patient stories. When did you do that?

Sir David Nicholson: That was when the first Francis report was published; so that would have been 2009. He published both the report and an annex with all of the patient stories in it.

Q90 Valerie Vaz: You did not do that at the time when you were at the SHA.
Sir David Nicholson: No.

Q91 Valerie Vaz: I suppose that is what struck me about your statement. It is very much like you are a process man and a procedure man, and I could not find anything—and please help me if I have made a mistake—about patients in there, what you are going to do and quality of care. Is that fair?

Sir David Nicholson: It is certainly unfair to say that I am a process man. Anyone who works with me or understands the way I work knows that I am absolutely focused on improving services for patients. Certainly in my substantive job, which was as the chief executive of Birmingham and the Black Country, there are lots of examples of how I drove patient improvement there, particularly around people with long-term conditions and hospital services. So there is a good record.

The issue for me is that during that period, across the NHS as a whole—not just in that part of it—patients were not the centre of the way the system operated, for a whole variety of reasons. It was not because people were bad or anything like that, but because there was a whole set of changes going on, a whole set of things that we were being held to account for from the centre, which created an environment where the leadership of the NHS lost its focus. I will put my hands up to that and I was part of that, but, in a sense, my learning through all of that is never to let it happen again.

Q92 Valerie Vaz: I also could not find an apology in there.

Sir David Nicholson: I am sorry, but I did apologise at the time. I subsequently apologised.

Q93 Valerie Vaz: Yes, but not in the statement.

Sir David Nicholson: Is there not one in the statement?

Q94 Valerie Vaz: I am asking you. It is your statement.

Sir David Nicholson: I am absolutely sure there is an apology somewhere in there.

Valerie Vaz: Good. Maybe you can find it later.

Sir David Nicholson: I am absolutely confident there is.

Q95 Chair: Can I turn to page 22, paragraph 75? Right in the last sentence you said: “I had oversight of the day to day operation of the three SHAs whilst also designing the future.” So you were the one in control. Is that right?

Sir David Nicholson: Where is this?

Valerie Vaz: It is the last sentence.

Sir David Nicholson: Okay, yes.

Q96 Valerie Vaz: You are the one in control. You are responsible for all the SHAs there.

Sir David Nicholson: I was responsible for the three SHAs at the time.

Q97 Valerie Vaz: That is what you said there—okay. Now, in paragraph 79, page 23, in the middle, you say: “My feeling was that people were not being properly held to account, for example, action plans were being agreed but not delivered. There were also a number of issues in the area that needed sorting out.” What did you do about it?

Sir David Nicholson: I sorted them out.

Q98 Valerie Vaz: What did you do?
**Sir David Nicholson:** If you think about that time, I was—

**Q99 Valerie Vaz:** No, no; I was not there. I am asking you because you said there were some issues and things were not being delivered. So what did you do about it, having said that you had oversight of all the SHAs?

**Sir David Nicholson:** I appointed a managing director for each of the strategic health authorities. As you can imagine, given that I was running three and at the time I was responsible for the national work on HR, the amount of time I could spend in each individual one was relatively limited, so I put people in to deal with that.

The issues that we were tackling were that many of the organisations were having difficulties delivering what you might describe as the basics for the service, as defined at that time. I have to say the definition at that time was essentially that access was the way in which quality was defined. So their ability to deliver their A and E targets and access waiting times for patients and to reduce healthcare-associated infections were the things that the whole of the NHS and those SHAs were held to account for and were effectively working on at the time.

**Q100 Valerie Vaz:** That was to you. They were obviously held to account to you.

**Sir David Nicholson:** Yes, and I was held to account nationally for those things.

**Q101 Valerie Vaz:** Yes. On page 25, in paragraph 84 you talk about talking to the three chairs. What did you talk about?

**Sir David Nicholson:** Sorry, I will just find—

**Valerie Vaz:** Do you see your quote: “I will continue to take oversight of the process for establishing the proposed new SHA and will continue in my role as Chief Executive, with the three Chairs to take overall responsibility for the management of the three SHAs…I will meet with them on a fortnightly basis”.

At that stage, when you were talking to these three chairs, did you find any rumblings about what was going on at Stafford hospital?

**Sir David Nicholson:** No. There were absolutely no rumblings. The local chair and the three boards continued to operate during that period. The local chair raised no issues. I am sure in his statement to the inquiry that he said he had no idea that the kind of appalling care that was going on at Mid Staffordshire was actually going on.

**Q102 Valerie Vaz:** So people are running an organisation and do not know what is going on. That is effectively what you are saying.

**Sir David Nicholson:** The SHA was not operationally responsible for the trust. There is an issue about accountability here that I want to explain. Part of the issue here is that people see the NHS as an organisation, when it actually is not. It is a healthcare system. It is a whole set of statutory bodies with their own legal responsibilities. Mid Staffordshire NHS trust was a statutory body with its own accountable officer, accountable to Parliament. The system is built up to make that accountability run at hospital level.

As you can read, both the Francis reports say that the primary accountability for what went wrong at Mid Staffordshire hospital was that particular hospital, and those individuals were held to account. As you know, the chair, the non-executive directors, the chief executive, the finance director, the corporate affairs director and the medical director all went. The nurse director was moved. So it is not true to say that people were not held to account in the NHS. They were and they went.

My accountability was very different from that in the sense that I was held to account for delivering the change: for delivering three SHAs into one; for moving...
probably 70 PCTs into about 40, or 32—I cannot remember the exact number—at that date; for making sure that all the organisations delivered what was regarded as the “must-be-dones”, which is essentially access and MRSA and C. diff. reduction. That was narrow. I accept that that was a narrow definition of accountability, but that was the way in which it worked. I think it shows in the Mid Staffordshire Francis report that that was a big failing in the whole system.

Q103 Valerie Vaz: And you were in the middle of it.
Sir David Nicholson: I was in that system—

Q104 Valerie Vaz: You were in the middle of it.
Sir David Nicholson: —and I was part of it, absolutely.

Q105 Valerie Vaz: Turn to paragraph 87, page 27, where it says that counsel to the inquiry said that Cure the NHS said it was chaotic. Cure the NHS described it as “chaos” in the west midlands, and you have refuted that. What would you call it then? You have just described something to me that sounds very chaotic.
Sir David Nicholson: No; I did not say it was chaotic.

Q106 Valerie Vaz: What would you call it then?
Sir David Nicholson: I think the system in the west midlands as a whole—

Q107 Valerie Vaz: No. What would you call it, Sir David? If it is not chaotic, what would you call it? What name would you give to this process that is happening that you are in the centre of?
Sir David Nicholson: We were taking through a set of changes that were very difficult, that involved losing members of staff, changing organisations, losing corporate memory, all of those things, but it was done in an organised and planned way. It was not haphazard and it was not chaotic. It was actually planned and organised.

Q108 Valerie Vaz: The core function of the NHS is to make people well. You did not know anything about that. None of these concerns that happened at Stafford hospital came through to you while you were undergoing this process.
Sir David Nicholson: None of the—we had no—I had no idea. The information was not brought to the SHA. We did not see any of the information that would lead you to believe that there was all of this going on in Mid Staffordshire. As shocking as it is, that is the truth. It is not to say there was not information around in the healthcare system before I got there—and by other organisations—but we did not in the NHS at that stage. Shropshire and Staffordshire were no different, I guess, from most other places, where there was no culture of sharing information across the system.

Q109 Valerie Vaz: We are just talking about your particular area, aren’t we?
Sir David Nicholson: Yes.

Q110 Valerie Vaz: Did you ever get information about mortality rates?
Sir David Nicholson: No.

Q111 Valerie Vaz: Never in all your time.
Sir David Nicholson: No.
Q112 Valerie Vaz: When did you first become aware of mortality rates generally?
Sir David Nicholson: When I was appointed as chief executive of the NHS, Dr Foster published a whole set of them, which I guess would have been in 2000 and—

Q113 Valerie Vaz: And you never knew in all your time in the NHS—from trainee—about people dying at all, at any level.
Sir David Nicholson: Of course, I—

Q114 Valerie Vaz: “Of course” in what way?
Sir David Nicholson: Sorry, I thought you were referring to hospital standardised mortality rates. I thought that is what you were referring to.

Q115 Valerie Vaz: Both.
Sir David Nicholson: I had not come across hospital standardised mortality rates during my period in Shropshire and Staffordshire, nor before that. It was only after that, and at that stage they were very controversial measures, I have to say. Part of the problem was that people got obsessed with the measure rather than what was underneath it. But, no, I did not have access to that information when I was at Shropshire and Staffordshire.

Q116 Valerie Vaz: Isn’t that unusual?
Sir David Nicholson: No.

Q117 Valerie Vaz: You don’t know anything that is going on in a hospital and you are supposed to be—
Sir David Nicholson: I didn’t say—

Q118 Valerie Vaz: You didn’t say that, okay.
Sir David Nicholson: —that I didn’t know anything that was going on in the hospital. If you look at the information that we routinely collected, it would not give you the information that would alert you to what happened at Mid Staffordshire.

Q119 Valerie Vaz: So you didn’t know that people were dying and you didn’t know about complaints; you didn’t know about these patient letters at all. You were just doing the process, but you were in the middle of it.
Sir David Nicholson: I have spent 20 years of my life running hospitals. I know exactly how hospitals run.
Valerie Vaz: We know.

Q120 Valerie Vaz: Let us turn to page 35, paragraph 110. You say: “On 27 October, I therefore went to Mid Staffordshire and visited both hospital sites, at Stafford and Cannock Chase. I believe that Martin Yeates, the Chief Executive, would have shown me around the hospitals, and we would have spoken to a few members of staff.”
Sir David Nicholson: Yes.
Q121 Valerie Vaz: You “would have”. You don’t know; you don’t recall.
Sir David Nicholson: I certainly went round the hospital. I go round—

Q122 Valerie Vaz: You did go round the hospital.
Sir David Nicholson: Yes, of course I did.

Q123 Valerie Vaz: Right, okay. So the “I believe” and “would have” are not correct. You did go round the hospital.
Sir David Nicholson: I did go round the hospital. One of the things about the way I work is that I do go round lots and lots of hospitals all the time. A lot of my working life is around meeting healthcare people and doing that.

Q124 Valerie Vaz: I understand that. We are talking about a specific time, 27 October 2005, so you did go round the hospital. Who did you speak to? You say: “…we would have spoken to a few members of staff”?
Sir David Nicholson: The point I am trying to make is that, given that I go round a lot of hospitals, I cannot recall exactly who I spoke to, in what order, in those circumstances.

Q125 Valerie Vaz: You must have had a diary or something, or some notes, because you would not have made a statement like this otherwise. I am pinpointing this key moment in time where you have already given evidence. I am not asking for anything different. I am just asking because you claim here that you were not sure whether you did go round the hospital or not, but you have. We have established that you have.
Sir David Nicholson: It is in my diary that I went round.

Q126 Valerie Vaz: So I am asking who did you speak to—“...spoken to a few members of staff”?
Sir David Nicholson: I always speak to staff. I always go round and speak to staff. I always speak to—

Q127 Valerie Vaz: Okay, I understand that, but we are trying to move forward, aren’t we? So I am trying to find out. You were there in the middle of Stafford hospital, where things are going wrong and you do not understand it. We are trying to find out how to make it better for the future. If it means you come out of your office at Richmond House and go down and visit a few hospitals or feed a few patients, maybe that is what you should be doing. Do you understand my drift?
Sir David Nicholson: Absolutely; I understand what you are trying—

Q128 Valerie Vaz: So you are a process man.
Sir David Nicholson: No, I am not a process man. I went round those hospitals in Staffordshire. I was responsible for 50-odd hospitals across that place. I probably visited all of them while I was there.

Q129 Valerie Vaz: “Probably”.
Sir David Nicholson: I cannot go back through them. I would have visited all of the hospitals. When I go round hospitals, what I try and do is first of all make sure that I speak to patients. I would have spoken to patients. I cannot remember the particular patients I spoke to on that particular day, but I did. I would have spoken to members of staff. I always make a point of talking to the staff away from the managers. The question that I always ask them is
something like, “When you are huddled together for warmth on a cold day having a grumble, what are the things that really worry you about this place?”

**Q130 Valerie Vaz:** Did you? Yes?

**Sir David Nicholson:** I always do that. If I see things that are wrong, I put them right.

**Q131 Valerie Vaz:** Good; thank you. Can we turn to paragraph 112 then? You said: “The two main concerns that were discussed during the meeting were the lack of senior individuals within the Trust to help the Chief Executive make things happen, and the poor relationship between the Board and the clinical staff.” What did you do?

**Sir David Nicholson:** Which number is this, sorry?

**Valerie Vaz:** Paragraph 112, page 36. Why didn’t you do something about it?

**Sir David Nicholson:** To help you with all of this, I spent 11 hours—

**Valerie Vaz:** It is me and the public—not just me.

**Sir David Nicholson:** —being cross-questioned by a QC in public. There are 500 pages of transcript. All of this information and more detail is available if you want it. What number is it—112?

**Q132 Valerie Vaz:** It is page 36, paragraph 112. What did you do and why didn’t you do something about it?

**Sir David Nicholson:** Okay. Martin Yeates and the chairman of the trust, Toni Brisby, had been brought in to the trust sometime before I got there to improve things in the trust. That is what they had planned to do.

What was clear was that Martin Yeates had been appointed on a temporary basis. The chairman was very keen to get him appointed permanently in that post because he needed a director of operations, a medical director and a nurse director, and he could not recruit them because why would people come and work for a temporary person? So we put plans in place at that stage both to bring the appointment of the chief executive to a head, but also then to make arrangements to appoint a director of operations, a medical director and a new nurse director. So we helped him and supported the organisation making those things happen. That is what we did.

Can I just say that there is an apology, and it is on page 3? I am sorry but I just could not find that earlier.

**Q133 Valerie Vaz:** That is okay; no, don’t worry. Let us go to page 37. It is a funny old trick; it is something that people do when they go on the witness stand. It’s, “I can’t remember”; “I can’t remember.” You seem to not be able to remember lots of things that go on. There it is at paragraph 116: “I cannot recall what we specifically discussed with regards to any recovery plan.”

**Sir David Nicholson:** It is not a trick.

**Valerie Vaz:** No, no.

**Sir David Nicholson:** I was responsible for 54 or 56 organisations. With regard to two thirds of them, I had literally never been involved in them before in my life. They were brand new to me. I was going through this for the very first time. The idea that I could recall in detail every single one of the meetings that I had during that period is quite difficult in those circumstances. It is not a trick.

**Q134 Valerie Vaz:** No, and this is what we are trying to find out. Is it appropriate for you, as head of the NHS Commissioning Board, to have all this power? That is the problem. This is what we are trying to find out for the future. You had all this power and you could not
visit every hospital, which seems to me to be the basis of accountability for people who pay taxpayers’ money and expect a good service. Let me take you to—

Sir David Nicholson: Sorry, but can I just say something on that? I go to hospitals all over the country. I have been in this post now for nearly—

Q135 Valerie Vaz: But you can’t remember which ones you go to. I suggest you keep a record.

Sir David Nicholson: —seven years. I do keep a record but I have not got—

Q136 Valerie Vaz: Good, but you didn’t in this case.

Sir David Nicholson: I do keep a record, and I can remember going to Mid Staffordshire, to Stafford general hospital, and I can remember going to Cannock Chase hospital. I can’t connect—

Q137 Valerie Vaz: Once. You remembered it once, didn’t you?

Sir David Nicholson: I have been to Stafford general hospital on a number of occasions.

Q138 Valerie Vaz: Did you? At paragraph 118 you say, “Aside from my meeting at Stafford Hospital on 27 October 2005, I cannot recall visiting the hospital on any other occasion during this period, or recall any issues being raised in relation to the hospital.”

Sir David Nicholson: I am sorry; I am obviously getting it wrong here. You asked me about my role as chief executive of the NHS, and I have visited Stafford general hospital a number of times since I have been the chief executive of the NHS.

Q139 Valerie Vaz: Since, yes. I am talking about what happened here.

Sir David Nicholson: I am sorry. That was a complete misunderstanding. I understand what you are saying.

Q140 Valerie Vaz: So you only visited it once, even though there were concerns about it.

Sir David Nicholson: There isn’t a hospital—in all of the hospitals that I was responsible for there were things that needed to be done, so it was not—

Q141 Valerie Vaz: You were adamant previously that you do not recall being shown round—“I would have been shown round”—but here you are adamant you never visited it again. Is that right?

Sir David Nicholson: There was no record of me visiting it again in my diary and I cannot remember having visited it again, apart from the interview which I did there.

Q142 Valerie Vaz: Now, in paragraph 129, the last sentence: “In fact, I seem to remember that there were no clinicians present at Mid Staffordshire’s Board to Board, which was striking.” What did you do about that? What did you say?

Sir David Nicholson: In the letter that I wrote in response to all of that, I said that it would take, in my view, two years for that organisation to become a foundation trust; a critical part of that would be strengthening the relationships between the clinicians and the managers, and they should get a proper medical director in place and make that happen. That is what I said in writing to them. There was a plan that came out of that that was agreed by the SHA and the trust, but, of course, we know I then moved on to my next job.
Q143 Valerie Vaz: Right, okay; so you could not follow it up. Even though you knew there were concerns and you knew they were not running the hospital properly, you didn’t follow it up, even though you were in your next job. You didn’t tell anybody else.

Sir David Nicholson: Of course I told somebody else and there is a record—there is a letter—that sets it out.

Q144 Valerie Vaz: Who did you tell?

Sir David Nicholson: I copied it to the managing director of the Shropshire and Staffordshire Strategic Health Authority. It was part of the team that was responsible there for delivering the foundation trust process across the whole of the west midlands. That is what they did. The NHS was being reorganised yet again at the time. I, with all of my colleagues, had to apply for one of 10 jobs that were put out. I was—how can I put it?—essentially sent to London to do the London job, and so I went off. But I left pretty extensive plans as to what needed to be done to get that organisation from where it was to become a foundation trust.

Q145 Valerie Vaz: Can I turn to page 53 now, paragraph 166? It is about the appointment of Martin Yeates. I suppose these are the lessons we learn going forward and this is partly why we are trying to find out what happened at the time, so please don’t be defensive about it all. You say: “I recall that Martin Yeates was enthusiastic about his role. I believe that he had been trying to secure a Chief Executive role for some time, and he was keen to prove himself.” You were the external assessor. Were those the only criteria you relied on to appoint him?

Sir David Nicholson: No, no. There was a detailed personal specification. There was a two-day process, which involved a whole series of stakeholders, including the PPI people, all of that, to help us assess the individuals whom we shortlisted, interviewed and then appointed for that. All that is documented—all that detail.

Q146 Valerie Vaz: But that is all you mentioned in your statement.

Sir David Nicholson: It is available. Yes, well, okay, I could have written all of that, but I did not.

Q147 Valerie Vaz: It is very kind of gossipy, isn’t it? “He wanted the job so I gave it to him and he was enthusiastic.” Those seemed to be the only two criteria that you chose to mention in your statement.

Sir David Nicholson: They weren’t the only criteria, and I guess if you read the transcript of the long period that I spent there—

Q148 Valerie Vaz: But this is your statement.

Sir David Nicholson: I know you are trying to concertina all of this into a very short period of time, and I understand that, but you will see that it was certainly more extensive than the way you have described it.

Q149 Valerie Vaz: Paragraph 168: “After the appointment of Martin Yeates I would have”—there is that phrase again—“made myself available upon request.”

Sir David Nicholson: Yes.

Q150 Valerie Vaz: Did you?

Sir David Nicholson: I am sure I did. I do not have a letter that says I did that. I make myself available to all chief executives, particularly newly-appointed ones. On reflection, we needed a much more kind of structured approach for new chief executives at the time.
Nevertheless, I would have made myself available, undoubtedly, to him. I am a very approachable individual, and I try and support chief executives when they are in difficulty.

**Q151 Valerie Vaz:** But later on you say: “I do not now recall any of the direct conversations with Martin Yeates at these meetings.”

**Sir David Nicholson:** As I say, he was one of 60 chief executives that I was having—

**Q152 Valerie Vaz:** So even at that time—he is newly appointed—there were no concerns raised at all with you or him about the hospital.

**Sir David Nicholson:** Don’t forget that he had been in post for some time with the chairman before I got there, so he had quite a lot of experience and was seen by everybody in the strategic health authority as part of the solution for that particular hospital—the bid to take that organisation forward.

**Q153 Valerie Vaz:** I have not confirmed it—we certainly have it in some of the background information we have received—but, even after he left, you still tried to secure him another position within the NHS. Is that right?

**Sir David Nicholson:** That is not true. That is not true.

**Q154 Valerie Vaz:** That is not true. So what is the truth then?

**Sir David Nicholson:** I was asked whether I thought it was appropriate to secure him a post somewhere else and I said no.

**Q155 Valerie Vaz:** Isn’t that sometimes the problem—

**Sir David Nicholson:** But that was not the problem in this case.

**Q156 Valerie Vaz:** Let me finish my sentence. Isn’t that sometimes the problem, because there is a feeling that there are people who are moving round the NHS, a bit like you? Even though something happens in Mid Staffordshire, off you go to London, and it is the same old people going round and round.

**Sir David Nicholson:** I am sure we will get on to me in a while—

**Q157 Valerie Vaz:** We are on to you, aren’t we?

**Sir David Nicholson:** —but in those circumstances it is true that sometimes people do not succeed as chief executives, not because they are not good managers and could find a role somewhere else, but because they are not suited to become a chief executive. Sometimes that does—

**Q158 Valerie Vaz:** Who finds that out and when?

**Sir David Nicholson:** Mainly the chair and the board would be the normal organisation that would do that. In the case of Martin Yeates, he stepped down when the report came out. The chair that was brought in by Monitor and the acting chief executive commissioned a report to say whether he had a disciplinary case to answer. That report said that he did.

As a foundation trust, they balanced off the problems for that organisation if they went through the disciplinary procedure against the cost to the taxpayer, and they judged that it was best to give him six months’ pay in lieu of notice. They agreed that with Monitor. The Secretary of State at the time wrote to the trust and said he did not think that was appropriate. Alan Johnson wrote to the trust, but that is what the trust did. So he was removed from post.
Q159 Valerie Vaz: Finally, at paragraph 200—I am just trying to work out the nature of your relationship and your role, which seems to be overarching and overseeing—you referred to “I appointed David Flory” and “I also appointed Sir Bruce Keogh”. Is that just you on your own appointing them or is there a board?
  
  Sir David Nicholson: No, no; there was a panel.

Q160 Valerie Vaz: So it is not you appointing; it is a panel.
  
  Sir David Nicholson: I am the officer who makes the decision, whereas, for example, in a foundation trust, or a trust, it is the chair who makes the appointment. In those circumstances, it is me that makes the appointment.
  
  Valerie Vaz: Thank you very much.

Q161 Andrew George: Looking at this issue from a wider perspective and the principles of how responsibility and accountability are discharged, which are partly covered by the more nitty-gritty questions that Valerie has just asked, in your opening remarks you said that the results of the Mid Staffs inquiry had given managers like yourselves the opportunity to reflect—in fact, the need to reflect—on the very grave outcomes and findings of that report. Yet, in terms of accountability, it seems to be only the clinicians—currently there are nurses before the NMC at this moment—who were being held to account. Do you think it is fair that managers have the luxury to reflect and front-line clinicians are held accountable?
  
  Sir David Nicholson: I think I said that the chair, the non-executive directors and all of the directors of that organisation left that organisation relatively quickly after it happened. That accountability played out pretty straightforwardly, as you would expect in the circumstances. So that did actually happen.

Q162 Andrew George: That is where the accountability stops—with them. As soon as they have gone, then that is it.
  
  Sir David Nicholson: The accountability for the quality of services at a hospital is the responsibility of that board. That is absolutely clear and set out. That is the legal basis of that organisation. Of course, Francis then did his inquiry and said that there was a basic system problem out there, which I think there was at the time, and, undoubtedly, it did affect the arrangements in there.
  
  If you are asking me about the issue of the professional accountability of managers, which I think Francis does talk about in terms of whether there should be regulation of managers, if that is where you want to take it, it is an interesting and important question. We need to think about it really carefully.
  
  From my own perspective, it is an odd position whereby, if you sit round a board table as a chief executive, with a nurse director who has a professional accountability, a medical director who has a similar professional accountability and a set of standards they are expected to deliver, a finance director who, again, has those arrangements, and an HR director, typically, who would also have all of those, the chief executive is the only one who does not in those circumstances. So I think there is a case for better regulation and a standard setting for chief executives of boards.

Q163 Andrew George: The report clearly says that there were serious, systematic failings throughout the NHS, which led to the outcomes at Mid Staffs. Indeed, it looks like there were a large number of other hospitals where there were very significant concerns about excess deaths as well. If there are systematic failings, who is responsible for the system that apparently failed?
Sir David Nicholson: The system that failed was designed in 2005 as part of the Government’s response to commissioning a patient-led NHS. It was given to me in my responsibilities to make it work. That is what we have been trying to do. The critical bit of that was not one of structure or organisation; it was one of whether quality was the organising principle. That is the thing that, right from the beginning of my tenure in this organisation, I have attempted to make a reality. You can see a whole series of things I have done to make that happen.

Q164 Andrew George: So it was a political failing; it was the creation of the system politically as a result of the reorganisation in 2005, and it was political decisions which led to the failure.

Sir David Nicholson: If you look at the organisation of the NHS at that time—and obviously I have been involved since the mid-1970s in the NHS—what you see is reorganisation on top of reorganisation on top of reorganisation. What you get out of that is a confusion about accountabilities and a confusion about who is responsible for what.

What you can see in that process is that the people who designed it in 2005 were not trying to create a confused situation, but, actually, when you added it to the other changes that had already happened in the past over the previous 10 years, it created an environment where the clarity of role that you have described simply was not there and the organisations were neither capable of making nor had the capacity to make the change required.

Q165 Andrew George: I put it to you that what appears to have been created—I think the Francis report identifies it and to a certain extent is guilty of it as well—is a management culture that seems to be practised in the arts of management babble, which heaps unrealistic pressure on the clinicians on the front line, and yet at certain tiers of management, and this is really what we need to find out, a blind eye is turned to the consequences of the unrealistic pressures that are placed on that front line. Do you agree with that description?

Sir David Nicholson: I understand the issue and have seen parts of the NHS where that has been the case, but I have seen great swathes of the NHS where that simply is not the case. There is a lot of evidence to support that. But when it happens in that way, it shows—and Mid Staffordshire shows—how quickly you can get into a place where patients are harmed if you do not get the right culture locally. That is true.

Q166 Andrew George: It is quite clear that nurses were reporting inadequate staffing levels and this was happening on a very regular basis at the Mid Staffs level, and yet insufficient or no action was taken. The pressure was on the service, and yet the managers failed to provide the staff because they had to do the system’s bidding, and they also had financial targets to meet. Are there not lessons that you yourself and those at your level need to learn from that and take forward?

Sir David Nicholson: Absolutely. When I was first appointed to the job, when I came into this particular job, I coined a phrase, which at one level sounds trite but it is really quite an important phrase—“Hitting the target and missing the point.” This is the dangerous place that some organisations got into. Even today, in some places, it happens now where, in a sense, the target becomes—the best example I can give is a conversation with a middle manager and an A and E consultant, which goes something like this: “Move that patient into a clinical decision unit or get them admitted because we will breach the four hours.” That is a bad, bad conversation to have.

Q167 Andrew George: Yes, but you knew that was going on at the time.
Sir David Nicholson: It is a bad place to be. Wherever I see it, in whatever I say, in all of the conversations I have, all the things I do with chief executives across the country, I say that that is absolutely the wrong conversation. The right conversation between a middle manager and the A and E consultant is, “How can we get the best experience for this patient? How can we get them to see the person they need to see as rapidly as possible and make sure that they get a good experience out of it?” Then you think about what you do.

That is absolutely about culture. It is about the way organisations operate, and sometimes—and this case is a good example—the NHS falls short. I do not accept that all the NHS all over is in that culture. There is a lot of evidence, whether you look at the staff survey or whatever, to show that is not the case.

Q168 Andrew George: But, still, you were presiding over a system in which those clinical priorities were being distorted as a result of trying to meet, for example, as you said, four-hour waiting targets in A and E, and you know full well that the pressures, for example, in Mid Staffs were financial pressures. They had targets to meet and a blind eye was turned to the consequences for patient care. You have to agree.

Sir David Nicholson: I absolutely do not accept that a blind eye was turned. If you look at the position of organisations across the whole of the west midlands at that stage, Mid Staffordshire was not on anyone’s risk list of organisations in difficulty. There were a lot of others that were, that we kind of got involved with in much more detail, but that organisation was not, and that was the tragedy of it in a sense. Because we were counting the kinds of things that you have just described—because the system was designed to do all of that—because we did not have access to a whole range of clinical data about that organisation, and because the system as a whole did not take seriously enough at that time the input of patients and their relatives, that is why it happened.

Q169 Andrew George: Who were you accountable to when you were overseeing the SHA and ultimately—

Sir David Nicholson: I was accountable to Nigel Crisp.

Q170 Andrew George: Then who was it when you took over his post?

Sir David Nicholson: I was accountable to Patricia Hewitt.

Q171 Dr Wollaston: Good morning, Sir David. You have talked about all staff within the NHS taking responsibility and reflecting on their own position. Can I ask how far you take personal responsibility for an organisation that has been shown to minimise patient complaints, gag whistleblowers, massage mortality data, bury bad news and, frankly, to lose sight of the patient in the bed?

Sir David Nicholson: Are you referring to the whole of the NHS when you talk about that?

Q172 Dr Wollaston: Yes; all of the issues that are being covered. How far do you personally take responsibility for that?

Sir David Nicholson: First of all, I do not accept the way you have just described the NHS. It is a much more balanced picture than you have described there.

Secondly, I have spent 35 years being a chief executive in the NHS. I am completely dedicated to improving services for patients. When I hear bad stories about the NHS, of course I feel responsible. I am like everybody else in that I listen to people, I go round and talk to people and of course I feel responsible for all of that. I have the privileged position
where I can try and do something about it, which, it seems to me, is what I need to focus my attention on.

But I do not accept the way you painted the picture. Indeed, it is a real problem for us at the moment—I think we will talk about it in a while—and I am not quite sure how we get ourselves out of this. On the one hand, if I say to you that year on year hospital mortality has gone down in this country, in English hospitals, over the last few years, with some dramatic reductions in some parts, when I say that it is almost as if I deny the appalling suffering that the individuals at Mid Staffordshire had.

Dr Wollaston: Can I stop you there?

Sir David Nicholson: Then, on the other hand, if I talk about the appalling suffering, many people in the NHS say to me, “Why aren’t you saying the good things?” So it is a balanced picture.

Q173 Dr Wollaston: It is a balance, yes.

Sir David Nicholson: That is what Francis says. He says that too often—and this is a big reflection for me—in relation to a complaint or a problem raised about the NHS, our response is “lines to take”, when actually it should be, “Let’s learn from all of this.” I think that is a big lesson for us all, me included.

Q174 Dr Wollaston: I completely accept there is a balanced picture and—believe you me—I am passionate about the NHS as well.

Can I take you back to a statement you made earlier that, when you were at west midlands, where you were responsible for 10 months, the NHS at that time was neither equipped nor capable of monitoring the quality? In fact there is evidence, isn’t there, that staff at West Midlands Strategic Health Authority were logging on to the data from Dr Foster from 2008 onwards?

Yet the response seems to have been to commission research to discredit the data. In other words, the response was not, on seeing mortality data, “Actually, this is very worrying. What can we do about our hospital?” It was, “Let’s see how we can discredit the data.” What I am interested to know is this. We are told that the strategic health authority commissioned that, but were you personally aware that that research was being commissioned to try and discredit the data?

Sir David Nicholson: Can I say that I was never the chief executive of West Midlands Strategic Health Authority, just to make that clear? I left in 2006. Nevertheless, it is an important issue. Can I talk about HSMRs a bit now? I do think this is a really important issue, not just for Mid Staffordshire but for the NHS as a whole. Hopefully, Bruce can help me in all this. I do think it is an important set of questions and it goes exactly to the point that you make there.

If you run a hospital—if you are responsible for a hospital—you can look at the number of patients that you treat over a period. That can be over a quarter or half the year, a year or whatever. What you do is you identify what the diagnosis for each of those patients is and then identify what the severity of their illness was. It could be that they were old, so, if you have heart failure and you are in your 90s, the chances are it is more severe than at other ages. It can be that you have other underlying conditions. So, out of that, you get a real picture for the diagnosis of your patients, how many there were and any kind of secondary conditions they have. Then you measure the number of deaths that you have in those circumstances. I am sure you know all this, but I think it is important to do that.

You then take that and compare it against the national average for a similar hospital with similar conditions. Out of that, you can work out whether the number of deaths you have is greater or less than might have been predicted from the model. As you know, it is an
average, so quite a lot of hospitals are below, quite a number of hospitals are above, and some are outliers in those circumstances.

The number that it gives you is the number over the average that that organisation experiences. What it does not say is how many of them were avoidable or—in the way it is described these days—unnecessary. Any avoidable or unnecessary death is a tragedy, and we in the NHS need to be focused on minimising that. But to go from that number of excess deaths to saying that they are avoidable is a big step to take.

What we know—and the west midlands is a really good example of this—is that the response very often to that first number, the excess deaths, is headlines that say all these deaths were avoidable, when the only way you can deal with that, the only way you can make a judgment about how many of those were actually avoidable, is to go through the case notes of the patients, talk to the relatives and the staff and understand it all. That is what we offered in Mid Staffordshire for everybody, and over 200 patients took it up. But it is very difficult, even in those circumstances. Now, what happened in—

Q175 Dr Wollaston: I’m sorry, but weren’t they right? They were right about what was happening at Mid Staffs, weren’t they?

Sir David Nicholson: Yes, but the point I am trying to make is that the obsession with the number, which is the point that you raised, is not the place to go. It is an indicator to go and look. The problem—

Q176 Dr Wollaston: But nobody did.

Sir David Nicholson: Exactly. That is the point I am trying to make. The issue in west midlands is that they got so excited about the number that they did not go and look. That was the terrible thing about the experience in the west midlands in relation to that—and they should have looked.

One of the things that we did—I did—as part of all this, when it became clear that that was what was happening, was that we set out in our operational guidance to all trusts now to look at their mortality data in detail. Your board has to look at it, and just because you are over or under should not give you either a false sense of security or otherwise. Even if you are under the average, you can still have problems in particular, so you have to look at it. What we have said in those circumstances is that, if you are an outlier, the strategic health authority has to be involved and has to go and look. For the last two years that is exactly what people have been doing. But it is an indicator.

Q177 Dr Wollaston: Yes. I asked you quite a specific question about whether you were aware that that research had been commissioned to discredit the data.

Sir David Nicholson: No, I wasn’t aware.

Q178 Dr Wollaston: So you were not aware of that. Thank you very much for clearing that up.

Another point of concern is that three reports were commissioned in 2008, probably to coincide with the 60th anniversary of the NHS, all with titles like “Achieving the Vision,” “Excellence in Quality,” and all that kind of thing. Actually, they contained some rather uncomfortable reading, none of them were published, and they had to be FoI’d in order to see the light of day. Were you aware of the contents of these reports?

Sir David Nicholson: All three of those reports were commissioned by the chief medical officer as part of him writing a report as part of “High quality care for all”. So it is part of the process that was gone through in all of that. Until the inquiry raised them with me, I had not seen those reports.
Q179 Dr Wollaston: You had not seen them.
Sir David Nicholson: I hadn’t seen them.

Q180 Dr Wollaston: How confident can we be, going forward, when we have reports that are, frankly, very critical—they do highlight many of the issues that then subsequently have come up in the Francis report, yet really very few of them make it into the final document—or how far do you hold yourself responsible for presiding over a culture that tended to bury bad news, with inconvenient truths swept under the carpet?

Sir David Nicholson: I don’t think that is the case.

Q181 Dr Wollaston: You don’t think that is the case. You don’t think it is unacceptable that some of the points that are raised in this did not make it into the final document.

Sir David Nicholson: Which particular points were you referring to?

Q182 Dr Wollaston: Where do I start?

Sir David Nicholson: The basic analysis that quality was not part of the organising principle of the NHS and that we were not geared up properly, either to monitor quality or improve it, is at the heart of “High quality care for all”. Many of the things, whether it is the way you regulate for quality, measure quality, or the development of the NHS Constitution—all of these things—were done in order to deal with that basic analysis. If you are asking me, having read all of those documents, whether I agree with the analysis that underpins them, some of it I do and some of it I don’t.

Q183 Dr Wollaston: But would you think it is fair to reflect that some of the very critical points that were made—things about cultures of fear, doctors distrusting management, all these kinds of things—are not very evident in the final document?

Sir David Nicholson: They are not very evidence-based in the documents either, having looked at them. I did not see them at the time so I can’t say—

Q184 Dr Wollaston: You say they are not very evidence-based, but they are very much the same things that come up in the Francis reports—so they were clearly correct.

Sir David Nicholson: No, I am sorry. If you take the JCI report, which is the one I guess you are particularly referring to, that talks about the culture of fear and all of those things. We have the largest staff survey in the world, a properly organised and properly audited survey, which has the highest standards in it. It is not a “ring round” to 50 people, which is what the JCI did. That paints a balanced picture of some problems in terms of culture but not the kind of thing that is described in that document. So I think the evidence does not support what the JCI say in those circumstances.

Q185 Dr Wollaston: Coming on to staff, and perhaps that culture of fear, and the use of gagging clauses against whistleblowers, are you aware of the extent of gagging clauses in the NHS? Is that something that you are personally aware of and what do you feel about them?

Sir David Nicholson: As someone who was personally involved in whistleblowing some years ago, I personally regard this as a really important issue for me. Wherever I see it, or if I have a whiff of it—and I think the Health Select Committee at one of its meetings had a whiff that there was a problem—I immediately intervene in the organisations themselves and tell them what their responsibilities are in relation to that.
I intervene directly with organisations that I feel are not providing the right kind of support to people who are whistleblowing. I have also written out to the service, as you will know, most recently in January 2012, where not only did I say people have a legal duty to do all of this but it is vitally important for patient safety to make it happen. So I am absolutely against them, and, wherever I see them, I try and stop them.

Q186 Dr Wollaston: So you were not aware of the high-profile gagging clauses and payments.

Sir David Nicholson: Whenever I get information about them, I intervene and put them right.

Q187 Dr Wollaston: You intervene and put them right; okay.

Finally—because I know other members are keen to come in—there is the issue about whether or not we tend to minimise patients’ complaints. Certainly, looking at an e-mail from Anna Walker, back in 2008 she talks about you describing campaign groups as “simply lobbying”. That is a culture that a lot of people feel unhappy about in the NHS.

You have talked about the importance of reading patient stories, but in fact very many people who complain about the NHS come across a very defensive culture, and that would certainly be reflected in what is said in that e-mail. If they are just described as “simply lobbying”, they are easy to ignore.

Sir David Nicholson: On that particular occasion, of course, Francis does reflect it in his report. I don’t know whether you want me to say what he says in it because I think it is quite important. It says: “Sir David Nicholson’s suggestions about CURE in May 2008, if expressed as recorded in Anna Walker’s note, would have been inappropriate. However, Sir David has denied that he would have said this or intended to convey such a sentiment, and this Inquiry accepts that whatever he was understood to have been saying he had no intention to convey any disapproval of CURE or suggestion to the HCC as to how it should approach this group.”

So Francis dealt with that in his inquiry. In terms of reflections and regrets in relation to all of this, one of the things I do regret very much is that, when all this blew up and the Healthcare Commission was engaged, I should have made efforts to meet Cure—and I did not. I dealt with them through intermediaries, and that was wrong. That is a big lesson for me. It became almost impossible during the inquiry to do it. I have tried afterwards, but, for obvious reasons, they do not want to meet me. For me, that is a kind of regret about what I should have done at that time.

I have a lot of experience of dealing with complaints as part of running trusts and hospitals and all the rest of it, and certainly with the organisations that I ran we had extensive ways of getting patient feedback and dealing with complaints. Those complaints are fantastic fragments of information if you really want to improve your service. It was not any accident to me that one of the problems at Mid Staffordshire was that they had an over-legalistic view to complaints so that they responded in very legal terms. When you look at some of their letters, they are absolutely appalling, and what must the patients have thought of them? Complaints are really valuable sources of information for organisations to improve services to patients.

Q188 Dr Wollaston: Do you think the NHS has got it right now?

Sir David Nicholson: No. There are lots of places that do it fantastically well and I have been there, seen them and spoken to them. That is why the Government announced the work that Ann Clwyd and Tricia Hart are going to do to lead some work on how we can get
best practice everywhere for complaints, because it is so important to take the service forward.

**Q189 Dr Wollaston:** Moving forward, I know that you have the confidence of the board to manage this very difficult transition period. Do you think, on reflection, that you are the right person to take the NHS forward in the long term, or do you feel that there is genuinely a concern that you could be personally conflicted, in that now we also have other hospital trusts where we are investigating excess deaths?

**Sir David Nicholson:** I set out before how important it seems to me. I have a duty and a responsibility to manage the organisation over these great changes. I also think that, if you look at my record of what I have actually done, you can see that I absolutely get the changes that need to happen to the NHS. On one of the things that I was responsible for—and you will remember it—“High quality care for all”, Ara Darzi wrote to me as chief executive of the NHS and said, “Should the NHS have a constitution? Should it set out somewhere what the principles, rights, responsibilities and values of the NHS should be? And, if they should have one, what should it look like?” I produced the NHS Constitution, which is a really important document, I think, in the sense that it sets out there a set of values and principles on which you can build the NHS.

Have we done enough? No, we absolutely have not. I do believe that, given my commitment to the Constitution, my understanding of the way the NHS operates, my commitment to patients and the way I can see things like transparency and opening up the NHS, I am absolutely the right person to take that forward.

**Dr Wollaston:** Thank you.

**Q190 Barbara Keeley:** Can I touch on those reports that my colleague has just referred to from the IHI, JCI and RAND Corporation? Particularly, there is a quote from one of them—and this is a point rather than a question—“We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations.”

**Sir David Nicholson:** I did not quite catch the first bit.

**Barbara Keeley:** “We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations...or any other topic relevant to quality.” I think that is particularly relevant in terms of the Francis report and inquiries that this Committee has done. If those reports were commissioned, they should have been released, and I think it says something about the culture of the NHS that they were not and they have had to be drawn out of you by Freedom of Information requests.

**Sir David Nicholson:** I have not seen them myself.

**Q191 Barbara Keeley:** You are the chief executive of the NHS.

**Sir David Nicholson:** I agree, and the chief medical officer was asked to do something on all of that. But the point that they make we built into the report, because part of the issue around it—and this may seem a small point, but I think it is a very significant, big point for the NHS—is that everyone was in favour of quality, but everyone thought it meant something slightly different.

One of the things that came out of “High quality care for all”, and particularly those conversations that you described there, was a definition of quality that covers effectiveness, safety and patient experience. You could not have one without the other. It was not possible for clinicians to say that the operation was a success but the patient had a miserable experience. That was not quality. Building patient experience into a definition of quality was really important. Is that fair, Bruce?

**Professor Sir Bruce Keogh:** Yes.
**Q192 Barbara Keeley:** It is a very serious thing to say about our national health service that conversations that were held on many aspects of quality did not touch on patients and their families. You said that you had to work through patient stories over a weekend. A weekend does not seem a very long time to me if we take into account the number of cases of low quality of care and the number of deaths, but that is just an observation.

**Sir David Nicholson:** The patient story thing is really important, because if you take the way I recruit staff to work for me now, one of the things we do as part of the recruitment is that we give them patient stories. Then we talk to them about what they would do in the circumstances they would find themselves in around those patient stories. It is only a small point, but I think it tries to make it alive to people so that when you are recruiting people at the moment you can get their understanding about what those patients might have felt and gone through.

**Q193 Barbara Keeley:** Can I take you back to your role in driving the quality of patient care, because you told us earlier you had spent 20 years of your life running hospitals?

**Sir David Nicholson:** Yes.

**Q194 Barbara Keeley:** At the inquiry, Francis questioned you about where responsibility and accountability for Mid Staffs lay between the trust, the PCT and the SHA. You said this: “Well, both the PCT and the SHA had responsibilities for quality, but the way that quality was measured at the time was relating to access and healthcare-associated infections.” In fact, what you were saying was that it was really just a subset of all the issues and nothing about patient safety and quality of care in those things. It was just access and healthcare-related infections. In fact, you went on to say: “There was no mechanism… to hold…the trust to account…for the detailed way in which clinical services were managed…We were neither skilled nor capable of doing that.” That is what you said.

I actually find that rather astonishing. It is an astonishing admission—

**Sir David Nicholson:** It is—

**Barbara Keeley:** Can I finish? It is an astonishing admission for somebody that was in your role at the time and who is in your role now that you were not skilled to hold the trust to account.

**Sir David Nicholson:** The difference I would give you is this. I was, as I say, substantively responsible for Birmingham and the Black Country SHA. We had done a lot of work on bringing clinicians into the strategic health authority, for building up our capacities there. I appointed a medical director in Birmingham and the Black Country Strategic Health Authority. It is now astonishing to imagine that most strategic health authorities did not even have a medical director, and some of them did not have a nurse director during that period.

**Q195 Barbara Keeley:** You said “we”. Do you include yourself in that—that you are not skilled to hold a trust to account? You were not skilled in that way.

**Sir David Nicholson:** I was referring to “we” as the strategic health authority.

**Q196 Barbara Keeley:** Did you have the skills and do you have the skills?

**Sir David Nicholson:** I absolutely have the skills. I have managed hospitals directly; I have managed clinicians directly and all the rest of it. The point I was making is if—

**Q197 Barbara Keeley:** So why were those skills not brought to bear on the Mid Staffs situation? You said that that accountability did not happen because “we were neither skilled nor capable” of doing that.
Sir David Nicholson: It was one person. If I take the Shropshire and Staffordshire example, there was no medical director. There had not been a medical director in that organisation. There was no mechanism in that organisation to do it.

Q198 Barbara Keeley: How many staff did you have and how many staff did the PCT have? How many staff did you have at the SHA?
Sir David Nicholson: In Shropshire and Staffordshire? I could not tell you that offhand.

Barbara Keeley: What is it roughly—50 or a 100?
Sir David Nicholson: I would have thought about 60 or 70.

Q199 Barbara Keeley: What about the PCT?
Sir David Nicholson: I could not give you that information offhand.

Q200 Barbara Keeley: Roughly—100, 200 or 300?
Sir David Nicholson: Genuinely, I could not give you that information.

Q201 Barbara Keeley: But between you, hundreds of staff with probably your sort of qualifications, you were not skilled or capable of holding the clinical management of that trust to account.

Sir David Nicholson: There were very few clinicians in the SHAs operating at that time. One of the things that I did when I became chief executive of the NHS was to insist that every strategic health authority had a nurse director and a medical director. In fact, the NHS did not have a medical director when I was appointed as chief executive, and one of the first things I did was appoint a medical director. We needed clinical capacity in that part of the system to enable us to start to do the sorts of things that you describe.

Q202 Barbara Keeley: So all your experience—your 20 years of running hospitals—does not give you the ability to hold a trust that gets into trouble to account. It does not give you that experience.

Sir David Nicholson: It helps you understand what is happening in an organisation, but unless you have the data and can talk to the clinicians directly—

Q203 Barbara Keeley: You could order up the data. Anybody in your structure, anybody in the PCT, could have said, “We have an issue here. We have a set of issues here. Things are going badly wrong. Let’s not leave it to them. Let’s ask some questions. Let’s get the data.”

Sir David Nicholson: The point is that the data that was available to the PCT, to the general practitioners, to the regulators, to all of those, did not indicate at that time that there was a problem in that organisation. Now we might wish it was different, and it is different today—there is a lot more data, a lot more knowledge and a lot more information—but at that time there was not.

Q204 Barbara Keeley: Let me take you back again to the question of whistleblowing. Substantial time was given at the Francis inquiry to whistleblowing. Of course, much has been written about it in recent weeks. Francis said that whistleblowing is only necessary because of the absence of systems that welcome the internal reporting of concerns. You have, in fact, touched on staff huddling together and having a grumble, though I think the issues were rather more serious than staff huddling together.
Sir David Nicholson: No, I agree.

Q205 Barbara Keeley: Concerns have to be raised externally if they can’t be raised internally. What did you do when you were chief executive of the strategic health authority, and what do you do now, as chief executive of the NHS, to support clinicians and managers to raise the essential issues about the quality of patient care? What have you done and what are you doing?

Sir David Nicholson: There is a whole range of things around all of that, from making sure and clear that each organisation understands what their responsibilities are, to making sure that every organisation has a proper policy in place that makes that happen, such as setting up the various helplines that have been set up in the NHS to help and support people to do that.

What I would say is that the staff survey results give you an indication that we are making some progress here. So the actual outcome of it, I think, is that we are making progress. We are by no means at the end of this journey at all, but, if you think about the statement, “My trust encourages us to report errors, near misses and incidents,” in 2006, 76% of the staff agreed with that and today it is 86%.

So there has been improvement over the period and people feel that they are doing that. It is not enough, and we need to get it much better than that, but that shows, in practice, on the ground, whatever it is, that we are trying to create an environment here and it is working in those circumstances.

Q206 Barbara Keeley: Okay. In what way do you think it is ever acceptable to use confidential gagging clauses and compromise agreements with staff who are departing—we have talked earlier about some staff departing—backed by very substantial amounts of taxpayers’ money? For example, £500,000 was reportedly spent on a gagging clause at United Lincolnshire Hospitals Trust. You talked earlier about clear accountability at every level. What accountability have we got if this organisation, the NHS, any part of it, pays somebody £500,000 when he was lining up to expose issues of patient safety at an employment tribunal?

Sir David Nicholson: It is completely and utterly unacceptable.

Q207 Barbara Keeley: You feel that is unacceptable.

Sir David Nicholson: It is completely and utterly unacceptable.

Q208 Barbara Keeley: So in no way did you sanction that, agree to that or think that was right.

Sir David Nicholson: I would never sanction anything of that sort.

Q209 Barbara Keeley: You did not in this case.

Sir David Nicholson: I did not—

Q210 Barbara Keeley: That is the case of the United Lincolnshire Hospitals Trust.

Sir David Nicholson: I understand you are going to talk about this in a bit more detail and the SHA are kind of setting out their responsibilities, but from my perspective—and this is at the nub of where we are getting ourselves into difficulty in understanding all of this—in my letters to the service and in the general way that I have conducted myself I have made it absolutely clear that it is unacceptable, and also illegal, for organisations to gag people around issues of patient safety and improving services to patients. It is completely and utterly unacceptable. The trust itself, as you know, denies that it did that, and no doubt you will have all that conversation when you see the individual.
However, there is an issue about the way in which compromise agreements are developed in the NHS. When the confidence breaks down between an employee and an individual, there are normally two ways in which that resolves itself. One of them is that there is disciplinary action taken, and that takes its course, but what happens in those circumstances is that people have to have due regard to the interests of taxpayers.

So, in some circumstances, organisations take legal advice and make a judgment that it will be in the interests of taxpayers to sign a compromise agreement. That compromise agreement should never, ever exclude people speaking out on patient safety issues. Absolutely, if we find any of that, we need to absolutely eradicate it. That is how not just the NHS but the world works. What has happened is that in some cases—not necessarily the Lincolnshire case—those two things have been confused.

**Q211 Barbara Keeley:** Where is the level of sanction for an award of £500,000 for somebody who was lining up to talk to an employment tribunal about patient safety? Where is the sign-off for that?

**Sir David Nicholson:** There is a whole series of things that you have said there that are bitterly contested and I do not want to get into that particular case.

**Q212 Barbara Keeley:** I have asked a question. Tell me where the sign-off is.

**Sir David Nicholson:** The arrangements at the moment are that, whatever the agreement is, it is a legally binding agreement between the individual organisation and the person involved. It is their statutory right as an employer to do all that.

**Q213 Barbara Keeley:** Where is the sign-off for the £500,000?

**Sir David Nicholson:** I am just going to come to that. The arrangement we put in place is that the sign-off for that is the strategic health authority remuneration committee. So it goes to the strategic health authority; this is for non-foundation trusts, I have to say, because it is different for foundation trusts. For non-foundation trusts, it goes to the remuneration committee of the strategic health authority; they look at all of that and they have to look at their compliance and all the rest of it. Then what they do, in those circumstances, if they think it is all above board, in the taxpayers’ interests and there is no gagging clause, is refer a business case to the Department of Health.

**Q214 Barbara Keeley:** So again, this one came to the Department.

**Sir David Nicholson:** This one actually did not. I will get on to that, but this is the process we have in place. It goes to the Department of Health, and then it goes to the Treasury to sign off. But the business case signed off by the Treasury relates to the interests of the taxpayer in all of this. The case in Lincolnshire was different. They went for a different arrangement, which—if I can get the title right—was a judicial mediation. In those cases, they do not have to get signed off by the Department and the Treasury.

**Q215 Barbara Keeley:** How convenient.

**Sir David Nicholson:** Pardon?

**Barbara Keeley:** How convenient.

**Sir David Nicholson:** Well, I am just giving you the answer to the question.

**Q216 Barbara Keeley:** What do you think, as chief executive of the NHS, of a loophole like that existing—where £500,000 of taxpayers’ money could be used to gag somebody who wanted to talk about patient safety?
Sir David Nicholson: As I say, the comments you make there are bitterly contested by the organisations involved—bitterly contested.

Q217 Barbara Keeley: What do you think of that as a use of taxpayers’ money?
Sir David Nicholson: In terms of the judicial mediation, it is the first time in my experience that I have ever seen that done. I have asked around and I do not think there is another example of that at all. If it is a loophole to get round the Department, then it needs to be closed and we need to think about how we might do that.

Q218 Barbara Keeley: Are you doing that?
Sir David Nicholson: We will absolutely do that to see what it is. It may not be possible, legally, to do it, but not giving the ability for the SHA remuneration committee to sign it off and for the Department and the Treasury to sign off the business case seems to me wrong.

Q219 Barbara Keeley: So no one signed that off apart from the trust. In the NHS, no one signed off that use of the £500,000.
Sir David Nicholson: It certainly did not come to the Department of Health and it didn’t come to the Treasury.
Barbara Keeley: I see; okay.

Q220 Chair: Can I ask a specific question about the Francis recommendations on the use of public money? You rightly say that compromise agreements have quite a widespread use in the private sector. There is a difference, isn’t there, where it is public money that is being used to achieve agreement in a compromise agreement? Do you agree with Francis that there should never be any circumstances where payments made in the context of a compromise agreement are kept confidential?
Sir David Nicholson: I do not understand the legal consequences of all that, but it seems to me, in terms of transparency and openness, that that should be the case.

Q221 Chair: In principle, fish-and-chip meals invoices appear on the website, and yet we spend hundreds of thousands of pounds and it is bound by a confidentiality agreement. That must be nonsense, mustn’t it?
Sir David Nicholson: For transparency purposes, it must be wrong.

Q222 Barbara Keeley: Can I take you back to what has happened in recent weeks as a follow-on from all of this? The NHS issued management directions in 1999 and 2004 on the use of gagging clauses, but it has been necessary, it seems, in recent weeks—particularly in terms of whistleblowers like Gary Walker being able to talk, for instance, to us as a Committee—for the Secretary of State to write to trusts to remind them of their obligations not to inhibit protective disclosures.

Why is it, given everything you have said about your interest in transparency, that bodies such as Patients First consider that their members are still prevented from raising concerns about patient safety? This absolutely goes to the heart of issues at Mid Staffs and the other hospitals where there are issues, as there was in the case of the United Lincolnshire. How is that the case?
Sir David Nicholson: Well, you had better ask them.

Q223 Barbara Keeley: You have an ineffective issuing of guidance and ineffective processes. You have £500,000 gags being put on people to stop them going through an
employment tribunal and revealing information that is presumably inconvenient. How is this happening? It just seems that the NHS is completely ineffective at dealing with this.

Sir David Nicholson: Again, I have to say that what you say about Lincolnshire is bitterly contested. Obviously, I do not want to go into the detail of that because you are going to have the opportunity to do that yourselves.

To keep repeating the fact like that does not help, but, as to the general point that you make, I think, in the vast majority of cases that we look at and work through, the kind of clauses that you have described do not exist to stop people talking about patient safety. But, even if they did, people have the protection of the law and will have the support and protection of the Department and myself to enable them to speak out on patient safety issues, even if all of that does not work.

Q224 Barbara Keeley: In the case of this particular one, because we will have the chance to explore it further, was it the case that, at the point where the person wanted to go ahead and there was a radio interview being taped, the person was being warned off and the Department was involved with that? The Department and the trust were involved in warning off that individual. How do these things happen?

Sir David Nicholson: I absolutely and categorically deny that the Department warned off any individual from doing anything. What happened in those circumstances—and this is part of the public record and the Today programme would recognise it—is that the programme rang the hospital and asked them what they thought about that individual going on.

The response of the hospital was wrong. They should not have got their lawyers to write to him to say that he should not talk about that compromise agreement. In the strict legal sense, he had signed a compromise agreement about the resources and what he was doing, but it was not covered. It was absolutely right, free and proper to speak out. If he feels he has something about patient safety to say, then he should be able to say it, and, if the hospital by accident—I do not know whatever arrangements happened at the hospital—put that letter out—they were wrong to do it. The spirit of it was wrong.

Q225 Barbara Keeley: My question was about the fact that the NHS issues management directions and yet it is ineffective. We have this sort of situation developing, we have had that sort of situation developing, we have had that sort of money paid out, and we have people being warned off speaking out about patient safety. Patients First say their members are prevented from raising concerns, so it is a bigger issue than just the one. The one is an example, but it is a much bigger issue.

Sir David Nicholson: If they want my permission to speak out, then speak out, because we will protect them in whatever way we need to.

Q226 Barbara Keeley: But the message has not got through.

Sir David Nicholson: Okay. Well, hopefully this Committee is an important part of it, and everywhere I go and everything that I say in relation to this reinforces this issue.

Chair: I would like to dwell on this for a second.

Q227 Valerie Vaz: I wanted to ask you, Sir David, that, if there are any gagging clauses out there for members of staff, members of the NHS, who are the subject of gagging clauses, do they write to you?

Sir David Nicholson: If they believe that the clause that they have stops them speaking out about patient safety, they can write to me.
Q228 Valerie Vaz: That is any gagging. You have said—you were categorical—you think they should not exist.

Sir David Nicholson: Yes.

Q229 Valerie Vaz: So, if they exist, they should write to you and let you know.

Sir David Nicholson: If it stops them talking about patient safety, absolutely.

Q230 Valerie Vaz: I want to turn to Francis’s recommendation at 179 where he says that they should not exist. Do you have a timetable for that particular recommendation?

Sir David Nicholson: They should not exist now.

Q231 Valerie Vaz: I understand that, but Francis has made a number of recommendations, and in that particular recommendation he said they should be banned.

Sir David Nicholson: They are.

Q232 Valerie Vaz: Do you have a timetable to write to everybody to say that they should not exist?

Sir David Nicholson: The totality of the Government’s response to all of those things in there will be coming out at the end of March. Part of the Government’s response will be to take on this very issue.

Q233 Chair: Can I ask you to enlarge a bit on this question of what is the scope of a potential confidentiality clause? It is very striking that the discussion is about people being free to raise concerns about—and the key phrase is—patient safety. There will be many people working in the health service who think they have a concern about the quality of care more broadly defined and who do feel themselves inhibited in speaking out when quality objectives of the NHS are not being met. Do they have the same assurance from the chief executive as somebody who is concerned about patient safety?

Sir David Nicholson: Yes.

Q234 Chair: So there is no magic in this phrase “patient safety”.

Sir David Nicholson: No.

Q235 Chair: It is “quality” more broadly defined in the NHS Constitution.

Sir David Nicholson: Absolutely; that is how you get change to happen. If people do not feel they can speak out, how do you make progress? It is really important. For most staff, in most circumstances, that is exactly what happens. They feel that the organisation encourages them to report incidents and all the rest of it, and it is absolutely the right culture we want to produce.

But, at the other end, there are people who believe they have to go through a whistleblowing process in relation to all of that and we should give them maximum protection. We should nurture them because we can learn from them.

Q236 Chair: But, as Francis himself makes clear, if the culture is right, the whistleblower is redundant because every employee feels encouraged—empowered—to raise broad-based concerns, where necessary, about patient quality rather than just patient safety.

Sir David Nicholson: And the staff survey reflects that.

Q237 Barbara Keeley: Can I finish off the points I was making by saying that, if we are looking on this Committee further into whistleblowing, which we will be, it would be very
helpful to have some information from trusts across the country of the level of pay-out that there has been on such agreements. Presumably, as the chief executive of the NHS, you can gather that for us.

**Sir David Nicholson:** We have it available. I think we have published it already, but, yes, I am very happy to give you any information you require on that basis.

**Q238 Dr Wollaston:** I have a further point. If they want to whistleblow about something that is just inconvenient for management rather than maybe a direct safety issue for patients—they are often loosely aligned, as you have pointed out yourself—could these people who are subject to these gagging clauses now be confident that they could raise those issues?

**Sir David Nicholson:** I am expanding the scope here, in a way. I can absolutely go with patient safety and quality. It seems to me that that is a really important part of that. As to the issue about inconvenience to local managers, I am not sure how you would define that. Apart from anything else, that might strike at the heart of what the alternative is between going to law or going through the disciplinary arrangements or whatever.

**Q239 Dr Wollaston:** But you yourself said, when we talked about your three bullet points for improving the future, that high-performing clinical teams measure things and benchmark themselves against other teams. But similarly that must apply to management. There may be things that actually expose management as poorly performing against other managers, and management is very closely linked to clinical performance. So should we not just get rid of these clauses altogether, particularly as we go forward, because all these organisations are going to be individual? Who is going to be holding all these hospitals to account?

**Sir David Nicholson:** The general kind of move here to transparency is an important part of all this, so I would be wide in my extension of what was suitable. I just think, presumably, at some stage there is some kind of ring to run around it because—

**Q240 Dr Wollaston:** Aren’t they in the public interest?

**Sir David Nicholson:** Absolutely. Anything that is in the public interest—that could be about the use of resources; it could be all sorts of things—I think needs to be out there and people need to be able to talk about it and to whistleblow if that is what they require.

**Q241 Chair:** Francis makes it clear, doesn’t he, that confidentiality clauses in compromise agreements are appropriate—definitely and clearly appropriate—where they protect knowledge, for example, about individual patient cases? So it is a question of the scope of a confidentiality clause.

**Sir David Nicholson:** That is why I was slightly worried about—you described it as management inconvenience, but it could, in other circumstances, be something else. But the general point—

**Q242 Dr Wollaston:** We can all see the difference between exposing intimate patient details and exposing something that is inconvenient about hospital management. I think there is genuine concern, as we move forward, about how accountable these trusts are going to be. We all have to have confidence that members of staff who see things that do not look or smell right have the confidence to raise them.

**Sir David Nicholson:** I completely agree with you.

**Dr Wollaston:** Thank you.
Q243 David Tredinnick: Sir David, I want to ask you some questions about Francis’s recommendations, starting with statutory duties.

Before I do, I would like to take you back to your opening remarks, if I may, when you said that the NHS at the time was incapable of monitoring what happened at the trust. I put it to you that the most fundamental statistic that you could look for as a manager would be the death rates in your hospitals—whether they were, as you pointed out in questioning from Dr Wollaston, avoidable deaths or other deaths. It was an absolutely basic statistic.

However poor the reporting structure in the NHS at the time was, there was a reporting structure and you had personal judgment. You could perfectly easily have been in there and said, “I want that information,” and the structure was there to obtain it. Is that right or not?

Sir David Nicholson: The information that we collected comes through the Health and Social Care Information Centre. That is the basis on which information is collected and that is the way that we use it as we take these decisions. At the time, this information was not freely available in the NHS. It certainly was not freely available to the strategic health authority.

Mortality rates, as a crude measure, were not part of the way in which anyone measured the way in which the NHS was operating at that time because they beg more questions than they answer. The answer was that it was not available, we did not use it and nobody was using it across the pack at that particular time. In hindsight, that seems extraordinary—I absolutely take that point—but we have put all of that right.

Q244 David Tredinnick: You also said that you got so excited about the numbers that you did not go and look. I find that quite extraordinary. How can you possibly look at a set of numbers that tell you a story and use that as a reason for not investigating the circumstances?

Sir David Nicholson: I agree, and that is the point I was making. The strategic health authority at that time, and the trust, looked at those numbers and said they did not trust the numbers. They then instituted a whole set of investigations to look at those numbers in a different way—and they were wrong. We have put clear guidance to organisations over the last period to ensure that people do go and look—not only the board, but also the external body, the strategic health authorities in this case. More recently, Bruce and his investigating team are going to go and look.

Q245 David Tredinnick: I put it to you that what occurred—and we have had this massive report—was not a failure of process but actually a failure of top management to make proper assessments within the current arrangements.

Sir David Nicholson: That is not what the report says.

Q246 David Tredinnick: I am not going to pursue that because we have other questions to go on to.

One of Robert Francis’s recommendations was that there should be an introduction of a statutory duty of candour with criminal liability for breaches—a statutory duty, in other words, that those in authority in the health service should be straightforward and honest. Do you agree with that?

Sir David Nicholson: The Government will be publishing their response to Francis at the end of March and Ministers are still considering this as a set of issues. However, I do think the spirit of it—that we should have a duty of candour—is absolutely right. So I have arranged to be written into all the contracts signed by NHS providers and those outside the NHS as part of the contractual arrangements for next year that they should have a duty of
candour that will use contractual arrangements to put into place. As to whether the Government finally decide to give it legal backing, that will come later.

**Q247 David Tredinnick:** Do you think that it will genuinely encourage a culture of frankness and openness?

**Sir David Nicholson:** I think it sets an expectation, which I think is a really important point.

**Q248 David Tredinnick:** How else would you do it if you don’t do it in that way?

**Sir David Nicholson:** We are putting in contractual arrangements. That is what I am doing. Organisations now are contractually obliged to fulfil that duty of candour.

**Q249 Chair:** We have been delighted about that since that is exactly what we recommended ought to happen when we reported on the complaints process about two years ago.

**Sir David Nicholson:** Yes, sorry, absolutely. So that is what we have done.

**Q250 David Tredinnick:** Robert Francis—going to another subject—told us that he had done his best in his recommendations to ask for as little change as possible in the NHS system, while, in so doing, insisting that measures that put the patient first rather than the system’s business be included. Do you agree with that?

**Sir David Nicholson:** Yes, I do.

**Q251 David Tredinnick:** What is your assessment of the change required in the NHS system to implement the Francis recommendations in full?

**Sir David Nicholson:** Do you mean the totality of them?

**David Tredinnick:** Yes.

**Sir David Nicholson:** It is a significant change programme for the NHS from, literally, top to bottom. It is setting out basic standards that patients and everyone can understand, and then assessing and inspecting against them. It is the introduction of a whole range of things that the chief nursing officer is leading around the changing way that nursing operates. It is rethinking the way in which we train, educate and bring forward our leaders. It is providing more information to patients around individual consultants’ performance and outcomes. It is giving patients better access to their records. It literally is from top to bottom of the NHS.

**Q252 David Tredinnick:** Is that the kind of advice you will be giving to the Secretary of State and the Prime Minister?

**Sir David Nicholson:** Absolutely. It is completely consistent with the general approach that I have certainly believed for many years in the NHS. What it shows, though, is how difficult that is to do and what a challenge it is to make it happen.

**Q253 David Tredinnick:** How important is giving patients choice in all of this?

**Sir David Nicholson:** Giving patients choice is an important part of giving them control. If you think about the challenges facing us, a critical part of that is patients taking more control of their health, of their healthcare and of the way in which they work in the NHS. So the idea of choice as being something that you do over here for elective care is a relatively narrow definition of choice. We need choice in all sorts of ways, whether it is through general practice or choice of treatment. All these things are just as important, and we need to make that part of the NHS going forward.
Q254 David Tredinnick: So do you say more responsibility as well—patients taking more responsibility?

Sir David Nicholson: Yes. One of the greatest challenges facing the NHS is the number of people with long-term conditions—diabetes, asthma and all of those.

Q255 David Tredinnick: Like obesity.

Sir David Nicholson: It is all of those sorts of things and the way we tackle them. If you consider that the average person with diabetes will spend, on average, about six hours a year with a health professional and 99.9% of their time not with a health professional, it is that time and how they use it, and the way they control their own health and healthcare, that is the determinant of whether and how successful we are in all of that.

Q256 David Tredinnick: I have two further questions. Robert Francis has recommended the introduction of a set of fundamental standards of safety and quality of care to be applied throughout the NHS, together with provision for enhanced quality standards and developmental standards to be set locally. What is your view on that?

Sir David Nicholson: I agree with that absolutely. The point that he particularly makes, I think, about the basic standards that he is talking about is that they are well understood by patients and the public as well as the regulators, because at the end of the day you cannot have an inspector and regulator in every ward and every department. Patients and their relatives need to be part of this process. Unless they can understand and the standards are meaningful to them as individuals, it is very difficult for them to be engaged. So it is very important that we get the right kind of standards that are understandable to patients.

Q257 David Tredinnick: Finally, earlier in the session, you said that the NHS was at a critical time in the next few days. Do you think, on reflection, that the Commissioning Board is too powerful, too large and too unwieldy?

Sir David Nicholson: No, I do not think that.

Q258 David Tredinnick: Can you explain why?

Sir David Nicholson: Yes. I do not think that is the case. If you think about most of the commissioning, it is done by clinical commissioning groups at a local level. There are a whole series of differences in the relationship between clinical commissioning groups and the Commissioning Board, as compared with PCTs and the centre.

We have a duty of autonomy, so we have a responsibility to ensure that those clinical commissioning groups are given the freedom that they need in order to meet the health needs of the local population, and they do have most of the resource for the NHS. Power, I think, in those circumstances lies absolutely with the clinical commissioning groups.

We see the NHS Commissioning Board as a way of supporting them to be the best clinical commissioners that they can be. If you set your stall out from that perspective, I think you get away from the idea of having some kind of central power and localised delivery system. It is very much the other way round.

David Tredinnick: Thank you very much.

Q259 Andrew George: As you go through the transition from NHS chief executive to chief of the NHS Commissioning Board, I get an impression of how you perceive the role of the chief executive of the NHS—a role that you will be leaving behind—from the answers you have been giving today.

On the one hand, if there is a systematic failure, then you offer the hospital pass, as it were, to the politicians for having created the environment in which those systems are failing
through reorganisation. You also seem to accept my view that there was a culture within the NHS that heaped unrealistic pressure on the front line and turned a blind eye to the consequences. That seems to be that the buck is further down below the responsibility of that of the chief executive. Is there a need for a chief executive of the NHS if the chief executive seems to have no responsibility at all?

**Sir David Nicholson:** I certainly did not agree with the bit about the blind eye and the rest of it. I said there were bits of the system where that happened, but I did not accept that as a definition of the whole of the NHS and the way it operates.

But there is a difference—a change—in my responsibilities. If you think about the job I have at the moment, I am accountable to a politician. I certainly did not want to leave you with the impression that I was heaping anything on the politicians about the design of the system. The point I was making was that it was being built on a set of other organisational changes on the back of other organisational changes, which very often were outside the time scale in which politicians might be thinking about the reforms of the NHS. So I was not saying any of that.

As the chief executive of the NHS, I think the mandate set out by the Government is a really powerful accountability document. That document, for the very first time, sets out exactly what is required by the Commissioning Board and from the chief executive of the Commissioning Board itself. That is the accountability document that I think has been missing in the past. We have never quite had that sharp accountability, which I think we do have now in this new role.

**Q260 Andrew George:** Looking back to where we were with the Mid Staffs situation—your “Sir Humphrey” role, in effect—what were you saying to the senior politicians who had created a system that was clearly failing? You seem to be saying at the moment that you knew that it was a systematic failure. What conversations did you have?

**Sir David Nicholson:** What I was saying—I said this at the time, and I said this publicly at the time—was that the last thing the NHS needed in 2006 was another set of reorganisations. Even though it was not perfect, and even though we did not want to go through a set of reorganisations, it was a consistent argument that, when I worked with Alan Johnson and Andy Burnham, we held on to quite strongly. Reorganising the NHS is a very difficult thing to do and it is fraught with risk.

**Q261 Andrew George:** So, by your own standards, you failed. It has gone through multiple—

**Sir David Nicholson:** I am just saying that was what happened. There is no doubt that the financial circumstances that the NHS finds itself in going forward changes the way in which we need to think about all of that. It was really clear to me in 2008-2009, when we started to think about what the NHS would need to do in a world where there was very little or no growth, that we simply could not afford the infrastructure that we had. We could not afford 150 PCTs and 10 SHAs and all of that.

As part of our solution, we had to radically change that. We also had to make sure that we embedded clinicians in leadership positions in terms of how we would take the service forward. The NHS system needed to change in all of that, and, of course, the coalition Government came along with a set of proposals.

**Q262 Andrew George:** A hospital I know that you should remember visiting, a fortnight ago, is the Royal Cornwall Hospitals Trust. Indeed, you came through the smaller part of that trust, the West Cornwall hospital in Penzance in my constituency, so thank you for coming.
You will know that at that trust staff morale is at rock bottom, that the latest report is showing that they believe there are significant safety issues within the hospital because of poor staffing ratios within the hospital, and yet the big obsession is seeking foundation trust status. It is quite clear that the message from above to that trust is that it must hit not just a recurring balance but pay off a legacy debt. Armed with all the knowledge and having had the opportunity—using your words—to reflect on the Mid Staffs situation, just in terms of taking the lessons that have been learned, isn’t that a recipe for another Mid Staffs?

Sir David Nicholson: You are right that I visited Cornwall a couple of weeks ago. That whole NHS organisation has been on a big journey of its own and I was really impressed with the stuff that was going on in Penzance. It is really interesting, ground-breaking stuff that is going on in relation to clinical services there, and I was impressed with the people that I met there.

If you think back to the position on Mid Staffs and their wanting to become a foundation trust, in a sense why shouldn’t they want to become a foundation trust? It seems to me that being accountable to your local population is a really good thing for an organisation, but, to be accountable, you have to be able to show that you are both clinically and financially viable going forward. You have to take the decisions and make sure that the patients are treated properly in those circumstances.

But, also now, we have introduced over the last few years, under the leadership of Bruce, a whole series of clinical quality bars that people have to go under. So it is no longer the case, if it ever was—but it is certainly no longer the case—that you can drive to foundation trust status and ignore quality. You have to do both of those things together.

I was very impressed with the people who were there. They were not deniers; they did not say they had no problems—they recognised the problems that they have and they are trying really hard to put them right. The most important thing for them is to put those problems right, and that is what I said to them. The most important thing is to get those issues right. In a sense, foundation trust status will take care of itself. If you can become clinically and financially viable and you can demonstrate to your patients that you are providing great services, being a foundation trust is of secondary importance.

Q263 Andrew George: The lessons learned, both in that hospital and indeed throughout the country, are that you will ensure—indeed in your new post you will ensure—that the obsession with the tick-box, target-meeting and meeting financial targets will not become supreme over issues of patient care, and you will absolutely commit yourself to that.

Sir David Nicholson: Absolutely. Hitting the target and missing the point is as true now as it was then. The thing we have learned from the foundation trust is, first of all, to make sure that clinical quality is up there when you are making your judgments, and, secondly, do not have unrealistic timetables to push people through.

Q264 Andrew George: The issue that is underlying this and found in the Francis report is the culture of fear, which was clearly identified within the service in Mid Staffs. Indeed, you must know full well that Mid Staffs is not the only place in which that culture of fear exists, and yet in your own evidence—in your statement to the Francis inquiry—you say that you do not accept that such a culture exists or existed. Do you go around with your head in the sand? Everyone knows that there is a culture of fear in the NHS.

Sir David Nicholson: I certainly do not, and I see a lot of the NHS and have very frank conversations with people in the NHS. There is little point in me wandering round being falsely reassured. It does not work. I am under no illusions as to the stresses and strains that people are faced with. If you think about what it is like running a big acute hospital at the moment, it is very tough to do that when you think about how you have to balance all the
responsibilities that you have on the one hand and be open and transparent on the other. It is very tough things that we are asking people to do.

I get all that anecdotal evidence and I understand all of that, but, if you look at the best indicator that we have at the moment, which is the staff survey, it gives you a much more balanced picture about what it is like to work in the NHS today. It is not saying it is easy, by any stretch of the imagination, and there are some places where there are real problems that we need absolutely not to flinch away from putting right, but overall I do not accept the overall charge.

Q265 Andrew George: In the Mid Staffs report it was quite clear that Helene Donnelly reported through her Datex on nearly 100 occasions about understaffing in her ward, and yet nothing was done about it. She gave up because they all went unanswered.

You know that that is not the only occasion and the only place where that is happening. How will you make sure in future that front-line staff—particularly registered nurses on wards—who want to maintain their professional standards, who actually care about their patients and want to make sure that the staffing ratios are adequate, are going to be listened to when they report inadequate staffing levels?

Sir David Nicholson: Yes. This is a really important issue, I think, and I do not know whether Liz wants to say anything about it. From my perspective, evidence and transparency are the watchwords here, because what Francis says—and I absolutely agree with him—is that we need to use much better what the evidence shows us about what are the right staffing levels for a particular ward, and we need to set that out. We should set out what the minimum staffing level is for each individual ward by using whichever tool that you use, and then we hold the organisation and everybody to account through that.

Liz Redfern: Yes. You mentioned Royal Cornwall earlier, and, of course, you are seeing there, I am sure, a huge cultural change because of visible good leadership through the chief executive, who happens to be a clinician, who goes out and about and gets people to talk to her. I think that is extremely encouraging.

The way we can change culture and leadership at every level, including down to the ward sister in a hospital setting, is absolutely crucial. I agree with David that it would be almost arrogant for anybody in a senior leadership position like mine to set, from a distance, what the levels need to be on a ward. It needs to be a local judgment based on good tools to see what is appropriate here for this staffing skill mix and this type of ward layout for these types of patients.

Q266 Andrew George: And that those are transparent.

Liz Redfern: And that those are transparent. I believe it should be reviewed at the board, using those tools at least twice a year in public, and the trust investment needs to move around in order to fulfil the various requirements, which will be changing all of the time in your average hospital or community team. It cannot be something we can set centrally. It has to be a local decision, well supported by leadership.

Q267 Chair: Would you also say engaging commissioners in making that decision?

Liz Redfern: Commissioners obviously need to be involved in that. Commissioners themselves have clinical leaders as part of them. It needs to be a conversation through all those key parties to decide how we are going to provide and commission care the best it can be for our patients and public locally. That needs to be a joint conversation, getting all of those things in place, and then commissioning appropriately and money flowing with that.
Sir David Nicholson: Commissioners have to be interested in staffing levels. If you accept that well supported and well staffed organisations provide great outcomes for patients, you have to be interested in that.

Chair: Absolutely. I agree, but I just wanted to check.

Q268 Barbara Keeley: Going back to the Francis issues around patient-staff ratios, there are some horrendous examples there of people spending long periods of time hunting down a nurse. That seems to be what it was; patients left in soiled bedding largely because there was nobody available to help them; patients falling—very many examples of patients falling—and making their condition worse. That is where we are with that.

Francis has said that the issue was the prioritisation of financial performance over those considerations of adequate staffing, which my colleague has just been touching on, and you have talked about local judgment with good tools. But the CQC tells us that 17 hospitals—it might be more than that, but they have talked about 17 hospitals—currently have inadequate levels of staff to provide safe levels of care. So we are in a situation where we have historic problems with the Mid Staffs issue, where it is quite clear that the staffing was woefully inadequate, and yet we have 17 hospitals that the CQC says currently have those problems.

The question is should we move—as Francis suggests we move rapidly—to a procedure to establish what each service requires in terms of staff members and skill mix. In fact, I have looked at a local hospital that is one of the safest hospitals in the country, and it has a higher ratio of staff to patients. But every time I ask questions here about it, we seem to get this wriggling going on—“Oh, well, it is also a question of leadership.” It does not seem to me that it is a question of leadership. Absolutely at base, it is about getting these ratios right, and if you do not get these ratios right things start to go wrong.

I was reading yesterday on social media an account of somebody who was not attended to overnight. They talked about one or two staff and maybe one healthcare assistant available overnight, with people left for long periods of time. Stories are coming in to us all the time that this is happening. The CQC is saying we have a number of hospitals where this is the case. All of this theorising about developing tools and “commissioners must take account of it”—they are not. It is an urgent thing to us here that something gets done about this.

Liz Redfern: Could I say a couple of things about that? One is that the 17 hospitals that were previously referred to by the CQC as having poor standards of staffing are not currently in that position. Many of them have been revisited by the CQC and been found to be safe. So it is not a current situation.

Q269 Barbara Keeley: But they were in that situation.

Liz Redfern: They were at that time, absolutely, and actions were taken.

Q270 Barbara Keeley: Stop on that point, though, because if we are not clear about this, if there is no procedure, no mechanism, then 17 more could be appearing. The CQC is quite behind in its workload, as we know from talking to it on other issues, so we cannot regard fixing the 17 that it last complained about as getting rid of the issue.

Liz Redfern: No; I am just making a factually correct statement. I am certainly not theorising about anything. I am not a theorist; I am a very practical person, who has been a nurse since 1970. I have worked in very many settings and seen over those 43 years the situation, particularly in acute wards, changing dramatically in terms of the environment.

All I was saying was that the issues of leadership are important, to support ward sisters, to support directors of nursing on trust boards, to get those numbers right in their local
context on a day-to-day basis. They need to be aware of all those examples that you have read on social media and responding to them. You respond on that—

**Q271 Barbara Keeley:** But clearly they are not, are they? Let us just be clear about it. I do not think going into denial about the state of things is helpful. We have this historic issue at Mid Staffs, which was an absolute abomination. We had the situation quite recently that 17 hospitals got into that state. We do not know at any point in time how many other hospitals will do so. We have lost 7,000 nurses over the last number of years, so it is clearly an issue. This needs attention and it needs it soon.

There are stories—I have had them as an MP and others get them, and there is a lot on social media about it—and we are not tackling this. Until we accept that this is an important thing and it must be dealt with, my suggestion is actually not just to look at failing hospitals—the 17 and the ones with the high mortality rates—but to look at what safe hospitals do. What do the best hospitals do? Why can we not find what the best, safest hospitals do, and adopt that?

**Liz Redfern:** That is absolutely part of the picture and goes on too, and you are right, that those needs—

**Q272 Barbara Keeley:** Why can’t we do that?

**Liz Redfern:** We are doing it in some instances. It is not as widespread as it might be, and we have to encourage trusts, clinicians and teams to learn from each other.

**Q273 Barbara Keeley:** Sir Bruce is looking at this now. You are looking at failing hospitals or hospitals with poor mortality rates. Why are you not looking at safe hospitals and finding what they do in terms of patient ratios?

**Professor Sir Bruce Keogh:** We have to start somewhere; that is the first point. Would you like me to get on to the subject of the review that I am conducting?

**Q274 Barbara Keeley:** No, it is just the patient ratios, because we keep coming back to it and I have to say that, whoever we ask—whether it is senior leaders in nursing or others—we never get an acceptable answer. I have never had an acceptable answer on this and it is very concerning.

**Sir David Nicholson:** Perhaps I will give you another unacceptable answer. In a sense, where in the world have people decided nationally from a Government Department to set nurse staffing levels—

**Q275 Barbara Keeley:** I am not suggesting that for a minute.

**Sir David Nicholson:** Where they have, it has failed very quickly.

**Barbara Keeley:** I am not suggesting that. I am suggesting looking at hospitals where it works, where there is good safety, and suggesting that that is adopted elsewhere. But clearly there is a denial about this; there is a denial in nurse leadership—yes, there is. We have asked this question here in this Committee—my colleague agrees with me—and we just get back bland answers, and we are getting another set of bland answers today. This is not being looked at, but it should be looked at and it has to be looked at.

**Q276 Chair:** Let me ask the question. Are nurse staffing levels being looked at, what is being found and what is being done about it?
**Sir David Nicholson:** This is a really important point, not least of all because, as we go through the next two or three years and the financial position gets tighter, we need to ensure that the staffing levels on wards are safe—and better than that.

There is a whole series of ways you can do that. As I say, some Governments in the past have said, “We will have a national way of doing it.” Generally speaking, they fall apart relatively quickly. Our approach to it is this. There are a number of tools that you can use as a chief nurse of a hospital that help you define what the right staffing level is. Any of these tools on their own will not do it because you need the engagement of the staff in the wards to enable you to do it.

What we are doing at the moment—what we plan to do—is to accredit the staffing-level tools so that we can say, “These are the ones that you should use,” and I think we have already got to a point where we are doing that.

**Liz Redfern:** We have.

**Sir David Nicholson:** Then every single hospital has to go through a process where they identify, ward by ward, what their staffing levels should be and they should publish it. In my view, as you come in the ward, it should show what the staffing level on that ward should be and what it is.

**Q277 Barbara Keeley:** Will that be required?

**Sir David Nicholson:** I do not have the power to require it, but it seems to me that is the general approach that we should—

**Q278 Chair:** You have the power to suggest to commissioners that this is what they should require as part of their commissioning process.

**Sir David Nicholson:** Yes, absolutely, and that is what I think we should do. I cannot force them to do it, but it seems to be good practice for them to do it. In that transparent way, if you are a patient or a member of staff on that ward, you can look, and you can make the assessment as to how well that is being dealt with. That is where we want to get to.

**Liz Redfern:** Absolutely. Those are the sorts of conversations I am personally having with the directors of nursing across the south of England—those sorts of issues about how we learn from each other. The other thing to say is that, since Mid Staffs, the original report and all the work that has been put in place around quality monitoring since then, on a very regular basis I, as the chief nurse for the south of England, for example, am looking at a whole range of indicators all of the time.

One of those is nurse-patient ratios, along with numbers of infections, how many people are falling, how many people have bladder infections and how many people have pressure sores. All of those are looked at regularly in order to try and predict where organisations may be going off the types of standards that we would expect. That is the system that is now in place that was not in place at Mid Staffs.

**Q279 Barbara Keeley:** Was it in place when the 17 that the CQC reported on slipped into having unsafe levels of care? How did that happen? If you were doing what you are doing—I do not know how long you have been doing that—why did we end up with a number of hospitals, and not one or two?

**Liz Redfern:** It is because of the limitations of looking at something from a distance versus the limitations of the responsibility of the trust board locally. I am able to look at nurse-patient ratios for a trust as a measure. That does not tell me how many nurses there are on any particular ward at any one time because that is the responsibility of the trust board. In that sense, those CQC cases were individual wards, individual services. It was not about the whole trust having a problem. That is the difference.
Q280 Barbara Keeley: But who wants to go into a hospital with the knowledge that there are unsafe levels of care on any of its wards? Frankly, you would not want to go near them.

Liz Redfern: No, absolutely not, which is why the local trust needs to be looking at that all of the time and to be on a day-to-day basis deploying staff in such a way.

Q281 Barbara Keeley: But they are not, are they?

Liz Redfern: In some instances they are not, and that is not right, and in some instances they are and have very sensitive systems—electronic and human systems—that track this and make those arrangements. You are absolutely right to say that we need to have everybody doing that.

Q282 Mr Sharma: What is happening to those who are not looking at it at this point?

Liz Redfern: I have made it clear professionally, as Jane Cummings, the chief nurse, has, that we would expect every director of nursing on a trust board to have a mechanism for doing this. They are both professionally accountable through their registration as well as personally responsible for delivering that huge investment that their trust gets in the right way for the quality of patient care through their nurse-staffing arrangements.

We expect them all to have a way of doing that. We expect them all to use one of the tools that Sir David has already mentioned. If they are not, then I would expect their trust board to hold them to account for that.

Q283 David Tredinnick: Can I go back to the levels of staffing in wards? It does seem to be incredibly simple for you to put out a circular saying, “We expect these levels to be maintained, and we want each and every one of you to report back via the structures about the levels of staffing in your hospital and the wards.” I cannot see that this is a complicated issue. It seems to be incredibly straightforward. If there is a variation of the numbers in the wards, then there should be a variation in the staff, and it is a very simple ratio issue, isn’t it?

Liz Redfern: Not necessarily, I am afraid.

Q284 David Tredinnick: Can you explain why not?

Liz Redfern: I say that based on my experience of running wards, hospitals and being a nurse. On the actual ward on a day-to-day basis, depending on the dependency of the patients and so on, it is never one thing. It is never just like that day after day. That is where you need to have people who are in charge of those wards, in charge of those hospitals, who help people intelligently to know what they need.

Also, if I could just say, of course the delivery of care on a ward—we are focusing on wards, but, of course, a lot of care goes on in the community—is not just about nursing. It is about the whole team—who else is there to support, to absolutely ensure nurses can do what they are paid and qualified to do and are not changing light bulbs or filling out bits of paper that they do not need to do. So it is about a whole team.

Again, just making some demand for a particular number of nurses takes no account of the other key employees—staff—in that ward who make huge contributions to the care of patients on a day-to-day basis. It is not as simple as that, I am afraid.

Q285 Andrew George: As to paediatric wards, where there is a—

Liz Redfern: There are intensive care units—

Andrew George:—mandated staffing level, you are suggesting on the basis of your answer that that is in fact wrong—in fact, clinically ill-advised.
Liz Redfern: No. What I am saying is that they use that, but, of course, that does not restrict them making those day-to-day changes. So in that sense, it is a guideline.

Q286 Andrew George: Would you not agree that having a guideline that it should never fall below this level at least gives everyone confidence? After you have used the tools to review the situation you can enhance levels beyond that baseline, just as you do on paediatric wards?

Sir David Nicholson: The evidence around the world for this is that that very quickly becomes the norm. No matter how you define the minimum, it suddenly becomes the norm. That is the danger.

Q287 Andrew George: It fails in Australia, does it?

Liz Redfern: There is some evidence emerging from Australia, which is fairly new. We need to keep an open mind on the evidence—of course. At the moment, I do not think there is sufficient evidence.

Q288 Chair: One of the immediate learning experiences of the whole Mid Staffordshire scandal—going right back to what Sir David said about what he found when he first took charge of the Shropshire and Staffordshire Strategic Health Authority—is surely that there needs to be open accountability around this issue of nurse and general staffing levels in care delivery, both inside and outside hospital. If commissioners are going to be part of the discussion about staffing levels, are providers then going to be accountable in public to the commissioners for the delivery of the staffing levels defined by the commissioner?

Liz Redfern: I can make a general point on that, which is that it is really important that, again, we do not lose the bigger picture here about the quality of care that the patients receive, of which staffing levels is a part. The commissioners certainly need to be concerned with a whole range of things through their commissioning conversations and through the plans that the trusts submit in response to those, of which staffing levels is a part. The overall aim of the commissioners is to get a quality of care that is safe, has good outcomes and a good experience. It is always a balance of all of those things.

Chair: I agree.

Liz Redfern: That is, in a sense, a thing that is embedded in the agreement.

Q289 Chair: But if what we are looking for—going right back to the beginning—is a culture change, then staffing levels, although of course not the whole of the quality of care experienced, are an important element in it.

Liz Redfern: Sure.

Q290 Chair: Sir David used the concept that things have to be, first, measurable and, secondly, accountable in public. The reason why I am picking it up is that it seems to me quite a good illustration of precisely the culture change that we need to deliver.

Sir David Nicholson: There is a slight danger—but only a slight danger—that commissioners will end up trying to run the hospitals, which is not what we are trying to do here. But I think it is perfectly legitimate for an agreement between providers and commissioners to be made, which sets out what the minimum staffing levels are across the wards and that that should be reported on in a public and open way as part of these arrangements. That is perfectly reasonable.

Q291 Dr Wollaston: Can I take you back to the important point you made about hitting the target and missing the point? Was that your phrase, Sir David?
Sir David Nicholson: Yes. Well, I think I made it. In 2006, when I got the job, it was one of the things I—

Q292 Chair: You will hear from whoever the author was if it was not you.

Sir David Nicholson: I know; that is always the problem. Somebody may say, “I said that.” The other thing I said a lot was that organisations should look out to their communities and patients and not up to the centre.

Q293 Dr Wollaston: I quote from the report “Achieving the vision”: “Because of the fear of what will happen if targets are not hit, it’s not uncommon for managers and clinicians to hit the target and miss the point.” That was taken from this report that interviewed 58 individuals. Were you one of those 58 individuals?

Sir David Nicholson: I was not, but I do go on about it quite a lot to my colleagues, so it may be that one of the people were interviewed.

Q294 Dr Wollaston: Yes, so they probably have picked it up, but they were also sharing that concern.

Sir David Nicholson: It is always a danger when you have targets. Targets in themselves are not bad. They can be really positive. If you think about healthcare-associated infection, all of those things have really powerful targets, which have broad understanding, clinical buy-in and you make it, although that one did not always have clinical buy-in, interestingly enough, but that is an example of that. It is the way you do it; it is the way you implement it. That relates to the culture, to the way people operate and to what the values of that organisation are.

Q295 Dr Wollaston: Do you think we have rather let Ministers off the hook here?

Sir David Nicholson: Fundamentally, if you think about the NHS plan and what happened at that time, the general approach was that the NHS was really rather good; quality of care was rather good. The problem was getting into the system. It was access. That was the focus of attention. In a sense, when we got to the point where we were resolving a whole load of the access problems, the issue about the quality of care became the issue. I do not know whether Bruce wants to say something about this.

Professor Sir Bruce Keogh: I am going to tell it from my perspective, and I suspect Dr Wollaston will see it in a similar way. If I go back to the early 2000s—as some of you know, I am a heart surgeon by background—I would sit in my clinic and two people would come in, usually a man and his wife. We would go through a long consultation on the relative merits and complications of a heart operation and a lot of hard-nosed facts. I would say to the man, who generally needed the operation, “Do you have any questions?”, and he would say no. I would turn to his wife and say, “Do you have any questions?”, and she would say, “Just one.” I always knew what it was. She would say, “When?”, and I would say 18 months to two years, and this look of abject terror would descend over her face, her eyes would cloud over
with tears and she would say, “We have waited a year to see the cardiologist and three months to see you. When is this nightmare going to stop?”

In a sense, I protected myself by hiding in the knowledge that the technocratic results of the surgery were as good as you would get anywhere in the world, and yet I increasingly began to realise—and that is one of the things that has driven me into this job—that we were offering a service that was technocratically good but was not good for the patient. It is terrifying, and I am sure the GPs had to pick up the fall-out from some of those conversations.

Then we went through a really difficult time of targets. I call it the waiting-list target. The term “access” is a little remote to me. So we had people waiting on waiting lists, worried whether they would die, and there was some really tough management to make that change. I was leading during that time two different heart surgery units, but one which had the longest waiting list in the country. We had patients on drips waiting for urgent operations, sometimes 20 at a time, and we had burgeoning elective waiting lists. This created a very significant tension. It was with a good relationship between effective managers and clinicians, who kind of aligned to say, “We are going to deal with this problem,” that we dealt with it.

By the time I was director of surgery at the Heart Hospital in 2007, which was a different unit, I would have a similar encounter with patients in the clinic and I would turn to the wife and say, “Any questions?” She would say, “When?”, and I would say, “What about next Thursday or Friday?”, or something. Again, a look of abject terror would descend because people did not realise that things could happen quite so quickly. That really changed the dynamic between the clinicians, who are trying to deliver a service, and those who receive it. Now they are no longer just frightened about whether they are going to get treated. The whole conversation has now shifted to quality.

The timing of all of that was quite interesting in the sense that it related also to the time that Ara Darzi came in as one of the Ministers and went through the process of developing “High quality care for all”, developing a definition of quality. That has enabled us to think about how we are going to drive quality forward in the NHS. The definition of quality was really quite an important step forward.

We are the only healthcare system in the world—and thank you, colleagues, in this room for getting it into legislation—that says that there are three domains of quality. One is effectiveness, and we have not been too bad at that in terms of the technocratic results of our interventions. We are ahead of the rest of the world in some aspects of safety, but we still have a long way to go. Frankly, when we have been looked at by independent observers such as the Commonwealth Fund, a think-tank in the United States, we do well. In most areas, they rank us generally number 2 of the seven big systems that they look at.

But we always fall down on timeliness, which is what I would call waiting lists, and, secondly, on personalisation. Personalisation means treating people who come into our service with the same level of courtesy that we would treat visitors into our own home and affording them appropriate respect, and, in commercial terms, providing a decent customer service. We have fallen down, in my view, badly on that. That has really come to light through events in Mid Staffs. That epitomises the problems that come out of that lack of focus.

When I look at the current reforms that have just gone through, putting aside all the structural issues, it seems to me that there are three main things that underpin those. The first is to make clinical outcomes the currency of the NHS. Patients get clinical outcomes; they want to get better. Clinicians get them; they want to get better. Now we have a situation where those clinical outcomes are the common goal of the managerial community, the professional healthcare community in the NHS and patients. So, in my mind, if we get this right, we have a set of common goals, which did not necessarily exist when there were tough battles around dealing with waiting-time targets and so on and so forth.
The second thing is the promotion of clinical leadership, which Ara Darzi started, and is now, I guess, best articulated by the clinical commissioning groups, a clinically-led and driven new commissioning board and a lot of clinical leaders associated with that. But I would like to say there is very clear evidence that in hospitals, where you have a high level of medical engagement, that translates into better clinical outcomes at every level from mortality downwards. So we need to promote that.

Again, as to the engagement of the clinicians in Mid Staffordshire—and I have said this to the Committee before—there was a failure of leadership and there was a failure of professionalism. To put that quite bluntly, when there are difficulties in a hospital—and I have had arguments with my own colleagues from time to time—if 10 consultants show up in a chief executive’s room and say “There is a real problem here,” you know which way that conversation is going to go. That never happened in Mid Staffordshire. There are issues about professionalism and medical leadership that we need to get to the heart of, and I have alluded to personalisation.

May I just, Chair, if you will forgive me, outline some of the processes that we are going to use to try and get to better quality? This is not in the wake of Mid Staffs, but this was really from Ara’s review, which was driven by David. We have a definition of quality. I am a firm believer, as you know, in the measurement and analysis of quality, and we are going to measure quality in all of those three domains. Hence we have a bunch of measurements for clinical effectiveness, a new series of measures for safety, and we are thinking through some good and concise measures on patient experience. We will publish those.

Indeed, in the time since I have been medical director and David has been chief executive of the NHS, we have published over 600 measures of performance on NHS Choices. Some of them, to be honest, are a little bit difficult to get to. We are focusing on how we reward people for improving quality. A good example would be fractured neck of femur. Over the last decade there has been a 25% reduction in death from fractured neck of femur, which is a terrible condition for elderly people who fall over, and in the last couple of years we have reduced it quite a bit further. We have done that by linking quality measures into payment for that condition.

The safeguarding of quality is an issue largely for the regulators. In terms of promoting quality, we are doing much of that through the newly announced and designed academic health science networks, which we believe will be significant agents for change. One of the things that is quite clear when you visit the academic centres in the United States, for example, is that, where the academic centres work in partnership with not just their local teaching hospitals but the equivalent of district general hospitals, you get a feeling of engagement that did not exist before, and that promotes innovation because many of the solutions to our problems do not lie in people sitting in darkened offices. They lie in the intellectual capacity of those who work at the front line in the system. In our case, that is a big intellectual reserve of 1.4 million people.

So we have, in my view, by using the academic health science networks as our drivers for change, the opportunity to innovate in a way that the NHS has not. I believe that innovation is one of our other missing ingredients, apart from the focus on patients. If we can get the innovation right, that takes us into a tipping point for our NHS because it will bring the newest treatments, be good for patients, exciting for clinicians and good for UK plc. Underlining all this, our focus has to be on leadership, and David might want to say something about the Leadership Academy and the focus that we are bringing.

The other thing that worries me a little bit on leadership is this. I have been on the Council of the Royal College of Surgeons on two occasions, and I have watched the leadership organisations of various clinical tribes, if you like, and interest groups slowly feeling that they have been relegated to the position of commentators rather than participants.
We have moves in place now to try and bring those organisations back into the mainstream delivery of the NHS, which is where, frankly, they would like to be. They do not want to feel excluded. I am sorry—this has been a long answer.

Chair: You have sat in respectful silence for quite a long period and I was looking for a way to bring you in, but you found it for yourself. Thank you very much.

Q297 Dr Wollaston: Can you clarify something? You talked about the three main points for the future and you talked about the clinical outcomes being the currency promotion of clinical leadership, but was your third point about personalisation or did we not get to the third point?

Professor Sir Bruce Keogh: I was trying to shorten my answer.

Q298 Dr Wollaston: Was that the third thing?

Professor Sir Bruce Keogh: Personalisation, in my view, is two things. We hear a lot—

Q299 Dr Wollaston: Was that the third thing?

Professor Sir Bruce Keogh: Yes. We hear a lot of rhetoric about personalisation, but personalisation is a spectrum. On the one hand, it is affording people, as I have said, the simple courtesies that you afford somebody who comes into your own home.

If somebody comes into a clinic, it is standing up, shaking their hands, opening the door, that sort of thing. That is just basic. At the other end of the spectrum, there is the sort of hard-core pharmacogenetics. There is a big opportunity for our NHS to try and get much more focused and targeted treatments.

As you well know, people come in and out of your clinic, you have to try different tablets and eventually you find something that works. But we are getting to a point now scientifically where we can start on, I guess, relating your genetic construct to how well you will benefit from different types of treatment. We have a unique opportunity in this NHS to take advantage of that. We probably lead the world in some of the intellectual capital around this, and we are currently working on how we can start to bring that to our patients.

Chair: The whole question of the implication of genetics is a subject probably for another day. A number of my colleagues want to get in.

Q300 Valerie Vaz: I just want to pick you up on a point that you made. Did you say that, because the 10 consultants did not go into the boardroom, that is what the failure was at Stafford hospital?

Professor Sir Bruce Keogh: No. I think that was a metaphor.

Q301 Valerie Vaz: What did you say exactly?

Professor Sir Bruce Keogh: I think that is oversimplifying it.

Q302 Valerie Vaz: What did you say then?

Professor Sir Bruce Keogh: The message that I was trying to get across was that when consultants really want something to happen in their hospital and really want to improve something, if enough of them want it and enough of them sit down and engage with their managerial colleagues, it will happen.

Q303 Valerie Vaz: That is the key point, isn’t it—“engage with the managerial colleagues”. But the person who appointed you, sitting next to you, has said that he thought
that there were no clinicians present at the board and yet he did not do anything about it. So I
don’t think you can just blame the consultants for not turning up in the boardroom.

_Professor Sir Bruce Keogh:_ I did not say the boardroom, actually.

_Q304 Valerie Vaz:_ Get cross if you like, Sir David, but I just have a question for
you, and this refers back to Mid Staffordshire and Stafford hospital. What do you see as the
role of the directors of public health, and did they ever come to you during your time there
and say, “We have concerns about the mortality rate”?  
_Sir David Nicholson:_ Honestly, I am not getting cross about all of this.

_Q305 Valerie Vaz:_ Just answer the question. Forget about it; I don’t mind if you get
cross. I just want you to answer the question.
_Sir David Nicholson:_ But you made an aside, a comment there, didn’t you? I didn’t do
nothing about it.

_Q306 Valerie Vaz:_ It was in your evidence.
_Sir David Nicholson:_ I set out to the chairman and chief executive what my
expectations were about them recruiting a medical director and getting clinicians engaged in
their service. That is what I did. I didn’t do nothing.

_Q307 Valerie Vaz:_ That never happened, and part of all our jobs is to follow up on
what happens. Lawyers do it all day long. You have to follow up what goes on. Doctors do it;
everyone does it.
_Sir David Nicholson:_ And I did follow up.

_Q308 Valerie Vaz:_ You didn’t.
_Sir David Nicholson:_ I did follow up.

_Q309 Valerie Vaz:_ You didn’t. Well, your evidence does not say you did.
_Sir David Nicholson:_ I did.

_Q310 Valerie Vaz:_ Can I just go back to my main point? Did a director of public
health, or anyone from public health, ever come to you and say they had concerns about the
mortality rate?
_Sir David Nicholson:_ No.

_Q311 Valerie Vaz:_ Not at all?
_Sir David Nicholson:_ No.

_Q312 Valerie Vaz:_ Sir Bruce talked about managers. Is there a managers’ code of
conduct that says—
_Sir David Nicholson:_ Yes.

_Q313 Valerie Vaz:_ What does it say about putting patients first?
_Sir David Nicholson:_ It says you should put patients first.

_Q314 Valerie Vaz:_ Right. Do you think that happened there?
_Sir David Nicholson:_ No.
Q315 Valerie Vaz: So what are you going to do about that now in line with the Francis recommendations?

Sir David Nicholson: I think we are going to respond to the issue about codes of conduct, manager regulation and accountability in management as part of the Government’s response. We have not finalised that. As I say, Ministers are still considering it, but that needs to be a part of our response.

Q316 Valerie Vaz: But you wanted to do that about the duty of candour. You have already done that in terms of the duty of candour—

Sir David Nicholson: We have put that in.

Q317 Valerie Vaz: Can I just finish what I am saying?

Sir David Nicholson: Sorry.

Valerie Vaz: You have done that in relation to the duty of candour and the Francis recommendations. You are choosing to do some, but not others. Is that right?

Sir David Nicholson: The thing about the duty of candour is that we are drawing up the contracts for 2013-14 at the moment. If we didn’t take the opportunity to do it now, we would not have the opportunity until 2014-15. In those circumstances, it seems to me that swift action is the right thing to do. We are taking a little bit more time because we do not have that timetable of discipline on us in relation to the second one. So we will take our time.

Valerie Vaz: Thank you.

Q318 Andrew George: Sir Bruce, in your description of this new world that we are moving into, you used a lot of conceptual management jargon, if you do not mind me using that expression, in terms of the hundreds of guidelines and measures and so on that will be put in place to address a lot of the failings in the system that you and, indeed, a lot of people have identified.

The Francis report has identified systematic failings. I recollect the period in 2004-2005 when a lot of systems were being changed and there was a lot of warm conceptual jargon used then to describe a lot of the management changes at that stage. If the system that you have described—and Sir David is clearly supporting—likewise fails, who will be held accountable?

Professor Sir Bruce Keogh: First of all, I have never been accused of speaking management jargon before, so I am not quite sure whether that means my conversion is complete.

Let me be quite clear. If I have given that impression, it is wrong. When I talk about measurement, I talk about clinical measurement. I believe—and I have a fundamental adherence to this—that anybody involved in healthcare should be able to describe what they do and define how well they do it. That applies to individuals and to organisations. I have used that in my own practice and I have used it to help develop heart surgery in this country.

Everything is around that principle. If you know what you are doing and how well you are doing it, and if you know that within the three domains of quality I have alluded to, then you will know where to improve. If you think that our hospitals are simply aggregates of different clinical services and those clinical services themselves are aggregates of different clinicians, the first line of defence in quality and the first line of accountability lies with the clinician in that private and trusted relationship with their patients. The next level of protection and accountability for quality lies with the trust board, and David Nicholson has clearly outlined the accountability there. The third level lies with the regulators.

But I think we need to get to a point where people recognise that the first building block of quality is around professionalism in that encounter between someone who feels
unwell, frightened and scared and needs help and the person that is offering that help. That is the first level of accountability.

**Q319 Andrew George:** The lines of accountability are at clinical level, trust board level and then with the regulators. The people who designed the system are not accountable.

**Professor Sir Bruce Keogh:** Of course the people who designed the system are accountable.

**Q320 Andrew George:** In what way? You have just described three tiers of accountability, but with Mid Staffordshire you had systematic failure. That was a systems failure. Who designed the system? Who created the system? Who analysed that system?

**Professor Sir Bruce Keogh:** I have no idea who designed that system. In terms of measurement, although you might think that is management speak, I go back to my point about everybody knowing what they do and being able to define how well they do it. I think we need to get to a point—and I promoted this well before I was ever appointed NHS medical director, both nationally and internationally—where each and every service line should measure, analyse and publish its results.

If I go back to my own specialty, we went through, in North America, in parts of Europe and particularly in this country, some difficult issues about how to analyse the results of heart surgery. You may think that is relatively easy and sort of binary, but it is more complex than that. We went through a process of working out how to publish those results in a way that did not unfairly penalise surgeons who took on high-risk cases, because the net result of that would be high-risk avoidance, and we went through a process of working with patients as to how to publish this data in a way that was clear and meaningful to them and also to cardiologists and others who referred patients. I believe that, ultimately, that is what every trust should be doing.

We have embarked on that journey and been on it for some time. We expect that in the quality accounts that we expect trusts to publish on an annual basis, and you will see that, as part of the NHS planning guidance for a number of specialties, we have now embarked on publishing this sort of data down at individual clinician level.

**Q321 Barbara Keeley:** I have to say I think you are slipping into the management jargon.

**Professor Sir Bruce Keogh:** Am I?

**Q322 Barbara Keeley:** You started your career as a surgeon and we have found that nurse leaders are just the same. Frankly, it does not help. I have to acknowledge that I started my career in the IT sector, so, across many years, I was used to jargon, but it is better not used as much.

As an MP, I have had a case of appalling NHS treatment of a constituent. It amounted to neglect and was a really bad case. The details, in many ways, were similar to the patients’ stories at Mid Staffs. I know that that family felt hurt, let down and angry—very angry—with the NHS, and probably always will. What we have coming out of the Francis report and the Mid Staffs situation is hundreds, if not more than a thousand; I do not know how many families there are.

I want to ask you—Sir David, more than anybody else—what you say to those hundreds of people in Mid Staffs who lost a loved one and whose memory of that loss is now stained by things like seeing them lying in soiled sheets, by falls, things that were avoidable, and by the complete neglect that I have seen in a constituent’s family, but here we have it echoed by hundreds, if not thousands? What do you say to those people?
Sir David Nicholson: All I can say in the circumstances that they find themselves in is that I acknowledge their grief and the hurt that they must feel and apologise on behalf of the NHS and myself for what they have happened to see.

As to whether there are things we can do to help them as individuals, one of the things we offered in Mid Staffordshire was a sit-down with a clinician and the case notes, to go through in detail what happened to their loved one so that we can all understand better what happened and what implications there were for the length of their life or their last few hours on earth. With all of those, we can do that, and we can make sure to do everything in our power to ensure that it does not happen again. One of the things about the Francis report, and indeed the action that we have taken since 2009, is designed with that in mind.

Chair: On that note, I am going to draw the session to a close. Thank you for coming.