1. Why governance matters – analysing systemic failures in the NHS

> It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.
>
> Florence Nightingale (1863) *Notes of Hospitals*[1]

I begin this book with two devastating case studies of harm wrought within the English National Health Service (NHS). Pressure from courageous whistleblowers over the tragic death of a toddler at the Bristol Royal Infirmary in 1995, and a mother at Mid Staffordshire NHS Foundation Trust in 2007, eventually resulted in official public inquiries. These two cases identified different systemic failings in governance as the root causes of scandalously poor care at each hospital and why patients died who would have lived if they had gone elsewhere. They exemplify Paul Batalden's observation that 'every system is perfectly designed to get the results it gets'.[2] The analysis of the two case studies shows that details matter if we are to understand systemic failures of governance. Although much of the book is grounded in the government of Britain, I also try to follow Alfred Marshall's invaluable advice to scholars, 'always to remember the one in many and the many in one'. So, the book's central subject is the challenge of governing well. Focusing first on the NHS demonstrates why it is so hard for governments to ensure that public services are of uniformly high quality. As I write, the NHS is struggling to remain an iconic legacy of the Attlee settlement, established by Labour governments from 1945 to 1951. That settlement set a central frame for post-war British politics until 1979. The subsequent radical changes in governance of the NHS, based on the idea of markets, are symbolic of the reach of the Thatcher settlement, which was established by her Conservative governments from 1979 to 1991.

The chapter has four sections. The first is about how the scandal at Bristol continued, in the 1980s, under the Attlee settlement, and the 1990s, in the 'internal market' of the Thatcher settlement. The second section is about how Blair's New Labour government aimed to fix the failures of self-regulation

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by the medical profession by requiring NHS organisations to implement systems of clinical governance and holding them to account with an independent inspectorate. The third section is about the grand strategy of the Blair government to remedy limitations of governance by targets and the 'internal market' with an attempt to make a regulated market work. That resulted in the scandal at Mid Staffordshire. The fourth section illustrates a recurring theme of this book: the failures of experiments with markets that developed for services under the Thatcher settlement. These services have characteristics that cause markets to fail (healthcare is the exemplar – see Chapter 8), and the UK lacks the institutions that could make them work. The final section outlines the structure of the argument in the rest of the book.

1.1 The Bristol babies' scandal

Mandy Evans remembers her son Joshua Loveday as being well and full of life for his first real Christmas in 1994 when he was 18 months old.[3] But there was a shadow hanging over those precious days: Joshua had a congenital heart defect, and would survive only if he had a successful switch operation. This major open-heart surgery transposes the great arteries through which blood flows to and from the heart.[4] Now only two or three babies die in 100 operations, and one has complications (such as brain damage). Back then, typically about 10 in 100 died.[5] But Joshua's operation was scheduled for 12 January 1995 in the Bristol Royal Infirmary, which *Private Eye* had called, in 1992, 'the killing fields' and 'the departure lounge'.[6] Dr Stephen Bolsin was the source of that information.[7] He had been appointed at Bristol in 1988 as a consultant anaesthetist, having worked at two specialist centres for paediatric cardiac surgery in London (the Brompton and Great Ormond Street hospitals).

Bolsin was deeply troubled about how much longer surgery took at Bristol because that increased the risk of bad outcomes.[8] From 1990, he courageously persisted in raising concerns over the evidence he had of the poor outcomes at Bristol, despite being under pressure not to do so. He had raised that problem with the trust's chief executive, Dr John Roylance; the professor of cardiac surgery at Bristol, Gianni Angelini; and the trust's medical director, Mr James Wisheart, who did the paediatric cardiac surgery with Mr Janardan Dhasmana.[9] On 19 July 1994, Dr Peter Doyle, the senior medical officer in the Department of Health, came to a meeting at Bristol. Bolsin went with him in a cab back to the station and gave him an envelope with data relating to his concerns. Doyle 'did not read it and put it away in a filing cabinet without further scrutiny', but he did seek reassurances from Professor Angelini and Dr Roylance.[10]

On 6 January 1995, Gianni Angelini tried to persuade Wisheart that it would be unwise for Dhasmana to proceed with Joshua's operation. Angelini discussed this with Roylance and Doyle, and put his views in writing.[11] On 11 January, at 5.30 pm, there was an extraordinary meeting of nine people

involved in paediatric cardiac surgery, to discuss whether that operation ought to go ahead. Wisheart did not disclose to those at the meeting that this was opposed by Angelini.[12] Nor that Dr Roylance had in mind commissioning an independent review of their service.[13] The outcome was the decision that Dhasmana would proceed with the operation. Bolsin was the only one who disagreed. He contacted Doyle to let him know that a switch operation was scheduled for the next day.[14] That evening, Doyle telephoned Roylance, expressing worries about the operation going ahead. Roylance said that, 'although he was a doctor, he could not intervene over the clinical judgement of the doctors directly involved'.[15] At 11pm, as Joshua's parents were going to bed, there was a knock at the door: they were required to sign the consent form for the operation. 'Mr Dhasmana said Joshua had an 80% chance of survival. They were reassured, signed the consent form and went to bed.'[16]

Stephen Bolsin wanted to tell Joshua's mother and father, who were staying at the hospital that night, to take Joshua away, but realised that, if he had done so, he would have been struck off the medical register. When his wife, Maggie, then volunteered to do so, he told her that would result in her being struck off the nurses' register. In 1996, Bolsin left Bristol for Geelong Hospital, near Melbourne, Australia – he was advised that he would not be appointable in Britain.[17] (Sixteen years later, in 2013, the Royal College of Anaesthetists awarded Professor Steven Bolsin the RCA Medal for promoting safety in anaesthesia that acknowledged his vital actions at Bristol, which he hoped would 'help people to stand up and speak out when they need to'.[18])

On the morning of 12 January, when the surgical staff tried to wheel Joshua away, Mandy Evans clung on to the trolley and was weeping hysterically as the hospital staff pulled her away. As they did so, she remembers 'being transfixed by the expression on the face of one of hospital staff. It wasn't blank, it was like fear. If I read it now, he was saying to me, "What are you doing? Take him away."'[19] The surgery lasted eight hours. Mr Dhasmana had to redo the switch operation. One of Joshua's coronary arteries was severed. At 7.30pm, Joshua's parents were told that he had died on the operating table.[20] When Dr Doyle was told of Joshua's death, he wrote to Dr Roylance, saying 'it would be extremely inadvisable to undertake any further neonatal or infant cardiac surgery'.[21]

In June 1998, the General Medical Council (GMC) found James Wisheart, Dr John Roylance and Janardan Dhasmana guilty of serious professional misconduct. Wisheart was criticised for not letting Dhasmana know that Angelini opposed the operation on Joshua, Roylance for not intervening, and Dhasmana for not stopping paediatric cardiac surgery before the operation on Joshua Loveday. Wisheart and Roylance were struck off the medical register; Dhasmana was allowed to remain on the register subject to a three-year ban on doing paediatric cardiac surgery.[22] Sir Robert Francis, the defence lawyer for John Roylance at the GMC hearings, had been so sickened by its punitive atmosphere that it had made him feel like emigrating.[23] Professor Martin Elliott, an expert paediatric cardiac surgeon, was at the GMC hearings

and was also distressed by 'the daily humiliation of the surgeons'. He was also troubled by 'the lack of criticism of wider system issues'. He argued that others at Bristol were equally culpable:

> It takes a remarkable amount of confidence to operate on a child, and one does the procedure within a team that is watching every aspect of your work and performance.
>
> Sometimes, when the outcome of a procedure has been poor and a child has suffered, it can be very difficult to operate the next day. I have felt this and I have relied on those around me to 'get me back on the horse'. … The surgeons may have held the knife in the operating room, but the cardiologists had the right and perhaps the responsibility to refer patients elsewhere, to a centre where results for such cases were known to be good. Just because the consent form is signed by the surgeon, it does not mean that they alone bear the responsibility for the outcome. I understand that, as a surgeon, one should have the insight and strength to be able to recognise that one should not be doing certain operations, but just as one may need moral support to get back on the horse, one may need as much or perhaps even more to be forced off it … and that is most effectively done by one's immediate colleagues and line management.[24]

At the GMC hearings, parents of babies who had died brought floral tributes, and those of children who were brain damaged or who had learning difficulties as a result of operations following surgery at Bristol displayed a board with 160 names. They pressed for a public inquiry, which began in October 1998. Its report (the Kennedy Report) was published in 2001.[25] Its expert statistical analysis estimated that, between '1988 and 1994, the mortality rate at Bristol was roughly double that elsewhere in five of seven years', and between 1991 and 1995 there had been about 30 excess deaths (as compared with other centres).[26] The Kennedy Report argued that:

> whatever the temptation to focus on the actions of individuals and to seek to blame someone when things go wrong, it is important to pay attention to the systems in which those individuals find themselves.[27]

So, how were the systems of governance in the 1980s and 1990s designed to enable Bristol to continue to deliver scandalously poor outcomes for paediatric cardiac surgery?

Good outcomes from paediatric cardiac surgery are more likely when concentrated in specialist centres that do high volumes of cases. That is why, in 1984, the Department of Health decided that paediatric cardiac surgery be

recognised as a supra-regional service for earmarked funding in a few designated centres governed by the Supra-Regional Service Advisory Group. Officials from the department, of whom Dr Peter Doyle was one, were key to the running of that Advisory Group. It was chaired by a chairman of a regional health authority; its members were doctors and NHS managers.[28] The Kennedy Report describes their choice of Bristol, as a centre for paediatric cardiac surgery, as 'something of a mystery' because 'problems about the adequacy of care were built into Bristol from the start'.[29] Care was delivered across two separate sites, there was a shortage of paediatric cardiologists, and the part-time paediatric cardiac surgeons did low numbers of operations.[30] The justification for choosing Bristol as a centre, rather than expanding the capacity of Southampton or Birmingham, seems to have been its convenience for parents living in the South West and Wales.[31] In 1991, Martin Elliott decided against moving to Bristol because he found its arrangements to be 'inefficient, archaic, inhibitory to progress and potentially dangerous'.[32] In 1992, when the low numbers of cases at the Bristol Royal Infirmary continued, the Advisory Group decided against its de-designation because 'it would be difficult if not invidious to [do that] on the basis of surgical expertise'.[33]

The leading psychologist Daniel Kahneman describes how the way we make decisions depends on how we frame our choices. And that, when we decide, we focus on the regret we imagine that we would feel afterwards, having made that choice, when outcomes are known.[34] In healthcare, typically, the choices are framed for us. The Kennedy Report points out that 'if it had been put to parents that by travelling 80 miles further up a motorway, the chances of survival of their child could well be doubled (or more) the parents would have probably opted for elsewhere'.[35] *Eighty miles?* If the choice were framed in that way, then most of us would willingly go to the end of the world. For Mandy Evans, the regret she experiences at the thought that had Joshua had his operation elsewhere, he could have survived, at times made her physically ill.[36] For Joshua's father, Bert Loveday, the choice was framed for him as either agreeing to the operation, to give his son a high chance of survival, or let him die. He was unable to cope with having signed the consent form for Joshua's operation. He became progressively more depressed and disoriented, participated in an armed robbery, gave himself up, got three years, and hanged himself in his cell. By 2000, three other 'Bristol parents' had died by suicide.[37]

In 1991, the Thatcher government aimed to introduce financial incentives to improve hospital performance in the NHS through competition. In this 'internal market', the NHS was reorganised into a 'purchaser'/'provider' split: local health authorities stopped running local hospitals and became 'purchasers' of hospital services, and NHS hospitals became self-governing NHS trusts (see Chapter 8). The 'purchasers' were supposed to contract selectively between hospitals competing on price and quality in a system in which 'money followed the patient'.[38] There was, however, a lack of comparative information on prices and virtually none on outcomes.[39] And, as the Blair government argued, in *The NHS Plan* of 2000, purchasers were deterred

from moving a contract for an obviously poor service away from a local trust because the resultant loss of income could destabilise the trust financially and undermine its capacity to deliver other services, such as accident and emergency services, where people want to go to their local hospital.[40] Paediatric cardiac surgery was, exceptionally, where the 'internal market' ought to have worked. The Advisory Group became the 'purchaser' and had data on costs and outcomes (mortality rates). Parents would have been willing to travel to a centre with better outcomes. But nothing changed. The Advisory Group relied on individual units to ensure a satisfactory service and lacked 'the machinery' (a spreadsheet?) to analyse mortality data.[41]

1.2 If Bristol was the problem, was clinical governance the answer?

Tony Blair's government, elected in 1997, sought to ensure that there was not another 'Bristol' in the NHS. They established the Commission for Health Improvement (CHI) in 1999 to inspect the implementation of clinical governance by NHS organisations in England and Wales. The CHI's rolling programme of clinical governance reviews assessed how effectively NHS organisations had implemented systems to assure and improve quality of care.[42] I worked for the CHI, as the director of the Office for Information on Health Care Performance, and was responsible for the analyses for our clinical governance reviews. From inspecting all acute trusts in England and Wales, we developed five golden rules:

1. *Judgement not standards*. We did not use standards because none were available from the Department of Health when we began. And we were concerned that doing so would lead to trusts responding by ticking boxes. The CHI's review manager organised the inspections for our review team, which included active clinicians and a member of the public, who were trained to exercise their judgement on what was, and was not, acceptable.
2. *Routinely collected data are inadequate*. Because the statistical data that were routinely available were so limited in scope (mainly mortality rates), our analyses were mainly of textual material: reports by external bodies, internal reports, minutes of meetings, and reports from the CHI's staff of feedback from local people reported to our publicly organised sessions. The CHI's analysts explored with each trust the issues that emerged in an interactive dialogue and prepared a report for our review team prior to their visit.
3. *Visits*. The week's visit by our review team was the focus of our inspections. They interviewed staff and met the trust board to investigate issues identified from the CHI's analyses. They experienced

the atmosphere at the trust and its likely impact on the quality of care. These visits provided ample opportunity for whistleblowers to relate their concerns, in confidence, to members of our review team.

4. *Self-assessments by trusts are unreliable*. We found that the trusts we had most heavily criticised for their weak clinical governance were in pathological denial about their problems.
5. *It is essential to inspect all general acute hospitals*. We found that quality varied greatly within the same general acute hospital, which had typically at least one dysfunctional clinical team. The challenge in organising inspections so that they are 'targeted and proportionate' is within hospitals – *not* choosing which hospitals to inspect.[43]

The 2001 Kennedy Report diagnosed institutional arrangements as the root cause of the Bristol scandal: there was confusion about which organisation was responsible for assuring and monitoring the quality of care. The report pointed out that in this confusion, the health, welfare and indeed lives of children were at stake in an administrative game of 'pass the parcel'.[44] My recurrent thought experiment at the CHI was to ask: 'If we'd done a clinical governance review of the Bristol Royal Infirmary in the 1990s would we have discovered what was wrong?' I knew we would not have been able to have done that from our analyses of routinely available statistical data at the hospital level: 30 excess deaths over five years is too small a number to be spotted. We would only have found out what was wrong from the serendipitous elements of the CHI's visits: reports to the CHI's staff at publicly organised sessions where parents and local GPs would have been able to voice their concerns in confidence. Plus, the week's visit by the CHI's review team offered safe opportunities for whistleblowing by any staff members who were troubled by poor quality of care and bad outcomes.

1.3 Mid Staffordshire – from clinical governance to market and regulatory failure

In 2002, the Blair government developed a grand strategy that aimed to improve patient care in another competitive market. The role of the Department of Health changed from being responsible for running the NHS to developing a competitive market for publicly financed hospital care. NHS patients could choose to go for elective care between NHS hospitals and thousands of hospitals and clinics in the independent sector. In 2004, the government reorganised regulation of quality of care in the NHS and independent sector:

- It abolished the CHI, and also the National Care Standards Commission for the independent providers of health and social care (17 days after it had just begun).[45]

- A new Commission for Healthcare Audit and Inspection, which became the Healthcare Commission (HCC), was established to regulate the quality of healthcare in the NHS and the independent sector.[46] (The HCC was later abolished in 2009 and replaced seven years later by the Care Quality Commission (CQC), spanning both the NHS/health and social care sectors in England, a role that it still has.[47])
- The government also established an organisation called Monitor to regulate NHS foundation trusts – a set of high-performing NHS trusts that had 'earned autonomy' to be freed from bureaucratic control by the Department of Health.[48] (Monitor became part of a wider body, NHS Improvement, in April 2016.[49])

In this new system, the Healthcare Commission assessed quality of care in annual health checks. These rated the Mid Staffordshire NHS Foundation Trust as 'fair' for 2005–06[50] and 2006–07, when it was praised for being one of the four '*most improved acute and specialist trusts*' (emphasis added).[51] In 2007, Julie Bailey was outraged at 'the gross negligence and cruelty in the treatment of her 86-year-old mother, Bella, at Stafford hospital in the eight weeks before she died'.[52] Julie Bailey became the whistleblower whose determination, and organisation of the pressure group 'Cure the NHS', led to a public inquiry into Mid Staffordshire NHS Foundation Trust.[53] (In 2013, *The Guardian* described the consequences: her mother's grave was vandalised and she moved into hiding after being subjected to threats and abuse.[54])

The report of the public inquiry into Mid Staffordshire NHS Foundation Trust, chaired by Sir Robert Francis, began by stating that: 'Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area.' These included patients being left in excrement in soiled bed clothes for lengthy periods, assisted neither in their feeding (when they could not eat without help) nor in their toileting (despite persistent requests for help); treated by staff with what appeared to be callous indifference; and denied privacy and dignity, even in death.[55] Over that period there were estimated to be 500 excess deaths.[56]

The Francis Report was scathing in its criticisms of Monitor and HCC. Monitor approved the application from the board of the Mid Staffordshire General Hospital NHS Trust to become a foundation trust in its 'elaborate, resource-consuming process'.[57] That process:

> failed to achieve what should have been its primary objective – ensuring that the only organisations authorised were those with the ability and capacity to deliver services compliant with minimum standards on a consistent and sustainable basis.[58]

Although HCC was 'the first organisation out of the plethora with relevant responsibilities to identify serious cause for concern, and to take the action

which led to the full exposure of the scandal', it had 'failed to prevent or detect over three-quarters of its lifetime what has been described as the biggest scandal in NHS history'.[59] Unlike at Bristol, that public inquiry had no need of expert statistical analysis because the appalling care at Mid Staffordshire was so glaringly obvious.

The Francis Report identified four key themes as explaining the chronic problems at the trust:

- The trust board leadership between 2006 and 2009 was characterised by lack of experience, great self-confidence, a focus on financial issues and on obtaining foundation trust (FT) status. It aimed only to meet targets and lacked insight into the impact of their decisions on patient care. The non-executive leadership remained aloof from serious operational concerns even when they had obvious strategic significance and the potential for causing risk to patients.
- The clinical executive leadership lacked, or did not raise, a strong professional voice on the board. The medical professional staff remained largely disengaged from management throughout the period and did not pursue their concerns effectively or persistently.
- There was a culture of tolerance of poor practice. The significance of concerning mortality figures or of patient complaints were constantly denied, and top managers operated in isolation with a lack of openness.
- The focus on achieving financial targets led to staffing cuts made without any adequate assessment of the effect on patients. Once it was appreciated that there was a shortage of nursing staff, ineffective steps were taken to address it. Serious concerns about accident and emergency (A&E) care were not addressed. Issues of poor clinical governance were not remedied.[60]

Florence Nightingale would have been appalled at the way hospital staff at Mid Staffordshire would do the sick harm, on an industrial scale, day in day out, for years. But, as the Francis Report observes, that record was hidden in plain sight from 'a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies'.[61] The system was so dysfunctional because its key players failed in their roles, did not understand what each was supposed to do, and failed to collaborate.

- The local 'purchasers' were so incapable at monitoring quality that 'it is not in the least surprising that, in spite of the rhetoric of quality, one of the worst examples of bad quality service delivery imaginable was not detected by this system'.[62] They took so long subsequently to address issues because of the obstacles to moving contracts identified by *The NHS Plan* in 2000.[63] In addition, the wide local media coverage of the

scandal at Mid Staffordshire had no impact on the numbers of patents 'choosing' to go there.[64]

- HCC relied on local organisations to check the veracity of trusts' self-assessments of the quality of their services, and Monitor to raise concerns over quality of care. But these organisations assumed that quality of care was being assessed by HCC and Monitor, and they detected Mid Staffordshire's self-assessments were wrong only after HCC's investigation.[65]
- HCC lacked financial expertise and Monitor lacked clinical expertise. Each worked quite independently of the other. So together they proved to be incapable of recognising that the severe reductions in costs and staff numbers by the board at Mid Staffordshire would impact on its safety and quality of care.[66]

So, how did such an incoherent and inadequate regulatory system ever come about? And why did the Blair government decide on their grand strategy in 2002? What did it get right and wrong? And what went so awry in its implementation?

1.4 Diagnosing the causes of systemic failures in governance of the NHS

Julian Le Grand described governance based on trust and altruism as one of the founding principles of the welfare state, as developed by the Attlee government from 1945 to 1951:

> Professionals, such as doctors and teachers were assumed to be motivated primarily by their professional ethic, and hence to be concerned only with the interests of the people they were serving. Politicians, civil servants, state bureaucrats, and managers were supposed accurately to divine social and individual needs in the areas concerned, to be motivated to meet those needs and hence operate services that did the best possible job from the resources available.[67]

Le Grand argued that the Attlee settlement assumed that *all* who worked in the NHS were 'knights' who were dedicated to healing and caring for patients and could be blindly trusted to act ethically and professionally. Any such lingering belief was shattered in 1998, which Kamran Abbasi described as an '*Annus horribilis*' for the medical profession. His leader in the *British Medical Journal*, titled 'Butchers and gropers', was about the:

> Horror stories of medical incompetence, arrogance, and libidinousness have filled newspapers; broadsheets and tabloids have been

> united in their condemnation of a profession unable to regulate itself except when it's too late.[68]

The Bristol scandal was just one horror story.

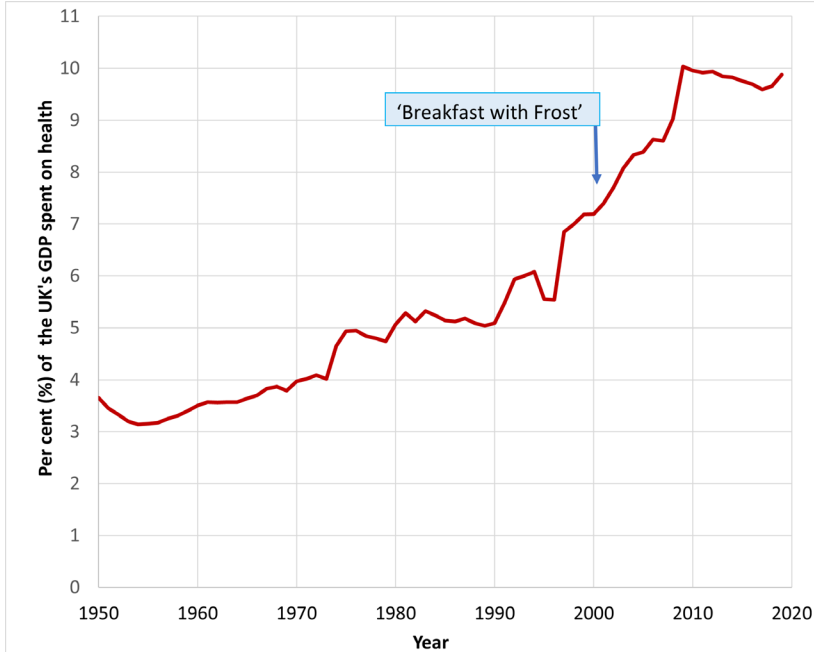
Le Grand also argued that in the Attlee settlement those in government and professionals could treat the recipients of their services as mere 'pawns' (for example, in the decision to locate paediatric cardiac surgery at Bristol and its consequences). The scandals at Bristol and Mid Staffordshire illustrate a classic problem of effective governance: the external agencies of government can be captured by the producers, for example, deciding against the de-designation of Bristol on the basis of surgical expertise.[69] (The way Julie Bailey, the whistleblower at Mid Staffordshire, was treated shows the intensity of this producer capture.) These scandals also show the problems of trying to govern healthcare by markets. In 1997, the Blair government abandoned the idea of hospital competition for the NHS and returned to governance by trust and altruism.[70] So, although the government set targets for reducing waiting lists, when hospitals failed to meet targets, they were rewarded with extra funding to do so. That, by assuming all were 'knights', created perverse incentives.[71]

In the midst of an acute 'winter crisis' in the NHS, in 1999/2000, Clive Smee, the chief economist of the Department of Health, was reading drafts of an OECD report. It described the NHS as underfunded, with outdated hospitals, poor clinical outcomes and long waiting times.[72] On Sunday, 16 January 2000, when interviewed on the television programme *Breakfast with Frost* – 'the most expensive breakfast in British history' – Tony Blair pledged the government to raising the percentage of GDP that the UK spent on healthcare to the European average.[73] This pledge was made without consulting his infuriated Chancellor of the Exchequer, Gordon Brown.[74] Figure 1.1 shows what that meant with a rapid increase in funding up to 2010. It also shows how the NHS was then subjected to no increase as a percentage of GDP for the next decade (2010 to 2020).

To justify the increased funding of the NHS, the Prime Minister's Delivery Unit (PMDU) held the Department of Health to account for transforming NHS waiting times. The PMDU, established in 2000, was led by Michael Barber to tackle 'awful' performance in the NHS, schools, transport and crime.[75] It set increasingly demanding targets to reduce the maximum wait for NHS patients for elective surgery, from 18 months in 2001, to 18 weeks in 2009.[76]

To ensure that the PMDU's demanding targets were met, the Department of Health's *The NHS Plan* of 2000 outlined what became a new regime of 'star ratings' (see Chapter 8).[77] Consequently, hospital waiting times were transformed in England (but not in the devolved countries of the UK).[78] Those at the heart of the Blair government recognised, however, that top-down targets could improve NHS performance from 'awful' to 'adequate' only; and the public wanted a service that was 'good' or 'great'.[79] Hence the government's later grand strategy, in 2002, was to move from governance by targets to a second attempt at an NHS quasi-market, which entailed radical changes to regulation of quality.

Figure 1.1: NHS spend as a per cent of the UK's GDP, from 1960 to 2019



Source: Office of Health Economics and OECD.[80]

The Commission for Health Improvement was an oxymoron: a supposedly 'independent' body subject to direction by the secretary of state for health. In my experience, officials in the Department of Health ceded power to bodies like the CHI as willingly a leech gives up sucking blood. So, they would have felt unhappy that the government's grand strategy had proposed establishing, as the CHI's successor, 'a new tough independent healthcare regulator/inspectorate covering both the NHS and the private sector, with a new Chief Inspector of Healthcare' – one not appointed by ministers and reporting annually to Parliament.[81] It did not happen. The Francis Report emphasised that the HCC's board was subject to being 'hired and fired by the Secretary of State' and described its system of regulation as one which it was '*given to run*' (emphasis added) by the Department of Health.[82] The department's abiding priorities were finance and hospital waiting times. That is what the Kennedy Report found in the 1980s and 1990s.[83] And, in 2000, for the regime of star ratings for hospitals, the Department of Health initially proposed that it would be driven by performance on waiting times and finance only. However, on this occasion the CHI was able to persuade ministers to incorporate assessments from its earlier inspections: otherwise, another Bristol could have become a 'high-performing' three-star trust.[84] The Francis Report points out that the HCC's inspections were based on a generic set of core standards 'formulated not by the regulator but by the government, thereby inhibiting the

engagement with the standards of those working in the system and therefore the effectiveness of the regulator'.[85]

The Department of Health required the HCC to develop a 'targeted and proportionate' system of inspections on a 'level playing field' for the NHS and independent sectors. The HCC correctly decided it could not organise its inspections of the thousands of organisations in the independent health and social care sector based on visits, but that did not entail doing likewise for the 156 general acute NHS trusts in England.[86] The HCC wrongly framed its regulatory task in terms of the relative *numbers* of organisations in the two sectors (dominated by the independent sector). But expenditure on private healthcare was about 7 per cent of NHS expenditure and it was concentrated on general and elective surgery.[87] A 'targeted and proportionate' system ought to have taken into account the far greater scale and complexity of care provided by the NHS. That is where the risk of failings in quality of care are highest and harder to identify from routinely available data. Instead, however, for NHS trusts, the HCC abandoned a rolling programme of visits for 'inspections' based only on the Department of Health's core standards, and analyses of the basic data that were routinely available, and self-assessments.[88] The way that the Department of Health framed the HCC's regulatory task proved to be quite incapable of detecting the pathologies of governance by targets, which the CHI had found in visits by its review teams.[89]

My second thought experiment is this: what would have happened if the CHI had continued its rolling programme of visits and inspected the Mid Staffordshire trust in 2006? The CHI's inspection of Mid Staffordshire in 2002 highlighted shortages of nurses, the poor quality of its clinical data, and that the board had prioritised improving its financial position and performance on waiting times over the quality of patient care.[90] Hence an inspection by the CHI in 2006 would have begun by looking for improvements in each of those problem areas. If the trust had claimed that its high mortality rates were a consequence of the poor quality of its clinical data, that would have raised *two* red flags. The publicly organised sessions arranged by our review manager also would have offered the same opportunity for the public to report episodes of truly appalling care, as found by the HCC's investigation in 2008.[91] So, if the Blair government had established as the CHI's successor 'a new tough independent healthcare regulator/inspectorate' that had followed the CHI's golden rules in framing regulation to be 'targeted and proportionate', would that have prevented the scandal at Mid Staffordshire?

1.5 The structure of this book – political settlements and their fault lines

Every system of governance, once established, will have some weaknesses – some key areas where things can go wrong or be badly handled. A concern for any state is inequality across geographical areas, the multiple factors that may

tend to make geography destiny for people depending on where they live. In Chapter 2, I take a long view at some fundamental geographical fault lines in Europe, beginning with how the Black Death in mediaeval times created a fault line between East and West Europe and Northern and Southern Italy, leading on to enduring centuries of inequalities between regions, and later to many of the failures of communism. Then, focusing down within the UK, and looking much more recently, the chapter also describes how Oldham (where I grew up) and Oxford (near where I now live) have grown apart over my lifetime.

The next two chapters explain the two major political settlements of post-war Britain, of Clement Attlee's Labour and Margaret Thatcher's Conservative governments. I look at how they created long-run systems of governance that went on to produce different outcomes for those living in Oldham and Oxford. Both settlements were important in establishing different set of *institutions*, defined by Douglass North as 'the rules of the game' that shape how people interact as members of organisations in social, political or economic settings.[92] This book focuses on how public institutions shaped systems of governance. The rules of the game of the Attlee settlement covered in Chapter 3 centred on institutions of central planning designed to tackle William Beveridge's five giant evils – 'Want, Disease, Ignorance, Idleness and Squalor'. Chapter 4 describes how, by the 1970s, those institutions were failing and justified the shift to a different set of rules of the game of the Thatcher settlement, which Chapter 5 shows were based on the ideology of neoliberalism. Chapter 6 uses the institutional economics of transaction costs, developed by Oliver Williamson, to examine the pros and cons of using markets in privatisation and outsourcing, and the consequences of financialisaton of those markets and housing. Chapter 7 deploys the economics of transaction costs to examine the marketisation of our schools and universities. Margaret Thatcher famously used to assert TINA – There Is No Alternative – to her neoliberal policies. Chapters 6 and 7 suggest that now there has to be. Chapter 8 is about why markets fail in healthcare and effective alternative systems of governance to steer healthcare in the 'iron triangle' of the objectives of cost control, equity and high performance. Chapter 9 compares systems of governance in England and Germany in response to the Covid-19 pandemic. It examines why Germany had a substantially lower mortality rate in the 'opening game' (before effective vaccines were available) and England was more successful in the 'middle game' (after vaccines became available). This chapter shows again the importance of authoritative independent bodies and courageous individuals. The Afterword looks towards a new political settlement to tackle our five giant evils from 40 years of neoliberalism: Want is even more acute, and we are troubled by systems that result in Insecurity, Ill-health, Miseducation and Despair.

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SSH here means 'Secretary of State for Health'.

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