INTERVIEW WITH IAN CUMMING

Andrew Severn

Ian Cumming was, at his appointment to the Lancaster Acute Hospitals Trust 11 years ago, the youngest chief executive in the NHS. The Journal finds him upbeat in his assessment of the future prospects for the University Hospitals of Morecambe Bay (UHMB), and in his role as deputy chairman of the Postgraduate Medical Education and Training Board (PMETB), an unrepentant and pragmatic reformer. His move this month to head the new North Lancashire Primary Care Trust offers him new opportunities to see through some of his more ambitious plans for Morecambe Bay.

It was a bad-tempered meeting of staff and managers while Ian was working as a research scientist in the Manchester Haemophilia Centre that started him on an accelerated career path. Having been challenged by his managers that if he felt he could do better he should try his hand at management he took up the gauntlet. He is modest about his progress through the ranks: the NHS of 1989 was struggling with financial problems and 'cuts' that dwarf those of the current era and his then senior management underwent a series of high-profile removals/resignations that led to him compressing ten years of career development into four and emerging at the top at the age of 30. Even the obligatory gap year saw him at new heights: 'I'm a passionate skier so I spent some time as a ski guide/instructor and hotel manager in the Alps.' An inspiration for those of his staff who want to depart from the usual constraints of study leave and take a real break.

Ian Cumming at the top

Did he have any special insights into the health service, coming from a clinical background?

The son of a general practitioner who worked a 1:2 rota for much of his career, Ian is no stranger to the stresses on professional performance and family life. And as a scientist working in an area of genetics that also involved patient contact and counselling it is probably no coincidence that his organisation is a frontrunner in initiatives to recruit others into areas traditionally the province of doctors, for instance in anaesthesia. Though, as he points out, this particular idea was not his, but that of an early mentor of his – Sir Donald Wilson, then chairman of the Mersey Regional Health Authority. *Was the idea of 'non-medical' anaesthetists just a case of dealing with restrictive practices amongst anaesthetists?* No, at the time there was a real manpower crisis in anaesthesia and the hallowed seven session working week was playing havoc with service development. *Did he understand that the seven session week was introduced in an attempt to curb exposure to noxious gases in the anaesthetic room and was no longer relevant to today's well-ventilated theatres?* He lights up at my gaffe, as if to say 'I didn't, but thanks for the insider information. I'll remember that next time I need to deal with anaesthetists.'

Certainly he has no time for restrictive practices, in whatever form they present. He is robust in his defence of evening elective working. 'Look at the banks: they used to open at 10 and shut at 3. Did you ever imagine that there would be a 24-hour Asda in Kendal? It's all happened in response to public demand.' And it's worked in the NHS even before the current round of evening lists/clinics. 'A few years ago we had a problem with surgical waiting lists. The trouble was with the vasectomies: not urgent cases but an embarrassment to our waiting list statistics. So we introduced Friday evening lists and the "patients" absolutely loved them. They didn't have to take time off work and they didn't have to make excuses to the lads in the pub. And the waiting list vanished.' The same success he claims of evening clinics in paediatrics – why should parents take time off work or children miss school?

Is he just a political pawn in his enthusiasm for reform?

He doesn't think so. The relationship between the public, the NHS staff and politicians is a complex, dynamic one in which two of the three forces can line up to reduce the influence of the third. If the politicians and the patients line up, the NHS staff and professional opinion may get a bad deal. The trick to avoid unnecessary political interference is to have the staff and the patients agreed on how the service should be delivered, but within both financial and political realities. If the public wants evening elective care, then we should provide it.

Does he think he can get his message across?

He admits to a management style that prefers discussion and debate to paper and email. During the Legionnaire's outbreak he realised that while he had an important role at the control centre there were examples of poor communication that could only be resolved by visiting the wards and laboratories and seeing for himself. I recalled that I had heard that he personally was able to intervene to procure resources outside the Trust where others were

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failing. 'It was something I could do. When we ran out of Legionella antigen test kits in the whole of the United Kingdom we chartered a light plane to collect a supply from Belgium and bring them back directly to Walney. And for the record, I didn't steal a helicopter. I heard there was a "spare" helicopter air ambulance in the area following maintenance and borrowed it. I gave it back later.'

How had the four major incidents (including a Manchester bombing) he has overseen changed his view of planning?
The major incident plans are sufficient for the practice events and at the start of an incident, he is well known to say, but on the day itself, all that matters to whoever is leading the response is the Table of Contents as an *aide-memoire*. When chlorine gas was pumped into the changing rooms at the Bubbles leisure complex in Morecambe the challenge of dealing with dozens of children clad only in swimming gear and, later, an equal number of worried parents, could not have been anticipated. The value of calling surgeons in for the cockling disaster was also questionable. Of the Legionnaire's outbreak he has more to say. Our local outbreak may have earned him fame (and an OBE) but he is keen to praise the staff of the organisation. An organisation the size of UHMB was far better equipped to handle the crisis than smaller organisations would have been. And he is pleased that the outbreak was identified more quickly than it would have been in, say, London or Manchester: with patients presenting at different hospitals run by different trusts it would have taken more than three cases for the outbreak to be drawn to the attention of the authorities. He is pleased that our experience has become the model for so-called Type 2 major incidents, ones in which the number of casualties and the type of problems cannot be anticipated at the outset. 'It could be influenza, or a terrorist biological attack, and though we have proved our ability to handle this pandemic we must focus on how we would respond if nosocomial infection is an issue.' For the moment, he has concentrated his thoughts on Type 2 incidents to the problem of fatigue, remembering that in the Legionnaire's outbreak the medical director had to escort one exhausted senior member of staff off the premises.

And the future?
He is in no doubt about the need to prepare for a different type of health service. Today's medical graduates need to prepare for 40 years of a radically different practice of medicine and a health service that will be unrecognisable. If British consultants remain amongst the highest paid in an open Europe, then British graduates will have to remain competitive in the presence of medical immigration or there will be a longterm decline in our ability to produce doctors. We also need to prepare for a different relationship with NHS trusts. The idea of a handful of 'acute physicians' having permanent contracts with an acute trust, with specialist physicians working for primary care trusts and contracting their services to trusts, is an entirely feasible prospect to him. A concept of employing 'acute surgeons' capable of operating on a cross-specialty 'basket' of emergency conditions is also worthy of consideration. As is the idea of contracting out some the elective work to surgeons in chambers or indeed the independent sector. As for Sir Liam Donaldson's plans for future regulation of the medical profession, he is supportive of the idea of improving working relationships between the General Medical Council and trusts at local level, and is currently charged with pulling together the PMETB's response to the consultation.

Is he worried about conflict with the Royal Colleges in his pursuit of his ideas?
Ian has shown himself more than up to the task and expressed frustration in the past about arbitrary judgements made by visiting members of the Colleges. 'I asked them to be specific in their demands and the purpose of their visit and then we could show them what they needed to know and answer their questions. But historically some of them just turned up with no real ideas about what they were looking for or how it was to be measured . . . We have to accept that training and service cannot exist in splendid isolation from each other.' To cap his interest in integrating considerations of training and service he has recently taken over from Sir Peter Simpson as the deputy chairman of the PMETB. It is another step along the road to his vision of the future health service with Colleges providing specialists trained to help the evolution of the service, and he is prepared that some may not welcome his oversight as a 'grey-suited manager'. But if anyone worries about study leave entitlement, he is conciliatory. He is keen to promote cost-effective study leave, but also wants the Trust to be able to direct individuals to specific activities. He favours the idea of exchanges between UHMB and its 'twin' in South Africa – as study leave. 'If every case of constipation you see is assumed to be HIV/AIDS and every chest infection tuberculosis due to HIV, then it changes your practice of medicine.'

Have there been any developments that we haven't got right?
When I suggested that the British Medical Association (BMA) had walked all over the Department of Health with the new contract he was keen to disagree. 'There were no winners in that process. The BMA certainly didn't come out on top. The problem with the new contract is that it isn't a professional one. I personally don't care if a consultant is at the Waterwitch at 5.30 pm so long as he is doing a good job and meeting all activity and other requirements, but try telling others who say he must be at work till 6.00 pm in accordance with the job plan.' On the much-vaunted appraisal process he is equally sceptical. Some directorates approach it as a box-ticking activity that can be done in the pub, others are more rigorous, but it hasn't yet delivered the changes it could have done – and indeed must do.

What has been his key achievement of the last 11 years?
He doesn't hesitate to answer, with enthusiasm – the Medical School. Though, as ever, he is keen to point out that the team has been responsible and that it isn't his solo effort. In a way, the Medical School epitomises the man: looking forward to a different sort of health service and providing local patients with a comprehensive service. Whether it be in the boardroom, the points of conflict on the ground or stealing a helicopter, I get the impression that for one high-flyer the altitude ceiling has not yet been reached.

The editor thanks Mrs Gail Cumming for raiding the family photograph album and wishes Ian and Gail success and happiness for the future.

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