



Health Committee

Oral evidence: [Pre-appointment hearing for the Chair of Monitor](#), HC 744

Tuesday 15 October 2013

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Grahame M. Morris; Mr Virendra Sharma; Valerie Vaz; Dr Sarah Wollaston

Questions 1–82

Witness: **Dominic Dodd**, Government's preferred candidate for the Chair of Monitor, gave evidence.

Q1 Chair: Thank you for joining us this afternoon. Congratulations on securing the Secretary of State's nomination to be chair of Monitor. We would like to ask you some questions about why you would like the job and what you see as your principal challenges when you start. Can we start at that very general level? What made you apply for the job? What do you see as your three key priorities?

Dominic Dodd: Thank you for considering me. I have been chair at the Royal Free for the last four and a half years and on the board for the last seven and a half. In that period of time and, indeed, more recently, we have been working quite hard on questions I think everyone wrestles with about how to improve the patient model and the clinical model of care. We have been doing that in a way that is based on the principles of integrated care.

Through that process, working with the commissioners and providers, it has become quite clear to me as chair that there are a number of factors that are completely mission critical to it, such as whether the incentive system or the tariff system is well aligned between commissioners and providers in the service of patients. There are also some tricky issues of choice and competition—I am sure you will be very interested in those—and issues relating to mergers and acquisitions in our local patch. In short, there is a whole series of things that lie within the remit of Monitor. I have increasingly come to the view that how well Monitor performs in its remit is absolutely critical to the space for innovation locally that I think will be required, given the challenges ahead.

That is the mind, if you like. The heart side of it for me is that I feel passionately about the NHS. I am one of those people who feel that it is a defining achievement of a civilised society that we provide health care on the basis of need and not on the basis of ability to pay. It is difficult to be at the Royal Free and not deepen that passion, because of its

pioneering history in providing free health care—the clue is in the name. For me, I suppose, it is the collision between that sense of what the service needs and the passion to keep the ethos it is based on.

Q2 Chair: I will ask one supplementary and then open the questioning to others. If you were now writing the history of your tenure as chair of Monitor, what would you hope would be the key achievements that people would remember you for?

Dominic Dodd: At Monitor?

Chair: Yes.

Dominic Dodd: We may come to this later in questions about what the challenges are, but I think that a fundamental tenet of good governance is knowing how you define success. At the level of overall duty, that is very clear for Monitor—it is about protecting and promoting the interests of patients. I think that we all know what that means. When you think through the patient lens, it means “Don’t harm me. Keep it safe. Fix what is wrong with me, treat me well and make sure my services are sustainable and affordable.”

As a provider and as a commissioner, it is very easy to think about how you measure success against those things. As a regulator, you are a little bit more removed. One of the major challenges is to trace a path between those kinds of outcomes for patients, the behaviours that are intended to be encouraged by regulatory action and the regulatory levers, whether they are formal or informal. I would hope, working with the board, that we would be able to be incredibly clear about that path and would know whether we were making the necessary changes in the behaviour of commissioners, providers and the system as a whole that did in fact lead to outcomes that were desirable for patients. That would be my primary hope.

Secondly—and very importantly—for better or for worse, we are in a situation where we need to operate as a team nationally. The consequences of not acting as a team across the various agencies—between NHS England, the CQC, the TDA, Monitor and others—are confusion at the level of the commissioners and the providers on the ground. That is not in the interests of patients, so it is a duty for all of us to make sure that we are aligned. One of the things that I would hope to be able to do, were you to feel able to approve my nomination, would be to work with the board on pushing further the good work that I think is already being done on that front, to make sure that there is a shared view, which is clinically-based, about the way in which the NHS should evolve over time.

I will add a third one and then stop, because I am sure you will want to ask other questions. I am a big believer in culture and tone in organisations and getting that right. I think it is extremely important that Monitor is independent, objective, analytical and evidence-based, but also that it demonstrates a really sharp understanding of the on-the-ground challenges of making change happen. I would want the combination of those two tones, if you like, to be recognised.

Q3 Barbara Keeley: I have a general question that will help the Committee and then a couple of specific points. How has your past career prepared you for this demanding, high-profile role as head of a prominent regulator?

Dominic Dodd: Clearly, the experience in my career that is most relevant is my time at the Royal Free. As I said, I have been there for seven and half years on the board and have

been chair for the last four and a half. As a result of that, I have had experience of life in an NHS trust, as it was, and then of life in a foundation trust. I have had on-the-ground experience of pretty much all of the aspects of Monitor's remit, be it FT authorisation, FT regulation, wrestling with tariff questions, or the issues of integrated care or choice and competition. In fact, I think the only area I have had not had any experience of is the continuity of services regime, for which I am grateful. That would be the main experience that is relevant.

I am also on the board of UCLPartners. That has given me a much greater appreciation of the challenges of trying to align research, training and clinical service across a large population, and the challenge of thinking about the population and not thinking about the institutions. That has been a really interesting experience for me.

I have spent time in the private sector in a consulting capacity. There are aspects of that that I think are relevant. My experience was about independent or external perspectives and challenging perspectives to clients. I think that gave me a grounding in the things that one has to learn as a non-executive over time. I learned a number of things that are specifically relevant to how you make change happen, for example. Often it was by failure—we learn by getting things wrong. I would pick one example. If you want change to happen and you lead with costs and think about quality afterwards, it will not work. That is a lesson I learned in the private sector that I think is very relevant to the NHS.

There is also the specific experience of being the branch manager of the London office of the consulting firm I worked at, which gave me a sense of some of the particular dynamics of organisations such as Monitor that do not have a specific, tangible product or service and are more about analysis and decision making.

Q4 Barbara Keeley: Your CV, which we have as notes from the Department of Health, lists you as having been an executive director of the Children's Investment Fund Foundation for a year. Do you see yourself as being able to use your experience there to promote social enterprise within the NHS, which is being talked about quite a bit at the moment? You have not mentioned it.

Dominic Dodd: No. I had a relatively short period of time there. I left the private sector full time in 2003 and had a period of time in the third sector. I think I had good learning. One thing there that was interesting goes back to the issue of how you measure success. How do you measure success in a charity, where you cannot measure it by money?

Q5 Barbara Keeley: Was it a successful charity?

Dominic Dodd: Yes, I think so. It is a very large foundation and is very active in sub-Saharan Africa, in particular. It has made some very tangible improvements in things such as the cost of antiretrovirals for children. Part of my concern there was to try to understand how judging success could be used in the way in which the foundation worked.

Q6 Barbara Keeley: Could you address my specific point?

Dominic Dodd: I do not have a particular agenda or feeling about what form of social enterprise or other forms of enterprise are appropriate. We can all think of third sector experiences in the NHS, such as the hospice movement, that have been fantastic for patients. I certainly think that, if commissioners faced with choices can see opportunities to improve services and reduce their costs from any sector, those should be considered.

Q7 Barbara Keeley: On that point, I looked up some figures around the charity. In one particular year, there was total expenditure of £53 million and only £27 million of grants made, so the ratio of costs to grants was not in the right direction. I do not think many people would look at those figures and think that was a very efficient charity, would they? Did you form that opinion when you were there?

Dominic Dodd: When I was there, we were in a period of building out the capabilities of the charity. It had around 40 people in it, so there was a lot associated with that. Obviously, the intent and purpose of having the money was to invest—that was absolutely the objective. I believe the numbers are a lot bigger now, but I am afraid I am not that close, and it was a number of years ago. There is this wrestle that one has between confidence about impact and amount of spend. That is a challenge that lots of charities face. The particular figures you quote may reflect its being in a transitional phase around that.

Q8 Barbara Keeley: Okay. You have talked quite a bit about your experience in the private sector. The longest period that you spent was with Marakon Associates, which is currently quoted on its website as saying that “now more than ever, there is an opportunity for ... healthcare companies to exploit the new market environment” and that private health firms have the opportunity to capture and retain new consumers. A few minutes ago you told us that you feel passionately about the NHS and the provision of free health care, yet for a very long period of time—the biggest chunk of your experience—you worked with a firm that wants to exploit the market environment and to capture and retain new consumers for private health firms. That does not really stack up, does it?

Dominic Dodd: Those are not my views. I am 10 years from the time when I was employed by Marakon.

Q9 Barbara Keeley: And you did not hold those views when you were there—you did not think that was a direction the organisation should be taking?

Dominic Dodd: That the organisation should be targeting health care? No, absolutely not. Ours was an advisory firm. Those are other people’s words on a website. They do not reflect my view.

Q10 Barbara Keeley: So you disagree with private health care, do you?

Dominic Dodd: No. I go to back to the point I made before. I think the critical question is choices for patients and choices for commissioners. Competition—or a particular sector—is not the objective. It goes back to this path—the objective has to be patients and quality for patients, within the constraints of the costs we all have to work within. If there are good choices from the voluntary sector or from the private sector, that is fine—those should be considered. I note that my understanding is that there is no particular requirement for commissioners actually to tender and go for a competitive process if they have taken the right approach of thinking through what the needs of the local population are and whether competition will deliver anything. If they have concluded that it will not and have done that appropriately, they do not need to do that.

Barbara Keeley: There are very mixed views about that issue.

Q11 Grahame M. Morris: In response to the first question from the Chairman, you mentioned new forms of innovation and so on. We have heard a little bit recently—not least from the Health Minister, Norman Lamb—about social investment, social enterprises and the mutual model. What are your thoughts about that—social investment that gives a return to the investors—within the NHS context? Do you have any particular views on that?

Dominic Dodd: I do not think I am close enough to the model and to the arguments to say a huge amount there. What I would say—I know that Monitor has done work on this—is that it is important that there are not artificial barriers, of whatever form, to people being considered. I know, for example, that there are thoughts about heavy working capital requirements for small voluntary organisations that may not be appropriate to the commissioning task at hand. Those are things that need to be addressed; I think the fair playing field review looked at them. I do not think it is for Monitor to have a preferred view about the model of care. It is for commissioners, particularly clinicians, working with providers and others in the local health economy, to figure out what works best for them.

Q12 Barbara Keeley: I will run with my question. You talked about challenge. If you think it is not for Monitor but for clinicians to have a view—

Dominic Dodd: And commissioners.

Q13 Barbara Keeley: Indeed. Only last week, we were in a situation where a very different view was emanating from Monitor. Will you challenge that view? Will you say that Monitor should not direct that savings could be made if operations were obtained in the same way as they are in India or whatever? Do you disagree with that sort of stance?

Dominic Dodd: No, I do not disagree with it. That piece of work was really looking at the Nicholson challenge and, I think, concluding that even if we work on all the productivity opportunities that exist and there are new innovations, there will still be a real challenge and the quantum of innovation is therefore really important. A few examples of different models, both within the UK and outside, were given.

Q14 Barbara Keeley: But I have to say that it did seem very directive. I read some commentary just this morning that said that it seemed like Monitor directing and dictating.

Dominic Dodd: That may come back to the importance of communication and tone on this. I have spoken with David Bennett specifically on the question of how to think about the choice and competition issue, and I do not think our views are different at all.

Q15 Barbara Keeley: So you would hope to change the communication and the tone.

Dominic Dodd: One has to caveat all of this slightly or add a little caution. I have not met the board of Monitor; I have met David Bennett on a couple of occasions as part of this process. I am giving you my impressions. I think that the work that has been done between NHS England and Monitor on guidance and case examples of how to think about choice and competition is a starting point for trying to clear up what is probably a good deal of confusion about what the rules really mean—

Q16 Barbara Keeley: I do not think that is the impression that was left by what David Bennett said last week.

Dominic Dodd: As I said, I do not think we are misaligned on that point.

Q17 Grahame M. Morris: I want to follow on that line, in relation to how the role of Monitor changed when we had the pause in the Health and Social Care Bill, which has since become an Act. It was originally set out as the sector regulator to drive forward competition, but after the pause it had to balance the tensions between being the sector regulator in driving competition and ensuring quality and integration. Personally, I am not quite sure how that works; I think the two are mutually exclusive. In relation to that, if we are looking at new ways of delivering services—new providers—is it any concern of Monitor that the provider might be a private sector company, where there is no accountability? They do not have to give answers to freedom of information requests, provide board papers or answer questions about their governance arrangements. Is that not relevant to Monitor as currently constituted or in your mind, as the chairman driving it forward?

Dominic Dodd: The change in remit that you describe is very clear. The duty is about promoting and protecting the interests of patients who use NHS services. Within that, there are particular duties in the competition area about addressing anti-competitive behaviour that is not in the interests of patients. I think that is very specific.

My understanding is that Monitor's response to that is largely a complaints-based, reactive response. For me, it goes back again to the whole question of how you define the success of Monitor. I would say that moving from a combined model of chair-chief executive to a separated model is an opportunity to further the work on asking the difficult questions about how the regulatory levers in all these areas are actually affecting behaviour and whether or not that behaviour is in the interests of patients.

Q18 Grahame M. Morris: Are transparency and openness apparent in that when there are issues of service failure where the provider is not the traditional NHS provider—in the out-of-hours GP service in the south-west, for example?

Dominic Dodd: I am a huge fan of transparency. At one level, an issue for commissioners to get right is to make sure that in their dealings with whoever is providing they set out what they think are the appropriate requirements.

Q19 Valerie Vaz: These are just general questions, before we move on to the main topics. The Liaison Committee has given us guidelines saying that we can probe you on independence and the selection process. From your CV, it is clear that you are linked to UCL, and the chair of NHS England is Malcolm Grant. Do you know him well?

Dominic Dodd: I really know him only through that connection with the board of directors of UCL, which meets quarterly.

Q20 Valerie Vaz: So do you know him well?

Dominic Dodd: I know him through that capacity.

Q21 Valerie Vaz: Do you know him well? Just answer the question.

Dominic Dodd: I have met him on at least a dozen occasions, yes.

Q22 Valerie Vaz: Did he suggest that you apply for the job?

Dominic Dodd: No.

Q23 Valerie Vaz: Did anyone suggest that you apply for the job?

Dominic Dodd: No. I was approached by Russell Reynolds, the head-hunters engaged by the Department of Health, and asked whether I was interested. I filled in the application form and went through the process that I guess is outlined.

Q24 Valerie Vaz: You are obviously still involved in UCL and the Royal Free. Do you find that that will be a conflict with the role you are taking on now?

Dominic Dodd: If I were to take on this role, I would need to resign from the Royal Free. The role with UCLPartners comes because of the role with the Royal Free, which is one of the founding partners, along with Great Ormond Street, Moorfields, UCLH, UCL and Barts, so I would be out of that. It is worth noting that we are actively considering mergers that would need to be authorised by Monitor. If the boards of Barnet and Chase Farm and the Royal Free and the governors of the Royal Free wanted to go along that route, I would also need to recuse myself from any decisions that were related to the Royal Free.

Q25 Valerie Vaz: That is quite helpful, because I do not think it was indicated anywhere that you were going to resign from those posts. There would be a conflict, wouldn't there?

Dominic Dodd: Absolutely.

Q26 Valerie Vaz: My colleagues have touched on your being managing partner at Marakon Associates. Did you advise any health care companies?

Dominic Dodd: I worked for a period of time for Hoffmann-La Roche, which is a pharmaceuticals company. I worked on questions about how it organised its group centre—organisational questions more than strategic questions.

Q27 Valerie Vaz: One of the things that David Bennett said to us was that although Monitor was not involved in competition as such, it would be complaints- driven—someone would have to complain that certain things were anti-competitive. How would you deal with some of your former clients coming to you with complaints that the NHS was not competitive enough?

Dominic Dodd: There is a long distance of time, but despite that I would always err on the side of recusing myself from any decisions that were involved. This is where transparency is really important. We should all be clear about what kind of roles we have had in the past, that should be on the public record and we should be able to recuse ourselves from those sorts of decisions.

Q28 Valerie Vaz: How would you do that?

Dominic Dodd: In that specific circumstance, one would hand over to a vice-chair or a senior independent director. I simply would not be involved in the decisions.

Q29 Dr Wollaston: I understand that during your Department of Health interview you were asked what you saw to be the chief challenges facing Monitor and how you would address those in the first year, were you successful. Could you let us know what your answer was?

Dominic Dodd: Sure. I think I mentioned four things, in particular, as challenges and five priorities. I will try to run through those quite quickly. There is the challenge of the change in the scale and scope of the remit of Monitor as it goes from being the FT regulator to being the sector regulator as well, and there are the challenges that that kind of change gives in an organisation. There is the challenge of having a smooth transition between a combined CEO-chair model and a separated one. I will come back to that, but it is obviously an important move and one that should allow for an alignment of governance models in the national bodies.

The third one—this is in no particular order—is the challenge of aligning effectively with the other national bodies. For example, Monitor needs to align with the TDA on FT authorisation and to deal with the CQC on key issues where it is absolutely imperative that we work as one. Managing the relationship with NHS England is particularly important. I have mentioned before the consequences of not getting that right, which are profound and extremely unhelpful on the ground, so I thought that was a key challenge. I also talked about the challenge of navigating the potential tensions that might be perceived within the Monitor remit between its role as FT regulator and as sector regulator, the potential tensions, which have been alluded to, between integration and competition, and how all those things actually work to the benefit of patients. It was a month or so ago, but I think those were the four I came out with.

I have covered a couple of the priorities. A major and central priority for me in the role of chair would be to be absolutely clear about how we measured the success of Monitor. That is the first priority—the path between regulatory levers and behaviours through to outcomes for people. The second one is making sure that we step up the efforts on alignment. The third one I mentioned was about tone, so I have already mentioned three of them. We need to get the tone right between independence and objectivity and understanding the barriers on the ground. Another area is effecting a smooth transition from the chair-chief executive model.

The final one, which I think is also very important, is making sure that Monitor uses this as an opportunity to reflect on whether it has the board composition right and has the mix of independent perspectives that are necessary. As is the case everywhere, this is something that needs to be worked through, discussed with the chief executive and discussed with the board. I would bring into that the perspective from the Royal Free that senior clinical challenge and perspective on the board would be a good thing. I certainly think that that is something to work on. I know that David Bennett has been going through the process of trying to hire a chief medical adviser, although I am not entirely clear about where we are in that. I do not think it is inconsistent with that process, but we would want to take a view both internally and, perhaps, with external challenge, on whether we have the right mix of perspectives on the board that we need for the task ahead.

Chair: Back to competition, I think.

Q30 Andrew George: That is right. Earlier, you said in relation to the regulatory role of Monitor that you saw that you were there to identify behaviours that are to be encouraged; you have referred to that on a number of occasions. On the competition-collaboration continuum, which you also painted in your answer to Sarah's question a moment ago, how much latitude do you feel Monitor has to interpret the regulations to encourage certain types of behaviour within that continuum?

Dominic Dodd: Maybe it helps to get specific about the kinds of behaviours that are important. For example, I think the behaviour of considering choices, if there are relevant choices, is an important behaviour of commissioners as they look at how to improve services. There is the behaviour of looking critically at the current provision of services and whether they are delivering what is required.

Q31 Chair: What role do you think Monitor has in that? Is it specifically an issue for commissioners?

Dominic Dodd: I was going to say that I would not pretend that I have a clear map. One thing that is important—it goes to the note on alignment—is that it would not be helpful if there were different views in the national bodies about the sorts of behaviours that will deliver good outcomes. That is a question not just for Monitor but for NHS England and others. I am not suggesting that I have the list. There are lots of behaviours from things such as the Keogh work and the Berwick review that are widely held to be important. I give the example of looking critically at information in order to decide how you can improve, as opposed to looking defensively at information to justify why you are doing okay. I think those sorts of things are really important. The national bodies should agree on what behaviours we are all trying to have. My point is simply that with all the different levers we have we should be pulling them in the same direction.

Q32 Andrew George: A lot of the criticism of the legislation implies that we run the risk of ending up with a more fragmented health system. Of course, commissioners may use the opportunity of their commissioning powers to integrate where there is a failure to integrate and to enable collaboration in order to strengthen a service. For example, they can strengthen the viability of a district general hospital by making sure that it has the critical mass within it to sustain itself. Do you see Monitor's role as being to recognise and support those types of trends?

Dominic Dodd: Again, it is easier for me to think of it in a local context. One of the widespread issues—I think it is not just an issue for us—is that from a patient's perspective it often feels as if no one is really fully managing your pathway and that you go from pillar to post repeating the same story. I know that the Committee has taken a lot of interest in integrated care. It seems to me that if commissioners have taken the view that a very integrated care approach to, say, the management of chronic conditions is a good one, the management of that pathway may itself be something that is amenable to choices. For example, people talk a lot about the London stroke pathway as an example of collaboration. It is, but there were also choices to commissioners about who would have the hyper-acute one and how it would work.

I do not think that, inherently, choice and integration need to be in opposition. The key question to ask at all these stages is, "Is this a good thing for patients?" A huge advantage of the change that was made in the passage of the Bill through to the Act is that it is very clear that that is the overarching duty. Were you to approve my appointment, it would be incumbent upon me as chair to keep the focus on that and to make sure that that is clear.

Q33 Andrew George: Finally, what lessons do you think you have learned from your years as chairman of the Royal Free? Let us take that as an example. On the one hand, there may be an opportunity to offer patients choice, which means that they may have choices outside an integrated foundation hospital, but from having served on the board of that hospital you may

see the necessity of ensuring that you have a range of services there because they all need to hang together and you need to provide a range of services and procedures. Is there anything you can take from that that will help inform the decisions that Monitor makes in relation to the configuration of services going forward?

Dominic Dodd: I think I have learned lots of lessons—by things working out and things not working out. In this area generally, I take away a couple of really important ones. One is that change will not happen unless there is clinical leadership and buy-in. That is an absolutely essential requirement for change to happen on the ground. To address the specifics of your question, if it is the clinical view that these are the right things to do, that is the prerequisite for me.

The second thing, which is a challenge, is that I think the local health economy—including the relationships between social care, community care, hospitals and the commissioners—is the really critical unit. Yet we are working in a system where, as a patient, you walk over invisible boundaries all the time. The really key issue is local health needs and how those are provided for. That is the right unit at which to look at it. This may be more on the informal than on the formal side of Monitor's powers, but in my view it would be good if Monitor could encourage both of those things.

Q34 Andrew George: I did not intend to come in again, but you have raised a big question in your answer; I do not know whether it was intentional. In the earlier part of your answer, you indicated that if it was the collective clinicians' view that a certain pathway should operate in that manner—I think you used words to that effect—the clinical view might well clinch any decision about the configuration of services. If that clinical view were to be in conflict with regulation that says that it would create a potentially anti-competitive set of circumstances, how would you address that?

Dominic Dodd: I think that would be a problem, because the clinical view is very important. I have looked somewhat at the guidelines that Monitor provides—it has the capacity to provide a lot of informal guidance, too—and my understanding is that, if commissioners have considered whether or not competition for a particular service would help and have concluded that it would not, and they have done so appropriately, that is consistent with the rules.

Q35 Chair: Do you think the system is currently sufficiently open to the disruptive innovator?

Dominic Dodd: You can certainly point to past disruptive innovations in the large and in the small. I think the hospice movement is a disruptive innovation. The London pathway for the homeless is a good example of disruptive innovation in a particular cohort of people. I am not sure that I know the answer to that question. What I am feeling is that the time available to us as a country to address the innovation that is required is relatively short. I am not sure that we have built up a track record in disruptive innovation, but the requirement for innovation, disruptive or otherwise—innovation that works—is going up.

Q36 Grahame M. Morris: I want come in on the issue of competition and choice. A little earlier, you mentioned that Monitor is reactive rather than proactive. What is your general view of the current situation, where Monitor would approach providers that bring complaints rather than seek out anti-competitive practice?

Dominic Dodd: My understanding is that it is almost entirely about complaints and reacting to those. I think there is a broader point. My sense is that the direction of travel Monitor has been going through in its strategy is a kind of three lines of defence view. This is true both in competition and elsewhere. If things have gone wrong or rules that are in the Act or whatever have been broken, enforcement action is necessary. But the second line of defence is to try to see problems when they are coming up and to make sure that they do not get to the stage of enforcement action. I am suggesting—the direction I see Monitor going in is consistent with this—that there is a first level, which is to try to encourage, with whatever levers are within the remit, the behaviours that will work for the patient. I think there is something about making sure that it does not get to the stage where enforcement action needs to be taken.

Q37 Grahame M. Morris: I know it is extremely difficult, because you are kind of walking a tightrope here. I am not advocating that Monitor should be an engine for privatising the NHS—quite the reverse—

Chair: But he is pushing you that way.

Grahame M. Morris: Absolutely not. Please don't misunderstand me; that is not my contention at all. For example, vast swathes of the country, including patients in the region and constituency that I represent, have very limited access to advanced radiotherapy. Is it part of Monitor's role to question why that is if there is no complaint from an NHS trust, a provider or a commissioner? Would that be part of your broader remit?

Dominic Dodd: You will have to forgive me—I may not be fully up to speed with all the details—but my understanding is that it is complaints-driven and is largely reactive.

Q38 Grahame M. Morris: Yes, it is. I am asking you whether you agree with that.

Dominic Dodd: I certainly agree with trying to avoid the situation where there is enforcement action, trying to identify issues earlier on and then trying to think collectively as an NHS system about what kind of behaviours we want to deliver the right outcomes.

Q39 Grahame M. Morris: Can I ask a related question? I am thinking about the section 75 regulations. We had a huge row in Parliament about whether there was any compulsion on commissioners to go to competitive tendering; it could be any number of things. Are you content in your own mind that Monitor can balance the competing tensions of ensuring that there is competition while addressing issues of not fragmenting the service and encouraging integration and joined-up pathways? What is your take on that?

Dominic Dodd: First, it is not Monitor's role to promote competition. Its role is to address anti-competitive behaviour that is not in the interests of patients. That is made very clear.

Q40 Grahame M. Morris: Can we reasonably expect Monitor to resist competitive tendering if it runs against the interests of integrated, joined-up services? Would that be grounds for not ensuring that a service is put out to competitive tender?

Dominic Dodd: This is when I wish I were a competition lawyer. My understanding is—

Q41 Grahame M. Morris: I mean just the broad principles. I do not expect a lawyer's answer.

Dominic Dodd: My understanding is that, if commissioners do the right thing in thinking through the options, decide on one particular path and that leads to an integrated service, they do not have a requirement to go out to tender for the sake of going out to tender.

Q42 Dr Wollaston: Following on from that point, much of going out to tender is very wasteful and costly for the NHS. In some examples, particularly in rural areas, it can actually act against providing greater choice, because smaller, locally facing, charity-run and third-sector organisations are often forced out by a much larger organisation that can put together a more professional bid. Do you see anything that you can do in your role as chair to try to save some of this huge amount of waste and confusion? We had David Bennett here telling us that in many of the examples where things were put out to tender it was not necessary to put them out to tender, but that message is not getting through because nobody wants to be the test case in court. How can we actually resolve this, because it is wasting huge amounts of money?

Dominic Dodd: It is, and it is making people unnecessarily anxious and risk averse. I think there is a huge duty to have clear communication. That is one of the informal levers—clear communication, with worked examples. I know that Monitor has quite a lot of emphasis on providing informal guidance. If the message is not getting out—

Q43 Dr Wollaston: Why do you think that is? You have put your list of priorities. I would like that to be added to it, if you would not mind. How do we get that message through? We are hearing it in this Committee from David Bennett, but it is not getting through to commissioners.

Dominic Dodd: I would categorise that in my priorities as priority 1, because it is about understanding how this path works. If it is not working, it is the role of the board—the chair and the non-executive director—to hold the executive team to account and to say, “You told us that this would happen. It is not happening, so what is the plan?” That is healthy board governance.

Q44 Dr Wollaston: Your experience has been very much city-based—the Royal Free and UCLPartners. Do you plan to get out and get some experience in rural areas? The trouble we have in the NHS is that it is very much city-focused, but local health economies work very differently in places such as Cornwall, which Andrew represents, and rural Devon, where I am. Can you assure the committee that you will consider those local health economies as well?

Dominic Dodd: Absolutely. I am very aware that the metropolitan areas have particular characteristics and issues that rural areas do not have. That is why some kind of one-size-fits-all view is simply not appropriate.

Q45 Valerie Vaz: I would like to ask you a few questions before moving on to chief inspectors. What did you say David Bennett was advertising for? Was it for chief medical officers or something?

Dominic Dodd: I think it was for a chief medical officer or a chief medical adviser, as part of the executive team.

Q46 Valerie Vaz: What do you think about that?

Dominic Dodd: My view is that we need to have a clinical perspective on the board. My view is also that those kinds of decisions are best made by boards. As I said, I have not met the board yet, so a first step would be to think through those sorts of questions. At the Royal Free, the nursing director and the medical director are obviously very present, but I have made it the practice to ensure that we have the clinical divisional directors for each of the divisions at board meetings. That is to make sure that in areas where there are very complex interdependencies across different services we really understand what is the clinical view. Personally, I think that is important.

Q47 Valerie Vaz: I am sorry for interrupting you, but what I am getting at really is, can you see yourself standing up to your chief executive and being independent? If you go into tomorrow—provided we all endorse you—will you be able to say, “Don’t do this”?

Dominic Dodd: If I did not, I would not apply for the role. I like to work by asking the chief executive and the executive team to propose what they think are the measures of success, the commitments that they wish to make and, importantly, what defines off-track performance that becomes a board issue. Then I like the board to debate that and to get to an agreement on the rules of engagement. That means that, when there is an issue of off-track performance, we all know that the non-executive directors will get very actively involved in challenging that. We are not in a situation where this role exists. This is a role that would need to be worked out with David Bennett and with the board, but I think those kinds of rules of engagement are really important.

There is one further thing that I might add. The distinction between strategy and operations is very clear in a trust and in other settings. It is a bit trickier in an organisation such as Monitor, because a lot of the decisions are kind of “case law-y” or set precedents, so we need to try to work out exactly what that distinction is. It may well be that the board has a finely tuned view of that distinction, which would be great, but on the outside I do not have that. I think it is a critical thing to have to make sure that the chair is running the board and the chief executive is running the organisation and is empowered to do so.

Q48 Valerie Vaz: Have you read the Francis report?

Dominic Dodd: I have indeed.

Q49 Valerie Vaz: You have?

Dominic Dodd: Absolutely I have.

Q50 Valerie Vaz: Robert Francis made some recommendations about the regulators. What do you think about those?

Dominic Dodd: To start with, the part of the Francis report that resonated the most and has relevance to all of his recommendations is the rather haunting phrase of “the business of the system” and how that gets in the way of thinking about the patient. I think about that a lot, and it concerns me a lot. There were specific recommendations about regulation. The most obvious one is about the structure of regulation and the CQC in its relationship to Monitor. Is that what you would like to talk about particularly?

Q51 Valerie Vaz: Yes. He said there should be just one, but we now have a proliferation. There seem to be so many cooks in there, including the chief inspectors, who seem to be wanting to tell you what to do.

Dominic Dodd: The structure of regulation is a matter for Government.

Q52 Valerie Vaz: I am asking you for your view.

Dominic Dodd: My view tends to be that you work with what you've got. Both the CQC, with its evolving inspection regime, and Monitor, which is six months into its new remit, have a job of work on their hands. There is value to focus on each of those. For me, there are some profound issues about avoiding marking your own homework. We have one regulator, the CQC, that is focused solely on care quality and how that is managed. If it passes problems over to others to resolve, it is not involved in marking its own homework, which is a good thing. The underlying issue—the issue that Mid Staffs clearly demonstrated—was very poor co-ordination. I know that a lot of work has been done to try to get co-ordination at the working level, with memorandums of understanding between the two regulators. My understanding is that people feel those are working well.

However, there are still key areas of overlap. Quality governance is a critically difficult issue. It is a legitimate interest of the CQC that it understands that, when it is inspecting, it is not inspecting something that one day will be okay and the next day will not, so it needs to understand that quality governance is in the right place. Equally, when Monitor is judging whether foundation trust applicants are well run, for example, it needs to understand whether they are well run for managing quality. So there are areas of overlap, which need to be very closely managed. At the board level, I would be asking whether there was more that we could do to ensure that there was that alignment and that there was a seamless process in key areas of licensing and in authorisation, for example.

Q53 Valerie Vaz: Do you see that you could actually try to resolve this issue? I am trying to get out of you that you will be more dynamic. The problem with Mid Staffordshire is that Monitor and CQC were involved. I know that is before your time, but I want to try to convey that the public will have confidence that with you at the helm this will not happen again. It is a tall order, but you applied for the job.

Dominic Dodd: I clearly understand the imperative for Monitor and the CQC to be very well co-ordinated. I think there is scope for asking whether there are further things that one might do at board level to effect greater co-ordination. I have to say that, simply by moving to a chair-chief executive model, that aligns better and means that there may be more opportunity for governance to work effectively, so that is a help. As in many areas of the NHS, we are trying to ensure single processes but with multiple structures; that is the challenge. It is true at the local level and at the national level. We all have to work incredibly hard at that.

Q54 Valerie Vaz: And to be ready to stand up. Part of the problem was the cosy relationships with everyone, so that no one felt able to renege on, talk to or even stand up to someone who may have appointed them to the post. I suppose I am trying to get out of you that you will be independent and able to stand up to the various vested interests that will tell you otherwise.

Dominic Dodd: I see the role as being accountable to Parliament and to the Secretary of State but serving patients. That would be my focus.

Q55 Valerie Vaz: You understand that a chief inspector can now tell you what to do. What do you think about that?

Dominic Dodd: I am afraid I do not know the latest developments on that front, so I do not know the detail. I do know that, in areas such as the FT authorisation process, it is absolutely for the CQC to say whether or not it is satisfied. If it is not satisfied, nothing will proceed from the Monitor side. The key issue is that the CQC has the authority to declare whether or not quality standards are being upheld and that there are implications from that declaration. I am afraid I do not know the detail you are referring to about inspectors.

Q56 Valerie Vaz: They have been in post, so I would have expected you to have been asked that question at your interview. Were you not asked the question about chief inspectors?

Dominic Dodd: I was not.

Q57 Charlotte Leslie: My apologies for having to slip out. I want to ask you about another relationship. How will you avoid duplication of the work of Monitor and the NHS TDA? How will you express clarity on the difference between the two roles?

Dominic Dodd: It is a very tricky one. I know there are trusts that have found it very challenging to go through SHA processes, TDA processes and Monitor processes, so I understand the on-the-ground challenge of that. I also understand that Monitor has to be held to account for its decisions on authorisation, so it is important that it owns those decisions.

My understanding is that there has been a considerable amount of thought about and work on how to avoid the situation where trusts are asked to do something with the TDA in the run-up and then to do exactly the same thing with Monitor; I think they called it trying to streamline the end-to-end process. One of my priorities would be to understand from both Monitor and the TDA how they felt all of that was going, but it is very important, in a system where it is sometimes quite difficult to pin down accountabilities, that it is very clear where the accountability for FT authorisation lies.

Q58 Charlotte Leslie: Given that we are talking about public accountability, do you think the lines are drawn clearly enough at the moment, or do you think further clarification is needed? What can Monitor do on that?

Dominic Dodd: I feel that that is one of those things you always need to work on. It never goes away as a challenge—you always have to be clarifying responsibilities. Clarity of roles and responsibilities is an essential part of making a team work, which is what we need to do. I suppose I agree with the spirit of the question.

Q59 Charlotte Leslie: In the face of many foundation trusts shifting into debt, how do you think Monitor should avoid corporate failures in those it regulates?

Dominic Dodd: Monitor needs to get more into early detection; it has been working on that. I know the changes in the risk framework that were announced recently have a few more of what one might call the leading indicators. That is part of the general shift towards really trying to avoid things getting into problems. However, if there is a quality issue that needs fixing that is going to cause a financial issue, we should spend the money to fix the

quality issue; I think that is something David Bennett has said and with which I totally agree. That has to be the right answer. Then we as the NHS team will figure out how to resolve the financial issue. It has to be that way round. I think the onus is very much on getting quality issues fixed.

There will be great pressure on financial performance. We know it ourselves at the Royal Free; it is harder and harder and harder. That comes back to my central concern, which is that we don't just pedal harder and harder on what we are doing currently, because that will not deliver. We need to change the way in which we deliver care in order to make sure that it is both high quality and lower cost.

Q60 Charlotte Leslie: Do you think Monitor should be moving more towards an early-detection model, as opposed to a firefighting model?

Dominic Dodd: My sense is that that is the way Monitor is moving.

Q61 Charlotte Leslie: There is obviously potential for a conflict of interest to emerge because of Monitor's position as a sector regulator and the risk that that could be compromised by its role in overseeing foundation trusts. To what extent do you recognise this risk? What safeguards should be put in place to guard against it?

Dominic Dodd: I do recognise the risk. Those kinds of conflicts of interest are not untypical in regulators, and not untypical in other organisations as well. There is a range of mechanisms that one can use to deal with them. It is very important that the overarching duty of protecting patients and promoting patients' interests is the arbiter of conflicts. It is also very important that you are transparent about conflicts, so that you describe what they are and let everyone know what they are, how you have approached them, how you have resolved them and what your thinking was. That is really important and allows you to be open to challenge, which is extremely important.

There are other mechanisms, ranging from what was originally thought of—Chinese walls—to separate structures. There is a whole panoply of things that one can do, such as recusing people or excusing others from certain decisions. I don't think I am in a position to really understand what the full range of safeguards is currently, but that is certainly something I would want to understand. I could then take a judgment on whether or not it was sufficient.

Q62 Charlotte Leslie: Are you satisfied that the primary duty to act in the best interests of patients is clear enough to resolve conflicts of interest in all situations?

Dominic Dodd: I certainly do not think that it is on its own; transparency, too, is required—at a minimum. While that is the general duty, we need to get a bit more specific about what that means. I am used to thinking of it as being good outcomes, safety, a good experience of care and sustainable care in terms of affordability and efficiency. Those are in the interests of patients. Others may have different views, but I think those are consistent with the way in which NHS England is thinking. Just throwing it out as a general duty does not resolve everything. It is not simply that—it is about transparency and being a bit clearer.

There may be other safeguards, but those have to be proportionate. You do not want particularly to throw in a huge amount of governance glue if it is not necessary, but, if it is, there need to be governance checks and balances.

Q63 Charlotte Leslie: In summary, what do you see Monitor's role as being for non-FT providers?

Dominic Dodd: The issue is really its role for the sector, which is to set rules on pricing, alongside NHS England, and to set rules on choice and competition that make the sector work for patients.

Q64 Chair: More than once in that round of questioning, you used the phrase "early detection". Early detection is one thing, but what does Monitor do if it detects early developing problems in independent foundation trusts? These are independent bodies. What do you do? What is next?

Dominic Dodd: You can change the period at which you monitor, require further information, explore what the issues are, meet the foundation trust chief executive chair—

Q65 Chair: Suppose you form the view that they are not up to the job.

Dominic Dodd: The powers are about serious breach or potential for breach of licence conditions. I imagine some judgment is required about how you interpret them, but in order to move to any of those enforcement powers you would have to believe that you were at that stage.

Q66 Chair: The reason I asked the question is obvious. It seems to me that the board of Monitor needs to form a view, and that view needs to be known by the foundation trusts, as to how it will react when foundation trusts appear to be getting into difficulty and not delivering a convincing response to developing difficulty.

Dominic Dodd: I agree with that. I would generalise the principle. If, as a regulator, you describe what you are trying to achieve, the clarity on that is itself helpful and allows for challenge.

Q67 Chair: Does Monitor have the power to do what you might want to do?

Dominic Dodd: In a sense, what I am describing is a vision of an engaged regulator. I have made a distinction between formal and informal powers. One does not want to use formal powers. In any regulatory environment, that is the last resort. In my view if, without stepping into other people's remits, by working closely with them you can push things in the right direction and be helpful, that has to be good.

Q68 Mr Sharma: Monitor is required to work with NHS England in order to set the prices for tariffs and to publish the national tariff document. How concerned are you that Monitor will be placed under pressure by NHS England to drive down prices in order to deliver immediate savings?

Dominic Dodd: On pricing, as you know, in a sense NHS England has to agree with Monitor's view and Monitor has to agree with NHS England's view. I go back to the point that Monitor has to be objective and independent, if it is anything. If it felt that it was the wrong thing to do, we would have an issue to resolve. However, it goes back to alignment. If NHS England and Monitor share the same view on what they are trying to achieve and have worked together effectively and engaged others and consulted appropriately, hopefully that situation should not arise.

Q69 Grahame M. Morris: I am quite intrigued. You are with the Royal Free and will know how important tariff income is. I wondered what other sources of income there are, if we are going for easy wins. Do you know off the top of your head what proportion of the Royal Free's income comes from private patients?

Dominic Dodd: Off the top of my head—let me get it right—I think it is about 3% or 4%.

Q70 Grahame M. Morris: So it is really quite small. The Royal Free's turnover is about half a billion, isn't it?

Dominic Dodd: It is about £550 million. Please don't hold me to the exact numbers, but I think that is roughly right.

Q71 Andrew George: In your role as a board member or in preparation for this role—particularly as Monitor has a role in assisting NHS England in the review of tariffs, which I understand is currently going on—have you ever looked at the handbook of tariffs for NHS procedures?

Dominic Dodd: I am afraid I have not looked at the detailed one. Is it quite long?

Q72 Andrew George: I have looked only at one specialty. I did not quite realise just how complex the whole thing is. It seemed that a tremendous amount of work needed to be undertaken there in order to make it fathomable. Leaving that aside, you will know that one of the main concerns about the setting of the tariff is that it does not create a climate in which there is an unintentional opportunity for certain sectors, particularly the private sector, to cherry-pick the easier work. I wonder to what extent in your previous work, certainly with the Royal Free, you have engaged with that and in that side of the debate, because it will be a very significant piece of work that Monitor will be assisting in resolving in the coming months.

Dominic Dodd: Yes; I know there has been a debate about the cherry-picking issue. It is clearly not right that tariffs that are blended across different case complexity should be paid to providers that for clinical reasons are dealing only with the simpler cases. I will say a couple of things on the price environment. It is very important that prices and costs match and that there is an understanding of activity. That is incredibly important for setting the right prices, but it is also incredibly important for running trusts and for commissioning. If you have done that well, in a way you legislate out some of the issues of cherry-picking. That is the first thing.

The second thing is that pricing is a lot about signalling. I feel that people have the opportunity to think through what is the unit that is actually priced. For example, are there opportunities to have a more year-of-care-type tariff, which would be more appropriate for chronic diseases? Should we think about having capacity-type tariffs for A and E issues? Those are the sorts of opportunities we need to think about. What you are describing is the HRG-level tariff—the payment-by-results tariff. I do not think that is the right one size fits all; obviously it is not.

Q73 Barbara Keeley: I want to come back to a couple of points, because I see some conflict in them. Earlier, you said that you feel passionately about the NHS and the provision of free health care but, as I pointed out to you, the bulk of your career experience comes from a company in the private sector that sees the current time as a prime opportunity for health care

companies to exploit the market and to capture and retain new consumers for private health firms. That does seem like a conflict to me.

You said you found some problems with tone and communication in what David Bennett said last week, because that seemed to be in conflict with what you thought Monitor's role should be, which was to work with clinicians and commissioners, not to set directions. If that sort of conflict with David Bennett continued, to what extent do you feel you would challenge him to protect free health care provision in the NHS? Would you actually keep him if you could not resolve such issues?

Dominic Dodd: On the first question, I wanted to move out of the private sector because I wanted something where I could feel a greater connection of mission: that is a personal thing. I have no problem with the private sector—I think well-run companies and organisations are very important to the economy—but it was a personal decision. I will leave that there.

I did not say there was a problem—I said it is really important that there is both a clear tone of objectivity and understanding of the barriers. I see work that Monitor has been doing on integrated care, which is looking specifically at the barriers in integrated care, as a good example of where—

Q74 Barbara Keeley: Excuse me, but that was not the example I was quoting. The example I was quoting was the example from last week.

Dominic Dodd: I was saying that it is not a problem. I am highlighting it not as a problem but as a really important priority going forward.

Q75 Barbara Keeley: So you do not have any problems with what was said last week—for instance, about transporting lots of people to regional centres for operations, as they do in India.

Dominic Dodd: No.

Q76 Barbara Keeley: I am trying to resolve what I see as a conflict in what you have said.

Dominic Dodd: I understand. My understanding is that that was an illustration of an innovation. I do not think it was intended to mean, “This is the solution that you must implement.” It is certainly not within the remit of Monitor to be able to decide that anyway.

Q77 Barbara Keeley: In my view, that is where things are going wrong. If it is not part of Monitor's role, the chief executive should not be coming out with that. You as an organisation should not be making pronouncements on things that are not within your role. Frankly, it would be up to you as chair to make sure that that did not happen. I am asking you whether you are strong enough to stand up to that.

Dominic Dodd: I think I have addressed the issue in the way I think about it, which is that the board needs to define clearly what success means for Monitor and to hold the management team to account for performing against that.

Q78 Barbara Keeley: If they have got the tone and communication wrong, what will you do?

Dominic Dodd: That is something we want to work through—absolutely.

Q79 Chair: But in that set of circumstances, if you agreed as a board what the tone and objectives of the organisation were going to be and either you as chair or your colleagues on the board were not content that the tone was right, measured against the agreed yardstick, presumably the performance of the executive team would become a matter for the board.

Dominic Dodd: Absolutely. I am used to the situation where, when the non-executive team appraise the chief executive, they do it with 360° feedback internally and with external feedback but also, importantly, against what was agreed we would define success as. In that way, you can have relatively objective discussions about how we are doing. That is good governance and is certainly what I would want to do.

Q80 Chair: But good governance also involves setting the parameters within which the executive team works—and enforcing them. That is the answer to Barbara’s question, isn’t it?

Dominic Dodd: Absolutely. I like the NHS healthy board-type approach to thinking about the role of the board, which is to set direction, keep score, hold to account and set the tone. That is what any board needs to focus on.

Q81 Chair: In the words of Jim Callaghan, you must either back him or sack him.

Dominic Dodd: Yes. I think you are not doing the job if you are not holding to account. There are lots of ways to hold to account, but ultimately that is the issue.

Q82 Chair: You are agreeing with me.

Dominic Dodd: I am agreeing with you about the role of the board in holding the executive team to account, yes.

Chair: I think it is important that it is clear. There are no other questions, so thank you very much.