HOUSE OF COMMONS

Health Committee

Oral evidence: 2013 accountability hearing with Monitor, HC 841

Tuesday 26 November 2013

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Written evidence from witnesses:

- Monitor

Watch the meeting

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

Questions 1-133

Witnesses: **Dr David Bennett**, Chair and Chief Executive, **Stephen Hay**, Managing Director of Provider Regulation, and **Adrian Masters**, Managing Director of Sector Development, Monitor, gave evidence.

Q1 Chair: Gentlemen, thank you for coming. I should say at the outset that I am afraid we are going to be interrupted by votes on the Floor of the House this afternoon, the first of which is quite imminent. So we are going to be a bit of a revolving cast, but we will try to make the best of that. Could I ask you, Dr Bennett, to begin with introductions? I do not think you personally need much introduction, but your two colleagues possibly do.

Dr Bennett: Yes. On my left is Stephen Hay. Stephen runs our provider regulation division and, like me, is an executive member of the board. Provider regulation is the bit of Monitor that looks after all the existing foundation trusts. Before that, Stephen also looked after the assessment of new trusts, so he knows quite a lot about that area too. Adrian is also an executive member of the board. He is responsible for an area we call sector development. The core bit of that is our new role in pricing, but he also, in particular, looks after our economic and policy functions.

Q2 Chair: Thank you very much. I would like to begin with what I hope will be a relatively brief question exchange about the governance of Monitor. You will know that Dominic Dodd was proposed as chair, the Committee demurred from that proposal and Mr Dodd then withdrew. I simply ask you to tell the Committee where that leaves Monitor in terms of its own governance, organisation and internal accountability systems.

Dr Bennett: Because I have been doing both roles—chair and chief executive—for a couple of years anyway, we had gone to great lengths to be as clear as we possibly could about how to maintain a separation between those roles, including asking my deputy chair, Stephen Thornton, to play a bigger role in the governance arrangements than would normally be the case. So, for the moment, we are keeping those arrangements in place. It is, of course, for the Department and the Secretary of State to decide about the specific appointment of a successor to me as chair, and I think they have written to the Committee—or I hope they have—saying what they are planning to do on that front.

Chair: I think it is in the post.

Dr Bennett: Right, so I am not sure what their specific plans are.

Q3 Chair: When this evidence session is published, we probably should include that letter. Thank you. Unless anybody wants to pursue that any further, I suggest we go into the meat of this afternoon's session.

I want to begin with the document you published, entitled "Closing the NHS Funding Gap", in which you published four broad headings where you thought the gap might be closed. Standing back from it, is that a definition of why it cannot be closed or a signpost as to how it can be?

Dr Bennett: It is most certainly meant to be a signpost as to what needs to be done to close the gap. From our point of view, one of the important messages there is that it can only be closed if there is a lot of innovation—a lot of new approaches—to the provision of health care, approaches that we have not seen today, or certainly have not seen in this country.

The second thing which that document highlights is that it is going to be a big ask. If you take all the things we could identify in terms of doing what is done today more effectively and efficiently, if you do everything we could identify in terms of doing things in different settings—more or less as we do them today but not in the same setting, so, of course, in particular this is about transferring care currently done in hospitals to outside hospitals—and a first cut at what some of the more obvious opportunities might be to adopt practices from other countries in order to innovate within the NHS, you cannot close the gap. In fact there is a big gap remaining. That innovation piece has to be much bigger than just the obvious options from abroad and it is going to be a real stretch to get there.

Q4 Chair: I suppose it is fair to say—is it not—that we could be more confident, we could get there in a service where there is a wide variety of current efficiency and quality outcomes if we could point to a single health economy where there was good progress being made and could say, "At least in that area, despite what is going on elsewhere, they are going to get there."? Is there anywhere where you think that is true?

Dr Bennett: I might ask Adrian for his view on that. One thing we would say is that you see examples of good practice in many health economies, England included, but I am not sure there is really good evidence of any health economy that has all the different pieces together in a coherent way. Adrian, what would you say?

Adrian Masters: Yes, I would agree with that. I do not think there is one health economy that has done everything needed.

Q5 Chair: Would it be a worthwhile analysis to look at one of the front runners and close the gap in that health economy between where they are likely to get to over the period to 2020 and where they need to get to and ask what is stopping it?

Adrian Masters: It is a good idea. For the planning round that we are preparing for over the next few months, we are going to look five years out and at two years in detail. We plan to set up that planning round in order to put in all the new ideas that people have about how we can change the pattern of care. Out of that planning round, we will begin to get a sense of which parts of the country have the best view of how the challenge is going to be met. So it is a good idea, but we should wait and see what the outcome of the planning round is that we are going to run between now and probably next June or July.

Q6 Chair: I have one more question and then I will pass it over to David Tredinnick. The concern everybody must have is that this is a real and present developing crisis, unless a way through can be found, not just for the trail blazers but for the bulk of the health economies.

Adrian Masters: Closing the gap looks out to 2020-21. In terms of current practice, you can see the current variation. You have a much clearer view of what could be done in the short term than you do, say, five years out. As you go five years out, you begin to say, "What are the new ideas and patterns of care that are going to close the gap?" I do not think it is surprising to say that we do not have a strong view at this stage as to what those might be. All we can call out, though, is that we need to deliver not only in terms of the current pattern of care—"Do it more efficiently," and take some of the good examples that we are already having, what you might consider the next pattern of care, things like Torbay, trying to provide better care and keeping people well outside hospital—but also we need to put effort now into what is going to be the next version, the third version, of the future pattern of care. So, in the short term, we have things that we know we need to do and we are going to look for this planning round to help us work out what is the next block of changes that we need to make.

Q7 Chair: I simply observe that we are running a stopwatch in this Committee now as to when the first mention of Torbay as a good example comes up, and the answer today is eight minutes.

Adrian Masters: I am disappointed that it was not earlier in a way.

Q8 Chair: It would be nice to have another example.

Dr Bennett: Yes. Therein lies a story, doesn't it?

Q9 Dr Wollaston: What if during your planning round you come to the conclusion that some forms of competition are wasteful and, therefore, it might not be possible? Does that not put you in conflict with your purpose as an organisation? Is there not a tension there, because there may be some circumstances in which having over-provision increases costs?

Dr Bennett: First of all, it is not the planning round as such that would reveal that. But, of course, you do point to a very big concern that lots of people have, which is that competition might be at least obstructing the ability to make the necessary changes and, as you suggest, may be even creating a degree of inefficiency because you need some extra capacity in order to make the competition effective. Those are important issues. It is not, I

do not think, the planning round that will reveal those. I think they have to be dealt with in parallel with the planning round.

Dr Wollaston: But would you be looking—

Chair: Sarah, that is a taster, if I may say so, of the discussion about competition which is to come after this Division and after David Tredinnick has had his question when we get back. We will come back as quickly as we can.

Sitting suspended for a Division in the House.

On resuming—

Chair: If we may, let us get started. I understand it is unlikely—but not certainly so—that we shall be disturbed again by a vote. Let us hope not. David Tredinnick has a question to ask you specifically on the funding gap and all that, but so does Andrew George. So can we go to him first, then back to David and then to Sarah on competition?

Q10 Andrew George: In terms of "Closing the NHS Funding Gap", the fourth of your four bullet points was in relation to "Allocating spending more rationally", which of course is not within the gift of Monitor. Given that that is perhaps a forlorn hope, to what degree is that a factor in the large extent of a financially challenged foundation trust, for example, that exists at present? How much would you say that a fairer, less historical and more objective, as you put it, funding mechanism or resource allocation would help to resolve the financial difficulties that they face?

Dr Bennett: There are interesting questions about the allocation of resources to individual providers. Indeed, there are interesting issues around the starting point, the structural position, of different providers. We observe that small and medium-sized providers, especially where they have multiple sites, perhaps if they have very old buildings and the like, will have structurally higher costs. There are all sorts of issues around that, but that is not what we were focusing on there. We were focusing there in particular more on the issue about, at its starkest, "How much do you spend on health care?" versus, "How much do you spend on things like prevention and public health?" We have not looked a lot at that because you are absolutely right that that sort of issue is also beyond our remit. If you were to ask what, in the long run, is one of the most effective ways of surviving at lower rates of increasing funding than the NHS has had historically, I would suggest that sorting that out by investing some of the money we currently spend on fixing people once they are ill in measures to prevent them from getting ill in the first place would enable us to have a healthier population and a lower level—maybe even a significantly lower level—of spending. But it is a massive challenge, of course, to get from where we are today to that world.

Q11 Andrew George: But where you are observing, and you are no doubt analysing very closely, the relationship between allocation and financial pressure, or indeed those trusts that are failing financially, is there a pattern that has emerged in terms of those whom Monitor believe are receiving historic underfunding, or who are significantly below what the Government have said is their target, for example, and the existence of trusts that are failing financially? Is there a pattern there?

Dr Bennett: Of course the funding allocation goes to commissioners, not to the trusts.

Andrew George: Quite, yes.

Dr Bennett: But then, of course, it finds its way to the trusts. In so far as what the trusts are paid is dependent on payment by results, or at least payment by activity, then you might say, to a certain extent, it does not matter how the commissioners are funded. If they are doing the activity, they get paid for it. In truth, of course, there is a big chunk of what they do that gets paid for not through payment by results but through block contracts or similar arrangements. What we can say is that, often, where we have a struggling trust, we also have a struggling health economy. As to whether they are struggling as a health economy because they are underfunded, it is a bit difficult for us to say, but you often see a struggling trust and an economy struggling, and commissioners and maybe other trusts in the area struggling as well.

Q12 Andrew George: The NHS Confederation says that your role should be expanded or you should take on the role of supporting financially challenged trusts. We know that you are the sector regulator, or at least have been. To what extent do you believe that you have a pastoral role, as it were, in supporting and assisting financially challenged trusts?

Dr Bennett: If a trust gets into difficulty, it is most certainly our job—and this is what Stephen spends his days doing—whether it is because of the quality of the care they are providing or their financial position, to try and help them get out of their difficulties. Sometimes, that may need money. We do not hold that money. We have to go to the Department of Health, sometimes in support of or alongside a trust, depending on the specific circumstances, and make a case for funding. We will only do that if we are satisfied that they have a credible plan to turn themselves around and a credible leadership to implement that plan. Sometimes, we will find a situation where the problems at the trust are quite structural in nature, things like being very small or having multiple sites and all these sorts of factors.

Stephen Hay: Or PFI.

Dr Bennett: A big PFI is another good example. Under those circumstances, we may have to seek more significant action to fix the problem, including restructuring the services. That is something that we are going to see more of in the coming years.

Q13 Andrew George**:** To what extent does that role harmonise with that of the Trust Development Agency—the TDA?

Dr Bennett: Yes, completely. We work very closely with the TDA for two reasons. One, we are essentially both doing the same thing. They have a much more direct hands-on relationship with their trusts, but, frankly, once our trusts are in serious difficulty, we have a pretty hands-on relationship with them as well. What we are trying to do with them is the same thing, and, furthermore, because there is this phenomenon of "struggling trusts often mean struggling health economies", you often find neighbouring trusts in difficulty and you cannot fix one without fixing another. A very good illustration of this is that we have a struggling trust in Milton Keynes. They had some quality problems; they fixed the quality problems, but then they became financial problems. It is now pretty clear that the financial problems can be fixed only with some rather more fundamental restructuring of services. The TDA has a not-far-away trust at Bedford, which has both quality and financial problems. Rather than try and fix them separately we have, along with NHS

England, commissioned some work to look across the whole health economy led by the commissioners, because that is where we have to start, to try and work out what the pattern of services needs to be in that whole health economy, and then, as a result of that, work out what we are going to do with Milton Keynes and what the TDA is going to do with Bedford.

Q14 Andrew George: Are there any lessons to be learned from the work that you have done so far in terms of, "Is there a pattern of financially failing and quality of patient outcome failing trusts?" Do the two go hand in hand? Where there are financially troubled trusts, is the pattern, in other words, the cause of that financial difficulty? Are there common themes which run through the trusts that you have found that are in difficulty?

Dr Bennett: Yes. We have done some work on them and Stephen might like to talk about that.

Stephen Hay: There is no doubt that where there are quality failings they almost inevitably then lead into financial failings because fixing the quality adds to the cost base. You can see at places like Mid Staffordshire, Milton Keynes and Morecambe Bay that substantial increases in the cost base then lead to financial difficulties. Actual financial failings, as David has said, could be a wide range of things from bad management, structural problems and big unaffordable PFI schemes to problems in the local health economy with the commissioners unable to afford the services that are being provided.

Dr Bennett: There are two important lessons that certainly I have learned over my time at Monitor. The first was to look at a very early stage, where you have a financially troubled trust, as to whether or not there are structural issues. To a certain extent, in the past, we used to focus on the leadership of the trust, the board, the management of the trust, and say, "If they are failing, often almost invariably there are weaknesses in the management," and we would try and fix that. But increasingly—and I think this is partly a reflection of the margin for things being less than perfect shrinking—we are seeing that even when you fix the management, if there are underlying structural problems, you still have not fixed the financial problem. Then that extends how long it takes to fix it. So one of the lessons is, at a very early stage, to try and understand if there are structural problems, so that we can get going on those straight away.

The second lesson I have learned—and this is a particularly recent one in a way—is that we have a failure regime which is institutionally based: it is about individual trusts. We are applying it for the first time at Mid Staffordshire, and the TDA applied it for the first time in South London. Particularly looking at Mid Staffordshire, what is absolutely clear is that we have a health economy that is failing and the worst consequence of that is in Mid Staffordshire, but it is most certainly not confined to Mid Staffordshire. What we really need is a failure regime for health economies. We can construct that and that is effectively what we are trying do with Milton Keynes and Bedford now, to say they are not in failure but they are struggling and we need to look at the whole health economy, not just individual institutions.

Andrew George: Thank you.

Chair: Can we move back to David and then on to Sarah?

Q15 David Tredinnick: I am sorry, Chair, that I was late after the Division. You have touched on various financial challenges facing trusts. What are your overall priorities? Can you list them in order of importance, please?

Dr Bennett: Among what sort of choices are you thinking of?

Q16 David Tredinnick: When you are dealing with the financial challenges of foundation trusts, what are your priorities? You must have some structure for choosing what to deal with first. Can you give me an idea of what is your top priority, your second priority and your third priority?

Dr Bennett: I will make one general statement and then pass to Stephen. My general statement is, as Stephen says, that you will often see quality and financial challenges at the same time. I am absolutely clear that we need to fix the quality problems first and, if those either exacerbate or lead to financial problems, then we fix those subsequently.

Q17 David Tredinnick: What do you mean by "quality problems"—quality of what?

Dr Bennett: It could be about patient safety, the quality of outcomes or about patient experience, all the things that the CQC looks at to determine whether or not a trust is providing adequate quality care. Those must be fixed first, but then, when it comes to addressing the financial problems, as I said, we have learned that we need to look at an early stage at whether there are underlying structural problems. Stephen, perhaps you might say a bit more about what we do.

Stephen Hay: You obviously have to make sure that the problems are fixed and find whether there are structural problems in the local health economy or not. Then the two things that really matter are that you need in place a robust plan to turn the financial problems around, and we will look to get that in place quickly with or without external help, and then you need a leadership team that you have confidence in that can deliver that turnaround. That will be the order we would look at it in.

Q18 David Tredinnick: I put it to you, despite what you are saying, that there are many people out there who think the sector is approaching a crisis point. Do you think that is fair?

Dr Bennett: The challenges are getting greater.

Q19 David Tredinnick: Can you expand that, please?

Dr Bennett: It is what we were talking about earlier on. Lots of people, including us, have taken a look at what the likely gap is between funding and the underlying costs of the sector, and most of us have concluded that if there was no significant change to the efficiency of the sector and funding does no better than increase with GDP—and of course that is better than it has been recently—you are looking at something like a £30 billion gap by 2021-22. You have a big gap there. I think you have a particular problem with 2015-16.

Q20 David Tredinnick: That was my next question. Where do you think we are going to be in 2015-16? What is your horizon? What does your vision tell you? What are you saying in the boardroom about it?

Dr Bennett: In 2015-16, as you will know, there is an additional £2 billion taken from the NHS to be put into the integration transformation fund. That is expected mostly to come

out of the acute sector, which means that the acute trusts in particular are going to face a very significant funding squeeze in 2015-16. So, although there is this challenge we were talking about earlier of, "How do you get yourself to a position where you can deal with a situation, say, in 2021-22?" just dealing with 2015-16, I think, is going to be a huge challenge particularly because of the need to get there very quickly. We are in intensive discussions now with NHS England, with the TDA and with the Department of Health to try and work out how that gap between underlying costs and funding can be closed in 2015-16.

Q21 David Tredinnick: I can see, and we have discussed this at length in this Committee, the Nicholson challenge with funding, but how do you respond to the criticism by the NHS Confederation, which said that you need to play a more active role in supporting financially troubled trusts? Do you think you have been dilatory in this respect?

Dr Bennett: I am not sure what it is specifically that they would want us to do that we have not been doing.

Q22 David Tredinnick: I cannot speak for the NHS Confederation, but I would imagine that the criticism has been put to you. My understanding is that they think you could have been more proactive in dealing with troubled trusts, that you could have been quicker off the mark when troubles occurred. I am asking you whether you think that is fair criticism. There must be some areas where you are less than happy about your performance. You cannot believe everything is right, surely.

Dr Bennett: No, of course not.

Q23 Chair: Can I read you the evidence they sent to us? "We are clear that the NTDA and Monitor need to play a more active role in supporting financially troubled trusts and to enable them to become sustainable or to make difficult change if this is not possible."

Dr Bennett: I said that there was a lesson to be learned about trying to identify where there are structural problems sooner rather than fixing the management first and then identifying any residual structural problems. We definitely need to do that. We also need to be requiring tighter time scales within which things get fixed. So, if there are structural problems, we need to confront them faster.

Q24 David Tredinnick: Do you think that part of the problem is your managerial system, that you do not have the report structure right, that you are not getting enough information back at the right time? You are a comparatively new organisation.

Dr Bennett: Certainly, there is a challenge and it is reflected in the big contrast between the TDA and Monitor. The FT policy establishes foundation trusts as autonomous bodies that are largely free to make their own decisions unless they get into serious difficulty, and at that point we step in. That then leaves open all sorts of questions about how closely we should be monitoring them. Should it be "Until they get into serious difficulty", "In order to anticipate whether or not they might do so", and, indeed, "What constitutes serious difficulty?" What we are increasingly doing is monitoring more closely and stepping in at an earlier stage. But it is a difficult judgment, and I am sure you will find other people who will say we are beginning to pay too much attention to what they are up to and, in some cases, even stepping in at too early a stage. But my sense is that we do need to be

monitoring more closely, trying to anticipate problems and stepping in more quickly where necessary.

Q25 David Tredinnick: Finally, do you think you have the capacity to do all this?

Dr Bennett: We are significantly increasing our capacity. In particular what I think— and Stephen and I have agreed—we need to do and we are doing is to get more senior people with real managerial experience to help turn around under-performing trusts.

Q26 Chair: Would it be fair to characterise or sum that up as a migration within Monitor away from being a regulator and a policeman towards being an intelligent shareholder on the part of the public?

Dr Bennett: If I may put it slightly differently, I would say we always were, I hope, an intelligent shareholder, but there are many different relationships between shareholders and the organisations in which they hold shares. If you like, it is a question of, "How long is the arm in an arm's length relationship?" I would say we are shortening the length of the arm a bit.

Chair: Okay. We will not play with the metaphor any further.

Q27 Dr Wollaston: I have one final point on your last comment. Do you know how many of those senior managers are also receiving redundancy payments from other parts of the NHS?

Dr Bennett: Which senior managers?

Dr Wollaston: You said you needed more senior people with managerial experience—that you are employing within Monitor.

Dr Bennett: We only have two at the moment, only one of whom has previously worked in the NHS and he was not made redundant.

Stephen Hay: He retired.

Dr Wollaston: So the answer is none. Thank you for clarifying that because I think it is a point of some—

Q28 Rosie Cooper: I am sorry, when you said that he retired, did he retire with a package of any sort?

Dr Bennett: I imagine he will have retired with his pension, as usual.

Q29 Dr Wollaston: But not a redundancy.

Stephen Hay: No.

Dr Wollaston: It has been quite a controversial issue, so thank you for clarifying that.

Chair: Sarah, I am sorry to interrupt you, but Valerie wants to come in on that before you go on to competition.

Q30 Valerie Vaz: Where are you getting these managers from?

Dr Bennett: As I say, we only have two at the moment and one—

Q31 Valerie Vaz: In response to Mr Tredinnick's question—

Dr Bennett: "Where are we going to get the future managers from?"

Valerie Vaz: that you are going to get some more managers. It would really help, Dr Bennett, if I might say so, not to repeat the question we are asking because it means you are not listening to the question we have asked. It is a very simple question. Where are you getting these managers from in relation to Mr Tredinnick's question?

Dr Bennett: We have yet to determine because that is what we are planning to do. However, I hope we can get some from within the NHS, because I think people with NHS experience will be helpful.

Q32 Valerie Vaz: But you must know where you are going to look for them.

Stephen Hay: I am interviewing a number of people between now and Christmas. I have a shortlist of about five or six senior people. I would say half of them are coming out of the NHS and half have other backgrounds, whether it is private sector, professional services or—

Q33 Valerie Vaz: Where are they coming from? Do you not know that your colleague is interviewing some people?

Dr Bennett: Of course I do.

Q34 Valerie Vaz: Right, so you could not answer that question. Where are they coming from—McKinsey, Deloitte, KPMG? What is their background? You have interviewed them, so you must have looked at their—

Stephen Hay: No, I am interviewing them between now and Christmas.

Q35 Valerie Vaz: But you have seen their CVs.

Stephen Hay: I have seen their CVs.

Q36 Valerie Vaz: So where are they coming from?

Stephen Hay: A number are current chief execs of NHS trusts or foundation trusts. There are two who have come out of the big accounting firms.

Q37 Valerie Vaz: Could you tell us who they are? Do you want to give us a breakdown?

Chair: No, I do not think—

Valerie Vaz: Do you want to write to us then?

Stephen Hay: No, I cannot, because some of these individuals are currently employed and will not know that they are on my shortlist yet.

Q38 Valerie Vaz: I think it is right for us to know where they are coming from given that the Secretary of State says he does not want any more managers and that you are just now appointing a whole load more managers. Maybe at the end of this process, you can say.

Stephen Hay: I have to put in the capacity to deal with the financial challenges that we have just been discussing, that there are going to be more FTs that get into difficulty, and I need to have, as the Committee has set out, more capacity to deal with those problems.

Q39 Valerie Vaz: You know that already, do you?

Stephen Hay: Yes because we can see that the number of FTs that are getting into difficulty is slowly rising and has been for a year or two. So, as David has said, we need to put more capacity into the team that I run.

Chair: Charlotte Leslie wants to come in and then we will go to competition policy.

Q40 Charlotte Leslie: I have a very short point. I think the reason people are concerned about it is that, in the past, managers have been taken from trusts that do not really have a track record of success and they are being put in charge of other organisations to take those forward. Are you able to provide us with assurance and reassurance that, if you employ managers from trusts, we will be able to look at those trusts which they have come from and see a mark of success—that we will not see them coming from a trust that has not performed well?

Stephen Hay: The quality of the work we do is based on the quality of the people we have. Therefore, we go to extraordinary lengths to make sure we only appoint high-quality people, wherever they come from. If somebody's name came across my desk that had question marks about where they had come from, in terms of a trust that had failed or wherever, we would investigate. We would do proper due diligence to understand whether that individual was responsible for that failure before we would begin to think about appointing them.

Charlotte Leslie: Thank you.

Q41 Dr Wollaston: Moving on to another issue, Sir David Nicholson told us that in his view we are getting "bogged down in a morass of competition law, which is causing significant cost in the system." He believes that legislative change may be required. Dr Bennett, what is your view on that and, with the Care Bill coming up, perhaps you could elaborate what change you would like to see.

Dr Bennett: This is, I think, quite a complex issue. There are two ways in which competition issues—or things that are perceived to be competition issues—are concerning people. One is around mergers and the other is around what commissioners do. If I could take the commissioner issues first, particularly the application of the so-called section 75 regulations—the procurement, patient choice and competition regulation—I think, unfortunately, there is an awful lot of misunderstanding and misinformation out there as to what those regulations do and do not require. They are not even fundamentally about competition. They are about doing commissioning well, and in fact they say that competition is only one of the tools available to a commissioner to secure better services

for their patients. They even explicitly talk about other things like, in particular, better integration of care.

These rules, apart from that bit about better integration, are essentially the same as the rules that have been in existence for quite some time. They used to be the "Principles and rules for co-operation and competition". They are hardly changed and the regulations are pretty well the same as the old rules. The biggest change is that we have different people doing the commissioning now, for a whole variety of reasons, and I think—not least, unfortunately, because it has become an incredibly controversial issue—those commissioners are very concerned about what this means for them. Fundamentally, if they are doing good commissioning that is improving the quality of care for their patients, they should not have any problems, but this is clearly not the perception. So, on this front, above all we have to find ways of talking to these commissioners, helping them to understand what the rules really mean. There is a whole variety of things that we need to do there and I have been in conversation with David Nicholson about how we can do this. Working jointly with NHS England on this will be very helpful because they have significant influence on commissioners and how they think about these things. I am hoping that, if we can explain to commissioners what it is that the rules do and do not allow them to do, we can deal with that, but I recognise that it is a huge challenge to explain it to people and there is a whole variety of things that we need to do.

On mergers, of course, what happened was that from April—and in fact before April—the OFT took over responsibility for looking at mergers involving foundation trusts, and, again, here I think that there is a huge amount of concern about the implication of the way those rules are being applied. People will cite Poole and Bournemouth as an example of where the rules got in the way of doing what some people at least think was the right thing to do. There is again a variety of issues, some of which are just about trying to help people understand what they can and cannot do, and there is a lot we can do on that front. One of the things with a merger is that it is extremely important to start with a good understanding of why it is that a merger is the right thing to do. I should say that, even where mergers have been allowed, the track record is not great. Being absolutely clear that, whatever the problem that a trust or a pair of trusts faces, merger is the right answer is the starting point, and I think we can help—it is a bit more about shortening the length of that arm—to try and make sure that they have that right.

The next bit is about understanding what the competition issues are that they need to worry about. For whatever reason, people are hearing all sorts of strange messages about concerns which we do not, frankly, understand. So we need to do more to explain to people what are the likely competition issues and what sort of advice they need, if they do need advice, to deal with those issues. In fact, we are going to go a step further, which is to do for ourselves, in parallel with the trusts thinking about whether or not they want to proceed with the merger, some of the work that the OFT would do so that we can help the trusts to understand, or the parties to understand, whether or not they are likely to have any issues and help them think through what they would do about it. If all of that is done well, that should deal with a lot of the problems we have.

There is another issue and I am not sure how to deal with it. This is about how you think about whether competition issues should be an obstacle to allowing a merger to proceed. The way the competition authorities think about this is that they first of all ask themselves,

"Is there a significant lessening of competition?" If the answer is yes, they then say, "Is this likely to be outweighed by the patient benefits that would accrue from allowing the merger to proceed anyway?" Then they try and work out exactly, or get the parties to tell them exactly, what those patient benefits would be. The problem is that there is a presumption that if there is a significant lessening of competition that is bad, and therefore you have to look at the concrete benefits of the merger and see whether they outweigh them. But the connection between there being a significant lessening of competition and that driving improvement in the quality or efficiency of care is a fairly tenuous connection. It is difficult. We can look at studies that tell us that competition does have some impact on the quality of care—and there are some studies done in England to show that—but to translate that into, "How fast and how effectively would that competition improve the quality of care?" is very difficult.

Q42 Dr Wollaston: One of the issues that is raised, of course, is that a lot of these judgments are clinical judgments about whether or not the care would be improved. What expertise would Monitor have to weigh up the financial and clinical benefits? Are you taking advice from clinicians if they are telling you, "Actually, we need to do this because it is going to improve the clinical care that patients receive."? That is a concern. The other concern is around the sheer cost of this. Very often there is a cost involved with a delay. Just to go back to Torbay—apologies, Chair—as you will know, they are wanting to undertake a vertical integration, but even then, even though there is not really a competition issue there, there is going to have to be a delay while it goes through the OFT; but the significant delays, the OFT tell me, are not during the OFT process but in getting everything ready in order for it to go to the OFT. There is a sense in which people are just drowning in the bureaucracy and cost, and it is having a chilling effect because of the joylessness, if you like, of it all and the cost of it all, when in fact what we want is these organisations to be making clinically-based decisions about integration. This is surely a huge barrier to that happening. Is that your view, Dr Bennett?

Dr Bennett: There were a few questions in there.

Dr Wollaston: I know.

Valerie Vaz: It was a speech, Sarah.

Dr Wollaston: It was a speech. I am sorry about that.

Dr Bennett: Fundamentally, it is all about what is going to drive improvements for patients. The competition is only there on the assumption that it will improve the quality of care for patients. But, as I say, the challenge is really, "Can you say how fast and how effective it will be at driving those improvements?" You asked, "Do we take clinical advice?" Of course, it is no longer our responsibility to look at the mergers—that weighing of these two things is now an OFT responsibility—but, in so far as we do look at these things, absolutely we take clinical advice; we absolutely must and do.

Q43 Dr Wollaston: The OFT have no clinical expertise, of course.

Dr Bennett: I presume they take advice, though.

Q44 Chair: Do you provide opinions to provide that advice?

Dr Bennett: As to the question of patient benefits, the more concrete thing—so, if you merge two institutions, what practical consequences will that have in terms of things like consultant rotas and so on?—we will advise the OFT on that, and in order to provide our advice, absolutely, we will take clinical advice ourselves. But, in the weighing of the impact of the lost competition against the benefits of the merger, that is now something which the OFT does. I want us to at least offer our advice to the OFT on both sides of that.

In terms of your example in Torbay, yes, it is a vertical integration, so it is two organisations essentially doing different things. Under those circumstances, you might normally expect there would not be a competition issue. Our people have taken a look at this. We give a lot of informal advice here to try and help organisations work out what is the right thing to do, and our feeling is that it should not be something that the OFT should be concerned about. If you think you are going through a merger which should not be a concern to the OFT, you do not even have to notify them. You can just self-assess that it is not an issue for the OFT.

Q45 Dr Wollaston: That is very important. They can just go ahead, in other words.

Dr Bennett: They can, yes.

Q46 Dr Wollaston: They do not need to wait for the OFT.

Dr Bennett: No.

Q47 Dr Wollaston: They are not aware of that, so that is great.

Dr Bennett: The OFT may notice that it is happening, might look at it and might decide, in general—I am not talking now about Torbay specifically—that they want to take a look at it. That could happen. But the parties can just get on with it if they want.

Q48 Dr Wollaston: The trouble is that they are doing all the preparation work because they just do not know and it is causing huge delays.

Dr Bennett: We have advised them that we think they should probably self-assess on this one.

Dr Wollaston: Right. Thank you for clarifying that.

Q49 Grahame M. Morris: That leads on to a number of questions that I want to ask Dr Bennett, and it goes back to the nub of the debates we had originally during the passage of the Health and Social Care Act, as it became, about what the consequences of competition would be. I did make note in an earlier answer to one of my colleagues—to Andrew George, it may have been—about the implications of the section 75 regulations, which you downplayed, I might say. I think it is deeply significant, and you said the only difference is that the people who are commissioning the services are different. I would respectfully suggest that there is a fundamental difference in that something like £7 billion, £8 billion or perhaps £9 billion-worth of NHS contracts are now provided by the private sector, which was not the case before. So there is a fundamental difference.

I want to ask some particular questions about the conflict with competition. There must be significant costs, Dr Bennett, about the application in terms of delays and what are the costs

within the system and the cost to patients of delayed decisions, merger decisions and so on. In his evidence, Sir David Nicholson raised some issues about the conflict between measures to drive up quality being either frustrated or even obstructed by the application of competition law, and he gave some particular examples. In fact, he wrote an article in the *Health Service Journal* in September and talked, for example, about the chief executive in an NHS trust who could not "buddy" up with the chief executive of a neighbouring trust that was having financial difficulties because of the application of competition law. He talked about a federated group of general practices being unable to come together and deliver a better-quality service more efficiently because of worries about the application of competition law. Most disturbingly, he gave an example of an NHS trust having to stop doing cancer surgery even though they did not need guidelines in this area.

What is your response to the views of David Nicholson, expressed in that article, in terms of the consequences of competition and how it is frustrating quality?

Dr Bennett: On the point about how much has changed, the point I was making is that the rules themselves have not changed very much at all.

Q50 Grahame M. Morris: Can I point something else out that I forgot to mention in my earlier question? When you said to Sarah Wollaston that it does not have to be referred to the Competition Commission, is not the problem that third parties—private sector companies, potentially—will say to the Competition Commission that they should be investigating because it is a hindrance to competition and the opportunity that they have of winning new business?

Dr Bennett: When I said it has not changed very much, I was talking about the rules. The rules are not very different at all. Most of what the Government did was put the old rules on a statutory footing. However, of course, because it was also controversial when the Bill was going through, and remains so now, part of what has happened here is that—and, of course, you simultaneously had the change in who was doing the commissioning, so you have a whole bunch of new commissioners, with the CCGs instead of the PCTs—they have just become very fearful, and I am afraid there is an awful lot of misinformation out there.

Q51 Grahame M. Morris: Is that not predictable? During the course of the passage of the Bill and the pause, was not all this pointed out—that there would be a feeding frenzy for competition lawyers, people having different opinions of how it applied in relation to the NHS and that there would be a consequential impact upon the quality of the service? Was not all that predictable? It was certainly raised during the course of the passage of the Bill.

Dr Bennett: The problem in part was simply that it was subject to so much very public debate that it got everybody anxious about it. Sometimes, people hear things that are not at all accurate but which are promulgated as if they are facts and that causes them to get very anxious about it. You were talking about the costs of it all, so that is what happens: people get anxious about it, think the only safe thing to do is to go and talk to a lawyer, and then it does get very expensive. That is what has happened, I completely agree, and that is not the way we should be spending the NHS's money.

On the points that David Nicholson raised, in the main, again, his concerns —

Q52 Grahame M. Morris: He gave some specific examples as well. He was not just talking in the round.

Dr Bennett: No, that is absolutely right. But those examples in many cases are a reflection of concerns people have about, "If in doubt, do not do it."

Q53 Grahame M. Morris: The risk averse.

Dr Bennett: There are so many people out there fearing that they are not quite sure what the rules are and therefore will not do it.

Q54 Grahame M. Morris: Can we conclude then that competition is a bad thing?

Dr Bennett: I think to conclude from that that competition is a bad thing would be a bit of a stretch.

Q55 Grahame M. Morris: I was leading you up the garden path there. Can I ask you another question about how we can clarify the position in respect of Monitor's guidance, because you are in the process of issuing some—

Dr Bennett: Yes.

Q56 Grahame M. Morris: You have consulted on the draft guidance, haven't you?

Dr Bennett: That is right; quite a while ago, yes.

Q57 Grahame M. Morris: Perhaps you could tell the Committee when the final guidance will be ready and what your views are in terms of how that will assist in clarifying the position?

Dr Bennett: I hope it will assist. It has taken rather longer than I would have wished to go from the consultation to the final version. The heart of it is that we have been having very long discussions with NHS England about how best to explain all this stuff in a way that I hope will alleviate some of the unnecessary concerns that commissioners have. We did agree it today, so it now has to go to the Department of Health for sign-off with the Secretary of State—I hope he is going to be happy with it—and then we should be able to get it out very quickly.

Q58 Grahame M. Morris: In terms of the consultation period, when the draft guidance was available, what kind of responses did you get during that period, and in the final guidance have you given some particular examples, as Nicholson did?

Dr Bennett: Most of the responses about which we could do anything were about trying to clarify things, and obviously we have tried to respond to those. In so far as anybody responded by saying, "We think this competition stuff is just inappropriate in health," there is nothing we could do about it. The regulations are the regulations and our job is to produce guidance about how we will enforce them. Being clear and practical about how the regulations are to be applied is very important. Part of the reason it has taken so long is that we have been trying to produce case examples, because it is very difficult to write general guidance that will be meaningful to commissioners and people out there. They are not experts in this stuff and yet they are being asked to operate in this environment. That is very difficult. We now have a number of those in, but we need to do more, and now that

the guidance is settled, I hope we can spend more of our effort on doing more case examples. That is very important. I want our people to get out there talking to these commissioners. We have 211 CCGs to talk to, but we need to do that. I am talking to David Nicholson about us doing it together again, so that they can understand that this is something that we are joined-up about.

Q59 Barbara Keeley: As part of your new role as sector regulator, you have announced a study into the GP sector and you have published your research into walk-in centres. I have a few questions around that. Who commissions and prioritises that sort of work? What is going to be next in your research programme? What is the status of publications like the one on walk-in centres, and how should commissioners and providers respond to them?

Dr Bennett: The decision about what areas to look at is a Monitor decision. It is within our general remit. In fact, technically, because we have concurrent powers with the Office of Fair Trading under the Enterprise Act, we can even do something called a formal market study, although that is not what these two studies are. In the case of GP services, the OFT was minded last year to do a review of GP services. We said we thought perhaps that was not ideal timing, first, because the system was going through a lot of change, and, secondly, we were just about to get the powers to do the same sort of thing, and we thought the whole point of giving these powers to Monitor was so that these issues could be looked at by a body that is focused on health rather than by the general competition authorities. That was one of the reasons why we thought we should look at GP services.

Walk-in centres was an example of a situation where we had a number of complaints being made about the way in which they were being closed, or at least existing contracts were not being re-contracted, and rather than look at every individual complaint we thought, "There is a pattern here. Let us look at it overall and start by trying to understand what is going on."

We started with a call for evidence, asking all interested people to tell us what they thought the issues were and also just gathering some facts. It turned out that we could not even find out how many there were initially. We discovered that in recent years about a quarter of all walk-in centres have been closed. We discovered, unsurprisingly, I think, that a lot of the people who use walk-in centres—and we did a survey of, I think, 2,000 users of walk-in centres—highly value them and, therefore, there were clearly concerns about the fact that they were closing.

At the same time, of course, we talked to commissioners, and commissioners expressed concerns: for example, they are concerned that, if they have to pay a walk-in centre every time a patient goes there but they are also paying the GP because that patient is on the GP's list, then they are paying twice for the same care to be provided, and obviously that is a very understandable issue. At the moment, all we have done is gather this evidence, and recently—the week before last—we published a summary of what it is we have heard, part of which is to say that there are clearly patient benefits to having these things and, therefore, we need to look very carefully at the consequences for patients if they are closed, although recognising there may be perfectly good reasons in individual health economies for why they are closed.

With GPs, we have been through, essentially, a similar process of asking for evidence. We are compiling the evidence and we will be publishing that in a few weeks. Of course, the

walk-in centres and GP services do link, but particularly with GP services, because both NHS England, as the commissioner of GP services and the holder of the contracts with GPs, and now the CQC, with Steve Field taking over as the chief inspector of general practice, will have a shared interest in looking at how the GP services develop. We have been working very closely with these bodies, so one of the things we will do as we decide what to do next, in collaboration with those other two bodies, is to work out who should do what.

Q60 Barbara Keeley: What tests did you see being applied to decisions to close walk-in centres? I have to say, there were two closed in Salford on a fairly arbitrary basis of just having to find some savings, and they were well used and did have high patient satisfaction. Did you find that there was arbitrary decision making around those decisions?

Dr Bennett: It was certainly variable and that is one of the things that concern us. This gets to the heart of some of the section 75 stuff. That seeks to make sure when commissioners make decisions that they make them in an objective, transparent and fair way. It does not dictate how they make them but that they must go through a fair process. We have found some cases where it is not clear that that is what happened.

Q61 Barbara Keeley: Okay. If we look at your later study, for which you have issued a call for evidence, on the GP sector, in terms of evidence to this Committee for today, the BMA have said they are concerned by your attitude to innovative models of primary care. They think you should move towards a payment system which better encourages integration and is based on outcomes, and they believe that you should be prioritising integration above the work you are doing around anti-competitive behaviour. So there is a very strong feeling that you perhaps do not have the right attitude towards innovation and that you are not prioritising integration, which they see as key.

Dr Bennett: I can say here and now that we think innovation and better integration of services are essential. Unfortunately, this is just another example of what we were talking about a moment ago, a misunderstanding about the extent to which these things can happen, given the rules around competition. There is no fundamental reason why integration and innovation cannot happen without contravening the rules, but this is where we need to help people understand that.

Q62 Barbara Keeley: Do you understand why the BMA are so concerned about your attitude to their innovative models of primary care?

Dr Bennett: I am not quite sure why they are concerned. I met with the GP leadership at the BMA last week to talk about this very issue.

Q63 Barbara Keeley: Did it not emerge?

Dr Bennett: They did not express a concern with our attitude.

Q64 Barbara Keeley: It might be something you ought to take up with them.

Dr Bennett: We need to talk to them again.

Q65 Barbara Keeley: Clearly, you do. Can we move on to the "Fair Playing Field" review? I want to ask about changes that we are likely to see as a result of that, but, in terms of

evidence to us here today, Marie Curie have said that they think the whole of your organisation "needs to enhance its understanding of the charitable sector and specifically charitable providers of NHS services." In fact, they have said that they think you should undertake an organisation-wide review of how your organisation relates to and works with the charitable sector, and they are keen to support you in doing that.

Dr Bennett: Yes.

Q66 Barbara Keeley: They are clearly concerned that you lacked knowledge in terms of that review and think that that is something you should address.

Dr Bennett: I would certainly say that when we were going through the process of designing these new licences for providers, which is the new regime that we have been operating since 1 April—so this is stuff we were doing a year or more ago and we produced some draft licenses and consulted—one feedback we got was that we were drafting licences in a way that did not work in certain respects for the charitable sector, and we have changed it. We had not understood, they explained what we had not understood and we changed it. If there are further things that we have not understood, then, absolutely, I would be keen to find out and work with them. The charitable sector plays an extraordinarily important role in the provision of health care and related services in this country, and we must do what we can to support it.

Q67 Barbara Keeley: As I say, Marie Curie are keen to support you in doing it, but they are alarmed enough, I think, to say that you should have an organisation-wide review of how you relate to them. So there must have been some underlying things coming along from the review. But the basic question is still there: what key findings were in the review and what changes do you think we are likely to see as a result of it?

Dr Bennett: In the "Fair Playing Field"?

Barbara Keeley: Yes.

Dr Bennett: There was quite a long list of 29 findings, if I remember correctly.

Q68 Barbara Keeley: What do you think are the most important?

Dr Bennett: The most important thing is the way commissioners go about what they do, the essence, in part, of the section 75 regulations about doing good commissioning, which includes treating all providers fairly, including charitable organisations, and there are many ways in which charities felt they were not treated entirely fairly. I would have to say that sometimes, I think, it is not reasonable for a commissioner to do what some charities might have wanted, but, equally, I would have said that to the independent sector, to NHS providers, as well. But there are definitely things that need to change.

A classic problem is that there are requirements of, say, working capital—very high levels of working capital, higher than is necessary—which a charity just cannot satisfy, so we are working with the commissioner bodies to see what we can do to address those sorts of issues. A more difficult one would be something around, say, the size of contract. Charities will say that often it is difficult for them because, of course, as you will know, many charities are very small organisations. They will say it is impossible for them to compete for a contract, to put in a tender for a contract, because it is just too big. But I can

see from a commissioner's point of view that it can be hugely inefficient for them to tender or commission the services that they need in lots of small packets. There are inevitable tensions here that have to be worked through and not everyone will be happy with everything. But there are things we need to look at. The most important for charities, and the whole reason for—or the thing that initiated—the "Fair Playing Field" review in the first place, is the way charities are dealt with from a VAT point of view. The Government either have, or have said they will—I do not know if you know where they have got to, but I think they have agreed—change the rules so that the charities are treated like the public sector providers for VAT.

Q69 Barbara Keeley: Going back to some of the points raised by the BMA, do you have any examples yet of how you are using your role to promote integrated care?

Dr Bennett: As a matter of fact, our duty is not to promote integrated care; it is to enable it. There are different duties across the system. NHS England has to promote it, and we have to enable it. I think I have that right. There are definitely different duties in different places. Ours is to enable. The reason that ours is to enable rather than promote is because we are not in a position to do much in the way of promotion. It is more about enabling, but pricing is an area where I think we can do things. I do not know, Adrian, if you want to say a bit about what you are thinking about in pricing.

Adrian Masters: Probably the most important thing we are doing at the moment is making sure we are not a barrier through the pricing system. We are encouraging people out there. We are encouraging—not just permitting—people by saying, "Go and look at new patterns of care, new types of care you want to provide and new integrated care, and, if you come up with a new pattern of care with your own local prices, that is fine within the rules." I would say to the BMA, "If you want to work locally to develop a new pattern of care with its own price, go ahead. We are very happy with that." In fact, one of the reasons we want to encourage it is because we think there is an opportunity to have this local innovation and then learn from it. We would go back later, have a review and see what has been done and try and share those lessons that have been learned. That is the general point.

Pioneers are worth mentioning as well. We are part of the group who are working on the 14 pioneers that the Minister has recently announced. Again, we would help with the selection of the 14 pioneer projects and continue to support those pioneers. If what they need is technical support to work out how to do pricing for the model that they are working on, we plan to provide some help and support in that process.

There are two things I would say on enabling: first, we are trying to show we are not putting up barriers, that we are encouraging people to innovate and come up with their own prices; secondly, we are trying to help that process by providing technical expertise and evidence of what is working so that other people can learn from it.

Q70 Chair: Andrew George wants to follow that up, but, before we go there, can I try to sum up what I think you have said to us about the competition issues this afternoon because it is quite important? I heard you essentially say that these are difficult issues and a lot of people have a lot of views about them, but if the law was better understood there would not be, you believe, a fundamental problem. The reason I sum it up that way is that that is not the evidence that Sir David Nicholson gave to us a fortnight ago, and nor, if I may say so, is it really the evidence you gave us on 11 June, when you said, "This is one of the absurdities of

where we are in danger of finishing up, isn't it—that you get a trust going out of business because it has insuperable problems, trying to fix the problem and not being allowed to fix it because it would reduce competition?" It is important to be clear: does the law need changing or not in your view?

Dr Bennett: In many respects, both on the commissioning and the merger stuff, it is about getting a better understanding of the law. But I did raise this very specific point about how you weigh the costs of losing competition against the benefits of going ahead, for example, with a merger. The way the competition authorities think about it is, I think, not taking sufficient account of the way that, while competition in health might lead to improvements, there is a danger that the potential benefits of competition are overstated. Whether fixing that problem requires a change to the law, or whether it is indeed fixable by changing the law, I do not know, but that is a problem that needs to be fixed.

Q71 Chair: Are you aware of, and do you agree with, the proposition that this is an issue that is being faced in other health economies elsewhere in the world? I was told recently that this is an issue that has been raised by healthcare providers in the United States and in some other OECD economies, not only in America, and that the issue of balancing competition against necessary change in a sector which is resource-constrained is faced elsewhere as well.

Dr Bennett: Yes. That is my understanding, indeed.

Q72 Chair: Would it, therefore, be sensible for this to be addressed as a serious—and, frankly, urgent—issue of policy by Monitor, presumably the TDA, NHS England and the Government, because you have highlighted an issue which is in danger of making trusts unviable that need not be unviable?

Dr Bennett: This specific issue does need looking at urgently.

Chair: Thank you. I had wanted to crystallise that because we appeared to be getting different evidence from different witnesses.

Q73 Andrew George: I want to bridge the discourse between your duty to enable integration and the pricing responsibility of Monitor. I want first of all to clarify in my own mind that you recognise that there is a potential and very real conflict between the enabling role—to enable integration—and your responsibility to drive out anti-competitive practice because certain structures of integration could be deemed by certain providers as a behaviour which is anti-competitive. I do not think I need to describe it. If you bundle a lot of things together, there is a risk that someone who might provide one aspect of that service will challenge that as being anti-competitive.

Dr Bennett: Frankly, there is so much concern and anxiety out there that, even if it was not true, people would fear it is true.

Q74 Andrew George: You cannot keep blaming the politicians for raising that.

Dr Bennett: No.

Q75 Andrew George: With my colleague Grahame, you were more or less saying that it is the politicians who have created the smokescreen of fear.

Dr Bennett: That was not what I was trying to say. There are all sorts of people engaged in it.

Q76 Andrew George: Who is?

Dr Bennett: I mean engaged in the discussion.

Andrew George: Okay. We will move on.

Dr Bennett: Where was I? What was your question again, please?

Q77 Andrew George: The conflict. Do you acknowledge there is a conflict is what I am asking?

Dr Bennett: Yes.

Andrew George: There is a conflict.

Dr Bennett: We have had our competition experts working with people working on these pioneers precisely to try and give them specific advice and avoid unnecessary or inappropriate concerns.

Q78 Andrew George: Is that right, Mr Masters? You have designed some of these potential collections, or at least—I am sorry—the environment in which new and innovative models of integration can be developed.

Adrian Masters: The general rule is that, if a commissioner wants to buy a certain service and that service is a very bundled or integrated service, that is a matter for the commissioner. The competition rules are not going to get in the way if a commissioner says, "This is the service I want to buy and it is actually quite integrated." There is one issue to do with, "How does it interact with choice?" and, usually, if there is a question of the commitment in the constitution that patients will have choice at the point of referral, there need to be mechanisms to handle that. Subject to that one proviso, if the commissioner says, "The best service I should commission is a very integrated, large-scale service," that is a matter for the commissioner. They then have to go through a process of how they do that and then the rules, section 75 and other rules, do apply. We have no picture in our heads of what is the right pattern of service that the commissioners should be buying. It is for commissioners to say, "This is the pattern or type of service we want to buy or commission." We will not get in the way of that.

Q79 Andrew George: Providing, you are saying, that the opportunity for patient choice remains throughout the pathway.

Adrian Masters: It is the specific commitment at the point of GP referral—"Do they have choice?"—that they have to answer. But that is in the constitution.

Q80 Mr Sharma: What if the commissioner says, "No, this is your choice. With the services we are buying, your choice does not fit in."? Then where does patient choice go?

Adrian Masters: The current situation is that the commissioner has to answer the question as to how they are going to give the patient the commitment in the NHS constitution of how they are getting choice at the point of GP referral for those particular services that

they are meant to get choice for. They could say, "You have a choice of going on to this integrated package of care or going to one of these other providers." That is totally fine, but, at the moment, they have to meet the constitutional commitment that patients are going to have a choice at the point of GP referral. Other than that, the pattern of services that the commissioners buy is a point for the commissioners to work out as to what is best.

Q81 Andrew George: So if at the point of GP referral the patient is offered an integrated pathway of care or an alternative which might mean that they can select other services of their own design—

Adrian Masters: They could go to another provider, yes.

Andrew George: To provide for their, say, long-term care for arthritis, or whatever it may be, they can make that choice.

Adrian Masters: Yes.

Q82 Andrew George: In relation to the setting now of the pricing policy, which you say is going to look pretty much the same in 2014-15 as it does now—I think that is what you were saying in your evidence—

Adrian Masters: Yes.

Q83 Andrew George: But just on the principle of it, if your role is to drive out anti-competitive practice, one of the criticisms of the existing pricing policy is that it creates an unfair playing field between, for example, providers of general hospitals and those, for example, private providers that can provide elective surgeries that effectively cherry-pick the easier-to-do or the lower co-morbidity procedures which that general hospital provides. This is a general theme that I am sure you are well aware of and the payment-by-results—the tariff—system currently enables that to happen. That is not something which the Act has created. It has been happening for some time and I acknowledge that. To what extent, first, do you acknowledge that that might be the case, and, secondly, do you believe it is possible to create a tariff structure which might fairly reflect the fact that some providers need to ensure they have a wraparound of intensive care and other support services, which the private sector depends on if things go wrong?

Adrian Masters: In the pricing system, a certain kind of bundle of care is specified in the things that we price. If the commissioner locally wants to buy that, plus some other add-ons—such as rehabilitation—that are not included in the local bundle, that is a matter for the commissioner. The commissioner has flexibility in the pricing system to negotiate and change the price. I just wanted to make the point that there is a lot of flexibility in the system for the commissioner locally. So in the usual bundle, for which there is a usual price, that assumes a mix of patients with different types and degrees of complexity. If the commissioner feels, "I am not actually sending the patients with that full range of complexity to this local provider," again the commissioner can negotiate and agree a lower price because "I am not sending you all the people assumed in that bundle. I am sending you less complicated ones so I want a lower price." That is totally open for the commissioner to negotiate with the—

Q84 Andrew George: That is the commissioner, not yourselves and NHS England.

Adrian Masters: Not us because we do not know what pattern of service they are buying. But if they want to vary it from the national standard, they can go ahead and do that and agree a different price. So that covers most of the cases where people talk about cherry-picking. The one area that is left is people say—and we are looking at the moment to see if we can find evidence for this—that they are more likely to make a surplus on elective care than they are on other types of care. Therefore, they are saying if some of the elective care is going elsewhere, "Without that surplus, we can no longer cross-subsidise other parts of our service." This is the other term that people point to. The way we come up with the prices is we get people to report the cost of those services to us. They take their total costs and allocate them to all their services, including elective care. What they are saying, in the way that the costs have been allocated, is, "We have not allocated all the right costs to this elective care, so we are not being paid the right amount." Over time, we need to improve the quality of the costing, so that the prices more accurately reflect the costs. That, again, is an exercise we have started working on as to how we can get better costing information and better reflect the cost in the prices.

Q85 Andrew George: You are in a very privileged position because, particularly with those foundation trusts that are in financial difficulty, you will be analysing and looking at the cost centres of the various departments, and no doubt procedures and so on, and recognising that there will be certain services which they need to have in place, intensive care services, accident and emergency services, anaesthesia and so on, which provide across a whole range of departments which are not in themselves easy to apportion to one particular procedure, for example. It may well be in those services that there are potential losses and, therefore, in an acute trust, they are seeking to make a surplus through elective activity in order to balance the books. How are they going to balance the books? Are you saying that they should be charging a great deal more for some of their core services for which there is not a payment-by-results system?

Adrian Masters: I will have a shot at an answer, and if I am not answering the right question, let me know. The way we come up with the prices is that we take the costs from the providers, they report it to us, report it against the services that they have provided and we calculate an average. That, based on that average, is what we pay. They should be getting a payment for the services covered by the tariff which reflects the costs of a reasonably efficient provider because it is based on the average. So, for most of those services that they provide, they are getting paid a price based on what it would cost an average provider. That is a reasonable way to go about it. They do have other sources. Depending on how you calculate the average, somewhere between 60% and 70% of acute hospital income is provided through tariff. For some providers it is more; some it is less, depending on what other mix of revenue they have. If you have R and D, for example, or teaching revenue, it is lower, and if you do not have that, it is higher. We do not try, in the national system, to fine tune every individual provider's match between their revenue and cost. We set reasonable national prices and then there is flexibility at the local level for the commissioner and the provider to make other payments based on their local situation to reflect the local cost.

Q86 Grahame M. Morris: If it is opportune, could I ask about the changes that came into effect this year on the marginal rate and what impact you think that has had, particularly in relation to emergency admissions?

Adrian Masters: As to the marginal rate rule, shall I say a little bit about what it is before I start?

Andrew George: Yes.

Adrian Masters: Back in 2001-02, 03 and 04 for emergency admissions people were paid a block grant, a block amount, and we had relatively low growth in emergency admissions. Round about 2004-05, we introduced a 98% A and E target, and a little later on we started paying people for emergency admissions. For every extra emergency admission, you got an extra payment. We had a very rapid growth in emergency admissions. We were paying for every extra one and you had the target. Over a period of time, six or seven years, it grew about 7% a year.

We could not afford for it to continue to be growing at that rate, so in about 2010-11 we went back, essentially, to a budget. We went back to a budget base and then saw a slow-down in the rate of growth of emergency admissions. That was done in 2010-11, and the basic rule has been unchanged since then. It has been 2010-11, 2011-12 and 2012-13, and the new rule we are putting forward has not changed from that. It is a continuation of the rules we have had since 2010-11. It has had this effect of slowing the rate of growth in emergency admissions. We are worried that if we change it by paying more for every emergency admission we would again see an acceleration of emergency admissions, and we think that is a bad way to run it. We have a fixed NHS budget and we do not think it is good value to be spending more of our budget on extra emergency admissions. We want to keep that budget control at the hospital level over growth in emergency admissions. Instead, we want to spend any money that we have—any flexibility that we have on the margin—on out-of-hospital care, trying to keep people supported and well, rather than being admitted to hospital, and have better schemes for discharging them after they have been in hospital.

The marginal rate does two things. One, it basically applies this budget control over growth in emergency admissions but it also puts money into a pot. For any admissions over the budget, the commissioner has to put money into a pot, and that money is intended or planned to be spent on how to avoid further admissions and how to do a better job of helping people be discharged from hospital. So that basic structure—

Q87 Chair: From the point of view of the acute hospital manager, they would have to know.

Adrian Masters: The question was, "Has it changed?" and I was trying to say it has not; it is still the same.

Q88 Grahame M. Morris: I was trying to get your assessment of whether it had worked, given that the Secretary of State has announced £250 million of additional resource.

Adrian Masters: I will come back to the Secretary of State. Yes, broadly speaking, I think the marginal rate rule has done the kind of job we wanted it to. We have made some changes to try and do it better, but it has done two things. It has helped control the rate of growth in emergency admissions, and it has directed attention by commissioners and providers in how they can work together to keep people well and supported outside hospital and to discharge them better once they have been in hospital. So, in terms of directing that attention and working together on that and of controlling growth of

emergency admissions, particularly short-stay emergency admissions, it has been helpful to the process.

Dr Bennett: Can I add, though, it does have two problems? The first is, while it has incentivised hospitals to reduce the rate of growth in admissions, there are clearly problems if there are unavoidable admissions and they are not getting paid enough for them. That is an issue.

Stephen Hay: We have had some FTs get into financial difficulties.

Dr Bennett: Yes, and we have trusts in difficulty because of that. The second problem is that, if that 70% which is held back from the hospital is not being spent effectively to either prevent attendance at A and E in the first place or to get them out once their treatment is complete, then you have further pressure on the hospitals, and I think most of us would agree that it is not all being spent as effectively as we would like. So there are problems.

Q89 Grahame M. Morris: Are you going to look at that again?

Dr Bennett: Adrian and his team have already made some proposed changes for 2014-15, but it needs a more thorough examination. Our problem is always—and this is the whole problem with the pricing system—that, if you tinker with individual things, you can improve this and make that worse at the same time, and when there is only so much money to go round you have to be very careful about how you do that. So we have made limited changes for 2014-15, but we need to look at how we are going to try and get this to work better in the long term.

Q90 Barbara Keeley: Has there been some sense of looking at the impact around this? You were talking about one set of levers, but surely at the same time £2.68 billion has gone out of adult social care and that clearly plays into this. You are talking about both avoidable admissions and people being able to be discharged. My own local authority is going through a situation of changing to substantial eligibility across this winter, which I am sure will have an impact, but there is a frustration that I feel—and certainly we feel on the Committee—that this is never looked at and these connections are never made. I do not know if you or somebody could commission it, but it seems to me that we are missing a trick in never looking at what happens in the three, six or 12 months after a social care authority has changed its situation, cut its budget and changed its eligibility, and the impact of that on the hospitals that usually fall into the catchment area of that authority. We are in the lucky situation, I suppose, of being able to do these comparisons because we have 152 separate social care authorities that can make their own decisions, but it is not entirely within the things you have just been talking about. It is that plus the surrounding—

Dr Bennett: I totally agree. Of course, you are getting to the heart of the challenges presented by the fact that social care and health care are separate.

Q91 Barbara Keeley: But they are and have been.

Dr Bennett: Yes. It certainly would not be true to say people are not worrying about it. One of the things that, hopefully, will come out of this integration transformation fund, the ITF—which is £1.8 billion at the moment and will be £3.8 billion from 2015-16, and that is why this extra £2 billion is going out of the acute sector—is at least that it is being spent

in a way that is intended to get more effective co-ordination between health and social care.

Q92 Barbara Keeley: But can I stop you? We had a rather depressing set of panels on this last week. The person from the Nuffield Trust was saying that the planning was nowhere near where it should be for that, and, when we spoke to the LGA health and wellbeing people in the afternoon, effectively they said, "They are talking," that they have relationships. Integration will not be at a point of working well enough to be the powerful lever it could be if that is the state of play at the minute. There was a very strong view that came over from the Nuffield Trust that the level of planning that we need to properly use that extra £1.8 billion was not there and that it is effectively just at talking level, relationship-building level. There is very serious planning that needs to be being done now and it is not being done.

Dr Bennett: I certainly agree that it needs to be done very seriously. This is outside our remit and this is—

Q93 Barbara Keeley: But you are a player in this.

Dr Bennett: We certainly see the consequences because of the impact it has on our trusts, so we are certainly strongly encouraging that there is this better co-ordination.

Q94 Barbara Keeley: But there is no point in hoping, given the evidence we have, that this is going to work itself through because it does not sound as if it is. Taking that £2.6 billion out of social care means taking people out of social care as well. My local authority has a real dearth of senior people now. How that all gets dealt with is difficult because they are both having to go through the difficult thing of making cuts as well as having cuts themselves and having fewer managers and senior managers.

Dr Bennett: I agree. I have very few levers to do anything about this particular issue, but I completely agree that it is an issue.

Q95 Grahame M. Morris: While we are in this section, I wonder if I might ask you a question about mental health and the Mental Health Act and how the tariffs apply there. You might be aware that the Committee did a post-legislative scrutiny inquiry on the 2007 Act, and the general conclusion was that it would be beneficial if there was a tariff for mental health services because the block contracting-in grant for mental health services makes it easier to cut. I wonder where we stood with that because it seems as if there are some reports that that is on hold and that it may not happen. Could you give us some clarification?

Adrian Masters: What has happened in mental health is they have defined the services they provide into 21 clusters. They are going through a process of collecting activity, cost and setting quality indicators against each of those clusters. The kind of cluster might be people with psychosis, and you might say people with relatively mild psychosis, medium psychosis and very severe psychosis. That is the kind of thing they would call a cluster—21 of those. In order to get to the point where you can specify a tariff, you need to have consistency of, "Within this block we have the same people—record the same patients." To set one number, one tariff, we need to say we have similar kinds of costs—how much it costs to treat a patient with the same designation.

If you talk to people in the sector, they are finally going through this process of allocating their patients into these clusters. They are collecting information about activity and cost,

they are looking at quality indicators and then they are talking to their peers about variation. They are finding it, I think, very helpful to reflect on their own practice and how it differs from others. The other thing they are finding is that there is not great consistency with any of these clusters about what does happen to a patient with a particular diagnosis because clinical practice varies an awful lot in mental health. You might have the same patient with post-traumatic distress disorder and different clinicians will put them on different types of treatment programmes. Therefore, the cost, when you look at how much it has cost for that particular condition, varies very widely. So we think it is going to be quite a while—and I think this is also the international evidence—before we can agree, for this particular kind of patient, "Here is a national price that we think should be paid."

Instead, what we are doing is encouraging people to use these clusters, increase their understanding of their activity and their clinical practice, increase their understanding of the quality of the results they are getting and then to negotiate locally as to prices. We are saying to them, "You should use those clusters as the basis of your local price negotiation with your local commissioners about how much you are going to be paid. Use your clusters, negotiate locally and build your understanding of what is going on; cost activity and quality." It is going to be quite a while—perhaps a very long time—before we can say that we know enough to say, "This is the right treatment and, therefore, this is the right price."

Q96 Chair: A segmented block contract.

Dr Bennett: That is the sort of first step.

Adrian Masters: Yes. It is a cost-volume contract against these segments, yes.

Dr Bennett: It is trying to find a pragmatic way through a very difficult problem.

Chair: Indeed.

Q97 Valerie Vaz: Can I take you now to the new regulatory framework that has just come into play on 1 October, the risk assessment framework? Are you aware of some of the criticisms that have come out from the Foundation Trust Network about this new framework?

Dr Bennett: I think we are.

Q98 Valerie Vaz: What would you say to that?

Dr Bennett: What specific criticisms are you highlighting?

Q99 Valerie Vaz: They seem to think that it is more interventionist, that basically what you are doing is measuring them as against performance targets as opposed to anything else.

Dr Bennett: I will pass to Stephen in a moment, but I want to come back to a point I made earlier, which is that it is all about the length of the arm between us and the trusts. While the legislation establishes, in principle—and this is going back to 2004 legislation and then reinforced by 2006, I think—that the foundation trusts should be autonomous bodies with a relatively arm's length relationship with us, as the sort of "shareholder" on behalf of the public and Parliament, nevertheless you could have very different lengths of arms and still be consistent with the legislation. My predecessors, although Adrian and Stephen were

involved in this, settled on a relationship with a degree of scrutiny and so on. I think, partly as a result of the increasing pressure on the system and partly as a result, I frankly think, of the public and Parliament having a lower risk appetite than they did back in 2004, in general—but we have seen it in the financial services sector as a very good example—for both of those reasons, my view is that we need a somewhat shorter arm and that is what the FTN is reflecting. Whether we have it right or not, to some extent, everyone will always disagree. Some will say it is still not short enough, and I get plenty of people telling me that, and the FTN will say it needs to be even longer still. That is the challenge we face—finding what is the right length of that arm.

Q100 Valerie Vaz: Are you satisfied that with what you have in place now you would be able to do that?

Dr Bennett: We have consulted on the risk assessment framework. Although there were some objections, there were never an overwhelming set of objections to any of our proposals. As to the length of the arm, we have to be pragmatic. It is where we feel it is about right. If the evidence is, for example, that we are having a lot of trusts fail and we are not either spotting it soon enough or not doing enough about it, we are going to have to shorten it a bit more.

Stephen Hay: It has only been in for six weeks, so we have limited experience. Certainly, on the financial side, we are running what are called shadow continuity of service ratings and they are not demonstrating a greater number of trusts hitting the threshold for investigation on financial issues than under the old compliance framework. On the non-financial side, the old compliance framework had become very complicated and you almost needed a PhD to understand how it operated. We have simplified it. We have reflected a lot of the learning coming out of Mid Staffordshire and some of the leading indicators around patient surveys, staff surveys and the quality governance framework in it to, as David says, pick up those issues at an earlier stage. But I think we are going to have to see how it plays out over the next year.

Q101 Valerie Vaz: That is what their concern was, that, coming out of Mid Staffordshire, you were going to become more interventionist as a result of what happened there. Are you saying that you are not more interventionist?

Dr Bennett: There are two stages to this. There is how closely do we monitor them and then how quickly and strongly do we intervene when we have reason to be concerned. So we are monitoring a different set of measures, but I do not think it is any more—

Q102 Valerie Vaz: Could you say what those sets of measures are?

Dr Bennett: It is things that Stephen suggested. One lesson from Mid Staffordshire is that there were lots of signals out there and somehow no one said, "There is a pattern here. There must be a problem behind it." We are trying to look at the sort of softer intelligence.

Stephen Hay: It is the soft intelligence.

Dr Bennett: Yes, things like staff surveys and patient surveys that might be good indicators of underlying problems that others have not found. That is one of the sorts of changes we have made. In other areas, we have taken things out and tried to simplify it. I do not think the monitoring regime has fundamentally changed the length of the arm. We

have changed the character of the arm to try and make it better—in particular, better at spotting things. Then there is the question of how quickly and strongly we intervene. I would say we are trying to intervene a bit faster and a bit more strongly, and that is because the system is under a lot of pressure and we cannot afford to have lots of seriously failing hospitals out there.

Stephen Hay: The other thing that is worth saying, David, is that I know the FTN are quite concerned about the proposals that we have to look at governance every three years, but that is simply because we find that, whenever we have a problem in a foundation trust that becomes a serious problem, where we have to step in, whether it is finance or quality, underneath it there are governance failings. The concept of doing a governance review on a rolling basis is to help the boards and us to identify where those failings are coming before we see the problems coming out in quality or financial failings.

Dr Bennett: If I may so, this is a perfect example. As Stephen says, we have refined our ability to even measure governance for an applicant trust. Frankly, we measure it better now than many of the FTs were measured when they went through. Even those that were good may have declined, and, as Stephen says, often, when we find a trust getting into serious difficulty, it is because their governance is not fit for purpose. We could just sit and wait until they get into serious difficulty and then find out their governance is not fit for purpose, but the patients are already suffering because the trust is already delivering poor-quality care. What we are saying is that we would like every trust, every board, to have a review of its governance at least every three years, so that it is more likely that the problems will be identified and sorted out, so that the underlying governance issues are sorted out before they become real problems for the quality of care. That is something where the FTN might say, "No, it is up to trusts whether they review their governance on a regular basis or not," and that is where we say, "We have done it on a 'comply or explain' basis." We have said, "This is what we expect. If you do not do it, you should at least explain why you are not doing it."

Q103 Valerie Vaz: Do you feel that the regime you have now will prevent another Mid Staffordshire or Morecambe Bay?

Dr Bennett: The most important change—

Q104 Valerie Vaz: That is, how long is a piece of string?

Dr Bennett: You can never say, never, can you? But the most important change that makes a Mid Staffordshire, and indeed a Morecambe Bay, less likely are the changes going on with the CQC. Morecambe Bay I think illustrates this. When we were assessing Morecambe Bay for FT status we spotted that there was a pattern of worrying SUIs—serious untoward incidents—in particular in maternity. So we stopped our assessment and said to the CQC, "Can you go and have a look because we are not sure there is not a problem here," and eventually they came back and said, "No, it is fine." Well, it was not, and the new inspection regime that the CQC is putting in place, I hope, will make sure that does not happen again.

Q105 Valerie Vaz: That leads me lastly on to the next area. The Select Committee and Robert Francis in his seminal work on Mid Staffordshire both said that there should not be two of you—CQC and Monitor—but you think there should be. Could you explain why?

Dr Bennett: First, I should say that that is a decision, ultimately, for the Government. However, I do share the Government's view that merging the two organisations would not be the right thing to do. That is for two fundamental reasons. First of all, if you were starting from scratch and there was no CQC and no Monitor and you were asking, "How do you regulate this sector?" there is an argument, I absolutely accept, for saying you will draw a dividing line between the two organisations in a different place to where it is today and maybe even just have one organisation. You could make that argument; I would not. I would say that, while that would provide some benefits, there is a huge merit in separating the body that says whether or not care is good enough from the body whose job it is to sort it out. Similarly, I think there is huge merit in separating the body that looks at the quality of care from the body that has to worry about whether the finances of a trust are in good order. This is as I said before: whenever we have a trust in difficulty, the first thing that we care about is getting the quality fixed and then we will sort the finances out. So, even with a blank sheet of paper, I personally would keep them separate. However, we do not have a blank sheet of paper. We have two organisations, both of which have been going through—or, in the case of the CQC, still are going through—a lot of change, and I think the last thing you would need is to add to that the complexity and challenges of putting the two together. Indeed, you could argue that some of the challenges that the CQC has faced have been a consequence of the fact that it was three separate organisations put together and that it is a challenging thing to do. I would not do it for that reason.

Q106 Valerie Vaz: Yes, and I suppose you would say that, would you not? It is like turkeys waiting for Christmas: why would you want to do yourself out of a job? Clearly, if you look at your evidence it seems to be littered with, "We are chatting with," "We are developing our relationship," and "We are talking to." So you are working together anyway, aren't you?

Dr Bennett: We are most certainly working together. I hope I have put forward—

Q107 Valerie Vaz: There is no reason, is there, why it could not evolve into something different, perhaps something more cost-effective?

Dr Bennett: I hope I put forward a cogent argument as to why I do not think it is right rather than just a purely self-interested one.

On the issue of working together, that is very important and we do work extremely closely together, at all sorts of levels. I have a conversation with David Behan probably every week. People in Stephen's organisation are talking to their opposite numbers in the CQC daily and sometimes hourly where there are problems in particular at trusts. It is absolutely essential that we work closely together. I don't think it would be right to assume that you can never have a single organisation where you have two divisions that do not have problems working together. So just because we are two separate organisations does not mean to say that we have to work together badly. I think we work together well.

Q108 Valerie Vaz: That is right. I am not suggesting anything about the quality of your work. I am just suggesting about how you do it and you have memorandums of understanding.

Something else was thrown at you like a curved ball out of Francis, which the Government put forward, and that is the chief inspectors. That is something new that you are working with. How does that fit into what you do?

Dr Bennett: That is all part of what I very much welcome, which is this more hands-on, specialist, feet-on-the-ground inspection regime that the CQC is adopting. You mentioned Morecambe Bay and it illustrates this. When, after we authorised Morecambe Bay on the basis that the CQC felt the care was all right and then it became clear over 11 months later that it was not, we asked Central Manchester University Hospitals NHS Foundation Trust to send their maternity people—who are real experts—in on the ground to look at what was going on, they were the ones who found the underlying problems. To my mind, that absolutely illustrates why you need real experts on the ground. So this new inspection regime, which was developed initially by Bruce Keogh in his 14 reviews and now Mike is picking it up, is exactly the right way to go. I entirely welcome it.

Q109 Valerie Vaz: Can I ask you one more thing before we move on to the last point? We were only given this today when it was put before us. You have a list of all the updated staff. Given what Robert Francis said, are you not surprised that, or perhaps you can explain why, under "Patient & Clinical Engagement" there was not anything?

Dr Bennett: Yes. One of the things that I am very clear about is that, although we draw heavily on external experts for advice on clinical aspects of much of what we do, we need more people with clinical backgrounds inside Monitor. My starting point for that is to appoint a medical director to run the unit that you mention. I have had a problem in that I know who I want to appoint and have known for many months, but I have had a problem getting the terms and conditions of that appointment agreed. That is why that unit is not yet established.

Q110 Valerie Vaz: Okay. How big would the unit be?

Dr Bennett: One of the things we have said is that we want the incoming medical director to work with us to design it, so the exact size remains to be determined. What we will finish up doing is having a relatively small unit—let me say between 10 and 20 people—but drawing heavily on real experts out there in the NHS.

Q111 Valerie Vaz: What exactly would they do?

Dr Bennett: There are the two roles: there is clinical engagement and patient engagement. On clinical engagement, we need a number of in-house clinical experts like the medical director and then I want them to reach out to clinical experts across the NHS, including the royal colleges, for example, and there are two things that they need to do for us. One is to bring genuine specific technical knowledge, clinical knowledge, to our decision making, and we have touched on those sorts of issues several times in the course of this afternoon. The second thing I want them to do, which at the moment mostly I and one or two other colleagues are doing, is to reach out to the clinicians as important stakeholders for all the things that need to happen in the NHS. If you take an example of the work that is going on at Mid Staffordshire to work out how to find a long-term solution there, we have clinical people leading that work, but they and us together have reached out to the Academy of Medical Royal Colleges to help us work out what the clinical solution should be there, and we have had an enormous amount of help from Terence Stephenson and his people. I want to do this more often, more regularly, on a broader base, so that we can establish strong ties with the clinicians in the health sector.

Valerie Vaz: Thank you very much.

Q112 Chair: Can I pursue the point about the medical director because you have made it clear for some months that you want to have a medical director in your senior executive team. Where is the hold-up?

Dr Bennett: There are Government processes and rules around—

Q113 Chair: How many months is it since you first put this proposal, presumably to the Department?

Dr Bennett: It is probably about three'ish.

Q114 Chair: "Ish"?

Dr Bennett: Three or four.

Chair: It is a subject the Committee might wish to pursue. To have one of the major regulators in the field, with you as chair and chief executive, wanting a medical director and not having one appointed I would have thought is something that my colleagues may wish to pursue.

Q115 Rosie Cooper: I must admit that I have written down, "Medical director—knows who it would be. How long will you wait to get the terms agreed?" What is the problem? You cannot not have clinicians right at the heart of what you are doing. How many people are suffering because of that?

Dr Bennett: I hope they are not suffering. We are, of course, able to reach out and get people to help us, but it is not quite the same as having a few people and a senior person in charge of them in-house.

Chair: The case makes itself, frankly.

Q116 Rosie Cooper: It does, and can I also say that, as a chair who has done a board-to-board with Monitor, one of the things you would be telling me is, "Hope is not a strategy," so hoping is not going to get this sorted out.

Dr Bennett: Yes, and indeed I am doing more than hoping.

Chair: By raising it here possibly.

Q117 Grahame M. Morris: Can I—

Rosie Cooper: Are you following on that point?

Grahame M. Morris: It is kind of related to that. It is separate but linked to it, so if you want to finish that, I will follow.

Rosie Cooper: I was going to go on to regulatory processes in non-acute trusts stuff.

Grahame M. Morris: It is kind of related to that, too. In terms of the budget and the emphasis—you mentioned the need to have a medical director, and, for those trusts that are put in special measures, we have read your evidence of the teams that go in—there seems to be a very large percentage of Monitor's budget, and this is the annual accountability hearing,

that goes into management consultants. I think it is of the order of 40%. How do you account for that, given that the general rhetoric from Government is to rely less on external management consultants and develop in-house talent that is more cost-effective and expertise that is relevant from within service?

Dr Bennett: Yes. Sometimes I think it is a mistake that they get labelled as management consultants as often they are accountancy firms and not doing traditional management consultancy. But they are external to Monitor and there are two reasons we use them. One is because we need expertise which it would make no sense at all to have permanently in-house. That would cost us more because we do not need that expertise very often, and, if we had them permanently on our books, even though they would cost less each per day, the total costs over the course of a year, or several years, would be much more. So it is partly about dealing with that.

The second reason—and particularly over the last few years—is that, as we have been taking on our new role, inevitably, it is taking us a while to build our new organisation and there is a limit to how fast we have been able to recruit people. For example, we have increased by 62% the number of people in Monitor over the last year, and I can tell you that that has been one enormous recruitment effort and has been very challenging. But we could not wait until we had completed the recruitment before we took on these responsibilities, because Parliament very kindly gave them to us straight away. We have been using consultants in part to make up for that gap. So, although we have increased the size of Monitor—the number of people working in Monitor—by 62% over the 12 months since I was last here, our total budget has gone up by something less than 10%. The reason for that is that, of course, once you recruit people and have them in-house, they are much cheaper than having to outsource.

Stephen Hay: One thing that illustrates David's first point is that my team have to run the annual planning review where we look at every plan of every one of the 147 foundation trusts. That has to be done in about a two-month period in May, June and July and there is no way that we have the staff to do that and then do the follow-on work. There is a massive spike in work that has to be done in those two or three months such that we have to buy it in because there would not be anything for them to do for the other 10 months of the year.

Q118 Grahame M. Morris: I know time is limited and we have had votes and so on, but particularly in relation to the South London Healthcare NHS Trust, and I do not know who footed the bill, it cost £5 million, did it not, for the review and there were criticisms about cost, the accuracy of the projections and about the level of expertise of the management consultants that were engaged to do that?

Dr Bennett: South London was a DH/Trust Development Authority issue because they were not FTs, but we have used consultants—by "consultants" I mean external bodies, contractors—as the special administrators in Mid Staffordshire, and, yes, it does cost a lot of money. Partly, that is because you are trying to do things as fast as you can, but it is also very complex. One of the things they spent enormous amounts of resources on, and therefore money, was trying to deal with local stakeholders who are very interested in, and concerned about, what is going. They are doing their best to keep them informed and it takes time and therefore costs money.

Chair: Do you want to pursue that?

Q119 Grahame M. Morris: There are issues around conflict of interest—that is the concern. Given the relatively small number of specialist accountancy firms that have this level of expertise, and that many of the board members and yourselves were formerly associated with these companies, is that a reasonable criticism?

Dr Bennett: We are trying very hard to deal with those conflicts. I have to say that, if you got in—for example, I formerly worked for McKinsey—my former colleagues from McKinsey here now, I think they would tell you I was an extremely difficult client and not a pushover. But just to make sure that there is no conflict of interest, I excuse myself from all decisions about using McKinsey.

Q120 Grahame M. Morris: But McKinsey have done very well and they made £1.9 million from Monitor last year, did they not?

Dr Bennett: They charged £1.9 million, yes. They were not the only consultants we used. McKinsey do have particular expertise in health. We are not the only ones who use them. There are some areas where they are the best, so that is who we use. It would be wrong to choose a second-rate consultant just because one of us had worked for the best one in the past.

Q121 Grahame M. Morris: I think the highest figure was for PricewaterhouseCoopers and it was £2.7 million, with £900,000 to KPMG and £800,000 to Deloitte. They are considerable sums.

Dr Bennett: They are considerable sums, but at least you will notice that they are not all in one place. We try and select the best provider for every individual problem and run competitive processes and use the Government consulting frameworks and so on whenever we do that.

Q122 Rosie Cooper: If I may, I would like to ask you about non-acute trusts and whether you are confident that the regulatory processes are sufficiently well designed to assess them because they are completely different from the acute sector. I am seeing a couple of those community trusts up front, and my guess is that, whatever it is you are measuring, you are on planet Zog.

Dr Bennett: We certainly need to change—and we have completely recognised this—or to adapt the way we look at trusts that are not the sort of traditional acute or mental health trusts that we are used to, and we have done that. One of the problems in almost anywhere except for acute is that the availability of information about these trusts is very weak, so it is very difficult to measure it. But we are trying to do our best in the circumstances. We chose not to—and you may disagree with this—say, "This is a sector with poor information that is not well understood. Therefore, we will not authorise anybody as a foundation trust." We have tried to be pragmatic and do the best we can, but we are also slowly getting them to produce more reliable data, so that, eventually, I hope every single bit of the provider landscape will be subject to the same degree of scrutiny as acute trusts are today.

Q123 Rosie Cooper: Can I ask just exactly what you measure and how you assess? Liverpool Community Health NHS Trust, for example, is showing there are no big concerns

from the TDA, and yet I believe that, in a short time, there will be concerns shown to be applicable to that organisation. It is sitting there and everyone finds it hard to assess. How do you know you are not going to allow community trusts through, for example—picking on them—which you would not let through if they were an acute trust and you had a better understanding?

Dr Bennett: There are two bits to that in a way. There is quality, and there is everything else. On the quality front, this is where Mike Richards and his colleagues have a big challenge, because they start with a regime which is better at understanding what is going on in acute trusts and elsewhere and so they are working very fast and hard to try and develop similar inspection regimes to the one they have for acute trusts in community care, mental health and ambulance trusts.

Q124 Chair: You might start by thinking about the name—chief inspector of hospitals.

Dr Bennett: Yes, it is interesting, isn't it, though it was not my choice? On the quality front, which I would always say is the most important—and I am sorry to pass the buck—that is the CQC, and I know Mike is very aware of the need to do that. On all the other dimensions that we look at, the governance, the financial performance and so on of a trust, the information is probably a little better, but it is still not good enough. Part of what we have to do is to force some of these organisations to get better at describing what they are doing so that we can understand it better.

Q125 Rosie Cooper: Their staff would probably appreciate that as well. It is a very difficult thing and I would like to come back to it on another occasion. I want to throw one final thing in, which I hope the Committee will discuss in the future. Last week, I met with a senior clinical psychologist who was—or she and her colleagues were—really upset in that there were no beds to admit a teenager who had attempted suicide three times in one week. There was nothing available between here and Leicester. How does that fit the idea that we are providing mental health—a different kind of trust—services that are needed out there? Mental health and community trusts, I think, are not measured as well as they might be by your good selves.

Dr Bennett: Or anybody else. I completely agree. I do not want to overstate it, but there is almost an obsession with acute trusts because it is the bit that people look at, where the light is shining. But we have to shine the light everywhere, so I could not agree more. We have to get much better information about what is going on and particularly on the quality front, as I think someone mentioned earlier on: is there a problem with the funding of, say, mental health being squeezed? But it is less clear what the consequences of that are because we do not have the equivalent of, say, four-hour waiting targets in A and E. We do not have the equivalents. It is absolutely right that we have to find better ways of measuring it.

Q126 Rosie Cooper: Can I put to you a question that I put to Jo Williams when she was here as chair of the CQC? They measure trusts; they measure this and that; but how do they measure, for example, care organisations going into homes? She said, "No, we could not do that. We could not go into the home of a person receiving the care to see." How do you spot what is happening and being delivered if there is nobody else there except the carer coming in? She could not assess that. Therefore, you are trying to assess a community trust that is going into homes, but you are not actually there. You do surveys of staff, and, for example, I

hear from last year's survey of Liverpool Community Health NHS Trust about bullying, the executives and real problems. What about flipping it over in this case and asking the recipients? Otherwise, how else would you ever find out what is really going on?

Dr Bennett: You are right to reflect on your conversation with Jo Williams because, again, this is fundamentally a CQC issue. What we are seeing, for whatever reason, is a complete change in paradigm at the CQC. The way they are thinking about how you assess the quality of care that provider organisations are delivering is fundamentally changing. It is all about the real experts, people with their feet on the ground. I think David Prior, Jo's successor, has said they would even contemplate things like hidden cameras. It is for them to work out the best way to do it, but you have to find a way of assessing the real experience of patients in these places.

Q127 Rosie Cooper: Absolutely, but I am saying to you, and perhaps you could write to me, that I want to try and understand, when you look at a community trust or a mental health trust, what you are measuring.

Dr Bennett: I am very happy to write to you on this, but one small thing I would say here is that when it comes to measuring quality, it is the CQC that is doing that.

Q128 Rosie Cooper: So what are you measuring? You are going to be part of the authorisation. Your name is going on the ticket. What are you measuring there? Are you saying, "Oh, I agree with them"?

Dr Bennett: On the quality front, we take the lead from the CQC.

Q129 Rosie Cooper: So what is different?

Dr Bennett: The other things we will look at, essentially, are the things we look at in all organisations—their governance, processes, the quality of the leadership of the people and the strength of their financial performance and position, "Do they have good plans and strategies?" It is all the same sorts of things that we look at in any other organisation.

Q130 Rosie Cooper: You will be busy in Liverpool, then.

Dr Bennett: Would you like us to write to you and set that out?

Rosie Cooper: Please.

Dr Bennett: Then we will.

Q131 Chair: Can I end with a slightly mischievous question? How much of your working day do you spend on the FT pipeline these days?

Dr Bennett: I thought for a moment you were going to ask me how much of the working day do I spend on Monitor. It depends how long your working day is. On the FT pipeline, actually—

Q132 Chair: The purpose of the question, plainly, is to wonder where that is in your order of priorities.

Dr Bennett: Yes. Goodness, where shall I start? Miranda Carter, Stephen and Adrian's opposite number, who looks after the assessment of trusts, has developed a very strong and, I think, important relationship with the TDA. One of the things we have explicitly changed over the last 12 to 18 months is that I want us to do whatever we can, without compromising our independence, to help the TDA get trusts through the pipeline. The reason that is incredibly important is that all we are doing when we assess a trust is saying, "Is this an organisation providing high-quality care on a sustainable basis?" Every single trust in the country, as far as I am concerned, ought to be able to answer yes, and it is not good that 97 of them at the moment cannot. So anything we can do to help David Flory and his people is important. David has acknowledged—I think he is saying—that 14 at the moment probably cannot make it in their current form. I think there will be challenges beyond 14, and of course there are the financial squeeze increases which will just make it even more difficult, but we still have to get them up to that standard. We are doing a variety of things to try and help on that front.

The other issue here goes back to the CQC. The Monitor board made a decision a few months ago. We said that, because the CQC has said its old paradigm of inspecting hospitals or provider organisations was not good enough, we are not going to authorise any more trusts until they can assure us that they have fixed that problem. On the non-acute trusts in particular, it has taken a while, because they have to work out how to do it. That is holding up the pipeline, but I think it is the right thing to do. When Mike is in there doing his inspections, I suspect he will find some problems in some of them and they might take a bit longer before they are ready to come to us, but, if there are problems, they have to be identified and dealt with. Does that answer your question?

Q133 Chair: Yes, it does, in a way that reassures that there is a commitment to quality across the piece. We started out with a lot of rhetoric about how this was all going to be complete by 2015. It plainly is not.

Dr Bennett: Yes. I think it was even April 2014, wasn't it, originally?

Chair: Forgive me, yes.

Dr Bennett: I always thought it was a mistake to set an absolutely hard deadline. I could see the merits of putting pressure on the system, because if you think that what this is about is getting trusts up to a standard—forget about the FT label or anything—we should do it as fast as possible. But the danger in my mind with setting a very short deadline was that corners would be attempted to be cut. Hopefully, we would have spotted it, but you would not want them cut in the first place. More flexibility around the time scale is right. I think David Flory and his people are very committed to getting these trusts up to the requisite standard as fast as they can, but I do not think there is any pretending but that it is going to be a very big challenge in some of these organisations.

Chair: Okay. We have taken up enough of your and our time. Thank you very much indeed for coming. We shall reflect on what you have said, as ever.