HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Regulating NHS foundation trusts, HC 1119

Monday 31 March 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon, Jackie Doyle-Price, Mr Stewart Jackson, Fiona Mactaggart, Austin Mitchell, Ian Swales, Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, National Audit Office, Laura Brackwell, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Dr David Bennett, Chief Executive, Monitor, and Una O'Brien, Permanent Secretary, Department of Health, gave evidence.

Q1 Chair: Welcome. I will start with you, David. The Report is quite kind to you, and when I read it, if I am completely honest, I didn't feel that same view that the report came to. There are all sorts of reasons and I will start with why. The trusts and organisations with foundation trust status should be performing better than those that are still seeking it. That is a generalisation, but it is where we ought to be, and the policy is that all of them should have foundation trust status within a time frame that you will not now meet. In fact, one in six trusts is now in breach of its regulatory conditions. That is a pretty poor record for a vital service among what should be better performing trusts. Why? You are responsible for regulating this lot.

Dr Bennett: Why is one in six in breach? Well, I would say two things. First, it is about where we set the bar that says, "If you fall below this you are in breach." We try to set it at a point at which we get the balance right between largely leaving well-performing trusts alone to do what they need to do—it is fundamental to the FT policy that they are reasonably autonomous and independent bodies—and intervening soon enough before things get seriously bad. Where we choose to put that bar obviously determines how many will be in breach, so I like to think that at least a reasonable proportion of those in breach are not in serious difficulty, but that we are stepping in early enough to try to get potentially serious problems sorted out before they become serious.

Q2 Chair: But let me say that, actually, the bar is there for them to get the status as well so, bar the one or two that got it wrong and whether they told you the truth, they obtained it and arrived with you meeting those conditions. Yet here we are with one in six, assuming that the data they gave you were correct—we will come back to that. It is not that you have suddenly raised the bar; that was the bar they had to meet to get their FT status.

Dr Bennett: That was the second part of my answer. I think there are probably four reasons why, having passed the bar, they then fall below it. One is that the leadership of these organisations changes over time. We cannot lock the leaders in—that would not be at all possible. We definitely have situations where trusts get into difficulty because the chief executive, maybe the chair and other key members of the leadership have changed, and, frankly, the new leadership team is not as strong as the one we authorised. That is one reason.

The second reason is that circumstances change. A trust that may have been performing perfectly well in a more benign environment—of course, for some of our older authorisations, that was certainly true—may not be performing so well as their circumstances get much more challenging, which they are. A closely related issue is that the bar has gone up. That is particularly true in relation to quality. So the quality regime, especially in a post-Francis environment, is tougher.

Q3 Chair: How many of those 26 have gone in post-Francis? Have 25 gone in post-Francis? I do not think many of them—because Francis is only just beginning to—

Una O'Brien: But the issues have been building up since 2010.

Chair: It doesn't matter. The bar is raised. In the Report, there is a chart about all of them that are still out, isn't there?

Dr Bennett: Yes.

Chair: One of the worrying things is that they are out for so long. Perhaps someone can tell me what table it is in.

Laura Brackwell: Figure 11.

Q4 Chair: There is another shocking fact. If you had a school that did not turn round from March—okay, that is Mid Staffs. If you take Heatherwood and Wexham Park, wherever that is—

Fiona Mactaggart: It's in my constituency.

Chair: Okay; sorry. It was in breach in July 2009. We are now almost five years on. If Ofsted did that, they would have been abolished a long time ago by Mr Gove.

Dr Bennett: I will come to the issue of time, but, to complete the answer, why did they get authorised? We thought they were above the bar—

Q5 Chair: You said the bar went up. I don't believe that the bar going up covers this list.

Dr Bennett: It does not cover the whole of the list.

Chair: It covers hardly any of it. Mid Staffs might hit the last half dozen, if I am being generous.

Una O'Brien: The first Report was in March 2010.

Q6 Chair: When did you change the standard?

Dr Bennett: We introduced a quality governance assessment as a result of the problems that were revealed at Mid Staffs.

Chair: When?

Dr Bennett: We started to apply that in 2012, so that accounts for some of these.

Mr Bacon: When in 2012?

Dr Bennett: Towards the end of 2012.

Q7 Mr Bacon: That would explain why the chart on page 40—figure 16—shows a marked upward tick from the middle of 2013 onwards, would it?

Dr Bennett: We introduced our quality governance criteria, but the CQC started introducing a more robust inspection regime as well.

Q8 Chair: The CQC have only just started doing that. That was the first one to be done. Anyway, I interrupted you. You had four reasons. One was that the staff might change, and two was the quality threshold. Go on.

Dr Bennett: First of all, the leadership changes. Secondly, the world gets more difficult for these trusts; they are more challenged than they were at the point of authorisation. Thirdly, we have raised the bar in some respects, particularly around quality; and, fourthly, we do not always get it right.

Fiona Mactaggart: Exactly.

Dr Bennett: This has to be a risk-based assessment. If we had said we will only authorise trusts that we are 100% certain meet a requisite standard, then we would be authorising almost no trusts.

Q9 Chair: Let me put to you what I think is the reason: you have grown too fast. Your budget has tripled in the last couple of years.

Dr Bennett: Yes, although—

Chair: If any organisation grows at that level, its ability to absorb that growth is affected. Your budget has gone to £48 million from £18 million, or something like that.

Dr Bennett: It has grown by a factor of three over a four-year period.

Q10 Chair: That's a massive growth.

Dr Bennett: It is, although you're looking at money rather than number of people, but the number of people has grown significantly as well. Most of that growth, though, is in our new responsibilities—preparing for and then taking them on.

Q11 Chair: Yes, one of the questions is whether you've got mission creep and too many responsibilities. That is something we saw with the CQC. You are just growing too much, you are spreading your functions, you have got mission creep and therefore your ability to keep a hold of these trusts and make sure, through the regulatory controls, that they do not run into trouble is weakened. That's the sort of conclusion I came to from this Report.

Una O'Brien: May I comment on that? I can understand why, when looking at the numbers, you would ask the question in that way, but I think we are looking at a very different situation from the one we dealt with with the CQC. The way I look at it is this, and it's interesting to have this discussion 10 years on from the creation of Monitor. In fact, it has grown step by step as more trusts have been authorised to become foundation trusts, so its ability to undertake this particular role—the authorisation and then the risk and financial assessment of foundation trusts—I think is solidified because of the gradual build-up of experience over a number of years. David can obviously comment on how the resources are organised internally in Monitor, and I know it could always do with more resources rather than less, but if you step back and ask yourself, "How has that function matured over that time?", I think it has happened really quite slowly, because the pace at which trusts were authorised to become FTs was quite steady. Indeed, in recent years, it has fallen off quite significantly.

Let me turn to the new responsibilities. Obviously, this was a crucial element of the discussion about the much-debated 2012 Act. New functions were given to Monitor to make it also the sector regulator for overseeing mergers and for ensuring that procurement is undertaken in a fair and proper way; and in order for Monitor to take on those additional responsibilities, it has obviously had to increase its staff and capacity, but that is quite a different function. Where we are poised now is really on the back of the constructive challenge we have had through the NAO's Report—to make sure that we can maintain the standard of staff and capability in Monitor as it now moves into this new role.

If I may, I will make this final point. We recognised that the expansion of Monitor was a challenge. We keep trying to learn from the mistakes we have made in the past in

rushing too much into a new organisation, so we staged the introduction—this was a debate that David and I had, with others—over a number of months. All the new powers came into effect first in 2013 and then in 2014; we did not bring them all in simultaneously.

We are in an interesting place right now, because it's just a few weeks before the final set of new powers is taken on. The Report has some challenging questions about being able to sustain the quality of performance in this much broader sector regulator role while still looking after the FTs.

Q12 Chair: Una, what you've explained to me is how you got to where you got to. As I look at the facts, it just strikes me that one in six in breach is too much. These are supposed to be the better hospitals. The ones that you are trying to get to foundation trust status are not ready for it yet. You are supposed to have the better managed, more sustainable trusts under that. You say it has come to an end. We read in the Report that actually Monitor is now going to start working with commissioners again; that is page 8, paragraph 18. On top of that, it has to work with the NHS Trust Development Authority. It is working with NHS England, setting tariffs. It is trying to do work on competition. What has happened, I think, is that its core purpose, which was the regulation of trusts that have FT status to ensure sustainability—that is another bit of it—is getting lost in a massive growth of functions where there is duplication with other bodies and just mission creep. That's the only way I can describe it—mission creep. I just think not that we are moving into dangerous territory, but that we are beginning to see difficulty in Monitor's sustaining the record we were hoping for.

Dr Bennett: I think the predominant explanation for the steady increase in the percentage of trusts that are in breach of their licence—there has been a steady increase; the chart shows it—is a combination of facts. A lot of the trusts were authorised a number of years ago, so we are seeing the consequences of the turnover in leadership of those trusts. Plus, it is a very much more challenging environment for them.

Chair: Turnover in leadership is not always bad. You are not really answering the question.

Q13 Fiona Mactaggart: Una, I wanted to come in on what you were saying about the new regulation of mergers and competition and so on. It strikes me that there is a substantial flaw in the process. I understand why it might be appropriate to have something other than the Competition Commission in view of what happened in Bournemouth and Poole, which seems to me to be completely bonkers by any description, but the Chair has already referred to the fact that Heatherwood and Wexham Park hospital has been inside the process for 53 months. The answer to that is a merger, yet there is no mechanism driving towards the merger.

There is a mechanism which is supposed to be making sure that the merger is not anti-competitive, but it seems to me that there is no equivalent—the Chair made the comparison with the Department for Education—which pushes people into places. Who is pushing Heatherwood and Wexham Park and Frimley Park into this marriage, which seems utterly essential if the budget is going to be squared?

Una O'Brien: I think David knows more about the detail of particular local circumstances, but I would say on the general point about the breadth and mission creep of the organisation that there was a debate going back to 2010 about how the new functions should be distributed. An argument was put at the time as to whether there should be an entirely separate body that would carry these two responsibilities, to put it in its most basic form: mergers and overseeing the competition rules on procurement. But I think the decision was reached that that would mean an additional body on the field. We did not think that would really help anybody, and the judgment was reached at the time when the policy was developed that the sort of organisation that Monitor had proved itself to be with its approach was best suited to taking forward these new roles.

That was the choice we faced, and that is why those functions are now grouped together within Monitor. It was thought through, the choice was made, and that is where we are. What we have to do now is make it work.

Dr Bennett: Can I just respond on Heatherwood and Wexham Park specifically? Who is driving that merger? We are. We have reached a conclusion that we are not going to be able to return Heatherwood and Wexham Park to a position where it is clinically and financially sustainable as a stand-alone organisation. The fact that Frimley Park are willing to take it under their wing is very attractive from our point of view, so we are strongly behind this process.

Q14 Fiona Mactaggart: So why is it taking so long?

Dr Bennett: Heatherwood and Wexham Park was the trust that initially got into a mixture of some limited quality and financial problems. They produced—

Q15 Fiona Mactaggart: They were always in financial problems; they just managed to pull the wool over your eyes.

Dr Bennett: You have said this to me before, and I think I have confessed that maybe they did. For sure, we put in new leadership on an interim basis. We got them to produce a recovery plan, but almost as soon as they had a recovery plan in place, their trading conditions got worse and the plan was obviously not going to work. That happened a couple of times and that was the point at which we said, "We are really struggling here to get a leadership team in place that can turn this trust around." That was when we concluded that the only viable solution was to bring in a much stronger, established, whole leadership team. The idea of just replacing a few key people—be they the chair and the chief executive and one or two others—was not going to turn it around. That trust needed to be embraced by a whole high-performing leadership team. We were very fortunate in having one nearby.

That is why it took us so long: it looked as though we were going to be able to get a turnaround on a stand-alone basis, but eventually it became clear that we could not. But we are absolutely behind the merger with Frimley Park and, although we are not the decision maker here, as we have a competition role, we have been working with Frimley Park to

ensure that the proposition they put forward is as far as possible not going to fall foul of the competition rules. I am very hopeful that that is what the OFT will decide in due course.

Q16 Fiona Mactaggart: Are the competition laws making it more difficult to achieve?

Dr Bennett: I don't think they are going to have a significant impact in this case.

Q17 Jackie Doyle-Price: Paragraph 3.19 of the Report states that trusts will recover from a governance breach within 12 months on average, but my local hospital trust is Basildon and Thurrock, and figure 11 tells us that it has been in breach on governance alone for 49 months—why?

Dr Bennett: Yes. It is unfortunate that some of our most difficult trusts—as you will see, they are all at the top of the list—are represented by members of the Committee, but it is a perfectly fair question.

Mr Bacon: It may not be an accident.

Dr Bennett: It may not be an accident—I hope it is—but it is a fair question. Basildon was a very different situation from, say, Heatherwood and Wexham Park: it was all about quality, as you know. I inherited Basildon, but, looking at the whole period in retrospect, we should have moved much more quickly to replace the leadership there. I think that is a trust that, with the right leadership, is now turning itself around, but we took too long to get the right leadership in there and there is absolutely a lesson in that for us.

Q18 Jackie Doyle-Price: I am glad that you acknowledge that, because effectively we have lost four years. You are right that we have got a new leadership team that has got a grip, but the longer the juggernaut is out of control, the more difficult it is to turn it around. Do you think you had the tools for the job?

Dr Bennett: I would say that one thing that has helped a lot is that the new CQC inspection regime is giving us much more insight into what is really going on in some of these trusts, so I think that is also a contributor to knowing what needs to be done to sort Basildon out. Basildon, as you know, is a trust which has not had really serious problems but has bounced in and out of issues for far too long: it has got better and then got worse again. What I think the new CQC inspection regime has done is really tell us what was going on underneath that caused these problems.

That has been a big improvement, and actually this is relevant to Heatherwood and Wexham Park as well. The new inspection regime has explained some of the cultural problems at Heatherwood and Wexham Park which underpin some of its difficulties. We have new tools as a result of the Health and Social Care Act that we got from April last year, which frankly make it easier for us to deal with the people issues that took longer than I would have liked at Basildon.

Q19 Jackie Doyle-Price: The reason I put it that way is that I am trying to investigate where we have a culture of regulatory underlap. Obviously, you are responsible for governance and finance and we have the care regulator in the CQC. Obviously, the commissioners have a role too. What strikes me about Basildon is that everyone had a responsibility, but no one was pulling all the parts together. You had a failure only on governance—the financial management was not really fit for criticism—but you cannot separate the governance issues from the care outcomes. As you say, the CQC regime has been strengthened and it has handled some serious issues. You said earlier that, actually, it was not that bad at Basildon, but, in terms of care outcomes, it really was. When I was having discussions with you and the CQC, it was like dealing with two silos. Are we any closer to tackling those underlaps under the new regime?

Dr Bennett: I am sorry if it came across that we work in two silos. I think, certainly since I have been at Monitor, we have worked closely with the CQC. But to be honest, I do not think we had enough insight into what the quality problems were at Basildon until the new regime at the CQC. So I do not think it was the case that there was a gap between us and we were unable to close it; it was that the absence of this sort of very intense inspection regime that the CQC is now putting in place meant that neither we nor the leadership of the trust had enough insight into what the real problems were that needed to be fixed.

Q20 Jackie Doyle-Price: That goes to the heart of what the issues were with governance, because if the leadership of the trust did not have enough understanding about what was going wrong, again, that shows that that was not fit leadership. Is there an issue that the relationship between Monitor and the leadership of that hospital was too cosy, because, 49 months, and it is still in breach?

Dr Bennett: No. We did, as I said, fail to remove the individuals quickly enough. Part of the problem was, when they first went in breach, which was before my time, we had an opportunity to replace some of the key individuals, and we did not. Operating in the legal framework we had then made it difficult to deal with it subsequently, although we did eventually.

Under the new legislation—this was something that we discussed at length with the Department—we now have a specific power that enables us to solve the problem that we had at Basildon; I will not go into the technical detail. We can get people out much more quickly and effectively.

Q21 Jackie Doyle-Price: When I was challenging you on this, the message I was getting was, "Yes, it's bad, but it's not as bad as it was." So the direction of travel was positive, but it is still way below what it should be. I really want to be satisfied that we are going to have much quicker and more prompt regulatory activism to improve performance when there is clearly an endemic problem.

Dr Bennett: I agree. As I said, the new and tougher CQC regime, and a more insightful CQC regime, will be helpful. The new legislative powers that we have will be helpful.

One of the lessons that I have learned over the four years now I have been at Monitor, increasingly, is that we need to be tougher with these organisations about giving them fixed time limits to sort themselves out, and being more prepared to intervene heavily if they do not sort themselves out within those time scales.

Chair: If we go to this list, if I take 14 over 18 months. Endlessly at this Committee, we get, "Ah, we have these new powers. Ah, there is this new legislation." I am always suspicious of an answer of that nature. Are they going to come off this list, David?

Dr Bennett: So, Mid Staffs—

Chair: Don't do them one by one. I want a general thing. If you say that you now have better powers and a better inspection from CQC, it is unacceptable that it is taking so long to turn around so many hospitals, which, I repeat, are the ones that ought to be the best.

Jackie Doyle-Price: In the case of Basildon, the action was taken only because all the local MPs basically marched up to the door and demanded it.

Q22 Chair: You have a list. Sherwood Forest. By when? What sort of time frame are you working towards?

Dr Bennett: I cannot give you something general. As you know, Mid Staffs has a special administration in place. I am not going to go through all of them, but just to illustrate the point, at Heatherwood and Wexham Park, we are waiting for the merger to happen. I hope that that will be very soon. I think Basildon is now making real progress.

Q23 Jackie Doyle-Price: Yes, but I suggest that it is no thanks to you. The reality is that Basildon got new leadership before it was put into special measures, when everything came to the political crunch point. That action was taken only because the local Members of Parliament had to say, "We have lost confidence in that leadership team", having been in discussions with you and CQC for two years.

Dr Bennett: You did tell us that you had lost confidence in the leadership team. We had problems with the leadership team as well. It was our ability to act that was the reason why we had not done anything, not that we did not believe you or that we were not aware of the problems until you pointed them out to us.

Q24 Jackie Doyle-Price: Are you satisfied that you have the power to replace individuals?

Dr Bennett: The new power makes a big difference. Milton Keynes is another example of a trust that had limited issues. It had quality problems in maternity, which were fixed, but then it got into financial difficulty. It produced a turnaround plan, it looked as if it

was on track to come out of the financial breach and then the floor fell away underneath it. It had a large increase in non-elective activity, which meant that it could not do elective activity and had a serious consequence on its margins. The whole health economy was slipping into difficulty. Nearby, Bedford Trust, which is not a foundation trust, was getting into even more serious difficulties. What we are doing there is a joint initiative with the TDA and NHS England to work out the right answer for the health economy and what to do with Milton Keynes and Bedford as a consequence.

Q25 Chair: And does the taxpayer really need three separate bodies to work on this one problem?

Dr Bennett: We have only one team working on it. It is just that we are collaborating—

Q26 Chair: You have three bodies: TDA, NHS England—

Dr Bennett: TDA, NHS England and Monitor.

Chair: We have a fragmented health service, and now we have a fragmented regulatory regime. It is no wonder that things are falling through the middle, such as Jackie's hospital, Fiona's hospital and my hospital. I could go on.

Q27 Mr Bacon: It is not three bodies; it is four. It is the three you said—NHS England, TDA and Monitor—and CQC. Una O'Brien, I must say I was pleased to hear you say that you came to the conclusion that you won't go and set up another body, because if you did there would be a Report in a few years' time with one of those NAO diagrams with loads of organisations. At least you have one fewer. But you still have issues about talking to the CQC.

I have to say, Dr Bennett, my impression of all this is coloured by two things. First, this Committee has looked at a lot of regulators over the years—Ofwat, the Charity Commission, the Office of Fair Trading. They either have legal powers but do not use them and are wet blankets; do not have the right legal powers so are not able to do anything; or, as in the case of the Occupational Pensions Regulatory Authority, have no objectives. You have been in front of this Committee a number of times and you are a lot more convincing—I don't want to use the word "plausible" because it's tendentious—than many previous witnesses that we have had from regulators. But that doesn't mean you are right. It might mean that you are good at pulling the wool over our eyes and that the experience on the ground is different. If I were to caricature it, it might be—I'm not saying it is—that there are lots of very highly paid people in Monitor who used to work for big consulting firms such as McKinsey, your own ex-firm, wandering around with clipboards, and, although they are brilliant people, they have relatively little understanding of what is really going on on the ground in the health service, as evidenced by paragraph 1.18 on page 18, which says that

there are "concerns that staff did not have sufficient operational experience or understanding of clinical issues".

At the end of the day, if you are going to have a healthy organisation, it must be well governed, have good finance and good people, who have a good understanding of the clinical issues—I am talking about the hospital, the trust or whatever it is that you are regulating. There is a concern that you have these different bodies that need to talk to each other, rather than regulating as part of one larger body.

The second thing that always ticks away in the back of my mind is that in the February 2002 meeting on setting up the national programme for IT in the health service—I am referring to the meeting in Downing street—the key player at that meeting to get this process pushed forward at top speed, apart from Simon Stevens, who is going to head up NHS England, was you, Dr Bennett, was it not?

Dr Bennett: No.

Q28 Mr Bacon: Was it not? Were you not there?

Dr Bennett: I started working for Downing street in June 2005.

Q29 Mr Bacon: Were you not at the February 2002 meeting?

Dr Bennett: No.

Q30 Mr Bacon: That's good information, and I shall check any sources that say contrary to that. As I say, you are generally much more convincing than many of the other witnesses we have had. However, there are still serious problems, and if it is an issue of governance rather than finance—that is to say, an issue that does not require the same kinds of intervention and ought to be solved much more quickly—that suggests that there is still a disjunction, or what Jackie Doyle-Price called a regulatory underlap. If you look at—

Chair: Let him answer.

Q31 Mr Bacon: I am sorry. Answer that, please.

Dr Bennett: Which one would you like me to answer?

Q32 Mr Bacon: The central point, I suppose, is whether you have enough of a grip on what you are supposed to be doing and whether you have the right staff with the right skills.

Dr Bennett: I can't answer the first question without running the risk of sounding plausible, but being wrong.

Mr Bacon: I know; it was an impossible question. I'm sorry.

Dr Bennett: Indeed. Do we have the right staff? No. We do not have enough people with both a clinical background and an NHS background, but we are working hard on that. It was essentially none when I arrived, but it is still not enough and we need to do more on that. One of the challenges—

Mr Bacon: Did you say it was none when you arrived?

Dr Bennett: It was none, yes.

Q33Chair: How many?

Dr Bennett: I beg your pardon—there were two people with NHS experience.

Chair: Out of your 450 staff?

Dr Bennett: There were—

Q34 Chair: How many now?

Dr Bennett: There are now 21 with NHS experience and—

Q35 Chair: Out of 450?

Dr Bennett: Well, we are not at 450 yet.

Mr Bacon: There are 337 so far.

Dr Bennett: Yes, but it is still a small proportion.

Q36 Mr Bacon: So the four staff who do clinical and patient engagement in the pie chart on page 17 are by no means all the people with clinical backgrounds?

Dr Bennett: There are 21 with NHS operational backgrounds, seven with clinical backgrounds. We need to grow this rapidly, but the problem we have on both fronts is that these people are paid very well elsewhere and we struggle to pay enough to attract people. For example, if we want to bring senior people from the NHS, we actually pay less than some of the senior people in the NHS.

Q37 Mr Bacon: So you are not competing with the private sector, and that was going to be my next question. If you take the pie chart—admittedly, this will include other things—£15.4 million is spent on central services divided by 78 staff. If you divide one by the other, you get £197,000, but of course, that will include computers and buildings, but presumably if

you take a tranche such as the pricing staff, of whom there are 44, £6.9 million divided by 44 gives £156,000. How much of each of those segments with the prices attached—the pounds million attached—are for things other than staff, and how much is your total salary bill?

Dr Bennett: So, in 2013-14, the total budget—I think the chart takes in the number of £48 million, which was our budget; we are actually going to spend slightly less than that at £46 million. I think £48 million is the number that this is based on—yes, it is based on £48 million, of which the figure of around £9 million was consulting.

Q38 Mr Bacon: It was £9 million of the £48 million?

Dr Bennett: External advice—I call it consulting.

Q39 Mr Bacon: Is that £9 million of the £48 million spread between those different pieces of the pie chart?

Dr Bennett: Indeed it is, yes.

Q40 Mr Bacon: What is your average salary?

Dr Bennett: I don't know what our average is. I am sure it—

Chair: Nine million pounds out of £46 million is quite high.

Q41 Mr Bacon: The reason I asked is because I remember that Partnerships for Schools, which had 111 staff, had an average salary of £85,000. Perhaps you can send us a note with a bit of a breakdown. It would be helpful to know in each of these segments what the top salary and the bottom salary is, where the median is and what the average is. I would like to get some sense of how much people are being paid. Our information, which could be inadequate or incomplete, is that Monitor, in attracting people, does not find pay a problem, but if it is because the NHS is paying even more, that says quite a lot about the NHS, frankly. So if you could send us more information on that, it would be very helpful.

Dr Bennett: It is particularly in senior roles where we struggle. There are two issues. One is pay. We have 29 people paid over £100,000 and their average is £126,000, but that is just of the senior group. That £126,000 compares with the £164,000 that the average trust chief executive is paid—the average—so you can see that that is the sort of challenge we have. There is a further problem, in that, for reasons I do not fully understand, if you are in the NHS and you switch to Monitor, which is essentially on civil service terms, you cannot bring your pension with you and you lose your years of service. If you were to be made redundant, you would be resetting the clock, so that is quite a severe disincentive.

Q42 Mr Bacon: Just the sort of idiotic thing you would hope that any well constructed policy would avoid, would it not, Una O'Brien?

Dr Bennett: I have no idea where the problem lies, but—

Q43 Mr Bacon: Isn't that crazy? Am I right in thinking, Dr Bennett, that your staff are paid for with the taxpayers' money?

Dr Bennett: You are right.

Q44 Mr Bacon: Most people would think of them—just like the TDA or NHS England—as, in some broader sense, part of the NHS family.

Dr Bennett: Yes.

Q45 Mr Bacon: Una O'Brien, why would you have a silly pension problem in this way?

Una O'Brien: The decision to put Monitor on civil service terms and conditions predates my tenure in this role, so nobody has suggested changing it, nor have we sought to, because there are big consequences for individuals in changing that over. We do have these boundaries between civil service and NHS terms and conditions in a number of our organisations, which is tricky. On the other hand, however, we are trying to keep a control on senior pay. We try our very best with David to give his organisation the flexibility it needs to be able to recruit people—

Mr Bacon: Ian Swales wants to come in on this.

Q46 Ian Swales: We have had exactly the same problem with NHS staff moving to local councils following the public health changes.

Una O'Brien: Exactly.

Ian Swales: Shouldn't a key aim be to have staff mobility across the care and NHS sectors and not to have these boundaries in place? As Dr Bennett said, as soon as you erect these barriers, people are unwilling to move. Is that not something that should be addressed?

Una O'Brien: Absolutely. Local government, the NHS and the civil service are three different sources of terms and conditions. Pensions are portable under the public sector pensions arrangements. On entitlement in the face of redundancy, however, unless, as I understand it, you are compulsorily transferred, if you leave one organisation and go to another as a new beginning, you are not able to carry that right to so many years if you are made redundant.

Q47 Ian Swales: It even applies if you end up rejoining the place you—if someone leaves the NHS for a local authority and then moves back to the NHS, there is no carry-through even if they end up back in the NHS.

Una O'Brien: There's nothing new about that. That has been the position the whole time that we have had the NHS.

Q48 Mr Bacon: I will turn briefly to these 29 people on over £100,000 and on an average of £126,000. Is the profile typically younger people who have spent a number of years in consultancy, whom you might therefore expect to get paid slightly less than a trust chief executive, or are they the sort of people who either might have been trust chief executives or could easily go and fill senior staff roles inside trusts, such as chief executive and finance director, whom you would therefore expect to be paying more?

Dr Bennett: We certainly have a disproportionate number of people in those roles who do have some NHS background—people who were prepared to accept the consequences of what we were just talking about and make the move anyway. Some of them have been trust chief executives and others have come from the private sector, but at the sort of seniority that you would expect. They could be a finance director or chief executive of a trust—not all of them, but many of that 29, yes.

Q49 Mr Bacon: This pie chart shows that there are 78 staff in central services. I know that that includes IT, finance, HR and buildings, but it still seems quite a lot out of 337. It is a lot more than you are spending on provider regulation and enforcement or pricing or any of these other things. What do they all do? Seventy-eight is a lot for central management in an organisation of your size.

Dr Bennett: What are they doing? They include people working, for example, in IT. We have a massive need to invest and upgrade our IT facilities, so there is a much larger number than there has been until recently in IT. There are quite a lot of people in communications, because we have a lot of interactions with local MPs, local newspapers and so on, which is a major resource. Those are two of the biggest—

Q50 Mr Bacon: Are they PR people?

Dr Bennett: No, they are not PR people. They are people who can write a press release saying, "We are doing this with your local trust."

Mr Bacon: That is PR. PR is often used in a pejorative sense, but I used to work in public relations and there is nothing wrong with it. You can earn an honest day's pay doing public relations if you are honest. I would like a more detailed breakdown of these 78 people and what they do. Perhaps you could do the same for the other members of staff as well.

Q51 Chair: I will go to Ian, but first I just want to ask one other question arising from this. You said in response to Richard that you are spending £9 million of your £46 million or £48 million on consultancy. That is a fifth of your budget. That is one heck of a lot at a time when Government is supposed to be cutting back on that.

Dr Bennett: Yes. I said that £9 million was the number in this £48 million, which is our budget. We will end the year on our budget, which is what this is, having spent £5 million, so we spent rather less than was in our original budget.

Again, a model I inherited at Monitor, which I think is a perfectly sensible model, was for quite a significant proportion of work to be outsourced. The first reason for that was to deal with peaks and troughs of demand. For example, every year we do a major exercise to analyse the annual plans of all the foundation trusts to see if we can spot potential problems coming. That is a very short, intensive effort, so we use outside accountancy firms to support us on that.

It is partly about managing peaks and troughs and partly about being able to bring in people with specific expertise for a limited period. Although of course on a per-day basis they cost a lot more than staff, I think that if we had tried to do all those things by recruiting people, particularly while we were building Monitor and we had lots of new things we had to learn how to do, it would have cost us a lot more and taken much longer.

I am very conscious of the concerns about the size of the consultancy budget. Especially now we are bigger, it is a bit easier to deal with the peaks and troughs problem. I am looking to see whether there are ways we could start bringing more of it in-house. To some extent, we have. That is reflected in the fact that we did not spend anywhere near as much as our original budget indicated.

Q52 Ian Swales: I'd like to pick up a wider point. Paragraph 1.3 notes that Monitor "has a statutory duty to protect and promote the interests of people using healthcare services, including a role in ensuring service continuity. This represents a shift in focus towards the sustainability of services in the round, rather than protecting individual NHS foundation trusts from failure." Dr Bennett, can you comment on how you are addressing that wider role, beyond simply either looking at foundation trusts and so on or looking at NHS trusts and seeing whether they can convert? How are you addressing that wider responsibility you now have?

Dr Bennett: On the sustainability of services, it is a natural extension of our role in overseeing the foundation trusts. It is a role that applies only to foundation trusts and the independent sector providers, although they are a relatively small part of the NHS—5% or 6% in total. That means that at its core is the introduction of a failure regime for foundation trusts, which we did not have before. This is the regime that we have used at Mid Staffs. One of the reasons why it took so long to sort Mid Staffs out was because we only got this failure regime earlier last year—I think I am right in saying that. It is about having the power, where a foundation trust seems to be in a position where it just cannot continue in its present form, to step in, appoint special administration and get it sorted out, which is what we have done at Mid Staffs.

Q53 Ian Swales: What about the point highlighted at paragraph 2.38, when the problems are not in the trust? The case study about Milton Keynes shown at figure 14 illustrates that, and, as the NAO notes, people "at the Trust told us that stand-alone interventions were insufficient". Despite the fact that Milton Keynes has been in breach for

45 months, the Report mentions that only recently has Monitor started talking to other stakeholders, commissioners, local authorities and so on. In other words, if the issues are outside the foundation trust—this may grow with the way budgets are now being allocated—what are you going to do about it, and do you have the resources?

Dr Bennett: This helpfully illustrates some of the reasons why some trusts have been in difficulty for a while. As I was saying, what happened with Milton Keynes was that it looked like a containable problem: there was a quality problem that got fixed, and then a limited financial problem, which it looked as if they were on track to fix, and then suddenly things deteriorated sharply.

We are increasingly observing in foundation trusts that the operating environment for these organisations is getting tougher and tougher. The ability of the management of a trust, no matter how good they are, to fix the problems within the trust itself is therefore getting more and more limited. Increasingly, if you have got a trust with some sort of structural problem, such as an operation that is sub-scale, it is not possible to deal with it just by managing the trust well—by maybe having very healthy margins over here to compensate for something that is sub-scale over there—because all the margins are being eroded. What we recognised was that we were getting a number of trusts where it seemed the only way to fix them was a rather more fundamental structural change. That is what is happening in Mid Staffs. Hence Heatherwood and Wexham Park, where the structural change is to merge it with another trust. That will be happening in other places.

In Milton Keynes, they themselves came up with the idea that they would merge with Bedford. As I said, Bedford is a non-FT that is struggling even more than Milton Keynes is. We took the view that although they were right to say that there was a structural problem that could not be solved within the boundaries of the trust, I was very uncomfortable to leap to the answer that you just put Milton Keynes and Bedford together and that is the way to do it. That was the point at which I engaged with the Trust Development Authority, since they look after Bedford, and NHS England, since they look after the commissioners, to say, "The three of us need to work together to get a plan for this health economy that tells us what we should do with Milton Keynes and Bedford, and whether or not that means putting them together."

Q54 Chair: Dr Bennett, you're going to get more and more of these, aren't you? Can you cope? What have you done? Have you looked ahead? How many do you expect to get in 2014-15, which is about to start? We have discussed your failure to get to grips with the list you have got here, and there will be more and more coming on stream because of financial difficulties, higher service standards and more money going to community services rather than hospital services. You are going to get more.

Dr Bennett: Yes, we are.

Chair: How many more are you planning for next year?

Dr Bennett: If I could, I will come to that in a moment.

What are we doing? One of the things I said was that we need to respond more quickly and more firmly. Yes, Milton Keynes was in trouble for quite some time before we

realised that the problems needed deep-seated change to fix them. In other environments, we are identifying this issue and stepping in much sooner. In Queen Elizabeth hospital in King's Lynn, for example, we are just about to send in the same sort of team that we sent in at Milton Keynes, but you will see that they are much further down our list. Still, they have been struggling for 23 months, so even that is not ideal. Part of what we are doing is sending them in sooner, recognising that we need to do this and working with the other two organisations.

Q55 Chair: Will your pie chart change? If you are going to have to do more of this stuff—Richard was asking about the number of people you have in central services—what you are going to have to have is more intervention.

Dr Bennett: That's right.

Chair: Will that change that pie chart?

Dr Bennett: At the moment, there is the actual work of working out what is the right strategy for Milton Keynes—another feature of Milton Keynes was that the local commissioners had been working on a service strategy for that health economy for more than a year. Of course, part of the problem was that there was a change from PCTs to CCGs. It is not really feasible to produce a sensible solution for a provider organisation if commissioners are not clear what they want to do. Part of the lesson, for me, was that we need to be more proactive in identifying where commissioners are struggling to find an answer. What we have done is send in a team to work with the commissioners to come up with a solution. We are overseeing it—

Q56 Ian Swales: How many of that team are external consultants, typically?

Dr Bennett: They are pretty well all external consultants. We are overseeing it, but we have outsourced the work.

Q57 Ian Swales: So the answer to the pie chart question is that it will not appear in your staff; it will just appear in bigger and bigger bills for consultants.

Dr Bennett: It may do.

Q58 Mr Bacon: Dr Bennett, could I ask you to come up with a note, perhaps in conjunction with the National Audit Office, that spells out what each of the 337 people you have at the moment does, with a much greater degree of granularity—I think that is the jargon word that people like—and a much greater degree of specificity about who does what within each of these sections, and how much each of them costs? Also, within each of the pie chart segments, could you tell us how much of that—I think you mentioned £9 million of the £48 million—is on consultants; again, by topic, and what each of them is doing? I think that would be very helpful for this discussion.

Dr Bennett: Yes.

Q59 Ian Swales: And don't you think it is important that Monitor builds up its own expertise in this area, rather than having constantly to buy in expensive expertise from outside?

Dr Bennett: Absolutely.

Q60 Ian Swales: I would not be surprised if external consultants say, "What we need to do is talk to all these other authorities and build a bigger and bigger project around it," because that is how they make money.

Mr Bacon: And possibly IT. You did actually mention that you need to build up your IT quite significantly.

Dr Bennett: Yes, although we are not outsourcing too much of that. If I could just take, then, this issue of what are we doing on health economies; are we outsourcing it and how many more do we expect—

Q61 Mr Bacon: I just want to pursue this. When you say you are not outsourcing too much of that, do you mean you are outsourcing just the right amount of it?

Dr Bennett: I will send you the figures.

Chair: Let us get an answer to Ian.

Q62 Ian Swales: My point was that I would have thought, given your duty and responsibilities, you ought to be building up your own expertise about what to do, and sharing that constantly around the country, in terms of what happens when a trust gets into trouble; but you have just told us that you outsource the job of sending in teams.

Dr Bennett: We do. First of all, Chairman, you asked me about what we are expecting in the future. Are we planning for it? We are increasingly saying, at the earliest point we can possibly identify there is some structural problem, that we need an effort of this sort. So we are doing it, as I said, at King's Lynn, at Milton Keynes—there will be others. In order to try and pre-empt there being too many, working with the TDA and NHS England we have identified 11 health economies that we think need support before they are in trouble, because we think they are struggling to develop plans. So we are trying to be pre-emptive.

All of this is outsourced. Because we are doing so much of it, I am now actively looking at whether we can bring it in-house, but one of the reasons why I have not considered this before is precisely because there is a limit on how fast you can sensibly grow. The rate at which we have grown, fast though it is, over the last several years, has not been limited by our budget—because we have underspent every year. It has been limited by our ability to recruit and assimilate good people. Outsourcing in the short term is, I think, a way of getting

self-contained teams that do not need much supervision. It is more expensive, but it is a way of doing it.

Q63 Ian Swales: On figure 11, in how many of these trusts that are listed are you paying for external consultants, would you say?

Dr Bennett: We have sent teams into five. We are considering others, but there are five with teams in—

Chair: On that list.

Dr Bennett: On that list.

Q64 Ian Swales: That takes away my next question, because I was wondering if we just had a long-running consultancy bill in all of these places, but it sounds like no. Presumably you try to time-limit the external interventions.

Dr Bennett: We do our best.

Q65 Ian Swales: My final point, then, is one for Una, which is about the responsibility for all of this. Where do you think it actually resides, in terms of ensuring this wider duty to ensure a continuity of service through whatever is happening in Monitor?

Una O'Brien: Well, Monitor's duties are clearly set down in legislation, and I think David has given the description that I would give of their role. It is absolutely imperative that the commissioners have got the money, so they spend the money and they determine what services they want for patients. Money well spent will drive change in the way services are provided. Providers need to be able to respond to that. The regulator of the providers therefore does need, in these particularly challenged health economies, to be working with the commissioners.

The reason the TDA are involved is that we know there is a group of just about 100 trusts that have not yet met the bar to be foundation trusts. The TDA effectively have a line management role for those organisations. In those health economies where there is a non-FT, it is quite legitimate for the TDA to be involved as well.

Just to give my sense of this issue, I do think there is one element that needs to be included: there are issues within the trusts themselves, and we have talked about some of those earlier—whether it is leadership or efficiency, governance or financial risk management—then there are the issues with health economies. David has referred to the fact that we now have tripartite working in the 11 economies which we think will be facing the biggest challenges.

Then thirdly, in terms of financial sustainability there is the work we do nationally, where we have got a programme of work which is a combination of cost containment and challenge to the integrity of plans. So for example, I will not go through all the national

actions, but the work that is done on the containment of the pay bill—done once, done nationally—supports all providers. There is the work that is done on the drugs budget, where we have frozen the increase in that budget for each of the next two years. Those are examples of things that we are doing nationally. It takes all three dimensions to support these challenges.

Q66 Ian Swales: The Secretary of State also now has a statutory duty on health inequality. Rather bizarrely, to my mind, the budgets are being moved towards giving more money to areas with long life expectancy, even though health inequality is mainly measured by difference in life expectancy. In other words, money is being moved away from the areas with the worst health inequality, as I understand it. Do you factor health inequalities into the work you are doing?

Una O'Brien: It's been a couple of years since I came before the Committee and talked about that issue.

Chair: Because we have so much on the agenda for today, Ian, we will come back to that at the end, if we can.

Una O'Brien: I could write to you with latest information on that.

Ian Swales: That's fine.

Chair: I am not being mean—it is hugely important, but I have to go to Austin, Fiona and then Amyas.

Q67 Austin Mitchell: You indicated right at the start that, since the principle of the system was that foundation trusts were independent, you took a light-touch attitude toward them and did not inspect them as effectively or closely. Is that still the case? How did you know which was the best without inspecting them?

Dr Bennett: The inspection of the trusts in terms of the quality of care that they are providing is carried out by the CQC, which, as I said, has significantly changed and improved its approach to inspection. In terms of other aspects of trusts' performance, we monitor quite closely a number of aspects of their financial performance and other aspects, such as the extent to which they are or are not meeting Government targets and so forth.

We have a very clear risk assessment framework, which says, "Here are all the things we are monitoring." It includes increasing what we hope will be the leading indicators of potential problems. Most recently, we have added some soft measures, such as staff and patient surveys. We monitor performance against all of the indicators. Most of them have very specific metrics—for example, if you breach any one of your waiting time targets for three consecutive quarters, we will act. There is a whole set of things of that sort.

On some of the softer intelligence, we simply say that if it looks worrying, we will investigate. We monitor all that and then step in when we are worried. One of the tricky issues, which comes back to the question of independence, is how worried we have to be

before we step in and start investigating. The trusts would like us to be very worried—so our arm is very long and we spend most of our time quite a long way away. Quite honestly, we have been shortening that arm a little bit, because we feel that because of the current financial environment—as well as recognising that there has been a considerable increase in concern about quality issues—we need to be stepping in sooner. If, when we investigate, we find that there is no problem, that is fine—we will leave them alone again. It is all part of us trying to reduce the risk of serious problems emerging.

Q68 Austin Mitchell: In this monitoring, what openings do you give for whistleblowers who are clearly going to be the source of major information about how well things are going? What kind of protection can you give them?

Dr Bennett: We have a very formal process. There is a dedicated individual—one of our central team—who deals with all whistleblowing issues. There may also be relevant whistleblowing issues, subject to appropriate confidentiality, such that if anyone whistleblows to another body, such as the CQC, on a foundation trust, then that body will tell us. We will tell the CQC if it is a quality issue. Whenever we receive a whistleblowing complaint, we investigate it. We will go to the trust—always subject to whatever confidentiality applies—

Q69 Austin Mitchell: Will you investigate it or will they?

Dr Bennett: If it is a quality issue, they do; if it is anything else, we do. Not only do we do that, but we monitor all complaints—not just whistleblowing complaints—to look for patterns, because it may be that sometimes an individual complaint appears not to be well founded, but if you start to see a pattern of complaints, you may conclude that even deeper investigation is required anyway.

Q70 Austin Mitchell: We have just been indicating that things will get tougher as the tightness of the necessary cuts hits home, and that is bound to lead to problems. Figure 16 indicates that the number of trusts in breach of their regulatory conditions is already increasing substantially. The problem, which I think you mentioned earlier, is how well equipped you are to deal with the surge of problems coming in.

Dr Bennett: We are very conscious of that risk, so we are constantly thinking about the likely demand and ensuring that we have sufficient resources. I am very clear, for example, that the people who assess applicant trusts have many of the same skills as the people who monitor and intervene at existing FTs. If we have to, we will take resources off the assessment of applicant trusts and use them in the regulation of existing FTs, because that is the most important thing.

Q71 Austin Mitchell: Is there a kind of emergency treatment?

Dr Bennett: There is a resource that we can redeploy, if necessary, on to the most urgent matters. One other thing that we are about to do is look at our experience of all the different ways that we intervene with trusts to try to establish which methods are having the most impact divided by how many people it costs us to do them. There is no reason to suppose that they all have equal impact, and it is the sort of thing that we have to do.

Q72 Chair: Out of interest, how much does it cost to register a trust as a foundation trust? What is the average cost?

Dr Bennett: About £200,000.

Q73 Chair: To you?

Dr Bennett: Yes.

Q74 Chair: How much is it to the average trust?

Dr Bennett: I do not know, because I am not sure that they calculate it. It is a lot of in-house people spending time.

Q75 Chair: But it is £200,000 to you.

Dr Bennett: Yes.

Q76 Austin Mitchell: You mentioned in the case of merger that we were discussing earlier that competition issues did not have a significant impact on that particular merger. Do they generally have an impact on your work? What is the impact of all the competition requirements?

Dr Bennett: I think I am right in saying that of all the competition issues that have been looked after since the new Act came into force, there is only one merger that was stopped because of competition issues, and that was the Poole and Bournemouth one. There are lessons to be learned from that, and we have said that we will work much more closely with any organisations planning to merge in future to ensure that it is a good idea and that any competition issues, if at all possible, are dealt with.

Q77 Chair: But there is a conflict between your competition duties and the bigger desire of the NHS, which is to go down the mergers route.

Dr Bennett: I would say two things about that. First, the decision-making body on competition issues in relation to mergers is not us. It was the OFT and the Competition

Commission, and it is soon to be the Competition and Markets Authority. We can work with organisations to make—

Q78 Chair: What is your role on competition?

Dr Bennett: On mergers, we have a duty to advise the soon-to-be CMA on what we think are the relevant patient benefits, but because of the problem that arose at Poole and Bournemouth, we have now agreed that we will advise them on what we see as the potential competition issues. Internally, our starting point is quite simply what looks to be the right answer for patients. If two trusts merge, there might be a consequent loss of pressure on those trusts to improve their performance, because they are no longer competing with each other. Where there are clear benefits in allowing them to merge, we simply ask ourselves, "What is in the best interest of patients?"

Q79 Chair: You ask yourselves that, but is the framework such that competition does not trump?

Dr Bennett: We are having ongoing discussions with the competition authorities on how to—

Q80 Chair: At the moment, it can trump.

Dr Bennett: There would be different views. Oh—

Q81 Chair: All of us hear gossip in the House about areas where there is a perfectly sensible discussion taking place between two authorities to merge something, and competition trumps and stops a sensible merger.

Una O'Brien: No—can I just be clear? With competition, whether it is down the route of procurement or in respect of the judgment made about a merger, the clear policy intention is that it should only ever have been in service of a better result for patients. It is never to be used as an end in itself.

Q82 Chair: But is the legislation framed properly, Una, to allow that to happen?

Una O'Brien: That is our intention. Obviously, the difficulty is docking the current legislation into—I think it is the Enterprise Act, and all of that. Recently, David met the chief executive of the new Competition and Markets Authority, who strikes me as an outstandingly thoughtful and sensible person around this issue. He is working with us and with Monitor to make sure that the regime of his organisation is fully aligned with this purpose. That is absolutely our intent.

Q83 Chair: But it is the regulation. I am just saying that perhaps it is an area where there is an unintended consequence.

Una O'Brien: If there is any problem with the regulations that gives the wrong impression—there has been a huge amount of misinterpretation and misunderstanding, and understandable fear around this. I think that people are worried, but the clear policy intent is that patients come first and competition is in the service of patient interests.

Chair: I understand the intent—

Q84 Fiona Mactaggart: That is not what most medical authorities think happened in Bournemouth and Poole.

Una O'Brien: That predates the sorting out of this. David, do you want to explain?

Dr Bennett: What happened in Bournemouth and Poole was unsatisfactory for many reasons, but frankly if Monitor had engaged at an earlier stage in the process we would have enabled the trust—the two trusts—certainly to get a faster answer, and I think possibly even to get a different answer. That is why I have said that from now on we will engage—

Q85 Fiona Mactaggart: But it would not have prevented other people trying to take a case, would it?

Dr Bennett: There are issues about whether or not it is a good idea to do a merger for the sake of patients anyway. Lots of mergers do not work out very well, so forget the competition issues; there are lots of good reasons to be very thoughtful about mergers. Aside from that, there are issues about how you analyse the competition impact and how you think about the direct benefits to patients of allowing the merger to proceed.

I think there are two things we can do. One is to work much earlier and much more closely with the organisations that want to merge, to make sure their case is robust. The second thing we can do is, as Una says, work with the competition authorities to try to ensure that they think about balancing the benefits to patients of allowing a merger to proceed, and the disadvantages—the costs—to patients of not allowing it to proceed. If you allow it to proceed, you will lose competitive pressure on the trust to improve its performance, but on the other hand, you can get benefits from merging, such as gaining scale and so on.

I am in discussion with the competition authorities about how to think about that in a health setting. At the moment, I have no reason to suppose that there is a fundamental legislative problem, but I think there may be some customer practice that needs to be thought about. If I conclude that there is a legislative problem, I will say so.

Q86 Fiona Mactaggart: May I draw your attention to paragraph 1.14 of the NAO Report, which refers to your role, Dr Bennett, and the fact that you have been acting as both chair and chief executive for a long time? We note that Mr Dodd, who was the Secretary of State's original proposed new chair, was not appointed following questions from the Health

Committee, which seemed to think that he was not able to stand up to you. What difference has the appointment of Baroness Hanham made?

Dr Bennett: Well, we now have split the roles, consistent with good corporate governance, and I am sure that Baroness Hanham will be standing up to me as appropriate.

Q87 Fiona Mactaggart: So far, no difference?

Dr Bennett: I didn't say that.

Q88 Fiona Mactaggart: You did not answer my question, though, so I will give you a chance to do so.

Dr Bennett: What difference has it made? I think that the argument in favour of split roles is that there is inadequate independent check and balance on the executive otherwise, which clearly you cannot have. So what I think we have got now is an independent check and balance on the executive. That does not mean to say that they have said, 'Aha, you were doing that wrong all along. Change it." That has not happened yet, but I suppose it could.

Q89 Chair: Una, do you want to take the opportunity to say something? Monitor is an organisation that is supposed to be sitting in judgment on the Government's structures—NHS foundation trusts. We have been waiting nearly four years for this appointment. It just does not sit well that Monitor itself is so deficient in its governance structure.

Una O'Brien: Of course it is very important that Monitor leads by example in this. I wish we could have sorted these things out a bit sooner, but just to fill in a little colour on the picture—

Q90 Chair: Four years.

Una O'Brien: If I could point out, in March 2011, David Bennett, who is sitting beside me, was recruited to be the chair of Monitor. That was one of the first appointments I dealt with when I joined. If you recall the history of Monitor from 2004 to 2010, Bill Moyes was joint chair and chief executive, so effectively, there was one executive chairman throughout that period. The issue about splitting the roles did not really emerge until David was appointed as the successor chair in March 2011.

When he came in as the chair, we then faced the question that he needed to recruit a chief executive. David very kindly agreed to cover both roles while we proceeded on that journey. It coincided with the intense row, if I can put it like that, about the Bill going through Parliament. One of the main areas that was contested involved the roles of Monitor. We judged that it would be extremely difficult to recruit a chief executive at that point, when it was very uncertain what type of organisation it was going to be. Every time we went out and did a market test on the job, we got very few people of calibre coming forward to apply.

As we then moved forward—David can correct me on the precise dates—it became clear once the Bill was through that we were in a different situation to sort this out. We then returned to the question of appointing a chief executive. At that point, David was approached by some of his own non-executive directors who said, "Actually, we think you would be a great candidate for chief executive of Monitor now the roles are resolved." We had discussions at the Department and with the Secretary of State, and we reached the conclusion that this was the best thing in the interests of the organisation. It was at that point that we determined that we needed to go out and recruit a chair.

I think it took too long in 2013 after that decision had been made. I personally think that Dominic Dodd was an outstanding candidate. He had the backing of the Secretary of State, but other people took a different view. We are extremely grateful to Baroness Hanham for stepping into the interim role.

Q91 Chair: She is interim, is she?

Una O'Brien: She is, and she has agreed to serve until the end of the calendar year. We are now going out to competition to appoint a permanent chair. I think it is important to fill in the rest of the picture, because we did actually have a chair of Monitor three years ago.

Q92 Fiona Mactaggart: We have treated figure 11 as though it were a comprehensive list, but a hospital which is not on that list and which must have given you a great deal of concern is George Eliot, which only last week was turned upside down from its original, different upside-down-ness. It was put out to some kind of offer of takeover some months ago, and then last week that was rescinded. What message do we think that sends to foundation trusts which are failing?

Una O'Brien: George Eliot is a trust which is looked after by the development authority, so I will comment briefly before David comes in. The decision that was made last week was made in the light of the series of developments that have taken place, specifically in the relationship between the Queen Elizabeth hospital in Birmingham and the George Eliot. After the initial decision to go out to tender for external management, the trust went into special measures, and there was a really good suggestion to team up the top management people at a successful foundation trust, the Queen Elizabeth, with the George Eliot in Nuneaton. That has proved to be an extremely beneficial partnership and is having a constructive effect on the George Eliot. It was for those reasons that the TDA stepped back and took the view that we had a workable solution that was worth proceeding with.

Q93 Fiona Mactaggart: So this is a partnership, not a merger.

Una O'Brien: That's where it is at the moment—it is a partnership—and I think that's where it needs to stay. The press release that the TDA put out was extremely clear that that buddying support is having a positive effect on Nuneaton and that that is the right relationship to continue into the future.

Q94 Mr Bacon: Can you just clarify which Queen Elizabeth you are talking about?

Una O'Brien: The University Hospitals Birmingham Foundation Trust, also known as the Queen Elizabeth. I'm from Birmingham, so I always refer to it as the Queen Elizabeth.

Q95 Chair: Is this an FT you're talking about?

Una O'Brien: It is a foundation trust.

Mr Bacon: My mother trained as a nurse there. I thought you might mean the King's Lynn one.

Una O'Brien: It's a fine place.

Dr Bennett: But George Eliot is not an FT.

Q96 Fiona Mactaggart: But the hospital that is taking it over, or not taking it over—acting as a partner—is. I am becoming obsessed with this issue of mergers and partnerships, because it looks to me as though they are invented when they have to be and there isn't a clear regime for how to address these issues. That's really what I'm trying to get at.

Dr Bennett: First, when you have trusts in serious difficulty, it can take quite a while to work out exactly what the nature of the problem is and what is the best answer, so I don't think it would be right to have a single solution or even a formula that says, "If this, then this," so you merge—

Q97 Fiona Mactaggart: No, I'm not asking for a single solution or a formula. I'm asking for a regime that ensures that the governance of this kind of thing, when it is invented, is done in a way that is accountable.

Dr Bennett: The governance of the process.

Fiona Mactaggart: Exactly.

Chair: You shouldn't just be reorganising and merging where they are in trouble. There may be a very good case for reorganising in an area that is working fine if you want to use your resources elsewhere.

Dr Bennett: In those sorts of situations—such as Milton Keynes and Bedford, where we are working with commissioners to work out what their longer-term plans are for the commissioning of services in that area, and then we will work out what is the right thing to do with Bedford and Milton Keynes—first, we have to get the buy-in of the commissioners, and they are there to represent the interests of the people who use the services. Secondly, if it does involve some reconfiguration of services or restructuring of hospitals, there will have to be a public consultation. So there are processes around this, but I think there is a general point. There is no doubt that the system is under increasing challenge. Living within a flat

budget when your underlying costs would otherwise be going up by 4% a year for year after year after year is quite challenging. One of the things that, in my view, is true is that we don't have all the outstanding leadership you would want to oversee this very challenging environment in 245 different provider organisations—147 FTs.

Q98 Fiona Mactaggart: How many extra ones do you expect there to be next year?

Dr Bennett: Among the FTs, there will probably be four or five that need very intensive care of the sort that we are now bringing to bear at Milton Keynes and Bedford.

Q99 Fiona Mactaggart: I was actually asking a slightly different question: how many additional foundation trusts do you think will be approved next year?

Dr Bennett: How many additional FTs? It's only going to be a handful, I think, realistically.

Q100 Fiona Mactaggart: Why has the number slowed down so acutely? Is that partly because of the problems that I have been talking about?

Dr Bennett: There are two reasons. One is the change in the CQC regime. When the CQC declared itself unfit for purpose, we said, "We can't authorise trusts on the basis of a CQC recommendation when it has just said it's unfit for purpose." So we have put our assessments of applicant trusts on hold while we wait for the CQC to inspect them, and that is starting to come through now.

The second reason why we are seeing far fewer is that the financial environment is getting much more challenging.

Q101 Fiona Mactaggart: Does that mean that the vision of a majority of NHS enterprises being foundation trusts is being abandoned?

Una O'Brien: No. It's still the policy intention.

Q102 Fiona Mactaggart: Yes, but I'm hearing that the policy intention isn't going to be able to be achieved—

Dr Bennett: It depends on what time scale you look at.

Q103 Chair: Forty-nine years at the current rate—two a year. Forty-nine years!

Dr Bennett: Yes, it is quite slow at the current rate, but there has been a hiatus—

Chair: A policy intention for 49 years.

Dr Bennett: There has been that hiatus because of the CQC.

Chair: Even if the current Government carry on for another 49 years, their policy intent will change.

Q104 Fiona Mactaggart: I have just one other question, which is about the role of these external consultants. As is completely clear, my local hospital trust has been through various iterations of attempts to sort it out. The thing that is most obvious to me is that the McKinsey experts who get sent in to deal with these things are not going to be there to deliver the change. That is an enormous risk in your approach. What are you doing to mitigate the risk of clever young boys coming in and saying, "Here's the way my management school told me to fix this problem: 'In you go—splat! I've got a whizzy answer!'"—and they're not there when the person who is trying to deliver the whizzy answer discovers that it doesn't work?

Dr Bennett: We're always very clear that you've got to have the right leadership in place to turn these organisations round. As I said, one of our biggest problems at Heatherwood and Wexham Park is being able to get strong leadership on a sustained basis. As you know, the chief executive, whom I think was doing fine, has just resigned.

Fiona Mactaggart: She was doing very well, but one of the reasons she's resigned is to make room for Frimley. It is not the only reason, but it is one.

Q105 Chair: Fiona, I'm going to stop it there, because we need to move on and I'm trying to finish by 5. Amyas.

Amyas Morse: I just wanted to ask you a couple of things about the longer term, please. As we look at you over the next couple of years, how are we going to know whether you're doing well or badly? Is it quite specific, measurable things? That is a fair question, I dare say.

Secondly, you said a lot of very good things on this issue, but you can't get round the fact that the characteristics of this is that the number of open cases you have is going up and up and up, and it is only going to increase. The solution seems to me to be mostly merging, and the rate at which you can broker merges is going to be pretty slow, so I suggest that this is going to get to be a very big staff. I am not finding fault, but that may also start to combine with real and more frequent competition issues as you get more acquisitive trusts. Have you thought about the scaleability of the organisation, so that you are really in control? I don't blame you for using consultants to get scale, but you are really in trouble if you are not in control of what they are doing and not really able to be directing and strategic, and to be on top of what they're doing. Right now, you have awareness of a lot of these things, but you'll soon reach the edge of that, surely, given the scale of increase in business you are talking about. What are your thoughts about that, and then perhaps you'd like to answer my first question?

Dr Bennett: This is my single biggest worry: how do we prevent too many organisations getting into serious difficulty as the pressures grow, and how do we cope with

those that do, because I do agree that it is very likely to increase? Merger isn't the only answer to these organisations—it shouldn't be, as I said. We can all point to plenty of examples of mergers not having solved problems at all. Although, as I mentioned earlier, another thing I'm very conscious of is that I don't think we've got enough leadership to go around. One benefit of mergers or chains or something of that sort is that you can deploy the good leadership you've got across more organisations—for example, the good leadership at University Hospitals Birmingham being deployed at George Eliot.

We are working, and need to continue to work, with our colleagues in the TDA and elsewhere on other ideas. Of course, what they were originally planning to do with George Eliot was an attempt to bring additional leadership capacity into the NHS. So I think we need to look at more of that.

Amyas Morse: I'm asking about your own organisation's ability to handle the pressure.

Dr Bennett: Yes. On the scaleability and so forth, it is a huge challenge and as I say, part of the challenge is being able to attract the senior people you need. That is where the real bottleneck is: it is senior people who can spend time with Chairs and chief executives, understanding the nature of the problems and working out what to do about them. We have recruited more senior people to do this, but we just need to keep working hard on that, because that is a big challenge. That is one part of the answer.

Actually, if at all possible, we need to reduce our dependence on external consultants, partly just because of costs—it is a much more expensive way of doing it—partly because all the intellectual capital you get from doing this stuff sits outside the NHS, not inside it. I don't think that makes sense. I mentioned earlier that I am looking at whether we can build in-house capability that we could share across the TDA, Monitor and NHS England to do the sort of stuff we are doing at Milton Keynes. But we have to be able to attract the right high-quality people to lead it, and I am not sure whether we can, and we need to be satisfied that we can cope with that. For sure, we will not grow it too quickly even if we do it, because of the challenges of growing quickly. Those are the sorts of things we need to do, but I'm not pretending it won't be difficult.

On objectives, and how you will know whether we are doing well or badly, we are just about to publish our new strategy, which reflects the much broader scope of responsibilities we have had since the Health and Social Care Act 2012 came into being. Alongside the strategy will be a set of objectives, both longer-term and shorter-term, against which people can hold us to account.

Q106 Ian Swales: Will you have measurables—KPIs—in them? I am sure that in your former life, you would always have said to organisations, "You must have KPIs."

Dr Bennett: We have KPIs around how fast we would like trusts to be fixed if they get into trouble. We do not meet them all the time; this report shows we do not. I could have fixed that problem easily by setting a lower standard, but I have not. But what is the right standard? Is it the right one to get the trust out of difficulty in 18 months?

Q107 Mr Bacon: If you are going to have a central capacity that keeps the intellectual capital that it builds in-house and that can be used by the Trust Development Authority and by NHS England, will part of building that involve having a conversation with the Department of Health about whether the rules should be rewritten in terms of civil service pay scales, so that it is along the lines of, for example, the Olympic Delivery Authority or Partnerships UK?

Dr Bennett: Yes, we have already started that conversation.

Q108 Mr Bacon: Right. Second question: on the Queen Elizabeth hospital, King's Lynn—sorry for the confusion earlier—you just sent in a contingency planning team, as reported in the *Health Service Journal* a few days ago. The chief executive, Manjit Obhrai, is quoted as saying: "We have always acknowledged that the trust faces long-term financial difficulties, which is why our regulator is providing additional support to work alongside our management team." That is after several previous looks, and special measures for quite a while. He goes on to say: "They will be looking at the wider health economy within the region, to ensure our services are sustainable for the future."

One of the comments on the *Health Service Journal* website is: "King's Lynn borders both the Peterborough and Stamford patch and the United Lincolnshire patch. None of them are exactly a rosy picture of financial health. When Manjit Obhrai says 'They will be looking at the wider health economy within the region', exactly how far does that stretch?"

Dr Bennett: Yes, this is a problem. That whole area of the country does indeed have a number of challenged health economies. You have to be careful, obviously, with these sorts of exercises, not to go so broad that you never find an answer because you are trying to boil the ocean, but we are very conscious of the need to look into neighbouring areas. Those areas, in any case, are being asked to produce their own plans, and I think at least one of them is one of the 11 getting additional central support.

Q109Mr Bacon: And you are also looking eastwards, towards the Norfolk and Norwich University hospitals?

Dr Bennett: Yes, absolutely.

Q110Mr Bacon: That directly affects my constituents. The King's Lynn hospital affects them less, unless the maternity unit at the NN is closed and people are pushed westwards, but plainly, anything done that involves another big trust is going to impact everybody locally.

Dr Bennett: Absolutely.

Q111Mr Bacon: How long is it going to take to come up with some decisions on this? It is described as a contingency planning team. Am I right to assume that that is code—perhaps not so much code—for a pre-merger team, or what?

Dr Bennett: No, it isn't code for anything. I will not go into the history of how the name arose, but it is just a team whose job it is to identify the best way of sorting out this trust.

Q112 Mr Bacon: And after 23 months on the list, how long is it going to take before they come up with an answer?

Dr Bennett: I think we are hoping for an answer in June.[1]

Q113 Chair: Can I just say that it is not your decision; it is the CCGs and NHS England. Why your decision?

Dr Bennett: Our decision on what?

Chair: On the future here.

Dr Bennett: We are doing it jointly with NHS England.

Q114 Chair: So there is a duplication.

Dr Bennett: No.

Una O'Brien: No—different roles.

Chair: Of course, there is.

Q115 Mr Bacon: You have one joint team doing it, both for Monitor and for NHS England.

Dr Bennett: Exactly.

Q116 Chair: Yes, but you wouldn't need a joint team if you didn't have separate bodies.

Dr Bennett: Absolutely. You would need exactly the same team.

Chair: Why?

[1] Note by witness: Monitor are planning to appoint a Contingency Planning team in July, who are likely to start work in the autumn with the project completing by the end of the year.

Dr Bennett: Because it is one team solving one problem. The only thing that would be different if NHS England and Monitor were one organisation is that, instead of there being somebody from NHS England on the steering group and somebody from Monitor on the steering group—let us say it is all in NHS England—there would be someone from NHS England's commissioning group and someone from NHS England's provider regulation group on there. Internalising it in one organisation would not make any difference to this at all.

Q117 Jackie Doyle-Price: I started off by saying that I thought this report was too generous to you, but I am now concluding that I am shooting the messenger.

My question is for Una O'Brien. Do we not have enough good quality leaders in the NHS—is that not what is really wrong—which is why Dr Bennett is looking at merger, increasingly, to tackle some of these leadership problems? If that is so, what is the Department doing about it?

Una O'Brien: Okay, well, I think you are absolutely right that we need to attract more high-calibre leaders. It is a difficult time to get people to step up and do these jobs, because there is a huge amount of public exposure and accountability, quite rightly, because the things that a chief executive of an NHS provider organisation deals with are about life, death and everything in between. There needs to be accountability and we also need great people.

Right now, we are doing a couple of things. First, we are investing in what I think will turn out to be a groundbreaking programme to attract new talent. We have just approved the first 50 people to go on an accelerated course at Harvard; 35 of them are clinicians. We want them to have world-class training, to be able to take on these jobs. That includes a group of people coming from outside the NHS. That is the first thing and I think it is a bold initiative, but it is needed, because we have to accelerate the growth of new leaders. We will evaluate it to make sure that it happens. Every one of those 50 people will be mentored by one of the best chief executives in the country and they will be put on difficult placements when they come back from their time at Harvard Kennedy School and Harvard School of Public Health.

The second thing we are doing, which is significant, is that we have asked Sir Stuart Rose to work with us specifically on this issue of leadership: the calibre of leaders and leadership development. He is currently giving his time gratis to go round the trusts in special measures, to talk to the people—as you know, in many of those cases the leaders have changed and, in others, various parts of the structure of those organisations have changed—to see what we need to do further to accelerate what is happening.

However, I agree with you. This is a combination of attracting—it is interesting that, when you go around the world and meet people who run provider organisations, you find that many of them in health care are run by clinicians, doctors and nurses, yet in England only a handful of people are doing that job. I recently met an outstanding chief executive at Addenbrooke's, a doctor, whom I think has come from Australia. He is brining a completely different life experience to that role. We just don't have enough clinicians who are ready to take on that responsibility. I think we need to do more to encourage them.

Q118 Jackie Doyle-Price: Dare I say that one reason why is that, historically, rather too much emphasis has been put on financial management, rather than care outcomes?

Una O'Brien: Absolutely. And we need both.

Q119 Jackie Doyle-Price: Exactly.

Dr Bennett, what is your reflection on that, in terms of sustainability, when you tackle an institution that is failing and you send in your consultants, but actually you have to leave it to them? Do you think that having really significant initiatives to improve leadership across the NHS is the only way you are going to get away from this, and that there are limitations on what you can do?

Dr Bennett: Absolutely. It is a major challenge. Running a hospital trust is an extraordinarily challenging job at the best of times. Under the current circumstances of a tough financial environment, I think it is an extremely difficult job.

Chairman, you mentioned Ofsted at the beginning. I think running a hospital is a much more challenging job than running a school, difficult as that is.

Chair: I think it is apples and pears. It is a bit unfair to make that comparison. But it is a hugely important job.

Dr Bennett: They are both very important. I think it is a really difficult job, and I don't know that we have enough people; it is not just chief executives, but medical directors and nursing directors.

Q120 Mr Bacon: Una O'Brien said something earlier and I missed which business school it was.

Una O'Brien: Harvard.

Q121 Mr Bacon: This Committee visited Harvard some years ago and met a New Zealand clinician who was doing research in, and training to be a general manager for, large acute hospitals. It always struck me as rather odd that we didn't do more of this. Will the unit that you, Dr Bennett, are talking about, which is going to be doing this consultancy work, have a role in growing the skills set within the NHS as well? Is it going to be transferring skills? Is that the idea?

Dr Bennett: That is certainly what we want. You could argue that, if you are an external consultancy, it is not in your interest to share knowledge; you just want to give them the answer. For us, it is totally in our interest to share knowledge.

We have to look at other areas where we can do this. We have to provide good practice and so on, and we have to nudge, at the least, all the trusts to make use of good practice.

Q122 Chair: Let me ask some quick last questions. The first is on people. You parachute these people in—the new chief executives and chairs—in a very non-transparent way, both Monitor and the development authority. That is not acceptable, particularly when you then see the outcome of some of these people who are parachuted in. You have to be more open and transparent about the process, about why people are being chosen and whether there has been a competition for the job. Would you like to comment on that? I am feeling sore about recent appointments in my patch. I accept that it is not a Monitor one; but it is as true of Monitor as it is of the development authority.

Una O'Brien: I take your point. We need to look at what we can do on that. I can only repeat what I have said before: when a place gets into real trouble, you want your most exceptional people to take on those jobs. For the most part, they are very difficult to persuade to do that. I think we need to take a fresh look at this, because the optics of that offer are not strong enough.

I know the situation in your own trust, and I know that you will be having some conversations about that. It ought to be a test that, in the places that are most challenged, the most competent people would be lining up to say, "I'd like to get in there. I believe that I could offer something." We just don't have that at the moment.

Q123 Ian Swales: One quick question on this. Are you spending enough time on growing your own? I was just checking. My chief executive in Teesside is an ex-nurse: Professor Hart, whom I am sure you both know very well. She is a former nurse. Are you saying that, in all the millions of people the NHS employs, there aren't the people who eventually can move up to those roles, rather than have people drafted in? Do you have a leadership talent spotting set-up?

Una O'Brien: Absolutely. The NHS Leadership Academy has identified the top 1,000 future leaders in the NHS. Plus, as I said, of the 50 who have gone to Harvard, 35 are serving NHS clinicians. But I think your point is very well made.[2]

Q124 Chair: I want to ask a few final quick questions that I don't think we have covered. One goes back to your extended remit, David. You are now setting the tariffs, aren't you, together with the NHS?

Dr Bennett: We are.

[2] Note by witness: In addition, we also thought that it would be useful to provide some further detail on work that the NHS Leadership Academy is doing in relation to managing talent in the NHS. In responding to this question, Una O'Brien referenced the NHS Leadership Academy identifying the top 1,000 future leaders in the NHS. To clarify, this refers to the scale of the NHS Leadership Academy's new suite of professional development programmes that by the end of 2014/15, will have supported several thousand staff (including doctors, nurses, AHPs, and managers) at every level of the NHS to develop the skills and behaviours to progress in their careers and ultimately to lead a more capable and compassionate health service.

Q125 Chair: Again, there is a conflict there on two levels. First, you are setting the tariffs, but you are supposed to be the competition adviser. I don't know how you reconcile that. Secondly, your interest is to protect the foundation trust, where one would hope that the tariffs would encourage a change of provision away from hospitals into community services. It seems to me deeply inappropriate that your remit has been extended to cover this. I cannot understand how you deal with the conflict.

Dr Bennett: Our interest isn't protecting foundation trusts, but to do the best for patients.

Q126 Chair: Your role is there. That is why I go back to core purpose. Your core purpose is the regulation of foundation trusts.

Dr Bennett: Not anymore, it isn't. Our core purpose is to protect and promote the interests of NHS users.

Q127 Chair: You could say that about CQC, NHS England—all of them.

Dr Bennett: Okay, but the important point is that it brings—

Q128 Chair: Well, it is quite important that you could say it of all of them. You then try to work out who is doing what. I see your core purpose to be foundation trusts. If you say it is not, that is a really important issue.

Dr Bennett: You were raising the issue of conflict. I was saying that our starting point is what is in the best interests of patients. If you look at other regulated sectors, where you have a regulator such as Monitor setting prices, one of the things the regulator has to consider as they set prices is the impact of any efficiency assumptions on those that are regulated. You cannot simply set prices lower and lower and have no concern about the impact. It is in nobody's interest to start driving businesses into bankruptcy. In that sense, we are in no different a position than we would be in if we did not have responsibility for the FTs.

Q129 Chair: In a roundabout way, that answer just makes my point. The answer is, of course, that is true. It is in your interests to ensure that the tariff is such that it doesn't undermine the viability of foundation trusts. It may well be, given where we are with the financing of the NHS and where we want to be in terms of non-hospital-based service delivery, that that is the wrong approach. Therefore, you are proving my point that you are not dealing with the conflict properly.

Dr Bennett: There are two reasons why I think that is not true. First, when we set our prices they have to be agreed by NHS England.

Q130 Chair: Two of you.

Dr Bennett: Yes, which means that there is an open and transparent process in public to agree to what the efficiency factor should be, rather than it being buried inside a single organisation. Making it open and transparent improves the accountability and the ability to challenge the assumptions we are making. The second thing is that it is not in our interests, because our fundamental objective is to make sure care is provided in the best interests of patients, to continue to keep care in hospitals when we know it needs to be moved out of hospitals.

Q131 Chair: How many foundation trusts are going to be in deficit by the end of this year?

Dr Bennett: Our current estimate is 39.

Q132 Chair: Thirty-nine out of 147.

Dr Bennett: A lot of them have small deficits. I think 17 have less than—

Q133 Chair: On top of those 39, how many have done things such as eat into their balances or borrow money?

Dr Bennett: They can't borrow money.

Q134 Chair: But they can eat into their balances.

Dr Bennett: No. This is their income and expenditure deficit, so eating into reserves is an in-year thing.

Q135 Austin Mitchell: How many of the 39 are due to PFI?

Dr Bennett: In our cases, a relatively small number—just two or three. Most of the PFI challenges are not with the foundation trusts.

Q136 Chair: That is scary. May I ask a final question about your relationship with NHS England? There are two things. I am told that there is a row going on—the *Health Service Journal* is my source, so you can tell me whether it is telling me the truth—over the choice and competition framework, which was supposed to be completed in July 2013. Having so many organisations around the place is leading to such great decision making. NHS England claimed that Monitor "unpicked the agreed content…of the choice and competition framework" and "pulled back from" the framework's "agreed philosophy". It said that the partnership with Monitor could prevent it from "providing the system with the clear, robust and consistent policy framework, evidence and advice it needs". That doesn't sound like a brilliantly wonderful constructive relationship.

Dr Bennett: Well, this is fundamentally about the so-called section 75 regulations—the procurement, patient choice and competition regulations. A form of those regulations was put in place by the previous Government many years ago, and a form of them is effectively required by European legislation. They govern the way that commissioners do their job, so they govern the way that NHS England does its job, in part. We, however, were asked by Parliament to enforce the application of these regulations. It is true that there have been some long discussions about what that means in practice. We issued guidance on the application of the regulations, which was agreed with NHS England at the end of last year, so I think that that comment predates that agreement. I think we have made good progress in aligning views on this.

Q137 Chair: When David Nicholson says that the NHS in its current form is unsustainable and that NHS providers are wasting energy pursuing foundation trust status when the model "is not going to work" in the future, do you agree with him?

Dr Bennett: I actually think—personal view—that we should not get obsessed about the foundation trust label. What we try and do when we set our bar that an applicant trust has to meet to become a foundation trust is, basically, to say that it has to be well managed and providing high-quality care on a sustainable basis. That is a bar that any provider organisation in the NHS needs to meet. Once it has met the bar, whether you call it a foundation trust or not I am less exercised about. The basic notion that ultimately—even if it takes much longer than we originally hoped—all NHS trusts should meet that bar is essential.

Q138 Chair: Do you have a new date for it? I jokingly said that it will take you 50 years, but that is a serious point if there were only two last year.

Una O'Brien: The one thing we are not going to do currently is set any date for it, because we have done that before and we have failed to meet it. That leads to all sorts of unintended behaviours, where people are racing to get over a line. We had issues with management teams being distracted by some pressure to become foundation trusts. We have seen evidence of that in Mid Staffs and in Morecambe Bay. So it would be wrong to set some sort of a date.

Secondly, when you look at a group of 102 trusts under the TDA, they are trusts that for the most part will reach this standard. Some of them will do so on their own, but others will have to find their way into a group or some other solution.

Thirdly, I spent four years working at one of the first wave of foundation trusts, and my experience of that—from not being an FT, to being one—and the implications for me as a director of that organisation were that the way in which we were held to account much more rigorously and the internal consequences of the foundation trust regime for how the organisation was run were really profound. I would certainly not want to go back to a place where those disciplines were somehow forgotten about or removed from most organisations.

Finally, quite rightly today you have challenged us very correctly and thoroughly on the list of the numbers of foundation trusts where their licence is in breach. Having said that, even in these difficult circumstances, we now have some very successful providers and hospitals, which are close to becoming among the top hospitals globally, because the

foundation trust regime has supported them to stand on their own two feet. You only have to look at the way in which some of the university hospitals have been able to utilise the rigour of the regime of being a foundation trust really to develop as organisations. We simply did not have that before.

Personally, my own view is that we should continue along this line, but not set false deadlines. This next phase is going to be more difficult.

Chair: Okay. Thank you very much indeed.