HOUSE OF COMMONS

Health Committee

Oral evidence: 2014 accountability hearing with Monitor, HC 766

Tuesday 2 December 2014

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Barbara Keeley, Grahame M. Morris, Andrew Percy, Mr Virendra Sharma, David Tredinnick, Valerie Vaz

Questions 1- 178

Witnesses: **Baroness Joan Hanham CBE**, Chairman, and **David Bennett**, Chief Executive, Monitor, gave evidence.

Q1 Chair: I think we are all set and ready to go. Thank you very much for coming today. For those following this debate on the transcript, could you please introduce yourselves before we start?

Baroness Hanham: I am Joan Hanham, chairman of Monitor. I was appointed in January and my appointment goes through to 2016.

David Bennett: I am David Bennett, chief executive of Monitor.

Q2 Chair: Thank you. Thank you for coming today. Could we start with you elaborating on Monitor's view of yesterday's announcement and whether that is going to be sufficient, and, particularly given the evidence that you have provided us with about the scale of trust deficits, how you feel that is going to fit in with those deficits? Is it going to make any difference, given that this money, I understand, starts from next year?

David Bennett: First of all, the most basic thing to be said is that we clearly welcome the fact that the Government have agreed to make some additional funding available for next year. As is more than evidenced, even this year is proving very challenging for the NHS, and next year was looking even more challenging, partly because it is just another year of flat real funding—that was the starting point anyway—against the usual rise in demand, but, in addition, there was some money being taken out of the acute sector particularly to be put in the Better Care Fund. Although that is now less than was originally proposed, nevertheless some is coming out. That will further increase the pressure next year.

The proposal from the Government that around £2 billion extra is to be put into the NHS budget for next year is clearly very welcome. That, I understand, is recurrent funding; so, as I think the Chancellor said, it will be put in the NHS baseline. It will recur each year and any further increases will be on top of that, which is also encouraging.

Barbara Keeley: You said £2 billion extra. Chair, I don't think that is correct. Everything that has been published since the weekend said that £1.1 billion to £1.3 billion of it is extra and the rest is from existing Department of Health budgets. We need to be clear about that and not use inflated figures.

Q3 Chair: Could you perhaps set out what your understanding is of where that money is coming from?

David Bennett: Yes. My understanding is that there is £1 billion of completely new money from the Treasury; there is £0.25 billion each year for the next four years also from the Treasury. This is the money coming from the bank fines, is it not?

Q4 Barbara Keeley: That is not recurring. That is just from a fund of—

David Bennett: It is for four years.

Q5 Barbara Keeley: Yes, but it will run out at that point.

David Bennett: Yes, quite.

Q6 Barbara Keeley: We need to be clear about that.

David Bennett: I am just explaining how I got to my £2 billion. Just over half a billion—£0.55 billion—is to come from DH savings and contingency.

Q7 Barbara Keeley: That is not extra; that is existing money.

David Bennett: That is existing money, but it is a commitment that it will go through to the NHS because at the moment it just sits in the DH budget.

Q8 Chair: It is shifting to front-line funding rather than the DH.

David Bennett: Yes. Then, somewhat similarly, there is a commitment from NHS England that £0.15 billion, also from efficiency savings and contingency, will be passed through to front-line commissioners and on to providers. That was how I got to the £2 billion.

Q9 Barbara Keeley: To be clear, there is only £1 billion of guaranteed recurring funding there because the other £1 billion is from fines, which will run out after four years, and the rest of it is from existing budgets.

David Bennett: That is my understanding.

Q10 Barbara Keeley: So it is not £2 billion: it is £1 billion.

David Bennett: But from the NHS's point of view, in terms of planning for next year, it is £2 billion that they were not expecting to get.

Q11 Barbara Keeley: But it is not additional.

David Bennett: Well, it is £2 billion—from the point of view of the NHS front line—

Barbara Keeley: It is not, I am afraid. Let us just leave it at that. It is not additional.

Q12 Chair: Your view is that it is additional and the view of some Committee members is that it is different.

Can I go back? One of the things that we heard, importantly, was that when trust deficits become so large and it becomes endemic—it becomes the norm to be in deficit—we heard from Anita Charlesworth that people, if you like, give up and it becomes the normal thing to be in deficit. Is that something that concerns Monitor? Do you feel there is a sense in which the system starts to give up, or do you think this money that has been announced will make a difference to that?

David Bennett: First of all, there is undoubtedly an "in principle" issue here. Whether you are talking about financial performance or operating performance—hitting access targets like A and E waiting times, RTT waiting times and so on—there is clearly an "in principle" risk that, if you get too many people missing their targets, then it gets more difficult to persuade them, "This is very bad and you mustn't do it." I would not say that we have got to that stage yet. Despite the fact that we do have a lot of trusts in deficit, although not all of them are intending to stay in deficit, at the moment they are seeing—and we are making it very clear to them—that that is not a circumstance that is acceptable and they should be doing everything they can to fix it; and similarly on their access targets.

Q13 Chair: In terms of when the money starts—the extra money will start next year—

David Bennett: Yes.

Q14 Chair: —do you think there is a danger that we will be playing catch-up, paying off debts from this year, or do you feel that the financial position at the end of this year is going to be containable?

Baroness Hanham: Presumably this depends on how it is allocated and under what heads—how it works. We would hope it would go into helping future performance.

Chair: Thank you. David is going to ask the next question.

Q15 David Tredinnick: I want to ask you a couple of questions about efficiencies and then staffing, and particularly agency staff. You have said that foundation trusts "can and need to deliver greater efficiencies while also planning for more significant change over the next 2 to 5 years." How realistic is this? In which areas do you consider these savings could be made?

David Bennett: There is no doubt that the NHS has a huge challenge on its hands because it needs to do two things simultaneously over the next few years. First, it has to keep pushing hard. Indeed, in some respects it has to push harder on generating or finding further efficiencies in the way it is delivering care today. There is no doubt that some organisations find that challenging, but there are huge gaps between the best and the not so good. We reckon that, if everybody got up to the top quartile, you could get something like a 5.6 percentage point saving in the total NHS spend. If you just moved the weaker performers up to the better performers, you could save about 5.6%. So there is still plenty in that sense to go at, but I do acknowledge that it will depend on local circumstances and in certain circumstances it can be a very challenging thing to ask trusts to do. That is the first thing they have to do.

The second thing they have to do is plan for the longer term. For funding of the NHS over the next Parliament, we made the assumption when we did the Five Year Forward View that we might get slightly better than flat real. We essentially said that if we get flat real but corrected for growth in the population, which is about 1.5% in real terms each year—which is where the £8 billion comes from—at the end of the Parliament that would be equivalent to an extra £8 billion a year. We acknowledged that, given the state of the public finances, it is unlikely that we could expect more than that, but in order to live with that and still provide good quality care the NHS has to make significant changes to the way it delivers care. In a sense, it is sort of good news in that those are changes that people have been talking about for a long while in many cases and that most people agree will be for the better from a patient's point of view. It is things like providing more care out of hospital, having a stronger focus on prevention and early intervention, and better co-ordination of the delivery of care. All of these are things that should be better for patients, but they do represent very significant change in many cases to the way the current providers of care operate. The challenge for the sector is that, over the next couple of years, they have both to deliver these efficiency savings in the way they are doing things today and start planning for, and indeed start to make some of, these more fundamental changes so that we can live within a moderate increase in budget over the life of the next Parliament.

Q16 David Tredinnick: Do you agree then with Duncan Selbie, the chair of Public Health England, who has argued that we need to reduce demand as well as look at the whole supply side issue? He has argued that risks are what we should be looking at: in order of

priority, tobacco, blood pressure, diet, exercise, lifestyle and alcohol. If we address the risk rather than the treatments, would we not reduce demand, and is not the whole focus wrong?

David Bennett: In many ways, yes. This is essentially what we have said in the Five Year Forward View. We said that we need a significant change to the way we allocate our spending. We need more on prevention, which of course is exactly the agenda that Duncan is speaking to, because it is better for the public if they are not suffering from obesity and diabetes as a consequence, and so forth, and it is better for the NHS because it takes the demand away—the stuff that is really expensive. But it does require quite a significant shift in how we allocate our resources.

Q17 David Tredinnick: And thinking—philosophy, attitude—from the top right the way through. I know we are short of time, so I will move straight on to staffing. Some of the nurses in my constituency go absolutely ballistic when they look at the money spent on agency staff in the service, with trusts spending £831 million on agency and contract staff in the six months to September, more than twice the planned amount. Is this not a massive waste of money and is not the agency side of this completely out of control?

David Bennett: Is it completely out of control?

Q18 David Tredinnick: Almost out of control.

David Bennett: It is certainly not where it needs to be; that is very true.

Q19 David Tredinnick: Why is it so when it is a catastrophic waste of money?

David Bennett: There are two aspects to this. It is for a variety of reasons, but in particular it is because of the quality agenda that is being driven by what has happened since Robert Francis reported on the Mid Staffs problems, and reinforced—in my view, fundamentally correctly—by the new CQC regime; that is driving up the need for trusts to provide higher staffing levels. That is something they are trying to do in a hurry. There are not more nurses available, although they are doing their very best to bring nurses in from outside England, where possible. The result is, inevitably, that, where they squeeze on supply, they find themselves having to go to the agency market, and, what is more, the amount the agency nurses or locum doctors, for that matter, can charge goes up. That said, some trusts seem to manage this rather better than others, and the simple fact is that the NHS is effectively a monopsony; it is the only purchaser—user—of these sorts of resources.

Q20 David Tredinnick: You used the word "monopoly".

David Bennett: Monopsony. They are a single purchaser of the services.

Q21 David Tredinnick: It is monopolistic pricing. Is that the problem?

David Bennett: No. What I was meaning was this. The NHS buys these services from lots of different agencies, and often individual doctors, but if the NHS were to get its act together and be more strategic in the way it makes that purchasing—

Q22 David Tredinnick: Hang on. You are Monitor and you are supposed to monitor what is going on. Surely you should be offering advice to these trusts on how they avoid these problems. What advice have you issued so far and what advice are you intending to issue, please?

David Bennett: We are working on this alongside the Department of Health and the Trust Development Authority because this is just as true for their trusts as it is for ours right now. So we have draft advice that we are starting to talk to the trusts about right now and we are continuing to make that advice as practical and effective as possible.

Baroness Hanham: Can I add that this needs a really hard look at now, but it is not new? When I was chairing a trust 10 years ago, my eyes used to glaze over at the agency costs, and in those days there was a bank that was made up of staff from the hospital itself who came in and did extra time. We have to start looking at why those sorts of arrangements are not working, in that the hospital can draw on its own staff; why it is that it is costing so much—the agencies just have their fees in their hand and they can charge that; and why it is perhaps that people find it more flexible and easy to work on an agency basis and therefore do not go for a permanent job. There are a whole lot of underlying issues here, all of which, as you rightly point out, are very expensive when you end up with them in your budget.

Q23 Chair: You are signatories to the Five Year Forward View. Do you support within the Five Year Forward View the proposal to allow foundation trusts to use their accrued assets to help support transformational change? Are you going to be making that possible?

David Bennett: Yes. First of all, we do not need to make it possible. The whole concept of the foundation trust policy is precisely that trusts are allowed to retain surpluses from year to year to build up a pot of money that they can then spend on improving care. This is exactly what they need to do. They do not need our permission whatsoever, and, absolutely, we would strongly encourage them to do that. It is one of the sources of capital that can be spent to make the changes that need to be made.

Q24 Chair: What about the situation with property across the NHS estate? Would it apply to that as well?

David Bennett: Yes. There is no doubt that, first of all, the NHS is unusually property heavy. If you look across various health systems around the world, the NHS has a higher intensity of investment in property than most health systems. The trusts themselves will acknowledge that many of them have surplus space. It is not necessarily entirely straightforward to realise it because, if you have a bit of space here and a bit of space there, you have to consolidate into something you can sell. But, working with the Department of Health, we will strongly encourage them, and I know the Department is looking at whether we can create some incentives. There is a bit of an issue here, which is that many trust boards—especially if they are in an area of the country where real estate is very valuable—see their spare estate as a sort of fund to keep for a rainy day. I think

perhaps it is raining—we need to spend this money. So we are looking at how we can encourage and incentivise them.

Q25 Chair: What presumably you do not want is for them to be using that to support revenue costs. You want to use it for genuine transformational change.

David Bennett: Absolutely.

Q26 Chair: Is that something Monitor can have a say over, to make sure that does happen, so that we do not just end up squandering these one-off injections?

David Bennett: We can. We are coming at it from the other end. We are saying, "You have got to change. You have to show us a five-year plan that acknowledges that a lot of change is needed and shows us how you are planning to make that change and how you are planning to fund it." I absolutely say at the moment that many trusts are not in the position we would want them to be, but we keep pushing them to get those plans organised. That is the mechanism for making sure that they are going to spend the resources available to them sensibly to make, as you say, transformational change rather than just supporting any year-to-year losses.

Q27 Barbara Keeley: There is a point to make on what Baroness Hanham said about the bank staff arrangements that used to exist. I have heard, certainly in parts of the north-west, that the opposite is now true. Doctors who want or are able to do extra shifts have to work in other hospitals, and the comment from the person I was talking to was that that is probably not the safest arrangement. As you said, the bank arrangements used to work quite well as a way of using people who are already in a hospital. It seems as if some hospitals have set up something to stop that. Is that something that, before I come on to the other question—

Baroness Hanham: The trouble, to some extent, about this is that this is a personal choice of the people who are offering their services. They make the choice themselves as to whether they want to do flexible arrangements—which actually they can now do in hospitals anyway because most trusts offer flexible arrangements for all their staff—or whether they see it as easier to go to an agency to be hired out for two or three hours. This is something that has beset the health service for years and we have never got to grips with it properly. NHS Professionals was set up, after all, to resolve this problem about staff and agency staff. As long as people can choose with their feet how they are going to want employment, it is quite difficult to lay it down. The trusts have to have a maximum amount of money that they are going to spend on agencies and make sure that, as much as they can, they can get in the permanent staff to do that; and recruitment is not easy now.

Q28 Barbara Keeley: Who is tackling this? We have raised a couple of points about it.

David Bennett: Do you mean the general issue of how we get down the numbers of agency staff?

Barbara Keeley: Yes.

David Bennett: The Department of Health is taking the lead, and we, the TDA and NHS England are all working with them.

Q29 Barbara Keeley: But it sounds as if there is a solution there that would be one to go back to, rather than expensive arrangements and trying to find some kind of banking arrangement.

Baroness Hanham: I am sort of throwing out where I think the problem has come from and these are areas that are going to have to be looked at, but I am bound to say they have to be looked at again because this has gone on for a long time. It has just got much more expensive as time has progressed.

David Bennett: NHS Professionals was before my time but it does seem the obvious answer. One of the things we need to understand is why it did not work last time and try and get something that does work this time.

Q30 Barbara Keeley: Moving on to the question I was going to ask, how do you respond to the criticism that the tariff is not creating efficiencies but simply paying providers less for the same work? In reality, has this not contributed to trusts' financial difficulties?

David Bennett: The most fundamental way in which the tariff promotes efficiency is that, every year, there is an efficiency factor and it sends a signal to the sector that this is the sort of efficiency you are going to have to generate if you are going to keep your finances in good order. We have tried to set an efficiency factor which is a stretch, because we need the sector to deliver as much efficiency as it can, but is nevertheless achievable. One of the things I said very clearly when Monitor took responsibility for price setting—this year was the first year and next year is the second—is that we should set prices on the basis of what we think is achievable, albeit that in today's circumstances it has to be as big a stretch as we can reasonably ask for, not on the basis of what makes all the numbers add up, not on the basis of affordability.

Q31 Barbara Keeley: Clearly it is not working, given the deficit position. The point implicit in my question was that it is not creating efficiencies. If it is paying them less for the same work, and they are now in financial difficulties, and they are not meeting what you say is a stretched target, what is the point? As the Chair asked in a question earlier, it was put to us in another panel that, frankly, people are just going to give up on this and say, "The patient outcomes and the other targets are the most important thing. Everybody is in the same boat. We are all just going to ignore this and go into deficit." You can create a situation where, if it is difficult to meet some targets, in the end this is the one that will not be met. What is the point in setting stretched targets that are making the problem worse?

David Bennett: It is a difficult balance. In so far as they are in deficit, it is because they are not achieving the efficiency that we hoped they would.

Q32 Barbara Keeley: But maybe the efficiency target is not the right one. That is the point I am making to you. Is there any sense at all in you making the problem worse at Monitor by setting targets that are not being met and the financial position is getting worse and causing deficit?

David Bennett: The trouble is there is no point in us setting a target which does not put them under pressure to maximise the efficiency potential. The NHS, collectively, has got to generate as much efficiency as it can.

Q33 Barbara Keeley: But if they are not and you are then giving them an additional problem of going into deficit, my question is what is the point of that? You are then giving them a financial problem on top of everything else.

David Bennett: This is my point about balance. Clearly setting a totally unachievable target is no help at all, but setting them a target which would be relatively easy for them to meet is wrong as well. There is a limited amount of science we can bring to bear, but it is as much a judgment as anything else within that spectrum as to what is the right point at which to pitch it—not least to send the right signals in terms of the extreme need to try as hard as people can at the present time.

Q34 Barbara Keeley: Indeed, but it has been suggested to us that this is being used as a budget equaliser to make the NHS funding envelope fit the situation. If that is the case, that is not wise, is it?

David Bennett: It is not.

Q35 Barbara Keeley: It is not.

David Bennett: My understanding is that it used to be. When we took over responsibility for pricing, I said, "We are not going do it that way. We are going to set a target based on what we think is achievable." No doubt people will argue with us about whether we have made the right judgment on what is achievable, but that is the way to think about it. It is not about making the numbers all add up. I precisely agree with you that if we finish up saying, "You actually have to do 7% or 8% because that is the way to make the numbers add up," people will think I am mad and then not even try.

Q36 Barbara Keeley: Surely it is different in different parts of the country too. My local hospital has a very good reputation; it is a big hospital—the Salford Royal. There are some parts of the country in which it is really difficult to get staff, difficult to get staff to stay and difficult for them to produce those efficiency savings. Surely all those factors have to be taken into account. As you read about it, some hospitals have a real struggle on their hands with the population they have, where they are geographically and the difficulty of getting staff to work there. That is not the same as a metropolitan area, an area like Greater Manchester and places like Salford where it is easier, though they would not thank me for saying that.

David Bennett: I have made this point many times. Some people simplistically say a trust that is not in deficit must have good management and one that is in deficit must have bad management. That is wrong—completely wrong.

Q37 Barbara Keeley: It is because they have different tasks.

David Bennett: They have very different sorts of challenges. Nevertheless, we want them all to do the best they can. When we get a trust that is in some financial difficulty, we will understand what it is that is causing that; sometimes we absolutely acknowledge that management are doing the best they possibly can but there is still a problem that has to be fixed. One of the things we are finding, I think unsurprisingly, is that in those situations where typically a trust has some sort of structural problem—for example, it might be on multiple sites, with old estate, and maybe if they are smaller sites in particular—no matter how well run it is, in today's climate it will never be able to survive as it is. Then we have to look at more fundamental change: are there ways of consolidating on to fewer sites? We can also agree an uplift to their prices if we believe that, even with them doing all the right things, they still could not manage without a deficit. That is an option too.

Barbara Keeley: Thank you.

Q38 David Tredinnick: I want to go back to the redundant buildings issue and the huge costs of maintaining obsolete buildings. I remember going round George Eliot hospital some years ago, just across the boarder in Warwickshire from my Leicestershire constituency, and the chief executives there were very concerned about the oversupply of buildings. It seems to me from your earlier answer that there is not a very fast way of managing redundant buildings. A business would normally treat this as an absolutely top priority because of the enormous costs associated with empty buildings.

David Bennett: I mentioned the point about them seeing it as a bit of a fund for a rainy day.

Q39 David Tredinnick: But that is not correct; that cannot be. It is very bad management on their part to think that they can translate a capital sum in that way at some point in the future because they have all the current costs on the current account.

David Bennett: No, I agree.

Q40 David Tredinnick: It is very poor management; so there should be advice out there, surely. I don't know what to say, but it reminds me—

David Bennett: In all honesty, part of the problem here is they worry that, if they sell the estate, they will have the money taken off them and the trust loses out. That is why we are working with the Department of Health to see if we can find a way of getting them to do the right thing and reassure them that they will be able to invest appropriately.

Q41 David Tredinnick: I do not want to make political points in this Committee, but in 1979, when the Conservatives came to power, nobody knew how many buildings the health service owned. You remember that. It was an absolutely hopeless situation. We did not even know what we had. This is a sort of corollary to that, is it not?

David Bennett: It is.

David Tredinnick: We have buildings here, buildings there and maintenance costs.

Q42 Chair: Is one of the problems that, when you put in place transformational change, it might not be seen to benefit the trust itself—it might be going into community services? Is that something that is driving the reluctance?

Baroness Hanham: This is something that should drive it, and should drive it very quickly, because the whole idea of the Five Year Forward View is, as you say, this change in the way that the services need to be run, doing far more bringing in the community and local people, with the services directly local and shared between the community and the national health service. Once it stops being just the national health service that holds this land and people get a glint in their eye as to what that might be used for in running a different service, I hope—and you cannot guarantee it—that that will begin to generate much more looking as well at what they have in facilities, because they might want to use the facilities or they might want to sell them and get the revenue to support this. With the forward view, quite a lot can come out of this that will be helpful in the end, particularly towards the areas you are talking about.

Q43 Chair: Your role is to support foundation trusts, is it not? Therefore, do they have concerns that, if they are putting that money outside the trust into community services, that might make their position more difficult with you? That is why I was asking whether it was something you are going to be supporting people to do.

David Bennett: Absolutely. We need to change mindsets. Monitor has two responsibilities in a sense. We are particularly overseeing foundation trusts, but we have a broader sector responsibility and that is the most fundamental thing. After all, our primary duty is to protect and promote the interests of patients, not the interests of foundation trusts. We have to get existing provider organisations—frankly, whether they are foundation trusts or any other sort of provider organisation—to be focused not just on what they look like and what they do today, but how they are going to contribute to the whole health system that they are sitting in, making the necessary change. Even over the last 12 months I have seen people beginning to think differently about that.

Chair: Thank you.

Q44 Valerie Vaz: I was going to follow up on that point because, clearly, this was bought with public money and so it does belong to the taxpayers—the general public. This one-off sale is quite worrying to me because there are lots of things that people can do with the estate. Two of the richest people in this country are the Duchy of Cornwall and the Duke of Westminster and they do not sell their land. I am wondering why the national health

service should be selling their land. Could we not come up with some other options—for example, leasing the land to other people? You are then going to be looking at very high rates in London compared with other parts of the country. There is a danger that people will think Charing Cross and Hammersmith hospitals can be sold off easily and they can move to the outskirts, which is what appears to be happening. It is prime London land, so you look at that, and then the services suffer. Who is in overall control of that and what do you think about some alternative to selling off, keeping it in public hands and just leasing it off as the Duke of Westminster and the Duchy of Cornwall do?

David Bennett: They hang on to the family silver.

Q45 Valerie Vaz: Absolutely. So why shouldn't we?

David Bennett: In some cases that may be right. The first thing we have to do is to make sure that the assets that are there are used to the benefit of the NHS overall. We know there are some situations where you may even have neighbouring trusts where one is short of land and another one has surplus. We need to find ways of getting that sorted out.

Q46 Valerie Vaz: Can you do that while they are in competition with each other?

David Bennett: Absolutely, yes. We just need to get the incentives right.

Q47 Valerie Vaz: You, as Monitor, can look at the whole estate, as it were.

David Bennett: This is the thing we are doing with the Department of Health. How can we incentivise the individual trusts to do what is in the best interests of the NHS overall?

Q48 Valerie Vaz: Can I go on to the staffing point? Two of my colleagues asked you about agency staff and you kept using the phrase, "We are working with this." What do you have on your Gantt chart as to the end point?

David Bennett: In terms of—

Q49 Valerie Vaz: When are you going to produce a report about it?

David Bennett: The objective is not to produce a report. The objective is to have practical help.

Q50 Valerie Vaz: When are you going do either? You have to do a report before you get practical help.

David Bennett: We are putting a team together right now. We have already started to have some conversations with trusts that have serious financial problems. We are putting a team together right now, and as soon as we have something which we think is usable we will start to share it with all of the foundation trusts, and I am sure the TDA will be doing it with their trusts. I would hope that we will be doing that within a month.

Q51 Valerie Vaz: Within?
David Bennett: Yes, and I hope the month after that we will be doing it a bit better.

Q52 Valerie Vaz: I do not know what you mean. You need to be more specific. There is a huge problem about agency staff and everyone has highlighted it. You know there is a problem.
David Bennett: Yes.

Q53 Valerie Vaz: Within a month—what? You are getting the team together within a month or are you actually going to —
David Bennett: No. Within a month I hope we will be starting to offer specific advice to trusts about the sorts of things they could do.

Q54 Valerie Vaz: Right, okay. By the time the next accountability hearing comes up, will we have tackled the problem?
David Bennett: I certainly hope we will have made some progress, yes.

Q55 Valerie Vaz: I still do not know what that means.
David Bennett: If you are asking me—

Q56 Valerie Vaz: Do you want to see the numbers coming down?
David Bennett: Yes, absolutely.

Q57 Valerie Vaz: What sort of figure do you have in mind?
David Bennett: I do not. I am not at a point yet where I have a specific figure in mind because the work is ongoing, but I certainly want to see it coming down.

Q58 Valerie Vaz: I was looking at the document that you produced—the supplementary briefing—and you mention that you have patient interests at heart. This is, after all, an accountability hearing. At the last one you had not even appointed a patient and clinical engagement person. You have done that now.
David Bennett: Yes.

Q59 Valerie Vaz: There is a little figure of 1 there, but for legal services you have 25, organisational transformation 2 and sector development 153. Is there a misbalance there? Are you going to get any more in that little team?

David Bennett: We are. The person we appointed to that role was Professor Hugo Mascie-Taylor, who unfortunately was not available as soon as we had hoped, but he is now with us full time. We are actively recruiting other people. We are recruiting a senior nurse and a deputy medical director; there is active recruitment. But it would be a mistake to think that those are the only people in Monitor with a clinical background. In fact there are 16 people around Monitor today with some sort of clinical background. There are over 100 now—126, actually—with some sort of NHS background. So we are working on it.

Q60 Valerie Vaz: "Working on it." There is that phrase again. That is fine—they would have that—but it is just that, as to patient and clinical engagement, there is still a paucity of people in that little team, is there not?

David Bennett: It does need more, but what I am trying to say is that that picture rather understates it. There is a specific organisation which at the point that picture was drawn only had one person in it, but there will be more, and there are already more dotted around Monitor.

Q61 Valerie Vaz: Can I now turn to the marginal rate rule and could you clarify something for us—for me perhaps? You set out a consultation in August. Was that for 2015-16?

David Bennett: Yes.

Q62 Valerie Vaz: You have now released a paper, presumably this press release—"2015/16 National Tariff Payment System."

David Bennett: This is from last week, yes.

Q63 Valerie Vaz: Is that as a result of the initial consultation in August?

David Bennett: Yes. We are legally required to consult on our proposals and that is what we have just launched. That is effectively our last opportunity to get input from the sector. So what we did—

Q64 Valerie Vaz: Why is that?

David Bennett: That is just the legal requirement. Once we have decided what we want to do, we then have to formally consult. Unless there is a formal objection, that is it, more or less. In order to try and get more involvement from the sector, we said we would do a prior consultation and that is the one that was launched in the summer.

Baroness Hanham: That was subsequent to other discussions which have been taking place all year on the way the tariff is going to be formed. The tariff for 2015-16 and the

way for setting it are slightly different from the previous one. I want to back up and say that this is not the first and the last bit of consultation. Stakeholders have been involved all the way through and have had some quite serious discussions on changes to the tariff, so they have not been excluded.

Q65 Valerie Vaz: That is fine. I am just trying to clarify something. It is good that you have these two sets because I was a bit concerned that you set it out on 26 November and you want them to reply by Christmas eve, which does not give them very long, does it?

David Bennett: No. That is exactly why, first, we did a prior consultation and, secondly, as Joan says, we have done lots of informal consultation as we go along.

Q66 Valerie Vaz: And you might well give them beyond Christmas, I suppose, if some are straggling.

David Bennett: The thing is that we do need to make sure that we have the new tariff in place.

Q67 Valerie Vaz: You are not going to be working over Christmas, are you?

David Bennett: No.

Q68 Valerie Vaz: So you can have a late submission, I am sure.

David Bennett: We will do our best to take everybody's submissions into account.

Q69 Valerie Vaz: Excellent. With this 2015-16, is this the 50%:50%?

David Bennett: Yes.

Q70 Valerie Vaz: Is that still based on the 2009 levels?

David Bennett: Yes, except that we have made very clear that, if there is a legitimate reason, those levels can be changed. The sort of legitimate reason that people may use is if, for example, there has been a change. Say one local A and E service has been downgraded, which means more is coming to another trust; then that trust should have its level rebased.

Q71 Valerie Vaz: Could I put it to you that it has changed over the five years—that 2014 is remarkably different in A and E compared with 2009?

David Bennett: Across the board.

Q72 Valerie Vaz: Across the board, bearing in mind that walk-in centres have been closed.

David Bennett: That is one of the things that would be a legitimate argument for why there needs to be a rebase. But you are right that, even where there is no discrete change like that, still the whole system is seeing more demand.

The whole purpose of the split tariff, which was introduced long before Monitor was responsible, was to try and reduce the level of emergency admissions. We have analysed this and it looks to us as though it has. They have still been going up, but it looks to us as if they would have gone up even more had the split tariff not been introduced. In recognition of the fact that it is adding to the financial pressures on those acute hospitals that have A and E services, this year we have done two things. First, we have said that, instead of a 70:30 split, there should be a 50:50 split, so that does the emergency admissions. The second thing we have done is lifted the price of what hospitals get paid for the A and E attendances relative to all other prices. It depends on the particular type of activity, but it is something like an average 5% increase.

Q73 Valerie Vaz: Who is happy with this new tariff?

David Bennett: Who is happy with it?

Q74 Valerie Vaz: Yes. You mention that you have had some good response to it.

David Bennett: Well, I had a pretty positive e-mail from Clifford Mann, who is the president of the College of Emergency Medicine.

Q75 Valerie Vaz: Really!

David Bennett: I have, yes.

Q76 Valerie Vaz: When was that? Could you share it with us all at some stage?

David Bennett: I would need to make sure that it is not—

Q77 Valerie Vaz: Maybe he is not very happy about the next stage, which we will come on to, which is the block contract. Do you have any plans for that?

David Bennett: The block contract is not really in the A and E area.

Q78 Valerie Vaz: Have you checked with Clifford Mann about that?

David Bennett: It is true that when we published our first consultation he was not happy with what we proposed, but that did not have the 50:50 split. That did not have this extra uplift for emergency attendances, so we have changed it precisely as a result of the responses we got to that first consultation that we did in the summer.

Q79 Valerie Vaz: So he is happy with the 50:50 then.

David Bennett: He is definitely happier.

Q80 Valerie Vaz: Happier—right. So he is not happy with the 50:50; he is happier than he was with the 30:70. Of course—who wouldn't be? That leads to my next point. Will you be scrapping the marginal rate rule in future?

David Bennett: We are redesigning the approach. One of the things we have said for 2015-16 is that we are happy if individual health systems want to adopt a different payment approach. We have proposed an alternative payment approach, which we have been discussing with the college, among others—

Q81 Valerie Vaz: Is this the block contract?

David Bennett: No.

Q82 Valerie Vaz: Is it something else?

David Bennett: Yes. It is a three-part system. First, there is a fixed payment for everybody in the urgent and emergency care network to cover their fixed costs, and then there is an activity-based payment, which is pooled across the network. One of the problems at the moment, as I am sure you know, is that all the focus of the incentive of the 70:30 split—or 50:50 from next year—is predominantly what goes on in the hospital, whereas what we really need is the whole urgent and emergency care system to work together as an effective network. The new approach is that there is a payment for activity that is pooled across everybody so that you can get the incentives right and not just focus on the hospitals. Then we are also saying we would expect a third element, which would be some sort of quality-based payment as well, just to try and make sure we have high-quality services.

Q83 Valerie Vaz: So for 2016-17 that will all change again. When do you think you would be able to put out a new consultation for 2016-17?

David Bennett: What I have just described reflects where we think the payment system needs to go in the longer term. We put out a very detailed set of suggestions on this back in the spring, and this is based on those suggestions and the feedback we got from them. Our expectation is that next year, hopefully, a number of systems at least will take us up so that they can pilot this, and then 2016-17 should basically see more of it. But it is absolutely going in the same direction; it will not be a change of direction in 2016-17.

Valerie Vaz: Thank you very much. Thank you, Chair.

Q84 Mr Sharma: Last year, we concluded that the pace of reform of the national payment system continued to be too slow, and written submissions we have received so far

are also saying the same thing a year on. Suggestions for reforming the system include a move to an outcome-based system, a capitation-based systems and a multi-annual tariff.

David Bennett: Yes.

Q85 Mr Sharma: Yesterday you published your plans for broader reforms to the payment system, but why has progress continued to be so slow in this area? What can be done to speed it up?

David Bennett: I have seen people's submissions. They are misrepresenting what has happened. Capitation payments are allowed this year and for next year, but we have only had three health systems take up the idea of putting capitation payments in place for this year—or at least three of them have. We recognise that that is not enough. So for next year we are not only saying, "You can do it," but we are publishing a lot of advice, examples and a toolkit for how to apply it. It is not straightforward. What is more, it has to be locally designed because a capitation payment is for a particular population—and different health systems may choose different populations—for a particular bundle of services; different health systems may choose different bundles. So you cannot just mandate it centrally. You have to design it locally. We have developed a tool to help people work out how to do it and we are also making Monitor people available to help more health systems work out how to do it. So far, we have somewhere between an additional five and 10 health systems expressing an interest to take it up next year. We would strongly encourage as many as possible to take this up. They could be doing it this year; they can do it next year, and we are trying to help them work out how to make use of it. That change has happened. So there is that.

You mentioned outcome-based payments. In mental health, for example, which is another area where we need to improve anyway, for 2015-16 we are saying that at the very least we now need all mental health providers to state against specific definitions what it is they are doing. At the moment they do not. They just have a block of money and then they do whatever they do. We are saying, "No. You have to describe what it is you are doing and how much of what it is. Here are the categories of things that you need to use as you describe what you are doing."

Secondly, we have said to commissioners, "If you want to pay for what they are doing on an outcomes basis, you can do that. Here are examples of what people have been doing this year." We already have people this year making payments on an outcomes basis but we want more to do it in 2015-16. Again, as it happens, we have a number of pilots that we are setting up so that more people are doing it next year.

We have also said that, if people want to use an outcome-based approach on things like elective care, that is fine too. Again, we are publishing more examples of this being done so that other health systems can see what some have done and hopefully will pick it up themselves. There has been a lot of progress. I do wonder whether part of the reason people say it's not moving is because a lot of this needs either to be done at a local level or needs a process of piloting and working out what works and then modifying it, which inevitably takes a number of years to work through. Therefore, there is a limited amount which we can now—and even in the future will be able to—mandate. A lot of this is about giving local commissioners much more freedom to decide how they want to pay for

services, but it is not mandatory and that is possibly why some of them are saying, "It has not changed." It has, but it has not changed in the sense of us mandating things.

Q86 Chair: We heard yesterday in the statement from the Secretary of State about facilitating multi-annual budgets. Do you feel that that goes far enough? Are you satisfied with the arrangements? Is that something you have advised as a positive?

David Bennett: We need to go further. I was very encouraged that the Secretary of State specifically mentioned this. We have said several times that we think a three-to-five-year settlement for the NHS, which allows commissioners to have a reasonable degree of certainty about their funding, combined with a tariff that is set for something like a three-to-five-year period, would be a much better environment for both commissioners and providers to do their planning. If the Government are moving in that direction in terms of funding, that is very encouraging.

Q87 Chair: Could you clear up one query that I have about the way all these different systems for payment interact with each other? If you have a health system where there is a year-of-care-type approach or a capitation-based approach and that patient then goes to an emergency department, would there then be no payment at all under the marginal rate rule because in fact it would all be bundled into that original payment?

David Bennett: It could be.

Q88 Chair: Or do they get two bites at the cherry in that they also get the separate admission?

David Bennett: We certainly do not want people being paid twice for just doing something—

Q89 Chair: Which takes precedence?

David Bennett: It is whatever the local commissioners want. We have said we will suspend payment by results if, for certain activities, commissioners prefer to pay for those services for at least some patients on the basis of, let's say, a capitation payment or a year-of-care payment or something like that.

Q90 Chair: Is it not going to get very complicated if people move from one area to the other?

David Bennett: It might be—

Q91 Chair: Are we building in a lot of complexity and would we not be best to have a system that looks nationally at having a year of care, that you have the same kind of cost whether you are somebody with diabetes and heart disease in one part of the country or another? Are we going to end up with big variations?

David Bennett: This is a very fundamental issue of policy, is it not? To what extent do you want an NHS that looks exactly the same everywhere across the country? It certainly does not at the moment. If that is what we were aiming for, we would have to make an awful lot of change. For the moment, in the Five Year Forward View, we have taken the approach of saying, "We want to limit the set of options that we expect local health systems to look at."

Q92 Chair: So we are not going to have a thousand flowers blooming.
David Bennett: No.

Q93 Chair: There is going to be a picking list from—
David Bennett: Equally, we do not want to mandate everything from the centre. It is trying to be sensible about compromising.

Q94 Chair: Right. So we will see different payment systems locally planned but with the flexibility to deliver multi-annual budgets. That is how you see it working.
David Bennett: Yes. Where I think we will finish up, as I say, is not with huge amounts of mandated stuff but menus of choices and limited menus, where, "If you want to deliver your care in this way, here is the payment system for you to use," and your options for how you deliver your care will be limited. You cannot do anything you want. We are going to try and put some boundaries around it precisely to avoid it getting excessively complex.

Chair: Thank you very much. We come on to Barbara.

Q95 Barbara Keeley: According to NHS Clinical Commissioners, "financial incentives and payment 'levers' often don't align with what commissioners may want to achieve and may not support commissioning intentions to move more services out of hospitals, shorten lengths of stay or prevent patients from entering hospitals in the first place". Monitor has also cited the payment system as a barrier to integrated care. Can you tell us how you are specifically planning to help integrated care pioneers implement new payment models and what you think the main obstacles to doing this are?
David Bennett: This is what I was touching on just now. One of the things I hear a lot from commissioners—and I do absolutely understand—is that the problem with payment by results, which is really payment by activity, is that it incentivises the hospitals to do activity, which is not exactly what you want if you want to move activity out of the hospital. This is exactly where we get to in encouraging and helping commissioners adopt different payment systems, like capitation-based payments or year-of-care payments, which are much better suited to providing integrated-type care. As I say, they can be done alongside suspending some of the payment-by-results approaches, and over time that will have to happen. I absolutely understand their point and this is what we are trying to help them fix.

Q96 Barbara Keeley: Can you say any more about the mechanics of what you have been doing? We had some evidence about it, but is there anything you want to add? It is a question of understanding what the obstacles are beyond the payment system. We understand that, but what other things are important with this? This is one of the big things we need to start changing, is it not?

David Bennett: Absolutely. I have a list here of seven things we are trying to do to try and enable integrated care, which is what our duty requires us to do. One thing stated in the licence for all foundation trusts providers—or, indeed, for that matter independent sector providers—is that they must in no way obstruct the integration of care. In our assessment of applicants for foundation trust status we have been very clear—although I fully acknowledge it is a message that still others are not hearing—that we are open to any model. For example, we had a community care provider who, when they came to us as an applicant to be a foundation trust, said they were thinking that, in advance of that, they wanted to do a deal with their two local authorities also to be providing social care. What did we think about that? We said, "Absolutely. We will just work out how to look at it." The second thing we are doing is making sure that the process of trying to become an FT does not get in the way of changing the models. Then there is the payment stuff, which we have talked about.

We are also helping the sector get better data. One of the big challenges around integrating care is having consistent information about all the different interactions an individual has with the health and—ideally—the social care system. If you do not understand that, it is very difficult to make sure you are wrapping the care properly around them. We are publishing either this month or next a guide to how to pull together better-linked data for individuals and we are also working with eight health economies to show them how to do it.

The fifth thing is that, where we have trusts in serious difficulty with the sorts of structural problems we were talking about earlier on, we have said we need to work with the whole health economy to sort out how to fix these structural problems because you cannot fix them just within the individual organisation. We are doing that in a number of parts of the country, and, as we do that, we are actively encouraging the people doing the work to look at these sorts of integrated care models. One example is at Tameside in Greater Manchester, which is a trust that is in a lot of trouble. We are now helping them, their commissioners and other providers in the area to try to finalise how Tameside can turn itself into an integrated care organisation, which I hope will not only be providing better care for the people in the area but also will address its financial problems. That is another thing we are doing. I have two more.

Q97 Barbara Keeley: Integrated care has always been difficult; at the start of this Parliament there were only three parts of the country judged to have made any success of it whatsoever. Is it not a bit of a tall order to ask a trust that, as you say, already has a lot of difficulties to do that as well?

David Bennett: Absolutely. That is why we are helping them. We have sent a team in to work with them and their commissioners to help them do it, absolutely. We know—

Q98 Barbara Keeley: That is seeing integrated care as a panacea for other problems then, is it not?

David Bennett: No; it is the specifics of Tameside in its local health economy. Its own commissioners had already come up with a hypothesis that the right answer was to turn itself into an integrated care organisation, but they were not able to go from an idea to something with a very sound business case and that is what we are helping them with.

Q99 Barbara Keeley: It would be nice if it happens, but it just sounds a bit unlikely to me.

David Bennett: It has to happen. If we cannot get organisations like Tameside—and there are others—to work effectively as integrated care organisations, then I do not know how we are going to deliver integrated care, which we all agree we need to do.

Q100 Barbara Keeley: But if they are lagging and not leading, if they have problems, it seems unlikely that they are going to make a success of this when leading organisations have not always made a success of it.

David Bennett: I can see your point, but—

Q101 Barbara Keeley: As I say, it would be nice if they could, but I think it unlikely.

David Bennett: That is why we are helping them. I completely accept that they are not able to do it on their own. The one benefit of them being in serious difficulty is that they and their commissioners know they have to change.

Baroness Hanham: It would also be fair to add that we are not just sitting on this. We have already set up pilots on how integrated care should work, which will feed back and provide a base for other people, and they are doing it from all different aspects of integrated care and bringing community care together. As David has said, the problem in some health economies is for them to know how to get started, because, as you say, this is not just the provider; this has to stretch right out into the local authorities, local communities and the voluntary sector—people all coming together. We are seeing those pilots beginning to work and we will be able to pull back the information from that. We are also starting to see community foundation trusts being set up; we approved two last week at the board. Community foundation trusts ought to be able to work with foundation trusts, again, on this whole programme. It has not been implemented, has it, over years, but there is now a very great determination that this has to be made to work, with the recognition that it will not be the same in every single local area?

Q102 Chair: Can I just ask this? Do you feel there is sufficient management staff within foundation trusts to carry forward some of the transformational change? We were hearing that in some places they are just trying to keep their heads above water.

David Bennett: Absolutely.

Q103 Chair: They have to try and divide their teams so that they have a separate team working on transformation. Do you think this is an issue? There is a myth that somehow management is flooding the NHS, when in fact we are quite efficient on management. Is that your view, or do we need more managers?

David Bennett: Is management flooding the NHS? I certainly have not seen it if it is—absolutely not.

Q104 Chair: That is what I am saying. There is sometimes a mantra you hear out there that somehow we are overrun with managers, whereas what we hear in this Committee is that, if anything, it is the other way round: you do not have enough managers to lead the transformational change. Is that your concern?

David Bennett: It is one of my biggest concerns. There is not enough management bandwidth in these organisations to deal with the day-to-day needs, such as driving their efficiency agenda, hitting their A and E targets and all the other things they have to do, and at the same time planning and starting to make this more transformational change. It is a nonsense to imagine that there is a great hoard of excellent managers out there who are just waiting to come in and run the NHS for us. Not only do they not exist but I doubt if they would be doing a better job even if they did arrive. We have a huge challenge, first, to support the people who are already in those roles. They are not all fantastic, but a lot of them are very good and they are all working extremely hard. I think we have to find more ways of making their jobs doable. Secondly, we have to make the job sufficiently attractive so that people at the levels below the senior leadership want to step up into the senior roles. I worry that we are a little bit too fond sometimes of attacking and criticising these people, which just makes the job very unappealing.

Chair: Thank you.

Q105 Rosie Cooper: I was interested to hear that you have just approved two community trusts to be FTs. What did you measure?

David Bennett: In terms of what?

Q106 Rosie Cooper: If you remember conversations we have had about Liverpool community trust and community trusts in general, it is very difficult for you to have things to measure. Liverpool community trust was being fast-tracked to be an FT until I got involved and then we know the debacle that there was. How can you assure me that you do not have any more surprises you are not aware of?

David Bennett: At the heart of it there is what we do with any applicant for foundation trust status, which is to examine in a lot of detail how their governance processes are working—particularly quality governance. Secondly, the CQC is now doing an in-depth inspection, so both of these trusts that we authorised had been subject to in-depth CQC inspections before we authorised them. That is at the heart of what we are doing.

Obviously, we also want to look at their current performance. But you are right in the sense that, say, unlike an acute hospital, we do not have lots of metrics—the equivalent of A and E waiting time targets and so on—for community care. Of course, that is also true in mental health. We do not have those measures that tell us how well the organisations are doing. This is one of the reasons why I am very pleased that we now have this much more in-depth CQC regime because I think that is more likely to reveal underlying issues.

Q107 Rosie Cooper: If I may say so, you are relying there on governance. It is at the heart of a democratic health service and it is absolutely essential to protect the people who pay for it, the people who work for it and the people who are treated by it. Do you agree that it is unacceptable for non-exec directors to act in contravention of the standing financial instructions, especially when they stand to make personal financial gain? You know what I am talking about.

David Bennett: I do.

Q108 Rosie Cooper: Do you not believe that that weakens the system of governance and undermines trust? Although it is an aspirant FT, where NEDs have acted in an ultra vires fashion, what, if any, disciplinary action should be taken, because the financial standing instructions say that there should be disciplinary action? It is not good enough, as in the case of the Royal Liverpool, to tell those non-exec directors that they have to pay the money back; that is not enough of a sanction.

How do we find out what is happening? Do you think that is okay? Do you think they should be disciplined? Do you think they would pass the fit and proper person test, and how do you know it is not happening in other places in the country, given that both internal and external audit did not pick this up until I asked about it?

David Bennett: There are a lot of questions there. Let me see if I can—

Q109 Rosie Cooper: I know, but they are really important.

David Bennett: No, I understand. I think it is important to say, just to make sure the whole Committee is clear, that the trust you are talking about—the Royal Liverpool and Broadgreen—is not a foundation trust. We took a look at it a while ago, said it was not ready and deferred it. It is not under our oversight at all.

You asked whether, in principle, if non-execs are acting ultra vires, if they are acting in contravention of their own financial governance requirements and, above all, if they are doing all of that for their personal gain, is that acceptable? Of course it is not—if that is true. I do not know the details of what has been going on at the Royal Liverpool, but, as you know, the TDA, which does oversee the trust, has agreed to have a review of what is going on there. Hopefully, that will reveal the specifics. As to whether that should result in disciplinary action, in part it will depend on the rules of the trust itself, but that is a decision fundamentally for the TDA.

Q110 Rosie Cooper: Absolutely, but my question to you is, if an aspirant FT had those people on the board, would you consider that they would pass the fit and proper person test, i.e. would pass your governance benchmark—I will use that word?

David Bennett: If a trust came to us where the current board—the current non-executives—had presided over what an objective review had revealed to be serious failings, we would not authorise them as an FT.

Q111 Rosie Cooper: But the situation here as to the chairman and some of the non-execs is this. When nurses are not getting a 1% pay rise, the chairman got an extra £20,000; other NEDs got £5,000. The only person who approved it was the past chief exec. The new chief exec has authorised another £2,500 to another NED. Do you think that is good governance?

David Bennett: It does not sound like it, but—

Q112 Rosie Cooper: They have all been asked to pay it back.

David Bennett: I cannot really comment on any specific situation where we have not had a proper and fair review of what has gone on.

Rosie Cooper: Okay, well I—

Chair: We are not here to judge that.

Rosie Cooper: Okay; I will make it apply. How does that affect the current—

Chair: Rosie, we are currently running late and have a lot of questions to get through. Rosie, I am sorry, we need to move on.

Q113 Rosie Cooper: But it is really important because we are all doing the semantics here. How does this affect its application to be an FT?

David Bennett: It is going to have to be resolved before it could become an FT.

Rosie Cooper: That is great.

Chair: I am sorry to rush, Rosie, but we have a lot to get through today and a lot of members have to leave. We are coming on to Grahame next.

Q114 Grahame M. Morris: Could I ask a question about mental health? Mr Bennett, in some of the earlier questions, you did touch on looking at an outcome-based payment system. I am sure you are aware that the Health Committee has looked at—well, done an inquiry on—child and adolescent mental health. There are major deficiencies in the service. The Care Minister, Norman Lamb, announced some additional resource—I think £150 million. In terms of the specifics about the impact of the tariff deflator, can you explain how the proposed new approach to payment mechanisms for mental health is going to

contribute towards what we all want—the chief medical officer, the Health Minister and the Committee—translating that into parity of esteem and improved performance?

David Bennett: Part of the parity of esteem issue is making sure that mental health gets a fair allocation of the total NHS budget, which is an NHS England issue but clearly important. One of the things the payment system can do, by getting trusts to be transparent about what it is they are doing, and even more so getting commissioners to pay for what is done on the basis of the outcomes produced, is hopefully to drive up the performance, and that is what we need.

Q115 Grahame M. Morris: Has the tariff deflator had an adverse impact on mental health services, and is it correct that the differential tariff deflator is not going to be applied again?

David Bennett: It is correct.

Q116 Chair: Which is—

David Bennett: It is true that there will be no differential tariff deflator applied between physical and mental health.

Q117 Grahame M. Morris: Is that based on analysis of the impact of the tariff deflator in 2014-15?

David Bennett: The tariff only applies to acute services at the moment.

Grahame M. Morris: Okay.

David Bennett: It was not the tariff deflator that was the problem before. But, in addition to the tariff, there can be what are called service development payments to different providers to reflect specific changes to their costs. NHS England said last year that, for the acute sector, there would be some correction made for the fact of the increase in staffing costs that we have already been talking about. People interpreted that to mean that there would, therefore, be a bigger efficiency ask of the mental health sector. It was not meant to say that but that is the way it was interpreted. We are making it very sure that that is not the way it is interpreted this time.

Q118 Chair: So did it happen or did it not happen?

David Bennett: NHS England tell us that, if you look at the totality spend on mental health, it went up with respect to physical health last year—no, it is going up this year if you look at commissioner plans. In very simple terms, no, it did not happen the way people feared it would.

Chair: Thank you.

Q119 Mr Sharma: Concerns have been expressed about your proposals to create a new marginal rate for specialised services. The FTN has described them as "essentially a second efficiency factor for all providers of specialised services" which "will greatly affect their ability to maintain and improve these services." What is your response to this?

David Bennett: The proposal, for members of the Committee, is that for activity in specialised services over and above, basically, the planned levels for this year would only be paid on a 50:50 split. The underlying reason for that is that NHS England is massively overspent on its specialised commissioning budget, and of course every pound spent or overspent in one area is a pound less to spend in another area. We cannot just ignore that. That is a problem and we agreed that, because the pricing arrangements are a joint agreement between us and NHS England, we would jointly see what we could come up with as a way of trying to manage that overspend. We have proposed that for any extra activity next year providers only get half of the normal payment. Our purpose is to create an incentive for providers to think very carefully about whether or not those specialist services are really needed. It is the case that they do have some influence over this, of course. Quite often these specialised services are as a result, effectively, of internal referrals within particular providers. So we get one consultant saying, "I think a further specialised type of treatment is necessary." We want to get the providers really focused on, "Is it really necessary?" It is only going to apply to a very small proportion of their total volume because it is only any extra volume that they want to do next year. That is the reasoning behind it.

Q120 Mr Sharma: The BMA have raised two specific concerns related to consultation on the tariff: first, that the time scale is too short for stakeholders to respond; and, secondly, that Monitor should report fully and transparently to the concerns raised by providers and commissioners during the statutory consultation process. What is your view on this?

David Bennett: As I was explaining earlier, in order to try and give people much more opportunity to comment on the proposals, in addition to the statutory consultation, which is 28 days—that is what the law says—we had a prior consultation and, as Joan was saying, lots of informal discussions as well. I think the BMA complaint was not in relation to statutory consultation, which has only just started, but in relation to our voluntary earlier consultations when we were trying to get people more involved. I asked my people to go back, when I saw their evidence, to try and understand what their concern was. Part of it was that last year they said that prior consultation, when we tried to help people, was too complicated. This year we have tried to simplify it and apparently they think we have made some progress in doing that. I hope we have made some progress in addressing their concerns, but we absolutely want all stakeholders—the BMA and everybody else—to have ample opportunity to comment and not just the statutory 28 days, because that is very short.

As to us taking note of what they and others have said, the fundamental problem is that we have finite resources and we have to push the providers to do as much on the efficiency front as possible so that those resources go—the money goes—as far as possible. I know this is tough for providers, and I understand that the BMA do not like it and the FTN do not like it, but, in the interests of getting the best for NHS patients out of the amount of money the NHS has been given, that is what we need to do.

Q121 Chair: Can we move on to the area of competition and system regulation? As you will remember, last year there was considerable concern expressed about the then Competition Commission blocking the merger between Poole and Bournemouth, and since that time we understand you have been working closely with what is now the Competition and Markets Authority—the CMA—and issued further guidance for organisations wanting to embark on this. That was a long preamble, but the question is, are you satisfied that those processes are now working more smoothly and are we going to see a repeat of Bournemouth and Poole and all of this?

David Bennett: I do hope not. We have done a lot. We have tried very hard to get alongside the CMA and make sure that they understand the distinctive characteristics of the health sector. We have made a lot of progress on that. I also wrote to the whole sector at the beginning of this year and said that, from now on, I want us to handle mergers or acquisitions that might go to the CMA differently and in particular that I want trusts that are thinking of making a merger or acquisition to come to us at an early stage so that we can help them to make sure that what they are proposing to do makes sense from the patients' point of view and help them navigate the process.

Since the new regime came into place, the CMA have looked at five proper mergers in the NHS. There were two in the independent sector, which I do not imagine you are concerned about, and there were two they were asked to look at which did not count as proper mergers and they just said, "You don't need to talk to us." But there were five that they did look at. Four of those five have been cleared. It is only Poole and Bournemouth so far which has not been cleared. This is evidence, at least in part, that this new process is working better and that we are aligned better with the CMA. We have run workshops and issued two lots of guidance—one jointly with the CMA and one on our own—about, in general, how to approach transactions; we are hoping that we have dealt with a lot of these issues. But we still have a number of new mergers coming down the pipeline and we still need to work hard with the trusts that want to make the mergers to make sure that they have really thought through that this is in the patients' best interests. If we can get that right, which obviously is the key test irrespective of any competition issues, we should be able to deal with any competition issues as well.

Q122 Chair: Last year you were undertaking a review of how your processes fitted in with competition law. When do you anticipate that will be completed?

David Bennett: It is all done. We did it at the end of last year. That is what my letter at the beginning of this year was saying: this is how it is all going to work.

Q123 Chair: Right, okay. There was a query raised by the Royal College of Nursing in their submission to us. They were asking, "What is the cost of legal advice sought through the NHS in preparing for mergers?" Have you made an appraisal about what this costs?

David Bennett: No, I have not, but I do recognise this is money being spent on lawyers, not on doctors and nurses, which—

Q124 Chair: It is a serious concern.

David Bennett: Absolutely. It is not what we want.

Q125 Chair: You have no estimate at all of what has been spent. Presumably you are looking at trust finances and they must tell you what they are spending on these kinds of things.

David Bennett: The truth of the matter is that, although every penny not spent on care to patients is unfortunate, these numbers are certainly not big enough to figure in a typical trust's annual reports or annual plan. But I know in some trusts significant amounts of money are being spent. We have said, as part of this new process, "Come to us at an early stage so that we can tell you what sort of advice you need." One of the concerns both I and Catherine Davies, who looks after this area in Monitor, had was that we were not sure they were always getting the best advice. We are trying to be very specific about the type of advice they need, including sometimes saying, "We think this is straightforward. You don't need advice."

Q126 Chair: Do you charge them for the advice you give them?

David Bennett: No.

Q127 Chair: It is a free service and they should be using you more rather than going to outside organisations for legal advice.

David Bennett: Yes.

Q128 Chair: Do you think there would be a case for asking trusts that are coming to you with a view to a merger to set out clearly what their legal costs are so that we can have some transparency around that?

David Bennett: Transparency is a good thing. Why not? Yes.

Q129 Chair: You think that would be a reasonable thing to ask.

David Bennett: Yes.

Q130 Chair: Finally, before I hand over, the Foundation Trust Network suggests that, for NHS providers to have confidence in seeking informal advice from Monitor, they should have a kind of Chinese wall between their provider function and their competition function—

David Bennett: Yes, I—

Q131 Chair: That Monitor, rather, should ensure there is a wall between the advice you are giving around competition and—

David Bennett: I saw that. I was not completely clear what they were concerned about. If we have an FT that is thinking about a merger, we care about that for two reasons. First and foremost, we care because they are an FT and we want to make sure that what they are proposing to do makes sense for them and the patients they serve. We also care about it from a competition point of view, in that sense, as a secondary concern. I could not see why we would want to put a Chinese wall between those two.

Q132 Chair: You would not think that was necessary.

David Bennett: Unless I have not understood what it was that they were wanting.

Q133 Rosie Cooper: May I come in? I want to explore that a little. We have Aintree hospital, an FT on the outskirts and close to my constituency, and the Royal, an aspiring FT but it has not got there. The chief executive just announced her retirement and, in so doing, said that a merger with the Royal, so that there is one hospital, is inevitable. That, of course, sends terror through the system when you look at the competition rules, in this sense. Would that be a merger, or, if this is the real answer, do they have to go out to competition so that people can pick off the services? They do not.

David Bennett: No. There would be a competition issue in relation to it as a merger, but there is no issue of having to compete the services, no.

Q134 Rosie Cooper: If they go to merge, what are you saying would happen? Where does competition come in?

David Bennett: It is a perfect illustration. As an FT they would come to us and say, "We are thinking of doing this." Our primary question would be, "Explain to us how this is going to help you provide better services on a sustainable basis to your patients and the patients of the Royal Liverpool?" It could be that they have very strong arguments. These may be the sorts of structural changes that need to be made in order to drive the efficiencies which we have been talking about a lot. That is our starting point. A merger like that almost certainly would fall within the jurisdiction of the Competition and Markets Authority, so at some point they would want to look at it. We would start by saying, "Let's be clear how this is to the benefit of patients. If we get that clear, then that is your case as well for taking it to the CMA when it gets to the time to ask them to look at it," which is why I am saying I do not really see why you would want to have a Chinese wall between these two things.

Q135 Rosie Cooper: It is really frightening that it is you almost driving tariff and with that tariff, as you have described it, you can incentivise the system. What I heard was that you can fashion the system to get to the solution, which probably means reconfiguration, which is almost the merger of those two hospitals, and yet no assurance can be given that that

would not be subject to competition and could be picked off. How does that encourage people to get behind getting the best services?

Baroness Hanham: I am sorry to intervene—and I am leaving the technical stuff, as you can understand—but my understanding too, of part of this, and David will shout at me if I am wrong, is that, when you are looking for a merger, one of the other things you have to look at is ensuring that patients still have a choice round about so that they are not just left with one unit, one service, that they have no choice about. You need to look at how close other facilities are. That is one of the things that is taken into account, but picking off services, like somebody buying—

Q136 Rosie Cooper: No, I accept that, but now we are talking about the two going into one. In reality, there is one hospital in Liverpool—the Royal.

Baroness Hanham: And there is another one round about.

Q137 Rosie Cooper: "Round about" would mean having to go to Warrington. These are huge distances. Even to go to Aintree that services my constituency, you can be talking 20—

Baroness Hanham: That would need to be taken into account, I think.

David Bennett: Yes. As I say, the starting point, however you are looking at this, has to be: why is this in the interests of patients? We know mergers are difficult and that they often do not work, so forget the competition rules. No one should be starting on a merger unless they are absolutely clear it is to the benefit of patients, and that is our starting point as well. If there is a strong case that the merger is in favour of patients, then, hopefully, even when the CMA look at it and say, "Yes, but there will be a reduction in choice," they will still say, "Nevertheless we can see that the direct benefits to patients of merging these services exceed the loss of choice that the patients will suffer." Our aim is to get to that position. There could be some marginal cases—and I do not know this one in particular—where the direct benefits are not that strong and there is a clear loss of choice. That is the point at which we may finish up having an interesting—and tricky, potentially—discussion with the CMA. It is ultimately their decision, but they are very clear that what they are trying to do is to make sure that if a merger goes ahead it is in the best interests of patients.

Rosie Cooper: Thank you—scary.

Chair: Let us move on to Andrew.

Q138 Andrew Percy: I turn to competition and the section 75 rules. Last year we recommended that further work be conducted by Monitor on this because there seemed to be considerable misunderstanding. There still seems to be a misunderstanding, perhaps because there is a huge debate around competition at the moment and whether it is the Competition Act, section 75 and all the rest of it, and what it actually means. What do you think, since the last hearing, has changed in terms of the understanding of the regulations, and what work have you completed since the last time we saw you on this?

David Bennett: We have done a lot to try and help people—commissioners above all, but providers to some extent—understand the rules better. We ran a series of 10 workshops around the country which I think just over 170 CCGs turned up to hear. We had tremendous feedback from those who did go: going in, 33% said they felt they understood the rules properly; coming out, 88% said they understood. So, at least for those that turned up, we seemed to have achieved something. We have run webinars, issued new guidance and we are running a helpline. Over the last year we have had 219 queries to our helpline, and we will go quite a long way—it is not just a quick phone call—and put quite an effort into helping commissioners understand how to do things that they want to do and to make sure that any concerns they have are dealt with. These are the sorts of things that we have been doing to try to deal with people's concerns.

Q139 Andrew Percy: I am sorry to interrupt. Is there any evidence that trusts are taking a kind of safe option of going out to tender on a competitive basis even if they believe that is not the best route for patients or for that service? Is there any evidence of that occurring?

David Bennett: One does hear reports of that anecdotally. That is the sort of thing—

Q140 Andrew Percy: Presumably if you hear reports of it anecdotally, then you will intervene.

David Bennett: If we have specific cases where it sounds like someone is doing something which is not right, yes, absolutely.

Q141 Andrew Percy: In those anecdotal cases, what have you done to intervene? How many examples are there and what has happened in each of those cases?

David Bennett: It is all part of the 219 cases that we have dealt with through our help facility. I cannot—

Q142 Andrew Percy: Somebody must be logging how many examples there are of people tendering on a competitive basis because they have misunderstood the rules or when they do not feel it is in the interests of patients. That is quite an important thing to log, is it not?

David Bennett: We have focused more on what sort of problems people are coming up with. Then we have published a set of frequently asked questions, "What are the most commonly raised issues or concerns?" and then, "What is the answer?" That is the way we have approached that.

Q143 Andrew Percy: But your evidence, as it were, today is that you feel, in the last year, the situation has improved and the commissioners now better understand the exact picture with regard to competition.

David Bennett: I believe it has improved. I should correct myself. I said 170. I should have said 70; I apologise; actually it was 71 CCGs that turned up to our workshops. It has improved and we are certainly working very hard to try and get it as good as possible. I am not going to claim that every commissioner has a complete and thorough understanding. I acknowledge that we have more work to do. I was somewhat encouraged by what the NHS Clinical Commissioners said in their submission to your Committee. They indicated that they felt there was some improvement, which is encouraging.

Andrew Percy: Thank you.

Q144 Mr Sharma: As an organisation, what progress have you made in developing your understanding of other parts of the provider landscape, including the third sector?

David Bennett: When you say "other", you mean other than—

Q145 Mr Sharma: There are many other providers, but we are more interested—

David Bennett: Do you mean other than the NHS?

Mr Sharma: Yes.

David Bennett: In terms of the independent sector, we have had to license them for the first time in the last year. I will get the number wrong, but we now have, I think, 95 independent sector providers of NHS care that are licensed by us, so we have had to put a lot of effort into understanding them. In terms of the voluntary sector, we continue to work with them because we understand that they face very specific circumstances. For example, we did a study into the provision of hearing aids where we had a number of voluntary organisations expressing concerns about whether access to choice about the provider of hearing aids was working effectively. We did this work together and, as a result, are making a number of suggestions for how commissioners can make more effective use of this thing called "any qualified provider" to help hearing loss. We are very keen to work with voluntary organisations. That is just one particular example over the last year.

Mr Sharma: Thank you.

Q146 Chair: Last time you came, David, I raised the issue with you about how some voluntary organisations feel they lose out because there might be a larger national charity that can put in a flashy bid but does not necessarily have any locally-facing presence. Have you looked at this specific issue further and also the fact that sometimes people question whether it is necessary for that to have been put out to tender in the first place? Are you seeing a reduction in the number of these occasions where things are put out unnecessarily to tender when the CCG could just make a decision in patients' best interests to incorporate the third sector into their pathways?

David Bennett: We do not collect systematic statistics, so I do not know whether there is more or less of that. As I am sure I mentioned last time, we did this work about 18 months or so ago now—we published it—the Fair Playing Field Review, much of which was focused on how the voluntary sector can be confronted with a fairer playing field as they

try and participate, for exactly the sorts of reasons you raise. We made a whole set of recommendations on things that should be done there and we continue to follow up with these recommendations. A lot of them are for commissioners. We are working with NHS England to try and get commissioners to change what they are doing. In all honesty, one would have to say commissioners, rather like provider organisations, have an awful lot on their plates, so I suspect it is there but it is not the only thing that they are focused on at the moment.

Q147 Chair: You are not really sure whether it has got better or worse.

David Bennett: I am afraid not. We do not collect those sorts of statistics. NHS England might; I do not know.

Q148 Rosie Cooper: There is an increased nervousness, which I might speak to you about afterwards, in particular cases.

How would you respond to the charge from the Foundation Trust Network that FTs now face increased scrutiny from Monitor and that "in some cases provision of regulatory information has been a distraction from addressing real issues"?

David Bennett: I absolutely understand their point. As the system is coming under increasing pressure—we have seen and talked about the financial consequence of that pressure, but, as we have touched on before, we are also seeing it in terms of meeting access targets and so on, which have real consequences for patients—we and lots of others are increasingly anxious to make sure that the sector is doing everything it can to deliver as good a service as possible. So, yes, we are asking for somewhat more information than we used to ask for and, yes, we are having more conversations with trusts than we used to.

We were talking about agency spend. I got the sense that the Committee was encouraging me to have conversations with trusts about agency spend. We are having conversations with them about lots of things. I do understand that there is a difficult balancing act here. I would say that, as we have those conversations with organisations which on the surface would seem to be doing okay, we discover that often they are still not doing quite what is standard practice in other organisations to run themselves as effectively as possible.

One example is that we have had a number of conversations recently about why trusts are struggling to hit their A and E target of 95% of patients being seen within 4 hours. One thing you discover is that it is all about getting patient flows right. Often the problem is that you cannot admit to a bed because you do not have a bed available and you do not have a bed available because you are not discharging enough. You discover that the better trusts make special arrangements to make sure they can discharge at weekends and other trusts do not. The result is that some organisations have a terrible problem on Monday and Tuesday; then they get back on top of it and Friday is all right; Saturday and Sunday are fine, but they stop discharging, and then by the time Monday comes around they are in trouble again.

There are other organisations that have sorted this out. Again, I accept that sometimes individual trusts have problems that are not so simple to fix, but sometimes they can fix

them; they are just not looking around them and finding out what other organisations do. I do not entirely apologise for doing things to find out where that is happening and saying, "Look, the trust down the road manages to do this. Why can't you?" That is the reason for doing more, and it is important right now because the system is under pressure. On the other hand, I do know that you can finish up—I have the same problem myself—spending all your time talking to people rather than doing the day job. We have to get that balance right and it is a delicate balance.

Q149 Rosie Cooper: Absolutely. I approve of that. I am really enthusiastic about making sure that there is a lot of transparency and that people are accountable, but there is a balance.

David Bennett: Yes.

Q150 Rosie Cooper: Absolutely. Last year we highlighted the need for Monitor to prioritise its work to support trusts in financial difficulty. The National Audit Office concluded that, although your regulatory approach has been effective, there is a question about how "scalable" it is. If there are so many trusts in financial difficulties and in breach, how do you weigh that up? It recommended that you established the best ways of reducing risk in the FT sector and focus your efforts there.

David Bennett: Yes.

Q151 Rosie Cooper: How sustainable and effective is your current regime as more and more trusts come to be in a financially difficult position?

David Bennett: Yes, it is something I spend a lot of time worrying about. We have just completed a review. I asked for a review of all the things we do in trying to deal with trusts that get into difficulties, to look over the last several years and work out which things seem to get the biggest bang for our buck so that we can focus on those. We are now in the process of reorganising the bit of Monitor provider regulation that does all this. There are some things we are just going to do less of. For example, we find with some trusts that, once you have had an intense period with them, worked out what their problems are and made sure they have a plan and enough capacity to implement it, our ongoing monitoring does not make much difference; they are off. In those circumstances we are going to scale down the amount of monitoring we do once they are off. It is that sort of thing we are changing. There are areas where we have said that, if we pool everybody that is doing a certain thing, they will be able to do it more efficiently. So we are doing that.

We are recruiting more people with NHS operational experience; we have probably doubled the number in the last year. We now have, as I mentioned earlier, 126 people, which is a quarter of Monitor—people with NHS experience of one sort or another. We are also recruiting more people as fast as we can find them. So we are doing lots of things. We have also done things like created this role that we call an improvement director. Where we have a trust in serious difficulty—not the former case where once the plan is sorted we can leave them to get on with it, but where it is a real mess—we are sending in

improvement directors, people with lots of experience of running NHS organisations, who can spend substantial time on the ground helping the local organisation sort its problems out.

Q152 Rosie Cooper: Do those improvement directors work for you or are you buying them in?

David Bennett: Yes, for us, though they are not all employees of Monitor. We want to get as many of them as we can as employees. A lot of them are recently retired chief executives and people like that, who do not want full-time jobs but are willing to work, say, a couple of days or three days a week for us at a particular trust, but they can still make a big difference. We are doing those sorts of things. It is a big challenge, though. We have 81 trusts in deficit at the end of the second quarter this year. That is a lot of organisations.

Rosie Cooper: Thank you.

Q153 Chair: Following on from what you have just said with your special administration regime, there have been calls recently for the special administration process to be reviewed. Your own estimate has put the cost of Mid Staffs at being between £12 million and £15 million; is that correct? What lessons have been learned from the Mid Staffs special administration issue?

David Bennett: We have had a number of exercises—including one we did jointly with the TDA and the Department of Health; the TDA did one special administration in south London as well—to try and learn the lessons. I suppose the most fundamental lesson—if this was not already obvious—is, "Don't do it if you can avoid it." It is a costly process. One thing that makes it costly, and Mid Staffs has really revealed this, is that you have to pay—this is what the law requires—insolvency or administration experts to run the trust. It is not just to sort out what the solution to its problems is but to run it on a day-to-day basis because that is the nature of the regime. That is what pushes the cost up. That alone is a good reason to not put a trust into special administration if you can avoid it. That is one lesson.

The second lesson from Mid Staffs—it now seems blindingly obvious but was less so when we started—is that, although the administration regime is designed to solve the problems in a particular organisation, once a trust is in really serious difficulty it is almost always the case that it is not the only bit of that health economy in difficulty and you cannot solve the problems just by looking at that organisation, as has been very clear with Mid Staffs, where we have said the best solution for this trust is to dissolve it and to move its hospitals under the care of neighbouring organisations.

Another lesson, which we have already put into practice in a number of places, is that, when you are looking at these badly failing organisations you need to look at the whole health economy.

The next serious failure of that sort that we had after Mid Staffs was Milton Keynes. It was not another Mid Staffs, I should stress, but it was an organisation where it became

clear that, without resolving its structural problems, it was not going to have a sustainable future. In thinking about it, they had come up with the idea that they would merge with another organisation that had even bigger problems down the road at Bedford, which is not a foundation trust; it is one of David Flory's trusts. It did not seem to us that simply putting together two struggling organisations was necessarily going to create one non-struggling organisation. We said, "We need to step back, work with commissioners to work out what they think they need to do in their health economy and then work out what that means, both for Milton Keynes and Bedford, looking at the two together." We set up a joint effort with TDA and NHS England, which we have led, starting with a particular focus on the commissioners. "What are your plans for the health economy in the longer term?" They had ideas about it but they were not fully formulated, so we helped them formulate their ideas. Then we worked out what that would mean for both Milton Keynes and Bedford, and now they are out to consultation on options. That has been a major learning from Mid Staffs. That is the better way to do it: work with commissioners on the whole health economy.

Rosie Cooper: That is really interesting. If a trust is in difficulty and you dissolve it and put it under the care of a neighbouring organisation—I think that was the quote you used, which I think is a really sensible, no brainer—the commissioners and everybody else in that situation, in a case I know, are all worried about competition. Where does that—

David Bennett: You do have to look at it, but this is a perfect illustration. If we or a trust go to the CMA and say, "We propose to merge this trust, this failing organisation, with this more successful organisation which we hope can turn around the failing organisation. Yes, it reduces choice and competition in this area, but we think it is best for patients, for all the obvious reasons," then we will have a powerful argument.

We did it at Mid Staffs, but I think an even more powerful example is Heatherwood and Wexham Park. That has been a trust we have been struggling with for a long while, partly because it has pretty deep-seated problems and partly because it is in the Slough and Maidenhead area of the country where it is difficult to attract the best leadership because they have so many other options. In the end we said, "We feel the only way to fix this trust is to find a high-performing leadership of another trust that is willing to take it on." We were very fortunate. There was another trust—one of the best trusts in the country—Frimley Park, also a foundation trust, just down the road who were willing to do that. The mergers happened. We explained to the CMA, "This is why it needs to happen. It is in the best interests of the patients." It was accepted, transactions were completed, and Frimley Park is now already starting to make some differences to the patients of Heatherwood and Wexham Park.

Q154 Chair: Are there ever any examples where you have that kind of arrangement in place and the reverse happens, in effect—maybe the failing trust drags down standards in the trust that is supervising them?

David Bennett: Yes.

Q155 Chair: Has there been any concern that that is a possibility?

David Bennett: That absolutely is a possibility. There are people who would cite many examples, but the one that is closest to my heart is Heart of England. Heart of England is struggling. Their chief executive just left. One of the reasons it is struggling is that many years ago now it took over Good Hope hospital, which was a neighbouring trust, which for years had been in great difficulty, and I do not think they have ever fully recovered from doing that. So, absolutely, you have to be very wary of this.

Q156 Chair: How do you make sure that you get the benefits from it but do not end up sliding down into the Heart of England sort of problems?

David Bennett: Yes, without the downsides. This is why when a trust wants to merge, whether they are doing it off their own bat or we have said to them, "There is this failing organisation. It would be helpful if you could help to sort it out," one of the first things we do is say, "Explain to us how this is going to be in the best interests of your current patients and the patients of the trust you want to take over." As part of that discussion, we ask for clear evidence for how they are going to deal with the challenges of doing that. That does not mean to say that it is not difficult.

Another example where we had all of that discussion, where we felt we had a very strong board speaking very coherently about how it was going to deal with taking over a failing organisation, was with King's College hospital, which undertook to take on the Princess Royal, which of course was part of the broken-up South London as a result of the TDA's special administration there. It was easy to see that, if they could pull this off, it was going to be in the best interests of patients because the Princess Royal was really not delivering good quality care. We felt that they had understood the nature of the challenges. I remember saying to one of my non-execs after we had had a board-to-board with them, "Frankly, if these guys can't pull it off, we are really going to struggle to solve these sorts of problems." They are finding it very, very challenging—even more challenging than they expected.

I am just about to commission a piece of work, which I hope I can get some academics to do for me, to look at both current transactions, such as King's with Princess Royal or Frimley Park with Heatherwood and Wexham Park—but there are others as well—to see what lessons can be learned real time and at the same time also go and look back at what lessons could now be learned from situations like Heart of England. I know it is difficult, but if we cannot get the better NHS organisations to help us fix the failing ones, I am not sure how we are going to fix some of them. We have to work out how to make it a success and try and make sure everyone understands.

Q157 Mr Sharma: There are many questions arising from the current situation in Wexham Park and the new trust taking over or merging those together and supporting each other, or whatever term we like to use in this case. Why did the system let it happen or get to that stage? Why was there no monitoring or check-ups before they arrived at that stage?

Secondly, did you give any time scale to the good trust, to say, "Look, you must deliver or improve some conditions through the next 36 months or 48 months"? What extra support are you offering to the trust so that they can work, because they need the extra

resources? They cannot deliver with the existing resources. So what is the offer to the new trust?

David Bennett: The question is, why did it get like this in the first place, and time scale and resources? Why did it get like this in the first place or why did we not spot it earlier? Collectively, we had not been doing a good enough job to spot situations at some trusts with some deep-seated cultural problems, and, frankly, it is only as the CQC has developed its new inspection regime, where it has got senior clinicians going in on the ground talking to lots of members of staff, spending real time in the trusts, that they are getting underneath these sorts of issues. I regret that we did not work out that is what needed to be done a lot earlier. We would have spotted Mid Staffs a lot earlier if we had had that sort of inspection regime. I am glad we have it now. So, yes, we and everyone else had missed it at Heatherwood and Wexham Park for a while.

In terms of time, yes, one of the challenges that good trusts who have taken on bad trusts have is that they say, "We do not want you, Monitor, criticising us for not meeting all our targets the moment we take on this struggling organisation," because obviously it is not meeting its targets. We agree with them an explicit time scale over which we expect them to improve the performance of the trust that they are taking on, and we have done that in the case of Heatherwood and Wexham Park. I can give it to you afterwards if you like, but I could not quote the exact time scale; it will be several years. Some of these organisations have deep-seated problems that are going to take a number of years to sort out.

As to resources, yes, we do not have any, but the Department of Health has agreed a very substantial package of resources as part of this merger and, in fairness to the people at Heatherwood and Wexham Park, one of its problems is that it is one of these trusts with a terrible, old estate. Until that was properly improved and invested in, it was never going to fix all its problems. As part of this merger with Frimley Park, the Department of Health have agreed capital injections to upgrade the estate.

Mr Sharma: Thank you.

Q158 Chair: Can I come on to the issue about co-ordination between Monitor and the CQC? I am not sure whether you have seen the Foundation Trust Network's evidence to us, but they have expressed concerns about some overlap and alignment issues. Do you feel you are working closely enough with the CQC to co-ordinate that work? Also, the point was raised by the Foundation Trust Network of having some organisations that might find themselves in the highest category of performance from one organisation and the lowest in the other, or, conversely, I think it was a fifth of the organisations surveyed said that they were being subject to sanctions twice—

David Bennett: The double jeopardy problem.

Q159 Chair: —for the same problem from both organisations. Clearly, that does not seem to be acceptable. Is this teething trouble or are we well on the way to sorting all that out?

Baroness Hanham: Can I let David answer the specific but say we have been very aware that this is being said or the understanding that there was a difference? Now, with the new CQC inspection regime, we are pretty clear what they do. They are looking for the quality, and, as David said, they go in mob-handed to talk to people and make sure that they get the full sense of that. They are looking, if I can say it, from the ward basis, the patient basis, up to what the board is doing. We are on the other side, making sure that the board is aware and doing what it should be doing; so our inspections are different. We have been putting that out so that people do understand now—or hopefully understand—that there is a difference in the emphasis of what we are doing. The double jeopardy I will leave to David because those were two specific areas, but there is a short explanation now that goes to people on the difference between the two. We have done that.

Q160 Chair: How much co-ordination is there in terms of the CQC having concerns about an organisation that might be in that position, very often, because they are in financial difficulties? We know that was the case in Mid Staff, for example: the pressure to meet targets led to the problems. How much co-ordination would there be with the CQC if they have concerns about quality? Do they come to you to liaise about what the financial position is?

David Bennett: Absolutely.

Baroness Hanham: We pick up from them. They tell us exactly what they think their inspection shows and whether they ought to go ahead or not, and we pick that up from them. David will pick up from there.

David Bennett: I probably talk to David Behan at least every other week, but probably closer to every week. I have frequent conversations with Mike Richards. Stephen Hay, who runs the provider regulation bit of Monitor, sometimes will be having daily conversations with Mike Richards, the chief inspector of hospitals. Our regional directors will be having conversations with the CQC's regional directors, and sometimes it can even be on an hourly basis. There are a lot of conversations, with complete alignment around individual organisations.

What is still an issue—David Behan and I have talked about this and, indeed, in a board-to-board we had with CQC we discussed it collectively as well—is that the high degree of alignment and co-ordination at still quite senior levels is not filtering all the way down either of our organisations. We have more to do. More junior people—and this is probably particularly true where the trust is not in any serious difficulty, so they do not see the senior people, or perhaps, if it is a CQC inspection, where they assemble a team, many of whom are not CQC people, where they are on the ground in the trusts—may not have as good an understanding about what the CQC does and what we do as we have at the senior levels. David and I talked about how we are going to get that communication. But certainly at senior levels we are working very closely together. There is a potential overlap in that the CQC is now being asked to look at aspects of governance, as we do.

We have taken the way we review governance with the CQC and the TDA so that we have a completely joined-up identical approach to looking at these sorts of issues. The basic approach is that, when the CQC go in with their feet on the ground, they look at governance and quality issues from the ward up to the board, and our focus is from the

board down to the ward; and we make sure it all dovetails. We are pretty joined up at the senior levels, but I accept we still have to do more to communicate all the way through the organisations.

On the point of the trust finishing up with different views being held by Monitor and CQC, no. If CQC say to us, "There is a problem at this trust," then there is a problem at this trust. We are not going to gainsay them on quality issues.

On the double jeopardy point, yes, let us suppose the CQC do an inspection and they say, "You need improvement. Here are the things you need to do better." We then turn up. It is the CQC's job to identify where improvement is needed; it is our job to make sure it happens. In that sense, yes, we do both have a conversation about the improvement that is needed. I am not sure that really counts as double jeopardy, though.

Chair: Thank you. We are going to finish on a challenging note, if that is all right, with question 21, from Andrew.

Q161 Andrew Percy: I am sorry for having to go out; there is a controversial planning application in my constituency which is taking precedence over everything.

In the report you received following the hearing last year, we emphasised the importance of Monitor being an enabler of change rather than an obstacle to change. We have had written submissions, one of which I will read to you, from the Foundation Trust Network, which seems to suggest that commissioners and providers think the current system is acting as an obstacle. The Foundation Trust Network submitted to us: "Current regulatory frameworks are not fostering a collaborative approach to improving services, but instead fuel institutionally-focused and target-driven behaviour."

Then the NHS Clinical Commissioners say: "For CCGs the regulatory system can hinder local plans to reconfigure services or change the delivery model of trusts in relation to moving care out of hospital." They go on to say: "…this can have serious consequences for CCGs trying to implement transformational plans in their local health economy."

As we are told constantly that we need transformational change throughout the system to deliver for our projected health care demographics in the future, what is your response to the suggestion that Monitor are acting as a block?

David Bennett: Those comments could apply to us or to the TDA. There is a process of change going on here which needs to happen in the organisations themselves. We were talking about this earlier, about the need for trusts—for FTs, for example—to not think about just what is in their best interests, but what is in the best interests of their health economy and what role they can play in the development. That is a change in mindset. To some extent, that means also that there has to be a change of mindset inside Monitor. I would say that is work in progress. On the one hand everyone accepts that as a matter of principle, but then when you are faced with a foundation trust that is missing its targets and maybe struggling financially, inevitably, the conversations our people have with that trust are focused on, "How are you going to fix your problems?" We all have to work harder on this because it is a change of mindset for everybody in the health service; I must

not say everybody because I am sure lots of people would argue they have always been focused on the health system. A lot of people in the NHS in leadership roles have to change from being focused on their organisation to serving the patients in the whole of their health system.

Q162 Andrew Percy: We hear week in and week out about how change is so difficult, that everybody wants it, but nobody quite seems to be able to deliver it in the way that we all seem to agree we need to deliver it. How much of this blockage is regulatory and how much of it, in your view, of what you have seen, is about resource?

David Bennett: I do not think it is regulatory. I am afraid I think that is used as an excuse. I am totally clear that we will do whatever it takes to facilitate sensible change. I was given examples where a trust came to us and asked if we would authorise somebody providing social integrated care, including social care. Absolutely; we will just work out how to do it, but of course we will do it. I think it is used as an excuse. The challenge is leadership capacity on the ground—the point we were talking about earlier. These people are having to deal with huge pressures today as well as trying to make the change for tomorrow.

Q163 Andrew Percy: Do you think this announcement of new transitional funding will aid that?

David Bennett: I hope so.

Q164 Andrew Percy: It does seem almost impossible to deliver the change that is required at the same time as responding to a massive increase in demand, particularly for hospital services, yet at the same time we are saying, "Move care out of hospitals."

David Bennett: Absolutely. It is a huge challenge; so the sort of investment that we have heard about can only help.

Q165 Rosie Cooper: Do you think the Better Care Fund is the answer?

David Bennett: The Better Care Fund should help in getting the whole health system and the local authorities better joined up to think about how you look after people without just sending them off to hospital. It will help. Is it the whole answer? No.

Baroness Hanham: It has the practical benefit of local authorities and health being able to pool their budgets. This has been one of the real blocks to community care up to now—that health has to pay for that and local authorities pay for that. But with the Better Care Fund you can now bring it all together.

Q166 Rosie Cooper: Absolutely, but the point that Andrew makes is about having, almost, pump-priming to make the change, and that money is not there because we are pulling it from one bit, plonking it in another bit and hoping. The strain right across is

incredible. We had people from Cumbria sitting there when we were doing the Health and Social Care Bill and they were hailed as the best way forward. The question I asked was, "Did you get any extra money to do this?" Yes, they got many millions. The rest of the system is trying to do it without any help.

Baroness Hanham: But they have now got some of the gates opened to let them do it. Whether the money is there or not, the principle that you can now put money into one pot and then use it—when you can actually get the money to put in the pot— seems to me to be a very important way to make this work.

Q167 Rosie Cooper: The elephant in the room we have skirted around a lot today in essence—and the FT network has vocalised it—is whether tariff is a means of, almost, recompensing people, an adequate and appropriate price for whatever service it is you are buying, or is it the means by which we will enforce reorganisation and regulation? Will we use that to turn the system?

David Bennett: Tariff has to facilitate change. If you want better integrated care you have to have ways of paying for it, with capitation, year of care and so on. That is exactly what we are making possible, but it is not going to make the change happen. For the change to happen, we need collaboration, and so the Better Care Fund is good in the sense that it encourages collaboration across systems.

Q168 Rosie Cooper: It is not providing real money.

David Bennett: Joan was mentioning the pooled budget. There is a requirement to put £3.8 billion in, but they have actually put in £5.3 billion. In the grand scheme of the NHS, even that is not a huge amount, but it is a step in the right direction. That is one thing we need—effective collaboration and co-operation across the different bodies involved. The other thing is that there will be a need for some investment to make the change happen. There is already some money in the system. We have been talking about FT surpluses, surplus land and so on. The announcement from the Government that it is going to invest in change in primary care is very welcome. That is the sort of thing we need.

Q169 Chair: Have you had any discussions about how this extra money is going to filter through into the system? Is that going to take place through the tariff, and in terms of discussions about how we are going to make sure transformation money genuinely goes into transformation rather than just aiming to—

David Bennett: Absolutely, yes.

Q170 Chair: What kind of oversight will there be on that?

David Bennett: We are working on that right now.

Q171 Chair: You are having discussions already about how that is going to—

David Bennett: Yes. We only found out about the money on Sunday.

Q172 Chair: Yes, so are you not sorted yet?

David Bennett: We won't go there.

Q173 Rosie Cooper: There is a quote from the FT network in here somewhere which says that the money that is going in will mitigate the lack of funds now and will not do what you are suggesting you hope it will, i.e. make the change—where did I get it—

David Bennett: That is the risk, is it not? Some of it is meant to. Of the however many billion it is the Government are putting in, some of it is meant to promote change and some of it is meant to close the funding gap, and we need both.

Q174 Chair: As to the money that is going in to close the funding gap—and I accept you have only had two days to start thinking about this—do you envisage or anticipate that will mostly take place through the payment mechanisms, through the changes to tariff?

David Bennett: How does the money sort of arrive?

Q175 Chair: How does it filter through?

David Bennett: There are lots of different ways of it happening. It could be through tariff, through specific payments to providers, or it could be payments to commissioners and then they use it to pay providers. There are lots of different ways of doing it. There is a meeting on Thursday to start to talk about how we are going to do that.

Q176 Chair: Some of the foundation trusts are in significant debt. Do you see that some of that money might be used to pay off their debts?

David Bennett: I sort of hope not.

Q177 Chair: No, you hope not.

David Bennett: Just to be clear about this, if a trust, whether it is a foundation trust or not, runs out of money, then the DH makes sure that they can pay their bills. That happens anyway.

Q178 Rosie Cooper: I have just found a quote which basically says that the FT network were hoping that the £1.5 billion that will go to the CCGs and specialised commissioning may be seen to ameliorate the worst of the tariff and the overall settlement. In other words, it is going in to plug the gap. How does—

David Bennett: They wrote that before the Government had made any announcements.

Rosie Cooper: True.

David Bennett: I don't know what they knew.

Andrew Percy: It has all been sorted now and everything is fine. We are all going to live for ever and be cared for. Everything is fine now, Rosie.

Rosie Cooper: Okay.

Chair: Thank you very much for coming today, David and Baroness Hanham.