Public Accounts Committee

Oral evidence: Circle's withdrawal from Hinchingbrooke Hospital, HC 971

Monday 02 February 2015

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Guto Bebb; Mr David Burrowes; Stephen Hammond; Chris Heaton-Harris; Mr Stewart Jackson; Austin Mitchell; John Pugh

Sir Amyas Morse, Comptroller and Auditor General, Gabrielle Cohen, Executive Leader, National Audit Office, Laura Brackwell, Director, Sue Higgins, Director and Richard Brown, Treasury Officer of Accounts, were in attendance.

Witnesses: Hisham Abdel-Rahman, Chief Executive, Hinchingbrooke Hospital; David Behan, Chief Executive, Care Quality Commission; Maureen Donnelly, Chair, Cambridgeshire and Peterborough Care Commissioning Group; Richard Douglas, Director General for Finance and the NHS, Department of Health; David Flory, Chief Executive, NHS Trust Development Authority; and Steve Melton, Chief Executive, Circle Holdings, gave evidence.

Q1 Chair: Welcome. There are six of you today. I was just told in our pre-meeting that there should have been a seventh person. It is crazy, but that is how the NHS is these days. David Flory is the only person who was here when we looked at this in 2012. Richard Douglas is standing in for Una. I shall remind you of what you said before. No doubt you have gone back over the transcript yourself, David, but you said: "I am seriously saying that the financial viability of the Trust can be secured." You went on to say: "My first level of confidence is that the organisation will trade in financial viability." We saw that there was a potential there to be achieved.

Neil McKay said: "We evaluated them, and we felt that in overall terms their proposals were reasonable." He then went on to say: "We used PwC, which is well experienced in this kind of area, to give us advice about the respective merits of an operating franchise versus the other options shown in figure 4." When I asked Una O'Brien, "What happens if this fails?", she said, "I am not expecting it to fail." That is a smattering of the views expressed across all the health bodies at the time that this could not go wrong. So, Richard, and David in particular, why did it go wrong? What did you guys get wrong?

David Flory: We went into the contract—the franchise agreement—with an expectation of success. It was a very new and unique situation to be in. There was no one version of the risk assessment for public consumption and a more private and harsher risk assessment that we were keeping to ourselves. The assessment that we shared at the last hearing was absolutely how we saw things at that time, and we had an expectation of success.

There are a number of reasons why it has not worked. First and foremost, the NHS has changed significantly in the two to three years since then. It is doing a lot more non-elective and elective work than it was at that time—more than we could have projected forward at that stage—so there is a pressure of demand on the service that is greater than anticipated.

Secondly, the financial environment in which the service operates has become tougher. The rate of increasing demand on the service has been greater than the movement in money year on year. Across the service as a whole, in all parts of the country, the demand for increases in productivity and efficiency are greater than before. In some situations, local health economies have not been able to keep in balance in the face of those pressures, and fundamentally I think that that is the case here.

We discussed at the last hearing—I remember this very clearly—the issues around Peterborough, in its proximity to Hinchingbrooke, and last year we identified that health economy, Cambridgeshire, including Peterborough and Hinchingbrooke, as challenged. It was very difficult for all bodies there to come together and make all the numbers add up in a sustainable way. As a result, this was one of 11 economies where further analysis and understanding of the problem was commissioned. It is very, very challenged in a service-delivery, economic sense. Hinchingbrooke is operating in that. Peterborough and Stamford is a large foundation trust. Addenbrooke's is clearly a large foundation trust. Hinchingbrooke has found it, I think, more difficult to trade successfully in that environment than we envisaged at the time of the contract being laid. In part, expenditure is up and cost improvement has been more difficult; and in part, income is down. A combination of all those things has put significant pressure on the financial trading account of the trust.

Q2 Chair: Before I come back on that, Richard Douglas, do you want to add to it from the Department's point of view?

Richard Douglas: I don't think I would say anything differently from David. Clearly, Una said we did not expect it to fail and we would not enter into a contract that we expected to fail at the start; but there is always a risk around this and, as David said, the trading circumstances for all of the NHS have changed quite significantly. David mentioned the activity numbers. In 2011-12, cost-weighted activity went up by about 1.5%. In '12-'13, it went up by about 1.5%. In '13-'14, it went up by about 2.5%. This year, it has probably gone up by about 4.5%. So there has been this unprecedented increase in overall levels of activity.

Q3 Mr Bacon: Could you just say those numbers again? It was 1.5% followed by—

Richard Douglas: This is cost-weighted activity, so you add the numbers together. In '11-'12, it was 1.4%. In '12-'13, it was 1.6%. In '13-'14, it was 2.6%; and currently, this year—I'm not quite up to the December numbers, but it is about 4%.

Q4 Mr Bacon: Can you just explain in English what cost-weighted activity is?

Richard Douglas: It essentially tries to add together all the bits of activity in a consistent way. If you have an elective overnight stay, it clearly costs more than an out-patient or a day case, so when you look at all activities, you weight them for the relative costs to get the overall increase in activity over time.

Q5 Mr Bacon: So when you say that it was up in 2011-12 by 1.4% on a cost-weighted basis, you are saying that the totality of activity—in the round—and its cost was 1.4% higher than the previous year.

Richard Douglas: Yes.

Q6 Mr Bacon: It doesn't sound that startling. You call it "unprecedented", but 1.4%—

Richard Douglas: That is why I say that actually 1.4% wasn't—the point I was trying to make was that at the start of this period, we were looking at about 1.5%; now we are looking at about 4%. That is the difference I was talking about.

Q7 Mr Bacon: Yes, I know, but what I am saying is that of those four numbers, only the fourth is even remotely startling. The first two sound within the margin of error—

Richard Douglas: For the first two years, you are absolutely right. In the first two years—we are going back here to '11-'12, when this started off—it was a 1.5% increase, which was about what we would expect. What I am saying is that where we are now, this year, it is significantly more than that.

Q8 Mr Jackson: Can I press you on the funding? We will ask Circle health care when we question those witnesses later, but the two key factors were clinical activity around accident and emergency and a reduction—the figure quoted at the time of the report and their withdrawal on 9 January was a 10% reduction. Can you clarify for the Committee where that figure of 10% comes from, because I think that is quite important?

Chair: I think that is more of a broad funding question.

Mr Jackson: Yes, but the development authority of the NHS will have a view on it. If I am not mistaken, the clinical commissioning group has received for the coming financial year one of the highest, if not the highest allocation of funding in England—5.63, against an average of 3.6.

Richard Douglas: The average for England is 3.6 or 3.7.

Q9 Mr Jackson: Right. So where does the 10% figure come from? There is a discrepancy between what the CCG, the commissioners and the acute trust were required to reduce expenditure by, which I think was 4%, and the 10% figure, which was the straw that broke the camel's back, or at least was one of the issues.

Richard Douglas: The allocation growth for the CCG, which is the number that you quoted—5.65 or 5.7, against 3.7 nationally—is the number for next year, so it is the growth for 2015-16 over 2014-15. For this year, I do not recognise the 10% income loss. I have not seen the in-year figures for this year, but the income growth last year, from what I can see from Hinchingbrooke's accounts, was broadly in line with the average for trusts of that size. The accounts income growth was about 4.5%, I think, for last year. I have not seen the income growth numbers for this year.

Q10 Chair: Let's get Maureen Donnelly to help us get to the bottom of that.

Maureen Donnelly: Our spend with Hinchingbrooke has gone up by about 5.5% in numerical terms, over the year period of the contract. Roughly, it has gone up from £86 million to about £91 million. We are the biggest commissioner from Hinchingbrooke. I think that their total income is about £110 million. That, by the way, is on a par with our spend on our other two acute hospitals.

Q11 Chair: So in '14-'15, there is a 6.5% increase in expenditure.

Maureen Donnelly: No, it is 5.5% over the three years.

Q12 Mr Jackson: What was the trajectory? Was it then going down?

Maureen Donnelly: The trajectory—the plan throughout the whole of the NHS—is to try to reduce some activities and to get it dealt with in other areas in a better way. That is what we are planning to do. The trajectory was not downwards, but it was fairly flat, in activity terms.

Q13 Mr Jackson: Moving on from there—and I will ask Circle this—was the cumulative impact augmented by penalty charges? Did the CCG put penalty charges up in the three years between 2012 and 2015?

Maureen Donnelly: All commissioners sign a national contract with their providers, which is for a particular level of activity and a particular quality of service, and it requires you to deliver certain constitutional requirements, such as A and E achievements. In the national contract, there are consequences if the parties do not meet what they have contractually agreed to. We levy those consequences if the parties—

Q14 Mr Jackson: To what extent?

Maureen Donnelly: In all years so far, the consequences we have levied on Hinchingbrooke have been less than the growth of spend on Hinchingbrooke.

Q15 Mr Jackson: What does that mean in English? How much?

Maureen Donnelly: Let me look at my figures.

Q16 Mr Jackson: We are trying to understand where the widely quoted 10% figure comes from.

Maureen Donnelly: By the way, I do not recognise the 10% figure. Most of the disputed amount for '14-'15—

Q17 Chair: You won't have decided '14-'15 yet.

Maureen Donnelly: No, we haven't, but we are fairly clear about where it might end up. For example, the final settlement in '13-'14 was 3.7% over the contract value we agreed with the hospital, and that is with £2.9 million deducted for the consequences. The consequences are partly for non-delivery of quality standards, and we also rigorously and forensically assess the invoices they send us, and if they are over the threshold, or they are up-quoting, we will challenge that.

Q18 Mr Bacon: Can I be clear about what you said? When you said 3.7%—

Maureen Donnelly: £3.7 million over contract value.

Q19 Mr Bacon: I am not clear about what that is. Is that an increase?

Maureen Donnelly: It is the increase of activity, for which we paid.

Q20 Mr Bacon: So what you are saying—one minute you were speaking in percentages, and the next minute in millions of pounds—is that there was a 3.7% increase in the trust's income, to which you were contributing, notwithstanding the £2.9 million of consequences, fines or penalties levied by you. Is that right?

Maureen Donnelly: Yes, they are £3.7 million over contract, with £2.9 million deductions.

Q21 Mr Bacon: Sorry, you just said £3.7 million. A minute ago you said 3.7%.

Maureen Donnelly: I should have said £3.7 million. My apologies.

Q22 Mr Bacon: So, net, net, net, they were £3.7 million up, notwithstanding the £2.9 million, yes?

Maureen Donnelly: Yes.

Mr Bacon: You are not saying they were £800,000 up. You are saying that, net, they were £3.7 million up.

Maureen Donnelly: But I don't think it was quite—yes, we are.

Q23 Mr Jackson: Will Circle try to clarify this, if possible? Where does this 10% figure come from? It was, as I say, widely quoted and was one key factor in your decision.

We can come back to the Department of Health, because the idea that it did not know there was going to be an increase in population and an increase in older people—that there would, for instance, be a faster-growing number of older patients—and an issue with social care in 2012 defies belief. We will come back to the NHS in a minute.

Can you give us those figures?

Steve Melton: In short, the 10% comes from me. We cited it in explaining the very difficult decision to withdraw from the contract. There were three factors. One was rising demand on the hospital, particularly accelerating in the last 12 months; the second was reducing funding—where I quoted the 10%; and the third was that the solution to this combination of issues as we understand it, across the whole of the NHS, is the reform of services in the way that NHS England's Simon Stevens has laid out in his five-year plan. That is not, in our view, sufficiently close on the horizon to give relief to Hinchingbrooke, hence to make the financial model sustainable.

To come back to your direct question on the numbers, the trust's income, as per its accounts over the last three years, has gone up by £1 million. So it has gone up from 111 to 112 over the three years of the franchise to date. During that time, the activity has gone up substantially. Across those three years, elective admissions have gone up by 25%; A and E attendances have gone up by 18%—and most of that in the last year—and non-elective admissions have gone up by 11%. The 10% was me explaining how those two factors—

Q24 Mr Bacon: Could you just say the last one again? 18%, and?

Steve Melton: 11% for non-elective admissions. So attendances at A and E are significantly higher even than admissions.

The 10% was me explaining the gap between those. In the last year, the trust has experienced pricing deflation of approximately 4% in line with national tariffs. This is a small trust with a very high dependency on payment-by-results tariffs—

Q25 Mr Jackson: But that is generic across all hospital trusts.

Steve Melton: That is generic, you are absolutely right.

In addition to that, 3% of reduction in income based on specialist and local tariffs: things like intensive care, maternity, etc. The final 3% is contractual deductions.

Q26 Chair: But you said, Mr Melton—or your company said—at the time you signed the contact that you would get over £300 million of savings. You are proud of having delivered £24 million, but you said you would get £311 million of savings. On the reduction in tariff, actually,

anybody in ’11-’12, would have known that we were reducing the deficit: they knew the pressure and knew Nicholson had banged on and on about the £20 billion gap. So it was not a surprise to you that your tariff is going to go down a little bit. You enter the contract confident that you would achieve over £300 million savings. Why didn’t you?

Mr Jackson: But they back-loaded their savings.

Chair: No, they quoted £24 million, not £311 million. Why didn’t you? You came into it knowing that, and we were sceptical.

Steve Melton: The savings case that we put into our bid was, over the life of the contract, just a little over 5% savings per annum.

Q27 Chair: It was a 10-year contract, wasn’t it.

Steve Melton: Over 10 years.

Q28 Chair: And you have saved £24 million: that is what your press release says.

Steve Melton: Over the first three years of the contract we have delivered on that 5% savings case.

Q29 Chair: You have saved £24 million against a target of £31 million, and you are moaning about a tariff reduction, which you should have predicted.

Steve Melton: We delivered on—

Q30 Mr Jackson: From the outset, in fairness, I found the previous chief executive of Circle an extremely unconvincing witness. He was not very compelling at all and was out of his depth, in my opinion, before the Committee when we looked at the health economy in Peterborough and Cambridgeshire in November 2012. But you read the same Report as us. You read all the evidence and you saw the disastrous mismanagement by the strategic health authority, whose chairman skipped off with however much public money by way of a pension. He is not here today. Did you not think at the time, as a senior manager at Circle Health, that this was a real risk you were continuing with and that it was going to be nip and tuck as to whether you could make it work? I am a bit concerned that you did not think that the Report was worrying enough for you to think about the future viability of the business.

Steve Melton: The National Audit Office Report described the savings case as ambitious. It had to be ambitious to turn around a hospital that was failing in quality terms and in financial terms and was faced with closure. The savings case is approximately just over 5% per annum. That is a little more than many other trusts in England are faced with delivering to deal with the same overall financial pressures that the NHS finds itself in.

We committed to that turnaround and we believe that, over the first three years, we have delivered that level of savings. What has changed for us is the baseline. The benefits case that the SHA put together assumed flat volume. It did not assume the unprecedented levels of increase in A and E demand and acute admissions that we have seen, and it did not anticipate the level of pricing reductions that I described earlier in terms of the 10% you were asking about.

Q31 Mr Jackson: Just for clarity—to be wholly fair, it is not exactly the case that you received a 10% cut in funding. You are talking about the differential between what you were expected to do and the broadly flat income that you received. Am I right in saying that? A different impression was created on 9 January, so we need to be clear what the situation is.

Steve Melton: It is effectively a 10% reduction in price per unit of activity.

Q32 Mr Jackson: Right. So you are not talking about a cash amount that was cut.

Steve Melton: No. The cash has stayed flat—virtually absolutely flat over three years—while the activity has increased in the dimensions I described. In the last year, A and E attendances have gone up, at times, by 30% per annum. Over a cumulative period of time, they are 13% up year on year. The importance of that is not just more activity; it brings with it in the current NHS climate very significant premium costs. For example, because we have difficulty like many other hospitals in discharging medically well patients to the community, we have a significant increase in beds and an increase in nurses. In the current recruitment climate, those are agency nurses at a premium cost. All those things add up to premium costs at the same time as price deflation.

Q33 Chair: Before we move on, I want to come back to the Department on the finance issue.

Sir Amyas Morse: I want to make quite sure that we are clear, Mr Melton. When you went into this contract, you absolutely and clearly undertook to take responsibility for the demand risk. So you did understand the initial risk, didn't you?

Steve Melton: We took on the risk in the contract. Based on what we could see looking forward at the time, we believed that we could see the trust through. The reality is that we did not see the rate of change.

Sir Amyas Morse: I understand what you could see at the time. But just to be quite clear, as far as the risk of fluctuation in demand is concerned, you took that risk on in the contract. Is that true?

Steve Melton: Yes, it is true.

Sir Amyas Morse: Thank you.

Q34 Chair: They took the risk, but you signed the contract and I want to get back to that. In your explanation, David Flory, you talked about the risk assessment. You talked about savings being unrealistic and the pressure on demand. When we talked to you two years ago, we were absolutely clear: we thought that you had not done a good enough risk assessment and that the projected

savings were unrealistic. I don't think we or the NAO were the first to say that. It wasn't rocket science to unravel that in the course of our inquiry. It strikes me that, within the Department or within somewhere, there is an accountability issue. There is someone who did not do the proper job before you signed the contract with Circle. I think Circle has things to answer for but I actually think that the Department—and you were in there at the time, David—did wrong, and someone has to be accountable. You are nodding, Mr Douglas.

Richard Douglas: Sorry, I wasn't quite sure whether that was a question or a statement.

Chair: Who is accountable? Tell me. There is frustration from this end of the table about things going ridiculously wrong that we sit here and talk to you about, and then you come back and say, "Yeah, well, we got it wrong." If you have a good explanation let us hear it.

Richard Douglas: David has given the explanation about what has changed. Clearly there was risk in this contract.

Q35 Mr Burrowes: The Treasury minute says at paragraph 6.3, "The TDA will monitor progress and take action if the Trust fails to deliver the plan." What action has been taken at an early stage?

Richard Douglas: We will get into issues about the action and how that has been managed. In terms of the contract overall, there was risk in the contract. Any major transaction will have risk in it. There would have been risk if we had carried on with what we had before; the track record on the previous way of running this wasn't fantastic. If you look at accountability—

Q36 Chair: But we were critical there, weren't we? We said that there was over-supply in relation to demand with the direction of travel of the NHS. We said it, and, surprise, surprise, two years later that is what happens.

Richard Douglas: We will come back to the question of whether there is over-supply. Despite what a lot of people have said, in most of the NHS we were not seeing that there was over-supply.

Q37 Mr Bacon: We are not talking about most of the NHS. We are talking about this area.

Mr Jackson: This health care economy.

Richard Douglas: At the time, there was a risk assessment. The NAO took the view and you took the view that that risk assessment was too optimistic. Clearly, this has not ended up the way we wanted it to, but we went through a process for assessing that risk. It went through a number of Departments and then it finally went to the Treasury. At the end of the day, the person who finally signed it off—the official—was me. All those major transactions, having been through all the processes, come to me based on the business cases that are presented.

Q38 Mr Burrowes: This is not just a one-off risk assessment. This is an ongoing process. It is not just a case of having done the risk assessment. For example, paragraph 2.6 of the Treasury

minute says that "Monitor will do so through its risk assessment framework. They have powers to intervene where needed to act on warning signs and manage risks, including helping the department to protect the taxpayer's investment". Where is the evidence of that ongoing risk assessment during the process?

Richard Douglas: David can explain the oversight that the TDA has provided since the contract has been in place and the interventions that have happened.

Q39 Mr Jackson: The point is that 35 miles away, you had what has now turned out to be the largest structural PFI deficit in England, at Peterborough and Stamford hospitals; you were warned about that by Monitor at the time and disregarded that advice, as did the strategic health authority. That would be bad enough of itself, but then 35 miles south in Huntingdonshire you have a situation where you award a private franchise to Circle health care, which again is risky, and both yourself and the strategic health authority, which existed at the time, do not seem to have taken any note of demographic changes, the ageing population, the fact that Cambridgeshire has one of the fastest growing populations in England. You just disregarded it. What ongoing risk assessment was ever done for both those hospitals?

Richard Douglas: I do not think that all the things you said were disregarded. When people looked at this, in both cases—both Peterborough and Hinchingbrooke—they took into account their best estimates of what would happen with demographic changes and so on. With giving the Hinchingbrooke franchise to Circle, the assessment at the time was that that was the best way of maintaining the services in a way that would deliver value for money for the taxpayer.

Q40 John Pugh: The thing is, you stated early on, Mr Flory, that there was an expectation of success. Had you come here and said, "We have had a turnaround team in and that hasn't worked. What have we got to lose by going down this particular road?" that would have been more plausible. We look at the NAO Report. You mentioned extraneous circumstances like a sudden surge in A and E, but even before that was identified the NAO Report said that the savings were "unprecedented as a percentage of annual turnover in the NHS", and you do not dispute that; that "Circle's bid did not fully specify" how savings would be made, and you do not dispute that; and that Circle will do better than anyone has ever done in managing that hospital in the past decade, and I do not think you would dispute that either because, presumably, the support was agreed.

That was the environment in which the choice was made. Under those circumstances, no rational person would expect success. They would hope and try for success, but would recognise that it was an extraordinarily high-risk venture, but perhaps there was nothing to lose. Is that not a more honest account of the scenario that prevailed in the Department of Health?

David Flory: Undoubtedly, in the period prior to the franchise, the trust had lost a lot of money on a year-on-year basis. The cumulative deficit at that stage was something in the order of—

Q41 John Pugh: Prior to the Circle contract, who did the turnover? What was the turnover team for the hospital?

David Flory: The strategic health authority.

John Pugh: It had been the strategic health authority, not external consultants?

David Flory: No, there might have been some commissioning of external consultants; I do not know. The trust had built up a cumulative debt on its year-on-year revenue account of £40 million. At the point of the letting of the franchise—to come back to the scenario that you paint, which was a very real one at the time—there was the question that it could not carry on like that.

John Pugh: Desperate times need desperate remedies.

David Flory: It could not carry on making losses to that extent and at the point of the franchise agreement, there was a question of running a year-on-year basis without adding to the cumulative deficit. The mechanism in the franchise to do that was to transfer risk for the first £5 million of losses to Circle—that was a real transfer of risk, which has materialised and been a hit that Circle has covered—and, potentially going beyond that, to begin to repay the cumulative deficit.

Chair: Mr Flory, I think what we are quarrelling with is that you did not say to us when we were questioning you two or three years ago, "This is risky. We acknowledge that there are a lot of savings out there that you have to get." Nicholson, your boss at the time was going around the country talking about cuts of £20 billion that had to be found somewhere in the NHS. If you had acknowledged all that, this would be an easier start. I want to move off this, but we feel that you came here super-confident, thinking that the PAC has got this completely wrong and this is not risky. That is why I took those quotes out. Now you are saying, "Of course it was risky. Of course we understood the risks, and the demand and supply in that particular area." That was not clear two and a half years ago.

Q42 Mr Bacon: Can I just ask one other thing? Mr Melton said, Mr Douglas, that the benefits case assumed flat activity. Is that correct?

Richard Douglas: I would have to check back on that. I do not know the answer to that.

Mr Bacon: Because the activity was nothing like flat, was it? You have been reeling off statistics on things that have shot up.

Richard Douglas: No.

Steve Melton: That was the assumption for non-elective activity.

Q43 Mr Bacon: Why?

David Flory: Because if we go back to the challenge in 2009—looking forward to the need to save £20 billion over the next spending review period— the expectation was that that would require a lot of transformation in the way that health care was delivered, and a big part of that would be that fewer people would be admitted to hospital non-electively, and instead would receive more appropriate care closer to home.

Q44 Mr Burrowes: Ms Donnelly, would that be your assessment of that? Is that the realistic position?

Maureen Donnelly: Our system—Cambridgeshire and Peterborough—is a very challenged system. Up to and including this year, I think that we were the second-lowest funded CCG per head of population.

Q45 Mr Burrowes: But would your assessment at the time been one of flat non-elective activity?

Maureen Donnelly: We were aware that activity was increasing. We were also aware that activity needed to come out of hospital and—

Q46 Chair: You were aware that activity was increasing—when?

Mr Burrowes: As far as you are concerned, non-elective activity was increasing.

Chair: When? In 2012?

Maureen Donnelly: We were aware right throughout the period that it was increasing.

Q47 Mr Burrowes: So there was a clear difference for the people on the ground. The commissioners responsible for commissioning health care were aware of an increase in activity, which is obviously at odds with your assessment.

Maureen Donnelly: May I just add that we were also aware that we had to try and control it and to cap it?

Q48 Chair: You were aware of policy, but you were aware of actuality.

Mr Bacon: Sorry, can you repeat that last point? I didn't hear it.

Maureen Donnelly: We were aware that we had to take whatever action we could to try and reduce the non-elective activity.

Q49 Chair: Can I just ask one question, then I will go to Stewart to take us on to another area? What has happened to Sir Neil McKay?

Richard Douglas: Neil left I think about two years ago, when we abolished the strategic health authorities.

Q50 Mr Bacon: Was he made redundant?

Richard Douglas: Yes, he was.

Q51 Mr Bacon: How much did he get?

Richard Douglas: I haven't got the numbers in front of me, but I think we have given those to the Committee before, because we gave a list.

Chair: I think you have. Can you remind us; can you give them to us again?

Richard Douglas: I can give them to you again. Sorry, I don't remember the numbers—

Q52 Chair: And is he still employed anywhere in the NHS, either at a consultancy level or in another capacity?

Richard Douglas: I am not aware of him being employed.

David Flory: I am aware that he is doing some consultancy work in some parts of the country.

Chair: For the NHS? For me, somebody has to be accountable. You don't just walk away from a decision because you have changed your job, and it is about time we just started getting a bit of responsibility and accountability into the system. Looking back at that hearing, I understand that you signed it off, Mr Douglas, but he was the guy doing the negotiating, and I just do not think it is acceptable that he now makes money as a consultant in the NHS.

Q53 Mr Bacon: Why would somebody pay for his advice, after he left this mess? That's what I don't understand. Why, Mr Douglas?

Richard Douglas: Well, I don't pay him for anything.

Mr Bacon: You are the finance director of the NHS. You are ultimately responsible for all the money. I am just curious; why would anyone want to pay for his advice with this track record?

Richard Douglas: Neil clearly has a lot of experience throughout the NHS over about 40 years, so I assume people wish to draw on that experience.

Q54 Mr Bacon: When was the last time any of you spoke to Sir Neil?

Richard Douglas: I can't remember. It must be at least 18 months to two years.

David Flory: Six weeks.

Q55 Mr Bacon: What was it about?

David Flory: It was about some work that he was doing for a local organisation in the midlands.

Q56 Mr Bacon: Were you involved in commissioning that work?

David Flory: No.

Q57 Mr Bacon: Has the CQC commissioned him to do work? Who has commissioned him to do work?

David Flory: A local NHS organisation.

Q58 Mr Bacon: Do you mean a foundation trust?

David Flory: It is either a CCG, a trust or a foundation trust.

Chair: Let's go back to Stewart who will take us on to another issue.

Q59 Mr Jackson: Before I go on to the CQC, can I just clarify something? I don't want to get into the political ramifications of whether this was a privatisation of an acute district hospital, but I just put it on the record that *The Times* reported on 27 March 2010 that the three preferred bidders put forward by the then Secretary of State were all effectively private sector bidders. I know that there is some controversy, because one was a part public sector bid with Peterborough and Stamford hospitals, which never came off. My question is more about process: what exemplars were used in designing this contract, because there is a question in the air, from a number of people from all sides, as to whether Circle health care had the capacity and expertise to take on what was effectively the management of an acute district hospital—the first in the country? What experiences did you draw on? What knowledge and examples did you use in terms of expertise to help draw up that contract, which would have been in 2009 going into 2010?

Richard Douglas: It would have been 2010, I think. Our strategic health authority did it based on its assessment and evaluation of the bids of Circle and the other bidders at the time, drawing on what it knew about the organisations and what it knew about the local health economy. As David said, it also drew on external advisers for that.

Q60 Mr Jackson: Who were the external advisers?

David Flory: I cannot recall, I'm afraid.

Q61 Mr Jackson: Specifically, did you use any examples of similarly sized acute district hospital set-ups in Europe or the United States that had the full range of clinical care of an acute district hospital?

Richard Douglas: I would have to go back to the evaluation for that. I have not gone back to the original evaluation for this—

Q62 Mr Jackson: Will you write to us on that specific issue?

Richard Douglas: I can indeed.

Q63 Mr Jackson: May I just go on to Mr Behan and the CQC? Where do I start? Would you agree that your organisation has been the subject of a great deal of criticism of its bona fides over the past few years?

David Behan: It is a matter of record. The Health Committee and others have criticised us, but over the past few years, we have been carrying out a radical review of what we do and how we do it. We have completely changed the structure of the organisation and the methods that we use. Yes, that criticism has been legitimate, and we listened to it, responded to it and changed what we are doing.

Q64 Mr Jackson: Really? In June last year, the *Local Government Chronicle*, in a report on your inspection regime, gave quotes from your staff that the new inspection regime was "unsustainable" and "inconsistent" and that staff felt "used, deflated and exhausted". One senior inspector was quoted as saying that the CQC was a "lynch mob not a serious regulator". Your own chairman was quoted in February 2014 as saying, "The CQC had failed totally…We are not fit for purpose at all."

The Health Committee in September 2011 found that the CQC was not "sufficiently clear and realistic" in its definition of its priorities and objectives and had "a lack of confidence in its ability to execute its main functions efficiently." That was relatively recently and before we go into the debacle of Cynthia Bower, who walked away with a £1.5 million pension pot in 2012 and was intimately involved in the Mid Staffs debacle. That is not to mention the fact that you rated Basildon hospital as good and a few weeks later it was assessed as the worst hospital in England. You took your eye off the ball with Winterbourne View and there were questions of efficacy and ethics on that. Recently, you wrongly categorised 60 general practitioners in Suffolk as a result of "a methodology mix-up", which caused an enormous amount of problems.

The reason why I mention all those things is that one has to ask the question: are you fit for purpose to judge an organisation that in May 2014 was winning awards as a result of demonstrable, clear, statistical data? Within four or five months, your report, based on anecdote—some might say tittle-tattle—rated it as inadequate and judged it one of the worst hospital inspections that you have ever undertaken. Do you think you are in a fit position to judge Hinchingbrooke hospital?

David Behan: That is the job I have been given to do. I went to the CQC in 2012. There is a new board and a new senior management structure in the CQC. We have completely changed the way that we inspect. A number of your comments and criticisms predate that. In 2013, we set out with a new approach to inspecting health and care services in this country. I said at the time it would take three years to deliver that strategy. We are now in our second year of delivering that strategy, and we have changed considerably. Yes, my staff are heavily committed to their work. I am on the public record as saying that at the minute we do not have enough staff to do the job that we are asked to do. Therefore, those staff who are undertaking the work are under some pressure. That is a matter of public record and I do not step back from that at all.

However, I suggest to the Committee that we have changed, and changed quite dramatically. The evidence for that is that there are improvements in our staff survey; that is a matter of public record. You referred to the Health Committee work; that was in 2011. I think that in its last meeting under the previous Chair, the record of that meeting was to note the progress that had been made by the CQC. Shortly, I expect to get the report of our last accountability meeting, which took place in December 2014, and they will comment on how they think we are progressing. So we have come a long way, we have done a lot, but there is still much to do.

In terms of our responsibilities in relation to Hinchingbrooke and what we found, this was the first of our inspections at Hinchingbrooke using the new methodology. More than 30 people were on that team. There were eight inspectors, and the rest were clinicians, doctors and nurses, as well as experts by experience.

Q65 Mr Jackson: We will come to who was on that team, because that is a pertinent issue.

I think that one of the most misnamed regimes in the NHS is probably your intelligent monitoring system. It is probably an oxymoron, given that in May 2014 the NHS trust won an award for quality

of care, based on 12 criteria, including the length of stay in hospital and the rate of emergency readmissions, and yet your intelligent monitoring system did not pick up that, within four months, you rated it as one of the worst inspections ever undertaken. Why do you think that was the case?

David Behan: The intelligent monitoring system is not a measure of quality; it is not a judgment around the services that it relates to. We use it, and the phraseology we have used it is that it is a "smoke alarm", to ask questions that lead to a decision on when we inspect and the priorities for that inspection. The CQC has never, ever claimed that the intelligent monitoring is any more than a tool to direct what we inspect, and when we inspect it.

We have developed that intelligent monitoring. In the first 50 inspections that we have taken, we have compared what the intelligent monitoring says with the outcome of the inspection, and it shows that there is a correlation that is greater than chance. I think that in 49 inspections that we have undertaken where we have correlated with the intelligent monitoring, 28 of our judgments were in line with what we expected to see and another 21 were not. And that goes both ways.

Q66 Mr Jackson: Well, no, except that you rated it in the lowest band of risk—band six—four months before you delivered a judgment that it was one of the worst inspections that you had seen and that the trust was inadequate.

David Behan: Yes, we did, and that plays exactly to my point that intelligent monitoring is a way of directing what we inspect, and any rating we give is not solely on the back of intelligent monitoring. It is on the back of the intelligent monitoring plus the data we collect prior to an inspection, the intelligence we collect from groups and interested parties in that locality, and what we find in the inspection, and that is how we get to our ratings. Ratings are not solely derived from the intelligent monitoring.

Q67 Mr Jackson: So you give it a six, which says there is no risk, which implores you to go and inspect it because you think there is a risk? I don't really understand. If it was rated four or five, or three, you'd think, "Well, maybe there is a risk. We should inspect it." What is the point? You say it's a smoke alarm. Someone has taken out the battery, or dismantled the smoke alarm, because it doesn't seem much of a smoke alarm to me, frankly.

David Behan: What I am saying to you is our judgment around the quality and safety of what we see in hospitals is not solely derived from the intelligent monitoring. The intelligent monitoring is used to direct our activity. We gave an undertaking to inspect all acute trusts by December 2015. Our focus initially was on those trusts that were at the highest risk, and once we had been through them we then started our programme to inspect all acute trusts. We went into Hinchingbrooke as part of that programme. As well as the ones that we rated as a six, which we found to be inadequate, we also found some that were rated as a two or a three, which we determined to be good. That is exactly my point. The correlation is greater than chance, but it is not a strong correlation. The intelligent monitoring, of itself, is not sufficient to arrive at a judgment; it needs to be supported by inspection.

Q68 Chair: Before you go on, may I just ask David Flory and Maureen Donnelly whether their monitoring was telling them that quality was an issue at the hospital?

David Flory: In our TDA oversight of the trust, we were looking at—

Q69 Mr Jackson: What oversight? We haven't heard about any oversight. We were promised oversight. You haven't yet enunciated any kind of oversight. Mr Douglas said that we would come on to discuss oversight, but he failed to answer Mr Burrowes's question. Is there any?

Mr Burrowes: I am still—

Chair: Okay. Answer on the general oversight, with particular reference to quality. Let's get an answer on the broader one.

David Flory: Hinchingbrooke, even under franchise, is an NHS trust. There is an accountability relationship from the NHS trust to the NHS trust development authority, and therefore there is an oversight and accountability responsibility. That is different for Hinchingbrooke and the franchise, however, because it is not a conventional trust board structure in that sense. The model of holding to account is different because the day-to-day operational management has been contracted to Circle.

Q70 Mr Burrowes: In the past two or three minutes I haven't seen any sort of caveat. You are still talking about the same processes of accountability, including with Monitor. There is nothing in the Treasury minute that suggests there is an opting out of monitoring, risk assessment and process.

David Flory: No, we have not opted out of monitoring. It is simply a different arrangement.

Q71 Chair: Why? That is what we are trying to get at. Why is it different?

David Flory: Because the constitution of the trust board is not the same as in an NHS trust.

Q72 Chair: It doesn't really matter, does it? What difference does that make?

David Flory: It makes a difference in terms of the day-to-day interaction with the management of the trust.

Q73 Mr Burrowes: The nature is different, but that doesn't stop your fundamental duty in terms of monitoring and assessment.

David Flory: No, it doesn't change. Our oversight is above that.

Q74 Chair: Do you chat to different people with different job descriptions?

David Flory: Yes, but with different levers of intervention.

Chair: Why? Explain that to me.

Q75 Mr Burrowes: They are different, and I want to know the difference. They may be different in nature, but they are not less. In terms of intervention, are you saying less or more?

David Flory: Different.

Q76 Mr Burrowes: Is it less?

David Flory: No, it is different. With a conventional NHS trust board, if significant problems emerge in the course of the TDA oversight, whether on the delivery of NHS constitution standards, on financial performance or on the quality indicators, we have a form of intervention with the trust board that leads to holding to account for improvement in any of those areas. One of the differences in this franchise arrangement is that the financial risk of deficit, up to a ceiling defined in the contract, has transferred to Circle.

Q77 Mr Jackson: That is irrelevant. We are talking about patient care, and I think you are trying to avoid a straightforward question, which is this: what was the overall response of the TDA, discharging the legal duties given to you by Parliament, to risk assess—Mr Douglas used the term "ongoing risk assessment"—between 2012 and when the inspection was undertaken, when no doubt you will have been alerted to the issues raised by the CQC? What did you actually do, on an ongoing basis, to risk assess Hinchingbrooke trust?

David Flory: I will come on to the quality aspects. My illustration of the financial situation was an example of why and how this is different from a conventional NHS trust. In terms of the quality, our oversight looks at a number of different areas, and one part of that is constitutional standards. I don't know whether that falls within your definition of quality, but it falls within mine—the number of patients who were seen quickly in the accident and emergency department, the time

that people wait to have an operation and so on. Throughout most of the franchise period to date, the trust has performed well against the delivery of constitutional—

Q78 Mr Jackson: That is not my question. I will repeat my question: what did you do? I am familiar with the regulations laid down by Parliament in terms of your responsibilities as the NHS trust development authority. I am asking what you did. Please disabuse me of the notion that you had not a clue what was going on at Hinchingbrooke until you read the report. I want to know what your authority actually did.

David Flory: The authority maintained an oversight of key performance indicators in the trust. The key performance indicators in the trust about service delivery did not present a problem that required an intervention. In large part, those standards were met. When they dipped below, inquiries were made about how that position was going to be—

Q79 Chair: Were there no complaints from patients or anything? Maybe you can answer, Ms Donnelly. It is quite surprising that CQC goes in, everybody thinks it is hunky dory and suddenly it becomes the worst hospital in the country. That does not happen. That is what we are struggling with here.

Maureen Donnelly: If I first say how we monitor, and then what we perceived in the hospital and our reaction to CQC. We have staff who are responsible for monitoring patient safety and quality. They report to a sub-committee on patient safety and quality every month, which reports to our board. That monitoring is a mixture of quantitative and qualitative data. For example, for all our providers—our three hospitals, the mental health trust and our community services—we receive data on any incidents or serious incidents, on mortality rates and on A and E.

Q80 Chair: So did you know?

Maureen Donnelly: In general, Hinchingbrooke has been reasonably good. We did have concerns over the past year on a few issues. The issues that we had concerns about were C. diff, which has never been good. MRSA has been good, but C. diff has not. Over the past six months on A and E—they were good on A and E up until last July. It has performed quite poorly since then, but it has in many other hospitals. We were concerned about staffing levels, and we were concerned about things like how long it took to get discharge letters out to GPs, and so on. We had raised them with the hospital, and we were going through the contractual processes of monitoring those and putting in place plans to address them, and, if necessary, imposing consequences if they did not meet them.

I have to say, though, that we have limited staff. The CQC, as Mr Behan said, had over 30 people they could put in, in depth over a period of time. Some of the issues that we have, we had already raised with them. We might have taken them further if we had not been aware that the CQC was about to go in. The report has said a number of good things about Hinchingbrooke as well, but we accept what CQC have said, and we are working with the hospital to address them and rectify them.

Chair: What comes out of that—this is just a comment, and no doubt we will consider how it is reflected in our Report—is that the two organisations that are supposed to be overseeing this

hospital failed. Both of you were, on the whole, satisfied with the quality of what was being delivered in Hinchingbrooke. Suddenly, out of the blue, in goes CQC and finds it to be the worst hospital in the country.

Mr Burrowes: We do not know whether it succeeded or failed, because we are not quite sure who is right.

Q81 Chair: Well, CQC is reviewing—there is a review of the original inspection report, isn't there?

David Behan: Yes. We went in to do the first inspection between 16 and 18 September. We went back on 21 and 28 September, and we went back in on 2 January.

Q82 Chair: Have you completed that, then?

David Behan: That is completed. I think the conversation has taken place between Hisham as the chief executive and the team, and they are now writing that up. That will go through our quality assurance process.

Q83 Chair: Can you share with us anything out of that?

David Behan: The good and positive news is that there have been improvements made. A lot of the issues that we identified in the report—practical issues that were observed and arose out of conversations that we had with both staff and patients—action has been taken on, and that is clear. There is more to do in relation to accident and emergency, but our view is that improvements have been made. A lot of those things that we wanted to see improve quickly are beginning now to be put in place, and improvements are being seen.

Q84 Chair: That is welcome, but there is a systemic issue. Before we move on to the next thing, Richard Douglas must answer for the Department. The two organisations charged with day-to-day monitoring of the hospital failed to identify, until CQC went in, what was clearly a very serious set of affairs around quality. What does that tell you about your current systems?

Richard Douglas: I think we have got to pick up from the work the CQC are now doing whether there are other indicators that would suggest to us the types of quality problem that CQC found. It is difficult to do, because the CQC themselves are saying that within their own intelligent monitoring, they were not picking this up.

Q85 Mr Jackson: I don't understand their intelligent monitoring system. It sounds like a lot of old management gobbledegook, frankly.

Chair: Somebody should have picked it up before it got to that stage, right? Somehow, the system failed to do that. Maureen Donnelly has said she picked up a bit, but David Flory picked up nothing.

David Flory: Can I complete my answer, please, Chair? We moved on from here. I was conscious that I was talking about financial oversight and the constitution standards oversight, but you moved on from me. I have got a little bit more to say, and if I may say it now, it might help us thinking about the TDAs.

Q86 Chair: Go on.

David Flory: The oversight includes the money to recap and the constitutional standards performance generally good recap. It also includes looking at the whole lot of measures that are directly about the quality of care, and proxies for the quality of care. We track staff and patient surveys carefully to look for signs that things are not quite right or are getting worse. Maureen has spoken about the C. diff rates; infection control advice experts from the CQC went to work with Hisham and his team to look at some of the issues around C. diff. We were aware of where there was underperformance in some areas of quality, driven by the data in front of us, and we respond appropriately with support and an intervention where required to seek improvement.

Our job, where we a see a problem like that, is for experts to help secure improvement. That was in place. What is not in place is 30-plus staff going from the TDA. We cannot do this across what is now 92 trusts. It is a different role from that of the CQC, which goes with an in-depth inspection team to interview staff, walk the wards and all those things. Our intervention is different, and it is essentially driven by the data in front of us on where there are problems. Where we see problems, there is then an intervention and a discussion with the trust about ways in which they will be improved and the support that we can provide for that improvement.

Q87 Chair: My answer to you is that you have to think about whether the data you are getting are appropriate. Finally, on this issue, Mr Rahman, were you aware of the absolutely appalling standards of care being delivered by your staff in the hospital?

Hisham Abdel-Rahman: First, let me introduce myself. I am a doctor in the hospital, and I have been working at the hospital for 14 years. I am an obstetrician/gynaecologist. My unit, which I led before, is CNST level 3 in the clinical negligence scheme for trusts. That is a measure of its safety. Level 3 is the highest level of safety in the country, and there are only 13 hospitals with that level of safety. I come from a clinical background, not accepting mediocrity but seeking only excellence and delivering it. That is my background. I have been in the hospital for 14 years.

The reason why I decided to step up to be a medical director, initially, followed last year by chief executive, is that I was absolutely confident that whatever I have achieved in my clinical background as an obstetrician/gynaecologist in my unit can be expanded to the rest of the hospital. In the first two years, the record—

Q88 Chair: I have allowed you a lot of leeway. It would be really helpful if you answered the question.

Hisham Abdel-Rahman: Yes, absolutely. In the first two years, the data provided, which is called intelligent monitoring, were always monitored either by the TDA or the CCG on a monthly basis, because they look into performance, quality and finance. Each one of them would come monthly and look through the data. The KPIs, or key performance indicators, are very

comprehensive. They look into data like mortality rates. For example, if you remember Mid Staffs, that was a very big smoke alarm telling us something was really wrong. If you look at the curve in Hinchingbrooke, it has always been in a downward trend, and it is below the national average. That is very reassuring, even when we talk about C. diff. In the first two years—

Q89 Chair: Mr Rahman, I am going to bring you back to a question. If the report is right, it was a shocking report. You are there day to day. You are there day to day. You are the guy in charge of this hospital and some of the quotes I have read in the press about the way in which your patients are treated are awful. Were you aware of that? Why did it take 30 people from the CQC to tell you that your standards of care were unacceptable?

Hisham Abdel-Rahman: We found the inspection by the 30 inspectors who came to the hospital problematic, because a lot of the data—

Chair: What does that mean?

Hisham Abdel-Rahman: I am coming on to explain that. They came latest on 2 January—this is the best example, to cut the story short—and they came quickly to tell me, "Improvement has been made on the wards, we are not worried any more. However, we are worried about A and E. We walked in and saw a doctor abusing a patient and shouting at him." Because that had just happened, I and my colleagues were able to go quickly to the A and E. We were lucky, because that patient stayed in A and E for less than four hours, so we could have easily missed him. When we looked into the notes, that patient was profoundly deaf, so he was not shouted at. That was an observation. So the problem of the 30 inspectors is you need to triangulate the hard-fact data, like mortality rates and infection rates. That is important, but it is just as important that you make a spot check over two days, seeing what you can see—but that is what you can see.

We had two problems with the inspectors. One is that we tackled them on some of the cases: we sent them 300 factual inaccuracies. That is hard data. They agreed with 65% of those, but, in spite of that, that does not change the rating. For the remaining cases, we asked them for facts and notes so that we could investigate. They failed to provide that, partly because that is not the process and partly because there were no notes.

Q90 Mr Jackson: Can I stop you there, because this is really important? You are alleging that 65—how many?

Hisham Abdel-Rahman: 65% of the 300 factual inaccuracies.

Mr Jackson: So they made 300 factual inaccuracies in the report and they agreed on 65% of them?

Hisham Abdel-Rahman: Yes.

Q91 Mr Jackson: Mr Behan, your organisation agreed that it made 200 factual inaccuracies in the report, according to Mr Abdel-Rahman. Would you like to respond to that before he makes any further comments?

David Behan: It is no secret that there has been concern expressed at Hinchingbrooke in terms of our findings.

Mr Jackson: Before we get on to the rationale and the apologia—

David Behan: We stand by our findings.

Mr Bacon: Except for these 65%.

David Behan: There is a proper process whereby—

Q92 Mr Jackson: Do you concede that there were around 200 factual inaccuracies in your inspection report?

David Behan: I concede—

Mr Jackson: Just answer the question: do you concede that?

David Behan: —we did make changes. Yes, we did. What I would argue with, though, is the substance of that. Some of those may be issues around presentation, spelling and so on. But did we change? Yes, we did.

Q93 Mr Jackson: Two hundred factual inaccuracies in an inspection report. What is your organisation—a used-car dealership?

David Behan: No, it is not.

Mr Jackson: It is supposed to be a proper regulatory body.

David Behan: Yes it is, and that is what I would contend.

Q94 Mr Jackson: Which is why one of your staff described it as a "lynch mob" and "not a serious regulator" in June in the *Local Government Chronicle*. You should be ashamed of yourself to admit that in this Committee.

David Behan: Sorry, I am not ashamed of myself. I am doing—

Mr Jackson: You are in receipt of public money to deliver accurate reports.

David Behan: And I believe that that is what we have done. That is what we have brought our best endeavours to do.

Mr Jackson: Perhaps Mr Abdel-Rahman will want to continue.

Chair: Let Mr Behan have his say and then we will go back to the Mr Abdel-Rahman.

David Behan: Well, Chair, has CQC had a troubled history? Yes it has. Have we acknowledged that and accepted that and started to do something about it? I would put to you that we have done. Have we finished that journey of changing what we are doing? No, we have not.

I am not coming here today to defend the indefensible. I am, though, coming here to say that the team that went into Hinchingbrooke went about that with their best endeavours, using the new methodology. We undertook our inspection, we did find good care at Hinchingbrooke and we have set that out in the report. We also found care that we think needs to improve, and it needs to improve quickly, and we set that out in the report. Our job is to ensure that we judge that care impartially and fairly and I believe that that is what we have done. We will go back—

Q95 Mr Jackson: But on your journey of discovery you have also traduced the reputation of a popular and hitherto successful community hospital. You must concede that that is the case.

David Behan: Chair, I would put it to you that what we have done is this. We have found what we have found, we have set that out and we have reported that in a public and transparent way.

Q96 Chair: I don't know how we resolve this, but let me ask Mr Abdel-Rahman a question before you come back. One of the things I quote is this. One of the inspectors who went in said: "I've never heard of another carer saying to a patient, 'Don't misbehave, you know what happens when you misbehave'. I have never heard of a patient who pushes their food away to have it pushed back and then pushed into their lap, and then being told off about that." Were those inaccuracies?

Hisham Abdel-Rahman: These are—

Chair: Were those inaccuracies?

Hisham Abdel-Rahman: Exactly, and this is what I am coming on to explain. In the first instance, where they claimed that this was—

Chair: Sorry, I just need a yes or no. Everybody is answering these questions—

Hisham Abdel-Rahman: But this is—

Chair: Were they inaccuracies?

Hisham Abdel-Rahman: Inaccurate, and I am trying to explain why they are inaccurate. In the first one—

Chair: They are inaccurate, are they?

Hisham Abdel-Rahman: They happened. What they heard is what they heard, but there is an explanation, and this is the difficulty about taking in evidence—something that you can witness. That is why I started by giving the example of the deaf patient who was shouted at. This is not dissimilar. This is a student nurse who was trying to use the same banter as the son is using with his father when it comes to mealtimes. Because she was a student, she did not realise that perhaps it is appropriate for the son to use that banter. She used to deal with him every single day and she felt

that was endearing, but obviously in a professional context—she is a student—she needs to understand that is different. That was not used in a context—

Q97 Chair: Okay, Mr Abdel-Rahman, let me stop you there. What you are accepting is that the behaviour occurred.

Hisham Abdel-Rahman: Yes.

Q98 Chair: In trying to sort out what really was the case, I suppose the pushing back of the food—

Hisham Abdel-Rahman: That was a stroke person. That was not accurate. That was a stroke person and, although he cannot use one of his hands, he insisted on being helped to eat. So although you can witness it, there is a good explanation for it, and it is because of the disability. And that is his choice; he can consent.

Q99 Chair: I have to say that we're going to run into terrible territory. We have the CQC saying that they stand by their findings. I have no idea what these—

Hisham Abdel-Rahman: May I just give one example, Chair? Some of the examples, like sedating patients, which would be a very dangerous allegation—

Chair: The what?

Hisham Abdel-Rahman: Sedating patients. That would be a very dangerous allegation. Some hospitals can be accused of going around sedating patients who perhaps have dementia or delusions just for the convenience of the staff. That can be abuse and a limitation of liberty. That is a very serious allegation. When it was made against us at the beginning, we had our own internal audit. We got an external university hospital to come to look at it, and the CQC itself referred us to the local authority to investigate that. None of them found that these allegations were true.

Q100 Chair: Mr Behan, do you want to respond to that? Then I'm going back to Stewart. I just think this is a muddy area, but go ahead, Mr Behan.

David Behan: I think what Hisham is referring to here, Chair, is the issue about the mental capacity legislation and its application in terms of people being able to consent to the treatment that they are being given. I think we have found in other places—not just in Hinchingbrooke but certainly in Hinchingbrooke, we found that there was concern about the way the Mental Capacity Act was being applied in relation to securing consent from people for treatment. That's what's at the bottom of this, and that's what we set out in the report—how that is being used.

Q101 Mr Bacon: Just for the avoidance of doubt, Mr Abdel-Rahman, I take it that it is common ground that there are some circumstances in which, in a hospital, sedating a patient is the right thing to do.

Hisham Abdel-Rahman: Absolutely.

Q102 Mr Bacon: The question is when it is done, to what extent and in what circumstances.

Hisham Abdel-Rahman: Exactly, and in our assessment, which we did externally after that—independently—we were proven to be absolutely doing the right things. There is always an issue of learning and improvement when it comes to documentation, for example, but not on an initial accusation that we are abusing our patient; that was my problem.

Q103 Mr Bacon: Can I ask Mr Behan a question about capacity—not mental capacity, but the capacity of your organisation? You did say you haven't got enough staff. Is there a number in your mind or in your business plan for the number of staff you ought to have—the establishment number of employees that the CQC should have—and you are x number short of that but working towards that target, or is it a more vague assertion that you are short-staffed?

David Behan: No, we have a business plan where these numbers have been worked out in terms of the number of people we need for each inspection and the length of time for each inspection. We need to recruit an additional 500, I think it is now, inspectors to allow us to do this. This didn't affect this inspection.

Mr Bacon: No, but just generally, what is your total establishment and where are you at the moment in terms of total employees?

David Behan: Our current total establishment—the plans for what we would ideally like to see would see us with an establishment of about 3,000 people, and we are currently at about 2,400.

Q104 Chair: Can I just ask one question of Steve Melton, and then I will go back to Stewart Jackson? Would you have withdrawn from the contract if you had not received an adverse CQC inspection report?

Steve Melton: Our reasons for leaving the contract are the rising demand, the falling funding mechanisms and our inability to see the light at the end of the tunnel, in terms of necessary reforms coming through in time. The CQC inspection process was going on in parallel through the last year, but it was not the reason for our withdrawing from this contract.

Chair: Okay.

Q105 Mr Jackson: Mr Behan, the medical advisory committee of clinicians at Hinchingbrooke recently wrote to you—I think it was you, although I stand to be corrected—in the light of the inspection report to say, among other things, "It is simply not possible to reconcile the vast reams of verified statistical data with a judgment of 'inadequate'." Why do you think they would say that? Those are 42 doctors, all of whom had attended a meeting of that committee in the wake of the report.

David Behan: I think they wrote to the inspection team; it would be wrong for me to speculate on why they wrote in. I go back to the point that a lot of what we set out in the report and

a lot of what was discussed with senior colleagues at Hinchingbrooke was what we found through the inspection. Was that a surprise to us? We did not expect to find what we found when we went into Hinchingbrooke—

Q106 Mr Jackson: Are you sure about that?

David Behan: Yes, I am sure about that—absolutely sure about that.

Q107 Mr Jackson: Let me ask you about Lee Barham. Lee Barham is a paramedic who was part of the inspection team. As I understand it, he was recently found guilty of professional misconduct. Do you think that is the sort of person you should have on the inspection team?

David Behan: I am familiar with this case, Chair. Yes, he was referred to the Health and Care Professions Council and, yes, it found a determination against him, but in its judgment—this is a matter of public record—it did not say that he should be disbarred from practice.

Q108 Mr Jackson: But one surmises that he could have a bit of an axe to grind against the management of the hospital—do you not think that?

David Behan: To the best of my knowledge, Chair, he wasn't employed by the hospital; he had been previously employed by a private ambulance trust.

Q109 Mr Jackson: Okay. What about Dr Nik Johnson? Can you confirm that your inspection team had a private meeting off-site with Dr Johnson, which in itself would have been strange? The fact that Dr Johnson is the parliamentary candidate for the Labour party for Huntingdon is by the bye, but why would you have an interview with someone who doesn't actually work for the trust but just does work on occasion on trust premises? Is it true that your inspection team had an off-site meeting with him to be "briefed on issues at the trust"?

David Behan: We have a number of conversations with people who work in the area, and not just with people who worked at the trust. In total, I believe that we spoke to 243 different people in relation to this issue; not all of them were employees of the trust. I include in there other agencies and other organisations. I think we speak to the clinical commissioning group; we certainly speak to the local Healthwatches, and that goes back to the point I was making earlier about our speaking broadly to people before we go in for any inspection, alongside the data we hold. So our inspection methodology requires us to speak to other people, and he was one of the people who were spoken to.

Q110 Mr Jackson: Did he initiate the conversation?

David Behan: I'm not sure, Chair. I was not personally on this inspection. However, I know that he was spoken to along with others.

Q111 Chair: So he was in a meeting with other people?

David Behan: No, I think it was a one-to-one with him, Chair, but I think he was one of a range of people who was spoken to as part of the inspection process; as I say, not all of them are employed by the trust.

Q112 Mr Jackson: So you think it is in order that you take the opinion of someone who has an axe to grind, potentially—allegedly, I hasten to add—and who does not work for the trust, and that opinion then informed the report?

I ask that because in January 2014, as part of a large postal survey across England, you solicited the views of 293 patients at Hinchingbrooke hospital. They scored the hospital across a number of measures at about 8.4—some as high as 8.7—yet you seemingly disregarded that in favour of a number of feedback cards from 17 patients and people like Dr Johnson. Do you not accept the feeling that the efficacy and propriety of that could be called into question?

David Behan: There are two issues there. The first is who we speak to, and those people are professionals working in services. I believe that we need to speak to those organisations as part of our inspections and the assessments we arrive at. In terms of the survey that was conducted, the findings of that survey are a matter of record and fact. You are absolutely right.

Q113 Mr Jackson: Was that incorporated into the inspection report?

David Behan: Yes. It was part of the background information that was used as part of the assessment. I have already given you an answer in relation to the relationship between intelligent monitoring and inspection. It was an outlier; we were surprised to find what we found at Hinchingbrooke. But the fact is that those patients and staff who spoke to us and raised those concerns did indeed speak to us and raise those concerns. Having listened to those and digested them, we need to take them into account. The issue about people who were told to soil themselves, for instance, came to us as a fact; I cannot discount that.

Q114 Mr Jackson: No, it did not come to you as a fact. That has not been verified or proved.

David Behan: All that I can say to you is—

Mr Jackson: The report says that it has not been verified or proved, so don't quote it as a fact; it is not a fact.

David Behan: It says that it has not corroborated it. It does not say that those patients did not say that to the inspectors.

Mr Jackson: You could say that the moon is made of cream cheese; we can't prove it, but it is not true.

David Behan: Yes but, with respect, I'm not saying that the moon is made of cream cheese.

Mr Jackson: No, but you said that it was a fact that those people were told to soil themselves. It is not a fact; it is an anecdote that you have not been able to prove.

David Behan: What I am saying is that my inspectors said that that was said to them.

Mr Jackson: But you cannot prove it.

David Behan: In order to prove it, I would need to go to the people this was said to. This incident took place between 16 and 18 September. That is what we have captured in this report.

Q115 Mr Jackson: Yes, but the context is that you are looking at a hospital which hitherto had won a patient care award. Should you not perhaps be a little suspicious of unsubstantiated innuendo masquerading as proven, demonstrable fact, Mr Behan?

David Behan: We should be healthily sceptical, yes. Inspection has been challenged for being over-optimistic and not being rigorous enough.

Mr Jackson: Quite.

David Behan: In my time, I have been challenged on being too soft and too hard. What I am trying to do as clearly and honestly as I can is say what my team found and how they recorded it. Is that comfortable? No, it is not comfortable. But that is what we have found and that is what we are standing by.

Q116 Mr Jackson: I can understand that you wish to be small "c" conservative in your approach because your track record is appalling and shambolic; you have admitted that. But going back to your inspection team, are you happy with who you appoint to be on that team in terms of conflict of interest and wider agenda?

David Behan: We ask all people going on inspections, as we did for this inspection, to complete a declaration. That is what happened. Those declarations, like ones that a number of firms use to audit organisations, are about whether you have any financial ties or any family ties with the organisation. That declaration was sought in all these teams.

Q117 Mr Jackson: I am not talking about financial interests. On your team, you had Dr Jonathan Fielden, who has publicly criticised Government policy on things like outsourcing in the past in his representative role for the BMA. He had an important role. You also had Dr Nigel Sturrock, who was a supporter of the "Keep Our NHS Public" campaign. My point is not that they are not entitled to have those views, but that there clearly might be a perceived conflict of interest when they are part of an inspection team making long-term value judgments on a private sector health care provider. Do you not agree that that is a potential issue?

David Behan: We need to be clear about people's declarations. As a consequence of this experience, we have amended our declarations form. It is not just about people you know, family, money and so on; it is about whether there are any other declarations that people need to make. Jonathan Fielden is a senior medical director at one of our leading London hospitals. Yes, he was previously engaged with the BMA, and he has said that he is no longer involved with it in that role. He has also set out where he is engaged in private practice. The truth is that we have historically been criticised for leading inspections where no clinicians are involved. We have radically changed how we inspect so that clinicians are involved in every inspection. Jonathan Fielden was one of the

senior colleagues—along with six other doctors and eight other nurses who are employed across the NHS—who was part of the inspection team. Members of our inspection teams have worked in private settings.

Q118 Mr Jackson: Yes, but this case is sui generis, in that it is the only acute district hospital in the private sector, so to have on your inspection team people who have a stated view that they do not support private involvement at that level is a conflict of interest. It is all very well saying that you will look at it now, but the damage is done on possible conflicts of interest.

David Behan: If you look historically at our inspections, we will have inspected 250 NHS trusts when we complete our round of inspection. In terms of straight health care, we will have inspected 2,500 providers of service, and the vast majority of those will be providers from the independent sector. We inspect treatment centres that are largely provided by the voluntary and the private sector. Virtually 90% of all residential care in this country is provided by private care homes and not-for-profit groups. Our track record on not being biased in how we inspect services in relation to the private sector speaks for itself.

Q119 Mr Jackson: One last question before I go back to the Chair. One of the key areas where you found the trust wanting was infection control. Can you just confirm that—I stand to be corrected if I am wrong—in the year up to the inspection, there were no MRSA infections? In fact, there were not any for two years. Is that the case?

David Behan: I think that is what Maureen confirmed earlier. I do not personally carry that information.

Q120 Mr Jackson: Okay. There were only six hospital-acquired infections of C. difficile in 12 months. What is the average number of C. difficile cases for an acute district hospital?

David Behan: I am sorry, but I cannot answer that question off the top of my head. I would refer to our experts, if they were available today—

Mr Jackson: Make an educated guess.

David Behan: I am being challenged on whether I have evidence of what I have found, and I will resist the temptation to make an educated guess. What I am clear about—we set this out in our report and in letters to the trust—is that we had concerns about hand hygiene and infection control. We did set that out in some detail in letters to the trust immediately following the inspection, as well as in our inspection report.

Q121 Mr Jackson: You are marking down this hospital on the basis of the generic term "infection control"—on the basis of no MRSA cases for two years and six cases of C. difficile in a 350-bed hospital in 12 months. You are saying that that is a major issue that informs the overall "inadequate" finding in the inspection report.

David Behan: It was one of the contributing factors to what we found. We also had concerns on care more generally—pressure control and catheter control. There were a range of issues that we

have set out and Professor Sir Mike Richards set out in the covering note to the report. It was not just one issue; it was a combination of issues that led us to expressing our judgment and our view.

Q122 Mr Jackson: Will you please write to the Committee—please do this is a timely way and do not take months and months—with a breakdown of all the factual errors that you concede were contained in your inspection report? We need to know whether this was a well-researched, fact-based report, rather than a farrago of sloppy, unprofessional anecdotes and innuendo.

David Behan: I will gladly set the record straight.

Q123 Mr Bacon: Just while we are at it, Mr Abdel-Rahman, will you send us your list? You said that it was 300 and that the CQC agreed with 65%. If we had your list as well as the CQC's, we could compare the two.

Hisham Abdel-Rahman *indicated assent.*

Q124 Chair: And we need them in a week. We are coming to the end of the Parliament, and we are trying to get our reports out before then.

I now want to go back to the closure, which is important, and remind the Committee that Mr Melton said that the CQC report wasn't an issue that he had regard to—it was running in parallel. First, how far advanced are your plans? Where are you on withdrawing?

Steve Melton: We are working closely with David Flory's organisation, the Trust Development Authority, on detailed plans for the transition. We are trying to progress plans to hand over responsibility formally at the earliest date, recognising that staff and patients need certainty in these situations. We are close to being able to share those with the teams locally. The board of the TDA is meeting the trust's board on Thursday of this week.

Q125 Chair: You will share them with the trust, so what is the timeline?

Steve Melton: All parties are seeking, if possible, to hand over formal responsibility to the NHS by the end of this financial year.

Mr Bacon: By the end of March?

Steve Melton: Yes.

Q126 Chair: Can I just hear from the two of you—we will then go to the Comptroller and Auditor General—about what arrangements you are making to ensure that patients in the area continue to be served by this hospital? Who will answer that?

David Flory: I will, Chair. There will be day-to-day business as usual in terms of ongoing service provision.

Q127 Chair: Is Mr Abdel-Rahman going to carry on as chief executive? Are you an NHS employee?

Hisham Abdel-Rahman: Yes, I am.

David Flory: We will work with the board. As Mr Melton says, our board meets with the trust board later this week to consider the improvement plan and to consider what changes we need to make at the trust in order to constitute what you would recognise as a traditional NHS trust board. We need to put that in place to govern the business and to take full statutory responsibility for the running of services at the point at which the franchise ends. We are doing that work.

Q128 Chair: So it will become a trust under you, like all the non-foundations? Will it become an ordinary trust, totally run by the NHS?

David Flory: Yes.

Q129 Chair: Have you lost money on this? Has the taxpayer lost money?

Richard Douglas: We have not. The deficit of up to £5 million has effectively been met by Circle. To the extent that the deficit this year runs beyond that £5 million cap, we will cover the deficit.

Q130 Chair: And the £2 million that they were contractually obliged to give you if they withdrew from the contract?

Richard Douglas: The £2 million effectively covers the costs of transition.

Q131 Chair: Is that on the table?

Richard Douglas: Yes.

Sir Amyas Morse: Pardon me, but I have one point of detail about your discussions. Perhaps I can ask you, Mr Melton. Exactly with whom are you conducting your discussions on the separation? Was the termination negotiated with you?

Steve Melton: The Trust Development Authority.

Sir Amyas Morse: Have you got a confidentiality agreement that is governing any part of those discussions?

Steve Melton: Not that I am aware of.

Q132 Chair: Mr Melton, you were an experiment, and my understanding is that many hospitals are looking at mutualisation. Having worked in the area, I am not sure I would call you a

mutual, but many hospitals are looking at mutualisation. You told us what went wrong, and the evidence that we got last time from Circle made it clear that your business model at Circle depends on attracting NHS business and getting money out of the NHS budget. Is your business model now broken? Would you think about going to another hospital? Is it a non-starter for you?

Steve Melton: I want to be really clear that we are very proud of what has been achieved in Hinchingbrooke over the last three years.

Q133 Chair: You have lost money, haven't you?

Steve Melton: We have lost money, indeed. We believe that applying our model of staff engagement and putting doctors and nurses on the front line in charge has delivered a substantial transformation in quality and above-average efficiencies compared with the rest of the NHS. The issue we've confronted is that the contract is not sustainable in its current form. I believe that the improvements that the NHS needs to achieve as a whole in terms of quality and efficiency can benefit from the kind of learning that we have established in Hinchingbrooke. We would be, on the right terms, really enthusiastic to continue this learning journey. It is with great regret that we have to leave this contract after only three years.

Q134 Chair: So would you bid for another one?

Steve Melton: We would have to look at what the terms are and whether we can create a stable commercial environment to attract the kind of investment that is needed to transform these kinds of services.

Q135 Chair: You would consider them for another one, would you, Mr Douglas?

Richard Douglas: There is nothing in Circle's performance that would say they would not be considered in the future, in the right circumstances.

Q136 Chair: I come out thinking—we had a session with you on financial sustainability of NHS trusts, and what came out of that session was the admission by Monitor that 80% of acute trusts are heading for a deficit in 2014-15—that the only way the system works is if you bail them out. You said you had bailed them out to the tune of—whatever it was, I can't remember the figure—£1.8 billion or something like that over the last seven or eight years. I am not convinced that, with the NHS in its current state, any private provider can survive, because the vast majority of trusts are dependent on a bail-out. Does that not damage the whole credibility? If you weren't bailing them out—not the ones you look after, Mr Flory, but the ones Monitor looks after—they would all be bust, or most of them.

Richard Douglas: I think it is very difficult at the moment for an organisation from outside the NHS. We did discuss this at the last hearing. To really turn around the finances of the NHS, we have to give more stability to people. We have to give more certainty over time to people around their income, regardless of whether it is an independent sector player or an NHS player. We also have to get all the bits of the NHS working far better together than we have. It is clear what we need to do; it is translating those words into action.

Q137 John Pugh: May I just ask a question about Circle Health? You reported a net loss of £46 million, is that right? I have a note here—Circle Health, the company that owns Hinchingbrooke.

Steve Melton: I don't believe that is correct. Which year are you referring to?

Q138 John Pugh: I don't have a year. It says here on my note that Circle Health recorded a gross profit, but its net profit was a loss of £46 million, of which £25 million appears to be cost of preference shares. Do you recognise the year?

Steve Melton: In the last full year that we reported, which was 2013, we made a loss of £13.8 million.

Q139 Chair: Across the organisation.

Steve Melton: Across the group—

Q140 John Pugh: How has this changed those accounts? Does that include Hinchingbrooke? How does Hinchingbrooke alter that figure?

Steve Melton: The way that Hinchingbrooke is dealt with in our accounts is as a cash item, so either we make a cash contribution to Hinchingbrooke or we get it out. In that case, our £5 million has been accounted for in our historical accounts.

Q141 Mr Bacon: Before we move on, can I put a question to Mr Douglas, although I would welcome comments from Mr Flory and others? Mr Melton referred to the learning journey, and Mr Douglas, you said that you would not necessarily be opposed to other contracts. Mr Melton said that if the terms were right, he would look at them. I count five bodies that were keeping an eye on the trust's executive management team: you had the clinical commissioning group, the trust development authority, the trust board, the Circle management team and the CQC. The CQC report said, at the bottom of page 12, going on to page 13:"Both the Circle management team and the trust board told us that the other was responsible for holding the trust's executive team to account. We considered that the governance systems in place were not sufficiently robust"—I would have thought that was something of a truism, in light of the fact that they were each pointing at the other in terms of who was holding the trust's executive team to account.

Meanwhile, you had both the clinical commissioning group, who plainly did not know enough of what was going on, and the trust development authority, who did not know enough of what was going on. So my question for you, Mr Douglas, is this: in terms of this learning journey, what are you, as the NHS executive management as a whole—federally or at the top level—taking away from this about the learning of how you improve the architecture, so that this type of thing does not happen?

Richard Douglas: David has already explained the model we had for accountability for this organisation. Looking at it now, there are things in it that appear to be a little muddled. We need

to sort out the internal accountability and how that relates to TDAs—that is the first thing we have to do.

The other thing from which we need to try to learn is that everything here—this is on the quality issues, not the finance issues—is because the data that David was getting, the data that we would see, and the data that was coming from intelligent monitoring and from the CCG did not identify the issues identified by the inspection. The question we have to ask ourselves is whether there is something more that we could be doing that would bring those problems to our attention beyond 30 people going in; or is it the case that the only way that this can be done is by having 30 pairs of feet on the ground doing an in-depth inspection of an organisation? If I can be honest, I do not have the answer to that question at the moment, but it is the question that we have to ask ourselves.

Q142 Mr Bacon: When do you expect to have an answer?

Richard Douglas: We have to work on evaluating what has happened. I know that you always want me to give dates and you always tell me that that it takes too long, but I hesitate to commit to a particular date on this. In the first quarter of the next year, we have to have a better view of what we have learned from all the CQC inspections to date and how that relates to the other data sources.

Q143 Chair: Do you have a moratorium on the nine trusts with which you are exploring mutualisation?

Richard Douglas: There are no trusts where this model is going forward in detail at the moment. I think that is right.

David Flory: That is right.

Q144 Chair: There are no trusts? Because I have a list here: Cheshire and Wirral Partnership NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Moorfields; Norfolk and Norwich; Norfolk and Suffolk; Oxleas; Surrey and Sussex; Tameside; and University Hospitals of Leicester.

David Flory: A number of trusts have expressed interest in mutualisation as a governance model going forward, and they are doing work as part of the exploration and potential piloting of that—the facilitation of that through the King's Fund—but that is quite different from the franchise model that we have been discussing today. As I understand it, that programme is not about to create a mutual governance structure for any of those trusts, but they are exploring what that might mean for them.

Q145 Chair: My main point was that you do accept that, if they cannot survive in the current financial climate with the systems that you have, it would not be very sensible to pursue that sort of experiment until you have sorted out a bit of stability and the incentive system is perhaps working properly.

Richard Douglas: I think that that is correct. If I was operating from the point of view of the private sector and looking at this, I would say that without a greater degree of stability I would want to be paid a premium far higher than we would be willing to pay. We have to sort that out.

Q146 Mr Bacon: Right, but we are not talking about what you would do in the private sector; we are talking about what you will do as a senior member of the NHS executive management team. In the short run, will you be letting any more of the contracts that the Chair has mentioned are in the offing while this uncertainty is still hanging over us?

Richard Douglas: I don't think that there will be any more of the type of franchising arrangement we have had until we have resolved some of these issues.

David Flory: Mr Bacon, you invited an observation in response to the question of lessons learned. First, to clarify, on the last point, there are currently no processes in train that can potentially lead to a franchising arrangement. To come back to your question, the observation that I would offer relates to the section of the CQC report that you highlighted. From my point of view, in terms of the responsibility of the TDA, the role of the trust board—the chairman and the two non-executives—and their powers and accountability vis-à-vis the franchisee and the running of the organisation has been too confusing and too complicated. One of the lessons that—

Q147 Chair: Say that again about the role of the trust board.

Mr Bacon: Too confusing and too complicated. I do not really understand "too confusing"—it suggests that there is a lower level of confusion with which you would be content—but I understand "too complicated".

David Flory: I stand corrected. It is confusing and too complicated.

Q148 Mr Bacon: So that needs to be simplified.

David Flory: Yes, I think so.

Q149 Mr Bacon: And, presumably, people of the right quality put in there. Mr Behan, I have counted in the Report that there were at least 29 people who went in. I think 16 of them were clinicians and 13 were not clinicians. There were nine CQC inspectors; there were two experts by experience; and there was the head of hospital inspections.

Obviously your team were under pressure. There are not enough of them. You have already said that. You also said in this particular case that was not a factor; but in terms of who they are, what sort of skills do they have, and are they the right skills? When you fill that gap between the 2,400 that you have and the 3,000 that you need—these extra 600; who are they going to be? Where are you going to recruit them, and will they be of the right quality?

David Behan: Two things to pull out of this: the number that I gave you—the 3,000—are the staff we need to run CQC. In addition, we take in what we call specialist advisers. These are the clinicians, the doctors and the nurses who join CQC, and effectively we buy their time from the trusts

that employ them or the organisations that employ them. So the seven, eight doctors that you referred to and the nurses that you referred to are bought in. They are in addition to the 3,000. We do not and have not had a problem in clinicians, doctors and nurses, coming forward to be members of the inspection team.

I am loth to raise it in terms of Stewart Jackson's earlier points, but the intelligent monitoring flags the issues that we need to look at when we go in, and that will indicate the types of clinical background we would want to put on the inspection teams.

Q150 Mr Bacon: I am really talking about the non-clinical people whom you have got. I am right that a lot of them are non-clinical, aren't I?

David Behan: Yes, they are.

Q151 Mr Bacon: What are their backgrounds, and do they have the right skills?

David Behan: The inspectors work for CQC. They will be from a health and care background, and over the past two years, since I took the job, we are only recruiting inspectors from a health and care background; but the non-clinicians will include things like clinical governance experts, people with a background in pharmacy, people who have worked in hospital management who were not clinicians, people who have run care homes but do not necessarily profess either a nursing or a social work background.

Q152 Mr Bacon: One more. Mr Flory, last week I had a meeting with a group of local people in connection with a foundation trust that appears to be facing some difficulties, in the east of England, as it happens; and it prompted a question in my mind. What is the point of having Monitor and the Trust Development Authority, when Monitor deals with foundation hospitals, which are supposedly capable of looking after themselves, and then, when it turns out they cannot, Monitor comes in; and you look after the others, which are less able to look after themselves, and then when they manifestly cannot, you come in? Why have two?

David Flory: Richard might have a perspective on the design of this, but our powers are very different and our responsibilities are completely different; so part of the foundation trusts earning autonomy is that the chief executives of the foundation trusts are accounting officers, as you are aware. The NHS trusts that have not earned that autonomy: the chief executives are accountable officers. I am effectively the proxy accounting officer for those, as of today, 92 trusts.

Q153 Mr Bacon: Yes, but in practice the foundation hospitals that get it wrong manifestly were not able to look after it satisfactorily, so they needed outside help. Where you are, as it were, by proxy the accounting officer for those that were less able to look after themselves in the first place, that does not stop us having a chief executive from the relevant hospital along. So in practice the distinction becomes less important. When you are getting into talking about a failure regime, when things have gone wrong, the distinction sort of dissolves, doesn't it?

Richard Douglas: I think once you get into organisations that are failing, the skill set that you require is very similar. Yes, they do have different functions as organisations, and David is very

much—because it is a special health authority, a creature of the Secretary of State. He acts very directly on behalf of the Secretary of State in intervening. I think constitutionally there is a significant difference; but if you go to what help people need for improvement, what help they need to turn around, you are looking at, for failing organisations, very similar skill sets.

Q154 Mr Bacon: And in nearly all cases, including foundation hospitals that have run into trouble, bail-outs from Mr and Mrs taxpayer.

Richard Douglas: Well, money that allows the organisations to keep going with strings attached to that money, yes.

Q155 Chair: We have another session after this one, so I will ask two more questions, then Stewart will ask one.

I was going to ask Circle, why are you registered in Jersey?

Steve Melton: The company is registered in the UK for tax purposes. All our operating companies are registered in the UK. The holding company, historically, has been registered in Jersey for completely unrelated—

Chair: For what reasons?

Steve Melton: For reasons completely unrelated to the tax treatment of the business.

Chair: What are they?

Steve Melton: I don't recall.

Q156 Mr Bacon: How do you know that they are unrelated, then, if you cannot remember?

Chair: I don't believe they are unrelated, Mr Melton.

Steve Melton: Because for tax purposes all of our operating companies are registered in the UK. We pay all of our taxes in the UK—

Q157 Chair: Well, why are you incorporated in the British Virgin Islands?

Steve Melton: We are not. One of the key things we have done in the last year is to restructure the ownership of the business, to transfer the part of the business that is owned by all the employees in the business into the same share ownership as the listed business, and—

Q158 Chair: You were registered there?

Steve Melton: I believe that, originally—

Chair: You have been there for ever, so it's not "originally".

Steve Melton: I believe that, originally, UK corporate law did not allow us to allocate shares other than to employees directly of the business. We have now, through our restructuring, managed to overcome those issues and we are not in that structure any more. In the current structure, the employees are the largest single shareholder in the listed business, with 25% of the business, and it is all UK-based.

Q159 Chair: But you have reduced their shareholding from 49.9% to 25%. I do not know why you have done that.

Steve Melton: Because in the process of restructuring the ownership of the business, we have written off investor loans to the business. So the employees now own 25% of the whole business net, and there are no debts outstanding to investors in that structure.

Q160 Chair: Are there are any intra-company loans involved, that take money out of the UK into either Jersey or, before that, into the British Virgin Islands?

Steve Melton: None whatsoever. We are fully registered for tax—

Q161 Chair: So you are making a loss.

Steve Melton: We are currently making a loss and we pay all appropriate taxes in the UK, and only in the UK.

Q162 Chair: Okay. And how long are you going to carry on making a loss? How are you going to turn it round?

Steve Melton: The reason we make a loss is because we are investing all our earnings from our health care activities in improving the services that we are developing and in growing the business. As many young, growing—

Q163 Chair: How many years have you been going?

Steve Melton: Eight years, I believe.

Q164 Chair: Eight years—and you can sustain that position, can you?

Steve Melton: We are clearly—

Chair: I am quite astounded. I am intrigued, really.

Steve Melton: We are investing in the business, and that is why—

Q165 Chair: And you had eight years of losses.

Steve Melton: That is why we are not yet—

Chair: Eight years of losses.

Steve Melton: At break even.

Q166 Chair: Eight years. When do you expect to turn around and start making a profit?

Steve Melton: In the next year or two.

Chair: Wow, we might have you back.

Finally, we have discovered that Sir Neil McKay—I hope I am pronouncing it right—has got a new job. He is chair of the joint management board for cardiac services in Manchester. That is probably one of a portfolio of jobs I bet are in the NHS.

The Committee would like to know what he got as a pay-off; whether he is getting paid for this; whether he gets any other money out of the NHS in any of its forms; and whether you are considering taking any action at all to get some responsibility together with accountability for what, given where we three years ago, was a rash decision.

Q167 Mr Jackson: Mr Behan has mentioned that you are going to look at the issues around conflict of interest, which widen it from financial.

Maureen Donnelly, you will know that there has been some controversy, which, to your credit, you did address in the letter you sent to local MPs on 19 January, about your own role as someone with political views that might not necessarily agree with the policy, which you robustly accounted for. But your colleague Jessica Bawden is also identified in the media as having a potential conflict of interest. First, would you like to comment on that and, secondly, do you think it appropriate that you look at potential conflicts of interest in the CCG, in terms of dealing with what is at the least a very controversial contract? Given the attitude of the public sector unions in Cambridgeshire and elsewhere, it has caused some contention.

Maureen Donnelly: Mr Jackson, I think that the contention was one paragraph in the *Daily Mail*—

Mr Jackson: And a photo.

Maureen Donnelly: It was a good photo—

Mr Jackson: It was a very flattering photo—

Maureen Donnelly: I was very pleased with the photograph. I was grateful to them as well.

Yes, I am a member of the Labour party and have been for most of my adult life. Yes, Jessica Bawden has been a member of the Labour party and, I believe, has been for quite a long time.

Neither of us is politically active, nor have been for some time. It is not my understanding that a political allegiance, rather than political activity, is a conflict of interest. I am sure you know, Mr Jackson, that the way I have behaved throughout the time that I have been involved in the NHS has been completely above board and has been entirely in the interests of the patients and public of Cambridgeshire and Peterborough to deliver the best possible health service within the budget that we get.

Personally and at the CCG, I have absolutely no problem with private providers. Some of the Keep Our NHS Public people who could be sitting behind me might not be entirely happy with that comment. As people know, for example, over the past year and a half we have put out to tender an £800 million contract for older people and adult community services, which by the way is the beginning of our entire strategy in our CCG to address the medium-term financial sustainability of our patch. It is not just Hinchingbrooke that is suffering, it is Peterborough—it is Addenbrooke's as well. We have to address that. So we put that out to tender. As it happens, there was a great deal of private sector interest, and I completely support that.

Q168 Mr Jackson: May I put it on the record that I am glad that Maureen Donnelly has had the opportunity to say that?

Chair: I would not like us to think you cannot have Labour party members serving on health boards, for heaven's sake.

Mr Jackson: There was quite fierce criticism in parts of the media, which Maureen described as inaccurate. I am glad that she has now had the opportunity to set the record straight. That is as it should be.

Maureen Donnelly: May I thank you for giving me the opportunity to do so publically?

Q169 Mr Bacon: May I encourage you to look at the *Daily Mail* song on YouTube? It only takes about two and a half minutes.

Maureen Donnelly: I rarely look at the *Daily Mail*.

Mr Bacon: It has got 2.5 million hits. I think you will find it worth two and a half minutes.