House of Commons
Health Committee

Annual accountability hearing with Monitor

Tenth Report of Session 2010–12

HC 1431

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Report, together with formal minutes, oral and written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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1 Introduction

1. Monitor is a Non-Departmental Public Body, independent of government and directly accountable to Parliament. Since 2004 Monitor has been the independent regulator of NHS foundation trusts, responsible for authorising aspiring foundation trusts and ensuring that trusts are legally constituted, financially sound and well-led in terms of both quality and finance. Monitor has certain powers to intervene in the event that it finds a foundation trust to be in breach of these conditions.

2. In addition to these responsibilities, the Health and Social Care Bill would significantly develop Monitor's role into that of a sector regulator for all providers of NHS care, with further responsibilities of setting prices, preventing anti-competitive practices and ensuring the continuity of services. As Monitor is changed into a regulator for all providers, its specific responsibilities relating to foundation trusts would be removed, leaving only certain residual powers. At the time this report was written, the Bill had not yet completed its progress through the House of Commons. Following a pause in consideration of the Bill, and the report of the NHS Future Forum,[2] the Bill was recommitted and a series of government amendments tabled, many of which proposed further changes to provisions concerning Monitor.[3]

3. Our inquiry was not intended to analyse the rationale for these changes. Instead, we have assessed Monitor's performance and the context for its duties as part of our series of sessions with regulators in health and social care.

4. On Thursday 14 July 2011 we heard evidence from Dr David Bennett, Chair and interim Chief Executive of Monitor, Stephen Hay, Chief Operating Officer, and Adrian Masters, Director of Strategy. We also received a range of written evidence, including from the Department of Health. We intend to repeat this exercise on an annual basis and will therefore invite Monitor to appear before us again in 2012, to update the Committee on progress.

2 See NHS Future Forum, *Summary report on proposed changes to the NHS*, June 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443

3 See Department of Health, *Government response to the NHS Future Forum report: Briefing notes on amendments to the Health and Social Care Bill*, July 2011. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127880.pdf

2 Context

5. The past year has been one of uncertainty and challenge for Monitor. The healthcare landscape is going through a period of significant change and is at the same time facing substantial financial challenges. The 'Nicholson challenge', which requires the NHS to make unprecedented efficiency gains of £20 billion by 2014–15, is placing pressure on those Monitor regulates to innovate and streamline the way services are provided. At such a time the need for effective regulatory oversight is more important than ever.

6. In the meantime, Monitor's own role is changing. Not only does the Health and Social Care Bill greatly extend Monitor's jurisdiction and duties (see Chapter 4), but other circumstances and policies have placed restrictions on certain aspects on Monitor's activities. Monitor noted in its annual report:

> The past year has seen a great deal of change and uncertainty in terms of policy development. We have had a new coalition Government, a health reform bill, significant public spending pressures and severe restrictions on arm's-length bodies' expenditure on external advisers, recruitment and communications activities.[4]

7. The policy uncertainty and spending restrictions affected Monitor's delivery in certain strategic areas such as 'promoting the development of well-led NHS foundation trusts' and 'contributing to and influencing the development of an affordable, devolved system of healthcare provision'.[5] Monitor has also had to find extra capacity to meet the 'substantial additional workload'[6] brought about by its new duty to risk assess transactions where foundation trusts take over the provision of community services.[7] In spite of recruiting 20 temporary staff to assist with this process,[8] Monitor's annual report notes that in some cases the risk rating process had to be delayed because it only had the resources to review so many transactions at any one time.[9]

8. Monitor has been far from a passive observer of these changes—the proposals have required Monitor to engage in consultations, roundtables, and reviews, all using time and resources, to evaluate proposed changes and to begin preparing for their implementation.[10] The continuing uncertainty over Monitor's future role also obliged Monitor to defer recruitment of a Chief Executive, so difficult was it to pinpoint exactly what the Chief Executive's duties would be.[11] The uncertainty has affected other staff too:

4 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p38

5 *Ibid.*

6 Ev 28 (Monitor)

7 For more details on Monitor's handling of these community services transactions, see Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p31.

8 Ev 28 (Monitor)

9 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p31.

10 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p 45.See also, for example, the report (dated 5 August 2011) of the roundtable discussion that took place in July 2011 http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor%20roundtable%20summary.pdf

11 Q 58

> There is uncertainty for our staff currently working in areas where the Health and Social Care Bill is setting an end date for that particular function. Staff in assessment and compliance will be affected by the transition in Monitor's regulatory function, and recruitment and retention of high quality staff during the transition in Monitor's regulatory function, and recruitment and retention of high quality staff during the transition may prove challenging.[12]

9. The proposed revisions to the Health and Social Care Bill following the Future Forum's report have clarified certain aspects of Monitor's proposed new role, but as the Bill itself is still passing through Parliament it remains unclear exactly what form Monitor's new duties will take. Much of the detail will be left to Monitor to decide. Monitor also anticipates that the recommendations of the Mid Staffordshire Public Inquiry could have implications for its operations.[13]

10. **Monitor's operations over the past year have taken place in an extremely challenging context—not only in terms of its own changing role under the Health and Social Care Bill and the arm's-length bodies review, but also in terms of the wider pressures and change in the healthcare landscape. Although the proposed revisions to the Health and Social Care Bill have helped to define Monitor's future role more clearly, and some uncertainty will be removed as the Bill progresses through Parliament, Monitor will continue to operate in an extremely challenging context in the years to come.**

12 Monitor, *Business Plan 2011–12*, April 2011, pp 54–55

13 Ev 21 (Monitor)

3 Foundation Trusts—Monitor's continuing duties

Assessing and authorising remaining NHS Trusts

11. Monitor is currently responsible for authorising NHS trusts applying for foundation trust status. Applicant trusts are assessed to ensure that they are legally constituted, financially sound and effectively governed.[14] The Health and Social Care Bill would require all NHS trusts to now seek foundation trust status. In the form it was first presented to Parliament, the Bill required all remaining NHS trusts to become foundation trusts by April 2014, after which point the legal basis for NHS trusts would cease to exist. Following concerns raised by the Future Forum,[15] among others, that the deadline was unrealistic, the Government has brought forward amendments relaxing its conditions: the majority of NHS trusts would now be *expected* to become foundation trusts by April 2014, and all would be expected to do so 'as soon as clinically feasible'.[16] An agreed deadline would be set for each trust.[17]

12. Monitor will be responsible for authorising and assessing this significant new wave of applicants. Even the new timetable remains challenging, not least because of the sheer number of trusts involved. As of 1 August 2011, 138 foundation trusts had been authorised. Monitor told us that this left approximately[18] 95 NHS acute and non acute trusts, 9 ambulance trusts, and 16 community trusts, all still seeking foundation trust status.[19] In short, almost as many trusts remain to be authorised in the next three years as have already attained foundation trust status in the last seven years. Monitor notes that in order to process applications for all remaining trusts it will need to assess up to five trusts a month.[20] When this is coupled with the fact that Monitor's assessment of even 'straightforward' applications takes between three and four months,[21] the timetable appears even more challenging.

13. **Monitor faces a significant challenge in assessing and authorising for foundation trust status the remaining NHS trusts. We welcome the Government's decision to change April 2014 from a legal deadline for the completion of this process to a less rigid target, albeit one the Government expects to be met. Nevertheless, sheer numbers alone**

14 Further detail on Monitor's current role in this respect can be found in Ev 21–22

15 NHS Future Forum, *Summary Report on proposed changes to the NHS*, p31

16 Ev 15 (Department of Health)

17 Ev 15 (Department of Health)

18 It is not possible to provide an exact number, because some trusts may consider merging with existing foundation trusts

19 Ev 52 (Monitor, supplementary written evidence)

20 Ev 31 (Monitor). In 2010–11, Monitor assessed an average of only one or two per month (Ev 31), although it should be noted that this pace was dictated by the slow rate of trusts being referred to Monitor by the Department of Health – see paragraph 14

21 Monitor states that this average assessment time is necessary it light of its "enhanced approach to quality governance and the need for trusts to develop robust mitigation strategies to address the tighter financial environment". Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p10.

make the assessment task formidable, and the Government must be prepared to be even more flexible if circumstances demand it.

14. The pace of the application and authorisation process is determined by: the work undertaken by the trust itself; the management of the 'pipeline' of applicant trusts by the Department of Health; and finally the assessment by Monitor. In recent years the rate of referral to Monitor has been slow: seven trusts were referred to Monitor by the Department of Health in 2009–10, and eleven in 2010–11.[22] Even when trusts make it to the stage of being assessed by Monitor, a proportion are not authorised due to issues identified during the assessment process.[23] In 2010–11 only half of the trusts assessed by Monitor were authorised as foundation trusts.[24]

15. Dr David Bennett, Chair and acting Chief Executive of Monitor, told us that Monitor was particularly keen to ensure that applicants would be referred to Monitor by the Department of Health in a phased manner:

> One of the things we are very concerned about is that they all finish up being back-loaded, which, apart from anything else, presents us with an almost impossible challenge. I have been very clear to the Department that [...] if you do that, we will not be able to do our bit.[25]

16. Monitor told us that it was taking what action it could to help prevent this scenario, working with the Department to 'help it ensure high-quality applicants were put forward', and with the Department of Health, the Foundation Trust Network, and strategic health authorities to 'share best practice in supporting the preparation and development of applicant trusts'.[26] In May Monitor agreed 'a range of mechanisms with the Department of Health to ensure our processes and approach were aligned'.[27]

17. **Monitor needs to be in a position to respond to the demands of applicant trusts, rather than trusts' programmes being artificially accelerated or delayed in line with Monitor's capacity. Monitor will, however, only be able to function effectively if the flow of applications through the pipeline is phased and not back-loaded. The Department of Health therefore needs to manage the progress of applications as far as possible to ensure Monitor is able to work effectively. Where this is not possible, the Department must either provide Monitor with the necessary resources to temporarily increase its assessment capacity, or should relax deadlines for a particular trust to enable assessment to be undertaken with due care and consideration.**

18. **The Department must resist the temptation to artificially accelerate the process by referring trusts to Monitor before they have reached an appropriate level—to do so would only hinder Monitor's capacity to handle more realistic applications.**

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22 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p10

23 Applications may be 'postponed' at the trust's request, to allow issues to be resolved, or 'deferred' by Monitor to allow trusts time to resolve issues otherwise preventing authorisation.

24 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p10.

25 Q 21

26 Ev 31 (Monitor)

27 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p14

19. If the numbers alone appear daunting, the challenge is further complicated by the fact that the group of remaining NHS trusts is likely to have a high proportion of trusts with quality or financial issues. In recent years, foundation trust status applications were deferred by Monitor for a variety of reasons, including:

> the lack of a robust process of board self-certification; a lack of evidence of sufficient board challenge in areas of key risk; mitigation strategies not robust enough; cost improvement plans needing more development in order to address quality concerns; a failure to address historical due diligence recommendations; and a failure to demonstrate credible plans to reduce private patient income below the private patient income cap once foundation trust status is achieved.[28]

20. Dr Bennett noted that some aspiring foundation trusts will face 'multiple challenges', including managerial shortcomings, issues with legacy debt or expensive PFI projects, and the need to make 'major productivity improvements'.[29] Sir David Nicholson, NHS Chief Executive, has estimated that about twenty foundation trusts will struggle to reach foundation trust status at all, and would need to be accounted for through other options such as takeovers and mergers.[30]

21. Trusts that have struggled to get over the bar up until this point may now find that the bar is moving even further out of reach. Monitor noted in its annual report that:

> Since we first started authorising foundation trusts, the economic environment has tightened and there are more risks facing provider organisations. In light of this, and given that all trusts are facing increasing financial challenges, delivering an all foundation trust economy by April 2014, which is the Government's expectation, will be challenging.[31]

22. In April 2011, Monitor reviewed and revised the financial assumptions used in the assessment of applicant trusts in order to take account of the latest inflation forecasts issued by the Office of Budget Responsibility. As a result, applications for foundation trust status considered by Monitor's board after 1 June 2011 were tested against efficiency assumptions for 2011–12 that were more demanding than previously.[32] The letter to foundation trust applicants announcing this change noted:

> We recognise the scale of the productivity challenge that the revised financial assumptions imply; however it is important that the assumptions reflect the

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28 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p13

29 Q 28

30 In evidence to the Public Accounts Committee, *National Health Service Landscape Review,* Thirty-third Report of Session 2010–12, HC 764, Q 88 (Evidence taken on 25 January 2011).

31 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p14

32 See correspondence from Stephen Hay, Chief Operating Officer of Monitor, to (among others) foundation trusts and foundation trust applicants, 27 April 2011, available at http://www.monitor-nhsft.gov.uk/home/information-nhs-foundation-trusts/correspondence-foundation-trusts-0. Specifically, the 'downside' case (the second, and more pessimistic, of Monitor's pressure and risk scenarios; as opposed to the 'assessor' case which is in line with Department of Health estimates) had been revised from an in-year efficiency requirement of 4.5% in 2011–12 to 5.3%. Once additional efficiency expectations for the acute sector were added on, the acute sector was to be tested against an in year efficiency assumption of 6.5% for 2011–12. Further details can be found in Mr Hay's letter of 27 April 2011.

> economic outlook and current policy framework. The changes are consistent with maintaining the current "bar" for achieving foundation trust status.[33]

23. Monitor did state that trusts currently undergoing assessment would be given extra time to provide evidence that they met these revised assumptions.[34]

24. Both Monitor and the Government have stated firmly that authorisation standards will not be lowered in order to assist remaining NHS trusts.[35] Monitor has, however, said that it will 'review our approach to assessment to ensure we make the best use of our limited resources—without lowering the bar'.[36]

25. **The Committee strongly supports the view that the standards for authorising foundation trusts must not fall as a result of the Government's desire to see all remaining NHS trusts become foundation trusts. We welcome the assurances on this point from both Monitor and the Government. We note that Monitor intends to review its approach to assessment in order to accommodate the extra demands on its capacity. It is imperative that any change in process does not alter the standards expected of aspiring foundation trusts, either directly or as a result of the space created by a less comprehensive process.**

Foundation trust performance and compliance

26. Monitor regulates foundation trust performance and operations to ensure they comply with the terms of their authorisation. In summer 2011 Monitor published its review of foundation trust performance for 2011–12.[37] The report shows that although most foundation trusts are performing well, a stubborn minority continue to have problems. Of the 136 foundation trusts in existence on 31 March 2011, 12 were rated 'red' for governance (the worst rating), and 24 were rated 'amber-red' (compared to 83 rated 'green' and 17 rated 'amber-green'). In terms of financial risk, 10 foundation trusts were rated at '2' or '1' (highest risk), compared to 13 rated at '5' (lowest risk).[38] Monitor has stated that a new foundation trust would not usually be authorised unless it had a rating of '3' or above,[39] demonstrating that some existing foundation trusts are falling below the standards expected of new entrants.

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33 *Ibid,* p1

34 Ev 23 (Monitor)

35 Monitor has stated this repeatedly: see for example the foreword to the Monitor's Business Plan for 2011–12, Ev 53, and Q 24. The Government has stated that "NHS trusts applying for FT status during this transition will be assessed against Monitor's standards with no easing of requirements" (Department of Health, *Liberating the NHS: Legislative Framework and next steps*, December 2010, paragraph 6.42).

36 Ev 31 (Monitor)

37 Monitor, *NHS Foundation Trusts: review of twelve months to 31 March 2011* http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-quarterly--29

38 58 foundation trusts were rated '4' and 55 '3'.

39 Monitor, *Compliance Framework 2011–12*, 31 March 2011, p23. http://www.monitor-nhsft.gov.uk/sites/default/files/COMPLIANCE%20FRAMEWORK_final.pdf

27. **Monitor's assessments of Foundation Trust performance show that although many foundation trusts are performing well, a significant proportion are still struggling to meet financial and governance standards.**

28. In addition to these ratings, Monitor also has the option to declare foundation trusts to be in 'significant breach' of the terms of their authorisation, described by Dr Bennett as 'a very, very clear signal to the trust that they have problems the board must really sort out'.[40] At the end of 2010–11 nine foundation trusts were in significant breach compared to 13 at the end of 2009–10. Three new trusts were found to be in significant breach during 2010–11, compared to 14 during 2009–10. Although Dr Bennett stated that this reduction was partly because 'there has been improvement and learning overall',[41] Monitor also attributes this reduction to two other factors. First, fewer foundation trusts were triggering governance indicators based on healthcare-acquired infection rates. Second, Monitor's governance triggers had been amended to reflect the removal by the Government of the 18 week referral-to-treatment target and the reduction of the A&E four hour waiting time target.[42] Dr Bennett stated that it was important for Monitor's triggers to adapt to reflect the Government's own expectations of performance, giving the example: 'if the trusts are required by commissioners to meet a 95% target then, unless there is an extraordinarily good reason, we are not going to have a 98% percent target'.[43]

29. **It is clear that some of the improvement in the numbers of foundation trusts in significant breach is accounted for by changes in targets which have been introduced by the Government. We agree that Monitor's compliance criteria should reflect the performance measurements used by NHS Commissioners, the CQC and the Government.**

30. Monitor has also stated that the number of foundation trusts in significant breach has reduced in part because 'the CQC has introduced its own compliance regime against registration standards and we are now reflecting their judgements in our own governance triggers'.[44] Monitor told us that the annual review of its compliance framework would revise how CQC judgements arising from the CQC registration process are incorporated into Monitor's governance risk ratings. Our report into the CQC highlighted our concerns regarding the rigour of some CQC assessments and, in particular, the information that feeds into them.[45]

31. **The Committee believes that the parallel existence of Monitor and the CQC creates a significant risk of cost and process duplication between the two bodies. It is essential that the scope and function of each body is clearly defined and that both bodies observe the limits of their responsibilities, while retaining a holistic view of the regulated organisations.**

40 Q 19

41 Q 68

42 Ev 24–25 (Monitor)

43 Q 69

44 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p6

45 See Health Committee, Ninth Report of Session 2009–10, *Annual Accountability Hearing with the Care Quality Commission,* HC 1430

32. Monitor has certain powers to intervene in the event that foundation trusts are found to be failing, including closing a specific service or requiring a board to take a specific action.[46] These powers were used on seven occasions in 2009–10, but not at all in 2010–11. Monitor stated that it did not resort to using its powers because the three trusts newly found to be in significant breach in the course of 2010–11 were so-classified for 'mainly financial' reasons, 'and at the time of each breach there was sufficient evidence of action being taken to ensure that Monitor did not need to use its statutory powers'.[47] Dr Bennett also told us:

> I imagine part of the reason is that, having used the powers [on previous occasions], and trusts having seen that we will use the powers where necessary, they have understood they might as well follow our advice anyway.[48]

33. Monitor has said that it would consider using its statutory powers in the future if the trusts in significant breach were found to be making insufficient progress.[49] **It is right that Monitor adapts its regulatory approach and its use of formal intervention powers to reflect the circumstances of individual cases and we accept Monitor's reasons for not using its formal powers in 2010–11. Nevertheless, we encourage Monitor not to be reticent to use its formal powers when necessary, and to regularly review the progress of trusts in significant breach.**

34. The current changes and financial pressures in the NHS are only going to make Monitor's compliance role more important, as Monitor itself has acknowledged:

> As the number and range of NHS foundation trusts increase, the scale, importance and profile of our compliance role also grows. There may also be an increase in those facing financial difficulties. For current foundation trusts, pressure continues to mount on both management capacity and financial viability as expectations and demand continue to rise and finances become more constrained.[50]

35. In the area of financial risk, Monitor has taken steps to reflect this climate. The same raised financial assumptions that were discussed in paragraph 22, relating to the authorisation of applicant trusts, are also being applied to the risk-rating of investments and transactions undertaken by foundation trusts.[51] In addition, Monitor's 2011–12 compliance framework changed the threshold of financial risk rating for escalation (the stage of the compliance process that prompts Monitor to consider placing the trust in serious breach and, consequently, potentially using its statutory powers of intervention) to include trusts rated at a financial risk of '2', rather than just '1'.[52]

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46 Monitor's current intervention powers are listed under section 52 of the National Health Service Act 2006

47 Ev 25 (Monitor)

48 Q 67

49 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p19

50 Ev 31 (Monitor)

51 Correspondence from Stephen Hay, Chief Operating Officer of Monitor, to (among others) foundation trusts and foundation trust applicants, 27 April 2011, available at http://www.monitor-nhsft.gov.uk/home/information-nhs-foundation-trusts/correspondence-foundation-trusts-0, p1.

52 Monitor, *Compliance Framework 2011–12*, 31 March 2011, p31. http://www.monitor-nhsft.gov.uk/sites/default/files/COMPLIANCE%20FRAMEWORK_final.pdf
See also Health Service Journal, *Intervention threshold lowered*, 7 April 2011.

36. **Over the next year, Monitor's foundation trust compliance role will become harder and more important. It must be prepared and resourced to meet this challenge. There will be more foundation trusts, many of them newly authorised, struggling to make demanding efficiency gains and to manage upheaval in the health landscape. Existing foundation trusts will also be affected. In this light, we welcome the fact that Monitor is increasing its monitoring of financial risk. We encourage Monitor to remain vigilant for further areas where closer scrutiny is needed.**

Increased independence for foundation trust governors

37. The Health and Social Care Bill changes Monitor into a regulator for the sector as a whole and proposes to remove Monitor's specific compliance powers over foundation trusts. The Bill makes provision to strengthen the powers of foundation trust governors and 'place genuine responsibility for performance on the organisations themselves rather than over-reliance on the regulator'.[53] The Bill makes explicit the duty of governors to hold their boards to account, and also gives governors powers to approve mergers, acquisitions, separations and other significant transactions.

38. The fact that this devolution of accountability coincides with substantial challenges to foundation trust performance, as noted in the previous section, has been a cause of concern for Monitor. Monitor told us:

> The proposed new responsibilities for governors do mean that a step-change would be needed in the capability of governors in order to ensure effective governance without the safety net which Monitor currently provides.[54]

39. Monitor also had concerns about the associated ability of directors to perform under the new regime and in the challenging financial context:

> Without the necessary skills, some NHS foundation trust boards of directors will find it difficult to deliver trust performance. Some boards may struggle with the extent of the challenge to plan and deliver simultaneous improvements in both cost and quality.[55]

40. In March 2011 Monitor published a report on lessons from foundation trusts that had gone into significant breach in the course of 2010. The report listed three main areas where trusts were experiencing problems, all of which highlighted issues at board level:

- formulating effective strategy for the organisation;
- ensuring effective performance—appropriate skills, effective information flows to the board, and board-level dynamics; and

53 Department of Health, *Liberating the NHS: Legislative Framework and next steps*, December 2010, p46

54 Ev 32 (Monitor)

55 Ev 32 (Monitor)

- ensuring accountability through trust boards holding the organisation to account for the delivery of the strategy and seeking assurance that systems of control are robust and reliable.[56]

41. **We are concerned about the proposals in the Health and Social Care Bill to reduce the financial oversight role of Monitor and increase the responsibilities of foundation trust governors in this area. We draw the attention of the House to the fact that Monitor reported in March 2011 that failures of governance within existing foundation trusts were a significant contributory cause to cases of significant breach during 2010 and we see little or no evidence that this position has changed sufficiently to justify the additional responsibility being placed on foundation trust governors.**

42. Monitor told us that providing foundation trust governors with the necessary skills would be:

> [...] a major development challenge where an early start is needed if it is to be effectively addressed over the next three years. In particular, governors will need good induction and ongoing training to ensure that they fully understand their statutory responsibilities and have confidence to take action.

43. Monitor does have a track record of supporting development for boards and governors,[57] and they told us that they would 'consider new models of delivery to support governor development', including 'supporting governors to undertake their roles and responsibilities effectively'[58] under the new regime. It is not yet clear, however, exactly what form Monitor expects this training and support to take. Dr Bennett told us that it was too soon to have developed a specific plan, 'because this is a very recent change', but that Monitor would work jointly with the Department and foundation trusts themselves.[59]

44. We do, however, have concerns over Monitor's capacity to provide this developmental support on the level required, given that its 2010–11 annual report shows that restrictions on Monitor's spending limited its ability to deliver in its strategy area of 'promoting the development of well-led NHS foundation trusts'.[60] Although Monitor was able to complete several objectives relating to development, several (including running projects to help boards improve their effectiveness in leading quality improvement; and developing a communications plan to help governors to understand their role and how to exercise their statutory responsibilities) were only partially completed, while others (including developing a programme to support medical directors in their role on the board of directors; and exploring opportunities to promote productivity improvement) were not completed. In each case Monitor cited that spending controls across all arm's-length bodies had prevented it from carrying out the work.[61]

56 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p18.

57 Ev 28–29 (Monitor)

58 Ev 32 (Monitor)

59 Q 43

60 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p38

61 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, pp 42–44.

45. **Development will be necessary if foundation trust governors are to have the skills required to successfully take on their new responsibilities and operate effectively in the new landscape. We note that Monitor's ability to provide development at the required level may be limited by spending controls on arm's-length bodies. When we next meet with Monitor, we expect to see clear evidence of their programme to support development for foundation trust governors. In the meantime the Government should provide additional resources to Monitor if required, or consider delaying the devolution of responsibilities until there is evidence that the effectiveness of foundation trust governors has been enhanced.**

46. Under the original terms of the Health and Social Care Bill, after April 2012 Monitor would have retained its special powers to intervene in the event of a significant breach for only a defined subset of foundation trusts, until April 2014. Following concerns expressed by the Future Forum, among others, about the ability of governors to assume the reins so soon,[62] Monitor's transitional powers were greatly extended, with Monitor retaining powers over *all* foundation trusts for an *additional* two years, until April 2016, whereupon the powers would be reviewed.[63] The Government stated that this extension was necessary 'to enable time for foundation trusts' governors to build capability in holding their boards to account'.[64] It was welcomed by Dr Bennett as 'a very useful much longer period to prepare governors to take on the [new] role'.[65] **We welcome the extension of Monitor's oversight powers for foundation trusts to 2016, and the fact that the powers will then be reviewed.**

47. **The Government's reforms and the financial context have placed Monitor in a position where its foundation trust duties have escalated, albeit on a temporary basis, and where its activities in both authorisation and compliance are likely to increase. Maintaining standards at this time will be vital. Monitor will need to adapt if it is to take on this additional workload without lowering its standards. The Government must ensure that Monitor has the resources necessary to maintain standards across foundation trusts while it retains responsibilities in this area. The next five years will be critical in ensuring that foundation trusts are in a fit state to survive and thrive in the new health landscape.**

Failure regime

48. These many concerns make it especially important to have an appropriate failure regime in place for foundation trusts. A strong distress regime (a precursor to 'failure' status) is also important, and Dr Bennett agreed that the Monitor's transitional powers over foundation trusts could effectively be used in this way.[66] However, he noted:

62 NHS Future Forum, *Summary Report on Proposed Changes to the NHS*, June 2011, p10

63 Under both scenarios, Monitor would retain powers over newly authorised foundation trusts for two years following authorisation.

64 Ev 15 (Department of Health)

65 Q 41

66 QQ 70–71

> The only difference is that our compliance regime applies to everything a foundation trust does. The proposal was that a failure regime would only apply to essential services. Therein lies a big question: how many of a foundation trust's services are to be regarded as essential?[67]

49. The failure regime proposed under the original form of the Health and Social Care Bill involved designating 'essential services' in advance. Following the Future Forum process, the Government stated that it had 'had concerns about the practicality of our current proposals for an up-front system of designating services for additional regulation, and we will be amending the bill accordingly'.[68] At the time of our evidence session, it was not yet clear exactly how the Government would structure its new regime, but Dr Bennett said he expected it to 'have the same basic design characteristics'.[69] Monitor told us that, whatever system was put in place, it would be important to have a failure regime that 'protects the services that patients need without propping up failing management teams if they are doing a bad job of running the service'.[70]

50. On 31 August the Government tabled amendments to the Bill, setting out the proposed new failure regime for foundation trusts. These amendments were tabled too late for us to consider them in full either in evidence or as part of this Report. We believe it is important for the new regime to dovetail with Monitor's compliance responsibilities and to have a thorough and effective distress regime. We look forward to hearing Monitor's view on whether the new regime meets these criteria and we will cover this issue in more depth next year.

67 Q 71

68 Ev 15 (Department of Health)

69 Q 2

70 Ev 54 (Monitor)

4 Monitor's new role under the Health and Social Care Bill

Sector regulator

51. Monitor's role will expand substantially under the Health and Social Care Bill. At present, Monitor is the regulator of foundation trusts alone. Under the Bill, Monitor will take on a number of regulatory functions that are currently the responsibility of the Department of Health, as part of the Government's aim to 'move away from a system of top-down performance management'.[71] Monitor will become the sector regulator for all providers of NHS healthcare, with responsibility for licensing providers, regulating prices, and preventing anti-competitive behaviour.[72] The Bill also provides for regulations to be made to extend Monitor's work into the field of adult social care, should this be considered necessary.[73] The sort of work done with foundation trusts, such as ensuring providers are legally constituted and have clear governance arrangements, will remain a strong element of Monitor's work. Monitor set out how it interpreted its new role:

> Monitor will be the sector regulator for health. Our core duty will be to protect and promote patients' interests. We will do this by ensuring that quality is maintained and where possible increased. We will also promote the provision of care that is economic, efficient and effective.[74]

52. The Government's evidence to the Committee set out its intentions for Monitor under the Bill and the changes made to Monitor's role following the Future Forum process.[75] The most controversial aspect of Monitor's proposed new role, that of 'economic regulator' with a duty to promote competition 'where appropriate', was toned down, with Monitor becoming a 'sector regulator' with powers limited to tackling specific abuses of competition.[76] Dr Bennett told us that most of the changes provided a clearer definition of Monitor's responsibilities in this area, rather than changing their substance:

> The issue of economic versus sector regulator is mostly about the signals you send. [...] It was always the case that our functions were those of only what you might narrowly call an economic regulator. The problem was that using that label in this sector caused people to think that our focus would be very commercial and very much a financial focus, about markets and so on, which is not right.[77]

71 Department of Health, *Liberating the NHS: Regulating healthcare providers—a consultation on proposals*, July 2010, paragraph 3.1

72 A full statement of the changes to Monitor's role can be found in the Health and Social Care Bill and accompanying materials.

73 Clause 60 of the Bill. See also Financial Times, 'NHS regulator to oversee care home operators', 12 July 2011.

74 Ev 53 (Monitor)

75 See Ev 14–16 (Department of Health). Dr Bennett also sets out his appraisal in Q 2.

76 For a summary of these changes, see: Department of Health, *Government Response to the NHS Future Forum Report: Briefing notes on amendments to the Health and Social Care Bill*, July 2011, paragraphs 66 and 67.

77 Q 10

53. Monitor's supplementary evidence set out their view of the changes relating to competition between providers:

> Our position has always been that we support competition only where it is appropriate and can deliver benefits for patients, rather than for its own sake. Although it was never Monitor's intention to promote competition for competition's sake, the amendments to the Bill provide certainty and reassurance to those who had voiced concerns over how we might approach our role. We welcome this.[78]

54. One of the Government's intended benefits of the change in terminology from 'economic' to 'sector regulator' is in the area of competition law. The hope, as set out by the Future Forum,[79] is that by clearly establishing Monitor as a sector regulator, with concurrent powers with the Office of Fair Trading to enforce aspects of competition law, Monitor is even more likely to be the first port of call for grievances relating to competition and co-operation issues in the health sector.[80] In this way, problems would be handled by a body with sector-specific expertise, rather than being raised in the courts. However, there remains considerable uncertainty in this area. The presence of Monitor, with all its powers, would not prevent issues from ultimately being taken to the courts,[81] and, as Dr Bennett has acknowledged, until competition law is tested in the courts it is unclear exactly how the UK Competition Act 1998 applies in detail to the health sector. Much remains untested.

55. **We welcome the fact that Monitor's new role, as set out in the Health and Social Care Bill, has been more clearly defined following the Future Forum process. The change in 'signal' from 'economic regulator' to 'sector regulator' is also welcome, and will address some of the concerns raised following the introduction of the Bill. It is unclear whether the change will result in challenges under competition law being handled in the way the Government hopes. It is also the case, as has been acknowledged by Monitor, that competition law in this area is largely untested. This is another area where Monitor's future workload is somewhat unpredictable. Monitor will need to plan for a range of contingencies, and the Government will need to adapt its support as appropriate.**

Transition period

56. The extent of the change to the scope and substance of Monitor's role should not be underestimated. Monitor will need to evolve into a very different organisation, with far wider responsibilities, by April 2012—an extremely short space of time, especially given the uncertainty that still surrounds much of its future role. Monitor told us:

> We do not underestimate the extent to which this will require a change in culture at Monitor. Up to now our focus has been on institutions—the foundation trusts—

78 Ev 53 (Monitor)

79 NHS Future Forum, *Choice and Competition—Delivering Real Choice*, June 2010, pp 29–30

80 Continuing the role of the Co-operation and Competition Panel (which, under the Bill, will be absorbed by Monitor).

81 Q 10

> albeit with the interests of patients and taxpayers as a backdrop. Their interests now need to come to the fore.[82]

57. Chris Ham, Chief Executive of the King's Fund, has also drawn attention to the complicated nature of Monitor's new role:

> Monitor will need to employ large numbers of economists, lawyers, accountants, and managers to deal with competition issues, providers who fail, price setting, licensing providers, and other work. Add to this the need for Monitor to work hand in hand with the Competition Commission and the Office of Fair Trading on competition, the Care Quality Commission on regulation of quality, and the NHS Commissioning Board on price setting, and the complexities of the proposed regulatory arrangements become apparent.[83]

58. It is also the case that, while the Bill provides many new duties, Monitor still needs to work out the detail of exactly how it will carry out its new responsibilities. In the course of a roundtable event held by Monitor in July 2011, to discuss its new role, several issues of uncertainty were discussed, not least the exact meaning of 'integrated care' in the NHS (something Monitor has a duty to promote).[84] Concerns were also raised about the capacity of Monitor to cope with the extension of its responsibilities into the area of social care.[85]

59. A particular issue is that, while developing its new role as a sector regulator, Monitor will still retain certain transitional duties relating to foundation trusts, such as responsibility for authorising aspiring foundation trusts and retaining statutory intervention powers in the event of a trust breaching the terms of its authorisation. As discussed in Chapter 3, under the Government's amendments to the Bill these powers will extend to 2016, and may well endure for longer if trust performance makes it necessary. The Government has acknowledged that these foundation trust-specific responsibilities could be in conflict with Monitor's new role,[86] and the Bill therefore seeks to place duties on Monitor to manage this conflict.[87] Dr Bennett described this as needing to 'construct a Chinese wall':

> There is a potential conflict of interest between being an FT regulator and being a sector regulator. We have to construct a Chinese wall between them. [...] The fact that we now have to keep that Chinese wall in place for five years and we will be looking at all trusts, not just a small segment of trusts, means the Chinese wall is even more important.[88]

82 Ev 52 (Monitor)

83 Chris Ham, *Competition in the NHS in England*, BMJ, 19 February 2011, Vol 342.

84 Monitor, *Roundtable Summary*, 8 August 2011, http://www.monitor-nhsft.gov.uk/sites/default/files/Monitor%20roundtable%20summary.pdf, p3

85 *Ibid.*

86 Department of Health, *Liberating the NHS: Legislative Framework and next steps*, December 2010, p120

87 See clause 62 of the Health and Social Care Bill, *conflicts between functions*

88 Q 58

60. Monitor noted that, in the event of the Health and Social Care Bill being passed, it would expect an increase in its budget in order to meet the cost of its additional duties.[89] An agreement 'in principle' had been reached with the Department of Health on implications for staffing and budget of the new sector regulator role;[90] discussions had not yet been held on agreeing resources for the continuation of Monitor's foundation trust compliance role.[91] Dr Bennett told the Committee that the new duties could be accommodated 'as long as we can scale up—and I see no reason why we should not be able to'.[92]

61. **The scale of change in Monitor's operations is significant, and many parts of Monitor's future role remain uncertain or unclear. This continuing uncertainty further complicates an already complex and challenging process of adapting to a substantial new role while maintaining residual foundation trust responsibilities. It is vital that the transition period is carefully managed, with each of Monitor's responsibilities, both old and new, being executed to a high standard. We are confident that Monitor is aware of the scale of this challenge, and we note that Monitor has begun to plan for the transition to its new role, as far as this is possible. When we revisit this topic next year we will evaluate how well Monitor has undertaken this transition.**

Working with the Care Quality Commission

62. Monitor's functions dovetail with those of the CQC, with the two organisations having 'distinct but complementary roles'.[93] While the CQC is responsible for assessing the quality and safety of services, Monitor has a role in ensuring the quality of governance and financial arrangements for foundation trusts. Monitor stated:

> Monitor is also concerned about quality, but our role is different in that we focus specifically on ensuring that the boards of NHS foundation trusts are doing their jobs properly, on quality as well as finance.[94]

63. Monitor works closely with the CQC during the process of assessment and authorisation of applicant foundation trusts,[95] making use of CQC assessments and quality and risk profiles. The two bodies are also in weekly contact 'to discuss urgent issues of concern relating to trusts' compliance with either their terms of authorisation or CQC registration'.[96] The two organisations also work closely together in the event of the CQC carrying out a responsive review into services at a foundation trust.[97] The extent of cooperation between the two is such that a 33 page memorandum of understanding exists to detail how the two bodies should interact. The memorandum states:

89 Ev 19 (Monitor)

90 Q 51

91 Q 51

92 Q 48

93 Ev 20 (Monitor)

94 Ev 20 (Monitor)

95 See, for example, Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p13.

96 Monitor, *Annual Report and Accounts 2010–11*, 14 July 2011, HC 1217, p30

97 *Ibid.*

> Monitor and the CQC recognise their respective statutory responsibilities and independence, but will always seek to collaborate and cooperate when relevant and appropriate to do so in delivering their core functions.[98]

64. The interaction between the two organisations will be developed further by the Health and Social Care Bill. First, as already noted, the Bill extends Monitor's responsibilities beyond foundation trusts to act as regulator for all NHS healthcare providers (and also, potentially into the field of adult social care), meaning that a far wider set of providers will now be subject to regulation by both bodies. Second, the Bill proposes that the CQC and Monitor will jointly administer an integrated registration and licensing regime for relevant providers, putting significant cooperation between the two bodies on a statutory footing. The Government's legislative framework for the Bill set out how the system should operate:

> The CQC and Monitor will retain separate responsibilities for their parts of the regime. This means that the CQC will continue to register providers of health and adult social care. Meanwhile, Monitor will license providers of NHS healthcare services. Our aim is for a streamlined process that helps to minimise bureaucracy and ensures that regulation of providers is proportionate. Both regulators will need to work together to develop streamlined procedures. [...] Monitor's powers to regulate prices and license providers will only cover NHS services. Providers of other care services, including adult social care, would still be required to register with the CQC but would not be required to hold Monitor's licence.[99]

65. Some evidence to the committee expressed concern at the ability of two distinct organisations to cooperate effectively at this level. UNISON stated:

> We believe there to be an inherent contradiction between the business model of Monitor and the quality care model of the CQC [...] Situations will arise where the CQC and Monitor are in conflict with each other.[100]

66. The NHS Confederation noted that evidence given to the Mid Staffordshire public inquiry had highlighted the potential advantages of a single economic and quality regulator.[101] We raised with Monitor the question of whether it would not be more efficient to merge the two organisations. Dr Bennett was adamant that merging Monitor and the CQC would not only provide little in the way of savings, but could also cause wider problems:

> The scope of what the CQC has to do is already enormous. [...] The leadership group of the CQC face a very challenging task. Frankly, so do we. As FT regulator, I think we have been doing alright. We have a major new role to build, create and get right. It would be an unmanageable task to ask one leadership group to take responsibility

98 CQC and Monitor, *Memorandum of understanding between the Care Quality Commission and the Independent Regulator of Foundation Trusts,* May 2011, p1.

99 Department of Health, *Liberating the NHS: Regulating healthcare providers—a consultation on proposals.* July 2010, paragraphs 4.4–4.5

100 Ev 38 (UNISON)

101 Ev 51 (the NHS Confederation)

> for both those challenges. I would also wonder how much could be gained from doing it.[102]

67. A further memorandum from Monitor stated that merging the two organisations 'could result in an organisation with such a broad remit that it becomes very challenging to manage effectively—putting patients at risk without reaping any significant reward'.[103]

68. Dr Bennett also argued that it was 'attractive that the quality regulator is unencumbered by considerations of financial performance',[104] a point that has been supported by the Foundation Trust Network,[105] Cynthia Bower (Chief Executive of the Care Quality Commission),[106] and the NHS Confederation.[107] The Government, too, has taken this stance:

> The Government believes that keeping the functions separate rather than combining them in a single regulator will allow any tensions to be resolved transparently and objectively, avoiding internal conflicts of interest; and will ensure that essential safety standards are not sacrificed in the interests of economic viability.[108]

69. **The Health and Social Care Bill further increases the level of cooperation required between Monitor and the Care Quality Commission, with the joint licensing scheme requiring particularly close interaction. In consequence, we discussed with Monitor the potential for merging the two organisations. We note that there are strong arguments in favour of retaining a separate regulator for quality issues: a single regulator would require substantial safeguards to ensure that quality and safety did not come second to financial concerns. We are also concerned about the scale of the challenges facing Monitor and the CQC, both of which are going through complicated transition periods, coupled with continuing uncertainty and financial risk in the healthcare landscape. Given these factors, and despite the obvious risk of overlap, we do not think it would be appropriate to consider merging the two organisations at this time.**

102 Q 3

103 Ev 54 (Monitor)

104 Q 3

105 Ev 43–44 (the Foundation Trust Network)

106 Health Service Journal, *In charge of the not-so-light any more brigade*, 28 July 2011 (interview with Cynthia Bower)

107 Ev 51 (the NHS Confederation)

108 Department of Health, Liberating the NHS: Legislative Framework and next steps, December 2010, para 6.73

Conclusions and recommendations

Context

1. Monitor's operations over the past year have taken place in an extremely challenging context—not only in terms of its own changing role under the Health and Social Care Bill and the arm's-length bodies review, but also in terms of the wider pressures and change in the healthcare landscape. Although the proposed revisions to the Health and Social Care Bill have helped to define Monitor's future role more clearly, and some uncertainty will be removed as the Bill progresses through Parliament, Monitor will continue to operate in an extremely challenging context in the years to come. (Paragraph 10)

Foundation Trusts—Monitor's continuing duties

2. Monitor faces a significant challenge in assessing and authorising for foundation trust status the remaining NHS trusts. We welcome the Government's decision to change April 2014 from a legal deadline for the completion of this process to a less rigid target, albeit one the Government expects to be met. Nevertheless, sheer numbers alone make the assessment task formidable, and the Government must be prepared to be even more flexible if circumstances demand it. (Paragraph 13)

3. Monitor needs to be in a position to respond to the demands of applicant trusts, rather than trusts' programmes being artificially accelerated or delayed in line with Monitor's capacity. Monitor will, however, only be able to function effectively if the flow of applications through the pipeline is phased and not back-loaded. The Department of Health therefore needs to manage the progress of applications as far as possible to ensure Monitor is able to work effectively. Where this is not possible, the Department must either provide Monitor with the necessary resources to temporarily increase its assessment capacity, or should relax deadlines for a particular trust to enable assessment to be undertaken with due care and consideration. (Paragraph 17)

4. The Department must resist the temptation to artificially accelerate the process by referring trusts to Monitor before they have reached an appropriate level—to do so would only hinder Monitor's capacity to handle more realistic applications. (Paragraph 18)

5. The Committee strongly supports the view that the standards for authorising foundation trusts must not fall as a result of the Government's desire to see all remaining NHS trusts become foundation trusts. We welcome the assurances on this point from both Monitor and the Government. We note that Monitor intends to review its approach to assessment in order to accommodate the extra demands on its capacity. It is imperative that any change in process does not alter the standards expected of aspiring foundation trusts, either directly or as a result of the space created by a less comprehensive process. (Paragraph 25)

6. Monitor's assessments of Foundation Trust performance show that although many foundation trusts are performing well, a significant proportion are still struggling to meet financial and governance standards. (Paragraph 27)

7. It is clear that some of the improvement in the numbers of foundation trusts in significant breach is accounted for by changes in targets which have been introduced by the Government. We agree that Monitor's compliance criteria should reflect the performance measurements used by NHS Commissioners, the CQC and the Government. (Paragraph 29)

8. The Committee believes that the parallel existence of Monitor and the CQC creates a significant risk of cost and process duplication between the two bodies. It is essential that the scope and function of each body is clearly defined and that both bodies observe the limits of their responsibilities, while retaining a holistic view of the regulated organisations. (Paragraph 31)

9. It is right that Monitor adapts its regulatory approach and its use of formal intervention powers to reflect the circumstances of individual cases and we accept Monitor's reasons for not using its formal powers in 2010–11. Nevertheless, we encourage Monitor not to be reticent to use its formal powers when necessary, and to regularly review the progress of trusts in significant breach. (Paragraph 33)

10. Over the next year, Monitor's foundation trust compliance role will become harder and more important. It must be prepared and resourced to meet this challenge. There will be more foundation trusts, many of them newly authorised, struggling to make demanding efficiency gains and to manage upheaval in the health landscape. Existing foundation trusts will also be affected. In this light, we welcome the fact that Monitor is increasing its monitoring of financial risk. We encourage Monitor to remain vigilant for further areas where closer scrutiny is needed. (Paragraph 36)

11. We are concerned about the proposals in the Health and Social Care Bill to reduce the financial oversight role of Monitor and increase the responsibilities of foundation trust governors in this area. We draw the attention of the House to the fact that Monitor reported in March 2011 that failures of governance within existing foundation trusts were a significant contributory cause to cases of significant breach during 2010 and we see little or no evidence that this position has changed sufficiently to justify the additional responsibility being placed on foundation trust governors. (Paragraph 41)

12. Development will be necessary if foundation trust governors are to have the skills required to successfully take on their new responsibilities and operate effectively in the new landscape. We note that Monitor's ability to provide development at the required level may be limited by spending controls on arm's-length bodies. When we next meet with Monitor, we expect to see clear evidence of their programme to support development for foundation trust governors. In the meantime the Government should provide additional resources to Monitor if required, or consider delaying the devolution of responsibilities until there is evidence that the effectiveness of foundation trust governors has been enhanced. (Paragraph 45)

13. We welcome the extension of Monitor's oversight powers for foundation trusts to 2016, and the fact that the powers will then be reviewed. (Paragraph 46)

14. The Government's reforms and the financial context have placed Monitor in a position where its foundation trust duties have escalated, albeit on a temporary basis, and where its activities in both authorisation and compliance are likely to increase. Maintaining standards at this time will be vital. Monitor will need to adapt if it is to take on this additional workload without lowering its standards. The Government must ensure that Monitor has the resources necessary to maintain standards across foundation trusts while it retains responsibilities in this area. The next five years will be critical in ensuring that foundation trusts are in a fit state to survive and thrive in the new health landscape. (Paragraph 47)

Monitor's new role under the Health and Social Care Bill

15. We welcome the fact that Monitor's new role, as set out in the Health and Social Care Bill, has been more clearly defined following the Future Forum process. The change in 'signal' from 'economic regulator' to 'sector regulator' is also welcome, and will address some of the concerns raised following the introduction of the Bill. It is unclear whether the change will result in challenges under competition law being handled in the way the Government hopes. It is also the case, as has been acknowledged by Monitor, that competition law in this area is largely untested. This is another area where Monitor's future workload is somewhat unpredictable. Monitor will need to plan for a range of contingencies, and the Government will need to adapt its support as appropriate. (Paragraph 55)

16. The scale of change in Monitor's operations is significant, and many parts of Monitor's future role remain uncertain or unclear. This continuing uncertainty further complicates an already complex and challenging process of adapting to a substantial new role while maintaining residual foundation trust responsibilities. It is vital that the transition period is carefully managed, with each of Monitor's responsibilities, both old and new, being executed to a high standard. We are confident that Monitor is aware of the scale of this challenge, and we note that Monitor has begun to plan for the transition to its new role, as far as this is possible. When we revisit this topic next year we will evaluate how well Monitor has undertaken this transition. (Paragraph 61)

17. The Health and Social Care Bill further increases the level of cooperation required between Monitor and the Care Quality Commission, with the joint licensing scheme requiring particularly close interaction. In consequence, we discussed with Monitor the potential for merging the two organisations. We note that there are strong arguments in favour of retaining a separate regulator for quality issues: a single regulator would require substantial safeguards to ensure that quality and safety did not come second to financial concerns. We are also concerned about the scale of the challenges facing Monitor and the CQC, both of which are going through complicated transition periods, coupled with continuing uncertainty and financial risk in the healthcare landscape. Given these factors, and despite the obvious risk of overlap, we do not think it would be appropriate to consider merging the two organisations at this time. (Paragraph 69)

Formal Minutes

Tuesday 6 September 2011

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Grahame M Morris
Dr Daniel Poulter
Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Draft Report (*Annual accountability hearing with Monitor*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 69 read and agreed to.

Resolved, That the Report be the Tenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 13 September at 9.30 am

Witnesses

Tuesday 14 July 2011 *Page*

Dr David Bennett, Chair and Interim Chief Executive, **Stephen Hay,** Chief Operating Officer, and **Adrian Masters,** Director of Strategy, Monitor. Ev 1

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List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430
Tenth Report	Annual accountability hearing with Monitor	HC 1431

Oral evidence

Taken before the Health Committee

on Thursday 14 July 2011

Members present:

Mr Stephen Dorrell (Chair)

Andrew George
Mr Virendra Sharma
Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Dr David Bennett**, Chair and Interim Chief Executive, **Stephen Hay**, Chief Operating Officer, and **Adrian Masters**, Director of Strategy, Monitor, gave evidence.

Q1 Chair: Thank you very much for joining us this morning. As I am sure you know, this was a session we originally timetabled for a few weeks ago and you were called away to give evidence to the Bill Committee. You are very welcome here this morning. Could I ask you to introduce your colleagues so that we know who we are talking to?
Dr Bennett: Yes. Stephen Hay is Chief Operating Officer of Monitor. He runs all our regulatory operations, which is both the assessment and compliance process for FTs. Adrian Masters, until recently, was Director of Strategy and Policy but has now also taken on the role of Transition Director, leading the work that we are doing to prepare for our new role.

Q2 Chair: Thank you very much. I would like to begin, if I may, by asking you to reflect on what that new role will be. It has clearly been an evolving scene. It would be interesting to the Committee to hear your view as to what was originally proposed, what is now proposed, what are the key changes and what are the implications of those changes.
Dr Bennett: Let me do this by going through each of the major functions that we will have. One overarching point that should be made is this. The Bill originally made it clear that our fundamental duty should be to protect and promote the interests of service users. That is not fundamentally changed, although it is given more emphasis in the amendments, which I think is a good thing.
We can then look at the components of our role, and I will start with perhaps the more straightforward ones such as pricing. We continue to have a role in setting prices and tariffs for the providers of NHS services. As before, we do that in conjunction with the Commissioning Board. The Commissioning Board defines what it is that should be priced and we price it. There is not a lot of change there. There are some requirements, particularly around issues of cherry-picking, which people were concerned about. We had said that we thought one of the ways to deal with cherry-picking was to make sure that prices were as reflective of the underlying costs as possible. That is now mentioned explicitly in the Bill, which is clearly a good thing. The whole role of the pricing function is as it was.
The second of our roles is around continuity of supply, making sure that essential services can still be provided even if the provider of those services gets into difficulty. This is also all wrapped up with notion of a failure regime: what you do as providers get into difficulty. That role, fundamentally, remains, but the specifics of the failure regime are being changed. The Government have not yet said what the details of the new failure regime will look like, but they have said that there will be a failure regime. My understanding is that it will still have the basic and important characteristics: it is coherent; it has a distress element as well as a failure element; it is objective, transparent and so on. As to the detail, we are still waiting to see exactly how they are going to amend that.
The next element of the role—the one, frankly, that was the most controversial—was originally characterised as being about promoting competition, which was an explicit duty in the Bill. That is now taken away as an explicit duty. It would be better therefore to characterise what we are doing in this area as being about co-operation and competition, which is, in effect, the way it is characterised today. The body that looks at this today is called the Co-operation and Competition Panel. The rules that state how players in the service should operate are called the Principles and Rules for Co-operation and Competition. That is the label I would give it. There is a stronger focus on aspects of co-operation as well as competition and, indeed, there are some changes around our role with regard to competition.
Some of this is mostly about restricting, constraining or defining how we should undertake our role. I would like to believe that, in almost all respects, these are things we would have done anyway, but the truth is the original version of the Bill did give us a lot of freedom to interpret how we would undertake our role. That is now more clearly defined and, in that sense, I think, is a good thing. As I say, the things we are constrained to do and the way we are constrained to operate are broadly the way we would have done things anyway.
There is a shift. As I say, the duty to promote competition is gone and, instead, we have a duty to promote an efficient, economic and effective provision of health care. What that does is to place any use of competition in the context of other ways in which you

can promote the interests of patients. In so far as we would conclude, in the future, that competition would be a useful way—among other tools we have available—to further the interests of patients, what it now requires is a much stronger burden of proof from us that competition is the right tool to use in those circumstances. Again, I welcome that. Even if we did not need such a strong burden of proof in the past, it was extremely important that we were very clear why we were doing things and, as far as possible, took all the relevant stakeholders with us. The best way to do that is to explain what the justification is. That is now a much clearer requirement on us. There is also a focus in the new duties on taking action with a view to maintaining, or even improving, the quality of care. Again, it is always important and not bad that we now have an explicit focus in that area.

There are a couple of specific things that have changed in the competition area as well as this significant change in emphasis. One of them is around the ability to promote any particular sector, for example to promote the public sector versus the private sector versus the voluntary sector. Neither we nor anyone else is now allowed to do that according to the new provisions, which I do not think is an issue. There is a second change, which is that the original version of the Bill allowed us to specifically require that one provider should make available some of their facilities to another provider. This has now been explicitly ruled out. This is an area where I wonder whether the full consequences are going to be quite what people were looking for. I can imagine some circumstances where, for example, one foundation trust wants to provide a service in the locality of another foundation trust and, in order to do that, they want to have access to the facilities of the second foundation trust. In the past, if we thought that was the right thing for patients, we could have required the second foundation trust to make their facilities available. We would not be able to do that now. There are other examples where you could imagine that it might be desirable. Of course, if the various players co-operate with each other, maybe it is not an issue and it is a power we would not have used anyway, but that is a rather specific change. Thus, there is clearly a significant change in emphasis in the co-operation and competition area of our responsibilities.

Finally, licensing is the vehicle through which we get to do a lot of these things. It is the way in which we make sure providers have to use the tariff that we set. It is the way in which we can stop anti-competitive behaviour if we see that going on and so forth. Licensing, essentially, remains as it was. Some of the details will change because the other things have changed, but, as a process, that remains as it was.

Chair: Thank you very much. That is a full answer. The reference to your role on care quality as well as economics raises a question that I know Valerie wants to put to you.

Valerie Vaz: I thought you were going to do that, Chairman. Go ahead.

Q3 Chair: The question we were asking ourselves, thinking about the roles of the different organisations here and given that we know there is a very long memorandum of understanding between you and the Care Quality Commission defining who does what, is whether it would be easier if it was one body rather than two.

Dr Bennett: My answer is no, and for two quite practical reasons. One is I think it is attractive that the quality regulator is unencumbered by considerations of financial performance, particularly looking at our current role as the FT regulator where we have to worry about the financial stability of the providers as well as the quality of the care they are providing. The fact that we do that separately from the CQC and they can focus entirely on quality—and, therefore, for example, in reaching a decision about whether or not the quality of care is acceptable they do not need to consider whether there are any financial consequences for the provider when they have reached that decision—is an attractive thing. That is one reason why putting the two together, in my view, would not be the right answer.

The second—and, in a way, this is an even more practical issue—is a managerial point. The scope of what the CQC has to do is already enormous. For the moment, it is further complicated because they are still in the process of merging three previous organisations. I have been involved in doing that sort of thing and it is a big task. I do not think there is any question but that the leadership group of the CQC face a very challenging task. Frankly, so do we. As FT regulator, I think we have been doing all right. We have a major new role to build, create and get right. It would be an unmanageable task to ask one leadership group to take responsibility for both those challenges. I would also wonder how much would be gained from doing it. I can see the downsides.

Q4 Valerie Vaz: You say in your memorandum, though, that there is overlap in some of the work you do and you mention quality as well as finance. Do you take that into account or not?

Dr Bennett: Our job is to make sure that trusts are well governed, and that is in terms of finance and quality. We do absolutely concern ourselves with quality, but we are very clear that, when it comes to the specifics of establishing whether or not a provider is meeting the essential standards of quality care, that is for the CQC to do, and then we base our decisions on their findings. That is why we have to work extremely closely together, but we are quite clear that, when it comes to really assessing whether the performance of a trust is acceptable or not, that is for the CQC.

Q5 Valerie Vaz: You are doing that and you have mentioned that you speak to them—I think—once a week. I am concerned or unsure about the mechanism of that. Do you pick up the phone to Dame Jo Williams and say, “By the way, this is happening and that is happening”? I wonder whether some of your role falls between the two stools, because you have mentioned that there is an overlap. I am concerned about the costs of running two big organisations. Could that not come under one body with different functions?

Dr Bennett: First of all, as to the issue of how we work together, as the Chairman said, we have a fairly detailed memorandum of understanding, which sets out a lot of how we work together. There are lots of formal processes and regular meetings with people at different levels in the organisation. That is true right the way up to meetings of the two chief executives. In addition, we have a lot of informal contact. A lot of that will be about specific issues. For example, if we find a trust where we are alerted to a problem—through some interaction we have either with the trust or with stakeholders in the trust—we will alert the CQC, and if they find an issue in one of the foundation trusts, they will talk to us in a similar way. There are informal exchanges as well as formal.

There is a degree of overlap. It is quite small and it would be fair to say it is deliberate. That is around what we call quality governance. In terms of the performance of trusts—whether they are delivering safe care—that is very definitely for the CQC. We have to worry about whether, overall, the trust is well governed. That includes, "Does it govern the processes around quality well?" It is not only, "Is it providing safe care today?", but, "Does it have the right processes and systems in place to ensure it provides high quality care in the future as well?" We look at that as, to a degree, does the CQC. There is a little bit of overlap there, but that overlap is a very small part of what either of us does. It helps to ensure that there aren't things falling between the gaps—or a gap, were there to be one between us.

You might say, "If we put the two together, would this reduce costs?" You could certainly say that the costs within that quality governance would be somewhat less. That would be a very, very small part of our total costs. You might say we could share back-office functions, "Wouldn't that, at least, reduce costs?" One, the Government has an initiative going on—and the Department of Health, of course, is fully involved in this—to arrange for all arm's length bodies to share back-office costs where possible, so that will happen anyway and, two, in a very specific area where Monitor and CQC could have duplication, which is their registration and our future licensing of providers, we are going to work together. Indeed, because they already have a registration process, they are effectively going to do it for us.[1] That means no extra cost, or at least minimal extra cost. Also, from the provider's point of view, it means they are not facing a new body asking for information. You would have one board instead of two. You might think you could have one chief executive rather than two, although, frankly, it is such a big scope that you would finish up with the equivalent of two chief executives anyway. I think the actual costs savings in relation to our total budget are likely to be very small.

Q6 Valerie Vaz: Focusing on the costs but also the way you do business, if you are doing business together anyway by picking up a telephone, what if you are in a meeting and someone tells you something very important that is going on in a trust, for example, the CQC are ringing up—as you seem to do a lot by telephone or in meetings—and no one is picking up and getting a grip of what is happening? Clearly, we can't lose sight of the fact that there is a lot of worry out there in terms of care of the elderly, what is going on in homes and that the CQC have been found to be failing in that regard. It is if something is not quite right—I am not focusing only on the costs—and how you work together. You clearly are working together, and maybe there is—I am just exploring it as a possibility to try and stop what is happening—an overlap of duties. Maybe it could be a board with two chief executives, two separate arms. You are doing two jobs now, aren't you?

Dr Bennett: As it turns out, I am, but they are not quite the same thing.

Q7 Valerie Vaz: Exactly. I don't know how you are doing that.

Dr Bennett: That is a separate question. The CQC themselves would confess there are some difficulties they are having to deal with. I do not think those are difficulties that have anything to do with potential or actual interfaces or overlaps with Monitor. For example, the issues in adult social care—we don't have any responsibility in adult social care—are about their inspection regime, and I am sure they are seeking to address those. I am absolutely clear that putting the two organisations together would not only not have changed that situation but, at the margin, would have made it more difficult. It would have made the managerial and oversight tasks of the board even more difficult because they had so much more to look at.

Q8 Valerie Vaz: But you are going to license a whole new range of providers, aren't you?

Dr Bennett: We will be licensing all providers, except perhaps the very small ones. That is why the administrative processes need to be fully integrated. Yes, you are right in the sense that either we or the CQC, in our current or future roles, might identify an issue in a trust or a provider which the other body needs to know about, and there has to be some mechanism—phone calls or whatever it is—to make sure that they find out. However, frankly, if we are all part of the same organisation, the same would be true. There is plenty of evidence of sometimes, within a single organisation, ineffective communication creating difficulties. I do not think putting them together would solve it.

Q9 David Tredinnick: I am very interested in what you are saying and my colleague's line of questioning. I am mindful of the fact that in the House we used to have three House Committees—there was an administration Committee, a catering Committee and, I think, a security Committee. Some years ago they were all amalgamated with much screaming and all the rest of it. Now everyone is very content and we have a streamlined organisation. Personally, intellectually, I cannot see how a hospital can be well governed by governors who are not focusing, as a core activity, on care quality. If they are focusing on care quality as part of their core activity, then I cannot see how you need a Care Quality Commission that is a

[1] *Note by witness:* It would be more accurate to say 'because they already have a registration process, it makes sense for them to take the lead'.

separate organisation, whether you have memorandums of understanding or not. What I can understand is that, at the moment, the Care Quality Commission is attempting to amalgamate three separate organisations. I think there is an issue right now about the practicality of drawing organisations together, but I am not at all convinced that separating out finance, care and quality, intellectually, is a sustainable approach.

Dr Bennett: I should point out that, in answering this, I am going to sound very self-serving because I am arguing that Monitor should continue to exist as a separate entity. I happen to believe that is right, but I recognise there is that issue. Of course, at the trust level, there is not the slightest question but that all aspects of running a trust, including the quality of care and the financial aspects, have to be viewed in an integrated way. Therefore, because our job is to make sure the trusts are well governed, we, too, have to be concerned about all aspects of governance. We have to be satisfied that the trust is able to deliver and is delivering safe care.

I am still unclear what the specific benefits would be from having one organisation looking at performance in terms of quality versus performance in terms of governance. As long as the two organisations work well together, I am not sure there is any significant difference in having the two put together. They would still be quite separate because they would be doing very different things most of the time, even if they were under the same board with maybe the same chief executive. I think you have to ask where the extra benefits would come from. You would still have different parts of one organisation needing to talk to parts of the other organisation and I am not quite sure what benefit you would get from putting them together. There might be some very small cost savings.

Chair: I think we probably need to move on.

Q10 Dr Wollaston: Can I take you back, Dr Bennett, to your initial response, bringing in two issues about integration and also a further issue about competition law? In particular, could you set out a little more how you see the difference between an economic regulator and a sector regulator and whether you agree with the Future Forum who felt this would be a mechanism to protect against EU competition law? I would like to come on after that to a question about supporting integration.

Dr Bennett: The issue of economic versus sector regulator is mostly about the signals you send. I think the reason the Government chose—and it was the Government's decision—to call us an "economic regulator" was because many of the functions they were proposing to give us are functions which other regulators have who call themselves economic regulators. In truth, if you look at all the different regulators—Ofcom, Ofgem, and so on—they will have a somewhat different mix of functions. It was always the case that our functions were those of only what you might narrowly call an economic regulator. The problem was that using that label in this sector caused people to think that our focus would be very commercial and very much a financial focus, about markets and so on, which is not right. It sent the wrong signals. The essence of this is about trying to send the right signal, that we are a regulator of the sector and specifically the health sector.

The Future Forum's point about EU competition law, essentially, is this. Today, EU competition law, brought through the UK Competition Act 1998, encompasses the health sector. It covers the whole of the UK economy. That is not changed by the Bill, either as originally proposed or according to the amendments. The issue is to what extent it applies in detail. In truth, we will only know that when it is tested in the courts—that is the nature of competition law—and it has not been. One of the reasons it has not been is because, today, there is a sector regime covering competition—in fact, co-operation and competition—and that is in the form of the rules, the PRCC. The body that looks at whether those rules have been adhered to is the CCP. Since that body exists, it means that it is less likely people will seek to use the Competition Act to address issues. They have an alternative place to go. The Government, in putting that on a more statutory footing and, in the process, giving the powers to Monitor—and, by giving Monitor concurrent powers with the OFT, moving a step beyond that—help to reinforce the notion that the first port of call when looking at competition and co-operation issues in the health sector should be the sector regulator, the benefit of which is then we can look at it, bringing in sector-specific expertise.

Q11 Dr Wollaston: To follow up on that, you have just said you will not know unless it is tested in the courts. The point is whether you are going to act as a buffer before the courts in discouraging people from taking legal action. Will you be able to say, "We do not think you should take legal action"? As you yourself have said, "It is untested and we don't know."

Dr Bennett: Yes, but I would not put it quite like that. If an issue is brought to us, we will be able to look at it using the sector-specific rules—PRCC—to determine whether or not there is an issue. That does not stop somebody ultimately choosing to take it to the courts. However, since it gives an alternative way of addressing the issues, one hopes that, as long as we can satisfactorily address people's concerns, we can deal with it within the sector-specific rules.

Q12 Dr Wollaston: Can I give you a relevant example of that? I know one of your other roles is going to be to support integration, although you did not mention it earlier. My area, Torbay, has a great reputation for horizontal integration, integrating health and social care. Their vision for the future is to look at the possibility of integrating vertically: having a single provider organisation that would combine the Torbay Care Trust, the foundation trust, the partnership trust—which is the mental health trust—and also the non-core GMS aspects of general practice. Would that be considered anti-competitive or would that be part of your role, if you are supporting integration, to make a ruling that, no, it is in the patient's best interest to have that seamless journey?

Dr Bennett: First of all, I should say the question applies today as much as it will in the future. The PRCC—the rules—apply in this sort of area and the CCP could look at what is proposed to determine whether it is consistent with the rules. What they might do today—and what we most certainly will do in the future—in looking at the extent to which any proposed merger or integration might reduce the degree of competition, is consider what the impact of that reduction in competition might be for patients, set that against the benefits for patients of the integration and then form an objective view as to what is in the best interests of patients.

Q13 Dr Wollaston: It is relevant, is it not, because they would argue you could have competition between competing care pathways, for example?
Dr Bennett: Yes.

Q14 Dr Wollaston: Is that how Monitor is likely to interpret it in the future?
Dr Bennett: It seems like a sound argument to me. One would have to look at the details of the case and really understand the specific situations in that locality, but the notion that you are moving towards a world where you have some competition between alternative providers of a whole integrated pathway sounds like a very plausible place to move to, yes.
Dr Wollaston: Thank you for that.
Chair: Valerie, could we move on to the questions of the implications on the operations of Monitor over the last year? I think that was yours.

Q15 Valerie Vaz: I noticed in your written evidence that you have formal powers to intervene and you did so in a number of foundation trusts. I wondered what that mechanism was, how you do it and how you see your future role.
Dr Bennett: We have a steadily escalating process of intervention. We monitor the performance of trusts. If we see evidence that they may be getting into a risky situation financially, in terms their governance, we will begin a dialogue with the trust.

Q16 Valerie Vaz: To take you back, how do you do that? You say you get evidence. Take us from first principles.
Dr Bennett: There are two basic types of performance measures that we look at. First of all, in terms of financial performance we calculate something called the financial risk rating. It is a combination of various measures of financial performance designed to give us an indication of a trust potentially getting into difficulty, for example, running out of money—as simple as that. It works on a scale of 1 to 5. If they score 3 or above, that tells us that they basically do not have any problems. If they are moving towards 2, that tells us we need to look rather more closely.
The second type of performance we look at is quality performance, particularly with regard to the performance metrics that the Government is interested in, things like waiting times and so on. We look at those partly because we want to make sure the trusts are meeting the targets that the Government or the commissioners are setting and regard as important, but also because we see the performance on those measures as a proxy measure as to whether the governance of quality is working well in a trust. Again, if we see trusts beginning to miss targets—and it is all very formulaic—

Q17 Valerie Vaz: Yes, but you have relaxed those targets now, have you not? Is that right?
Dr Bennett: No. We largely follow the operating framework. As the operating framework has changed, we have changed those things which we monitor. We have an interesting challenge—which I was discussing only yesterday—in that it is quite clear we should be regulating and not performance managing these trusts. If you finish up measuring everything they do and seeking to intervene every time they do something which is slightly off target, you are managing them and not regulating them.

Q18 Valerie Vaz: Are you saying that you need to change your powers?
Dr Bennett: No. I am saying that, as the number and complexity of the metrics the Government and the commissioners are interested in has increased, there is a danger for us. If every single one we add on is another proxy measure of governance, we finish up virtually performance managing them. Therefore, in one or two areas, we have said we will not look at every last performance measure that commissioners should be looking at but use a slightly smaller set. Our real focus is to understand whether the trust is governing itself well and we are using its performance against these measures to tell us whether it is governing itself well.

Q19 Valerie Vaz: What do you do? You have powers of intervention and you formally intervene. What does that mean and what is the outcome?
Dr Bennett: This is where we get to the escalating process. If we see that a trust is missing its targets or that its financial risk rating is deteriorating, in the first instance we will probably talk to them and ask them to explain to us what is going on. That may happen at a relatively informal discussion, if it is a fairly minor movement. If it is a significant issue, we can have a very formal meeting with the trust board where we ask them to explain exactly what had been the issues and what they have done about them.
If we think the board does not fully understand the nature of its problems and does not have in place actions that look to us credible to address those problems, then we may put the trust in significant breach. That enables us to ask for extra information from the trust, monitor very closely whether they are addressing the problems and suggest what they should do in order to fix their problems. It will go alongside pretty regular meetings between the senior executive in Monitor and the board of the trust. I should also say that putting a trust in significant breach—which we do not do very often—is a very, very clear signal to the trust that they have problems the board really must sort out.

Q20 Valerie Vaz: Does that information come out to patients then, or is it still discussions among you and the trust?
Dr Bennett: The key elements of it are made public. Whenever we have the meeting we will follow up with a letter, which is made public.
Stephen Hay: We publish when a trust is in significant breach. If we intervene again, we have to issue a public notice of intervention explaining what we have done and why.
Dr Bennett: The final step in this escalating process is to use our formal intervention powers. Up to now a lot of it has been about suggesting what the trust should do. Mostly, they do the things we suggest. However, if we feel a trust is not doing what needs to be done, and in particular if we feel that there is a real failure of leadership in the trust, we will use our formal intervention powers. That is sometimes to tell them they must seek additional help, which can come in a variety of forms, but also very occasionally—and formally only ever twice—to remove the chair of the trust and put in a new chair, on an interim basis, to provide stronger leadership for the trust.

Q21 Chris Skidmore: I want to move on to what may be a significant problem in the future, which is the current process of assessing whether trusts can have foundation status. We have 137 foundation trusts at the moment and I believe there are another 90 that need to be assessed before April 2014. At the same time, in this financial year, you have only managed to effectively assess and approve seven trusts. You have stated in your evidence to us that getting them all assessed and signed up as foundation trusts "will be challenging" and that "The Department of Health will need to work extremely hard to ensure that trusts meet the required standard and are put forward to Monitor in a timely fashion otherwise it is unlikely that this deadline will be met."
I want you to comment further on that evidence. The way we are going, do you think that it will be possible by April 2014 to get every trust signed up as a foundation trust?
Dr Bennett: It will be very challenging. It is worth mentioning that one of the other changes—and I did not do all the detail, you are right—in the recent Government amendments is to provide some flexibility around that 2014 date. Nevertheless, the Government are clear that they want to get most trusts through by that point. One of the things we are very concerned about is that they all finish up being back-loaded, which, apart from anything else, presents us with an almost impossible challenge. I have been very clear to the Department that: one, if you do that, we will not be able to do our bit, but, two, when you tell us you are going to deliver the trust to us, be realistic; do not just take the total number of trusts divided by the total number of months and tell us you are going to deliver that in each month because we know you will not. In any case, if we are not aware of a likely spike towards the end, then we will not be able to plan for it. I am encouraging them to bring as many forward as possible so that it is manageable for us, but also to be realistic. Then, once they say—and they have not yet got their final profile—what they are willing to commit to, we have to look at what we can do on our side.

Q22 Chris Skidmore: You have so far had 13 put forward to you this financial year, of which six were either postponed or deferred.
Dr Bennett: I think that is right, yes.

Q23 Chris Skidmore: That was because you did not feel they could meet the standard—the bar that you set—that is understandably high.
Dr Bennett: Yes.
Stephen Hay: If they are deferred, it is a formal decision by us that they are not yet ready. If they postpone themselves, it means that they have realised that they are not going to get through the process and need to do further work. Then they come back.

Q24 Chris Skidmore: You are absolutely clear that, in terms of the standard you set for becoming a foundation trust, that bar will not be lowered. You will not compromise on that standard at all.
Stephen Hay: Absolutely.
Dr Bennett: As I have said many times, our bar is set in order that we can be confident these trusts are well governed in terms of finances and quality. I do not think that is a bar that should be moved.

Q25 Chris Skidmore: In terms of telling the Department their time scale is inappropriate, given that that standard will remain, you are willing to tell them that.
Dr Bennett: Absolutely.

Q26 Chris Skidmore: Talking about the standards of foundation trusts and the importance of becoming one, you are probably aware of the recent research published by the University of York's Centre for Health Economics on foundation trust status. They believe that the actual foundation trust status itself makes little difference to the general performance. The research from the Centre for Health Economics suggests that though foundation trusts generally perform better against some key financial and non-financial indicators than non-foundation trusts, that difference is not attributable to their foundation trust status. Instead, the differences are long-standing and existed prior to the reform. Would you challenge that research or do you think there is a case in point?
Dr Bennett: The first thing I would say is they do accept, which is our view as well, that the process of becoming a foundation trust usually leads to an improvement in performance. They are saying, however, that once they are a foundation trust there is no further acceleration away of the FTs versus non-FTs. We have taken a look at their report. Frankly, there is not enough evidence at the moment to be sure about it.
We commissioned a similar piece of work ourselves some time ago from an economics consultancy, which reached a different conclusion. We need to understand why there is this difference. If their conclusion were to be robust, we need to think about what we can do about it. In the early days, people thought foundation trusts were a sort of elite and they ought to be much

better than the rest. As we turn all trusts into foundation trusts, they are not going to be elite: they are going to be all of them. Nevertheless, as part of becoming a foundation trust you get a greater degree of independence and autonomy. While, to a degree, that should be beneficial in and of itself because it enables a trust to connect better with their local communities, you would like to think it would also lead them to do things they could not otherwise have done and that would have been manifest in a better performance. If the evidence is that that is not happening, we would need to try and understand what could be done to encourage it more. Adrian, you have looked at it. I do not know if you want to add anything.

Adrian Masters: I read the report a couple of days ago. The York report is essentially consistent with previous reports, in that it is clear FTs perform better than non-FTs. It is not in their report, but—from elsewhere—we know if you talk to the chairs and chief executives of FTs they will say the regime is better because they have more freedom and they can make decisions more quickly. Also, if they generate a surplus they get to make their own decisions about how to invest it to the benefit of patients, which they value. When you look to try and see if we have data that show whether the gap between how non-FTs perform and how FTs perform is increasing or is about the same, nobody has been able to find evidence—including in the York report—that the gap is actually increasing.

People then debate why that might be the case. One thing is: is it a question of the evidence? If you talk to some FTs, they will give you anecdotal evidence. The Health Committee itself published a report in 2008 which brought out some of these examples, where, if you go to individual FTs, they will say, "Yes, it is different because we can make these investments and we are improving our services faster than we otherwise would." That is anecdotal evidence.

Some people say if you look at the actual measures you can use—you need to have a long-run sequence of measuring the same type of quality to check for the change and you have to look over a long period of time—the truth is that the quality of data, and the depth to which we consistently and systematically measure outcomes, have been poor in the system. It is one of the reasons why the Government are trying to push for a better way of measuring the quality of care. It could be that it is a question of the evidence. If we had a better system of looking at the quality of outcomes, we would see something in that data which would support the anecdotal data we talked about.

Another possibility is that you could say the incentives have not been strong enough. We have given them extra freedoms, but for them to make use of the extra freedoms, they need stronger incentives which are good incentives. Again, you might say that because commissioning has not worked to date as well as we would have wished, the incentives have not been strong enough to see the gap increase.

Q27 Chris Skidmore: I am quite interested by this. What incentives would you be thinking about—payment by results or something like that?

Adrian Masters: Payment by results and the strength of commissioning are probably the two key ones. At that level, a lot of the things the Government are trying to do will provide us with a better basis for saying, "Now that we have given them the freedoms, do we have in the data an increasing gap between FTs and non-FTs to support what we get from, basically, case studies—anecdote—at the moment?"

Q28 Chair: Can I bring you back to the body of providers that are trusts that still have to be got over the bar if we are going to have 100% foundation trusts as the basis for provision in the Health Service? It is presumably correct that, among those that are not yet foundation trusts, those who have significant financial or quality problems are over-represented—let me put it no stronger than that—and the circumstances in the Health Service in the next few years are likely to be tighter and more challenging for management than they have been in the last few years. These are institutions that have not been able to get over the bar so far and the bar is becoming relatively more difficult for them to get over. Is it fair to conclude from that nexus of circumstances that, in truth, very few of these bodies are going to qualify properly for foundation trust status without significant reconfiguration of the services they deliver?

Dr Bennett: Fundamentally, one would have to say it is a question for the Department, because it is the Department who are charged with the job of getting them over the bar. They are the ones who are in discussion with the trusts to really understand the nature of the problem. We can only report what we hear from the Department.

Nevertheless, you can see different categories of challenges, and some trusts will face multiple challenges. There is a managerial challenge in some trusts—they do not have good enough leadership teams—and hopefully that can be addressed. There are some trusts with legacy debt or very expensive PFIs. Frankly, they need some form of financial restructuring in order to deal with them. I know that, right now, the Department is doing a very detailed study of the PFI issue. As I understand it, their emerging conclusion is that there are not that many trusts where the PFI is the fundamental problem, but there are a few and they need to find a solution to that. It is certain, however, that a lot of trusts will need to achieve major productivity improvements. This is true of FTs as well, not just of non-FTs. Improving productivity will include major changes to the way they work, and some of those changes will have knock-on consequences for the configuration of their services. They may be relatively straightforward things, like reduction in length of stay. That is a classic way in which you can drive up productivity and improve patient care at the same time, but the end result may be that you need fewer beds, fewer wards and fewer nurses. In that sense, you need to change the configuration of what you have.

However, you may also decide, if you have multiple sites, that you need to concentrate services on one site. You may even find situations where one trust says, "Frankly, we are not in the best position to provide the service. A neighbouring trust can do it better."

Therefore, the service would no longer be provided at one site but at a neighbouring trust site. Then you are into proper reconfiguration. Yes, I am sure that is going to be needed and, as I say, even some of the current FTs are going to need to do that. In some sense, all trusts forever more will need to do that. As technology and demographics change or for all sorts of reasons, such as real estate gets too old, there is a need to move services around and reconfigure them.

Q29 Chair: Are you comfortable that the changes coming forward from within the management teams, both of foundation trusts—to take your point—and non-foundation trusts, are at a pace that is consistent with what we in this Committee refer to as the "Nicholson challenge," the pace that is determined by the availability of resources?
Dr Bennett: I cannot answer that question for the non-FTs because we do not have any direct involvement with those. As to foundation trusts, I meet with chairs or chief executives of the FTs on a regular basis. A consistent concern they raise, as they move from improving productivity by what many people term "addressing the lower hanging fruit"—the relatively straightforward improvements—to having to think about these more significant changes, is that they will find it difficult to make the changes as quickly as they need to, given the time scale within which the £20 billion, or whatever, needs to be saved. By the way, of course, it will not just be this £20 billion. There will be more after that as well. They are certainly nervous that they will not be able to get the changes through as fast as they need to.

Q30 Chair: What is the response of Monitor if it is in conversation with a specific foundation trust where those concerns are raised? In effect, what that chairman or chief executive is saying to you is, "We may pass your bar now but, at some point in the future, unless we deal with these concerns, we won't."
Dr Bennett: Yes. At the moment, it is only a very few trusts where this is a specific issue. In particular, we seek to get the commissioners to take a larger responsibility for supporting the reconfiguration of services. The commissioners, as representatives of the patients' interests and the bodies that are looking across all providers—not just a particular trust—are in the best position to work out the best solution with the trusts. I think this is a nettle they need to grasp more firmly.

Q31 David Tredinnick: You have this responsibility for making sure these foundation trusts are financially robust. What happens if one of them runs out of money? Do you have a pot of gold that you are given to help them out?
Dr Bennett: We do not.

Q32 David Tredinnick: What happens if there really is a crisis and you get a call saying, "We can't pay the nurses on Friday"?
Dr Bennett: I mentioned the issue of the failure regime and the fact that we need one in the Bill because we do not have a coherent one at the moment.

Q33 David Tredinnick: There is a gap. Do you think that is a problem?
Dr Bennett: If a trust needs funding, we—or, more specifically, they—have to turn to the Department of Health. That is the only source of funding. To address one very specific point, I would be very disappointed—to put it mildly—if a trust phoned up and said, "We cannot pay the nurses on Friday". That means all of our risk monitoring and anticipating problems would not have worked.

Q34 David Tredinnick: That is something I want to come on to. For 2010–11, Monitor's review of the performance of foundation trusts showed that of 12 foundation trusts, 9% are rated red for governance. I am used to dealing with traffic lights when we look at food, but here we are looking at hospitals. Presumably red is bad, not, as it might be in China, good. Is that right?
Dr Bennett: It is the UK version.

Q35 David Tredinnick: Why have you moved to change the rating system to go from 1 to 5? Is that not likely to cause confusion?
Dr Bennett: I clearly did cause confusion.

Q36 David Tredinnick: Why did you do it?
Dr Bennett: There are two—

Q37 David Tredinnick: You admit it caused confusion—
Dr Bennett: No, I am sorry. I caused confusion perhaps in my earlier answer.

Q38 David Tredinnick: Was it confusing to begin with and it has been made more confusing, or did you relieve or create the confusion? I am trying to be helpful.
Dr Bennett: I hope I did not create confusion earlier, but maybe I did. There are two parameters that we look at, financial and quality. We measure financial risk on a scale of 1 to 5.

Q39 David Tredinnick: That is 1 to 5.
Dr Bennett: We measure governance, and particularly quality governance, using traffic lights.

Q40 David Tredinnick: That is red, amber and green, is it?
Dr Bennett: Correct.

Q41 David Tredinnick: Thank you very much. From April next year, the majority of foundation trusts will move to even greater self-governance with Monitor retaining transitional powers—we have touched on that—to scrutinise and intervene until 2016. How confident are you that governance and financial compliance standards will be upheld, especially in the weaker FTs—for instance, the 12 that are red-rated that I have referred to already?
Dr Bennett: We did have concerns about that. The Government, in the original version of the Bill, put in some transitional arrangements so that we could continue some compliance for those trusts that seemed most at risk. However, in the amendments, it is

proposed that our compliance regime stays in place for all trusts through until at least 1 April 2016. That is a very useful much longer period to prepare governors to take on the role.

Q42 David Tredinnick: What action are you taking to ensure that the governance systems are fit for purpose at the point of hand-over?
Dr Bennett: We need to work out what—

Q43 David Tredinnick: Do you have a plan? Is there something in place at the moment?
Dr Bennett: Not specifically at the moment, because this is a very recent change. Also, it is something we need to do jointly with the Department and, indeed, with the FTs themselves. We need to work out how to do it.

Q44 David Tredinnick: Your response to the Government's original proposals stated that Monitor should, for the time being, retain the function of monitoring the financial security of foundation trusts and, if necessary, intervening. Do you still hold those views?
Dr Bennett: We still retain that.

Q45 David Tredinnick: Do you agree that that is a good policy?
Dr Bennett: Yes.

Q46 David Tredinnick: Do you think that Monitor should retain any of its other duties that it is scheduled to relinquish?
Dr Bennett: This is the thing that has changed. We were to relinquish our compliance role for probably the majority of trusts from, originally, April next year. We now retain that for all trusts through to 2016.

Q47 David Tredinnick: Are you not really up against a massive bottleneck here? You are trying to maintain a high standard, as I understand it, but you are not going to get them all checked through in the time.
Dr Bennett: We are not going to what? I am sorry.

Q48 David Tredinnick: If you are going to retain this responsibility, is that not a huge burden for you? Are you geared up to do that because of these recent changes? It is a burden in the sense that it is extra work. Whether it is a good thing or not is a political issue. You have been given this extra charge. Is that going to be very difficult for you to deal with? It is unexpected, I suppose, is it not?
Dr Bennett: In essence, what is being asked is simply that we continue to do what we are doing today. In that sense, there is no increase in the burden at all, except that we will have more foundation trusts over time, and that was happening anyway. If the Government are to achieve their ambition of an all-FT sector by 2014, there will be an acceleration of the number of new FTs appearing and we are going to have approaching twice as many at the end of the period as we have today. Under the original proposals, that would not have represented any increase in the burden on us because the majority of trusts would no longer have been under our umbrella. We will now have to increase our capacity. What we have been asked to do is exactly the same thing that we have been doing for many years now. As long as we can scale up—and I see no reason why we should not be able to—we should be able to manage that.

Q49 David Tredinnick: You will have to take on a lot of extra people.
Dr Bennett: We will need some additional staff, yes.

Q50 David Tredinnick: At a time of massive constraints elsewhere in the Health Service with the "Nicholson challenge" and all these things, you will be going against the trend, won't you?
Dr Bennett: Yes, and of course we will need to take on some extra staff for our new roles.

Q51 David Tredinnick: That is all cleared and sorted, is it? You have the clearance for that, have you?
Dr Bennett: For the new sector regulator role, we have agreed in principle with our sponsors in the Department what that will imply in terms of the number of staff and budget, although we do not have formal approval for that. For the continuing and growing in scale role of compliance monitoring, we will have to have the discussion with the Department. We have not done that yet because this is a very recent development.

Q52 David Tredinnick: There is no money there yet.
Dr Bennett: There is not yet, no.
David Tredinnick: Thank you very much.

Q53 Andrew George: First of all, I apologise for the fact that I was not here when you arrived but, because of the nature of parliamentary business, these things happen. I want to ask you about the manner in which you assess an applicant foundation trust during the process of authorisation, particularly in relation to their financial competence. As you know, there is variability in the resource allocation across the country as a whole, some areas being way above their target, others being very significantly below. To what extent, when looking at those applications, are you able to see or identify issues of, for example, historic debt and so on, possibly being explained by long periods of the PCT being significantly below their target? Perhaps it is a resource allocation issue rather than a financial competence issue, for example.
Dr Bennett: It is certainly something we look at, but Stephen could address this.
Stephen Hay: The assessment process is built on a business plan the hospital puts together that is underpinned by a financial model that goes out every five years. That financial model is built up with the revenue and the cost drivers. We look at the underlying assumptions and assess those assumptions against what we know is realistic and not realistic. Where the assumptions are considered to be unrealistic, we do what we call a sensitivity analysis, which is where we change the assumptions and see what the financial profile looks like in the future with

what we consider are more realistic assumptions. That is the basis on which the financial analysis is done.
To answer your question about historic debt, historic debt can be seen within the balance sheet of an organisation. You will identify it in terms of the work we do, and the key issue is whether the hospital can generate the profits and the cash flows to service and repay that debt over the period at which we are looking. In terms of allocations, we are looking to see whether an applicant foundation trust is going to be financially viable or not. It is difficult to then say, if it is not, that the reason for that is because of allocations in the local health economy.
Dr Bennett: To build on that, when we are looking at the projected income stream for a trust we will obviously compare that with historic performance. If a trust, for example, assumes that there is going to be a sudden acceleration of income—maybe imagining that their PCT is suddenly going to get more money—then we will certainly be asking questions about the basis on which they think that is likely to happen.

Q54 Andrew George: On scrutinising their structures and financial planning, if you find that they are an efficient and lean operation and they are more comfortably achieving a recurring balance but are still carrying some historic debt from the past, will that mean they will not achieve authorisation? If you have a deadline of 2014 coming up, will you be obliged to authorise those trusts or will you simply say, "Sorry, the gate is closed to you"?
Dr Bennett: The gate does not close but the bar does not move. Absolutely, if they have a heavy burden of legacy debt—even if they are now very efficient and, aside from that, their financial performance looks all right—and when you add in the legacy debt, their financial performance does not look sound or does not look as if they would be financially viable long-term, that would be a barrier to authorisation. This is exactly why the Department is having to work with the applicant trusts to identify those where their legacy debt is a potential barrier and find a way of dealing with it.

Q55 Andrew George: Do you fear the Government's expectation that all trusts should become foundation trusts by a set point might result in a dumbing down of standards? I don't know whether this question has been asked before, but do you think this might, in effect, require you to lower the bar as far as authorisation standards are concerned—across the board, not just financial competence?
Dr Bennett: As long as the governance arrangements of Monitor remain as they are, it cannot require us to lower the bar. We are an independent body and we set our own bar. We will not be lowering it. We are very clear that the bar is set in order to reassure us and everybody else that the trusts we authorise are well governed and financially sound, in so far as one can be sure about that. There always will be some uncertainty, but, as far as possible, that is what we seek to do and what we should continue to seek to do.

Q56 Andrew George: You might therefore expect, for those that could not achieve straddling this bar, perhaps the only solution, if a deadline is being set, is for them to be taken over by other competent and authorised foundation trusts.
Dr Bennett: I know that is one of the solutions the Department is looking at for some of the troubled trusts. In particular, if the trust's problem is that it has a weak management team, by merging it with a much stronger trust it may well be that you address that problem. All I would say is you need to be satisfied that that is going to be true. It may be one thing for a good trust management team to manage an existing well-performing trust, but adding the burden of a failing trust may still be a very big stretch for them. If the underlying problems are issues like legacy debt or a configuration which is structurally unviable, you have to ask to what extent merging one trust with another would fix those problems.

Q57 Andrew George: With regard to the transition from where you are now to where the Government want you to be following the passage of the Bill into Act, what discussions or reassurance have you had that you will be given the freedom to adjust your structures and also have sufficient budget to be able to perform all your functions?
Dr Bennett: I have no reason to suppose that we will not have the freedom to adjust our structures. As far as I am concerned, that is very much an issue for the Monitor board and, as I say, I have no reason to suppose anyone is going to try to prevent us from doing whatever we feel is the right thing to do. In budgetary terms, we need to agree with the Department a budget which gives us sufficient resources to do what we are being asked to do. We have had a number of discussions and we have an indicative agreement, at least with regard to our new sector regulator role. We do not actually have a budget yet.

Q58 Andrew George: In those circumstances, you have not appointed a chief executive either. Is the uncertainty of the last year a reason or cause for that post being unfilled?
Dr Bennett: I certainly would not connect the fact that we did not appoint a chief executive to any discussions about our budget. The reason we have not appointed a chief executive is because, at the time at which we began the recruitment process—back in March, pretty well as soon as I was appointed as chair—we needed to get on with it because, of course, by 1 April we were to take on our new responsibilities and we did not want the chief executive turning up on 2 April. We moved quickly and, recognising we did not exactly know what structure of the organisation into which the individual was going to have to fit was going to look like, we defined a very broad and, no doubt, demanding specification for the person we were looking for. We went through a thorough search process to try to find a suitable person but, at the end of the day, the board took the view that, although we got some very good candidates, we did not have anyone who fully met our requirements.
In the meantime, not only had our role become clearer, but there had been significant changes as a result of these amendments. One of the most important changes

was the decision to keep this compliance role for at least another five years. The reason that is important is that there is a potential conflict of interest between being an FT regulator and being a sector regulator. We have to construct a Chinese wall between them. The nature of that Chinese wall—what it looks like—will impact on the chief executive's role. The fact that we now have to keep that Chinese wall in place for five years and we will be looking at all trusts, not just a small segment of the trusts, means the Chinese wall is even more important and the impact on the chief executive's role even more significant.

When the board was confronted with strong candidates who nevertheless did not quite meet our very broad-ranging specification—and a recognition that we would benefit from being able to do the organisational thinking that would help us to be much clearer about what roles we needed to fill among the senior leadership team—we decided the best thing was to put a hold on the recruitment process and do the organisational work, now that we are much clearer about what our responsibilities are going to be.

Q59 Andrew George: So it is now that you are clearer, not that you are awaiting the clarity of outcome from the parliamentary processes.

Dr Bennett: Of course, the parliamentary process may make further changes. I can only say I am hoping that we are reasonably close to what it is going to look like, but if Parliament changes it we will have to deal with it.

Q60 Andrew George: I have one final question, and this may stray into an area you touched on earlier. Given your role in preventing anti-competitive behaviour, to what extent have you had discussions with the OFT about how your role in that regard cross-references or interplays with the role of the OFT, which obviously has the same function?

Dr Bennett: At this stage, we have only made preliminary contact. It is one of the many things that we need to do but, absolutely, we need to do that.

Q61 Andrew George: I am sure you understand, but you see that there is a difference as a result of the listening process—

Dr Bennett: Yes.

Q62 Andrew George:—on promoting competition. You can identify that that is significantly different from preventing anti-competitive behaviour.

Dr Bennett: Clearly, there are differences arising from the changes to the Bill and we did talk about that a little earlier.

Q63 Andrew George: I thought you had, but I wanted to cover that aspect of it.

Dr Bennett: Clearly, there are differences and they will have to be reflected in the way we work, which is, I suppose, an illustration of the benefit of waiting until we are reasonably certain.

Q64 Andrew George: That role of preventing anti-competitive behaviour is one which straddles that of the OFT. I can't see how you can fulfil that role without regular reference to the OFT and its functions.

Dr Bennett: Indeed, and the proposal is that we will have concurrent powers with the OFT. Absolutely, we will have to work closely with the OFT. Other sector regulators have to do that as well, so at least there is custom and practice that we can build on.

Q65 Valerie Vaz: I have some quick follow-up questions. You mentioned that you used the traffic light system for quality. Does the CQC use that as well?

Dr Bennett: No. It has a different system. Our traffic lights are for quality governance. Governance is our focus.

Q66 Valerie Vaz: Picking up a point made by my colleague, did you get legal advice on whether competition law applied?

Dr Bennett: We did not take legal advice because, of course, the policy is the Government's. It will, in due course, be our job to interpret it, but the policy itself is theirs.

Q67 Valerie Vaz: Do you have a contingency fund for any legal action that might be taken against you?

Dr Bennett: Going forward, we are going to have to think about this. At the moment, I do not believe we do. I suppose there is an implicit guarantee from—

Stephen Hay: There is a memorandum of understanding between Monitor and the Department of Health that would fund us in cases of significant litigation costs.

Adrian Masters: Under the current budget, we could also be challenged—judicial review and so on. The way the memorandum of understanding currently works at the Department of Health is that, for any significant case, they would fund that separately from our normal budget.

Q68 Valerie Vaz: Looking at your written report, in paragraph 3.34 you mention that in 2010 you did not use your intervention powers but you used them on seven occasions the previous year. Could you explain why you have not used them?

Dr Bennett: Of course, the obvious answer is there was no trust that got to a point where we felt the need to use the powers. I mentioned earlier that we seek to persuade trusts to make changes that we think are appropriate where they are not already doing so and, in the main, they will do so. Why has it changed? It is a little difficult for me because I was not there before. I imagine part of the reason is that, having used the powers, and trusts having seen that we will use the powers where necessary, they have understood they might as well follow our advice anyway. Also, there has been an improvement overall in performance. You could say that was partly because trusts that had issues got fixed earlier on. I am sure there will still be trusts with issues, but I think there has been improvement and learning overall. That is part of it as well. There will also be just simple statistical fluctuation. In five years, if you look back, you will see the number will go up and down. They are small numbers.

Stephen Hay: There is one other reason as well. Last summer we changed our annual planning process. For the last four or five years, that annual planning process has been basically the same for every foundation trust. Last year, we did a two-stage process. The first stage was the same for everybody, but we then identified the higher risk foundation trusts—whether it was on quality issues or financial issues—and did a deep dive. That deep dive enabled us to understand some of the issues they were facing. We called them in for more of an informal meeting with David and me, or with David or me, to have a conversation about some of the risks that we saw they were facing to try to be more preventative upfront. We cannot prove it, but that could be another reason why we have seen a reduction in the number of significant breach decisions we have had to make.

Q69 Valerie Vaz: I have one last question. I mentioned earlier that, in your memorandum, you say the A&E four-hour waiting target was reduced from 98% to 95% and also that the 18 weeks' referral to treatment waiting target was removed. Could you explain what that is and why you did it?
Dr Bennett: This is an example of us following the Department's operating framework. The Department changed its A&E target from 98% to 95% and decided to drop the 18-week waiting time targets—which are now reinstated. Our change was largely reflecting the changes the Department had made.
Adrian Masters: These are triggers for us to try and identify where there may be a governance problem. As the system changes, we adjust what triggers we use. For example, with the CQC coming in with their registration standards and so on, that has been added in as a trigger. If they have a problem with the CQC, then that trigger is now in our system. As the Government introduce their Outcomes Framework, we will be looking at that to see if there are triggers we should put in. We are using these as triggers and, as the system changes, the triggers we use are adjusted.
Dr Bennett: In part, this is about minimising the burden on the trusts. If the trusts are required by commissioners to meet a 95% target then, unless there is an extraordinarily good reason, we are not going to have a 98% target. That just makes life difficult for them.

Q70 Chair: I have some concluding questions. You referred to your desire to see a failure regime. As you know, this has been the subject of substantial discussion in the foundation trust sector in particular. The previous Government were committed to introducing a failure regime. We are roughly 10 years on now and we have not had one yet. What is your level of comfort that you are going to get agreement on a failure regime, given the history? That is the first question.
The second and more immediate question in my mind, if I am honest, is that, before failure, there needs to be a distress regime. We were discussing circumstances in which distress may increase in the foundation trust sector, for which you are already responsible. Do you see that the transitional powers oversight can be used effectively as a form of distress regime?
Dr Bennett: Yes.

Q71 Chair: If you do, is it realistic to have a distress regime without any money attached?
Dr Bennett: First of all, on this issue of distress, at the moment we operate a distress regime. It is part of our compliance regime. When we see a financial risk rating falling down to 2, it does not mean that the trust is in crisis but it does mean it is heading for distress. That is when we start to intervene. In so far as we are going to retain our compliance regime through to 2016, we will still have that operating. Even had that gone away, we would have strongly argued that any failure regime should have a distress element to it, and indeed the Government's original proposals did. We would argue that should stay. The only difference is that our compliance regime applies to everything a foundation trust does.
The proposal was that a failure regime would only apply to essential services. Therein lies a big question: how many of a foundation trust's services are to be regarded as essential? That is still under discussion. I think it is very important that a distress regime is there. It is much better to deal with distress and fix problems at that stage than to let it go to failure, but precisely what it will look like is for the Government to determine. Am I confident that they will come forward with a failure regime which will be coherent and provide money to fund what needs to be done, and so on? I am hopeful. We had one that looked as though it could do it, although it had some challenges, which is why they have gone back to the drawing board. They have said they are going to come up with something that has the same basic design characteristics. I think that would be good.
Chair: You are hopeful and it is often better to travel in hope than to arrive. Thank you very much for your evidence.

Written evidence

Written evidence from the Department of Health in England (MON 01)

1. This memorandum has been prepared by the Department of Health in England in response to the Commons Health Select Committee's call for evidence to assist it in it exercising on behalf of Parliament to review the performance of The Independent Regulator of NHS Foundation Trusts, known as Monitor. The Department is grateful for the opportunity to contribute to this process. This submission is based on Monitor's current legislative role and describes:

— an overview of Monitor's role and responsibilities;

— Monitor's role in determining whether NHS trusts are ready to become NHS foundation trusts;

— regulating NHS foundation trusts;

— the current legislative framework for Monitor; and

— proposals in the Health and Social Care Bill.

Monitor's Role and Responsibilities

2. Monitor was established in January 2004 to authorise and regulate NHS foundation trusts. They are a Non-Departmental Public Body of the Department of Health, are independent of central government and directly accountable to Parliament. Monitor was established under the Health and Social Care (Community Health and Standards) Act 2003, subsequently included in The NHS Act 2006. A description of the legislative functions are at Annex A.

3. The Department reviews Monitor's financial and operational performance and risks at a general and strategic level through regular meetings. It does not assess Monitor's assessment or regulatory functions towards NHS foundation trusts. Regular meetings are also held between both Ministers and the Permanent Secretary and Chief Executive of the NHS and the Chair and Board members of Monitor, as well as meetings at officials level.

4. NHS foundation trusts are at the cutting edge of the Government's commitment to the decentralisation of public services and the creation of a patient-led NHS. NHS foundation trusts have been created to devolve decision making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of their local people. There are currently 137 NHS Foundation Trusts, including 41 mental health and two ambulance foundation trusts. They have a cumulative turnover in excess of £29.2 billion and employ around 471,000 staff. There are 112 trusts who have not yet achieved foundation status and we are actively working with them. Three trusts provide high secure services and under current legislation are ineligible to apply for foundation status. A further trust, Hinchingbrooke Healthcare NHS Trust is seeking a management franchise option in advance of a foundation trust application.

Monitor's Resources

5. Monitor describe their mission in their Business Plan 2011–12, which is to provide a regulatory framework which ensures that NHS foundation trusts are well led (from both a finance and quality perspective) and financially robust so that they are able to deliver excellent care and value for money. To achieve this, Monitor has a Board of five non executive directors (currently one vacancy which is intended to be filled in the Autumn) and a senior management team of six. The Chairman, David Bennett, is covering the chief executive duties until a substantive appointment is made. Monitor employs some 120 staff. In addition, they have recruited around 20 temporary staff to work on the transfer of community services into existing foundation trusts. Monitor is subject to the Government's recruitment controls and submitted a business case to the Department for these staff, which was accepted. Monitor's grant-in-aid budget in 2011–12 for core functions is almost £14.4 million. They have also been allocted £1m transitional funding as it gears up to take on its new functions in 2012–13. Further funding may be made available by the Department, if a need for more resources is identified.

Monitor's Role in Determining whether NHS Trusts are Ready to Become NHS Foundation Trusts

6. Monitor receive and consider applications from NHS trusts seeking foundation status which have been supported by the Secretary of State for Health, and look at three areas:

— *Is the trust well governed* with the leadership in place to drive future strategy and improve the quality of patient care?;

— *Is the trust financially viable* with a sound business plan?; and

— *Is the trust legally constituted*, with a membership that is representative of its local community?

In addition, Monitor will consider the quality governance of applicant trusts as a key element of the authorisation process.

7. NHS Trusts prepare an integrated business plan and complete a long term financial model describing their plans for the first five years as a foundation trust. These are extensively tested during an assessment period which lasts between three to four months for straight forward applications. The assessment includes Monitor's Board interviewing the applicants Board.

8. Monitor sets the terms of authorisation with each applicant trust which desribes the conditions under which an NHS foundation trust is required to operate. This will cover:

— a description of the goods and services related to the provision of healthcare that the NHS Foundation Trust is authorised to provide;

— limits on the amount of income that the NHS Foundation Trust is allowed to earn from private charges;

— limits on the amount of money that the NHS Foundation Trust is allowed to borrow; and

— financial and statistical information the NHS Foundation Trust is required to provide.

If Monitor is satisfied that these criteria are met, the trust is authorised to operate as an NHS foundation trust.

Regulating NHS Foundation Trusts

9. Once NHS Foundation Trusts are authorised, Monitor regulates their activities to ensure that they comply with the requirements of their terms of authorisation. There are a set of detailed requirements covering how foundation trusts must operate. In summary they are covered by the Monitor compliance framework and include:

— the general requirement to operate effectively, efficiently and economically;

— requirements to meet healthcare targets and national standards; and

— the requirement to cooperate with other NHS organisations.

10. The board is the first line of regulation in NHS foundation trusts and must submit to Monitor annual and in-year information to determine their financial and governance risk ratings. Monitor's Compliance Framework describes how they assess risk to compliance, guide the intensity of its monitoring and signal to the foundation trust its degree of concern with specific issues identified and evaluated. Foundation trusts who are considered to be at higher risk of not complying with their terms of authorisation are subject to more frequent reporting and closer inspection. Where problems start to develop, Monitor make sure the trust has an action plan in place and assess progress against the plan. Monitor works alongside the Care Quality Commission to achieve this goal in terms of quality of care.

11. Monitor also has powers to intervene in a NHS foundation trust in the event of failings in its healthcare standards, or other aspects of its leadership, which result in a significant breach of its terms of authorisation. Monitor may remove any or all of the directors and appoint interim directors ahead of substantive appointments.

Current Legislative Framework for Monitor

12. NHS Foundation trusts are established by the Health and Social Care (Community Health and Standards) Act 2003, as consolidated by the NHS Act 2006. Chapter 5 of the 2006 Act sets out the requirements for authorisation of NHS foundation trusts. Schedule 7 of the Act gives the requirements for the constitution of a public benefit corporation, which covers:

— Foundation Trust constitution;

— Membership requirements;

— Board of Governors;

— Board of Directors;

— Register of members; and

— Auditors and accounts.

Schedule 8 describes the functions of Monitor. Schedule 9 covers transfer of staff to NHS foundation trusts, while Schedule 10, the audit of accounts of NHS foundation trusts. A full description of the current legislation for Monitor is at Annex A.

Proposals in the Health and Social Care Bill

13. The NHS White Paper, *Equity and excellence: Liberating the NHS*, sets out the Government's long-term vision for the future of the NHS. The vision builds on the core values and principles of the NHS—a comprehensive service, available to all, free at the point of use, based on need, not ability to pay. The White Paper proposed that Monitor will be developed into a regulator for all providers of health and adult social care services by 2013. This is subject to the passage of the Health and Social Care Bill.

14. It proposes that the CQC and Monitor will be jointly responsible for administering an integrated and streamlined registration and licensing regime for relevant providers. CQC will continue to register a wide range

of health and adult social care providers for quality and safety. Monitor will license a subset of providers of NHS healthcare services to deliver its regulatory functions.

NHS Listening Exercise and Government Response

15. The proposed changes to the role of Monitor were subject to a two month pause in the passage of the Health and Social Care Bill announced by the Secretary of State for Health to the House of Commons on 4 April. He proposed to take the opportunity of a natural break in the passage of the Bill "to pause, listen and engage" NHS staff and stakeholders and make improvements to the Bill, where needed. The Department launched an external facing engagement programme with a new NHS Future Forum, chaired by Professor Steve Field.

16. Professor Field published the NHS Future Forum's findings on 13 June 2011. This was followed by the Government's response on 14 June which included proposing a number of changes to the Bill with regard to Monitor's future role. These are described in the following paragraphs.

17. Monitor's core duty will be to protect and promote patients' interests. The Government will remove Monitor's powers to "promote" competition as if it were an end in itself. Monitor will be limited to tackling specific abuses and unjustifiable restrictions that demonstrably act against patients' interests, to ensure a level playing field between providers. Monitor will be required to support the delivery of integrated services for patients where this would improve quality of care for patients or improve efficiency.

18. The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by Ministers. This includes guidance on how services should be bundled or integrated.

19. The Government propose to narrow Monitor's powers over anti-competitive purchasing behaviour so that these are more proportionate and focus on preventing abuses rather than promoting competition. Monitor's powers to open up competition by requiring a provider to allow access to its facilities to another provider will be removed.

20. The Government intend to maintain the existing competition rules for the NHS introduced by the last Government (the Principles and Rules for Co-operation and Competition), and give them a clearer statutory underpinning. The body that applies them, the Co-operation and Competition Panel will transfer to Monitor and retain its distinct identity.

21. Proposals to give Monitor concurrent powers with the Office of Fair Trading will be retained. This will ensure that competition rules can be applied by a sector-specific regulator with expertise in healthcare. The Future Forum recommended that this was the best safeguard against competition being applied disproportionately. The Bill does not change EU competition law.

22. The Government strongly expects that the majority of remaining NHS trusts will be authorised as foundation trusts by April 2014. The NHS Trust Development Authority will support this process and maintain the momentum, which will be essential for overall delivery. It will not be an option to stay as an NHS trust, but there will no longer be a blanket deadline in the Bill for abolishing NHS trusts as legal entities. All NHS trusts will be required to become foundation trusts as soon as clinically feasible, with an agreed deadline for every trust. The stringent tests set by Monitor will remain and they will continue to obtain assurance from the Care Quality Commission as part of the authorisation process.

23. To enable time for foundation trusts' governors to build capability in holding their boards to account, the transitional period where Monitor retains specific oversight powers over foundation trusts will be extended to 2016. Monitor's oversight will last until two years after a foundation trust is authorised, if that is later, and the transitional powers will be reviewed further in 2016.

24. There will be an effective failure regime that ends the culture and practice of hidden bailouts and gets the right incentives into the NHS, whilst protecting essential services. But we have heard concerns about the practicality of our current proposals for an up-front system of designating services for additional regulation, and we will be amending the Bill accordingly.

25. The Government will amend the Bill to require foundation trusts to hold their board meetings in public. We will introduce a "duty of candour": a new contractual requirement on providers to be open and transparent in admitting mistakes.

26. The Department is working on the changes required to the Health and Social Care Bill as a result of the NHS Future Forum's recommendations and intends to bring the Bill back into Parliament later in the summer.

27. We estimate Monitor's running costs to be in the range of £50 million–£70 million per year. This may be subject to change following the amendments to Monitor's role as a result of the Listening Exercise. Work on estimating Monitor's future running costs will remain ongoing in 2011 and we would be able to provide further refinements of our estimates in due course. Subject to the legislation the budget would be agreed by

the Secretary of State and Monitor would need to report annually on expenditure and demonstrate value for public money.

June 2011

Annex A

FULL DESCRIPTION OF MONITOR'S STATUTORY FUNCTIONS—THE NHS ACT 2006

PRIMARY LEGISLATION

Established by the Health and Social Care (Community Health and Standards) Act 2003, as consolidated by the NHS Act 2006. Monitor must act "in a manner consistent with the performance by Secretary of State of his duties under sections 1, 3 and 51 of the NHS Act 1977".

Monitor is accountable to Parliament, and is accountable to the Secretary of State in one respect—the provision of reports and any information relating to Monitor's functions requested by SofS.

SECONDARY LEGISLATION

No secondary legislation.

DIRECTIONS

Monitor is not subject to direction by the Secretary of State.

INTERACTIONS WITH OTHER LEGISLATION

The Regulator must co-operate with the Care Quality Commission in the exercise of their respective functions (section 70 of the Health and Social Care Act 2008).

FULL LIST OF CURRENT STATUTORY FUNCTIONS

Primary legislation

The Independent Regulator of NHS foundation trusts is a corporate body responsible for setting the terms of and granting authorisation to NHS foundation trusts. It is also responsible for monitoring compliance of NHS foundation trusts with the terms of their authorisations and with the requirements which are set out in Chapter 5 and Part 2 of the 2006 Act. Section 32 of the 2006 Act provides that the regulator *must* exercise its functions in a manner consistent with the performance by the Secretary of State of his duties under section 1,3 and 258 of the 2006 Act. Schedule 8 to the 2006 Act makes further provisions about the functions of the Regulator. These and other functions of the regulator include the following.

Functions relating to remuneration, pensions, staff and superannuation

— The regulator *must* pay the chairman such remuneration and such other travelling expenses as the Secretary of State may determine (Paragraph 3(1) of Schedule 8).
— The regulator *must* pay members other than the chairman of Monitor such travelling expenses and other allowances as the Secretary of State may determine (Paragraph 3(2) of Schedule 8).
— The regulator *may* after consulting with the Minister for the Civil Service as to numbers and terms and conditions of service, employ such staff as the regulator may determine (Paragraph 4 of Schedule 8).
— The regulator *must* pay to the Minister for the Civil Service, at such times as the Minister may direct, such sums as he may determine in respect of any increase in entitlements due to the Chairman of Monitor by way of sums payable out of money provided by Parliament under the Superannuation Act 1972 (Paragraph 5 of Schedule 8).

General and specific powers

— The regulator *may* do anything which appears to it to be necessary or expedient for the purposes of or in connection with the exercise of its functions including acquiring and disposing of property, entering into contracts and accepting gifts of property (Paragraph 8 of Schedule 8).
— The regulator *may* with the consent of he Secretary of State borrow money temporarily by way of overdraft, but may not otherwise borrow money and *may* also conduct, commission or assist the conduct of research (Paragraph 9 of Schedule 8).

Functions relating to reports and other information

— The regulator *must* prepare an annual report on how it has exercised its functions during the year as soon as possible after the end of each financial year and *must* lay a copy of this report before Parliament (Paragraphs 11(1) and (2) of Schedule 8.

— The regulator *must* in respect of each financial year prepare a report which provides an overall summary or the accounts of NHS foundation trusts in respect of each financial year and must lay a copy of this report before Parliament (Paragraphs 11(3) and (4) of Schedule 8).
— The regulator must provide the Secretary of State with such other reports and information relating to the exercise of the regulator's functions as he may require(Paragraph 11(6) of Schedule 8).
— The regulator *must* keep and prepare accounts for each financial year in such form as the Secretary of State may direct (Paragraphs 12(1) and (2) of Schedule 8).
— The regulator *must* send copies of the annual accounts to the Secretary of State and Comptroller and Auditor General within the period after the end of the financial year to which the accounts relate as the Secretary of State may direct (Paragraph 12(3) of Schedule 8).
— The regulator *must* respond in writing to any recommendation which is made by a Committee of either House of Parliament or Committee of both Houses, and relates to the exercise by the regulator of its functions(Paragraph 13 of Schedule 8).

Functions relating to the provision of private health care

The regulator *may* provide an authorisation to NHS FTs to restrict the ability of FTs to provide goods and services for purposes other than those of the NHS. The regulator must exercise this power with a view to securing that the income of a NHS FT derived from private charges should not exceed a specified cap referred to as the private patient income cap.

Functions relating to de-authorisation of foundation trusts

— The regulator *may* give the Secretary of State a notice to enable an NHS foundation trust to be de-authorised where specified grounds are satisfied and *must* consult the Secretary of State as well as other specified bodies before giving the notice (Sections 52B(1) and (4) of the 2006 Act).
— The regulator *must* publish guidance as to matters specified in section 52C(1) that it proposes to consider in making determinations as to whether the making of a de-authorisation order is justified and as to whether to give notice for a de-authorisation order to be made and consult the Secretary of State and other bodies before publishing any such guidance (Sections 52C(2) and (3) of the 2006 Act).
— The regulator *may* give the Secretary of State notice to enable an NHS foundation trust to be de-authorised under trust special administrators arrangements, where specified grounds are satisfied, must give the Secretary of State a report stating the reasons why the grounds for giving such notice are satisfied and *must* consult the Secretary of State as well as other bodies before giving such notice(Sections 65D(1) (3) and (4) of the 2006 Act)

Other miscellaneous Functions

— The regulator *may* designate property as protected property if he considers that it is needed for specified purposes and an NHS foundation trust may not dispose any property without the approval of the regulator (Section 45(1) and (4) of the 2006 Act).
— The regulator *must* conduct an annual review the limit of an NHS foundation trust's borrowing (Section 46(3) of the 2006 Act).

Directions

— The regulator *may* give directions to NHS foundation trusts on how their accounts are to be drawn and information to be given in the accounts (Paragraph 25(2) of Schedule 7)

Interactions with other legislation

— The Regulator *must* co-operate with the Care Quality Commission in the exercise of their respective functions (section 70 of the Health and Social Care Act 2008).

Written evidence from Monitor (MON 02)

1.0 Executive Summary

1.1 Monitor welcomes the Health Select Committee's inquiry into our role and work. As Monitor is directly accountable to Parliament, we are keen to ensure parliamentary engagement with our work.

1.2 This paper covers only Monitor's current role as, at the time this written evidence was produced, the proposals in the Health and Social Care Bill relating to Monitor's proposed new role were under review.

1.3 The past year has been extremely busy for Monitor, especially given an increase in risk-assessing transactions, in particular resulting from the Department of Health's Transforming Community Services (TCS)

initiative, and our ongoing assistance with the Mid Staffordshire Public Inquiry, to which Monitor gave evidence in May 2011.

1.4 In terms of our assessment role, 2010–11 saw only 11 trusts referred to Monitor by the Department of Health. Out of these, only seven were authorised. Approximately[1] 89 acute and mental health trusts (c 74 acute trusts and c 15 mental health trusts), c 15 community trusts and nine ambulance trusts are yet to become foundation trusts.

1.5 In relation to our compliance role, 2010–11 saw a sharp decline in the number of foundation trusts found in significant breach[2] of their terms of authorisation—three (mainly for financial reasons) compared to 14 in 2009–10. This can be attributed to several reasons, explored in more detail below.

1.6 2010–11 saw significant changes to Monitor's leadership and leadership structure. We moved from having an Executive Chair, Dr William Moyes (who departed in January 2010), to a Chair, Steve Bundred, and Interim Chief Executive, Dr David Bennett. Following the Secretary's announcement that he wanted to expand Monitor's Board and appoint a new Chair to reflect our proposed new role, David Bennett replaced Steve Bundred as Chair on 1 March 2011. We hope to make a permanent appointment to the Chief Executive role in July 2011.

1.7 We have continued to work closely with the CQC to inform our assessment and compliance work on foundation trusts. Monitor and the CQC are committed to identifying where improvement is needed and to ensuring that our approach is co-ordinated in order to deliver real benefits for patients, while not duplicating regulatory activity.

2.0 Introduction

2.1 Monitor is the independent regulator of NHS foundation trusts. Established in 2004,[3] we authorise and then regulate NHS foundation trusts, ensuring they are legally constituted, financially robust and well-led in terms of both quality and finance. It is our role to make sure NHS foundation trust boards operate effectively so that trusts are well run on behalf of patients and taxpayers. When problems occur, we seek to identify them early so that robust plans can be put in place to resolve them before they become major concerns.

2.2 We have specific statutory functions and discretion over their delivery. Our primary responsibilities are:

- assessing applications for NHS foundation trust status and authorising successful applicants;
- designing and operating the regulatory regime to ensure that NHS foundation trusts are financially robust and well governed;
- taking action if there is evidence that an NHS foundation trust is in significant breach of the conditions Monitor sets for the way it operates;
- reporting on the performance of the foundation trust sector and providing details of regulatory action we have taken;
- taking and enforcing decisions on matters concerning the Principles and Rules for Co-operation and Competition within the NHS foundation trust sector;
- supporting the NHS foundation trust sector to operate effectively, efficiently and economically; and
- setting the reporting requirements for NHS foundation trusts.

Underpinning this is our duty to exercise our own functions effectively, efficiently and economically.

2.3 There are currently 137 NHS foundation trusts, which represent 57% of all acute providers, 73% of all mental health providers and 18% of ambulance trusts. Overall, health expenditure represents around 8.5% of GDP[4] and just over a quarter of this—more than 30 billion pounds—is currently spent on NHS services provided by foundation trusts.

Monitor's business model and staff

2.4 Monitor currently has 113 staff. This has increased slightly since March 2010, when we had 101. This increase in staff has been necessary due to several reasons:

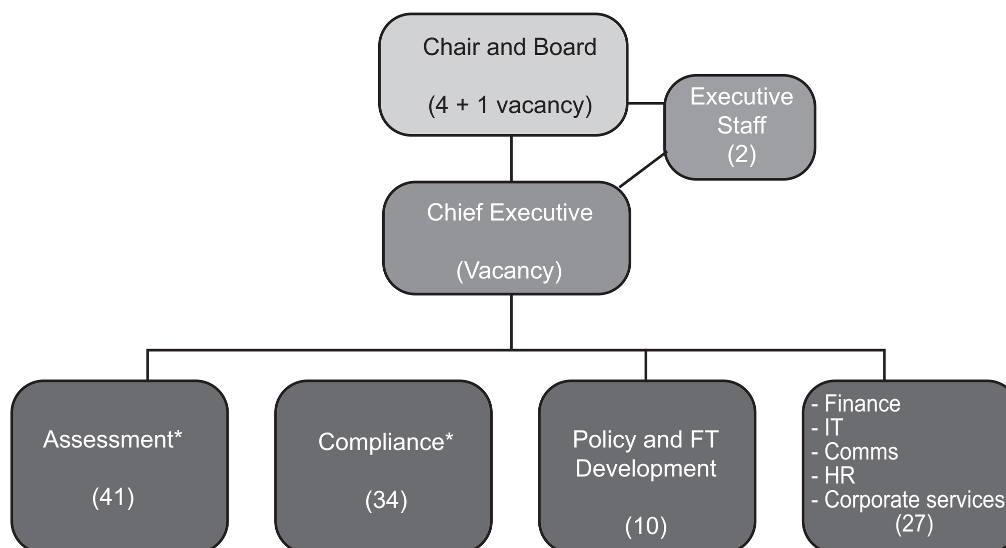
- The past year has seen a significant increase in demand on Monitor's staff resource given an increase in risk-assessing transactions, in particular resulting from the Department of Health's Transforming Community Services (TCS) initiative, and our ongoing assistance with the Mid Staffordshire Public Inquiry.

[1] The figures given are approximate as some trusts may merge with existing foundation trusts.
[2] We use the term significant breach when we consider a foundation trust has significantly breached the conditions it signed up to when it became a foundation trust.
[3] The Health and Social Care (Community Health and Standards) Act 2003. The provisions of this Act that relate to Monitor and NHS foundation trusts have now been consolidated into the National Health Service (NHS) Act 2006/
[4] House of Commons Library Report *NHS: funding and expenditure* http://www.parliament.uk/briefing-papers/SN00724, January 2011.

— The work of our regulatory operations teams has increased as more foundation trusts have been authorised and more trusts with problems identified. We have reviewed the capacity and capability of these teams and increased staff levels within the compliance team as a result. We continue to monitor staff capacity across the organisation.

Figure 1

Monitor's structure and staff numbers



* Assessment and Compliance include legal specialists

Figures correct at 12 May 2011

2.5 Nevertheless, to ensure that we remain a small, focused organisation which is as cost-effective as possible, our business model relies on buying-in expertise during times of peak activity and to work on specialised subjects/projects, rather than employing staff on a permanent basis. This includes additional IT and legal support as necessary, as well as additional capacity around our Annual Planning Round, specific projects and other busy periods.

Financial position

2.6 Monitor's budget for the 2010–11 financial year was £17 million. Our actual net expenditure was £14,761,000 (2009–10: £15,653,000). The under spend and decrease in net expenditure from 2009–10 was largely due to the impact of Government spending controls imposed from May 2010 in order to deliver the Government's target of £6 billion efficiency savings across the public sector.

2.7 Staff costs in 2010–11 increased in line with our budget plan. They represent 72% of gross expenditure at £10,555,000 (2009–10: £9,027,000). Other operating costs include property, office expenses and consulting.

2.8 A comprehensive review of Monitor's activities and our performance against business objectives during the year will be set out in our Annual Report, to be published in July 2011.

2.9 The budget for 2011–12 is broadly the same as that planned for last year, showing a modest increase of £0.8 million (to £17.8 million) to reflect growth in Monitor's operational team as we manage the transactions relating to the Transforming Community Services programme and our compliance team deal with the growing number of foundation trusts.

2.10 However, if the Government's proposals to change the regulatory framework of the NHS are approved by Parliament, this would require Monitor to take on additional functions and therefore to grow as an organisation. We would expect an increase in our budget to meet these resulting extra costs.

Monitor's 2009 economic impact assessment

2.11 In 2009, Monitor commissioned Frontier Economics to undertake an economic evaluation of the impact of Monitor's assessment and compliance functions. The study used case studies to consider the impact of Monitor's processes on the financial viability and governance of NHS foundation trusts.

2.12 The subsequent report, *Measuring Monitor's impact: Economic evaluation report*[5] found a range of evidence to suggest that Monitor's assessment and compliance regimes deliver value by requiring NHS foundation trusts to improve their efficiency and financial sustainability.

Key findings from 2009 analysis

2.13 *Maintaining the assessment bar would lead to cumulative savings of £271–£389 million by 2012–13.* Analysis across relevant case studies suggests Monitor's decision to defer some NHS trusts from achieving foundation trust status resulted in these organisations revisiting cost improvement plans and/or re-evaluating capital investment programmes. The new plans are estimated to deliver cumulative savings of £271–£389 million by 2012–13 across nine case studies. Although data availability on quality outcomes is limited, these savings have not been found to have a measurable negative impact on MRSA rates, cancelled operations or elective waiting times.

2.14 *Improved efficiency in NHS foundation trusts has led to an increase in surplus margin of 0.8%.* The econometric analysis finds that the assessment process has delivered savings of £130 million to date. It has led to an increase in surplus margin of 0.8% and a 7% increase in efficiency in day cases.

2.15 *The compliance regime results in financially challenged NHS foundation trusts turning around performance rapidly and delivers savings as a result.* Analysis across the relevant case studies suggests that NHS foundation trusts in deficit experience considerably quicker turnarounds than equivalent NHS trusts. The speed of the turnaround delivers savings compared with a scenario in which Monitor does not exist.

Close working with CQC

2.16 Monitor and the CQC work closely together and have distinct but complementary roles: The CQC is responsible for safeguarding appropriate standards of quality and safety within adult health and social care in England. It registers all adult health and social care providers, (including NHS foundation trusts), and monitors providers' compliance with their registration requirements on an ongoing basis.

2.17 Monitor is also concerned about quality, but our role is different in that we focus specifically on ensuring that the boards of NHS foundation trusts are doing their jobs properly, on quality as well as finance.

2.18 Having a separate regulator making the judgements about quality and safety ensures that they have an independent view which is not influenced by financial issues, this mitigates the risk that safety and quality is unduly compromise. This is better for patients.

2.19 Together, Monitor and the CQC are committed to identifying where improvement is needed, and to ensuring that our approach is co-ordinated in order to deliver real benefits for patients, while not duplicating regulatory activity.

2.20 We work closely with the CQC to inform our judgments about quality governance in foundation trusts.

2.21 From April 2010 all health and adult social care providers who provide regulated services were required to register with the CQC. Twelve foundation trusts were registered with conditions which meant that the CQC had concerns that these organisations were not meeting essential standards of quality and safety. We made clear to those trusts their responsibility to return to compliance with their registration and reflected this in our own regulatory risk ratings, keeping in regular contact with the trusts to review their progress. Eleven of the 12 foundation trusts have had their conditions lifted; Mid Staffordshire NHS Foundation Trust remains registered with conditions.

2.22 We speak on at least a weekly basis with the CQC to discuss issues of concern relating to trusts' compliance with either their terms of authorisation[6] or CQC registration. We also work closely with the CQC when it carries out a responsive review at an NHS foundation trust. This takes place when concerns are raised over compliance with the essential standards of quality and safety. We will take account of the governance risk this review reflects and adjust the risk rating for the trust accordingly. Once the review is complete, our regulatory action will be based on the outcome. More detail on our approach is set out in the *Compliance Framework*.

2.23 We have also enhanced and formalised the way we work with the CQC when assessing foundation trust applicants, specifically we now:

- hold a joint meeting with the CQC and SHA as part of the assessment process to understand their current view of the aspirant foundation trust from a quality and safety perspective;
- share quality concerns identified in the assessment process with the CQC and will request them to consider the impact of these concerns on their overall view of clinical quality of the organisation before concluding on the authorisation decision; and

[5] *Measuring Monitor's impact: Economic evaluation report* http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/about-monitor/what-we-do/measuring-monitors-impact-economic-ev

[6] The terms of authorisation are a set of detailed requirements covering how NHS foundation trusts must operate. The terms of authorisation for each foundation trust can be found on Monitor's website: http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory

— require confirmation of any quality concerns from the CQC at two points in our assessment process to ensure we have an up to date view from the CQC before we take our authorisation decision.

2.24 To reflect the ongoing developments in our operational practices, in May 2011 we revised our memorandum of understanding with the CQC.[7] This document sets out in detail how we work together when concerns emerge about an NHS foundation trust and how we ensure joined up regulation. We revise this document on an ongoing basis to ensure that it is up to date.

2.25 We have asked the CQC to participate in our Annual Plan Review process for 2011–12. This should increase our collective ability to spot potential issues early.

The Public Inquiry into Mid Staffordshire NHS Foundation Trust

2.26 Monitor has given evidence this year to the Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust.

2.27 We continue to monitor Mid Staffordshire NHS Foundation Trust closely and are working with the Care Quality Commission to review its progress in delivering the required improvements.

2.28 In our annual report for 2009–10 we reported on how we had focused on learning from the unacceptable failings in care at Mid Staffordshire NHS Foundation Trust. We commissioned our internal auditors to conduct a lessons learned exercise and published the audit report,[8] and our response, in September 2009.[9] The internal audit report made 14 recommendations, all of which Monitor's Board accepted. We have made changes to the way we work as a result. For example in assessment:

— We have enhanced the way we assess quality governance in applicants to ensure that boards have robust arrangements in place to identify and manage risks to quality. This is particularly important in an environment of tighter public finances. These arrangements are then tested by Monitor during the assessment process.

— We have strengthened our assessment process to take a more detailed look at the quality impact of cost improvement plans and we now take a broader view of performance and seek a wider range of information and intelligence on the quality of care, with the CQC's judgements being the key element.

2.29 These and the other changes are all reflected in Monitor's *Guide for Applicants.*[10]

2.30 We have given the Inquiry our full assistance and very significant focus during the past 12 months. The Inquiry is likely to publish its full findings in the autumn. When the Inquiry reports its findings we will study these carefully and, where there are new lessons to learn or recommendations that relate to our role, we will act on these, working closely with the CQC where appropriate.

3.0 Monitor's Current Role

Assessment

3.1 This section deals with Monitor's current assessment activity and our activity during 2010–11. Points relating to future assessment activity and the Government's 2014 deadline for all trusts to become foundation trusts are dealt with in section five, below.

3.2 Monitor operates a rigorous assessment process that challenges NHS trusts applying for foundation trust status. We must be confident and able to provide assurance to Parliament and a wide range of stakeholders that NHS foundation trusts will be legally constituted, financially sustainable and effectively governed. These are essential requirements for NHS foundation trusts to be able to operate with sufficient autonomy, to deliver national health priorities and to become increasingly responsive to local needs.

3.3 Monitor applies standards to the assessment process that are designed to prevent newly authorised applicants from being at significant risk of failure. This approach has been revised to include recommendations arising from an internal audit review into Monitor's ways of working following the failings at Mid Staffordshire NHS Foundation Trust (see separate section on Mid Staffordshire NHS Foundation Trust below).

3.4 These standards are known as the assessment bar. The bar is comprised of three main areas of assessment:

— *Quality bar*—This incorporates the CQC's registration standards, the Secretary of State gateway threshold, and Monitor's governance risk rating (by reference to its Compliance Framework). From 1 April 2010 applicant trusts have had to demonstrate that:

(a) they are registered with the CQC without compliance conditions;

(b) they continue to meet the quality threshold set by the DH at the time of Secretary of State referral;

[7] http://www.monitor-nhsft.gov.uk/home/about-monitor/how-we-do-it/working-partnership, May 2011.

[8] *Learning and Implications from Mid Staffordshire NHS Foundation Trust* http://www.monitor-nhsft.gov.uk/sites/default/files/KPMG%20report.pdf, June 2010.

[9] *Learnings and Implications from Mid Staffordshire NHS Foundation Trust,* http://www.monitor-nhsft.gov.uk/sites/default/files/Update%20on%20progress%20following%20internal%20audit%20report%20of%20Sep%202009.pdf, August 2010.

[10] http://www.monitor-nhsft.gov.uk/sites/default/files/Amendments_Applying_NHSFT_Status_July_2010.pdf, July 2010.

(c) the CQC's current judgement of compliance against registration shows:

- the overall level of concern is no worse than "*moderate*" and with "*high confidence*" in capacity;
- the CQC is not conducting or about to conduct a responsive review into compliance;
- no enforcement/investigation activity is ongoing or planned including preliminary investigations into mortality outliers; and

(d) they have a governance risk rating, assessed by reference to the recently published *Compliance Framework* of no worse than amber/green.

- *Governance*—Monitor challenges Boards to ensure they are discharging their duties effectively in terms of quality governance (structures and processes above and below board level to lead on trust-wide quality performance) and corporate governance. For Quality Governance we have developed a comprehensive framework and associated good practice guidance which we use to test the applicant trust's quality governance arrangements). Corporate governance is tested through review and challenge of the evidence to support the applicant trust's self-certification on organisational capacity covering, effectiveness of sub-committees, risk and performance management. We also review targets and standards, performance and the adequacy of the financial reporting procedures where our work is supported by an opinion from an independent accounting firm.
- *Financial viability*—applicant trusts must demonstrate that they can with a high likelihood generate a sustainable net income surplus by year 3 of the plan and maintain a reasonable cash position. By high likelihood we mean after a reasonable set of downside risks have been applied but taking into account the trust's mitigation plans, this is known as the downside case. It is against this case that Monitor makes its authorisation decision. The risks that Monitor typically takes into consideration as part of the assessor and downside case include a view the implied efficiency requirement in the system (where we publish our assumptions which are applied to all trusts) and on a case by case basis views on the achievement of activity assumptions and CIPs. In addition to sustainable surplus by year 3, applicants must demonstrate a minimum financial risk rating of 3 in the first year of projections unless exceptional circumstances exist and receive a clean working capital opinion from an Independent Accounting firm.

Assessment activity during 2010–11

3.5 Monitor has maintained its high standards of assessment. However, 2010–11 was characterised by fewer trusts being referred to us by the Department of Health with only 11 referred to us between April 2010 and the end of March 2011. In 2010–11, we assessed 13 NHS trusts for NHS foundation trust status. Seven of these were authorised. The other six were either postponed[11] or deferred.[12]

3.6 Monitor remains committed to seeing all trusts capable of becoming foundation trusts, including ambulance and community trusts, come forward to Monitor for assessment, and will be working with the Department of Health to help it achieve this before April 2014.

3.7 In the past year, we have further developed our assessment methodology to incorporate ambulance trusts and community trusts. We authorised the first two ambulance trusts on 1 March 2011.

3.8 In feedback from our 2010–11 NHS stakeholder perception survey, 93% of stakeholders agreed that our assessment process is rigorous.

Quality governance

3.9 As part of our continuing focus on quality governance, we implemented the *Quality Governance Framework* from August 2010. The framework assesses the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides. We are looking for evidence that:

- boards accurately understand the quality of the care their organisation provides;
- boards are able to assess and mitigate risks to quality (including the impact of Cost Improvement Plans);
- quality is seen as a responsibility of the entire board, not only the medical and nursing directors; and
- trusts are committed to continuous quality improvement, and have put in place the tools to address poor performance.

3.10 All trusts with an authorisation date after 1 August 2010 have been assessed against this revised framework. These trusts have told us that they found the *Quality Governance Framework* challenging yet fair.

[11] A postponement is at the trust's request. Where issues arise during the assessment process which require resolution before an authorisation decision can be made, applicants may write to Monitor to request a period of postponement.

[12] A deferral is a Monitor decision. An application may be deferred if the outstanding issues identified as preventing a successful application are capable of satisfactory resolution and capable of being properly addressed within a reasonable period of time and are likely to be resolved or addressed within that period.

3.11 The National Quality Board, of which Monitor is a member, has since built on the *Quality Governance Framework* in its publication *Quality governance in the NHS—a guide for provider boards.*[13] This guide considers how to govern for quality, both in terms of driving continuous improvement across the organisation and ensuring that the essential levels of quality and safety are met. It recognises that processes and structures are vital in governing for quality, but also that values and behaviours are essential to a culture that supports quality.

Financial assumptions

3.12 Monitor publishes financial assumptions which provide an estimate of the efficiency requirements for trusts over the next five years. These are used to assess the financial plans of all applicant trusts and for risk rating certain investments and transactions undertaken by existing NHS foundation trusts. The published financial assumptions are calculated using an evidence based methodology and are reviewed as new evidence comes to light and policy develops, for example the publication of the Comprehensive Spending review, the Operating Framework and latest inflationary information from the Office of Budgetary responsibility. Typically they are reviewed at two points in the financial year in the Autumn and the Spring, with the purpose of the review to determine whether the existing assumptions remain valid or if changes are required to ensure that the financial assumptions reflect the most current data to ensure good decision making both by trusts and by Monitor's Board.

3.13 Existing NHS foundation trusts are likely to consider these assumptions as part of their own annual planning.

3.14 Monitor uses two scenarios as the starting point for its financial assessments: the assessor and the downside case. The assessor case efficiency requirement reflects the expected pressures and risks to providers' costs and incomes and is in line with estimates published by the Department of Health. The downside efficiency requirement builds on the assessor case, but reflects a more pessimistic view of the expected pressures and risks.

3.15 In April 2011, we reviewed the financial assumptions used in the assessment of applicant trusts in light of the latest inflation forecasts from the Office of Budget Responsibility. We communicated the revised assumptions to NHS trusts, foundation trusts and SHAs.[14] These changes reflect changes to the economic outlook and policy framework.

3.16 Any trust's application that is considered by Monitor's board after 1 June 2011 will be tested against the revised assumptions. Monitor will give additional time to applicants currently with us for assessment should they request it in order to provide the evidence required to meet the revised assessor and downside cases.

Developing the assessment process

3.17 Given the challenges the sector is facing, in 2011–12 we will enhance and develop our assessment function by:

- reviewing the assessment process to ensure it remains efficient and appropriately challenging; and
- working with the Department of Health to co-ordinate, as far as possible, the requirements made of foundation trust applicants across the SHA, Secretary of State and Monitor phases of the process.

Compliance

3.18 Monitor's role as regulator is to provide a regulatory framework which ensures that NHS foundation trusts are well-led (from both a finance and quality perspective) and financially robust so that they are able to deliver excellent patient care and value for money.

3.19 We operate a risk-based regulatory regime for NHS foundation trusts. Through this we have:

- set clear regulatory requirements that hold boards accountable for the performance of their NHS foundation trust;
- introduced transparent financial reporting to the NHS aligned with accepted accounting practice; and
- set the limits of NHS foundation trust borrowing.

3.20 Where necessary, we have demonstrated our ability to address financial and service performance failures. Our risk-based approach holds NHS foundation trust boards accountable for the early identification and effective resolution of problems. If they fail to do this, Monitor can use its formal powers to intervene, for example requiring the board to take specific actions or advice. If Monitor's Board does decide to intervene, it is always with the aim of resolving issues as quickly as possible and in the most effective way. We therefore work closely with the Care Quality Commission so that there is appropriate and co-ordinated action.

3.21 Essentially, Monitor's regulation consists of monitoring to ensure compliance with the NHS foundation trust's Authorisation. Details of Monitor's monitoring regime are contained in the *Compliance Framework*[15] which is mandatory guidance. Monitor updates this guidance yearly following public consultation.

[13] Department of Health, *Quality governance in the NHS—a guide for provider boards*, March 2011 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125239.pdf

[14] http://www.monitor-nhsft.gov.uk/home/information-nhs-foundation-trusts/correspondence-foundation-trusts-0

[15] *Compliance Framework 2011–12*, March 2011 http://www.monitor-nhsft.gov.uk/sites/default/files/publications/COMPLIANCE%20FRAMEWORK_final_4.pdf

3.22 The Compliance Framework for 2010–11 was published on 31 March 2010. It was updated in July 2010 to take account of the changes in the 2010–11 Operating Framework to national healthcare targets and standards, which Monitor uses as triggers to identify whether an NHS foundation trust is at risk of breaching its Authorisation.

3.23 Monitoring of compliance by NHS foundation trusts with their terms of Authorisation is complemented by Monitor's statutory powers of intervention[16] and enforcement (see section 52 of the 2006 Health Act). The Compliance Framework covers these powers and describes how and when Monitor is likely to engage them.

Monitor's approach to regulation

3.24 Monitor's approach to regulation is one of risk management. Monitor must be confident and able to provide assurance to Parliament and a wide range of stakeholders that NHS foundation trusts remain legally constituted, financially sustainable, effectively governed and locally representative. These are all essential requirements for foundation trusts to be able to operate with sufficient autonomy, to deliver national health priorities and to become increasingly responsive to local needs.

3.25 Monitor's compliance philosophy is set out in full in the first chapter of the various versions of Monitor's Compliance Framework. Importantly, core principles which have consistently over time shaped Monitor's approach to regulation, are as follows:

— self-regulation by boards of directors of NHS foundation trusts;
— proportionality;
— transparency;
— based on trust;
— confidentiality;
— minimal duplication of regulation; and
— minimal information requirements.

3.26 These core principles have not changed in substance since Monitor first introduced its compliance regime in March 2005. Effective self-governance by NHS foundation trusts is essential. The board of a foundation trust takes primary responsibility for compliance with the trust's terms of Authorisation. The framework set out in Monitor's mandatory compliance documentation is largely aimed at satisfying Monitor that trust Boards and Chairs are receiving independent assurance where appropriate and are discharging their responsibilities effectively. In other words, the Boards of foundation trusts are the frontline of regulation, and Monitor does not seek to performance manage their operations. Monitor's regulatory compliance processes have been designed to implement Monitor's published approach to regulation.

3.27 In addition to the board of NHS foundation trusts, every trust is required to have a "Board of Governors". The Governors have a key role. They are the direct representatives of local interests within foundation trusts and ensure that the local community and wider stakeholders are directly involved in the governance of the organisation.

3.28 Governors should work closely with the board of directors whilst also holding them to account for the performance of the trust. They have a number of statutory responsibilities, including:

— Appointing/removing the trust Chair and Non-Executive Directors.
— Determining the pay and terms of office of the Chair and Non-Executive Directors.
— Approving the appointment of the Chief Executive.
— Safeguarding probity and good quality healthcare.
— Receiving annual report and accounts.
— Appointing/removing the Auditor.
— Ensuring the trust operates in accordance with its legal framework.

Regulatory action in 2010–11

3.29 During 2010–11, three trusts were found in significant breach of their terms of authorisation: Poole Hospital NHS Foundation Trust; Blackpool Teaching Hospitals NHS Foundation Trust; and Tameside Hospital NHS Foundation Trust. This compares to 14 in 2009–10. There are a number of factors likely to have contributed to this sharp decline. In particular, fewer trusts were triggering our governance framework due to breaches of national targets and standards, which we use as proxy indicators for effective governance. The reason for this is two-fold.

— Firstly, in 2010–11, fewer foundation trusts were triggering our governance indicators based on healthcare-acquired infection rates. Compared to 2009–10, the number of MRSA infection cases in foundation trusts was lower. Our revised annual planning process (see below for further detail) may have also been a factor in the decline in the number of trusts found in significant breach.

[16] Monitor's formal powers of intervention are described under Section 52 of the National Health Service Act 2006. We have used our powers to intervene directly on 12 occasions—at eight foundation trusts—in the six years since 2004.

— Secondly, in July 2010 we amended the governance triggers we use to identify whether a trust is at risk of breaching its terms of authorisation to reflect the following amendments to the Department of Health's *Operating Framework* in June 2010:

— the A&E four-hour waiting time target was reduced from 98% to 95%; and

— the 18 weeks referral-to-treatment waiting time target was removed.

3.30 In 2010–11, the reason three trusts were found in significant breach of their terms of authorisation was mainly financial and at the time of each breach there was sufficient evidence of action being taken to ensure that Monitor did not need to use its statutory powers. Should any trust in significant breach fail to make sufficient progress, Monitor would consider using its statutory powers in the future.

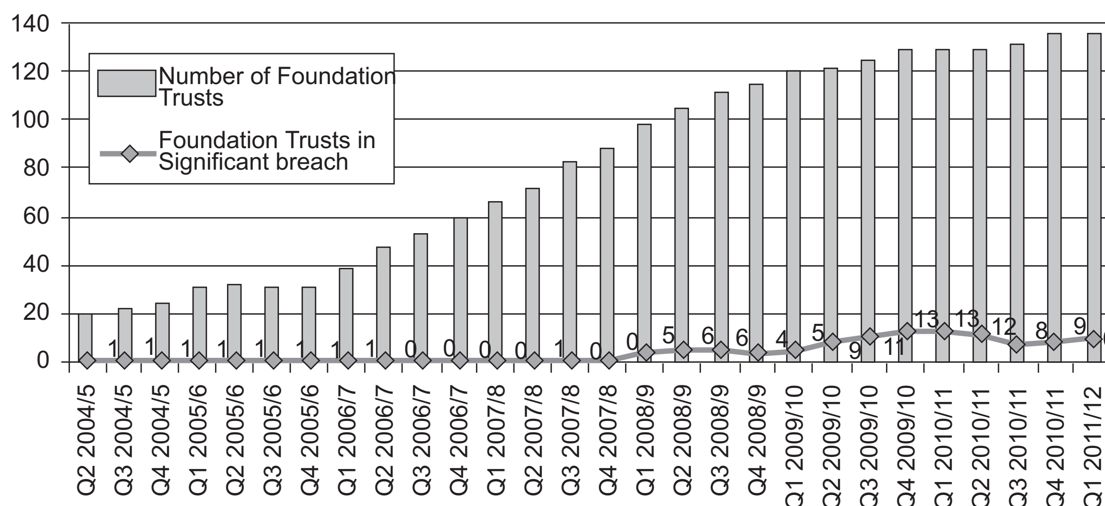
3.31 At the year-end point, there were also fewer trusts in significant breach of their terms of authorisation (13 at 31 March 2010; nine at 31 March 2011), although this decline is less marked than the number found in breach over the course of 2010–11 compared to 2009–10.

3.32 Seven trusts were removed from significant breach during 2010–11, having demonstrated that they had taken action to sustainably address the issues identified. Examples can be provided to the Committee upon request, of actions these trusts took to demonstrate improvement following Monitor's decision to find them in significant breach and our work with them during that period.

3.33 In total, since Monitor's regulatory regime began in 2004, we have found 21 trusts in significant breach of their terms of authorisation.

Figure 2

THE NUMBER OF FOUNDATION TRUSTS BEING FOUND IN SIGNIFICANT BREACH IN RELATION TO THE TOTAL NUMBER OF FOUNDATION TRUSTS



3.34 During 2010–11, we did not use our intervention powers. We used them on seven occasions in 2009–10.

Figure 3

ALL OF MONITOR'S FORMAL INTERVENTIONS BY TRUST, THE REASON FOR AND DATE OF THE SIGNIFICANT BREACH DECISION AND THE LENGTH OF TIME SPENT IN SIGNIFICANT BREACH

NHS Foundation Trust	*Monitor Board meeting at which decision made to find trust in significant breach*	*Time spent in significant breach (months)*	*Reason*	*Formal Intervention details*
Mid Staffordshire NHS Foundation Trust	03-Mar-09	27	Governance, healthcare targets and standards	Monitor has formally intervened **twice** at this trust.
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	29-Jul-09	22	Financial governance	Monitor has formally intervened **once** at this trust.

NHS Foundation Trust	*Monitor Board meeting at which decision made to find trust in significant breach*	*Time spent in significant breach (months)*	*Reason*	*Formal Intervention details*
Basildon and Thurrock University NHS Foundation Trust	25-Nov-09	19	Governance, healthcare targets and standards	Monitor has formally intervened **once** at this trust.
Dorset County Hospital NHS Foundation Trust	28-Oct-09	19	Financial governance	Monitor has formally intervened **once** at this trust.
Milton Keynes Hospital NHS Foundation Trust	02-Mar-10	15	Governance, healthcare targets and standards	Monitor has formally intervened **once** at this trust.
Royal National Hospital for Rheumatic Diseases NHS Foundation Trust	01-Aug-08 (removed 27-Oct-10)	27	Financial governance	Monitor has formally intervened **three** times at this trust.
Colchester Hospital University NHS Foundation Trust	30-Sep-09 (removed 29-Sep-10)	12	Governance, healthcare targets and standards	Monitor has formally intervened **once** at this trust.
Bradford Teaching Hospitals NHS Foundation Trust	01-Oct-04 (removed 01-Oct-05)	12	Financial governance	Monitor has formally intervened **twice** at this trust.

3.35 In March 2011, we published a report[17] which set out key learnings from NHS foundation trusts that were found in significant breach during 2010. This report looked at issues that led to these trusts getting into difficulty, as well as points relating to their improvement and, in some cases, subsequent removal from significant breach. The main areas where trusts were experiencing problems were:

— formulating effective strategy for the organisation;

— ensuring accountability through trust boards holding the organisation to account for the delivery of the strategy and seeking assurance that systems of control are robust and reliable; and

— ensuring effective performance—appropriate skills, effective information flows to the board, and board-level dynamics.

3.36 Monitor expects to deal with more trusts that are in difficulty as the foundation trust sector expands in size and financial conditions tighten.

Preparing for future risk (the annual plan review process)

3.37 The National Health Service Act 2006 requires foundation trusts to provide Monitor with information regarding their forward plans.

3.38 A key focus of our work in the past year has been to ensure that both NHS foundation trusts and Monitor are better sighted on future risk. APR requires foundation trusts to prepare a three-year strategic and financial plan and to provide us with board certifications on financial performance and governance.

Key steps in the process include:

3.39 The trusts submit their plans on 31 May. All plans are subject to a stage one review, a two-day desk top analysis completed by Monitor's compliance team.

3.40 Following this, where weaknesses are identified in a trust's planning process, or where concerns are raised over financial stability or financial or quality governance, trusts may be subject to a stage two review, a more in-depth assessment of whether the underlying risks were significant to their terms of authorisation. The second stage of the annual plan review also means that we at Monitor are more aware of risks in trusts which has not already required additional regulatory oversight on the basis of which we could ensure the trust boards were focused on those risks and had plans in place to mitigate them.

3.41 We then meet those trusts identified as high or medium risk, to ensure the trust board is focused on the risks facing the organisation and has plans in place to mitigate them.

[17] *Key learnings from regulatory action in 2010*, Monitor http://www.monitor-nhsft.gov.uk/sites/default/files/publications/Key%20learnings%20from%20regulatory%20action%20in%202010.pdf

3.42 Our approach to the annual plan review process encourages trusts to put greater focus on strategic planning to ensure they identified potential challenges to both the quality of care they provide and their financial performance. Flagging the risks early in this way could have contributed to the fact that fewer trusts were found in significant breach or required our intervention in 2010–11.

3.43 For Monitor, the process means an improved awareness of risks in trusts which are not already on our radar (trusts that are already in significant breach of their terms of authorisation, or those where action plans are being developed to address issues, are not selected for a stage two review). If regulatory action is later required at a trust which has been reviewed at stage two, we have a significant knowledge base to build on in order to take prompt and effective action.

Annual reporting

3.44 Foundation trusts are required to submit annual accounts and reports to Monitor. Monitor, with the agreement of the Treasury, sets the form for the accounts and reports in the NHS Foundation Trust Annual Reporting Manual. We consult on proposed changes to the manual each year. Foundation trusts are then required to lay their reports and accounts before Parliament, and Monitor produces a consolidation of the trusts' accounts which is also laid before Parliament.

Quality reporting

3.45 The aim of quality reports is to develop more transparent and accountable public reporting, ensure that boards have clear priorities and achievable plans in place for driving improvement, and help to inform the development of Quality Accounts, a legal requirement for all NHS organisations from 2010 as set out in Lord Darzi's *High Quality Care for All.*[18]

3.46 The specific requirements for quality reporting in the NHS were initiated by Monitor and piloted first in foundation trusts.

3.47 NHS foundation trusts have been required to produce quality reports since 2009. This means that they have to develop a clear narrative explaining the quality of the care they offer and their priorities for improvement. Quality reports are provided to the governors of the foundation trust and therefore reinforce that line of accountability to patients and the public.

3.48 During 2010 Monitor required a test run of external assurance of some aspects of the 2009–10 quality reports. We reviewed sample reports, obtained feedback from foundation trusts through questionnaires and workshops and also sought feedback from assurance providers. Following feedback and consultation, we updated our approach, publishing this on 31 March 2011 in *Detailed Guidance for External Assurance on Quality Reports.*[19] In summary, we are requiring for the year ended 31 March 2011:

- a limited assurance report on the content of the quality report which will be published in foundation trusts' annual reports; and
- a separate governors' report—prepared by the foundation trust's auditors—covering external assurance on two mandated and one locally selected indicator for all foundation trusts.

Risk rating significant community services transactions

3.49 The Department of Health's Transforming Community Services (TCS) initiative required all primary care trusts to dispose of their provider functions. The provision of community services is being transferred to existing providers or undertaken by a range of new organisations such as social enterprises.

3.50 Monitor requires NHS Foundation Trusts to report proposed transactions that exceed, or are likely to exceed, the thresholds set out in the *Compliance Framework*. The *Compliance Framework* splits major investments into material and significant transactions, based mainly on their size relative to the size of the NHS foundation trust. Large-scale mergers and acquisitions have inherent risks and Monitor's role in this area is to ensure that NHS foundation trusts do not jeopardise their quality of services or financial stability.

3.51 Monitor does not have any role in approving plans for acquisitions, but considers their impact on the NHS Foundation Trust's "risk rating."[20] We then issue an "indicative risk rating". This represents Monitor's view of the risks facing the combined organisation as a result of the transaction. We do not publish these ratings, we communicate them to the trust Board. The purpose of the risk evaluation process is to consider how the proposed investment may affect the risk profile of the NHS Foundation Trust and to share our concerns with the foundation trust's board so it can seek to mitigate them.

[18] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf

[19] http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/detailed-guidanc-0

[20] Monitor assigns risk ratings to indicate the risk of a foundation trust failing to comply with its terms of authorisation in two areas (1) **Finance** (1 to 5 scale; a rating of 5 indicates the lowest risk of breaching the authorisation and a rating of 1 indicates the highest risk, in which case formal statutory intervention by Monitor is likely)) and (2) **governance** (traffic light rating system).

3.52 The board of the NHS foundation trust then decides whether or not to approve the acquisition, taking Monitor's risk evaluation into account.

3.53 The process for assessing the risk of significant transactions, and issuing an indicative risk rating to the foundation trust, takes approximately three months, depending on the complexity of the transaction involved.

3.54 With many NHS foundation trusts choosing to take on the provision of community services, Monitor has seen a significant increase in its work in this area. 31 significant transactions (some of which were multiple transactions by a single foundation trust) were referred to us in 2010–11 and early 2011–12.

3.55 To accommodate this substantial additional workload, we almost doubled the capacity of our assessment team, on a temporary basis.

Developing our regulatory approach

3.56 In 2010–11 we revised our *Compliance Framework*[21] following consultation, as we do every year. This ensures our regulatory framework is fit for purpose, reflecting the context in which NHS foundation trusts operate.

3.57 We carried out preparatory work during the year to incorporate Monitor's *Quality Governance Framework* into our regulatory approach. This framework was developed as part of the process we use to assess if trusts are ready to become foundation trusts, as outlined above. Following consultation, the *Compliance Framework* for 2011–12 requires a revised certification on quality from boards of foundation trusts, confirming (or otherwise) that they have had regard to the *Quality Governance Framework*, serious incidents and complaints.

3.58 Other key changes were:

- taking account of relevant priorities from *The Operating Framework for the NHS in England 2011–12*, which was published on 15 December 2010, including new referral-to-treatment waiting time measures and A&E clinical quality indicators;
- revising how we will incorporate CQC judgments in our governance risk ratings to reflect the development of the CQC's approach since introducing registration;
- refining our approach with regard to incorporating asset efficiency within our financial risk ratings;
- including the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST) levels in our governance risk rating;
- assessing the governance implications of material data submission failures or misrepresentations by NHS foundation trusts on a case-by-case basis; and
- clarifying the regulatory consequences of a financial risk rating of 2.

Development

3.59 For an NHS foundation trust to succeed, strong leadership at the top of the organisation is essential. The board sets the direction, culture and strategy of a foundation trust and is accountable for performance. Monitor's assessment and regulatory roles have given us significant insight into the development needs of foundation trust boards and we use this experience to support development programmes across the sector. Our role is to work with partners to stimulate the development of training and tools to strengthen the capabilities of NHS foundation trust boards of directors, boards of governors and senior management teams.

3.60 Examples of our development programmes include:

- Service-line management[22]—an innovative approach to the management of NHS services that encourages clinical leadership, improved efficiency and better quality care;
- Non-Executive Director Development Programme—to build leadership at board level; and
- Strategic Financial Leadership Programme—a business school-based development programme for finance directors to support new ways of working in a fast changing NHS.

3.61 During 2010–11, we worked with the Foundation Trust Network to develop a programme specifically for chairs of foundation trusts and aspirant foundation trusts. Cass Business School was commissioned to develop this course, with the aim of creating a programme which caters for chairs of all backgrounds. The course includes:

- a learning programme of value to chairs who are new to foundation trusts or new to the NHS (or who would like a refresher of their knowledge/skills), to further their understanding of the NHS and of foundation trusts, and to help them in their role; and
- a flexible and high level master-class and discussion-based programme which aims to bring together

[21] *Compliance Framework 2011–12*, March 2011 http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0

[22] More information on Service Line Management can be found on Monitor's website: http://www.monitor-nhsft.gov.uk/node/370/

foundation trust chairs with experts in both the wider public and commercial sectors, thus also catering for chairs with considerable experience both within and outside the NHS.

3.62 Several foundation trust chairs were involved in scoping this programme, which will be launched later in 2011.

Working with governors and members

3.63 Local accountability is a fundamental part of the NHS foundation trust model and governors make a vital contribution by appointing the majority of the board of directors and holding them to account.

3.64 In December 2010, we launched a survey of governors to establish how effective and confident they feel they are in their roles. The results will be summarised in a report (with anonymised data) which will be made available to all trusts in July 2011. We will make further use of the survey results in 2011–12, working with the Department of Health and other partners to develop programmes to support boards of governors.

3.65 We have also been involved in a range of other events for governors held by partner organisations, including attending and speaking at national development days held by the Foundation Trust Governors' Association.

3.66 During December 2010—January 2011, together with the Foundation Trust Network, Electoral Reform Services and Membership Engagement Services, we carried out a joint research project into the current approach of FTs to recruiting and engaging members, and good practice in these areas. A report on the research will be published in July 2011.

4.0 Organisational Changes

Changing leadership

4.1 2010–11 saw significant leadership change within Monitor. Monitor was initially established in 2004 with an Executive Chair, Dr William Moyes. Following Dr Moyes' departure in January 2010, the leadership of the organisation was split to incorporate the separate posts of Chief Executive and Chair. Steve Bundred was appointed as Chair from May 2010, and Dr David Bennett was appointed interim chief executive pending a permanent appointment.

4.2 Following a recruitment campaign handled by the NHS Appointments Commission on behalf of the Secretary of State, David Bennett was appointed to the position of Chair with effect from 1 March 2011, replacing Steve Bundred.

4.3 David Bennett's appointment as Chair followed the Secretary of State's announcement in November 2010 that he wanted to expand Monitor's Board and appoint a new Chair, to reflect our proposed change in role.

4.4 David's priorities in his new role will be to ensure that we remain strongly focused on our compliance and assessment activities; to ensure we are prepared to take on the new role that is proposed in the Health and Social Care Bill if approved by Parliament; and to build strong and collaborative relationships with key partners and stakeholders.

4.5 Monitor also launched its recruitment campaign to appoint a permanent Chief Executive in March with the aim of making an appointment in July 2011. David Bennett will continue to carry out the role of Interim Chief Executive until the appointment of a permanent Chief Executive.

Monitor's Board

4.6 The Board has responsibility for the overall management and performance of the organisation and the approval of its long-term objectives. It is responsible for ensuring that any necessary action is taken to ensure that Monitor's objectives are met.

4.7 Until July 2010 Monitor's Board had five members: a Chairman and four non-executive directors. Following Baroness Murphy's departure at the end of her term of appointment there are currently three non-executive directors. The National Health Service Act 2006 states that the regulator is to consist of a number of members (but not more than five) appointed by the Secretary of State. One of the members must be appointed as Chairman and another as Deputy Chairman. No individual or group of individuals dominates the Board's decision making. Collectively, the non-executive directors bring a valuable range of experience and expertise as they all currently occupy, or have occupied, senior positions in the healthcare sector, in industry and in public life.

4.8 All of the Board members are appointed by the Secretary of State for Health.

5.0 Monitor's Strategy for 2011–12

5.1 Monitor's strategy for the 2011–12 is outlined fully in our Business Plan. The key points are set out below.

5.2 Monitor's aspiration continues to be an affordable, devolved healthcare system in which patients and service users receive excellent care and taxpayers achieve value for money, through autonomous, well-led, financially robust providers that respond to commissioners' requirements and patients' and service users' choices. Our role is to provide a regulatory framework which ensures that NHS foundation trusts are well-led (from both a finance and quality perspective) and financially robust so that they are able to deliver excellent care and value for money.

5.3 We have five strategy areas to help us deliver our mission. Four of these relate to the professional delivery of our core functions. The fifth area enables us to continue to deliver these functions to a high standard. Our five strategy areas are:

1. Operate a rigorous assessment process and support the development of all eligible applicant trusts to become NHS foundation trusts, ensuring they are well-governed, financially robust, legally constituted and meet the required quality threshold.
2. Operate a proportionate, risk-based regulatory regime, alongside the Care Quality Commission, that ensures that NHS foundation trusts are well-governed (from both a finance and quality perspective) and financially robust. Where needed, ensure interventions are timely and effective to prevent and remedy significant breaches of their terms of authorisation.
3. Promote the development of well-led NHS foundation trusts that are capable of delivering excellent care and value for money as they respond to commissioners' requirements and patients' and service users' choices.
4. Work with partners to contribute to and influence the development of an affordable, devolved system of healthcare provision. Ensure that the system has a coherent regulatory regime and effective incentives for providers to deliver excellent care for patients and service users and value for money for taxpayers.
5. Continue to improve as a high-performing organisation that attracts, develops and retains talented people; operates efficiently; remains legally compliant; and meets high professional standards.

5.4 In addition to our key strategy areas, Monitor's work will continue to be guided by clear principles, including:

- focusing on improving care for patients and service users and delivering value for taxpayers;
- being demonstrably independent and impartial;
- working with our partners and engaging with our stakeholders to seek their views;
- being open about the decisions we make and how we have reached them;
- continually reviewing the impact of our regulatory regime and how we can deliver better value for money;
- communicating clearly and effectively;
- being legally compliant at all times and managing legal risk; and
- being a source of high-quality information on the NHS foundation trust sector.

5.5 In order to carry out our role successfully we will work effectively and closely with our partners. Nationally, we work in partnership with a number of stakeholders, such as the Department of Health, the CQC and the Co-operation and Competition Panel, to regulate the healthcare system. We will also continue to build effective working relationships with a number of advisers, including other regulators and auditors in the healthcare sector and various intensive support teams at the Department of Health, to help inform and support the operation of our regulatory regime.

5.6 In carrying out our functions, we will seek to work with primary care trusts and strategic health authorities in 2011–12 to predict and identify significant financial and governance risks in NHS foundation trusts which arise from issues in their local health economy. We will also begin to work with newly-emerging organisations, such as the shadow NHS Commissioning Board and pathfinder commissioning consortia, where appropriate.

5.7 We continue to participate fully in the National Quality Board to help drive forward the national quality agenda. This has included active contributions to developing quality accounts, the implementation of better reporting on quality performance, the quality information strategy, the recent publication of *Quality Governance in the NHS—a guide for provider boards*, based on our *Quality Governance Framework*, and the *Review of Early Warning Systems* and update following the failings at Mid Staffordshire NHS Foundation Trust.

5.8 In addition, we will work with The Information Centre for Health and Social Care and others to help shape the information architecture of the NHS, and will continue to work with the Foundation Trust Network to share learning and support the dissemination of best practice where appropriate.

6.0 Proposed Changes to Monitor's Current Role

6.1 There have been significant changes proposed to continue the reform of the NHS since the Coalition Government came to power in May 2010. This section relates to the proposed changes to Monitor's current

role. It does not consider the proposed new role for Monitor as, as outlined above, at the time this evidence was submitted, Future Forum's report was still under consideration by the Government.

Assessment

6.2 The Government has set a deadline of April 2014 for all of the remaining acute and mental health trusts, alongside all 11 ambulance trusts and approximately 15 community trusts, to become NHS foundation trusts, or part of an NHS foundation trust.

6.3 The deadline of April 2014 for all remaining acute and mental health trusts to become NHS foundation trusts, or part of a foundation trust, will be challenging. The Department of Health will need to work extremely hard to ensure that trusts meet the required standard and are put forward to Monitor in a timely fashion otherwise it is unlikely that this deadline will be met.

6.4 Over the last year, the pipeline of acute and mental health applicant trusts continued to be slow. This situation will have to improve significantly in 2011–12 if we are to assess and authorise all trusts (including ambulance and community trusts) by the Department of Health's April 2014 deadline. This could mean assessing up to five trusts a month—a significant increase from the average of one/two per month assessed in 2010–11. We will therefore review our approach to assessment to ensure we make the best use of our limited resources—without lowering the bar. We will continue to review the requirements for any additional assessment capacity in discussion with the Department of Health to ensure that this matches the expected pipeline.

6.5 Monitor is committed to supporting the Department with the programme of preparation for applicants as much as we can, especially in relation to those trusts with significant issues around their financial viability and governance, while maintaining our independent view on individual assessments.

6.6 However, our main priority is to ensure that our assessment standards remain high and consistent throughout the drive to ensure all eligible trusts reach foundation trust status. The rigour of our assessment process is widely acknowledged and we will continue to maintain our high standards to ensure that only those organisations that are financially and clinically viable, well-governed and legally constituted are authorised. We will also ensure that the assessment of ambulance and community trusts is carried out with the same rigour and professionalism as that for acute and mental health trusts and will continue to promote and enhance our framework for the assessment of quality governance at applicant trusts.

6.7 In response to the challenges we face, we will:

- enhance and develop our assessment function by:
  - reviewing the assessment process, given the increase in applicant trusts and proposed future changes to Monitor's structure, ensuring this is cost-effective, focused, efficient and robust. This will take into account how the forthcoming health legislation will affect the existing function and any findings from the Mid Staffordshire NHS Foundation Trust Public Inquiry. Any changes will be communicated to all aspirant, applicant and existing foundation trusts.
- strengthen our networks with partners to support the pipeline of applicant trusts and early problem identification in foundation trusts, and to co-ordinate any required interventions by:
  - working with the Department of Health to help it ensure high-quality applicants are put forward for NHS foundation trust status;
  - working with the Department of Health, the Foundation Trust Network and strategic health authorities to share best practice in supporting the preparation and development of applicant trusts;

6.8 We will work to a process we have agreed with the CQC for assessing quality and safety risks in applicant trusts. We will continue to focus on co-ordinated action by ensuring that the CQC's concerns at registration, or resulting from their Quality and Risk Profiles, are fed into our assessment process, highlighting any known risks at trusts.

Compliance

6.9 Monitor is likely to see a significant increase in the number of foundation trusts we regulate, although they will begin to move out of our compliance regime from April 2012 if the Health and Social Care Bill is approved by Parliament. As the number and range of NHS foundation trusts increase, the scale, importance and profile of our compliance role also grows.

6.10 There may also be an increase in those facing financial difficulties. For current foundation trusts, pressure continues to mount on both management capacity and financial viability as expectations and demand continue to rise and finances become more constrained.

6.11 The NHS as a whole, and the foundation trust sector within it, faces the challenge of improving value—that is, the quality of care provided for every pound spent. *The Operating Framework for the NHS in England 2011–12* lays out responses to the £20 billion efficiency savings challenge—including an effective price reduction of 1.5%; the introduction of a maximum tariff and an extended number of normative tariffs, and continued reductions in pricing for some activity, such as the 30% marginal tariff for emergency activity above 2009–10 levels.

6.12 We will continue to focus on ensuring that foundation trusts deal with the significant productivity challenge they face in the next few years—improving the quality of service for patients while controlling costs.

6.13 In response to the challenges we face, we will enhance and develop our regulatory compliance function by:

- working with partners and stakeholders to ensure that the *Compliance Framework* and other compliance documentation are effectively embedded, to enable Monitor to identify, assess and address risks in the foundation trust sector;
- building the capacity to handle the escalation and compliance work arising from the regulation of an increasing number of NHS foundation trusts and a potential increase in those facing financial difficulties;
- handling the increased workload associated with risk rating an increased number of transactions involving NHS foundation trusts;
- co-ordinating our work with the Care Quality Commission regarding the early identification of problems and to determine when regulatory actions are required at NHS foundation trusts;
- working closely with the Department of Health, strategic health authorities, commissioners and relevant newly-emerging organisations to find solutions to issues, such as contract disputes and trusts with persistent financial and quality challenges, which are beyond the ability of the foundation trust to solve alone; and
- preparing for the evolution of our regulatory responsibilities to reflect the proposed changes in the NHS landscape.

6.14 Our approach to regulating the NHS foundation trust sector will also continue to be shaped and informed by the Better Regulation Task Force's principles of good regulation:

- proportionality;
- accountability;
- consistency;
- transparency; and
- targeting.

Development

Governors

6.15 The Health and Social Care Bill makes the responsibilities of foundation trust governors much clearer and more transparent. It both retains the existing statutory powers of and implicit duties on governors and gives them new powers. These include powers to approve mergers, acquisitions, separations and other significant transactions, to approve amendments to the constitution and to call a director to attend a special general meeting to obtain information about a trust's performance. The Bill would allow a foundation trust to change its constitution if a majority of the governors and directors voted to approve the amendment.

6.16 The proposed new responsibilities for governors do mean that a step-change would be needed in the capability of governors in order to ensure effective governance without the safety net which Monitor currently provides. This is a major development challenge where an early start is needed if it is to be effectively addressed over the next three years. In particular, governors will need good induction and ongoing training to ensure that they fully understand their statutory responsibilities and have confidence to take action.

Boards

6.17 Without the necessary skills, some NHS foundation trust boards of directors will find it difficult to deliver trust performance. The savings envisaged by an effective tariff reduction are testing. Some boards may struggle with the extent of the challenge to plan and deliver simultaneous improvements in both cost and quality.

6.18 We will continue to work with partners to develop tools and training materials to support both executive and non-executive directors in building their trust's capacity to lead improvements in quality and productivity. We will also consider new models of delivery to support governor development.

6.19 We will work with partners to promote the development of stronger foundation trust boards by:

- supporting boards of directors in the delivery of quality governance and robust cost improvement plans;
- supporting governors to undertake their roles and responsibilities effectively; and
- exploring new models of delivery for development approaches such as service-line management.

6.20 However, if the Health and Social Care Bill is approved by Parliament, we will be encouraging third parties such as the Foundation Trust Network to take a more active role in the development of foundation trusts, as Monitor will have a broader role, covering the whole sector.

June 2011

Written evidence from Healthcare Audit Consultants Ltd (MON 03)

SUMMARY

We recommend:

— a more active stance is taken to regulation and management in comparison with the light–touch approach adopted previously;

— a review is made of all the performance of all regulators over the last 10 years with a view to learning the lessons for Monitor's potential role in the future;

— the creation of one regulator covering both economic and quality issues; and

— a prior review of the accountability arrangements of NHS Foundation Trusts. More attention needs to be given to their failure regime, transparency and accountability if they are to develop as the model for healthcare provision.

Finally we consider that the particular risks in healthcare regulation mean there is no room for complacency in the NHS with many examples of areas of potential regulatory concern. We therefore make a series of recommendations in the final section of this paper addressing many of the enduring concerns about healthcare in the UK which need to be covered when the scope of Monitor's activity is determined.

1. INTRODUCTION

1. Our perspective is as independent advisors on healthcare issues experienced in a wide range of healthcare matters. As far as this consultation is concerned we consider both Monitor's existing role and what it has achieved and what its proposed new role as economic regulator for the NHS might be. The case for strong regulation of healthcare is supported by both economic theory and practical evidence.

2. MONITOR'S ROLE

2. Our comments address both the historic role of Monitor and its proposed future role. It is independent of central government and is directly accountable to Parliament for its work which consists of:

— determining whether NHS trusts are ready to become NHS Foundation Trusts (FTs);

— ensuring that NHS FTs comply with the conditions they signed up to—that they are well led and financially robust; and

— supporting NHS FT development.

3. Historically therefore Monitor has existed to support NHS Trusts becoming FTs and therefore we have to ask the primordial question: have NHS FTs justified the hopes on their creation and is there continued support for this policy?

4. We believe that the establishment of FTs as "strong" organisations capable of becoming autonomous and having more freedom to develop and compete in the healthcare market place is still an incomplete process with uncertain outcomes. There is little evidence available to justify the additional support and resources made available to FTs. Although there would be some support for the proposition that Monitor has sharpened aspects of management and financial performance, there were always strong and weak providers. Moreover, since FTs were established, the extent of the growth in resources has been unprecedented (and therefore they have yet to be tested in more difficult times); in addition the development of FTs has been accompanied by an unwelcome development in the reduction of FT's activities that are subject to civil society participation, oversight and scrutiny. There is also worrying evidence that FTs are being encouraged by commercial advisers to establish opaque internal structures which by mimicking standard commercial practice to hive off property and facilities from operational services and to enter into complex "commercial and in confidence" arrangements creates the danger that a Southern Cross situation could arise ie where a FT may raise capital on the back of its status as the owner of long term healthcare assets which may end up in the hands of commercial partners at the expense of the impact on operational services (examples of such presentations by commercial advisers can be made available on request).

5. *We recommend* therefore that before the terms of reference of the regulator are established there is a review of the accountability arrangements of FTs. In particular we feel that the failure regime of FTs and their accountability and transparency should be strengthened. Given the unwelcome events at Southern Cross, establishing ways of introducing commercial practices into healthcare may not be now regarded as such a strong selling point.

3. Lessons from Other Areas of Regulation

6. Many lessons are available from other sectors on the role of regulation and the potential problems that can emerge.

7. Financial services regulation has been characterised as light–touch and was ineffective in protecting the public from excessive risk-taking and its impact.

8. Similarly, an over-enthusiastic embrace of light-touch regulation has led to criticisms of the railways regulator, pensions regulator and in education.

9. We are still concerned in healthcare at the over-reliance on self-certification as illustrated by recent failures of the Care Quality Commission, light-touch and an unwillingness to recognise that regulation is difficult dirty work requiring relentless attention to detail and an unwillingness to accept easy excuses.

10. *We recommend* a review is undertaken of the results of the performance of all the major regulatory regimes seeking to protect the public and that the case between light-touch regulation compared with proportionate regulation is examined.

4. Use of Resources Available for Regulation

11. The arguments for splitting economic and quality regulation are not compelling. While there may be specific economic and quality concerns that require the focus of specialist regulators we view it as a disadvantage for either side to be blinkered to the concerns of either quality or financial consequences.

12. We believe that the regulatory regime is distorted by an over-emphasis on economic issues. CQC seems to have been under-resourced in comparison with Monitor. Just as management is expected to address both quality and economic performance there are advantages in creating one regulator for healthcare.

13. *We recommend* a review of the case for creating one regulator rather than splitting economic and quality regulation in healthcare.

5. The Difficulties of Regulating Healthcare

14. We detect a lack of understanding of the real difficulties of regulating healthcare which in our view healthcare requires a more direct approach to regulation and management of the risks than in other industries.

15. In "Global Corruption Report 2006—Special Focus—Corruption and Health", Transparency International summarise the characteristics of healthcare that make it difficult to manage effectively without running the risks of excessive corruption and bad practice:

> No other sector of society has the specific mix of uncertainty, asymmetric information and large numbers of dispersed actors that characterise the health sector. These features combine in ways that systematically create opportunities for corrupt behaviour, while making it difficult to ensure the transparency and accountability that would inhibit this.
>
> — An *imbalance of information* prevails in health systems: health professionals have more information about illness than patients, and pharmaceutical and medical device companies know more about their products than public officials entrusted with spending decisions. Making information available can reduce losses to corruption.
>
> — The *uncertainty in health markets*—not knowing who will fall ill, when illness will occur, what kinds of illnesses people get and how effective treatments are—is another challenge for policy-makers, as it makes it difficult to manage resources, including the selection, monitoring, measuring and delivery of healthcare services and the design of health insurance plans.
>
> — The *complexity of health systems*, particularly the large number of parties involved, exacerbates the difficulties of generating and analysing information, promoting transparency, and detecting and preventing corruption. The relationships between medical suppliers, healthcare providers and policy-makers are often opaque and can lead to distortions of policy that are bad for public health.

16. This report covers the world-wide situation and details many examples of corruption and abuse costing many billions of resources and many lives lost. This can elicit a complacent response in the UK where such scandals do not exist in the same way. But that is to underestimate the controls that have applied in the past to prevent this and to turn a blind eye to some particular problems in the UK.

17. For example the UK system of checks and balances applying to the NHS included a very hands-on attitude from successive Secretary of States; there were high levels of accountability for anything going wrong, and multi-tiered supervision, monitoring and support mechanisms operating at local (unit and area), regional and national levels with audit teams operating on an internal and external level to focus on value for money and stewardship.

18. This inevitably generated resistance and calls for "liberation" from interference and pressures to reduce intrusive management. But this can lead to politicians caving into such pressures and courting popularity by acceding to reducing supervision, cutting red tape and unpopular interference.

19. However there are very real downsides and unintended consequences. Thus:

- Provider interests can become dominant—in a non-market system such as the NHS the patient voice can be easily lost. If FT accountability is reduced and regulation ineffective then provider interests can dominate e.g. we are already seeing plans for excessive consolidation of maternity services which is convenient for consultant obstetricians but reduces access and increases risks for patients. The UK already has the largest maternity units in Europe. Other examples include resistance to consolidation of services that would actually benefit from larger area consolidation in cancer, stroke and pathology services.
- Essential controls can be lost—the NHS has benefitted from the back stop of referral to the Secretary of State. In our own area of work there are many examples where referral to the Independent Reconfiguration Panel has resulted in changed plans more sensitive to patient interest. We are concerned that the level of local authority scrutiny of FTs is to be much reduced in the future leading to the acceptance of major reconfigurations that may not be in the interest of patients.
- Transparency can reduce—as FTs mimic commercial best practice, more of their work is now not available for scrutiny, much of the business is conducted in secret and minutes and papers are not available. This provides cover for abuse unless controls are reintroduced.
- Access can reduce and inequality can increase—already the UK suffers from some of the highest levels of inequality in Europe which is mirrored in the distribution of healthcare resources. Without strong resistance and countervailing action financial pressures will reduce access for patients, and those without private transport will be adversely affected.
- Quality can suffer—already we have seen that the pressure to become an FT may have resulted in inappropriate pressures within an organisation e.g. Mid–Staffs. As financial pressures increase in the coming years, healthcare quality may suffer. This was the case in the past as waiting times escalated when budgets were under pressure. Without high-level monitoring and performance management quality suffers.
- Opportunities for overt corruption and dodgy dealing will also increase. Managers under pressure locally will have increased opportunities for inappropriate risk-taking. Again commercial experience should caution the NHS over allowing too much freedom to local managers.
- More activity will become "commercial and in confidence" as complex commercial structures are created internally as well as externally. Transparency will reduce and opportunities for abuse increase.

20. The past track record of the UK government and its NHS provides ample examples to justify high levels of scrutiny, transparency and challenge. Thus we observe:

- The national NPfIT programme to develop a national IT infrastructure is an obvious example of policy-making being captured. The business case was highly speculative and would never have been approved without highest level interference.
- Use of very expensive management consultants known to spend lavishly on lobbying, political sponsorship, fund raising contributions and policy manipulation.
- The PFI programme which has burdened the public purse with ever escalating financial costs.
- The escalating healthcare inflation rate which was much higher than general inflation indicating capture by vested interests.
- The difficulties encountered in imposing the most effective procurement of goods and services as local managers negotiate over national agreements.
- Local clinical resistance to working in networks which may be better for overall quality and economy but challenges local interests.
- The parallel NHS and private healthcare sectors creates hidden costs and inflexibilities difficult to expose and unravel.
- The NHS is vulnerable to predation by commercial partners eager to secure rights over assets and income streams eg in PFI deals, land deals and sale and lease back arrangements made possible by the new freedoms given to FTs.
- Many opportunities exist to relocate services overseas to escape UK tax jurisdiction (eg property services but potentially many more).
- The chequered history of the healthcare regulators and auditors in exposing and challenging quality and financial scandals.

- The increasing use of "commercial and in confidence" arrangements to deny transparency. This works only against the interests of the NHS who could learn from open book transactions.
- Dissatisfaction with the treatment of whistle-blowers.
- Continuing controversy over the ability of drugs companies to market inappropriate treatments and pills of dubious clinical merit at the expense of the NHS and patients alike.

21. *We recommend* therefore that in drawing up the regulatory regime in healthcare consideration should be given to the following areas and suggestions for action:

Transparency

22. Transparency should be the operational principle guiding the NHS with exceptions needing justification. Government departments, NHS and non-NHS hospitals, commissioners and other agencies handling health service funds must be subject to independent audits. Governments and health authorities have a responsibility to ensure that information about tender processes, including offers to tender, terms and conditions, the evaluation process and final decisions, are easily and publicly available on the Internet.

Codes of conduct

23. The introduction and promotion of codes of conduct, through continued training across the health system, is a must for regulators, medical practitioners, pharmacists and health managers. These codes ought to make explicit reference to preventing corruption and conflicts of interest that can lead to corruption, detail sanctions for breaches and be enforced by an independent body.

Overview and Scrutiny

24. All NHS bodies should introduce avenues for public oversight which improve accountability and transparency. It is essential for public policies, practices and expenditures to be open to public and legislative scrutiny, while all stages of budget formulation, execution and reporting should be fully accessible to civil society.

Whistleblower protection

25. Arrangements for whistleblower protection for individuals working in procurement bodies, health authorities, health service providers and suppliers of medicines and equipment should be reviewed.

Reducing incentives for corruption

Arrangements for payments to providers, staff and suppliers should be under constant government and regulatory review and subject to audit at all levels. Doctors, nurses and other health professionals should be paid appropriately, commensurate with their education, skills and training.

Conflict of interest rules

Regulators have the responsibility to adopt conflict of interest rules. Governments must push for transparency in drug regulation processes, reduction in the excessive promotion of medicines, tougher restrictions on the over-prescribing of drugs by doctors, and closer monitoring of relationships between health departments and the drugs industry. Medical licensing authorities need to define the specific rules for doctor behaviour regarding conflicts of interest (in particular in relationships with the pharmaceutical and medical device industries) and obtain the necessary resources to enforce these rules. Although existing rules go some way to addressing these concerns there remains on-going controversy over the local effectiveness of the controls in operation in this area and these need regular review and amendment as required.

Integrity pacts and debarment

An integrity pact should be applied to major procurement in the health sector. Companies found to have engaged in corrupt practices must be debarred by governments from participating in tender processes for a specified period of time.

Rigorous prosecution

It is essential that prosecuting authorities strengthen the message that corruption has consequences by rigorously pursuing corrupt acts that are clearly proscribed by law. Special anti-corruption and fraud agencies to detect corruption and promote preventative measures in the healthcare sector must be equipped with the necessary expertise, resources and independence to carry out their functions, and be backed by functioning independent courts.

June 2011

Written evidence from the British Dental Association (MON 04)

Executive Summary and General Points

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

2. In its present form, the Health and Social Care Bill requires Monitor to license primary care providers. The Secretary of State can create exemptions via regulation. As we made clear in our response to the Government's White Paper *Regulating Healthcare Providers*, the BDA does not consider that imposing a further level of bureaucracy on primary dental care will provide any benefit to patients, dentists or commissioners.

3. Monitor has made it clear that it regards its priority to be the licensing and regulation of Foundation Trusts and not primary care providers.[23] The BDA welcomes this practical approach to market regulation. We have sought clarification from Ministers that dental practices will be exempt but await confirmation.

4. General dental practice has always existed in a competitive market. Patients can choose which practice they attend. An effective and clear system of market regulation already exists. The Office of Fair Trading already has the authority to address patient concerns and anti-competitive behaviour. We seek assurances that there will be no duplication of regulation in this area.

5. In order to ensure that the dental budget is spent in the most appropriate way, the BDA considers that it will be more important for the NHS Commissioning Board's commissioning processes to be held up to scrutiny, a role Monitor explained as being in the Bill already in its evidence to the Committee in February[24] and which we also called for in our response to *Regulating Healthcare Providers*.

Response

6. We believe that all regulation must be proportionate, non-duplicative, tailored to the sector, in patients' best interests and represent value for money. We have grave doubts that regulation of primary care dental providers by the Care Quality Commission fulfils these criteria and cannot see the advantage in economic regulation by Monitor.

7. Privately-funded health and social care providers are excluded from regulation by Monitor on the grounds that they already exist in a market. We consider that the same applies to dentistry, including those with an NHS contract, as dental practices are independent businesses. We understand from its response to *Regulating Healthcare Providers* that Monitor does not see primary care as an area for regulation or licensing and we seek assurance that this is the Government's understanding too.

8. As private businesses, all primary care dental practices (including practices offering only NHS services) are subject to existing competition laws and are, where necessary, regulated by the Office of Fair Trading (OFT). There does not appear to be any reason to suggest that OFT's role in relation to dentistry, whether NHS or private, is to be discontinued. This role has been in evidence as recently as in June 2011, when OFT released its findings on the impact of a merger between Integrated Dental Holdings and Associated Dental Practices. In order to maintain high levels of quality in NHS dental care, the companies were obliged to relinquish NHS contracts in certain areas.[25]

9. The NHS Co-operation and Competition Panel investigates cases arising in procurement, mergers and advertising for NHS-funded services and this body will in future become part of Monitor.

10. In the Government's response to the Future Forum's recommendations[26] it states that:

> "We will retain our proposals to give Monitor concurrent powers with the Office of Fair Trading, to ensure that competition rules can be applied by a sector-specific regulator with expertise in healthcare."

11. The dental profession recognises the importance of regulation in markets but we have concerns that "concurrent powers" will result in confusion and duplication. We ask the Committee to seek clarification and assurance from Monitor that, if this proposal is taken forward, clear processes will be put in place to delineate the separate roles of the OFT and Monitor to avoid duplication.

12. In its response to *Regulating Healthcare Providers*[27] Monitor itself recommends exempting holders of General Medical Services and Personal Medical Services contracts from registration saying that:

> "Our initial view is that primary care provision could potentially be exempt from the requirement to hold the economic regulator's licence where the services are under the GMS/PMS contracts. Our reasoning is as follows:

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[23] In Monitor's responses to the NHS reform White Papers, c.f paragraph 12 below.

[24] This role is supported by Monitor in its evidence to the Committee in February: http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/796/796we05.htm

[25] http://www.oft.gov.uk/news-and-updates/press/2011/64–11

[26] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127578.pdf

[27] *Monitor Response to Regulating Healthcare Providers* 11 October 2010 p 18.

— there are no requirements to set prices associated with this form of provision;

— there is no identified need for sector-specific competition provisions; and

— the arrangements for ensuring continuity of services can be managed through commissioners and there is therefore no need to put such regulatory requirements on these providers.

However, because we would not be licensing GPs, it would be necessary to impose provisions on all other providers of NHS care."

Monitor's reasoning applies to holders of General Dental Service and Personal Dental Service contracts as well, with the exception of NHS patient charges which in any event are set by Parliament. It follows that, if the body charged with regulating providers of NHS care does not deem it appropriate to license general medical practitioners, general dental practitioners should also be exempt from the licensing structure.

The Role

13. The BDA welcomed the assurances given by the Secretary of State, Andrew Lansley MP, to the Health Select Committee's further inquiry into commissioning to the effect that the functions being given to Monitor are primarily a reconfiguration of its existing role, rather than new powers.[28]

14. It is proposed that Monitor will have a role in ensuring that commissioning is based on quality of outcome and "wider social benefit"[29] rather than just price. The BDA welcomes this approach and considers that Monitor should apply this scrutiny to the decision-making of commissioners of care.

June 2011

Written evidence from UNISON (MON 05)

1. Introduction

1.1 UNISON is the largest public sector union with over 1.4 million members working across a range of public services that help and care for the most vulnerable in our society. In the health service, UNISON has 450,000 members employed across the NHS. We are pleased to have the opportunity to make a submission to the Health Committee in relation to its scrutiny of Monitor.

1.2 As a leading voice for health and social care staff, UNISON is instrumental in influencing policy at regional, national and international level. We work collaboratively with Government and other UK and international unions on health and social care issues, including areas of practice and care. UNISON also works closely with each of the health regulators to establish standards and policies in education and patient care. UNISON is a diverse organisation, enabling us to have a broad perspective of health and social care services. We are a key stakeholder and value the opportunity to participate in any attempts to improve patient care and public protection.

1.3 We hope that the Health Committee will take into account the weight of UNISON's views. We have sought to include information which we believe the committee will find helpful.

2. UNISON Comment

2.1 UNISON has serious concerns over the potential conflict of interest between the roles of Monitor and the Care Quality Commission (CQC). We believe there to be an inherent contradiction between the business model of Monitor and the quality care model of the CQC.

2.2 With the increased powers for Monitor proposed in the Health and Social Care Bill we believe this contradiction will increase further. In promoting competition and price driving service provision rather than quality we see that situations will arise where CQC and Monitor are in conflict with each other.

2.3 For example how would Monitor deal with a situation where a Trust's business plan was either just breaking even or in need of some remedial action based on the performance indicators set by Monitor yet the CQC's assessment identifies a need for investment to improve quality standards. Any further investment by the Trust could worsen the performance indicators set by Monitor and potentially warrant increased intervention yet by such investment could get a clean bill of health from CQC. How would Monitor resolve such conflicts?

2.4 Arguing that the market can provide solutions we believe does not hold water as evidenced by the introduction of competition and private contractors in the 1980's into cleaning in the NHS with price being the driving factor and the resultant reduction in quality and increase in hospital infection.

2.5 David Bennett, Chair of Monitor, has likened the NHS to utility companies and argued that it was ripe for dismemberment following the lead of the privatised utilities and railways. UNISON has real concerns over the "level playing field" that lays ahead for NHS Trusts when Mr Bennett clearly sees plurality of provider and competition as the means of providing NHS services. How does this sit with the provision of quality care?

[28] Examination of witnesses (questions 433–528) Health Committee—Minutes of Evidence.

[29] *Choice and Competition* NHS Future Forum 2011.

2.6 We would argue that this view is further compounded by Mr Bennett quoted in the Times[30] as saying: "I think over time an amount of price competition will be appropriate," … "The question for us is, would we seek to force a degree of price competition? And we would have to be very careful about doing that because there is a risk to quality."

2.7 So risk to quality is clearly an issue and as stated earlier allowing competition and price to be the driving factors for services leads to reduced quality of service and increased risk to patient safety.

2.8 As a regulator what guarantees can Monitor provide to ensure that quality will take precedence over cost when its overall aim is focused on a business model and competition? How will Monitor use regulation to enforce quality over cost within health providers?

2.9 We believe using a business model, competition and price as the driving force for determining the provision of NHS services is too great a risk to quality care and patient safety. Light touch regulation further increases those risks. Evidence such as Mid-Staffs shows that organisations focusing on achieving their business plan and seeking to achieve Foundation status lose sight of quality and results in compromised care and patient safety.

2.10 Even with Monitor taking on board the recommendations of the Mid-Staffs enquiry earlier intervention still poses significant risks when competition and price is the prime driver for NHS services and quality secondary.

2.11 Since the Health Select Committee commenced the evidence session, the Future Forum reports have been published and on Monday the Department of Health (England) published the government response to this. However whilst the language has changed in relation to the role of Monitor we do not believe the over riding policy has changed and therefore remain concerned about the role of Monitor and its interface with the CQC.

2.12 We believe also there may be further valuable lessons to be gained from Robert Francis once the Mid Staffordshire inquiry has concluded. In particular the conflict of external regulation, and the implication of managing differing priorities relating to these reporting structures. Robert Francis said in his earlier report "if there is one lesson to be learnt, I suggest it is that people must always come before numbers"[31]

June 2011

Written evidence from the Equality and Human Rights Commission (MON 06)

Introduction

The Commission welcomes the role of the committee replacing that of the Privy Council as a means of regular and transparent national review of these bodies.

The Commission will seek to co-operate with future committee reviews to assist its own role as the regulator for equality and human rights.

The Commission will take into account the conclusions of the current committee sessions in its own responses to the human rights and equality performance of services cited in recent reports.

Our Role

The Equality and Human Rights Commission (EHRC or the Commission) was established by the Equality Act (2006) and commenced operation on 1 October 2007. It is an independent statutory body with a duty to promote equality, human rights and good relations in England, Wales and Scotland. In February 2009 the Commission received "A" status accreditation as a National Human Rights Institution. Under the Equality Act (2010), protected equality characteristics include: age, disability, gender, race, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity, marriage and civil partnership.

Summary of Submission

The Commission welcomes the opportunity to submit our comments on the committee's forthcoming review of the regulatory performance of the Care Quality Commission (CQC) and Monitor, particularly in light of the recent Winterbourne incident, the CQC Report on Dignity and Nutrition in hospitals, and the Parliamentary and Health Service Ombudsman's (PHSO) report "*Care and Compassion*". We also welcome the committee's recent review of the General Medical Council (GMC) and Nursing Midwifery Council (NMC). This submission only reflects our views concerning the first two above named bodies.

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[30] In need of a spoonful of competition to revitalise NHS—*The Times* 25 February 2011.

[31] Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 to March 2009 Volume 1, Robert Francis QC, London:The Stationery Office, February 2010.

Recommendation

The Commission would welcome a greater need for all regulators within the sphere of health and social care to have a general duty of co-operation, as proposed in the Health and Social Care Bill.

Background

1. The Health Select Committee Report of February 2011 examined the progress and issues faced by the GMC as it was undertaking its long term aim to introduce "revalidation" of doctors. It appeared particularly valuable for the committee in its report to identify a need for a more regular and transparent scrutiny of such bodies. The current sessions indicate that this wider role may now be extended to other workforce regulators as well as to service regulators, including CQC and Monitor.

2. We firmly believe that in all issues concerning the key aims of health and social care in England, there is a need for consistency and shared regulatory principles amongst relevant bodies, even as these are applied to different groups or circumstances. The Health and Social Care Bill proposals seek to strengthen regulation of key health standards such as those around patient safety, but the Commission has been concerned that with substantial devolvement of power, the net result would be more of the gaps that continue to arise and are highlighted in the above national reports. We also believe that standards can potentially help with commissioning arrangements.

3. However, the Select Committee proposals (February 2011) may contribute to ensuring regular robust and proportionate national scrutiny of regulators. This would help to challenge poor regulation that contributes to greater likelihood of abuse or lack of care, whilst actively seeking and encouraging better regulatory practice.

4. The Commission will seek to co-operate with future committee reviews in line with strategic priorities, resources and to assist in our role as the regulator for equality and human rights.

5. The Commission is currently undergoing substantial reform which will lead to a smaller more focused EHRC, acting as a regulator. Current challenges to public provision, in particular NHS reform and negative reports of abuse and financial scandals in the care sector, warrant the need for a co-regulatory approach between EHRC and key bodies in the health and care sector. This would help to clarify equality and human rights obligations and how these should be factored into the approach relevant bodies take to regulating the health and adult social care sectors.

6. A Memorandum of Understanding (MoU) was agreed on 11 March 2010 between EHRC and CQC in response to recommendation 2 of the PHSO's report "*Six Lives*" (March 2009) "... that those responsible for the regulation of health and social care services (specifically the Care Quality Commission, Monitor and the Equality and Human Rights Commission) should satisfy themselves, individually and jointly, that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory requirements". The MoU was also an important milestone to help drive the EHRC's approach to social care reform, set out in our report "*From Safety Net to Springboard*" (published February 2009). MoU objectives for the first year of operation have been focused on plugging key gaps identified in the CQC's movement towards a single registration system for providers of care.

7. As part of initial outcomes for 2010–11, EHRC and CQC have scrutinised CQC's tools for regulating the sector, resulting in identification of a need for guidance for CQC inspectors which extrapolates the equality and human rights dimensions of the CQC's essential standards (the approach used to monitor providers). This guidance will be published this summer. Another example is intelligence, whereby EHRC officials are working with CQC's intelligence team to amend how CQC staff will be able to evaluate provider compliance in respect of equality and human rights legal obligations. A further example is training, whereby agreement has been reached for EHRC Transfer of Expertise staff to work with the CQC's Learning and Development team to advise and assist with the training of CQC inspectors (and other staff). We believe this approach is ground breaking but at an early stage. We will evaluate it in due course to determine how it contributes to tackling the neglect or abuse like that cited.

8. The inclusion of rights as a back stop to what should be about common sense, care and compassion, need not be problematic or complicated. It does however back up risk based inspection that can identify and usually act on issues at an early stage, but if necessary is reinforced by the respective powers of associated regulators. Regulation and inspection must include the meaningful threat of removal of licence but have such transparency to also drive commissioning and the choices of individual users; it has to be both "carrot and stick". We argue that this is a basis for the stronger but more proportionate regulation we believe the NHS White Paper has proposed. As a simple illustration, staff may act straight away if they see a hazard, but may pass by a patient in degrading circumstances to do this. Both issues need urgent attention but current inspection and service norms have so far been better at embedding health and safety than fundamental human rights.

9. We still unfortunately find that some regulators do not adequately reflect the impact of equality or human rights to their role, creating obstacles to progress in this vital respect, but which we cannot ignore baring in mind the lessons of the above reports. At present this leaves us to either seek legal enforcement of large national bodies which is expensive and protracted, or, we would need substantially greater resources which are not an affordable option, and runs counter to our own reform vision.

10. In this context we believe the committee holds the powers to oversee all bodies, ourselves included, to ensure that regulation and regulators in the health domain are contributing to wider national aims. To this end, we will seek to provide input and to respond to future reviews in line with EHRC priorities and resources.

11. The commission will include the conclusions of the current committee sessions in its own responses to the human rights and equality performance of services cited in recent reports.

12. For some years the Commission has responded to such reports as that of the PHSO "*Six Lives*", as well as seeking proactively to establish collaboration between standard setting, regulatory and inspection bodies that could do more to prevent a "Cornwall Trust",[32] a "Maidstone and Tunbridge Wells"[33] or a "Mid Staffs"[34] case. This has been a difficult task, but we argue particularly in health that equality and human rights principles are largely co terminus with service quality, patient choice and above all patient safety.

13. In 2008 as the then Health Bill established the framework for CQC regulation and inspection, we had already agreed with the Department of Health to work with the new body on the need to embed equality and human rights in accordance with regulatory principles. Our MoU with CQC is long term but we have found CQC a willing and committed advocate of embedding rights this way. The MOU is one of our most formal joint arrangements, and there is no one size fits all manner of collaboration. The MOU also does not fetter either of our own regulatory obligations; which in the case of the commission includes the oversight of the CQC's own equality and human rights duties.

14. EHRC engaged in dialogue with Monitor during 2009–10. However, due to current NHS reforms, we agreed to park discussions about appropriate collaboration until the statutory framework of Monitor was clear. EHRC is keen to engage with Monitor when this happens because Monitor has a significant remit covering NHS foundation trusts, is likely to have an important role as economic regulator in a more diverse care market and also has its own legal obligations in respect of equality and human rights law.

15. EHRC is also mindful that forthcoming social care reform will have a significant impact on vulnerable people, particularly in the harmonisation of care legislation recommended by the Law Commission in May 2011 and the implications arising from the Dilnot Review on funding which is anticipated in July 2011.

16. We are now considering our own response to the spate of reports this spring. This does not preclude some direct enforcement action. Our own powers particularly in respect of human rights are used with great care, but we cannot ignore such reports as that of the PHSO in "*Care and Compassion*" that use terms indicating possible systemic failures. The Winterbourne View case in particular now re emphasises the need for more robust regulation. The Commission is deeply concerned about evidence of institutional abuse.

17. We still believe that the long term route we are taking alongside CQC is the best way to build proportionate and appropriate but robust regulation; though we hope the committee has the opportunity to discuss with them on the modes of inspection most likely to observe some of the degrading treatment that has been observed in reports this spring. For example, it was very effective for CQC to use experts by experience and unannounced spot visits at odd times in their Dignity and Nutrition report. It may be in the public interest to use the covert forms of inspection via broadcasters like the BBC Panorama programme on Winterbourne View if it will help prevent breaches of fundamental human rights. We do not have such powers to conduct unannounced visits, but as part of our collaborative regulation arrangements we are seeking to use powers in a complementary fashion. For example, we can work with others where indications of risk may flag up an urgent need for them to carry out visits, and/or follow with their own or our powers of further investigation.

18. Winterbourne View also strongly suggests that staff cultures, attitudes and behaviours can be so powerful as to allow them to adopt a caring appearance that would cover up abuse even on spot visits, particularly when they have situational power over people in very vulnerable circumstances. In turn, this suggests the need to cross reference action by service regulators with equivalent steps by professional regulators who must also recognise their role in ensuring the right conduct and competences are in place for both new and existing staff. We welcome the review of some of these bodies now by the committee.

19. As part of the Commission's submission on the Health and Social Care Bill, we have suggested that the duty of co-operation between CQC and Monitor should in fact be a general duty for all regulators working within health or social care. The scrutiny role of the committee would be a regular effective forum to require bodies to justify their individual or joint action in pursuit of greater patients' safety, service quality or reduction of health inequalities.

20. The Commission would be happy to further discuss the issues raised in this submission with the committee or individual members as deemed appropriate.

June 2011

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[32] http://www.communitycare.co.uk/Articles/2006/10/12/56048/Cornwall-Partnership-NHS-Trust-gets-lowest-rating-for-quality-of-learning-difficulty-services.htm

[33] http://www.guardian.co.uk/society/2007/dec/14/nhs.health?INTCMP=SRCH; http://www.telegraph.co.uk/news/uknews/1565780/Case-studies-Wretched-death-of-C.diff-victims.html

[34] http://www.telegraph.co.uk/health/healthnews/7306349/Patients-abused-and-neglected-by-hostile-staff-at-scandal-hospital-inquiry.html

Written evidence from the Association of Directors of Adult Social Services (MON 07)

Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children's Social Care within their Local Authority.

ADASS welcomes the opportunity to contribute to the work of the Health Committee with regard to the scrutiny of both the Care Quality Commission (CQC) and Monitor and makes the following points:

Care Quality Commission

ADASS acknowledges that the Care Quality Commission has been through a period of very substantial turmoil over the past decade as the role of regulation and performance improvement has seen many changes in policy and direction. Above all, we would like to see CQC develop with confidence its proposals to be a world class regulator, and develop the processes, partnerships and staff competences that would accompany this.

1. ADASS welcomes the expertise and understanding of the value of the social model held by CQC. The achievement of user outcomes rely upon an integrated approach and CQC work reinforces this connection. It will be critical that as CQC evolves that this is maintained and expanded, and builds on the organisation's very strong traditions in citizen focus and involvement.

2. ADASS welcomes the new arrangements towards "Sector-led Improvement" following the discontinuation of CQC activity in making council annual judgements. Councils (ADASS) are well placed (in terms of expertise) to drive forward sector-led improvement and within these rapidly emerging dynamics. The role of CQC in undertaking risk based inspections is seen as an important dimension in complementing the public assurances provided by the sector. We welcome the new balance being placed upon the sector taking responsibility for itself as the starting point for management. ADASS retains concerns that "sector led" is being applied to councils only and that the care sector as a whole is not investing enough in its own performance and quality systems.

3. Following the cessation of ratings of providers, ADASS retains concern over implementation of the replacement Excellence Scheme (this is still subject to consultation, which closes on 1 August) with specific reference to the proposals to only differentiate excellence to those providers that pay a fee to CQC to register for the Excellence Scheme, whilst other providers not signing up to the scheme will be restricted to being differentiated as either meeting essential standards or not. We think that this "opt in" system will not help the public with easy to access and understandable ratings of all care provision.

4. ADASS expresses concern over availability of updated information on providers judged performance on the CQC website, which can be three years or more out of date. We acknowledge that this is compounded by the change in legislation under which CQC stopped awarding quality ratings from July 2010, but the considerable time-lag restricts the public from making informed choices about providers at a time when national policy supports choice as a core value.

This concern about currency of existing CQC judgements is also compounded by the experience of Directors (and reinforced by recent analysis by Community Care magazine obtained by FOI requests) of significant drop in the number of inspections and the availability of CQC Inspectors and support staff. We think on reflection this movement has been ahead of the ability of providers and commissioners to strengthen the sector led approaches.

ADASS notes the shift by CQC towards risk-based inspections and the proposed increased use of remote intelligence to trigger inspections. Whilst the emphasis upon reduce burden is welcomed, ADASS is concerned as to the reliability of remote intelligence systems as opposed to face-to-face contact, alongside the perception that service users, carers and families do not always exercise their rights to complain and staff maybe reluctant to whistle-blow on poor practice.

5. In response, ADASS acknowledges the collaborative approach being taken by councils, health partners and providers in leading improvements, and ADASS has developed Advice Notes to further strengthen approaches to safeguarding vulnerable adults.

6. ADASS also notes the considerable attention that councils give to work with providers to drive up standards. Councils are heavily engaged in contract monitoring and have extensive contact with service users through assessments, reviews and ongoing working. These activities provide councils with the intelligence and leverage to seek improvements in service delivery and securing improved outcomes for service users and carers. ADASS would want to work with the support of providers to reinforce the legitimacy of these roles.

7. ADASS welcomes coproduction with the Department of Health in the design of a new integrated outcomes framework and ADASS notes the valued input of CQC in this process. This collaborative approach signals a new relationship between national and local structures and importantly establishes the pursuit of improved outcomes as the key driver for the health and social care sector.

8. ADASS welcomes the Government's response to the NHS Future Forums recommendations to increase level of user, carer and citizen engagement in the health and social care system. The interface between CQC, HealthWatch, Councils, Health &Wellbeing Boards , the NHS Commissioning Board and providers require further details but ADASS feels confident that the expertise held in both CQC and councils can greatly contribute to the development of the approach.

9. Finally, ADASS is fully engaged in the development of quality standards through active participation in the NICE work programme. The development of these standards has clear reference to the work of CQC and provides another example of collaborative approaches to secure improved outcomes for service users and carers.

Monitor

10. ADASS welcomes the Government's response to the NHS Future Forum's recommendations to re-focus the emphasis of Monitor upon choice and quality. This is considered an important development to providing cohesion across the whole sector towards securing improved outcomes for service users, carers and the wider public, whilst also stimulating choice and control. This is entirely consistent with the Vision for Adult Social Care, published by the DH and endorsed by ADASS.

11. ADASS suggests that Monitor's role in pursuing choice and quality imperatives alongside competition will need to develop explicit guidelines for the development of integrated services under partnership with other public sector provider (these guidelines should have flexibility to identify risks and rewards across the system in preference to a solution driven by profitability in the Foundation Trust model). We presume too that this will require the evolution of relationships between Monitor and local Health and Wellbeing Boards.

12. ADASS welcomes the role of Monitor to add financial audit/scrutiny into the system and ADASS strongly urges that this financial expertise is also applied in the financial evaluation of large providers as part of the commissioning process. This expertise should complement the service delivery expertise held by commissioners and combined should provide public assurance on both the quality and stability of providers.

June 2011

Written evidence from the Foundation Trust Network (MON 08)

Introduction

1. The Foundation Trust Network (FTN) is the membership organisation for authorised NHS foundation trusts and those aspiring to achieve foundation trust status. We have over 200 member organisations providing care across the acute, mental health, ambulance and community services sectors.

2. The FTN welcomes the opportunity to inform the annual reviews being carried out by the Committee. Our comments are limited to the Care Quality Commission (CQC) and Monitor as the primary regulatory agencies to which FT boards are held to account.

Executive Summary

3. In our brief submission we argue for:

- continued separation of regulatory functions in respect of quality and finances;
- a pan-NHS dialogue on appropriate applicable quality standards;
- clarity on the role commissioners have in quality oversight;
- a risk-based, proportionate and effective approach to quality regulation;
- an appropriate accommodation of different care settings by the regulators;
- further exploration of how care pathways as well as organisations can be regulated effectively;
- a continuing clear rationale for data collection;
- appropriate inter-action of CQC and Monitor in exercising their functions;
- alignment between policy and regulatory activity; and
- monitor to develop appropriate community services indicators as soon as possible.

Care Quality Commission

4. The FTN agrees that there should be a robust system of quality regulation that gives the necessary assurances to patients and the public about the standards that can be expected from the service. We are in no doubt that achieving this will be a significant challenge.

The need for separation of regulatory functions

5. There is a question of whether quality and financial regulation should be integrated into the functions of a single regulatory body—we do not consider this would be appropriate in health given the experience of other industries, where because quality potentially loses out relative to financial concerns they have been kept

separate. To give an example, in the case of the water industry, Ofwat undertakes pricing and the Environment Agency and the Drinking Water Inspectorate are between them responsible for water quality standards. However, there does need to be a coherent understanding between the regulators of the cost of achieving requisite quality standards for the purposes of price setting and affordability in the system.

Standard setting

6. As there is no direct payer relationship between the provider and the consumer accessing NHS services and because a finite resource available through government allocations, a tailored approach to determining industry-wide quality standards is necessary distinct from other regulatory regimes. An accommodation needs to be reached between the regulator, providers and other stakeholders on what quality standards are required and acceptable.

Role of commissioners

7. Among the other stakeholders, commissioners will undoubtedly be concerned with health outcomes which suggests a legitimate concern in respect of quality, but the shape and extent of this role is as yet unclear and would benefit from further clarity, having due regard to who is accountable for quality and avoiding undue bureaucracy.

A risk-based approach

8. CQC must be risk-based regulator. While the CQC states this intention we consider that this needs to be demonstrated more in its actions—there should be a more strategic analysis of issues which lead to appropriate responses. There is growing evidence from recent inspection activity that the CQC needs to re-examine its approach to the principles of Better Regulation, including proportionality, transparency and consistency.

9. We are concerned that the CQC currently has insufficient means of compiling and analysing data into a reasonable set of risk profiles which we believe has led to behaviours being exhibited which are unhelpful in the promotion and support of improved quality outcomes.

10. We believe CQC interventions are occasionally disproportionate and inappropriate with an undue focus on, and escalation of, essentially immaterial matters leading to the consequential risk of issues of greater significance becoming more difficult to distinguish and observe. The FTN is receiving escalating member concerns that the classifications of incidents in its inspectors' reports are causing unnecessary problems for providers in mental health and community services—in particular:

— the current classifications of minor, moderate and major and the lack of proportionality in the approach of inspectors on allocating breaches of compliance by category, where we have many examples of relatively trivial breaches that are clearly recognised as not being systemic and which do not impact of patient care being categorised as major;

— an inconsistency around guidance on registration where some organisations have had to register many sites and other only a few leading to the lack of a level playing field;

— a large number of examples showing a lack of consistency in categorisations between different inspectors across different sites;

— the lack of dialogue around reports;

— a media approach that sensationalises incidents and unnecessarily damages the reputation of organisations for relatively trivial breaches; and

— a number of organisations having lost business as a result of an intemperate approach by the CQC when dealing with minor and moderate concerns;

11. The detrimental impact can be further compounded by how these measures are reflected in the Monitor Compliance Framework risk ratings. The FTN has discussed its concerns directly with the CQC which has appeared receptive and responsive to our concerns. We look forward to working with them on resolving these issues at the earliest opportunity.

12. We would also observe that the approaches taken by the CQC are dominated by an acute care mindset which is an inappropriate means of gauging the standards of, for example, mental health and community services. All healthcare services should be judged with equal rigour but the judgement should be made with due regard for the setting in which the care is provided.

Care pathways and being fit for purpose

13. There is increasing focus in the service on the need to develop patient-centred care pathways as a means of improving patient experience, quality outcomes and productivity levels. However, to date, the CQC has been a regulator of organisations rather than pathways. As pathways become more widespread it will be important that the regulatory regime reflects this in its working.

14. As part of the debate on being fit for future purpose, it will be important that organisational resources required to be given over to the task, both at a CQC and provider level, do not divert any more resources than are necessary away from patient care.

15. There should be a clear rationale behind data requests and there needs to be a wider public understanding of the resource implications of collecting data—information is a powerful and welcome driver to underpin performance improvement and accountability but within finite resources of the NHS spend, new data requests will necessarily impact on what funds remain available to invest in patient care.

Inter-action with Monitor

16. The CQC's judgements and analysis of quality are fundamental to the functioning of the system and as such they need to be credible. The inter-action of the CQC and Monitor's activities and how they inform each other means that if CQC escalates issues through defensive behaviours, this impacts on the risk-rating that Monitor will give organisations and give rise to perhaps unnecessary monitoring activity.

17. The CQC should have at least some regard for economic data to be able to appreciate the relationship between financial pressures and quality thresholds—though the decision about trade-offs between finances and quality (assuming market-entry quality criteria are met) should remain a clear responsibility of provider boards.

Monitor

18. Monitor has been enormously important in bringing better standards of financial discipline to NHS providers. It takes a welcome risk-based approach to regulation (insofar as it can rely on others' judgements by way of proxies as outlined above) and the Compliance Framework has provided a useful set of disciplines to which FTs can work.

19. We are presently evaluating the impact of the revised proposals for Monitor's role as a result of the NHS Future Forum's listening exercise and government response, but will limit our comments here to extant arrangements.

Flexibility

20. Monitor's approach is rational and while we would sometimes consider that their chosen measures could be better if different, or that there could be greater discretion around interpretation of measures, this is normally a direct consequence of having to regulate with regard to the extant DH operating framework requirements.

21. We would observe that while this has been reasonably acceptable to date, we do have concerns that the extension of this principle to current DH operating framework policy, for example on readmissions, could soon put unnecessary strains on the sector—as such there could be some benefit in Monitor being given further freedom to apply a degree of flexibility.

22. To illustrate by example, our experience of the readmissions policy has highlighted incongruence between Monitor acting as regulator and DH wanting to evaluate the impact of new policy. Here, Monitor legitimately wants to see progress on realisation of cost improvement plans across all year quarters, whereas DH wants to evaluate the impact of the readmissions policy in quarter 1 which suggests it would be prudent for providers to wait for the conclusions of this review before committing irretrievably to a particular course of action.

23. It will be important that Monitor develops with some urgency appropriate measures for community services and we note the current consultation taking place in this regard. We would make the same point that we made about the CQC above that the indicators chosen need to be appropriate to the care setting.

24. The key concern we currently have is in the inter-action between Monitor and the CQC. Monitor rightly relies upon the CQC for judgements on quality. If these are disproportionate, this is compounded by the Monitor Compliance Framework risk ratings and what can be a minor series of non-systemic issues that do not in any way endanger patients, and where the recovery plan has been accepted by the CQC, can earn the foundation trust an 'amber-red' or even 'red rating' for governance. This can have a knock on impact on the financial arrangements with banks and other lenders that puts well performing foundation trusts in danger of losing banking arrangements that were agreed on a more favourable risk rating.

June 2011

Written evidence from the NHS Confederation (MON 09)

About the NHS Confederation

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation representing all types of providers and commissioners of NHS services. The NHS Confederation includes the NHS Employers organisation, which represents NHS organisations in England on workforce issues and has particular expertise of professional regulation.

Our response complements that of the NHS Confederation's Partners Network, which represents independent sector providers of NHS care, and of the Foundation Trust Network, which reflects the particular perspective of NHS foundation trusts.

1. Executive Summary

- Our submission covers general points on regulation, including the contribution of professional regulation and commissioning, but concentrates on the operation of the CQC and Monitor.
- Effective regulation is fundamental to maintaining public confidence in services and ensuring patients receive safe, effective care.
- Clear, realistic expectations are needed of what regulation can achieve in terms of standards of care: the NHS Confederation believes regulation should only be responsible for minimum standards of entry either to a profession or for organisations to the market.
- CQC, Monitor, GMC and NMC regulation are just part of NHS regulatory and oversight mechanisms. There is a complex range of requirements that result in overlap and duplication, but potentially also failure to act on issues of poor quality care because of confusion about responsibilities. Better alignment of the different types of regulation and processes is needed.
- The legislative framework and associated regulations have provided an unduly onerous framework for CQC registration, which has been hampered in its operation by insufficient CQC resources.
- The trust or organisation-level unit of registration is too large to provide the public with meaningful assurances of care standards care in particular units or facilities.
- Our members have particular concerns about the operation of the CQC and question whether it is fit for purpose including:
  - The CQC is insufficiently risk-based or proportionate in its approach.
  - It is insufficiently independent of government.
  - CQC's model of regulation and inspection is:
    - Too generic and takes insufficient account of the particular considerations for different types of service.
    - Insufficiently flexible to respond to emerging models of care or service changes readily.
    - Inconsistent with variations of approach between regional offices and inspectors.
    - Not sufficiently effective in influencing standards of care provision and does not represent value for money.
  - Registration processes are cumbersome, bureaucratic and poorly administered and subject to significant delays.
  - CQC information, advice and guidance have been inadequate and not available sufficiently early in processes.
- We recommend the CQC:
  - Develops a constructive relationship with our members to determine a more effective regulatory model and approach.
  - Adopts a more-tailored approach to regulating the different types of services.
  - Provides named CQC contacts to give consistency and continuity for providers.
  - Reviews the use of 'location' as a key concept for registration as this has been difficult to apply meaningfully in some services.
- The costs of regulating health and social care are significant and primarily met by providers, including the costs of administrative and management processes to comply with regulatory requirements. For public-funded services, this can divert resources from front-line care.
- Economic and quality regulation should remain separate but closely-aligned. Monitor and CQC must be held accountable for how they discharge their duties to cooperate.
- Setting the legislative framework for Monitor's new role will be crucial to its effective operation as sector regulator. However, it will be essential to learn and develop future policy from its operation. This would be aided by setting out how it conducts its role in secondary legislation which could be more-easily amended if unintended consequences occur.

- We would like to see a clearer statement of intent at the outset about how the procurement and competition regimes will operate and how Monitor will balance its competing duties.
- We welcome proposed amendments to the Health and Social Care Bill that would allow the Secretary of State (SoS) to report on national organisations, and we expect the SoS to assess regularly how Monitor fulfils its role and duties in the interest of patients and taxpayers.
- When considering our evidence, we urge the Committee to bear in mind the following points on the overall regulatory system:
    - Member concerns about the bureaucratic nature of many requirements.
    - The need for the government to take a systematic and longer-term approach to regulation, which should be informed by the findings of the public inquiry into Mid Staffordshire NHS Foundation Trust.
    - The need to clarify the role of commissioners in promoting and assuring quality.

2. Introduction

2.1 The NHS Confederation supports strong, effective regulation. This is fundamental to reinforcing public trust in both the individuals and organisations providing care, and to helping safeguard patients and ensure they receive high-quality and safe care provided by well-run organisations.

2.2 As organisations working in the public interest, regulators must be accountable for their performance and practice. We therefore welcome this opportunity to submit evidence to inform the Health Select Committee's scrutiny of the CQC and Monitor. Our members have direct experience of the requirements and operation of these regulators on a daily-basis and are well-placed to make observations about their effectiveness.

2.3 Our submission draws extensively on member feedback and intelligence, as both providers and commissioners of care, and employers of healthcare professionals. It also draws on NHS Confederation seminars held in winter 2010–11, which considered how economic and quality regulation should operate and included participants from patient groups, other interested parties and NHSC members.

2.4 Our submission covers:

- The proper role and operation of regulation.
- The extensive regulatory and oversight structures for healthcare, and their inter-relationships, including between regulation and commissioning.
- CQC's role as a quality regulator, including detailed comments about its operation and registration.
- Bureaucracy and the costs of regulation.
- Monitor's future role.
- Coordination of quality and economic regulation.

3. The Proper Role of Regulation

3.1 The NHS Confederation believes that it is essential all regulators have clear objectives and understanding of their role (and how this relates to other regulators), which underpins their operation. Our recent regulation seminars identified five key elements as the proper focus of regulation:

- Protecting people from harm, especially the most vulnerable in society.
- Protecting and promoting the patient interest.
- Assuring the quality of services and delivery of good outcomes for patients.
- Ensuring access to essential services.
- Changing behaviours and internalising good practice to achieve the desired objectives.

3.2 All regulation should be consistent with better regulation principles, ie risk-based, proportionate, consistent, targeted, transparent and accountable. However, we question whether current healthcare regulation consistently adheres to these principles.

3.3 We suggest there is a need for much greater honesty with the public about what both professional and service regulation can deliver. A realistic understanding is needed of what regulators can actually achieve, and the likely costs of different regulatory approaches, which should inform their practical operation. We believe regulators should be responsible for setting minimum standards that guarantee entry to a profession or allow organisations to provide care. Responsibility for improving quality lies elsewhere, not least with providers themselves.

3.4 Recent debate has questioned whether existing regulatory structures can prevent failures in care, often advocating a more inspection-based approach. However, inspection-based regulation can only give assurance that things were right at a particular time and location, although inspections (including unannounced inspections) should be an important tool for any regulator. No regulatory system can ever prevent all failures of care, and designing a system that seeks to do so is likely to be unsustainable financially and overly-disruptive to delivering care.

3.5 The NHS Confederation believes primary responsibility for delivering safe and high-quality care and ensuring organisations are well-run and financially viable lies with the Board and frontline clinicians. The regulator's role should be to encourage providers to develop more robust systems for monitoring and delivering quality, and to reinforce that with an effective enforcement regime.

4. Current Regulatory Framework for Healthcare

4.1 While important, the GMC, NMC, CQC and Monitor are not the only regulators with oversight for healthcare standards. In the joint NHS Confederation/Independent Healthcare Advisory Services report *What's it all for?*[35] we identified over 69 bodies with oversight of healthcare providers, including powers of regulation and inspection. These include the Health and Safety Executive, other professional regulators (such as the Health Professions Council), the Medicines and Healthcare products Regulatory Agency, and many others. Additionally, commissioners have an important role in assuring quality.

4.2 We are concerned there is a tendency to view individual regulators in isolation, without recognising the interconnectivity of their roles and impact on healthcare provision. Often responsibilities overlap and there is insufficient clarity about respective roles and functions. This can not only result in duplication, but also cause things to slip through the cracks, as there is insufficient clarity about who is responsible for taking action. Effective regulation requires all regulators to find ways of managing their respective roles and inter-relationships, and any potential tensions between their different roles and objectives (such as between quality and access, competition and safeguarding services) to deliver over-riding benefits for patients.

4.3 Despite the many bodies with oversight of the quality and safety of healthcare, high-profile failures of care continue to raise significant questions about the effectiveness of current regulatory structures. This undermines public confidence in the regulators' ability to prevent unacceptable standards of care/safeguard those using services. Recent events have particularly called into question the CQC's effectiveness, and its ability to safeguard vulnerable individuals.

4.4 Each high-profile failure of care tends to result in ad hoc regulatory responses, and the incremental growth of regulatory and oversight processes. These are often costly, burdensome, duplicative and bureaucratic, and add little to guaranteeing quality, safety and access for patients.

4.5 A more systematic approach is needed, and we hope the public inquiry into Mid Staffordshire NHS Foundation Trust will result in a sensible and considered approach to the respective roles and functions of the different parts of the regulatory and oversight structures. This should avoid another costly and radical revision of regulatory structures. Such an approach is particularly important given current proposals for Monitor to take on the role of sector regulator for health and social care, particularly to clarify how it should operate and work with the CQC in discharging its responsibilities.

4.6 A significant gap in the current structures is how to deal effectively with service failure and closure of services, particularly where they are uneconomic or (as in the case of Southern Cross) are provided by financially unsound organisations where the market seems unable to develop an acceptable solution of its own accord. This issue must be addressed before the proposed health reforms begin to take effect.

5. Professional Regulation

5.1 Professional regulation should set the standards for education and training, competence and conduct for individual professionals, which help to create a culture and guide individual professionals to act in patients' interests. These apply and be enforced whether individuals work as clinicians or as managers.

5.2 The NHS Confederation has supported the revalidation of doctors and NHS Employers has worked to develop appropriate processes to achieve its implementation. Revalidation can provide useful checks of individual professionals' competence, but these should be part of a wider system of appraisal and performance assessment by employers. Employers must have appropriate systems in place, and it is their responsibility to pick up early indications of a failure to deliver appropriate care and take action.

5.3 It is also important that professional regulators and the CQC are clear about their reciprocal responsibilities in the quest to maintain quality and ensure that information is shared readily and appropriately with each other.

6. Regulation and Commissioning

6.1 Commissioning can play an important role in driving quality and access, but there is currently no agreement about the role of commissioners as part of NHS regulatory and oversight structures.

6.2 The Health and Social Care Bill is clear that clinical commissioning groups will have a duty to seek to secure continuous improvements in the quality of services and health outcomes. While agreeing these are core functions for commissioning organisations, our members have warned against loading responsibilities for quality monitoring and service improvement on commissioners in a way that is inappropriate and undeliverable.

[35] NHS Confederation and Independent Healthcare Advisory Services (2009) *What's it all for?*

6.3 A distinction should be drawn between these commissioning responsibilities and the responsibility of all organisations providing NHS services to ensure their quality, safety and effectiveness. A more realistic view of commissioners' responsibility and scope in the new system should include:

— assuring themselves only registered providers are added to local service directories;

— gathering patient and public feedback of their experiences of using services;

— monitoring trends in reported experience and outcomes, complaints and serious incidents;

— making this information available to the public and to individual referrers in accessible formats; and

— taking prompt, appropriate action if any information received gives cause for concern or further scrutiny.

6.4 In practice, the 'right' approach will depend on factors such as the number of providers a commissioner relates to, their quality and safety record and the local priorities for health and service improvement, but no approach will be comprehensive or fail-safe.

6.5 The NHS Confederation believes agreement is needed on what is a reasonable and appropriate role for commissioners in assuring and promoting quality, and their responsibility to quality regulators. It will be especially important that the new clinical commissioning groups and NHS Commissioning Board do not develop additional regulatory-type requirements for providers that duplicate CQC requirements or act as barriers to entry for new providers.

7. CQC'S Role as a Quality Regulator

Strategic concerns about the CQC

7.1 Many of our members, both NHS and independent sector providers, have considerable concerns about the operation of CQC, the current registration system and its model for monitoring quality. They question whether the CQC is sufficiently risk-based or proportionate in its approach and model of regulation is well suited to current and emerging models of care, particularly its ability to assess quality across patient pathways.

7.2 Fundamentally, there is insufficient clarity about whether CQC's focus should be "quality" regulation or assuring minimum standards. We suggest CQC can only set and enforce the minimum standards of safety and quality all providers must meet in order to provide care. While these standards may rise over time, operating these minimum requirements for entry to the market effectively must be CQC's core role, particularly given proposals to encourage new providers of NHS services.

7.3 We suggest the CQC lacks sufficient independence from government, making it difficult for them to be an objective advocate of quality, particularly at a time of significant public expenditure constraints. This raises questions about whether the CQC should speak out about the impact of funding constraints on its capability to discharge its functions and, more generally, the impact on quality for publicly funded health and social care services.

7.4 We are concerned the CQC is being expected to do more, including taking on regulatory functions from other bodies, but with limited resources and when the efficacy of its current approach is being fundamentally questioned. Pressure on CQC resources has resulted in the demise of positive initiatives to promote active information sharing with other regulators and co-ordination of activity (planned collaborative reviews) and the end of service reviews looking across pathways.

7.5 We also suggest that the CQC is insufficiently accountable for the cost-effectiveness of its operation and quality and performance of its regulatory approach. Feedback from our members continues to question CQC's effectiveness and its actual impact on quality and safety standards. We believe the CQC should consult regulated providers to help determine its regulatory model and approach, which would be consistent with better regulation principles.

Concerns about the CQC's approach to registration:

7.6 These include:

— Their generic model underpinning registration means that sometimes guidance does not make sense in the context of the particular service being inspected or inspectors do not understand the services they are inspecting adequately. This is a particular concern for providers of mental health, ambulance and community services, who often state that the CQC's approach is too acute and social care focused. For example, it took significant time to resolve issues for the registration of air ambulances.

— CQC's approach lacks sufficient flexibility to accommodate new service models or rapid service changes readily. At a time of major service change in the NHS, this presents particular problems for maintaining service continuity while changes to registration are made.

— The unit of registration (the NHS trust or group in the case of independent sector healthcare and social care providers) is too large to provide a meaningful assessment of quality for users of services. This will be increasingly important as NHS trusts amalgamate and provide a range of services in different settings.

— Some service providers have found the key concept of "location" difficult to apply meaningfully to their registration, particularly ambulance services and services provided in the community and people's homes.

— CQC's apparent failure to coordinate activity and share information internally, eg between those undertaking assessments of mental health providers under the Mental Health Act and more general inspections.

Use of Quality Risk Profiles

7.7 Our members have several concerns about the CQC's Quality Risk Profiles (QRP) and CQC's reliance on QRPs to pick up early indications of poor quality care and provide the basis for action. These include:

— the accuracy of some information contained in their QRP; and

— whether QRPs take sufficient account of the intrinsic risks associated with certain procedures and types of care or the vulnerability of service users.

7.8 Members of our Mental Health Network have particularly questioned the CQC's understanding of risk in a mental health context.

CQC processes

7.9 Members have found CQC processes often cumbersome, bureaucratic and poorly administered, with delays in responses. This results partly from the current legislative framework, which requires providers to notify the CQC of detailed service changes. This imposes significant burden on providers and the CQC, which has apparently not had sufficient resources to deal with these applications quickly and effectively. Examples include:

— Providers must notify any change in registered manager, even if the registered manager held this position at another of the provider's locations.

— Providers must submit a new Statement of Purpose with each registration application and variation.

— Delays in providing submission references for forms submitted electronically making it difficult for providers with multiple CQC applications.

— Delays in issuing certificates and processing variations to registration.

7.10 Our members indicate that CQC advice and information has not been sufficiently consistent, clear or timely. In particular:

— ambulance trusts, mental health trusts, community and independent sector providers report inconsistent advice and approaches by different regional offices;

— the CQC website is poor with limited availability of online forms and inadequate guidance to support their completion; and

— CQC helpline staff do not appear to have the necessary knowledge to provide the clarification of guidance required.

7.11 The requirements of registration and ongoing compliance are complex, and organisations need practical, detailed information to help navigate them. Our members suggest that registration should be underpinned by a better understanding of how different types of service are provided in the NHS, with more tailored guidance for different types of service, including using specialist inspectors. They would like to see named CQC contacts to provide continuity and consistency, and improve the quality of advice. This should contribute to a more effective and tailored approach to quality regulation that is better able to pick up early indications of poor quality care.

Bureaucracy and the costs of regulation

7.12 The costs of operating the CQC and associated administration in providers to monitor and demonstrate compliance are significant. Preparing for registration and on-going compliance are immensely bureaucratic processes demanding significant resources. Our members continue to question whether this provides value for money, particularly its impact on quality and safety standards.

7.13 All providers, including the NHS, pay fees to cover CQC's costs of operating registration, and are on a trajectory to cover these costs fully. Despite initial promises that registration would be cost-neutral to the NHS, NHS organisations pay significant fees to the CQC. Some providers have faced considerable increase in this year's fees, which have been difficult to fund in the current financial climate, and in some cases, diverted funding from frontline services.

7.14 NHS Confederation members continue to highlight the significant, on-going costs, processes and functions associated with CQC registration. Given current government commitments to reduce bureaucracy and red-tape, we find it surprising the statutory regulatory systems are major drivers of this. Many members believe more could be done to simplify CQC's burden on providers without undermining its effectiveness. This should yield administrative cost savings for providers and result in reduced fees.

7.15 The NHS Confederation believes the CQC should be more transparent in setting its fees, particularly explaining how these relate to the costs of regulating different sectors, and the CQC fee structure should include incentives for providers to improve their quality. We are concerned that the latest scandals may result in a significant shift to the CQC adopting a more direct/inspection-based approach, with all providers having to bear the full extent of these costs irrespective of their quality and safety standards. We suggest that if a level of regulation and scrutiny is required in the public interest, these costs should be borne centrally by the public purse rather than diverting resources from front-line patient care.

8. Developing the Role of Monitor

8.1 NHS Confederation members are familiar with Monitor's risk-based operation as regulator of NHS foundation trusts, which has helped to drive up financial and governance standards.

8.2 Current health reforms propose a new role for Monitor as sector regulator for health and social care. This has caused significant concerns, particularly the rigid application of economic regulation and competition principles to the English health market, which is relatively undeveloped and has some peculiarities, such as commissioners as third-party payers.

8.3 The NHS Confederation believes creation of an appropriate economic regulation regime and regulator is an essential part of the new system. However, this must be:

- based on a primary duty to protect and promote the interests of people who use healthcare services and taxpayers by promoting the economic, efficient and effective provision of NHS services; and
- tailored and able to be applied flexibly to different types of service and locality.

8.4 We welcome the government's recognition that the Health and Social Care Bill should place an additional duty on Monitor to promote co-operation and integration where appropriate, alongside its duty to promote competition.

8.5 A clearer statement of intent at the outset about how the procurement and competition regimes will operate and how Monitor will balance its competing duties would provide some reassurance. It is important to be clear that Monitor's role is to provide a framework to support local commissioners rather than make local decisions, but that where local commissioning decisions are challenged, Monitor will judge the appropriateness of them.

8.6 Careful consideration is needed in setting the legislative framework for Monitor's new role as sector regulator to avoid creating perverse incentives and unintended consequences. These might be overcome by setting out Monitor's high-level duties in primary legislation, with detail of how it conducts its role expressed in secondary legislation, which can be amended if unintended consequences emerge.

8.7 There will undoubtedly be a period of learning and it will be important to ensure there is an opportunity to learn and develop policy and carry out proper evaluation. We believe that the Secretary of State for Health could be responsible for regularly assessing how Monitor is fulfilling its role and duties in the interests of patients and taxpayers.

9. Coordination of Economic and Quality Regulation

9.1 Ensuring close integration and alignment between economic, service and professional regulation is vital, in theory and in practice, for effective regulation and to minimise duplication and overlap, and ensure the adequate provision of safe care. For example, some elements of CQC registration already relate to the financial viability of organisations.

9.2 Recent evidence sessions at the Mid Staffordshire public inquiry have highlighted the benefits of a single economic and quality regulator for health and social care. While this could lead to better co-ordinated economic and quality regulation, we are concerned there is a danger quality will be continually trumped by economic considerations.

9.3 On balance, the NHS Confederation believes separate economic and quality regulators are more appropriate. However, Monitor and CQC must be held accountable for how they discharge their duties to cooperate and practically work together to safeguard and promote patients' interests effectively. We also suggest better alignment of financial incentives and quality objectives is essential to ensure better coordination of approach.

June 2011

Supplementary written evidence from Monitor (MON 02A)

1.0 Introduction

1.1 This written memorandum addresses points raised by the Committee in Monitor's oral evidence session that we wish to respond to in greater detail in order to assist the Committee. In particular, it addresses Monitor's proposed new role as set out in the Health and Social Care Bill, as our last written submission was produced during the Listening Exercise and therefore did not cover this.

1.2 This submission does not address all of the elements of Monitor's current or proposed new role.

2.0 Monitor's Proposed New Role Following the Listening Exercise

2.1 Following the Listening Exercise, the Government set out changes to the Health and Social Care Bill. A number of these changes impact on the role proposed for Monitor. This section outlines what the key elements of Monitor's role would be if these changes are approved by Parliament, and how we would carry out our proposed new role.

How Monitor would carry out its proposed new role

2.2 Much of the detail of how we would carry out our duties (whether with regard to the provision of integrated care or more broadly) is something we will need to work out. However, our absolute priority is that everything we do must be driven by what is best for patients.

2.3 Supporting this, there are a number of principles we will be guided by in carrying out our proposed new role:

- We will need to be measured in the steps we take.
- We will do our best to take account of the capacity of the system to change and to balance this against the need for change.
- We need to make decisions on the basis of evidence and facilitate the collection of new evidence where it doesn't currently exist.
- We will also be alive to the specific circumstances of health, even as we seek to learn lessons from elsewhere.
- We will make sure we consult widely before acting, so that all relevant voices are listened to.
- Above all, we will need to listen to the patients' voice. It is their voice and their needs that matter most.

2.4 What is also clear is that Monitor will have to be flexible so that we can support innovative commissioners and providers.

2.5 We do not underestimate the extent to which this will require a change in culture at Monitor. Up to now our focus has been on institutions—the foundation trusts—albeit with the interests of patients and taxpayers as a backdrop. Their interests now need to come to the fore. Whatever we do must be driven by what is best for patients and for taxpayers.

Monitor's continuing responsibilities during transition

2.6 Although the blanket 2014 deadline for an all foundation trust provider sector has been lifted, all trusts will be required to become foundation trusts as soon as clinically feasible. There will be an agreed deadline for every trust and the majority are expected by the Department of Health to meet this date.

2.7 There are currently 138 foundation trusts (as at 1 August 2011). There are c.95[36] NHS acute and non acute trusts, nine ambulance trusts and 16 community trusts still to become foundation trusts. Monitor will continue to assess and authorise these trusts as they work to become foundation trusts by 2014.

2.8 To become a foundation trust, the organisation must be able to demonstrate that it is financially robust and that it has strong governance, both in terms of quality and finances. In Monitor's view, these are standards that all providers of NHS care should be expected to meet.

2.9 We believe that the process of preparing for, applying and achieving foundation trust status improves the quality of governance and financial management at a trust, to the benefit of patients and tax payers. There is analytical evidence to support this view.

2.10 The autonomy and freedoms that come with foundation trust status ought also to lead to continuing improvements in performance as compared with non-foundation trust status. Insofar as there is evidence that this is not happening, Monitor needs to work with policy makers and foundation trusts to understand whether changes might be made to address, for example, any barriers to innovation and improvement.

[36] There is no exact number, as some trusts may consider options such as merging with existing foundation trusts.

2.11 We will maintain the high standards which trusts will need to meet in order to achieve foundation trust status and we will continue to obtain assurance from the CQC as part of the authorisation process. The Government has said that it has no intention of asking Monitor to lower its assessment bar and this is something we are equally clear about. It is not in the interests of patients and the public for trusts that are not well run or financially strong to be granted the independence and autonomy that comes with foundation trust status.

2.12 Monitor will continue to have transitional powers over all foundation trusts until 2016 to maintain high standards of governance during the transition. This will give foundation trusts time to develop their governance arrangements, and will give governors time to learn how to use their powers effectively, which is in the best interest of patients.

Monitor's proposed new responsibilities

2.13 Monitor will be the sector regulator for health. Our core duty will be to protect and promote patients' interests. We will do this by ensuring that quality is maintained and where possible increased. We will also promote the provision of care that is economic, efficient and effective. This makes it clear that Monitor's role will be to put patients first and to protect and promote their interests above all else.

2.14 We believe it is valuable to have a sector regulator which is independent of direct political influence, accountable to Parliament, can build specialist skills and ensures that there is full transparency over its actions.

2.15 In carrying out our duty, we will be required to support the delivery of integrated services for patients where this would improve quality of care or improve efficiency. We have always been clear that we support better integration of health services where this is of benefit to patients. We believe that there are significant opportunities to promote the interests of patients through the integration of care and are fully supportive of any changes to the reforms that make this clear and help us to make this happen. It is our view that competition and co-operation are not mutually exclusive. Competition does not and should not have to come at the expense of beneficial collaboration.

2.16 The new duty means that Monitor will have to consider the benefits of co-operation alongside the risks of anticompetitive behaviour. This is a way of ensuring we have the right kind of competition and only where it is helpful for patients. It could mean, for example, that tariffs for whole pathways of care need to be developed. However, the detail of how we implement the duty is something that we will have to consider once Parliament has had its say on the Bill.

2.17 We would have a vital role in making sure that the players within the sector work together to give patients choices about their health care. This means that we will tackle specific abuses and restrictions that act against patients' interests, including ensuring a level playing field between providers. A level playing field is important to allow the best providers to flourish. A lack of a level playing field between providers of healthcare could result in resources not being allocated to the best provider. This in turn could result in higher costs and/or poorer choice and service quality to the detriment of patients and tax payers.

2.18 The Bill has made it much clearer that competition is a means to an end and not an end in itself. This means, amongst other things, that we will need to look closely at costs and benefits where competition is proposed as a way to promote patients' interests, and these will always have to be evaluated against other ways of promoting and protecting patients' interests. Our position has always been that we support competition only where it is appropriate and can deliver benefits for patients, rather than for its own sake. Although it was never Monitor's intention to promote competition for competition's sake, the amendments to the Bill provide certainty and reassurance to those who had voiced concerns over how we might approach our role. We welcome this.

2.19 The Co-operation and Competition Panel (CCP) will have a continuing role in advising Monitor on competition issues. This is something we welcome as a sensible way to manage the risks of the transition given the CCP's skills and experience in this area. We already work closely with the CCP and look forward to continuing to do so when it becomes part of Monitor.

2.20 We also welcome the Government's proposal to retain the existing competition rules for the NHS introduced by the last Government (the Principles and Rules for Co-operation and Competition), and give them a clearer statutory underpinning.

2.21 In terms of other changes, there is now more clarity on some of the key areas of Monitor's proposed new role that caused concern. For example, the proposals are very clear that there will be no privatisation or cherry picking:

- There was some concern that the original proposals created the potential for privatisation. There is now an explicit requirement in the amended Bill that Monitor should not seek to increase the market share of any type of provider. This makes it clear that Monitor's role is to champion patients' interests, rather than to act in the interests of any particular provider group.

- There was also concern that the Health and Social Care Bill would enable private providers to "cherry pick" routine and less complex healthcare services and interventions that are cheaper to provide and more profitable. The concern was that this would leave the NHS to deal with the higher-cost, more complex and long-term conditions with inadequate remuneration, causing the destabilisation of local hospitals. A proposal has now been included in the Bill to address this concern. This means that Monitor would be given a specific duty to set prices that reflect all underlying costs, so there should no longer be any cherries to pick.

2.22 In order to ensure that patients always remain at the heart of everything Monitor does, the Bill places us under a new duty to carry out appropriate public and patient involvement in the exercise of our functions. Monitor will also be under a new duty to obtain appropriate clinical advice.

2.23 The Government has decided to retain proposals to give Monitor concurrent powers with the Office of Fair Trading, to ensure that competition rules can be applied by a sector-specific regulator with expertise in healthcare. The Future Forum recommended that this was the best safeguard against competition being applied disproportionately.

2.24 It is Monitor's understanding that the original Bill did not change the application of EU competition and procurement law to the NHS and that this has not changed with these amendments

2.25 There are no changes to Monitor's proposed new functions on price-setting and supporting the continuity of vital services in the event of financial failure, and its function of licensing providers, as outlined in the original version of the Bill.

2.26 In Monitor's view, the significant changes outlined above define and constrain the way in which Monitor has to behave, focusing on areas where people expressed concerns.

2.27 However, there are a small number of areas in the original Bill, such as access to facilities (for example, where commissioners might apply for access to provide GP-led services in a hospital's Accident and Emergency facility) which—used carefully—might have been beneficial as a way of integrating services and improving patient benefits, but which are no longer possible. In our view access to facilities could have encouraged innovation and the provision of services in ways that benefit patients.

2.28 We look forward to seeing the proposals relating to the failure regime. We support the Government's determination to bring forward an effective failure regime that reduces the risk of hidden bailouts, while protecting essential services.

2.29 In Monitor's view, it is important that there is a robust failure regime covering all providers, which protects the services that patients need without propping up failing management teams if they are doing a bad job of running a service. The most important thing from a patient's point of view is that they are reassured that, even if their providers get into financial difficulty, the service will still be there.

2.30 It is also important that reconfiguration remains possible where it is evidence-based and clinically appropriate and leads to high quality patient care.

2.31 Overall, our view is that the new proposals are helpful in providing clarity on Monitor's primary duty and responsibilities, and in making it clear that Monitor's role will be to put patients first and to protect and promote their interests.

3.0 Monitor and the CQC

3.1 The Committee raised the question of whether there would be any advantage to be gained from merging Monitor and the CQC. Monitor's views on this are as follows:

- It is important that patients know that one regulator is directly responsible for looking after what they care about most—safety and quality. This is the CQC's role. To be able to do this important job properly, it is desirable that there is no risk of the CQC being influenced or distracted by financial considerations, especially given the complex nature of quality measurement in healthcare. Of course, some body does have to look at quality and financial performance together. This is first and foremost the job of trust boards. Monitor's job is to make sure that trust boards are undertaking this critical role effectively, and to seek remedial action if they are not.
- There is also a management scope issue. The broader an organisations' remit, the more difficult it becomes to manage and the more its focus is diluted. In healthcare regulation, diluting the focus on quality could pose a real risk to patients. Both Monitor and the CQC already have important and challenging roles which are likely to increase further if the Health Bill is passed by Parliament. Merging Monitor and CQC could result in an organisation with such a broad remit that it becomes very challenging to manage effectively—putting patients at risk without reaping any significant reward.
- Combining different organisations is complex and often does not produce the anticipated benefits, while the risks and costs of the change itself can be significant.

3.2 Monitor and the Care Quality Commission work closely together and have distinct but complementary roles. Together, Monitor and the CQC are committed to identifying where improvement is needed, and to ensuring that our approach is co-ordinated in order to deliver real benefits for patients while not duplicating regulatory activity.

4.0 Monitor's Accountability

4.1 Monitor's accountability is clearly set out in the Bill. It outlines that:

4.2 Monitor is and will remain an independent non-departmental public body. What we can and cannot do will be set out by Parliament in legislation.

4.3 We will continue to be accountable to Parliament and subject to parliamentary scrutiny; as Accounting Officer, Monitor's Chief Executive can be called to account in Parliament for the stewardship of the resources within the organisation's control; Select Committees can call us in and hold us to account; we will still be required to account to central Government for our use of resources, to lay our annual accounts and annual report before Parliament; and MPs and Peers can table questions about us.

4.4 The Secretary of State will appoint (and can remove) the Chair and non-executive members of Monitor's Board.

4.5 Monitor will be under a specific duty to ensure that its regulatory activities are transparent, proportionate, consistent, targeted only at cases where action is needed and not in conflict with our transitional role over foundation trusts.

4.6 We will also be accountable to those we will regulate, who will be able to appeal, for example, to the Competition Commission or to go to the courts if they feel that we are not operating fairly.

August 2011

Written evidence from the Royal College of Nursing (MON 10)

1.0 Introduction

With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes the Health Select Committee's decision to hold annual review meetings with the Care Quality Commission (CQC) and Monitor and is pleased to have the opportunity to submit written evidence in advance of the sessions on 28 June 2011.

2.0 Monitor

2.1 *Executive Summary*

- The RCN continues to support the introduction of Foundation Trusts on a case by case basis. Despite ongoing discussion about the proposed role of Monitor, the RCN believes that it is important to remember that the regulator will continue to retain its core duty of authorising and regulating Foundation Trusts.
- We welcome the Government's decision to remove the blanket deadline in the Health and Social Care Bill for abolishing NHS Trusts as legal entities, although we recognise that the Government expects that the majority will be authorised as Foundation Trusts by April 2014. The RCN would like assurances that the bar set by the regulator will not, in reality, be lowered in order to achieve this timetable.
- Given the size and influence of Foundation Trusts, the RCN believes that there is a need for Monitor to ensure the integrity of democratic representation within these organisations.
- The RCN believes that the proposed changes to the NHS necessitate a very clear set of standards and credible checks and balances in the system. If the number and type of providers increases, it is important to ensure that they operate in ways that deliver high quality, safe care.
- The RCN is pleased that the Government listened to concerns that the RCN and others have raised about the role of Monitor as set out in the Health and Social Care Bill. We welcome the news that it will no longer have a duty to promote competition as an end in itself. We have consistently argued since the publication of the NHS White Paper in July 2010 that competition over price must not override quality.

3.0 Core Duties

3.1 The future role of Monitor has come under much discussion in light of the Government's Health and Social Care Bill. However, despite any additional duties placed on Monitor in the future, it will continue to undertake its current remit as the regulator of NHS Foundation Trusts.

3.2 The RCN continues to support the introduction of Foundation Trusts on a case by case basis. However, there are considerable risks in moving all remaining Acute Trusts to Foundation Trusts status within a short timeframe, which could result in a lower level of quality. We welcome the Government's recent decision to remove the blanket deadline in the Health and Social Care Bill for abolishing NHS Trusts as legal entities, although we recognise that the Government expects that the majority will be authorised as Foundation Trusts by April 2014. The RCN will seek assurances that the bar set by Monitor will not, in reality, be lowered in order to achieve this timetable.

3.3 Given the size and influence of Foundation Trusts, the RCN believes that there is an increasing need for Monitor to ensure the integrity of democratic representation within these organisations. In a survey of RCN members[37] in February 2010, the majority viewed local control of a Foundation Trust, with the full engagement of community and staff constituencies in their governance, as one of the greatest benefits.

3.4 However, RCN members expressed concern that too much emphasis on a "big business ethos" could squeeze out patient, public and professional engagement. As Foundation Trusts reach critical mass, we believe Monitor should look to strengthen governance arrangements, promote best practice public patient involvement and encourage partnership working.

3.5 RCN members argue that too many Foundation Trusts do not effectively communicate their service plans to nurses, patients and members. In addition, members believe there is a lack of practitioner engagement in the development process of Cost Improvement Plans and the organisational levels at which crucial decisions are being made in Foundation Trusts. This creates a potential for "top-down" management in achieving cost savings and efficiency targets with little or no ownership at clinical team level.

3.6 The RCN has concerns regarding transparency, as RCN members feel that Foundation Trust Boards conduct their business in private.[38] We accept that there may be some need for parts of Board meetings to take place in private. However, the majority of business could and should be discussed in an environment in which staff are not excluded. We would also like to see Monitor call for more information to be publicly available following Board meetings.

3.7 The potential for successful Foundation Trusts to merge with and take over failing NHS Trusts holds the prospect for creating provider organisations whose size and revenue will far exceed anything that we have previously seen in the NHS. For this reason, along with the increase in numbers of Foundation Trusts, there is a need for Monitor to be sufficiently resourced to continue to regulate and manage the risks of failure of Foundation Trusts. The system of regulation as a whole needs to be made to work well, including clear accountabilities as well as robust checks and balances. We also believe that it is important that Monitor and CQC work closely together, particularly in the areas of inspection and delivery of frontline care.

4.0 Health and Social Care Bill

4.1 The RCN is pleased that the Government listened to concerns that the RCN and others have raised about the role of Monitor and welcomed the news that it will no longer have a duty to promote competition as an end in itself.

4.2 We consistently argued since the publication of the NHS White Paper in July 2010 that competition over price must not override quality. We were concerned that the issue of promoting and regulating competition may hinder Monitor from the most important issue of regulating a national health service, which delivers integrated, collaborative and comprehensive care.

4.3 The RCN was unsettled by comments made by the Chair of Monitor, David Bennett, which compared the role of Monitor to those bodies that regulate the utilities and telecommunications sectors. However, we were pleased to see that the Government has since distanced itself from these comments.

4.4 Under the Government's proposals to amend sections of the Health and Social Care Bill, Monitor's core duty will now be to "protect and promote patients' interests". The RCN is awaiting further detail on how Monitor will support the delivery of integrated services for patients, where this would improve quality of care or increase efficiency.

June 2011

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[37] http://www.rcn.org.uk/__data/assets/pdf_file/0006/314619/05.10_New_Foundations_the_future_of_NHS_Trust_Providers_Report.pdf

[38] http://www.rcn.org.uk/__data/assets/pdf_file/0006/314619/05.10_New_Foundations_the_future_of_NHS_Trust_Providers_Report.pdf

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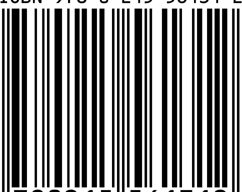
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