



House of Commons  
Health Committee

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# 2013 accountability hearing with Monitor

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**Ninth Report of Session 2013–14**

*Report, together with formal minutes relating  
to the report*

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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.

### Current membership

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[Rosie Cooper MP](#) (*Labour, West Lancashire*)

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[Barbara Keeley MP](#) (*Labour, Worsley and Eccles South*)

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### Publication

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<sup>1</sup> 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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## Summary

Monitor has an “exceptionally challenging” role, as the sector regulator for health services in England. In the Department of Health’s view, Monitor is managing the transition to its new functions well, and is “well placed to go from strength to strength as an effective regulator in the health and social care system.” The Foundation Trust Network (FTN) told us that in their view, “Monitor has made considerable progress in adapting to its new sector regulatory role, including successful introduction for FTs of the new licensing regime.” However, the challenges for Monitor are greater than ever.

### Monitor’s view on the NHS financial position

In the light of Monitor’s evidence on the NHS financial position, the Committee remains concerned that the model of care provided by the health and care system is not changing quickly enough, with the result that pressures continue to build, threatening the financial stability of individual providers, and therefore the quality of care provided. These pressures are likely to be particularly marked in the acute sector as plans are prepared and implemented to achieve the resource transfer required by the introduction of the Better Care Fund from April 2015.

### Provider regulation

As the NHS financial situation tightens, the challenge for Monitor in supporting trusts in financial difficulty is likely to increase, and it is therefore essential that the organization continues to prioritise and resource its work in this area. It is also important that pressures within individual providers are addressed in the context of the local health economy. The requirement for major change in the care model can only be delivered if individual providers, and Monitor as their regulator, look beyond preserving existing structures and address the need to develop different structures to meet changing needs.

Monitor’s role includes assessing new Foundation Trusts. However following changes to the CQC’s inspection and rating regime, Monitor’s Board decided not to finalise any assessment decisions on applicant trusts until updated assurance could be received from the CQC under their new inspection regime, and no new Foundation Trusts have since been authorised. The Department of Health has also abandoned its original objective that the majority of aspirant Trusts should become Foundation Trusts in 2014. We welcome this change of approach which focuses on the requirement to improve the underlying reality rather than meet an artificial timescale.

In October 2013 Monitor introduced a new Risk Assessment Framework for overseeing the governance and finances of Foundation Trusts. Evidence to the Committee suggests that Foundation Trusts are currently subject to closer supervision and scrutiny by Monitor than was envisaged by ministers when Foundation Trust status was originally put into legislation. While the Committee is sympathetic to the view that Monitor must satisfy itself that Foundation Trusts are adequately addressing the issues they face, it is also important that heavy handed regulation does not inhibit necessary change. At a time when NHS providers face an unprecedented need to change the care model, Monitor must be a

facilitator of change, not an obstacle.

This year the Committee received evidence of some ongoing concerns about overlap and lack of clarity between organisations involved in regulating and overseeing the NHS. The Committee has expressed concern before about the impact on patient safety of unclear regulatory responsibilities, and the fact that recent institutional change may have compounded this problem reinforces the need for it to be addressed as a matter of urgency. The Committee has therefore recommended that Monitor and the CQC should meet jointly with those organisations which expressed concern on this subject to this Inquiry and should ensure that all parties are clear how it is planned that these concerns will be addressed.

It is essential that Monitor's approach is appropriate for all types of trust, and Monitor has acknowledged this. The Committee has recommended that Monitor keeps its processes under review to ensure they are appropriate to all types of trust.

The Care Bill proposes to give the CQC specific powers to monitor the financial strength of approximately 50 to 60 care providers whose financial collapse could trigger a local crisis in the delivery of care. We have reiterated our earlier recommendation that the Government should reconsider its decision to allocate this role to the CQC and that it should instead ask Monitor to undertake this role. Although this development would divide oversight of adult social care between Monitor and the CQC, it would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance.

## **Pricing**

In last year's Accountability Report the Committee recommended that Monitor should attach a high priority to its work on the tariff. We do not believe that Monitor's record on this to date constitutes an adequate response to this, as the Committee believes that that the current tariff arrangements often create perverse incentives for providers and inhibit necessary service change. The Committee therefore repeats its recommendation from last year that Monitor should attach a higher priority to its work on this subject and further recommends that Monitor and NHS England should initiate a formal joint process for a prioritised review of the NHS tariff arrangements with the objective of identifying and eliminating perverse incentives and introducing new tariff structures which incentivise necessary service change.

Concern continues to be reported to the Committee about "cherry picking". As we recommended in our report on Public Expenditure, it is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement. The Committee welcomes the fact that Monitor has acknowledged the need to improve the quality of the costing on which prices are based; improved cost information is a key part of the wider tariff review proposed by the Committee.

The Committee has heard that the marginal rate rule, while it has the potential to act as a lever to reduce levels of emergency admissions and improve care outside hospitals, also carries the risk of pushing trusts into financial difficulty where admissions are unavoidable. Monitor also told us that the proportion of funding retained by commissioners "is not all being spent as effectively as we would like". Changes have been introduced this year to the marginal rate rule for emergency admissions, to allow for revised baselines, and with the aim ensure that money retained through the application of the rule will be spent more transparently and effectively, to enable more patients to be treated in community settings. We will seek an update on progress in this important area from Monitor and from NHS England later in 2014.

Monitor told the Committee that "it is going to be quite a while" before national prices can be established that will enable the introduction of a well-based tariff in mental health. Since our accountability hearing, concerns have also been raised about differences in the changes being made to the prices paid for care in the acute sector and the non-acute sector. This may raise questions about the relative priority of acute and non-acute care, and undermine delivery of the objective of parity of esteem between mental and physical healthcare. The Committee will return to this issue in our inquiry into Child and Adolescent Mental Health Services.

### **Competition and integration**

The Committee notes David Bennett's argument that the Section 75 rules are, except for the references to integration, essentially the same as the "principles and rules for cooperation and competition" which have been applied for several years. However, many new commissioning organisations have expressed concern about the impact of these principles on their actions. The Committee therefore recommends that Monitor undertakes a programme of meetings and visit to ensure that commissioners understand the practical implications of the Guidance which was issued in December 2013.

The Committee recognizes that Monitor's developing role as the health and care sector regulator requires it to develop a detailed understanding of a wide range of providers including primary care and third sector providers. Concerns have been expressed to the Committee by representatives of both the third sector and primary care that Monitor has not yet developed this understanding in sufficient depth. The Committee will seek specific evidence on this matter at its next accountability hearing.

Monitor is taking steps to improve the support it provides to Trusts contemplating the merger process, following the case of Bournemouth and Poole. The Committee remains concerned, however, that uncertainty persists in this area; it therefore recommends that Monitor should work with the Competition Commission, and in future the Competition and Markets Authority, to develop joint guidance, similar to the joint guidance it developed with NHS England on the Section 75 regulations, which demonstrates how trusts should ensure that institutional structures are not allowed to impede necessary change in the care model. Monitor would need to ensure that such joint guidance is consistent with its statutory duty to enable service integration.

The Committee continues to believe that the development of a more integrated care model

is fundamental to the delivery of high quality good value care. In addition to its work as the routine regulator of the health and care sector, this report therefore contains two specific recommendations addressed to Monitor which are repeated here and which are intended to facilitate the longer term reconfiguration of the health and care sector:

- Monitor should launch a review with NHS England of the structure and level of National Tariff payments designed to identify and eliminate perverse incentives and incentivise necessary service reconfiguration;
- It should launch a review with the Competition Commission and, in future, the Competition and Markets Authority, of the effect of competition law on necessary institutional change to ensure that existing institutions are not allowed to impede necessary service reconfiguration.

### **Monitor as an organisation**

Recruiting the right staff in the right numbers to deliver its new functions effectively is essential for Monitor; and it is important that an organisation with such a central role has appropriate clinical input. The Committee was frustrated to learn that the Department of Health delayed the appointment of a Medical Director for several months due to an argument about appropriate pay levels. The Committee regards this as an absurd distortion of priorities and strongly supports the formation of a fully staffed Patient and Clinical Engagement Team within Monitor at the earliest possible date.



# 1 Introduction

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1. The Department of Health provides the following summary of Monitor's role and functions:

Monitor is the sector regulator for health services in England. Its job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercises a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners - implemented in part through licences it issues to NHS-funded providers.

Monitor was originally established in 2004 but the regulatory landscape has changed significantly in the last twelve months and the Health and Social Care Act 2012 expanded the regulator's role considerably. From 1st April 2013 it has been Monitor's overarching responsibility to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. In fulfilling its role Monitor is responsible for ensuring that:

- a. public sector providers are well led and provide high quality care to their patients;
- b. essential NHS services continue if a provider gets into difficulty;
- c. the NHS payment system rewards quality and efficiency; and
- d. choice and competition operate in the best interests of patients.<sup>2</sup>

2. In the Department of Health's view, Monitor is managing the transition to its new functions well:

Over the last year, Monitor has undergone significant change to its role following the Health and Social Care Act 2012. Monitor has adapted well to this change, making good progress in authorising new FTs, ensuring the continuity of services in under-performing FTs, and by ensuring that its organisational capacity is stronger. The Department believes that Monitor is well placed to go from strength to strength as an effective regulator in the health and social care system.<sup>3</sup>

3. The Foundation Trust Network (FTN), the membership body for NHS acute hospitals, and community, mental health and ambulance services that treat NHS patients, states that "Monitor has made considerable progress in adapting to its new sector regulatory role, including successful introduction for FTs of the new licensing regime."<sup>4</sup>

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2 [Department of Health](#) (AMO 0002), paras 3 – 4

3 [Department of Health](#) (AMO 0002), para 36

4 [Foundation Trust Network](#) (AMO 0007), Summary

4. However, as the Committee argued in its report of last year's accountability hearing, Monitor's role remains complex and demanding<sup>5</sup>; the British Medical Association (BMA) have echoed this warning, describing Monitor's role as "exceptionally challenging".<sup>6</sup>

5. Against this background, the Committee held its annual accountability hearing with Monitor on 26<sup>th</sup> November 2013. This is the third such accountability hearing the Committee has held with Monitor in this Parliament. The Committee took oral evidence from Dr David Bennett, at the time Monitor's Chair and Chief Executive; Stephen Hay, Managing Director of Provider Regulation; and Adrian Masters, Managing Director of Sector Development. The Committee received nine submissions of written evidence. In addition, this inquiry has been informed by some of the oral and written evidence submitted to the Committee's other recent inquiries, including its inquiries into the Implementation of the Health and Social Care Act 2012 and into Public Expenditure; and its annual accountability hearing with the Care Quality Commission (CQC).

6. One of the Committee's roles is to hold pre-appointment hearings in connection with appointments to the Chairs of relevant non-departmental public bodies. On 10<sup>th</sup> October 2013, the Secretary of State informed the Committee that the Government's preferred candidate for the post of Chair of Monitor was Dominic Dodd, and the Committee held a pre-appointment hearing on 15<sup>th</sup> October 2013. The Committee did not endorse Mr Dodd's appointment, and Mr Dodd subsequently withdrew from the selection process. Baroness Hanham has now been appointed as Interim Chair of Monitor, and the Secretary of State has informed the Committee that the Department will advertise for a new Chair by the autumn. The Committee will hold a pre-appointment hearing once a preferred candidate has been selected.

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5 Health Committee, Tenth Report of Session 2012–13, 2012 [Accountability Hearing with Monitor](#), para 5

6 [British Medical Association](#) (AMO 0003), para 1

## 2 Monitor's view on the NHS financial position

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7. The Committee's recent report into Public Expenditure discusses the NHS financial position in detail. At this year's accountability hearing the Committee gave Monitor the opportunity to provide its views on the current financial situation facing the NHS, and in particular to discuss Monitor's recent publication *Closing the NHS Funding Gap*.<sup>7</sup> In its written evidence to the Public Expenditure inquiry Monitor said:

On the basis of the track record of Foundation Trusts in recent years, the Annual Plan Review indicates the sector will continue to be resilient in the short term. However, we know that the number of foundation trusts in financial distress has increased, as has the number struggling to meet operational demands. The outlook on overall funding is uncertain and the spending review has confirmed that financial pressures will increase beyond 2015/16....<sup>8</sup>

....Without transformational change, for example through integration of services and service redesign, efficiency opportunities are likely to become increasingly difficult to identify and deliver which may lead to increasing financial distress across the FT sector.<sup>9</sup>

8. Monitor reported that the percentage of acute NHS FTs subject to regulatory action grew from 13% in April 2011 to 24% at the end of October 2013.<sup>10</sup>

9. Dr Bennett told the Committee that one of the important messages of *Closing the NHS Funding Gap* was that the funding gap "can only be closed if there is a lot of innovation—a lot of new approaches—to the provision of health care, approaches that we have not seen today, or certainly have not seen in this country." He also stated that in his view, "it is going to be a big stretch to get there".<sup>11</sup>

10. When asked whether there was a single health economy that they could identify where good progress was being made, Dr Bennett replied that while "you see examples of good practice in many health economies", he was "not sure there is really good evidence of any health economy that has all the different pieces together in a coherent way".<sup>12</sup>

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7 [Closing the NHS Funding Gap – how to get better value health care for patients](#), Monitor, October 2013

8 [Monitor](#) (PEX 0018) para 2.2

9 [Monitor](#) (PEX 0018) para 2.6

10 [Monitor](#) (AMO 0010) para 3.20

11 Q3

12 Q4

## Funding Pressures in 2015–16

11. Dr Bennett highlighted “a particular problem with 2015–16”,<sup>13</sup> when the Government plans that the Better Care Fund should transfer £2bn from traditional NHS providers to community based health and social care provision. He told the Committee that Monitor expects that this transfer will result in reduced funding for NHS acute care providers:

In 2015-16, as you will know, there is an additional £2 billion taken from the NHS to be put into the integration transformation fund. That is expected mostly to come out of the acute sector, which means that the acute trusts in particular are going to face a very significant funding squeeze in 2015-16. So, although there is this challenge we were talking about earlier of, “How do you get yourself to a position where you can deal with a situation, say, in 2021-22?” just dealing with 2015-16, I think, is going to be a huge challenge particularly because of the need to get there very quickly. We are in intensive discussions now with NHS England, with the TDA and with the Department of Health to try and work out how that gap between underlying costs and funding can be closed in 2015-16.<sup>14</sup>

12. **The Committee drew two conclusions from the evidence presented by Monitor:**

- a) **It remains concerned that the model of care provided by the health and care system is not changing quickly enough with the result that pressures continue to build, threatening the financial stability of individual providers, and therefore the quality of care provided;**
- b) **These pressures are likely to be particularly marked in the acute sector as plans are prepared and implemented to achieve the resource transfer required by the introduction of the Better Care Fund from April 2015.**

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13 Q19

14 Q20

## 3 Provider Regulation

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### Authorising Foundation Trusts

13. Monitor has run the authorisation process for Foundation Trusts since 2004. The Government was previously intending 2014 as the target date for all Trusts to have become FTs, and at last year's accountability hearing, Monitor reported that it was scaling up resources to allow it to manage an expected increase in the number of assessments it needed to process.<sup>15</sup>

14. However, Monitor have reported to us this year that the introduction of the Care Quality Commission's new inspection regime has had implications for the current authorisation process:

Monitor's Board needs to be assured of the quality of care at applicant trusts before they are authorised as foundation trusts. In light of the CQC's work to design and pilot a new inspection regime during 2013/14, our Board decided not to finalise any assessment decisions on applicant trusts until updated assurance could be received from the CQC under their new inspection regime.

In order to minimise the effect on trusts in the pipeline, we worked with NHS TDA and CQC to make sure that:

- applicants closest to referral from the NHS TDA and those that we were already assessing were prioritised for an updated CQC inspection. Three of the four acute trusts currently with us for assessment will have been inspected by early December.
- an inspection approach for non-acute trusts is developed as soon as possible. CQC's expectation is that it will pilot this in the new year; and
- we can continue to work with applicants as the CQC transitions to its new regime.

As a transitional measure, pending finalisation by the CQC of their approach, we decided to split the assessment process into two phases for recent applicants. The first will focus on areas that will benefit applicants most through early identification of issues, whilst minimising the risk of duplication in the second phase. The second phase will commence when a CQC inspection has been satisfactorily completed.

For deferred and postponed applicant trusts, we do not expect to start reassessing them until the outcome of their CQC inspection is known. Deferral periods have been extended to allow for this.<sup>16</sup>

15. According to Monitor, the NHS TDA estimated in July this year that 14 of the trusts in its portfolio could not be put forward for NHS foundation trust status in their current organisational form. Therefore 69 trusts remain in the NHS TDA pipeline. The Department of Health reports that it now considers that "the majority of aspirant Trusts will now not become FTs in 2014. The key challenge now is that we ensure that aspirant trusts achieve the transition to FT at the right time for them."<sup>17</sup>

16. Dr Bennett was supportive of this decision:

The danger in my mind with setting a very short deadline was that corners would be attempted to be cut... more flexibility around the time scale is right...I think David Flory and his people are very committed to getting these trusts up to the requisite standard as fast as they can, but I do not think there is any pretending that it is going to be a very big challenge in some of these organisations."<sup>18</sup>

**17. Following changes to the CQCs's inspection and rating regime, Monitor's Board decided not to finalise any assessment decisions on applicant trusts until updated assurance could be received from the CQC under their new inspection regime. No new Foundation Trusts have since been authorised, and the Department of Health has abandoned its original objective that the majority of aspirant Trusts should become Foundation Trusts in 2014. We welcome this change of approach which focuses on the requirement to improve the underlying reality rather than meet an artificial timescale.**

## Regulating Foundations Trusts

18. Monitor now issues as provider licence which was granted to NHS Foundation Trusts on 1st April 2013. This replaced trusts' Terms of Authorisation as Monitor's main regulatory tool. Other providers of NHS funded health care services must hold a provider licence from 1st April 2014, unless they meet exemption criteria set out by DH.<sup>19</sup> Monitor reports that:

While the licence sets out requirements for trusts covering pricing, competition and integration, the important and associated challenge for Monitor during the year was to adapt our framework to assess trusts' governance and financial risk against this new licence regime.<sup>20</sup>

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16 [Monitor](#) (AMO 0010), para2.7, 2.9

17 [Monitor](#) (AMO 0010), para 2.18; Department of Health, para 14

18 Q133

19 [Monitor](#) (AMO 0010), para 3.3

20 [Monitor](#) (AMO 0010), para 3.3

19. The FTN praise Monitor's introduction of the licensing system, saying that it has been "genuinely consultative in developing proposals and acted on feedback from our members"<sup>21</sup> They do, however, identify areas where they believe further work is needed:

Our members reflect a generally smooth transition to the new licence regime. However, aspects of the regime need further work including:

- Designation of Commissioner Requested Services (CRS) i.e. services identified by commissioners as essential to keep going if a provider gets into difficulty
- The Risk Assessment Framework
- Risk rating forward plans
- Governance risk ratings and proposals for governance reviews.<sup>22</sup>

20. Until the introduction of the provider license this year, Monitor had previously monitored foundation trusts' compliance with the terms of their authorisation under the Compliance Framework. This has been revised and is now known as the Risk Assessment Framework, which came into force on 1st October 2013. According to Monitor,

The principles behind the (RAF) are similar to those Monitor has used so far in regulating NHS foundation trusts in that they are used to hold foundation trusts to account for their quality governance and financial stability. They do not represent any fundamental change to the regulatory approach Monitor has adopted.<sup>23</sup>

21. However, the Foundation Trust Network expressed concerns in their written evidence. According to the FTN, the Francis inquiry "raised questions about the efficacy of [Monitor's] regulatory oversight, and, more generally, about the quality of NHS care, leading to increased expectations of regulation and all regulators".<sup>24</sup> This, they argue, has the potential to have a damaging impact on Monitor's regulatory approach:

This low-trust environment has created external pressures on Monitor to become more interventionist in its regulation of foundation trusts and more risk-averse. This desire to "prevent another Mid-Staffs" risks creating an over-bearing and expensive system of regulation in response to one or two worst-case examples. It also threatens to replace risk-based regulation with performance management, a shift clearly evident in Monitor's growing scrutiny of A&E performance against targets".<sup>25</sup>

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21 [Foundation Trust Network](#) (AMO 0007), p1

22 [Foundation Trust Network](#) (AMO 0007), para 7.3

23 [2012 Accountability hearing with Monitor - response](#), p7

24 [Foundation Trust Network](#) (AMO 0007), para 2.3

25 [Foundation Trust Network](#) (AMO 0007), para 2.4

22. The Foundation Trust Network reports concern amongst its members around both financial risk monitoring and governance monitoring, arguing that “the Risk Assessment Framework ... appears to herald a more cautious and interventionist approach from Monitor, risking inappropriate regulatory action against many more trusts.”<sup>26</sup> The move to a more ‘interventionist’ approach was discussed with Monitor in oral evidence. Dr Bennett told the Committee:

The FT policy establishes foundation trusts as autonomous bodies that are largely free to make their own decisions unless they get into serious difficulty, and at that point we step in. That then leaves open all sorts of questions about how closely we should be monitoring them. Should it be “Until they get into serious difficulty”, “In order to anticipate whether or not they might do so”, and, indeed, “What constitutes serious difficulty?” What we are increasingly doing is monitoring more closely and stepping in at an earlier stage. But it is a difficult judgment, and I am sure you will find other people who will say we are beginning to pay too much attention to what they are up to and, in some cases, even stepping in at too early a stage. But my sense is that we do need to be monitoring more closely, trying to anticipate problems and stepping in more quickly where necessary.<sup>27</sup>

23. He went on to say:

I think, partly as a result of the increasing pressure on the system and partly as a result, I frankly think, of the public and Parliament having a lower risk appetite than they did back in 2004, in general—but we have seen it in the financial services sector as a very good example—for both of those reasons, my view is that we need a somewhat shorter arm and that is what the FTN is reflecting.<sup>28</sup>

24. As Stephen Hay pointed out, at the time of our oral evidence session the new Risk Assessment Framework had only been operational for six weeks, so Monitor told us that they “will have to see how it plays out over the next year”.<sup>29</sup> Dr Bennett told us that in his view a pragmatic approach was needed: “As to the length of the arm, we have to be pragmatic. It is where we feel it is about right. If the evidence is, for example, that we are having a lot of trusts fail and we are not either spotting it soon enough or not doing enough about it, we are going to have to shorten it a bit more.”<sup>30</sup>

**25. It is clear to the Committee that Foundation Trusts are currently subject to closer supervision and scrutiny by Monitor than was envisaged by ministers when Foundation Trust status was originally put into legislation. While the Committee is sympathetic to the view that Monitor must satisfy itself that Foundation Trust managements are**

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26 [Foundation Trust Network](#) (AMO 0007), summary

27 Q24

28 Q99

29 Q100

30 Q100



**addressing the issues they face, it is also important that heavy handed regulation does not inhibit necessary change. At a time when NHS providers face an unprecedented need to change the care model, Monitor must be a facilitator of change, not an obstacle.**

## Supporting Foundation Trusts in financial difficulty

26. Monitor explained that there are two stages to its regulatory oversight of Foundation Trusts—firstly, how closely they are monitored, and secondly, how quickly and strongly Monitor intervene when there is cause to be concerned.<sup>31</sup> In terms of Monitor’s response to Foundation Trusts in difficulty, Dr Bennett told the Committee that there were two important lessons he has learnt in this area. The first lesson was to look at an earlier stage at whether there are structural issues:

To a certain extent, in the past, we used to focus on the leadership of the trust, the board, the management of the trust, and say, “If they are failing, often almost invariably there are weaknesses in the management,” and we would try and fix that. But increasingly—and I think this is partly a reflection of the margin for things being less than perfect shrinking—we are seeing that even when you fix the management, if there are underlying structural problems, you still have not fixed the financial problem. Then that extends how long it takes to fix it. So one of the lessons is, at a very early stage, to try and understand if there are structural problems, so that we can get going on those straight away.<sup>32</sup>

27. Secondly, Dr Bennett emphasised the need to work more broadly across whole health economies, rather than just at individual institutions:

We have a failure regime which is institutionally based: it is about individual trusts. We are applying it for the first time at Mid Staffordshire, and the TDA applied it for the first time in South London. Particularly looking at Mid Staffordshire, what is absolutely clear is that we have a health economy that is failing and the worst consequence of that is in Mid Staffordshire, but it is most certainly not confined to Mid Staffordshire. What we really need is a failure regime for health economies. We can construct that and that is effectively what we are trying do with Milton Keynes and Bedford now, to say they are not in failure but they are struggling and we need to look at the whole health economy, not just individual institutions.<sup>33</sup>

28. When asked whether he thought the sector was approaching “crisis point”, Dr Bennett told the Committee that “the challenges are getting greater”.<sup>34</sup> Monitor’s written evidence shows that the number of Foundation Trusts in difficulty has substantially increased over the past year, and the increasing financial challenges for the NHS is likely to translate into

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31 Q101

32 Q14

33 Q14

34 Q18

increased workload and challenges for Monitor; in response to this, Dr Bennett told us that they “are significantly increasing their capacity”, and that they plan to “get more senior people with real managerial experience to help turn around under-performing trusts.”<sup>35</sup>

**29. The challenge for Monitor in supporting Trusts in financial difficulty is likely to increase as the NHS financial situation tightens. It is essential that the organization continues to prioritise and resource its work in this area.**

**30. It is also important that pressures within individual providers are addressed in the context of the local health economy. The requirement for major change in the care model, referred to in this and many other reports of this Committee, can only be delivered if individual providers, and Monitor as their regulator, look beyond preserving existing structures and address the need to develop different structures to meet changing needs.**

### Co-operation with CQC and other organisations

31. The Francis report into the failings at Mid Staffs has implications across the NHS and the organisations that work with it; when asked if they thought Monitor’s new Risk Assessment Framework for monitoring Foundation Trusts could prevent another Mid-Staffs, Dr Bennett said that in his view “the most important changes that makes a Mid Staffordshire, and indeed a Morecambe Bay, less likely are the changes that are going on with the CQC.”<sup>36</sup> However Stephen Hay told us that lessons learned from Mid Staffs have informed the development of the non-financial elements of the new Risk Assessment Framework:

On the non-financial side, the old compliance framework had become very complicated and you almost needed a PhD to understand how it operated. We have simplified it. We have reflected a lot of the learning coming out of Mid Staffordshire and some of the leading indicators around patient surveys, staff surveys and the quality governance framework in it to, as David says, pick up those issues at an earlier stage.<sup>37</sup>

32. The issue of better joint working with the CQC was also raised at our evidence session:

On the issue of working together, that is very important and we do work extremely closely together, at all sorts of levels. I have a conversation with David Behan probably every week. People in Stephen’s organisation are talking to their opposite numbers in the CQC daily and sometimes hourly where there are problems in particular at trusts. It is absolutely essential that we work closely together.<sup>38</sup>

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35 Q25

36 Q104

37 Q100

38 Q107

33. However our written evidence revealed some ongoing concerns about overlap and lack of clarity between organisations. In the view of the Foundation Trust Network:

Clarifying Monitor’s relationships with other regulatory and oversight bodies for the NHS, particularly their respective roles and responsibilities, is vital. We welcome steps Monitor, Care Quality Commission (CQC) and NHS Trust Development Authority (TDA) are taking to clarify operation of the failure regime, particularly special measures, but our members continue to report confusion about these new approaches and the regulators’ respective roles.

There is significant potential overlap between Monitor and CQC on the governance and leadership of organisations, particularly with development of CQC’s ‘well-led?’ domain, and with NHS England. Similarly, Monitor must work closely with the TDA to avoid overly burdensome and duplicative processes and requirements on aspirant trusts as they make their case for FT status.

The absence of a consistent and coherent approach to common concerns by the different bodies risks duplication and confusion, and inconsistent assessments of compliance or trusts being penalised twice for the same issue. Both CQC and Monitor use definitions of “fit and proper person” as part of their registration/ licensing requirements but it is unclear whether the two approaches align.<sup>39</sup>

34. The Royal College of Nursing echoed this:

There are also now many agencies with a regulatory remit over different parts of the health care system: Monitor with its license for FTs, and in 2014, license for some larger providers of NHS care, the Trust Development Agency (TDA) for non-FTs, and NHS England as part of contracting and defining currencies for nationally priced services[6]. This is without including others such as the CQC, Healthwatch etc. This can seem bewildering and raises serious concerns around inconsistencies if they do not work together successfully.<sup>40</sup>

**35. The Committee has expressed concern before about the impact on patient safety of unclear regulatory responsibilities. The fact that recent institutional change may have compounded this problem reinforces the need for it to be addressed as a matter of urgency. The Committee recommends that Monitor and the CQC should meet jointly with those organisations which expressed concern on this subject to this Inquiry and should ensure that all parties are clear how it is planned that these concerns will be addressed. The Committee requests that Monitor submits a report of this process to the Committee before 30th June 2014.**

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39 [Foundation Trust Network](#) (AMO 0007), paras 3.1-3.3

40 [Royal College of Nursing](#) (AMO 0006), para 5.3

## Approach to non-acute Trusts

36. In their written evidence, the FTN state that "it is essential that Monitor's approach is appropriate for all types of trusts, not just acute trusts". They added that "feedback from our Members indicates that Monitor needs to strengthen its understanding and approach to community and mental health service providers as well as tailoring its approach to the particular issues and needs of integrated service providers, which provide social care as well as NHS services." Specifically in relation to authorisation, the FTN report that "some non-acute providers question the relevance of some information requested and aspects of the process to their type of organisation."<sup>41</sup>

37. David Bennett agreed that there was a need to focus on all types of trust: "I do not want to overstate it, but there is almost an obsession with acute trusts because it is the bit that people look at, where the light is shining. But we have to shine the light everywhere".<sup>42</sup> In terms of Monitor's approach, Dr Bennett said:

We certainly need to change—and we have completely recognised this—or to adapt the way we look at trusts that are not the sort of traditional acute or mental health trusts that we are used to, and we have done that. One of the problems in almost anywhere except for acute is that the availability of information about these trusts is very weak, so it is very difficult to measure it. But we are trying to do our best in the circumstances. We chose not to—and you may disagree with this—say, "This is a sector with poor information that is not well understood. Therefore, we will not authorise anybody as a foundation trust." We have tried to be pragmatic and do the best we can, but we are also slowly getting them to produce more reliable data, so that, eventually, I hope every single bit of the provider landscape will be subject to the same degree of scrutiny as acute trusts are today.<sup>43</sup>

38. Monitor sent us further information outlining its approach to non-acute trusts. Monitor currently oversees 41 mental health foundation trusts and three ambulance trusts, reporting that it applies to them "a similar level of scrutiny as their acute peers":

As with acute providers, we gather financial and non-financial information on a quarterly basis in coming to a view of the organisation's compliance with the governance and financial requirements of their license. The financial information we gather is the same across all foundation trusts.

The non-financial information we gather generally informs our views of governance performance. Trusts are rated against a small number of relevant national access or outcomes targets for that provider. These targets differ across acute, mental health and ambulance foundation trusts, but can include, for example, performance against the Care Approach Programme targets (mental health trusts) and emergency response time targets

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41 [Foundation Trust Network](#) (AMO 0007), paras 4.3, 12.1

42 Q125

43 Q122

(ambulance trusts). Any CQC concerns are also taken into consideration, as are other material third party concerns.<sup>44</sup>

**39. The Foundation Trust Network told us that "it is essential that Monitor's approach is appropriate for all types of trusts." We agree. We are pleased that Monitor has acknowledged the need to "shine the light everywhere", not just on acute trusts, and we recommend that it keeps its processes under review to ensure they are appropriate to all types of trust.**

## Financial regulation of social care

40. The Care Bill proposes to give the CQC specific powers to monitor the financial strength of approximately 50 to 60 care providers whose financial collapse could trigger a local crisis in the delivery of care. Subject to the Bill receiving Royal Assent, from April 2015 CQC will:

"i. Require regular financial and relevant performance information from some providers.

"ii. Provide early warning of a provider's failure.

"iii. Seek to ensure a managed and orderly closure of a provider's business if it cannot continue to provide services."<sup>45</sup>

41. The CQC said that this "will strengthen our ability to help make sure that concerns about people's care are identified and acted upon as early as possible." They add that they will:

"i. Carry out financial checks on a small number of providers (based on their size, local or regional concentration and specialisation of services which makes them difficult to replace).

"ii. Monitor risks to financial sustainability and, depending on the level of risk, ensure these providers have effective 'sustainability plans' in place to satisfy us that it can manage the risk. We will need to be sure that the provider is taking sufficient steps to address a threat to their business sustainability. We will be able to commission an independent business review to help the provider become financially sustainable.

"iii. Require information from providers in order to facilitate an orderly closure of a provider's business, should that become necessary, and ensure the continuity of care for people who use the service.

"iv. Oversee and coordinate the process when a provider fails across all involved local authorities, and communicating nationally on progress to provide reassurance and information."<sup>46</sup>

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44 [Monitor supplementary information](#) (AMO 0013), para 3.2

45 Health Committee, Sixth Report of session 2013-2014, [2013 Accountability Hearing with the CQC](#), para 52

42. The CQC has been asked to take on this additional responsibility because it relates specifically to adult social care, a sector which Monitor does not cover. The Government's response to their consultation on Market Oversight of Adult Social Care explained the reasoning behind the CQC being tasked with these functions:

the Government believes there are greater benefits for service users to having a single regulator which oversees care and support services and can build a picture of overall performance combining quality and financial data. Consequently the Government will legislate to enable the CQC to undertake this function.<sup>47</sup>

43. In oral evidence to the Committee, David Behan of the CQC said that in order to fulfil their obligations the CQC would need to "buy in skills from organisations that do insolvency work". David Prior explained that the CQC did not have the financial skills that were required and it is highly unlikely that they would want to have them in house.<sup>48</sup>

44. We asked for Monitor's view on the allocation of responsibility for adult social care financial regulation, and they responded as follows:

Ultimately, it is for the Department of Health to determine where this responsibility should sit. However, it is recognised that we have insight into financial regulation that may be useful to the CQC as it develops a framework and we will work collaboratively with them to provide advice where that is helpful.<sup>49</sup>

**45. We recommend that the Government should reconsider its decision to allocate responsibility for the financial regulation of social care to CQC and that it should ask Monitor to undertake this role. Although this development would divide oversight of adult social care between Monitor and the CQC, it would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance.**

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46 Health Committee, Sixth Report of session 2013-2014, [2013 Accountability Hearing with the CQC](#), para 53

47 Health Committee, Sixth Report of session 2013-2014, [2013 Accountability Hearing with the CQC](#), para 54

48 Health Committee, Sixth Report of session 2013-2014, [2013 Accountability Hearing with the CQC](#), para 55

49 [Monitor supplementary information](#) (AMO 0013), para 3.1



## 4 Pricing

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### Recent and future changes to NHS pricing

46. Monitor and NHS England are now jointly responsible for the NHS payment system.<sup>50</sup> The Committee's report on last year's accountability hearing emphasised the importance of the setting of the tariff, and recommended that Monitor attach a high priority to this new area of its remit.<sup>51</sup>

47. Monitor's written evidence provides the following summary of their proposals:

Our proposed national prices for 2014/15 are broadly similar to those in 2013/14, having been adjusted only for efficiency (4%) and inflationary factors (e.g., the increase in drugs prices) to ensure some predictability of income for providers while we develop the longer term strategy.

However, we have made changes in two important areas for 2014/15 based on our engagement with the sector. Following a review of the marginal rate rule for emergency admissions, we made significant changes to the way baselines and re-investment plans were determined locally, with commissioners held firmly to account for the first time. Local health economies will also be able to adopt alternative payment approaches where this is in patients' interests, as long as they do so transparently and have engaged constructively on the available options.<sup>52</sup>

48. Monitor states that its proposals for the payment system in 2014/15 are designed to help commissioners and providers over the coming year address the strategic challenges facing NHS care in their localities in three ways:

by offering more freedom, to encourage the development of new service models;

by providing greater financial certainty to underpin effective planning; and

by maintaining incentives to provide care more efficiently.<sup>53</sup>

49. Monitor state that currently there are problems with information on costings:

To fully redesign the payment system to underpin a sustainable NHS we need reliable evidence about the likely impact of innovation in service delivery and quality, complete information about provider costs and patient outcomes. Unfortunately, the quality of information available at the present time is

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50 [Monitor](#) (AMO 0010), para 4.23

51 Health Committee, Tenth Report of Session 2012-13, 2012 [Accountability Hearing with Monitor](#) para 96

52 [Monitor](#) (AMO 0010), para 4.27-4.28

53 Monitor website, [Regulating Prices for NHS Funded care](#)



generally poor. We therefore decided to keep the tariff largely the same during the first year for which we had pricing responsibility. The stability this offers ensures that we have adequate time to consult on any changes and to test the impact of any proposed alternatives.

However, although we chose not to make significant changes to the tariff, we have chosen to define a set of principles for the sector to use when thinking about integrated care and explained the significant flexibility they have within the existing rules, provided they are open and transparent about how they are using that flexibility.<sup>54</sup>

50. Looking forward to the 2015-16 payment system, Monitor report that they are “considering changes to the payment system” as well as “developing a shared long-term strategy with NHS England.”:

The spending settlement for 2015/16 requires a comprehensive analysis of opportunities for using the national tariff to signal where greater efficiency is possible, through productivity improvements or shifts in the way care is delivered. In particular, we are addressing the misaligned system incentives for urgent and emergency care and the proactive co-ordination of health and social care for vulnerable and ageing populations.<sup>55</sup>

**51. The Committee does not believe that this record constitutes an adequate response to its recommendation in last year’s Accountability Report that Monitor should attach a high priority to its work on the tariff. The Committee believes that that the current tariff arrangements often create perverse incentives for providers and inhibit necessary service change.**

**52. The Committee therefore repeats its recommendation from last year that Monitor should attach a higher priority to its work on this subject and further recommends that Monitor and NHS England should initiate a formal joint process for a prioritised review of the NHS tariff arrangements with the objective of identifying and eliminating perverse incentives and introducing new tariff structures which incentivise necessary service change. The Committee requests that Monitor submits a report of this process to the Committee before 30th June 2014.**

### “Cherry picking”

53. In our evidence session with Monitor, we returned again to issues of “cherry picking”. In oral evidence to the Committee, Adrian Masters discussed two different ways in which ‘cherry picking’ might conceivably occur. Firstly, in relation to and concerns that the providers might choose to treat only less complex patients who were therefore less costly to treat, Adrian Masters told us that local flexibilities should enable commissioners to re-negotiate prices if this were to emerge as a problem:

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54 [Monitor supplementary information](#) (AMO 0013), para 2.2

55 [Monitor](#) (AMO 0010), para 4.29-4.30

In the usual bundle, for which there is a usual price, that assumes a mix of different patients with different types and degrees of complexity. If the commissioner feels “I am not actually sending the patients with that full range of complexity to this local provider”, again the commissioner can negotiate and agree a lower price because “I am not sending you all the people assumed in that bundle. I am sending you less complicated ones so I want a lower price.” That is totally open for the commissioner to negotiate....<sup>56</sup>

54. While Dr Masters suggested that that flexibility should cover most cases of ‘cherry picking’, he stated that Monitor were conducting further research into claims that providers are more likely to make a surplus on elective care than other types of care, and use that to cross-subsidise other parts of the service: “Therefore, they are saying, if some of the elective care is going elsewhere, “without that surplus, we can no longer cross-subsidise other parts of our service”. In connection with the Committee’s inquiry into Public Expenditure, Anita Charlesworth of the Nuffield Trust pointed to the example of maternity services as a type of care that is generally perceived to be loss-making.

Everyone in the NHS says you lose money on normal maternity. Women have to have babies and it costs money to deliver those, so it can’t be sensible to price the system where everyone loses money on maternity. If you are a big teaching hospital, you make money on certain types of, say, cancer care, and so you can cross subsidise. If you do not offer that other service, then you are just left picking up the pieces, but you have to deliver the care. When we had quite high growth rates you could cope; these sorts of things were not ideal but they did not really bite. We need to get much better at making sure that we understand cost and that we price according to that.<sup>57</sup>

If we do things such as systematically underprice maternity, we will lead to people being in difficulty who might be perfectly efficient. Equally, if we overprice some bits of complex surgery, we will make people look very good financially when actually they could be very inefficient. That does not help the system overall; it means that where the problems emerge may not reflect what is underlying them. So I would like much more focus on getting the prices right.<sup>58</sup>

55. Dr Masters told us that “Over time, we need to improve the quality of the costing, so that the prices more accurately reflect the costs. That, again, is an exercise we have started working on as to how we can get better costing information and better reflect the cost in the prices.”<sup>59</sup>

**56. Concern continues to be reported to the Committee about “cherry picking”. As we recommended in our report on Public Expenditure: it is important that payments to**

56 Q83

57 Public expenditure oral evidence, [20 Nov 2013](#), Q166

58 Public expenditure oral evidence, [20 Nov 2013](#), Q195

59 Q84

providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement. The Committee welcomes the fact that Monitor has acknowledged the need to improve the quality of the costing on which prices are based; improved cost information is a key part of the wider tariff review proposed by the Committee, which would also assist in the elimination of “cherry picking”.

## Emergency admissions tariff

57. The marginal rate rule for emergency admissions was introduced in 2010-11, with the intent of slowing the growth in emergency admissions. Under the marginal rate rule, trusts are only paid at 30% of the usual NHS price (tariff) for emergency admissions above a baseline set in 2008-9, with commissioners retaining the other 70% in order to enable them to invest in better admissions management.<sup>60</sup> Monitor provided the following summary of their recent work on the marginal rate rule:

We reviewed the marginal rate rule for urgent and emergency care during 2013 and decided to retain it albeit with new flexibilities for local circumstances. In partnership with NHS England we have sought to make local commissioners more accountable for the way any retained funds from the marginal rate are spent. We will evaluate the impact of this when making decisions about the tariff for 2015-16. We are also researching the cost structures of the urgent and emergency care networks set out by the Keogh Review to inform the design of new payment approaches.<sup>61</sup>

58. During the oral evidence session, Monitor explained some of the perceived advantages and disadvantages of the marginal rate rule:

Broadly speaking, I think the marginal rate rule has done the kind of job we wanted it to....It has helped control the rate of growth in emergency admissions, and it has directed attention by commissioners and providers in how they can work together to keep people well and supported outside hospital and to discharge them better once they have been in hospital....

Can I add, though, that it does have two problems? The first is, while it has incentivised hospitals to reduce the rate of growth in admissions, there are clearly problems if there are unavoidable admissions and they are not getting paid enough for them...we have had trusts in difficulty because of that. The second problem is that, if the 70% which is held back from the hospital is not being spent effectively to either prevent attendance at A&E in the first place, or to get them out once their treatment is complete, then you have further

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60 [Monitor](#) (PEX 0018), 4.1

61 [Monitor supplementary information](#) (AMO 0013), para 2.3

pressure on the hospitals, and I think most of us would agree that it is not all being spent as effectively as we would like.<sup>62</sup>

59. The Urgent and Emergency Care review, published in November 2013, states that NHS England expects to make "significant progress over the next 6 months" in developing new payment mechanisms for urgent and emergency care, in partnership with Monitor.<sup>63</sup>

**60. The Committee has heard that the marginal rate rule, while it has the potential to act as a lever to reduce levels of emergency admissions and improve care outside hospitals, also carries the risk of pushing trusts into financial difficulty where admissions are unavoidable. Monitor also told us that the proportion of funding retained by commissioners "is not all being spent as effectively as we would like". Changes have been introduced this year to allow for revised baselines, and to ensure that money retained through the application of the rule will be spent transparently and effectively, to enable more patients to be treated in community settings. We will seek an update on progress in this important area from Monitor and from NHS England later in 2014.**

## Mental health tariffs

61. Evidence received during the Committee's post legislative scrutiny of the Mental Health Act 2007 in 2013 suggested that the continuing use of block contracting in mental health services made them "much easier to cut", and that introducing a payment by results system for mental health might be beneficial.<sup>64</sup> We questioned Monitor about what progress had been made in this area to date, and they reported that while work is now ongoing to collect activity and cost information and to set quality information for mental health 'clusters', this work is revealing wide variations in both cost and clinical practice. This means that, in Monitor's view, "it is going to be quite a while" before national prices can be agreed in this area. Meanwhile, Monitor are advising those working in this sector to use clusters and to increase their understanding of their own activity and clinical practice, and use this to negotiate locally on prices.<sup>65</sup>

62. Since our accountability hearing in November 2013, there has been considerable debate about differences in cuts to the tariff price paid to the acute sector and the non-acute sector, with critics arguing that this has the potential to undermine the Government's commitments to achieve parity of esteem in mental health. We will explore these issues more fully in our inquiry into Children's and Adolescent Mental Health Services.

**63. Monitor told the Committee that "it is going to be quite a while" before national prices can be established that will enable the introduction of a well-based tariff in mental health. Since our accountability hearing, concerns have also been raised about**

62 Q88

63 NHS England, [Urgent and Emergency Care Review](#), 13 Nov 2013, p28

64 Health Committee, First Report of Session 2013-14, [Post-legislative scrutiny of the Mental Health Act 2007](#), August 2013, para 35

65 Q95

**differences in the changes being made to the prices paid for care in the acute sector and the non-acute sector. These changes raise important questions about the relative priority of acute and non-acute care, and undermine delivery of the objective of parity of esteem between mental and physical healthcare. The Committee will return to this issue in our inquiry into Child and Adolescent Mental Health Services.**

## 5 Competition and integration

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64. In its report of last year's accountability hearing with Monitor, the Committee concluded that "the likely practical effect of these provisions [on competition and choice] has been the subject of considerable argument; the Committee will seek evidence of their actual effect in practice at our next accountability session with Monitor". It also committed to continue to seek evidence on integrated care pathways.<sup>66</sup>

65. In evidence to the Committee's inquiry into the Implementation of the Health and Social Care Act in June 2013, David Bennett told the Committee that "this regime is an attempt to avoid it become a highly legalistic, lawyer-driven process. That is not to say it could not happen, but certainly our goal will be to avoid it becoming such"<sup>67</sup>. However, according to Sir David Nicholson, Chief Executive of NHS England, it is becoming exactly that:

I think we have a problem, which may need legislative change to make it happen. If I think back to the conversations we had with the most senior politicians in the Government around the reforms and changes that we are having, they were very clear that the intent behind all of this was that competition was there to serve, not to control. One of the things that we constantly said was that competition was a tool to improve quality, to be used when commissioners felt it was the right thing to do, not something that would be brought in externally; indeed, much of the conversation around the powers of Monitor was about making that the case.

For whatever reason, legislatively and in practice, that is not what is happening. What is happening at the moment—you all know cases as well as I do—as people move to using lawyers in all of this, we are in my view getting bogged down in a morass of competition law, which is causing significant cost in the system. We do not have a total for that, but undoubtedly we will find it in time. More than that, it is causing great frustration for people in the service about making change happen. That may be because of the way in which we are interpreting the law—we are talking to Monitor—but it may be because that is the law, in which case to make integration happen we will need to change it ...

.... Part of the problem is that when people are uncertain about what to do they tend to ask for legal advice. Once you start asking for legal advice, you get yourself into a whole set of legal arguments and controversy. Irrespective of where I, David Bennett or anyone else is, that is where people have got to.

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66 Health Committee, Tenth Report of Session 2012-13, 2012 [Accountability Hearing with Monitor](#), para 79; para 86

67 Health Committee, oral evidence, Implementation of the Health and Social Care Act, [11 June 2013](#), Q196

You have competition lawyers all over the place telling us what to do, which is causing enormous difficulty.<sup>68</sup>

66. The Foundation Trust Network argue that, “operating within this framework, NHS providers are increasingly in a position where they are unable to achieve what they need to at the required speed.”<sup>69</sup>

67. This chapter considers two distinct issues relating to competition arising from the Health and Social Care Act 2012. These are:

- Section 75 regulations
- Mergers

68. Alongside provisions relating to competition, the 2012 Act gave Monitor a duty to enable integrated care. This is discussed in the final section of this chapter.

### Competition–Section 75 guidance

69. The Section 75 regulations have proved an enduring theme in evidence submitted to this Committee, both in this inquiry and previous inquiries. In evidence to our inquiry into the Health and Social Care Act 2012, the Nuffield Trust argued that a lack of guidance for commissioners had exacerbated the problem:

The controversy has escalated because of the absence of practical guidance for commissioners on how to interpret and use the new regulations on competition and patient choice. Ministers have promised that guidance will be produced by Monitor and NHS England in the near future. As a result of this absence of guidance, commissioners do not know what the scope of potential regulatory action in the area of competition and choice might be in the future, nor how vigorously it will be policed. Potentially, the scope of the regulator’s duty to prevent anti competitive behaviour could be wide, judging by the recent documents published by the Cooperation and Competition Panel in between December 2012 and March 2013.<sup>70</sup>

70. The King’s Fund made similar points:

In the past, commissioners—who often lack skills and experience in managing procurement—have tended to adopt a cautious approach, engaging in sometimes cumbersome and unnecessary tendering processes for fear of finding themselves in breach of competition law. This risk is that, faced with further confusion and uncertainty, they become even more risk-averse, potentially undermining efforts to deliver integrated care. It is therefore essential that Monitor and NHS England produce detailed guidance to clarify

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68 Health Committee, oral evidence, Public Expenditure inquiry, [5 November 2013](#), Q59 - 60

69 [Foundation Trust Network](#) (AMO 0007), para 2.8

70 Nuffield Trust, (HSCA 37), para 4.4

how the Section 75 regulations—and competition more generally—should be implemented by commissioners.<sup>71</sup>

71. The importance of Monitor promptly issuing clear guidance has been repeatedly emphasised to the Committee. Most recently the King's Fund reiterated the case for this:

In previous evidence to this Committee, we have stressed the need for detailed guidance and support for commissioners to help them sensitively navigate procurement law if they are not to become disproportionately risk averse. In the past, commissioners have tended to adopt a cautious approach to procurement, engaging in sometimes cumbersome and unnecessary tendering processes for fear of finding themselves in breach of competition law. This risk is that, faced with further confusion and uncertainty, they become even more risk-averse, potentially undermining efforts to deliver integrated care. It is therefore essential that Monitor, working with NHS England provide clear detailed guidance and ongoing support for commissioners.<sup>72</sup>

72. Monitor reports that since April 2013 it has received 90 requests for informal advice in this area, from providers, commissioners and patients. The ten most frequent requests between April and July 2013 are, in order:

- I think I unfairly lost a tender—what should I do?
- Does my service count as a health care service for the purposes of the Procurement, Patient Choice and Competition Regulations?
- How do the Procurement, Patient Choice and Competition Regulations apply when commissioning is delegated to local authorities?
- How do the Procurement, Patient Choice and Competition Regulations apply to integrated care?
- I think there is only one capable provider—do I need to go out to tender?
- A CCG has a conflict of interest in a procurement—what should I do?
- Does patient choice apply to my service?
- Should patients be offered a choice of provider if they wait longer than 18 weeks?
- Is this transaction a merger and if so, what do I do?
- What is the role of providers in reconfiguration of services?

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71 King's Fund (HSCA 68) para 14.

72 [TheKing's Fund](#) (AMO 0009) para 7



73. These topics account for nearly 70% of the requests Monitor received. It should be noted that these queries apply to the actions of both commissioners and providers.<sup>73</sup>

74. Monitor's draft guidance was published for consultation in June 2013<sup>74</sup>, and the finalized guidance was published in December 2013, after the Committee's accountability hearing in November. The evidence received by the Committee therefore related to the Draft Guidance, rather than the final version.

75. Marie Curie Cancer Care stated that the draft guidance "risks adding to the confusion" rather than providing clarity,<sup>75</sup> and the BMA also raised concerns about the guidance:

It would be helpful to include comprehensive examples of circumstances where commissioners can award contracts to a single provider without running a competitive tendering process within Monitor's finalised guidance.<sup>76</sup>

Monitor's draft guidance for commissioners does not offer sufficient assistance for commissioners concerned about the competing interplay of integration and competition in specific commissioning instances. Clinical Commissioning Groups should be able to promote integration without the fear of being considered anti-competitive and more needs to be done to guide commissioners as to when they can promote integration.

Monitor's draft guidance states that commissioners may not have to tender where the benefits of tendering would be outweighed by the costs of publishing a contract notice and/or running a competitive tender process. The wording is vague and will leave commissioners open to challenge. It is a commissioner's duty to procure services within rules set down by European and UK law. The requirement to act proportionately is contained in the Regulations, but there are no details about what 'proportionality' means in law. We believe that there is a risk that providers will be able to challenge decisions made by commissioners not to competitively tender for reasons of proportionality using European and domestic competition law, which will hold more weight than Monitor's guidance. Monitor therefore needs to be exceptionally clear in its guidance to prevent such occurrences..<sup>77</sup>

76. David Bennett set out Monitor's position at our accountability hearing on 26<sup>th</sup> November. Discussing the application of the Section 75 regulations, Dr Bennett argued:

I think, unfortunately, there is an awful lot of misunderstanding and misinformation out there as to what those regulations do and do not require. They are not even fundamentally about competition. They are about doing

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73 [Monitor](#) (AMO 0010), para 6.15 – 6.16

74 [Monitor](#) (AMO 0010), para 6.7

75 [Marie Curie Cancer Care](#) (AMO 0001), paras 19

76 [British Medical Association](#) (AMO 0003) para 5

77 [British Medical Association](#) (AMO 0003), paras 6 - 7

commissioning well, and in fact they say that competition is only one of the tools available to a commissioner to secure better services for their patients. They even explicitly talk about other things like, in particular, better integration of care.

These rules, apart from that bit about better integration, are essentially the same as the rules that have been in existence for quite some time. They used to be the “Principles and rules for co-operation and competition”. They are hardly changed and the regulations are pretty well the same as the old rules. The biggest change is that we have different people doing the commissioning now, for a whole variety of reasons, and I think—not least, unfortunately, because it has become an incredibly controversial issue—those commissioners are very concerned about what this means for them. Fundamentally, if they are doing good commissioning that is improving the quality of care for their patients, they should not have any problems, but this is clearly not the perception. So, on this front, above all we have to find ways of talking to these commissioners, helping them to understand what the rules really mean. There is a whole variety of things that we need to do there and I have been in conversation with David Nicholson about how we can do this. Working jointly with NHS England on this will be very helpful because they have significant influence on commissioners and how they think about these things. I am hoping that, if we can explain to commissioners what it is that the rules do and do not allow them to do, we can deal with that, but I recognise that it is a huge challenge to explain it to people and there is a whole variety of things that we need to do.<sup>78</sup>

77. Dr Bennett cited the inexperience of new commissioning organisations as one of the reasons why they may be behaving in a cautious way:

....you have a whole bunch of new commissioners, with the CCGs instead of the PCTs—they have just become very fearful, and I am afraid there is an awful lot of misinformation out there.....You were talking about the costs of it all, so that is what happens: people get anxious about it, think the only safe thing to do is to go and talk to a lawyer, and then it does get very expensive. That is what has happened, I completely agree, and that is not the way we should be spending the NHS’s money.<sup>79</sup>

78. Dr Bennett expressed hope that the finalised guidance would assist commissioners:

I hope it will assist. It has taken rather longer than I would have wished to go from the consultation to the final version. The heart of it is that we have been having very long discussions with NHS England about how best to explain all this stuff in a way that I hope will alleviate some of the unnecessary concerns that commissioners have.

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78 Q41

79 Q50 - 51

....Most of the responses about which we could do anything were about trying to clarify things, and obviously we have tried to respond to those....

...The regulations are the regulations and our job is to produce guidance about how we will enforce them. Being clear and practical about how the regulations are to be applied is very important. Part of the reason it has taken so long is that we have been trying to produce case examples, because it is very difficult to write general guidance that will be meaningful to commissioners and people out there. They are not experts in this stuff and yet they are being asked to operate in this environment. That is very difficult. We now have a number of those in, but we need to do more, and now that the guidance is settled, I hope we can spend more of our effort on doing more case examples. That is very important. I want our people to get out there talking to these commissioners. We have 211 CCGs to talk to, but we need to do that. I am talking to David Nicholson about us doing it together again, so that they can understand that this is something that we are joined-up about.<sup>80</sup>

79. Monitor's finalised guidance was published in December 2013, shortly after our accountability hearing. Monitor has also supplied us with details of its plans to raise awareness of the guidance:

Our Guidance on Procurement, Patient Choice and Competition Regulations was published in December 2013 as soon as it was signed off by the Department of Health.

We are planning an awareness raising programme from January throughout 2014 to ensure commissioners and stakeholders are well informed about the guidance, the arrangements we propose to support trusts contemplating mergers and our consultation on the revised approach to risk assessing transactions. A key aspect of our engagement campaign is to highlight how the rules can be applied, practically, to improve patient care.<sup>81</sup>

**80. The Committee notes Dr Bennett's argument that the Section 75 rules are, except for the references to integration, essentially the same as the "principles and rules for cooperation and competition" which have been applied for several years.**

**81. The Committee recognises however that many new commissioning organizations have expressed concern about the impact of these principles on their actions. The Committee therefore recommends that Monitor undertakes a programme of meetings and visits to ensure that commissioners understand the practical implications of the Guidance which was issued in December 2013.**

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80 Qq 57-58

81 [Monitor supplementary information](#) (AMO 0013), para 1.2

## Other parts of the sector

82. Since our last accountability hearing, Monitor has begun to undertake studies to evaluate whether particular aspects of the sector are working well for patients. In March 2013 it published its Fair Playing Field Review; in June 2013, it announced a call for evidence on the operation of the GP sector, and in November they published initial findings from a study to review the closure of walk-in centres in England.<sup>82</sup>

83. In its written evidence, Marie Curie argued that Monitor as an organisation does not yet sufficiently understand the third sector, and, whilst making good efforts to engage with them, needs to improve this understanding:

Whilst Monitor colleagues working on Fair Playing Field review clearly worked extremely hard to understand the realities of the third sector during the course of the review, this required a sustained effort on the part of the charitable partners concerned. It would appear clear that the whole of the organisation needs to enhance its understanding of the charitable sector and specifically charitable providers of NHS services<sup>83</sup>

84. In response to this, Dr Bennett said that Monitor had made changes to the new provider licence following feedback from the charitable sector.<sup>84</sup> He also discussed other problems faced by charitable sector providers, including working capital requirements, contract size and the way in which charities are dealt with from a VAT point of view.<sup>85</sup>

85. In their written evidence, the BMA also raised a specific concern about the potential operation of competition in primary care:

Within primary care there is a consensus emerging that larger groupings of GP practices, such as federations or alliances, are highly desirable if GPs are to cope with increased demand. This will allow them to pool resources and to provide innovative, integrated services. However, GPs are wary of pursuing such groupings due to concerns that they may be in breach of competition law. The fear that such groupings could be deemed anti-competitive by the Competition Commission is directly hampering innovation. Conglomerations of GPs such as federations and alliances could offer significant quality and efficiency improvements, and potentially make inroads to tackling problems surrounding A&E pressures. We are keen to see that such innovations are not inhibited by the competition regulations..<sup>86</sup>

**86. The Committee recognises that Monitor's developing role as the health and care sector regulator requires it to develop a detailed understanding of a wide range of providers including primary care and third sector providers. Concerns have been**

82 [Monitor](#) (AMO 0010), paras 6.20, 6.21, 7.5

83 [Marie Curie Cancer Care](#) (AMO 0001), paras 10 - 11

84 Q66

85 Q68

86 [British Medical Association](#) (AMO 0003), para 8

expressed to the Committee by representatives of both the third sector and primary care that Monitor has not yet developed this understanding in sufficient depth. The findings of the Fair Playing Field review demonstrate the need for Monitor to develop a better understanding of the third sector, and the Committee will seek specific evidence on this matter at the next accountability hearing.

## Competition–mergers

87. In June 2013, in oral evidence to the Committee’s inquiry into the implementation of the Health and Social Care Act 2012, David Bennett told the Committee that, in contrast to the section 75 regulations which in his view do not represent a significant change, the involvement of the OFT and the Competition Commission in health sector mergers was a change.<sup>87</sup> David Bennett argued, at that time, that the length of time being taken by the OFT and Competition Commission to consider health sector mergers was due to the fact that they were still learning about the sector: “As to whether this is going to be a persistent problem, we have to see”.<sup>88</sup> He went on to say:

This is one of the absurdities of where we are in danger of finishing up, isn’t it—that you get a trust going out of business because it has insuperable problems, trying to fix the problem and not being allowed to fix it because it would reduce competition, which is the same result? I agree. This is something the OFT needs to look at. We have made the point to them.... I think we need to wait and see how it works.<sup>89</sup>

88. In October, the Competition Commission announced its decision to reject the proposed Bournemouth and Poole merger. Monitor stated in its written evidence that this “has given rise to concerns within the NHS that the application of competition law to such mergers ... might prevent or slow down the process of providers restructuring.”<sup>90</sup> Monitor report that it was with this in mind that they, the OFT and the Competition Commission published a joint statement in October on public hospital mergers. They report that the statement explains “how the three organisations will work together to reduce the numbers of mergers requiring notification to the OFT and minimise the risk of lengthy merger review.”<sup>91</sup>

89. David Bennett discussed this with us in oral evidence. He told us that many of the issues could be addressed by Monitor providing more support and advice to trusts contemplating or planning a merger:

On mergers, of course, what happened was that from April—and in fact before April—the OFT took over responsibility for looking at mergers

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87 Health Committee, oral evidence, Implementation of the Health and Social Care Act, [11 June 2013](#), Q150; Q215

88 Health Committee, oral evidence, Implementation of the Health and Social Care Act, [11 June 2013](#), Q 219

89 Health Committee, oral evidence, Implementation of the Health and Social Care Act, [11 June 2013](#), Q223, Q225

90 [Monitor](#) (AMO 0010), para 6.25

91 [Ensuring that Patients Interests are at the Heart of Assessing Public Hospital Mergers](#) – Joint Statement from the Office of Fair Trading, the Competition Commission and Monitor, 17 October 2013

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

The next bit is about understanding what the competition issues are that they need to worry about. For whatever reason, people are hearing all sorts of strange messages about concerns which we do not, frankly, understand. So we need to do more to explain to people what are the likely competition issues and what sort of advice they need, if they do need advice, to deal with those issues. In fact, we are going to go a step further, which is to do for ourselves, in parallel with the trusts thinking about whether or not they want to proceed with the merger, some of the work that the OFT would do so that we can help the trusts to understand, or the parties to understand, whether or not they are likely to have any issues and help them think through what they would do about it. If all of that is done well, that should deal with a lot of the problems we have.<sup>92</sup>

90. However, Dr Bennett went on to highlight a further issue that he told us he was “not sure how to deal with”:

This is about how you think about whether competition issues should be an obstacle to allowing a merger to proceed. The way the competition authorities think about this is that they first of all ask themselves, “Is there a significant lessening of competition?” If the answer is yes, they then say, “Is this likely to be outweighed by the patient benefits that would accrue from allowing the merger to proceed anyway?” Then they try and work out exactly, or get the parties to tell them exactly, what those patient benefits would be.

The problem is that there is a presumption that if there is a significant lessening of competition that is bad, and therefore you have to look at the concrete benefits of the merger and see whether they outweigh them. But the connection between there being a significant lessening of competition and that driving improvement in the quality or efficiency of care is a fairly tenuous connection. It is difficult. We can look at studies that tell us that competition does have some impact on the quality of care—and there are

some studies done in England to show that—but to translate that into, “How fast and how effectively would that competition improve the quality of care?” is very difficult.<sup>93</sup>

91. The Committee asked about what input Monitor provided to the competition authorities about this, and David Bennett responded:

As to the question of patient benefits, the more concrete thing—so, if you merge two institutions, what practical consequences will that have in terms of things like consultant rotas and so on?—we will advise the OFT on that, and in order to provide our advice, absolutely, we will take clinical advice ourselves. But, in the weighing of the impact of the lost competition against the benefits of the merger, that is now something which the OFT does. I want us to at least offer our advice to the OFT on both sides of that.<sup>94</sup>

92. When asked to sum up whether, in his view, the law needed changing to address this, David Bennett reiterated his point about weighing the costs of losing competition against the benefits of mergers:

In many respects, both on the commissioning and the merger stuff, it is about getting a better understanding of the law. But I did raise this very specific point about how you weigh the costs of losing competition against the benefits of going ahead, for example, with a merger. The way the competition authorities think about it is, I think, not taking sufficient account of the way that, while competition in health might lead to improvements, there is a danger that the potential benefits of competition are overstated. Whether fixing that problem requires a change to the law, or whether it is indeed fixable by changing the law, I do not know, but that is a problem that needs to be fixed.<sup>95</sup>

93. Following the session, we wrote and asked Monitor for further information on how Dr Bennett’s point above might be addressed, as well as what specific things Monitor had learnt from the Bournemouth and Poole experience about what it could do better next time. Monitor stated that:

What is now clear, reflecting on this process, is that merger parties need to have a fully developed understanding of the patient benefits they expect to achieve from a merger and how they will achieve them before going to the competition authorities.<sup>96</sup>

94. At the same time as it responded to the Committee, Monitor also wrote to all Foundation Trusts, setting out three issues relating to mergers in health that it believes need addressing:

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93 Q41

94 Q44

95 Q70

96 [Monitor supplementary information](#) (AMO 0013) , para 1.1

(i) Making sure any merger is based on a sound analysis of the clinical and other sources of patient benefit that should accrue from the merger, and that there are robust plans in place to make sure those benefits are realised in practice.

(ii) Ensuring that there is a realistic and shared understanding across the sector, and between the sector and the competition authorities, as to how to weigh such benefits of a merger against the costs to patients of any reduction in competitive pressures on providers arising from a merger.

(iii) Ensuring that any statutory review of a proposed merger can take place swiftly and without excessive cost.<sup>97</sup>

95. In its letter to NHS Foundation Trusts, Monitor sets out plans to address the first and third of these points, including providing support to trusts throughout the merger process, and engaging with Trusts at an earlier stage in the process. Monitor also proposes to set up a dedicated team to engage with trusts involved in merger processes. The letter outlines what Monitor hopes this extra support will achieve:

I hope...that the additional support outlined above will mean that, in future, hospital mergers will only be advanced where there is clear evidence that they are in the overall interests of patients. This should reduce the number of mergers requiring notification to the competition authorities, and, given that the OFT has said that it will give significant weight to our advice in its considerations should a merger be notified or called in for review, should also mean that the parties are better placed to engage with the process so that the review can be completed swiftly, with few transactions being subject to a second phase review (currently, by the Competition Commission)...<sup>98</sup>

96. With regard to the second point, “ensuring that there is a shared and realistic understanding across the sector, and between the sector and the competition authorities, as to how to weigh the benefits of a merger against the costs to patients of any reduction in competitive pressures on providers arising from a merger,” David Bennett states in his letter that he intends “to continue our dialogue with the sector and competition authorities.”<sup>99</sup> Monitor’s response to the Committee provides further detail:

We will undertake our own (limited) analysis of the potential competition costs of a proposed merger, starting with the advice provided by any professional advisors to the parties, alongside our analysis of the benefits to patients that should arise from the merger. We will use these analyses to work with the parties to try to ensure that cases proceed only where the benefits to patients of proceeding with the transaction outweigh the costs. This should mean that many cases will not even need to be notified to the competition authorities, but where they are called in the parties should

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97 [Arrangements to Support NHS Trusts Contemplating Mergers](#), Monitor, January 2014, p2

98 [Arrangements to Support NHS Trusts Contemplating Mergers](#), Monitor, January 2014, p3

99 [Arrangements to Support NHS Trusts Contemplating Mergers](#), Monitor, January 2014, p3



have just about all the information they need to make their case already prepared in the appropriate format, thereby speeding the review and reducing the risk of a further review.<sup>100</sup>

97. Monitor states in its response that “the Department of Health is fully behind these proposed arrangements for supporting trusts contemplating mergers” and that they “are seeking feedback on the arrangements from the sector”.<sup>101</sup>

**98. The Committee shares the widely expressed concern that the Competition Commission decision in the case of Bournemouth and Poole demonstrates that a new obstacle has been introduced which threatens to further slow the pace of change in the health and care sector in England. The Committee has repeatedly expressed its concern that the pace of change in the sector is glacial, and that failure to increase it threatens both the viability of the sector and the quality of the services it delivers.**

**99. The Committee notes that Monitor is taking steps to improve the support it provides to Trusts contemplating the merger process, following the case of Bournemouth and Poole.**

**100. The Committee remains concerned, however, that uncertainty persists in this area; it therefore recommends that Monitor should work with the Competition Commission, and, in future, the Competition and Markets Authority, to develop joint guidance, similar to the joint guidance it developed with NHS England on the Section 75 regulations, which demonstrates how trusts should ensure that institutional structures are not allowed to impede necessary change in the care model. Monitor would need to ensure that such joint guidance is consistent with its statutory duty to enable service integration. The Committee will seek specific evidence of progress on this matter at the next accountability hearing.**

## Integration

101. The Foundation Trust Network report that its members “continue to seek clarity from Monitor on reconciling obligations on enabling integrated care with promoting choice and preventing anti-competitive behaviour”. In oral evidence, Monitor reiterated that the two are not mutually exclusive:

I can say here and now that I think that innovation and better integration of services are essential. Unfortunately, this is just another example of ... a misunderstanding about the extent to which these things can happen, given the rules around competition. There is no fundamental reason why integration and innovation cannot happen without people contravening the rules, but this is where we need to help people understand that.<sup>102</sup>

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100 [Monitor supplementary information](#) (AMO 0013), para 1.1

101 [Monitor supplementary information](#) (AMO 0013), para 1.1

102 Q61

102. In its written evidence, Monitor reported that enabling integration has formed an important part of its work this year:

Monitor is actively fulfilling its duty to enable care to be delivered in an integrated way where this will improve the quality or efficiency of care patients receive, or reduce inequalities of access or outcomes.

In most cases, it will be for commissioners, working with local providers, to design, develop and fund better and more integrated patterns of care. We are not prescribing a single model.

Our role as the sector regulator is to work with others, particularly our national partners, to remove barriers and consider how to enable integrated care provision. The requirement for care to be delivered in an integrated way will feature in our policies in areas like assessment, licensing, choice and competition, and pricing (the latter two will be developed collaboratively with NHS England).<sup>103</sup>

103. Monitor's evidence includes the following table outlining its approach to enabling integrated care across the different areas of its work<sup>104</sup>:

<b>Monitor policy area</b>	<b>How we are enabling integrated care</b>
<b>Assessment</b>	We are yet to assess an integrated care organisation or NHS body that provides significant amounts of social care for NHS foundation trust status. Some trusts have expressed concern that Monitor's NHS foundation trust assessment process does not sufficiently take into account the needs of organisations that take, or wish to take, an integrated approach to delivering services across health and social care. However, we want to encourage such providers to innovate and have now ensured our assessment process can accommodate integrated care organisations.
<b>Licensing and enforcement</b>	Our provider licence includes a specific condition that requires all licence holders not to take actions that could reasonably be regarded as detrimental to delivering care in an integrated way. We are currently developing guidance on this licence condition to illustrate how we would expect licensees to meet this requirement.
<b>NHS payment system</b>	Our design of financial incentives through the payment system allows us to encourage a shift to more integrated service delivery. The current "payment by results" system has often been cited as a barrier to it. The national tariff, to be published in December 2013, removes any barriers to integrated care created by the existing payment system. Specifically, Monitor's policy around local variations in the 2014/15

<sup>103</sup> [Monitor](#) (AMO 0010), para 5.1-5.4

<sup>104</sup> [Monitor](#) (AMO 0010) Figure 4, Policy areas that enable integrated care

	national tariff allows commissioners and providers to vary from national currencies and prices when this is in patients' best interests. The local variation rules allow for innovative approaches to payment, such as the Year of Care (capitation) approach.
<b>Competition and choice</b>	<p>We do not believe there is an inherent conflict between integration, choice and competition; in our view, integrated services that seek to provide the best care for patients will raise very few competition issues. An example of this is sharing patient information to improve co-ordination. If tensions do emerge, we will always take the perspective of patient interest and suggest remedies.</p> <p>We have drafted supplementary guidance for providers and commissioners to dispel concerns that choice and competition might be incompatible with integrated care.</p> <p>This includes drafting frequently asked questions around integrated care. We hope that, as a result, competition will be cited less frequently as a barrier.</p>

104. Monitor report that they are providing integrated care pioneers with “expert strategic planning support and practical advice on regulations that may affect their plans. “ They also state that they will work collaboratively with pioneering sites to design, test and evaluate new, innovative payment approaches that support the delivery of integrated care (such as capitation models), and that they will share the experience gathered from the pioneers’ activities.<sup>105</sup>

105. In written evidence to this inquiry, both the King’s Fund and the BMA argue that more progress needs to be made by Monitor on developing alternative payment systems to better support integrated care. The King’s Fund’s memorandum states that:

While Payment by Results continues to have a role, alternative complementary payment systems are also needed to provide incentives which support the development of innovative local models of care, particularly in the direction of integrated care. As such we welcome Monitor’s decision to agree to new rules for agreeing local prices and ‘flexibilities’, which are now referred to as ‘local variations’.

Despite high-level support for integrated care from ministers and government, the progress in developing innovative payment systems that provide the right financial incentives for integrated care continues to be slow and there is a need for a much greater sense of urgency from Monitor to enable this.<sup>106</sup>

106. The BMA argues that the current payment by results system can often act as a barrier to integration, “creating perverse incentives which lead to silo type thinking and behaviour”, and state that in their view, “little progress has been made by Monitor to shape

<sup>105</sup> [Monitor](#) (AMO 0010), para 5.7

<sup>106</sup> [TheKing’s Fund](#) (AMO 0009) paras 9-10

the future of the payments system, and this is having a negative impact on integration.”<sup>107</sup> They suggest that allowing providers to delay efficiency savings through a multi-year tariff could encourage providers to undertake long-term efficiency savings, and suggest that “a multi-year tariff, tied in with CCG contracts, could provide both stability and encourage innovation from providers.”<sup>108</sup> In its supplementary evidence, Monitor provided further information on payments systems:

The National Tariff for 2014/15 introduced new opportunities to vary national prices. Changes to the standard NHS contract also give commissioners and providers more leeway for change. We want all parties within a local health economy to start using these new opportunities to make lasting changes to the patterns of care in patients’ best interests.

However, we realise that giving commissioners and providers the opportunities to break out of current patterns of care is only a first step towards transforming the services each local health economy needs. We also recognise that not all local health economies are in a position to implement new payment variations. Many local health economies need more support from the payment system, so future National Tariffs must include information, incentives and rules that do more to help.

We will seek to learn, along with the sector, what works in relation to enabling integrated care. This knowledge will be played into our work on an annual basis.<sup>109</sup>

**107. The Committee continues to believe that the development of a more integrated care model is fundamental to the delivery of high quality good value care. In addition to its work as the routine regulator of the health and care sector, this report therefore contains two specific recommendations addressed to Monitor, intended to facilitate the longer term reconfiguration of the health and care sector, which are repeated here, and on which the Committee will seek further specific evidence:**

- a) **It should launch a review with NHS England of the structure and level of National Tariff payments designed to identify and eliminate perverse incentives and incentivise necessary service reconfiguration;**
- b) **It should launch a review with the Competition Commission, and, in future, the Competition and Markets Authority, of the effect of competition law on necessary institutional change to ensure that existing institutions are not allowed to impede necessary service reconfiguration.**

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<sup>107</sup>[British Medical Association](#) (AMO 0003) para 10

<sup>108</sup> [British Medical Association](#) (AMO 0003), paras 10-11

<sup>109</sup> [Monitor supplementary information](#) (AMO 0013), para 2.1

## 6 Monitor as an organisation

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108. The Health and Social Care Act 2012 expanded Monitor's role considerably, and as the Committee argued in its report of last year's accountability hearing, Monitor's role is complex and demanding; the BMA describe Monitor's role as "exceptionally challenging".<sup>110</sup> To meet these challenges, it is important that Monitor has sufficient staffing and expertise, underpinned by robust internal structures. The RCN highlight the importance of Monitor retaining an open approach to evaluation and learning over time:

The RCN would like to again highlight that much will be proven by how all elements under Monitor's remit, including pricing, their advice on mergers, commissioning the Trust Special Administrator for FTs under the failure regime etc, will work together. This will either help or hinder the ability of the NHS to deliver safe, high quality care and stay within a challenging budget. The RCN urges an open attitude for agencies such as Monitor to evaluate their approach and to work with others on making improvements in the best interests of patients.<sup>111</sup>

109. As part of this year's annual accountability process, the Committee posed the question "what does success look like for Monitor?" and asked what measures it currently used to monitor its own performance. Monitor responded as follows:

We are fundamentally concerned with ensuring that the health sector works well for patients and that overall the NHS is delivering better care, more efficiently. Our role in ensuring foundation trusts are well governed and in regulating the sector from an economic perspective means that we are at the heart of delivering many of the changes and improvements that are needed. In particular we have set ourselves the following high level objectives:

- In Assessment, to make significant progress, working with the Trust Development Authority, to ensure all public providers achieve the minimum standard needed to become a foundation trust;
- In Provider Regulation, to ensure that the majority of foundation trusts are providing high quality care on a sustainable basis in a way that supports commissioners to deliver the best possible outcomes with the money available to them. Where trusts have difficulty in achieving this, to resolve issues swiftly in support of commissioners' objectives;
- In Pricing, to ensure that the system does not act as a barrier to change but incentivises quality and efficiency improvements as well as rewards providers that deliver good quality care; and

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110 [British Medical Association](#) (AMO 0003), para 1

111 [Royal College of Nursing](#) (AMO 0006), para 6.1

- In Co-operation and Competition, to apply the rules relating to Procurement, Patient Choice and Competition to help commissioners deliver better care for their local populations and to help ensure the merger regime works for the overall benefit of patients.

We are currently defining a set of more detailed and specific outcomes against which we can measure our performance in the coming year. This will be published as part of our Business Plan for 2014/15. This will form the basis of a more comprehensive performance measurement framework which we will develop later in 2014.

This performance framework will take account of our new roles and responsibilities, some of which come into force in April 2014. The new framework will use a range of performance measures to track the progress and success in achieving our goals. We are also assessing whether to commission an evaluation of the impact of our work on patients.<sup>112</sup>

**110. The Committee welcomes Monitor's plans to develop more detailed and specific outcomes against which it can measure its own performance, and a more comprehensive performance measurement framework, and we will consider progress against these outcomes as part of our next accountability review with Monitor. The Committee believes that its two recommendations set out in Paragraph 107 will facilitate these developments.**

111. The Department of Health report that Monitor has been working to recruit new staff and diversify its skills base. Monitor's staff base has increased from around 160 in March 2012 to nearly 300 by March 2013. It is predicted to increase further to around 420 by March 2014.<sup>113</sup> Monitor provided the following breakdown of staff by function area:

Assessment–44  
Provider regulation–78  
Sector development–80  
Co-operation and competition - 29  
NEDs–4  
Executive Office–4  
Legal services–25  
Patient and clinical engagement–0  
Strategic communications–28  
Organisation transformation–20

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112 Monitor supplementary information, para 4.1

113 [Department of Health](#) (AMO 0002), para 7

112. The RCN raised concern in its written evidence about whether “appropriate clinical advice is sought and applied as Monitor continues to refine their approach to their new responsibilities” and argued for a formal role for nurse representation to ensure effective clinical advice is supplied throughout all levels of the organisation.<sup>114</sup> Monitor reported in its written evidence that:

All Executive Directors have been appointed, except for the Medical Director (whose appointment awaits government approval). This has delayed recruitment to the ten-strong Patient and Clinical Engagement team.

We do recognise the importance to the organisation of people with a clinical background. A total of four clinicians have been recruited to our teams working in Co-operation and Competition, and Policy. Additionally, we have seconded five quality governance associates from the NHS.<sup>115</sup>

113. When questioned further about this, Dr Bennett said:

One of the things that I am very clear about is that, although we draw heavily on external experts for advice on clinical aspects of much of what we do, we need more people with clinical backgrounds inside Monitor. My starting point for that is to appoint a medical director to run the unit that you mention. I have had a problem in that I know who I want to appoint and have known for many months, but I have had a problem getting the terms and conditions of that appointment agreed. That is why that unit is not yet established.<sup>116</sup>

114. Dr Bennett expanded on the importance of clinical engagement:

On clinical engagement, we need a number of in-house clinical experts like the medical director and then I want them to reach out to clinical experts across the NHS, including the royal colleges, for example, and there are two things that they need to do for us. One is to bring genuine specific technical knowledge, clinical knowledge, to our decision making, and we have touched on those sorts of issues several times in the course of this afternoon. The second thing I want them to do, which at the moment mostly I and one or two other colleagues are doing, is to reach out to the clinicians as important stakeholders for all the things that need to happen in the NHS... I want to do this more often, more regularly, on a broader base, so that we can establish strong ties with the clinicians in the health sector.<sup>117</sup>

115. In follow up information received by the Committee on 24<sup>th</sup> January, Monitor provided an update on recruitment:

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114 [Royal College of Nursing](#) (AMO 0006), para 3.4

115 [Monitor](#) (AMO 0010), para 8.5-8.6

116 Q109

117 Q111

Monitor has been recruiting over the past 12 months to allow us to undertake our new regulatory responsibilities. Great care has been taken to ensure that we recruit people with the right skills and expertise to ensure that we fulfil our core function of protecting and promoting the interests of patients. In addition to recruitment, where we will continue to enhance our resourcing strategy, we have developed a core set of internal training courses as part a commitment to provide staff with ongoing learning and development. We will continue to recruit as our new activities get underway; we will be working with the Department of Health to ensure that recruitment to business critical senior roles requiring a salary over a threshold set by the Department can be progressed quickly without detriment to our business operation.

The Committee specifically asked about recruitment to the position of Medical Director. We have only just been able to conclude discussions with the Department of Health about remuneration for this position—we can now progress this apace. Delay in recruitment to this post has led to a delay in recruiting to the Patient and Clinical Engagement team; we are now initiating recruitment for an interim resource to support the Medical Director. However, because it is important to have people with a clinical background in the organisation we have already recruited four clinicians to work in our Co-operation and Competition and Policy teams. We also have five quality governance associates seconded to us from the NHS.

We have recently recruited an Enquiries Director to work within the Co-operation and Competition team to help us develop our capacity for providing informal advice to the sector. Sector engagement specialists will also be recruited to work across our functions to ensure as full an understanding as possible. We will discuss with the Department our requirements for any further recruitment to the Co-operation and Competition team as the need arises.<sup>118</sup>

**116. It is essential that an organisation with such a central and crucial role as Monitor has appropriate clinical input. The Committee was frustrated to learn that the Department of Health delayed the appointment of a Medical Director for several months due to an argument about appropriate pay levels. The Committee regards this as an absurd distortion of priorities and strongly supports the formation of a fully staffed Patient and Clinical Engagement Team within Monitor at the earliest possible date.**

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118 [Monitor supplementary information](#) (AMO 0013), para 4.2



# Conclusions and recommendations

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## Monitor's view on the NHS financial position

1. The Committee drew two conclusions from the evidence presented by Monitor:
  - a) It remains concerned that the model of care provided by the health and care system is not changing quickly enough with the result that pressures continue to build, threatening the financial stability of individual providers, and therefore the quality of care provided;
  - b) These pressures are likely to be particularly marked in the acute sector as plans are prepared and implemented to achieve the resource transfer required by the introduction of the Better Care Fund from April 2015. (Paragraph 12)

## Provider Regulation

2. Following changes to the CQCs's inspection and rating regime, Monitor's Board decided not to finalise any assessment decisions on applicant trusts until updated assurance could be received from the CQC under their new inspection regime. No new Foundation Trusts have since been authorised, and the Department of Health has abandoned its original objective that the majority of aspirant Trusts should become Foundation Trusts in 2014. We welcome this change of approach which focuses on the requirement to improve the underlying reality rather than meet an artificial timescale. (Paragraph 17)
3. It is clear to the Committee that Foundation Trusts are currently subject to closer supervision and scrutiny by Monitor than was envisaged by ministers when Foundation Trust status was originally put into legislation. While the Committee is sympathetic to the view that Monitor must satisfy itself that Foundation Trust managements are addressing the issues they face, it is also important that heavy handed regulation does not inhibit necessary change. At a time when NHS providers face an unprecedented need to change the care model, Monitor must be a facilitator of change, not an obstacle. (Paragraph 25)
4. The challenge for Monitor in supporting Trusts in financial difficulty is likely to increase as the NHS financial situation tightens. It is essential that the organization continues to prioritise and resource its work in this area. (Paragraph 29)
5. It is also important that pressures within individual providers are addressed in the context of the local health economy. The requirement for major change in the care model, referred to in this and many other reports of this Committee, can only be delivered if individual providers, and Monitor as their regulator, look beyond preserving existing structures and address the need to develop different structures to meet changing needs. (Paragraph 30)
6. The Committee has expressed concern before about the impact on patient safety of unclear regulatory responsibilities. The fact that recent institutional change may have

compounded this problem reinforces the need for it to be addressed as a matter of urgency. The Committee recommends that Monitor and the CQC should meet jointly with those organisations which expressed concern on this subject to this Inquiry and should ensure that all parties are clear how it is planned that these concerns will be addressed. The Committee requests that Monitor submits a report of this process to the Committee before 30th June 2014. (Paragraph 35)

7. The Foundation Trust Network told us that "it is essential that Monitor's approach is appropriate for all types of trusts." We agree. We are pleased that Monitor has acknowledged the need to "shine the light everywhere", not just on acute trusts, and we recommend that it keeps its processes under review to ensure they are appropriate to all types of trust. (Paragraph 39)
8. We recommend that the Government should reconsider its decision to allocate responsibility for the financial regulation of social care to CQC and that it should ask Monitor to undertake this role. Although this development would divide oversight of adult social care between Monitor and the CQC, it would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance. (Paragraph 45)

### Pricing

9. The Committee does not believe that this record constitutes an adequate response to its recommendation in last year's Accountability Report that Monitor should attach a high priority to its work on the tariff. The Committee believes that the current tariff arrangements often create perverse incentives for providers and inhibit necessary service change. (Paragraph 51)
10. The Committee therefore repeats its recommendation from last year that Monitor should attach a higher priority to its work on this subject and further recommends that Monitor and NHS England should initiate a formal joint process for a prioritised review of the NHS tariff arrangements with the objective of identifying and eliminating perverse incentives and introducing new tariff structures which incentivise necessary service change. The Committee requests that Monitor submits a report of this process to the Committee before 30th June 2014. (Paragraph 52)
11. Concern continues to be reported to the Committee about "cherry picking". As we recommended in our report on Public Expenditure: it is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement. The Committee welcomes the fact that Monitor has acknowledged the need to improve the quality of the costing on which prices are based; improved cost information is a key part of the wider tariff review proposed by the Committee, which would also assist in the elimination of "cherry picking". (Paragraph 56)
12. The Committee has heard that the marginal rate rule, while it has the potential to act as a lever to reduce levels of emergency admissions and improve care outside hospitals, also carries the risk of pushing trusts into financial difficulty where

admissions are unavoidable. Monitor also told us that the proportion of funding retained by commissioners "is not all being spent as effectively as we would like". Changes have been introduced this year to allow for revised baselines, and to ensure that money retained through the application of the rule will be spent transparently and effectively, to enable more patients to be treated in community settings. We will seek an update on progress in this important area from Monitor and from NHS England later in 2014. (Paragraph 60)

13. Monitor told the Committee that "it is going to be quite a while" before national prices can be established that will enable the introduction of a well-based tariff in mental health. Since our accountability hearing, concerns have also been raised about differences in the changes being made to the prices paid for care in the acute sector and the non-acute sector. These changes raise important questions about the relative priority of acute and non-acute care, and undermine delivery of the objective of parity of esteem between mental and physical healthcare. The Committee will return to this issue in our inquiry into Child and Adolescent Mental Health Services. (Paragraph 63)

### Competition and integration

14. The Committee notes Dr Bennett's argument that the Section 75 rules are, except for the references to integration, essentially the same as the "principles and rules for cooperation and competition" which have been applied for several years. (Paragraph 80)
15. The Committee recognises however that many new commissioning organizations have expressed concern about the impact of these principles on their actions. The Committee therefore recommends that Monitor undertakes a programme of meetings and visits to ensure that commissioners understand the practical implications of the Guidance which was issued in December 2013. (Paragraph 81)
16. The Committee recognises that Monitor's developing role as the health and care sector regulator requires it to develop a detailed understanding of a wide range of providers including primary care and third sector providers. Concerns have been expressed to the Committee by representatives of both the third sector and primary care that Monitor has not yet developed this understanding in sufficient depth. The findings of the Fair Playing Field review demonstrate the need for Monitor to develop a better understanding of the third sector, and the Committee will seek specific evidence on this matter at the next accountability hearing. (Paragraph 86)
17. The Committee shares the widely expressed concern that the Competition Commission decision in the case of Bournemouth and Poole demonstrates that a new obstacle has been introduced which threatens to further slow the pace of change in the health and care sector in England. The Committee has repeatedly expressed its concern that the pace of change in the sector is glacial, and that failure to increase it threatens both the viability of the sector and the quality of the services it delivers. (Paragraph 98)

18. The Committee notes that Monitor is taking steps to improve the support it provides to Trusts contemplating the merger process, following the case of Bournemouth and Poole. (Paragraph 99)
19. The Committee remains concerned, however, that uncertainty persists in this area; it therefore recommends that Monitor should work with the Competition Commission, and, in future, the Competition and Markets Authority, to develop joint guidance, similar to the joint guidance it developed with NHS England on the Section 75 regulations, which demonstrates how trusts should ensure that institutional structures are not allowed to impede necessary change in the care model. Monitor would need to ensure that such joint guidance is consistent with its statutory duty to enable service integration. The Committee will seek specific evidence of progress on this matter at the next accountability hearing. (Paragraph 100)
20. The Committee continues to believe that the development of a more integrated care model is fundamental to the delivery of high quality good value care. In addition to its work as the routine regulator of the health and care sector, this report therefore contains two specific recommendations addressed to Monitor, intended to facilitate the longer term reconfiguration of the health and care sector, which are repeated here, and on which the Committee will seek further specific evidence:
  - a) It should launch a review with NHS England of the structure and level of National Tariff payments designed to identify and eliminate perverse incentives and incentivise necessary service reconfiguration;
  - b) It should launch a review with the Competition Commission, and, in future, the Competition and Markets Authority, of the effect of competition law on necessary institutional change to ensure that existing institutions are not allowed to impede **necessary service reconfiguration**. (Paragraph 106)

### Monitor as an organisation

21. The Committee welcomes Monitor's plans to develop more detailed and specific outcomes against which it can measure its own performance, and a more comprehensive performance measurement framework, and we will consider progress against these outcomes as part of our next accountability review with Monitor. The Committee believes that its two recommendations set out in Paragraph 107 will facilitate these developments. (Paragraph 110)
22. It is essential that an organisation with such a central and crucial role as Monitor has appropriate clinical input. The Committee was frustrated to learn that the Department of Health delayed the appointment of a Medical Director for several months due to an argument about appropriate pay levels. The Committee regards this as an absurd distortion of priorities and strongly supports the formation of a fully staffed Patient and Clinical Engagement Team within Monitor at the earliest possible date. (Paragraph 116)

# Formal Minutes

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**Wednesday 19 March 2014**

Members present:

Mr Stephen Dorrell, in the Chair

Andrew George  
Barbara Keeley  
Charlotte Leslie

Andrew Percy  
Mr Virendra Sharma  
David Tredinnick

Draft Report (*2013 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 116 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Ninth 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.

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[Adjourned till Tuesday 25 March at 2.00 pm

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/mon-2013/?type=Written#pnlPublicationFilter>.

### **Tuesday 26 November 2013**

*Question number*

**Dr David Bennett, Stephen Hay and Adrian Master, Monitor**

[Q1-133](#)

## Published written evidence

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The following written evidence was received and can be viewed on the Committee's inquiry web page at <http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/mon-2013/?type=Written#pnlPublicationFilter>. INQ numbers are generated by the evidence processing system and so may not be complete.

- 1 Marie Curie Cancer Care([AMO 001](#))
- 2 Department of Health([AMO 002](#))
- 3 The British Medical Association([AMO 003](#))
- 4 South West Whistleblowers Health Action Group ([AMO 005](#))
- 5 Royal College of Nursing ([AMO 006](#))
- 6 The Foundation Trust Network ([AMO 007](#))
- 7 The King's Fund ([AMO 009](#))
- 8 Monitor ([AMO 010](#))
- 9 Geoff Hill ([AMO 012](#))
- 10 Monitor supplementary ([AMO 013](#))

# List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the Committee's website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom).

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

## Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699
Sixth Report	2013 accountability hearing with the care of the Quality Commission	HC 761
Seventh Report	Public expenditure on health and social care	HC 793
Eighth Report	Public Health England	HC 840

## Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and	HC 639



	Midwifery Council	
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)
<b>Session 2010–12</b>		
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 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)