



House of Commons
Committee of Public Accounts

Monitor: regulating NHS Foundation Trusts

Fourth Report of Session 2014–15

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

*Ordered by the House of Commons
to be printed 18 June 2014*

HC 407
Incorporating HC 1119, Session 2013–14
Published on 4 July 2014
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No 148).

Current membership

[Rt Hon Margaret Hodge](#) (Labour, Barking) (Chair)
[Mr Richard Bacon](#) (Conservative, South Norfolk)
[Stephen Barclay](#) (Conservative, North East Cambridgeshire)
[Guto Bebb](#) (Conservative, Aberconwy)
[Jackie Doyle-Price](#) (Conservative, Thurrock)
[Chris Heaton-Harris](#) (Conservative, Daventry)
[Meg Hillier](#) (Labour, Hackney South and Shoreditch)
[Mr Stewart Jackson](#) (Conservative, Peterborough)
[Rt Hon Anne McGuire](#) (Labour, Stirling)
[Austin Mitchell](#) (Labour, Great Grimsby)
[Andrea Leadsom](#) (Conservative, South Northamptonshire)
[Nick Smith](#) (Labour, Blaenau Gwent)
[Ian Swales](#) (Liberal Democrats, Redcar)
[Justin Tomlinson](#) (Conservative, North Swindon)

Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Ian Blair and Sue Alexander (Committee Assistants) and Janet Coull Trisic (Media Officer).

Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is pubaccomm@parliament.uk.

Contents

Report	<i>Page</i>
Summary	3
Conclusions and recommendations	5
1 Monitor's regulation of NHS foundation trusts	9
2 Monitor's resources and capability	12
3 Monitor's new responsibilities	14
Formal Minutes	15
Witnesses	16
List of printed written evidence	16
List of Reports from the Committee during the current Parliament	17

Summary

The number of NHS foundation trusts in difficulty is growing, casting doubt on Monitor's effectiveness as their regulator. At the time of our hearing Monitor estimated that 39 of 147 foundation trusts would be in deficit by the end of 2013–14. At 31 December 2013, 25 trusts (one in six) were in breach of the conditions set when they were awarded foundation trust status. These trusts were in financial difficulty, or had inadequate governance arrangements, or both, and Monitor expects the problems to grow. Some had been in breach of their regulatory conditions for over four years. Furthermore there are potential conflicts between Monitor's traditional role of regulating NHS foundation trusts and the new responsibilities it has been given in the health sector. At present Monitor relies heavily on consultants and it is not clear whether the organisation can build the capacity to carry out effectively its expanded remit. Responsibility for overseeing the provision of healthcare is fragmented, and there is a strong risk of regulatory overlaps and gaps between Monitor's role and those of other bodies, including the Care Quality Commission, the NHS Trust Development Authority, NHS England and the Department of Health.

Conclusions and recommendations

1. Monitor was created in 2004 as the independent regulator for NHS foundation trusts. It determines whether NHS trusts are ready to become foundation trusts and operates a regulatory regime designed to ensure that the 147 trusts that have achieved foundation status continue to be financially sustainable, well-led and locally accountable. It intervenes where there is evidence that an NHS foundation trust is in breach of its regulatory conditions. Monitor's remit is expanding, with significant new responsibilities, including setting prices for NHS-funded care jointly with NHS England, and preventing anti-competitive behaviour by healthcare commissioners and providers. Monitor is independent of government in terms of its regulatory decisions, but is accountable to Parliament and the Department of Health (the Department) for its performance and value for money.
2. **Some NHS foundation trusts have been allowed to struggle for far too long in breach of their regulatory conditions.** It has taken Monitor too long to help trusts in difficulty to improve, with three trusts having been in breach of their regulatory conditions since 2009. Trusts may get into difficulty for a number of reasons. Sometimes the underlying cause is internal, such as poor leadership, and sometimes the difficulties relate to wider problems in the local health economy, such as when local commissioners are in financial difficulty. Monitor has taken too long to identify clearly the reasons for trusts being in difficulty, and to take decisive action. It has adopted an incremental approach to intervention, in the hope that trusts will recover, rather than taking radical action at an early stage.

Recommendation: Monitor should investigate quickly, to diagnose the underlying causes of the problems which each trust in difficulty faces, and then take faster, more decisive action to address them, to turn around failing trusts sooner.

3. **Monitor's job is becoming harder as more foundation trusts get into difficulty.** In an environment where there is a shortage of good leaders, increased financial pressures and greater emphasis on the quality of care; the demands on Monitor will increase. We expect Monitor to make better use of its resources to drive improvement. At the time of our hearing, over 26% of trusts were predicted to be in deficit by the end of 2013-14. At 31 December 2013, 17% of the 147 NHS foundation trusts were in breach of their regulatory conditions, up from 11% two years previously. Intervening in these trusts is resource intensive for Monitor. It does not at present enjoy the appropriate capacity and skills and relies heavily on consultants. It is unlikely therefore that it will have the capacity to maintain its current regulatory approach should the number of trusts in difficulty continue to rise. It may need to adopt different approaches to dealing with trusts in difficulty, to cope with the increasing demands on its resources.

Recommendation: Monitor should evaluate the cost-effectiveness of different regulatory interventions, and use this information to direct its work and make the best use of its resources.

4. **Monitor's effectiveness is hampered by a lack of clinical expertise and frontline NHS experience.** While Monitor employs people with financial and business expertise, it lacks sufficient numbers of staff with experience of running or working in a hospital trust. Only 21 of Monitor's 337 staff have an NHS operational background and only 7 have a clinical background, which damages Monitor's credibility in dealing with trusts and its effectiveness in diagnosing problems and developing solutions. Monitor also makes extensive use of external consultants to fill gaps in its capacity and expertise. However, its use of consultants has been costly, accounting for some £9 million of Monitor's £48 million budget in 2013-14. The use of consultants has also restricted Monitor's ability to build in-house expertise and knowledge. Both Monitor and NHS foundation trusts face a real challenge in recruiting the excellent leadership they need to take the NHS forward in these financially challenging times.

Recommendation: *Monitor should set out how it will: fill gaps in its capacity and expertise; exploit the skills and knowledge from the consultants it employs; and develop a staffing model which sets out the balance of clinical, financial and other expertise it requires.*

5. **The movement of staff between the NHS, local government and the civil service is hindered by the differing terms and conditions of service, limiting the transfer of skills and knowledge and inhibiting integration.** Monitor presently spend almost one-third of its budget on central services with 30 individuals employed to work on strategic communications. Nearly 30 of Monitor's staff are paid over £100,000 a year. Monitor has struggled to recruit staff with a background in the NHS, particularly for senior roles. NHS staff cannot transfer their accrued pension rights and they lose continuity of service if they join Monitor, as it employs staff on different terms and conditions based on those in the Civil Service. As a result, the years of service such staff accrue under the NHS pension scheme would not be taken into account in calculating the amount of compensation due if they were to be made redundant by Monitor. Similar barriers affect staff transfers between the civil service, the NHS and local authorities, which impedes the transfer of knowledge and skills between different parts of the health and social care system.

Recommendation: *The Department, in conjunction with the Cabinet Office and HM Treasury, should set out what steps they are taking to remove disincentives, such as the inability to transfer accrued rights, to the flow of staff between different parts of the health and social care system, and to facilitate and encourage the free flow of staff.*

6. **There is a risk of actual or perceived conflicts between Monitor's role of regulating NHS foundation trusts and its new responsibilities.** Monitor now has a duty to protect and promote the interests of patients and a role in ensuring the continuity of essential health services. This significantly widens its remit into new sensitive areas, taking it beyond protecting individual NHS foundation trusts from failure. For example, potential conflicts arise from Monitor's new role in setting prices for NHS-funded care, and it will need to reconcile tensions between supporting the financial viability of trusts and the wider objective of providing more care outside hospitals in the community in the interests of patients. Similarly,

conflicts could arise from Monitor's new responsibility for preventing anti-competitive behaviour by healthcare commissioners and providers, particularly when considering proposals for trusts to merge. It is not clear how Monitor will assess the impact of proposed mergers on patients, including weighing up the benefits of potential improvements in care quality against possible disadvantages, such as longer journeys or reduced competitive pressure between providers.

Recommendation: *Monitor should explain how it prioritises the protection of patients' interests above those of NHS foundation trusts, and demonstrate how it does so in practice, to allay concerns that its new responsibilities are conflicting.*

7. **There is potential for overlap between all the bodies responsible for regulating the NHS, including Monitor, as well as for gaps in oversight.** Monitor is increasingly involved, working with the NHS Trust Development Authority and NHS England, in health economies facing tough challenges. It is also engaged with commissioners who are struggling to find an answer to problems in the local health economy in difficult financial times. There are therefore at least three national bodies working closely with the Care Quality Commission and the Department and with commissioning groups and individual trusts on the same problems.

Recommendation: *The Department should review its regulatory, oversight and monitoring arrangements to ensure it eliminates duplication and fills any potential gaps.*

8. **The Department confirmed that it was still the Government's policy intention that all trusts should become foundation trusts, but it had not set a target date for this to be achieved.** However, just two NHS trusts gained foundation trust status in 2012-13 and, as at 31 December 2013, 98 NHS trusts remained.

Recommendation: *The Department should set out how it intends to meet the objective of all NHS trusts achieving foundation trust status.*

9. **It is wholly inappropriate that the same person acted as both Chair and Chief Executive of Monitor between March 2011 and January 2014.** This was contrary to corporate governance good practice and Monitor's own guidance to NHS foundation trusts. A non-executive Chair provides an independent check on the executive by scrutinising performance and holding management to account. Monitor lacked this important governance mechanism for nearly three years up to January 2014, when the Secretary of State for Health appointed an interim Chair who will serve for up to a year.

10. **Recommendation:** *The Department should appoint a permanent non-executive Chair of Monitor through an open, competitive process by the end of 2014 at the latest.*

1 Monitor's regulation of NHS foundation trusts

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and Monitor about Monitor's performance in regulating NHS foundation trusts, and how it is responding to the new challenges it faces.¹

2. Monitor was created in 2004 as the independent regulator for NHS foundation trusts. It assesses NHS trusts for foundation trust status, and authorises those that meet the required standards to become foundation trusts. It regulates the 147 trusts that have achieved foundation status, and intervenes where they breach their regulatory conditions to help them improve. Monitor is an executive non-departmental public body sponsored by the Department. It is independent of government, in terms of its regulatory decisions, but is accountable to Parliament and the Department for its performance and value for money. In regulating NHS foundation trusts, Monitor has to work with other bodies including the Care Quality Commission (which regulates the quality and safety of healthcare), the NHS Trust Development Authority (which oversees the performance of the remaining NHS trusts), NHS England and local clinical commissioning groups (which commission healthcare from trusts).²

3. To earn the greater financial and operational freedoms that foundation trust status brings, NHS trusts have to demonstrate to Monitor that they are financially sustainable, well-led and locally accountable. Despite this, at 31 December 2013, 25 NHS foundation trusts (one in six) were in breach of their regulatory conditions, an all-time high. One trust was in breach on financial grounds, nine on governance grounds, and 15 on both financial and governance grounds. At the time of our hearing Monitor estimated that 39 of 147 NHS foundation trusts (some 26%) would be in deficit by the end of 2013–14.³

4. Monitor told us that there were four main reasons why trusts were in difficulty after gaining foundation trust status. Firstly, key members of the leadership teams of some trusts had changed over time and the new leadership was not as strong. Secondly, the financial environment in which trusts were currently operating was much more challenging than when many trusts were authorised. Thirdly, the standards Monitor expected in relation to care quality had become more demanding, following the failings in patient care at Mid Staffordshire NHS Foundation Trust. And lastly, Monitor had on occasion made the wrong decision in granting foundation trust status to trusts that were not strong enough.⁴

5. When NHS foundation trusts are in breach of their regulatory conditions, Monitor intervenes to help them improve. For example, it may require them to change their Chair or Chief Executive, employ turnaround directors, or commission external consultancy support. Despite

1 [C&AG's Report, *Monitor: Regulating NHS foundation trusts*, Session 2013–14, HC 1071, 26 February 2014](#)

2 [C&AG's Report, paras 1, 2, 4, 1.5](#)

3 [Qq 1, 12, 131–132; C&AG's Report, paras 2.2, 3.14](#)

4 [Qq 2–3, 5–8, 12](#)

this, some trusts have been in breach of their regulatory conditions for a long time—three of the 25 trusts in breach at 31 December 2013 had been in this position for over four years.⁵

6. Basildon and Thurrock NHS Foundation Trust is one of the three trusts which have been in breach of their regulatory conditions since 2009. By 31 December 2013, it had been in breach for reasons of care quality for 49 months, since 2009. Monitor failed to give appropriate challenge until local MPs declared they had lost confidence in the Trust's leadership. Local Members of Parliament declared that they had lost confidence in the Trust's leadership. Monitor acknowledged that it should have moved much more quickly to replace senior staff at the Trust. It believed that the new leadership team were now turning things around, but it accepted that reaching this point had taken far too long. It agreed that it should have been prepared to intervene more strongly when the Trust did not sort itself out within a fixed time period. In addition, Monitor noted that, prior to the Care Quality Commission's new inspection regime, neither Monitor nor the Trust itself had had sufficient insight into the underlying causes of the problems.⁶

7. Monitor admitted that it had been slow to improve the leadership at Heatherwood and Wexham Park NHS Foundation Trust. At 31 December 2013, the Trust had been in breach for 53 months, despite Monitor's interventions. Monitor told us that it had decided that replacing a few key people was insufficient to turn the Trust around, and that it needed to strengthen the whole leadership team. It had also become clear to Monitor that the Trust would not be able to return to a position in which it was clinically and financially sustainable in its own right. With Monitor's support, the Trust was now pursuing a merger with nearby Frimley Park NHS Foundation Trust.⁷

8. The Department acknowledged that there was a shortage of good leaders across the NHS. In particular, in contrast to some other countries, not enough clinicians were involved in running trusts. The Department told us that it was taking steps to attract and develop more high-calibre leaders. It had approved the first 50 people, including 35 clinicians, to attend an accelerated course at Harvard Business School, and it had asked Sir Stuart Rose to work with it, to improve the calibre of NHS leaders.⁸

9. For a growing number of NHS foundation trusts in difficulty, the underlying causes are not necessarily about leadership, or other matters internal to the trust, but are rooted in the wider local health economy, such as local commissioners being in financial difficulty. Monitor told us that the ability of trusts to fix problems on their own had become increasingly limited. In some cases, managing the trust well was not enough and more fundamental structural change was required. In these circumstances, Monitor needed to work with other bodies, including the NHS Trust Development Authority and NHS England, to develop a plan for the local health economy as a whole. While this was now happening in relation to Milton Keynes NHS Foundation Trust and Bedford NHS Trust, Monitor acknowledged that Milton Keynes had been in trouble for some time before it realised this was the right approach. Monitor told us that it was now seeking to step in sooner in similar cases, such as at the Queen Elizabeth Hospital NHS Foundation

5 [Qq 3, 4; C&AG's report, paras 3.26–3.27, Figure 11](#)

6 [Qq 17–21, 23; C&AG's report, Figure 11](#)

7 [Qq 13, 15, 53; C&AG's report, Figure 11](#)

8 [Q 117](#)

Trust in King's Lynn. Monitor noted that it was now responsible for the failure regime. This responsibility gave it the power to appoint a special administrator, if it became clear that an NHS foundation trust was not sustainable in its existing form, and helped Monitor take appropriate action sooner.⁹

10. The proportion of NHS foundation trusts in breach of their regulatory conditions has increased significantly in recent years. At 31 December 2013, 17% of trusts were in breach, up from 11% two years previously. Monitor told us that it expected the number of trusts in breach to continue to rise. Coping with this increase would be challenging for Monitor, as intervening in trusts in difficulty was resource intensive, particularly in terms of the demands on its senior staff. Monitor noted that it was working with the NHS Trust Development Authority and NHS England and, as a result, they had identified 11 local health economies which they considered would benefit from early support.¹⁰

11. The Department confirmed that it was still the Government's policy intention that all trusts should become foundation trusts, but it had not set a target date for this to be achieved. However, just two NHS trusts gained foundation trust status in 2012-13 and, as at 31 December 2013, 98 NHS trusts remained.¹¹

9 [Qq 24, 26, 52–54; C&AG's Report, paras 18, 3.28](#)

10 [Qq 62, 70, 105; C&AG's Report, paras 3.30–3.31, Figure 16](#)

11 [Qq 101–102, 138; C&AG's Report, para 12](#)

2 Monitor's resources and capability

12. Monitor's spending trebled between 2010–11 and 2013–14, as the job of regulating NHS foundation trusts became more challenging and it prepared to take on new responsibilities. In 2013–14, its budget for core running costs was £48 million. Approaching a third of this amount (over £15 million) was earmarked for central services, compared with £9 million for regulating NHS foundation trusts and £5 million for assessing NHS trusts applying for foundation trust status.¹² Following our hearing, Monitor advised us that most of the 78 central services staff worked in strategic communications (30 people) or knowledge and information management (23 people).¹³

13. The number of staff Monitor employs has also increased significantly in recent years. At 31 December 2013, it had 337 staff, 75% of the 450 staff it expects to need to carry out all its functions. Monitor told us that it made extensive use of consultants to plug gaps in its expertise and to deal with peaks and troughs in its workload. It acknowledged that using consultants was both costly, accounting for £9 million of its £48 million budget in 2013–14, and did not help it to develop its own knowledge and expertise. It was seeking to reduce its dependence on external consultants and was looking into whether it could build in-house capability, which it could then share with the NHS Trust Development Authority and NHS England.¹⁴

14. The National Audit Office reported that Monitor's staff were high calibre, particularly in terms of their financial and business expertise. However, some had insufficient operational experience or understanding of clinical issues, which damaged their credibility and effectiveness. Monitor confirmed that just 21 of its 337 staff had an NHS operational background, and only seven had a clinical background. It told us that it was working to increase these numbers, but was finding it difficult to attract senior people, who could potentially earn more in the NHS. Monitor also confirmed, however, that nearly 30 of its staff were paid more than £100,000 a year.¹⁵

15. Monitor reported that recruiting staff from the NHS was made more difficult by issues relating to the terms and conditions of different organisations. As Monitor employs staff on civil service terms and conditions, people joining from the NHS could not transfer their accrued pension rights, and their service would not be classed as continuous. This meant that, in the event of staff being made redundant by Monitor, the years of service they had accrued under the NHS pension scheme would not be taken into account in calculating the amount of compensation to which they would be entitled. The Department indicated that similar issues had arisen in relation to the transfer of NHS staff to local government.¹⁶

16. Monitor's Chief Executive, David Bennett, had also acted as its Chair for nearly three years between March 2011 and January 2014. Corporate governance good practice, and Monitor's own guidance to NHS foundation trusts, is that the same person should not be both Chair and

12 [Q 10; C&AG's Report Figure 2](#)

13 [Written submission from Monitor](#)

14 [Qq 10, 37–39, 51, 105; C&AG's Report para 8, 1.8, Figure 2](#)

15 [Qq 32, 36, 41; C&AG's Report, para 1.18](#)

16 [Qq 41, 46–47](#)

Chief Executive. Monitor accepted that the roles should be split to provide a check and balance on the executive.¹⁷

17. The Department told us that it had considered recruiting a new Chief Executive in March 2011, when David Bennett took up the role of Chair. However, it had decided to wait until the Health and Social Care Bill had been passed and there was certainty about Monitor's role in the reformed health system. In the meantime, it had intended that David Bennett would carry out both roles. In 2013, the Department and David Bennett agreed that he should remain as Chief Executive and a new Chair should be recruited. However, in October 2013, the candidate proposed by the Secretary of State for Health was not endorsed by the House of Commons Health Committee. In January 2014, the Secretary of State appointed Baroness Hanham as the interim Chair. Baroness Hanham agreed to serve until the end of 2014, and the Department is planning to make a permanent appointment through a competitive process.¹⁸

17 [Qq 88–90; C&AG's Report, paras 10, 1.14](#)

18 [Qq 90–91](#)

3 Monitor's new responsibilities

18. Under the Health and Social Care Act 2012, Monitor has taken on a broader role as the sector regulator for health services. It has a statutory duty to protect and promote the interests of people using these services, and a role in ensuring the continuity of essential health services. Its remit has expanded to include significant new responsibilities relating to pricing and preventing anti-competitive behaviour by healthcare commissioners and providers.¹⁹

19. Since April 2014, Monitor has been jointly responsible with NHS England for pricing NHS-funded care. The level at which prices are set affects how health services are organised and the financial viability of individual organisations, including NHS foundation trusts. We asked Monitor how it would manage the conflict between protecting trusts from failure and encouraging the provision of care in the community rather than in hospitals—which could undermine trusts' viability. Monitor told us that its duty was now to protect and promote the interests of patients and not to protect trusts. In addition, it had to agree prices with NHS England and be open about the assumptions underpinning its pricing decisions, leaving the way open for challenge.²⁰

20. Monitor's new responsibilities for preventing anti-competitive behaviour include advising the competition authorities (now the Competition and Markets Authority) about proposed mergers of trusts. Monitor explained that its role involved advising on what was in the best interests of patients—while mergers might bring benefits in terms of scale, there might also be a loss of competitive pressure on the trusts involved to improve their performance. The Department acknowledged that there had been misinterpretation and misunderstanding over the question of competition, resulting in understandable concern. It said that the policy intent was that competition should serve patients' interests.²¹

21. In relation to the specific case of Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, and Poole Hospital NHS Foundation Trust, whose proposed merger was rejected, Monitor acknowledged that what had happened had been unsatisfactory. It recognised that it should have worked with the two trusts at an earlier stage to reach a faster, and possibly different, outcome. In the light of this, Monitor intended to work earlier and more closely with organisations that wanted to merge, to make sure that the case to do so was robust. It would also work with the competition authorities to seek to ensure that they considered both the benefits to patients of allowing a merger to proceed, and the disadvantages to patients of rejecting it.²²

19 [Q 52; C&AG Report, paras 1.3, 1.6](#)

20 [Qq 124–125, 130; C&AG's Report, para 1.6](#)

21 [Qq 77–78, 81, 83](#)

22 [Qq 84–85](#)

Formal Minutes

Wednesday 18 June 2014

Members present:

Mrs Margaret Hodge, in the Chair

Jackie Doyle-Price

Mr Stewart Jackson

Anne McGuire

Austin Mitchell

Nick Smith

Ian Swales

Justin Tomlinson

Draft Report (Monitor: regulating NHS Foundation Trusts), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 21 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Fourth 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.

[Adjourned till Wednesday 25 June at 2.00 pm]

Witnesses

Monday 31 March 2014

Questions

Dr David Bennett, Chief Executive, Monitor and **Una O'Brien**, Permanent Secretary, Department of Health

[Q1-138](#)

List of printed written evidence

- 1 Department Of Health ([MTR0002](#))
- 2 Monitor ([MTR0001](#))

List of Reports from the Committee during the current Parliament

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

Session 2014–15

First Report	Personal Independence Payment	HC 280
Second Report	Help to Buy equity loans	HC 281
Third Report	Tax reliefs	HC 282