To: The Board

For meeting on: 30 July 2014

Agenda item: 4

Report by: David Bennett, Chief Executive

Report on: Public Accounts Committee report: *Monitor: regulating NHS Foundation Trusts*

Background

1. In February 2014, the National Audit Office (NAO) published its report on Monitor's regulation of NHS foundation trusts (FTs). This report was based on the NAO's analysis of evidence collected between July and November 2013 and covered our regulation of FTs over the 9 years from the establishment of Monitor in 2004 until that time. The NAO's conclusion was that "Monitor has achieved value for money in regulating NHS foundation trusts….[and] has generally been effective in helping trusts in difficulty to improve".

2. It is worth noting that, of the 163 NAO reviews conducted under the current Government, up to and including the report on Monitor, the report on Monitor was one of only ten that received a positive conclusion on value for money.

3. However, the Public Accounts Committee (PAC), following a hearing in March 2014, issued its own report on Monitor ('Monitor: regulating NHS Foundation Trusts', attached at Annex B to this report) on 4 July 2014. In this report the PAC made a number of recommendations relating to the further improvement of Monitor, to which the Department of Health will be responding formally (advised by Monitor) in the form of a Treasury Minute. These recommendations are as follows:

    i. 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

    ii. 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

    iii. 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

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

4. In practice, and consistent with our strong belief in continuous improvement, Monitor has already implemented a significant number of changes along the lines proposed, or has plans in place to do so. Below is described what we are doing in the areas identified for improvement by the PAC. This information is provided in order to assure the Board that the Executive Committee takes these issues seriously and is committed to always challenging the organisation to do better.

Recommendations i. and ii.

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.

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.

5. Monitor's work in this area is reflected in our three year strategy where we identify a number of relevant priorities:

   - **"Minimising the impact on patients of poorly performing providers of NHS services by identifying problems early and acting quickly"**
   - **"Helping to strengthen the capabilities of individuals and institutions"** to reduce the risk that FTs get into difficulty
   - Similarly, **"Reducing the risk that providers fail by helping to develop robust local service strategies"**
   - **"Taking a health-economy-wide approach to resolving problems when a provider does fail"** so that we can deal with the underlying causes of failure and restructure a failing provider for long term sustainability

6. A more detailed list of actions taken, underway or planned for this year is shown at Annex A to this report.

7. Important context for all of Monitor's work in this area is:

   a. Increasing numbers of FTs are having to address deep-seated problems that will unavoidably take many years to fix. These can be due to structural cost disadvantage – such as old and efficient estate or sub-scale service lines – where significant capex and/or reconfiguration of services is required, or cultural problems, particularly poor alignment of clinicians and management. We estimate that this applies to about half the 21 FTs currently subject to enforcement action.

b. In some cases we help trusts fix the problems that put them in breach of their licence, only for other operational or leadership issues to emerge which require continued intervention. This was the case with the three trusts in breach since 2010, although resolutions are imminent: Basildon has just come out of special measures; Mid Staffs is being dissolved; and Heatherwood and Wexham Park is being partnered with a neighbouring high-performing trust while a merger goes through.
c. In order to get the best solution for patients, we are increasingly working with partners across the system to find whole-health-economy solutions rather than focussing solely on individual FTs. We pioneered this approach in Milton Keynes and Bedford, for example. However, this usually means it takes much longer to resolve issues than would be the case were we to focus more narrowly on our FT responsibilities.
d. Leading turnarounds at a local level requires outstanding turnaround leaders. It is increasingly difficult to find such leaders or to persuade those that do exist to take on these challenging roles.

8. Notwithstanding all of this, we must, of course, constantly challenge ourselves to find better solutions to resolving problems at struggling and failing trusts. Although we have already learned lessons, we must strive constantly to find ways to identify problems sooner and to act more quickly and more effectively.

Recommendation iii.

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.

9. This is also an area where work is already underway.

10. **Fill gaps in capacity.** Monitor is still growing to fill its wider role as health sector regulator and most of our vacancies are currently outside those parts of the organisation responsible for FT governance regulation. However, it is the case that we find it challenging to recruit senior individuals into this area, especially given the restrictions we face on the terms and conditions we can offer. In particular, it is very difficult to recruit people with NHS experience; partly because – unlike a number of other health Arm's Length Bodies (ALBs) - we are not able to pay at the same levels as the NHS, and partly because NHS employees face a loss of accrued pension rights and other benefits associated with continuity of service if they join Monitor. In this regard we welcome the PAC's recommendation that DH should "in conjunction with the Cabinet Office and HM Treasury, 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 encourage the free flow of staff".

11. **Exploit skills and knowledge of consultants**. We use consultants for two main reasons. Either because we need to meet a short term need where it would be more expensive to recruit full time staff (e.g. our Annual Plan Review work) or because we need access to particular expertise not available to us internally.

While it would not be sensible to stop doing the former, we are actively considering how we might build an internal capability to do some of the specialist work that is currently being outsourced in those circumstances where the projected volume of work looks sufficient to support a critical mass of people internally. Our primary focus in this regard is in the areas of trust sustainability reviews and the development of health economy solutions for struggling trusts. Already we have a small but growing Monitor team working alongside a number of consultant teams making sure there is effective knowledge transfer and, in some cases, sharing the work load. Our ambition is to grow this into a significant internal capability, potentially saving several £ms, although a perverse consequence of the pay constraints under which we have to operate is that it is proving difficult to make this saving by attracting individuals into this area because our terms, especially for the most senior people, are uncompetitive.

12. **Balance clinical, financial and other expertise.** When first set up, Monitor's particular focus was on improving the financial performance of the NHS provider sector, and this is still reflected to a significant degree in the mix of people we employ in provider regulation. We have recognised for some time, however, that we now need access to a broader range of expertise. In the main, we secure access to clinical knowhow through our various medical advisors – medical experts who are employed by the NHS and provide advice to us on an ad hoc basis. It is our intention to continue doing this as it enables us to access a very wide range of experts while avoiding the cost of employing them on our own books. Nevertheless, we recognised in 2012 that we should have somewhat more clinicians working for us, and that we should have a medical director providing leadership to this group and to our medical advisors. After a difficult recruitment process – where again constraints on our ability to pay NHS rates were a problem – we now have a Medical Director (Executive Director of Patient and Clinical Engagement). Our problems in recruiting individuals with operational experience from the NHS are described above.

Recommendation iv.

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

13. Monitor's primary duty is to protect and promote the interests of patients.

14. Like all sector regulators Monitor has multiple levers it can operate to promote and protect the interests of service users. We must, therefore, balance the effectiveness of these different levers as we decide how to use our regulatory powers.

15. One of the key levers is ensuring FT providers are well-led and providing high quality care on a sustainable basis, which is clearly in patients' interests. However, this does not mean protecting an FT when this is not in patients' interests. When things do go wrong at an FT the focus of our work is on the needs of patients. We do this by working with all stakeholders in a local health economy to ensure the best possible sustainable services are in place.

Safeguarding current (and often failed) organisational forms has no place in this work.

16. Our work in Pricing and Co-operation and Competition covers all types of providers and commissioners of NHS services and focuses on ensuring NHS services for patients (not providers) are the best that they can possibly be.

David Bennett
Chief Executive

Making a difference for patients:

Monitor's mission is to make the health sector work better for patients. Accurate and timely representations to parliament are required of Monitor and being held to account by parliament helps to ensure that we are effective in delivering for patients.

Public Sector Equality Duty:

*Monitor has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In drafting this report consideration has been given to the impact that the issues dealt with might have on these requirements and on the nine protected groups identified by this Act. It is anticipated that the issues dealt with in this this paper **are not** likely to have any particular impact upon the requirements of or the protected groups identified by the Act as this paper addresses an internal process within Monitor that is not related to staff.*

Exempt information:

None of this report is exempt from publication under the Freedom of Information Act 2000.

Annex A - Changes we have already implemented or have plans to implement in the current year that address recommendations i and ii

1. In October 2013 Monitor replaced its Compliance Framework with the Risk Assessment Framework (which describes how Monitor oversees FTs' compliance with the governance and continuity of services requirements of their provider licence). The Risk Assessment Framework (RAF) has a much stronger focus on leading indicators of potential problems at trusts. However, in light of the increasing operational pressure on the system, we are planning a further review of the RAF (annual plan action 1.13, to be undertaken in the final quarter of 2014/15) to determine whether we should modify it so that we can step-in sooner at trusts that are getting into difficulty

2. Actions to look sooner at underlying causes of problems at struggling trusts, especially:

    a. Explicit sustainability analyses – usually as part of a CPT - at trusts where we are concerned that there may be deep-seated structural problems. We do this having recognised that slow turnarounds at trusts such as Mid Staffordshire NHS Foundation Trust have been, at least in part, a result of underlying structural problems. For example, we have done this at Peterborough and Stamford Hospitals NHS Foundation Trust and are just beginning a review at Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust
    b. Explicit reviews of cultural issues, again in recognition of lessons learned at trusts where improvement has been very slow, such as Heatherwood and Wexham Park Hospitals NHS Foundation Trust or University Hospitals of Morecambe Bay NHS Foundation Trust. The forthcoming introduction of the Well Led Framework into the assessment process includes more consideration of cultural issues and the CQC inspection regime is now includes a greater focus on cultural issues at providers.

3. Taking a local health economy approach to resolving structural issues where these have been identified at individual trusts. This is in recognition of the difficulties we have had in resolving financial problems on an individual trust basis where there have been wider challenges in the local health economy (e.g. Milton Keynes and Bedfordshire)

4. In 2013 we created our enforcement team to provide a resource of senior and experienced provider regulation actioners to focus on our most troubled trusts

5. This year we introduced the Special Measures regime including Improvement Directors and buddying arrangements in order to improve the speed and effectiveness of our turnaround work – e.g. Basildon and Thurrock University Hospitals NHS Foundation Trust

6. We are currently undertaking a review of the effectiveness of current interventions with a view to focusing our resources on those interventions that have the biggest impact

7. We are also trying to identify new ways of working with failing trusts to turn them around, including exploring options for drawing more effectively on the leadership capacity of other organisations, work that is being supported by a study being undertaken by Sir David Dalton

8. In order to provide a strong focus on the improvement of struggling trusts we are also considering the creation of an ‘Improvement Division’. This would be a unit of operational experts, ideally including a number of the best operational people from the NHS. However, we will need to secure a limited amount of additional funding and ability to recruit NHS staff to do this.

9. Finally, since November 2012 we have for the first time had access to a Trust Special Administration regime for foundation trusts. Once available we moved immediately to place our longest-standing failing trust (Mid Staffordshire NHS Foundation Trust) into special administration. Although this is a process we should only use as a last resort, it is an important addition to the tools available to us. We are currently completing a ‘lessons learned’ exercise on this first Trust Special Administration.

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

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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 has 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 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	Nick Smith
Mr Stewart Jackson	Ian Swales
Anne McGuire	Justin Tomlinson
Austin Mitchell	

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