

**Monitor**

**Mid Staffordshire NHS Foundation Trust:**

**The Case for Appointing a Trust Special Administrator**

**Presented to Parliament pursuant to s.65D(6) of the National Health Service Act 2006.**



## Executive Summary

1. Mid Staffordshire NHS FT (“MSFT” or “the Trust”) was authorised by Monitor as a foundation trust (“FT”)<sup>1</sup> on 1st February 2008. In the following year, the Trust was subjected to a review by the then Healthcare Commission (“HCC”) into reported high levels of patient mortality and poor standards of care. This review identified serious concerns about the management of patients admitted with emergencies and concluded that the care of patients was unacceptable.
2. The Trust was found by Monitor to be in significant breach of its terms of Authorisation as a Foundation Trust in March 2009 on grounds of poor governance and a failure to meet its general duty to exercise its functions effectively, efficiently and economically.
3. Following the HCC review there have been a number of further reviews into the quality of care at the Trust, including an initial independent inquiry undertaken by Robert Francis QC, which reported in February 2010. In response to the recommendations of these reviews, the Trust invested significantly in additional staff at a time when increasing financial constraints were being placed on NHS organisations.
4. Clinical performance at the Trust improved as a result of these investments. However, they have contributed to a chronic deficit at the Trust, which now requires significant external financial support from the Department of Health (£21m received in the financial year 2011/12 and a further £21m planned for the financial year 2012/13) in order to pay its debts as they fall due.
5. Despite repeated attempts to turn around its financial position, the Trust continues to be financially challenged and would require further financial support to continue operating. Accordingly, the Trust remains in significant breach of its terms of Authorisation as a Foundation Trust on financial and governance grounds.
6. The challenges facing MSFT are complex and there is no strategy in place to ensure that the Trust is able to secure a sustainable future for its services to patients within its existing configuration and organisational form. When it became apparent that the Trust could not find a way to sustain both financial balance and high quality clinical services, Monitor appointed a Contingency Planning Team (“CPT”) to the Trust to investigate how services could be delivered on a sustainable basis for the patients of Stafford and Cannock. The CPT began its work in October 2012.
7. The CPT reported to Monitor in January 2013 its conclusion that the Trust in its current form is neither financially nor clinically sustainable in the long term. The CPT has also advised Monitor that, in its view, neither the Trust nor its commissioners would be able to effect the changes required to deliver sustainable services in the future.

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<sup>1</sup> See Annex for details of NHS trusts and NHS foundation trusts

8. The National Health Service Act 2006 (as amended) provides a power for Monitor to appoint a Trust Special Administrator (TSA) to an NHS foundation trust if Monitor is satisfied that the NHS foundation trust is in financial failure, that is, the Trust is, or is likely to become, unable to pay its debts. The CPT recommended that Monitor should consider using this power to appoint a TSA at the Trust. The TSA would be required to make final recommendations to Monitor on how to deliver clinically and financially sustainable services to the local population. On the 27th of February 2013, the Monitor Board agreed that the preferred option should be to appoint a TSA at the Trust.
9. During March 2013, Monitor carried out the statutory consultation required before appointing a TSA. Responses were received from the Secretary of State for Health, the Care Quality Commission, the Trust, the National Commissioning Board and local commissioners in the Staffordshire area. Respondents supported the appointment of a TSA and emphasised the need for the TSA to act swiftly to minimise instability in the local health economy and to bring about improved services for patients.
10. Monitor is therefore of the view that the Trust is in financial failure and should be placed into Trust Special Administration. A number of respondents to the consultation raised the need to have senior clinical input to the Trust Special Administration and this has informed our decision to appoint three people to act as joint Trust Special Administrators (TSAs). One of the TSAs will be an experienced clinical practitioner and the other two will be insolvency practitioners.
11. The TSAs will develop a solution to provide safe and sustainable services for the patients of Mid Staffordshire.
12. The following report explains in detail why it has proved so difficult for MSFT to maintain both financial balance and high quality services in the context of the Mid Staffordshire local health economy and why appointing TSAs at this juncture is, in Monitor's view, the best available option for ensuring that people served by MSFT continue to have high quality, sustainable health care services.

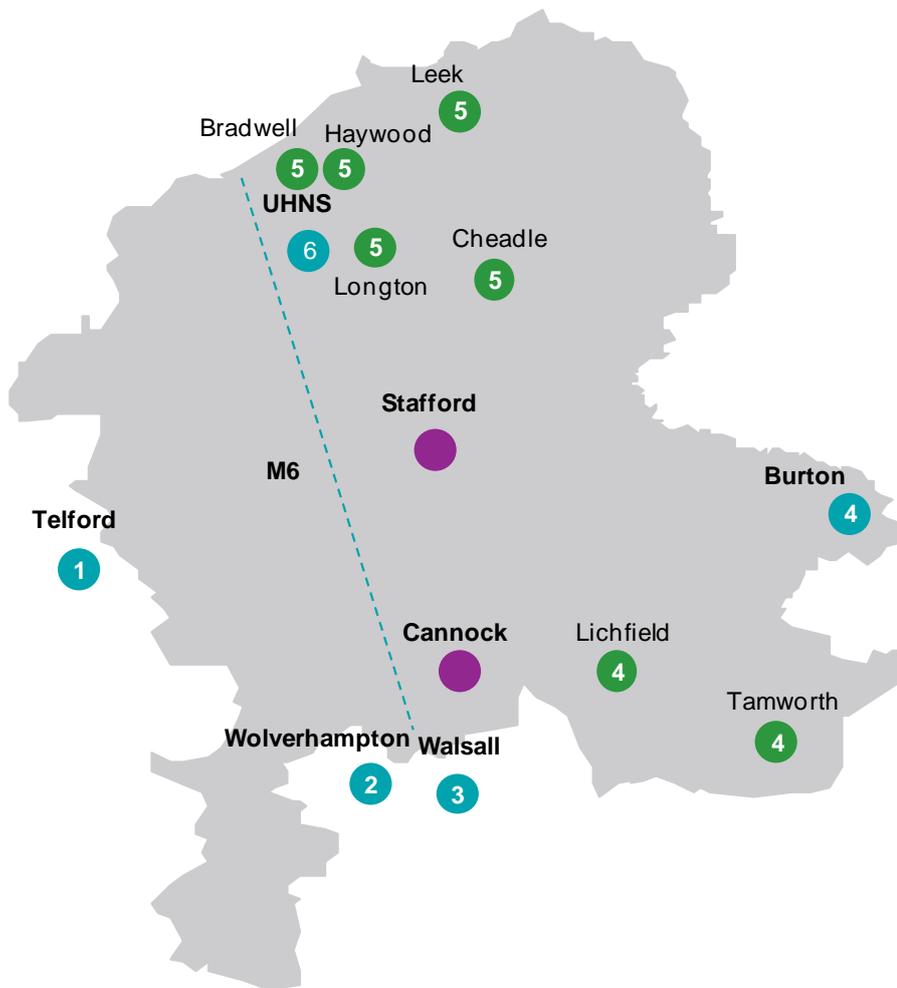
### **Overview of the Mid Staffordshire local health economy**

13. MSFT is a relatively small trust serving a catchment area that is also served by a relatively large number of alternative providers. It is a 344 bed acute trust located on two sites: Stafford Hospital (built in 1984) and Cannock Chase Hospital (built in 1992). MSFT has an annual turnover of about £155m. The Trust serves a population of approximately 200,000 people and employs around 3,000 members of staff.
14. The wider Staffordshire health economy comprised, until April 2013, one PCT cluster, Staffordshire, that brought together NHS North Staffordshire, NHS South Staffordshire and NHS Stoke on Trent. The Staffordshire cluster worked with the Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups (CCGs) and together the organisations had a budget of approximately £330m.

15. MSFT is surrounded by five other acute trusts:
  - University Hospital of North Staffordshire NHS Trust (“UHNS”) and Royal Wolverhampton NHS Trust (“Wolverhampton”) are tertiary hospitals providing a range of complex and specialist services.
  - Shrewsbury & Telford Hospitals NHS Trust (“Telford”), Burton Hospital NHS Foundation Trust (“Burton”) and Walsall Healthcare NHS Trust (“Walsall”) are more similar to a traditional district general hospital.
  - Only Burton is a Foundation Trust with the other four being at different stages of the foundation trust pipeline.
  
16. The main acute patient flows follow the M6 corridor: North to UHNS and South to Wolverhampton and Walsall. There are fewer patient flows East and West, to Burton and Telford respectively.
  
17. Staffordshire & Stoke on Trent Partnership Trust (SSoTP) provide community services for the whole of Staffordshire including the community hospitals in the North.
  
18. Burton Hospital operates the community hospitals in Lichfield and Tamworth.
  
19. South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide inpatient and community mental health services for South Staffordshire.
  
20. A summary of the financial situation of the surrounding acute trusts is:

<b>Organisation</b>	<b>2011/12 Turnover</b>	<b>2011/12 Surplus / (Deficit)</b>
Shrewsbury & Telford Hospitals NHS Trust	£300m	£50k
Royal Wolverhampton NHS Trust	£374m	£8.7m
Walsall Healthcare NHS Trust	£227m	£3.6m
Burton Hospital NHS Foundation Trust	£171m	(£5.3m)
Staffordshire & Stoke on Trent Partnership Trust	£204m	£1.5m
University Hospital of North Staffordshire NHS Trust	£426m	£3m

21. Map of acute hospitals and community sites in Staffordshire



### Overview of the history of MSFT

22. Multiple clinical reviews have taken place at the Trust since concerns about the clinical standard of care were raised in a 2009 HCC report that revealed a higher than expected number of deaths at Stafford Hospital.
23. In March 2009, the HCC published its investigation into emergency admissions and the apparently high mortality rates at MSFT. The review was conducted between March and October 2008 by the Healthcare Commission. Its recommendations included:
  - The A&E department must be adequately staffed and equipped at all times such that it meets the needs of patients and the service is safe;
  - Improve access/advice from critical care team; and
  - Resource non-elective theatre sessions to reduce delays.

24. In April 2009, Professor Sir George Alberti published his report. He reviewed the procedures for emergency admission and treatment at MSFT and reviewed the progress against the recommendations of the HCC report. His recommendations included:
- Increase senior cover and training in A&E;
  - Improve care of the elderly, particularly in enhanced networking with community, primary and social sectors;
  - Accelerate towards new ways of working, including networking particularly for emergency surgery; and
  - Increase the number and training of qualified nurses.
25. In October 2009, the Royal College of Surgeons conducted a review on concerns raised about the general surgical service following a series of serious untoward incidents. This review was requested by the Trust and included these quotes:
- "The service provided by the general surgical unit is inadequate, unsafe and at times frankly dangerous"
  - "The general surgical department must not be allowed to continue to operate as it does currently"
  - "The general surgical team is probably the most dysfunctional encountered by any member of the review team"
26. In February 2010 Robert Francis QC published his report into the care provided at MSFT. He reviewed the period January 2005 - March 2009 and concluded that patients were routinely neglected and did not receive appropriate levels of care. His report commented:
- "The trust should not provide services where it cannot achieve a high-class standard"
  - "The Trust should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership"
27. In October 2010 John Wallwork published his report on the future clinical strategy for MSFT. The first report prepared by Robert Francis QC recommended that the Secretary of State for Health consider whether he ought to request Monitor to exercise its power of deauthorisation over the Trust. The Secretary of State stressed the primary importance of getting the clinical structures right within Staffordshire and the need to focus on providing the best quality of care. To support this objective, he commissioned a report to give a view of the optimal clinical structures and configuration of services in the area. Prof. Wallwork's recommendations included:
- Improve integration with primary care and encourage joint working with paediatrics
  - Agree the model of intermediate care potentially splitting step-up and step-down;
  - Agree plan for development of stroke services including development of acute services at MSFT;
  - Continue work on gastrointestinal and emergency surgery to develop partnerships;
  - Build a single paediatric emergency pathway (as opposed to A&E and a Paediatric Assessment Unit);

- Develop sustainable plan for maternity services given the challenge of appropriate level of neonatal care service; and
  - Develop a plan for Cannock which builds on rehabilitation and day-case strengths.
28. In response to these numerous reviews, the clinicians and management at MSFT have taken considerable steps to drive clinical improvements. The Trust has increased the presence of senior staff, both recruiting more senior nurses and increasing the level of consultant-delivered care. The Trust is also working more closely with neighbouring providers, particularly in certain surgical services, with several services such as vascular surgery now operating as a network across the region. The Trust has also changed internal processes to enable clinicians and managers to better understand their service performance and to help identify any potential problems.
29. In 2011, MSFT was part of a joint provider and commissioner health-economy wide review of clinical services to inform local commissioning intentions. This involved collaborative work involving over 100 people through five Clinical Working Groups (CWGs) who met to review current service provision, identify what best practice care should look like and to set out the implications for MSFT. Most of the CWGs were co-chaired by both a local GP and a consultant from MSFT and included a hospital governor representing the perspectives of patients. Subsequently, these implications were turned into actions which MSFT has started to implement to improve the quality of care it provides.

## Detailed analysis of MSFT

### Overview

30. The key services delivered at the Trust's two main sites are outlined below:

Stafford	Cannock
Fully admitting A&E (8am - 10pm)	Minor Injuries Unit (8am - Midnight)
Surgical emergency admissions (8am - 10pm)	Elective orthopaedics
Obstetrics led birthing unit	Elective day surgery
Routine elective care	Inpatient elderly care
Inpatient paediatric services	Inpatient rheumatology
Outpatients & diagnostics	Outpatient & diagnostics

### Financial performance overview

31. Since becoming a foundation trust in 2008, the Trust's retained underlying deficit has deteriorated by over £40m, with a further forecast underlying deficit of £18.8m in FY13. The Trust is forecast to deliver a deficit for the foreseeable future with limited opportunities in its current form to sufficiently improve the situation.
32. In order to breakeven by FY18 the Trust needs to achieve an average efficiency of 7% of relevant income in each of the 5 years (average of 6.3% of cost). At this level of efficiency the Trust would still require additional cash support of c. £73m.
33. The continued delivery of deficits with no plan for resolution is unsustainable and means that vital resources are, and will continue to be, diverted away from other parts of the NHS to maintain safe and high quality services at MSFT.

### Summary financial performance over the last three years

34. To fully understand the underlying financial challenges facing the Trust it is necessary to consider the recent financial performance of the Trust, how it has responded to the challenges it has faced since its establishment and its current financial position.
35. The table below outlines the financial performance of MSFT over the previous three years and shows a deterioration year on year. The key points are:
- Total recurrent revenue has increased by £4.8m (3%) over the three years predominantly due to changes to patient care related income. Additionally during the

period the Trust received a total of £13.7m of non-recurrent income, most notably from the Primary Care Trust.

- Total expenditure including non-recurrent items grew over the three years by £19m showing the overall cost base of the Trust increasing at a far greater rate than the increase in income as the Trust continues to improve its operational and clinical performance. Including the above financial support, the Trust recorded a deficit in FY10 of £4.7m; this has increased in each year to reach a deficit in FY12 of £19.9m.

#### MSFT Financial performance FY10 –FY12

Currency: £ 000	FY10	FY11	FY12	%change
Recurrent Income	147,361	151,875	152,144	3%
Recurrent Expenditure	(146,311)	(157,506)	(161,592)	(10%)
<b>Underlying EBITDA</b>	<b>(1,050)</b>	<b>(5,631)</b>	<b>(9,448)</b>	<b>(1000%)</b>
Depreciation and Amortisation	(6,532)	(6,580)	(6,529)	0%
Net Financial Interest	41	51	17	(59%)
PDC Dividend	(3,725)	(3,445)	(3,460)	(7%)
Other	(82)	-	-	-
<b>Underlying Surplus/(Deficit)</b>	<b>(9,248)</b>	<b>(15,606)</b>	<b>(19,420)</b>	<b>(110%)</b>
Non Recurrent Income	4,500	6,075	3,216	(29%)
Non Recurrent Expenditure	-	(4,300)	(3,707)	-
<b>Total Surplus/(deficit)</b>	<b>(4,748)</b>	<b>(13,861)</b>	<b>(19,911)</b>	<b>(319%)</b>

#### Operating costs

36. MSFT planned an overall reduction in operating expenditure in FY13 from FY12 of £5.4m (3%). The key drivers of this cost reduction are:
- A significant reduction in agency staff cost of £2.4m and £0.7m of reduced substantive pay cost;
  - A £1.3m net reduction in raw materials and consumables cost;
  - A £2.4m reduction in consultancy costs; and
  - An increase in other costs totalling £1.3m including depreciation cost (£0.3m).
37. The largest area of expenditure is pay. The Trust plans to reduce its pay expenditure to £108.3m in FY13 compared to FY12's cost incurred of £111.4m. The plan assumes an overall increase in clinical staff and a reduction in non-clinical staff compared to that in FY12. As at September 2012 MSFT was broadly on target with the planned expenditure on pay. However the Trust continues to face significant recruitment issues in certain staff groups including: consultants, junior doctors, nursing, managers and administration. As a result, there have been high agency and bank costs that have offset underspend in certain staff bands.
38. The Trust is on track to deliver £10.2m of cost improvement plans in FY13.

## **Cash flow**

39. There has been a substantial reduction in the Trust's cash balance during the period FY11 to FY12. The Trust started FY11 with an opening balance of £10m; this reduced to a closing cash balance of £1.4m and was followed by a further reduction to £0.5m at March 2012. This movement included additional cash support of £21m in March 2012, of which £5m was to allow the Trust to pay PDC dividend arrears and a PDC dividend that fell due. Because the Trust is failing to achieve a surplus before depreciation, interest and amortisation, an unstable cash position has been created.

## **Estate management**

40. The Trust provides services from two sites, Stafford and Cannock, with the majority of acute services being provided at Stafford. Neither site has any PFI commitments. Cannock has nine available wards, of which only three are used: two wards run by the Trust and a ward run in collaboration with local Community Trust (Staffordshire and Stoke-on-Trent Partnership NHS Trust). A review of space utilisation at Cannock showed the following occupancy: 43% MSFT, 37% third party and 20% not utilised. Most of the third party utilisation is taken up with short term leases. At Stafford there are fifteen ward-based areas, including Paediatrics and Maternity. One of these wards remains empty and is currently being used as spare clinical space to facilitate general improvements to the others.
41. There are seven theatres in use at Stafford and five at Cannock; the main surgical specialties have a utilisation rate of over 90%, however the specialist surgical specialties have a lower utilisation rate. The usage of the theatres at Cannock is particularly low. For the period 8 Oct 2012 – 4 Nov 2012 there were 160 available half-day sessions for the four theatres used for orthopaedics (data was not available for theatre 5). Only 96 (60%) of these sessions were used indicating a significant amount of unused capacity. The utilisation for the 96 sessions was 85%, compared to the target of 90% demonstrating some additional capacity available even within the sessions that were being used.
42. The costs associated with managing the Trust's estates are more than 6% of its annual revenue, which compares with a national average of less than 1% for all trusts and just over 1% for all foundation trusts.

## **Conclusions of the Contingency Planning Team**

### **Operational sustainability:**

43. The Trust has made significant progress in establishing its operational sustainability by implementing both strategic and tactical change over the past 18 to 24 months. These improvements have been driven by greater alignment between the Trust's strategy, its organisational design and enabling functions. Examples include (but are not limited to):
- The engagement of clinical staff in the management of the hospital (e.g. through appointment of clinical directors to head each of the Trust's four directorates);

- The development, implementation and embedding of a risk management process which is well used and understood by staff;
  - Focused improvements in performance management through the implementation of specialty level performance meetings supported by an integrated performance dashboard;
  - An established Project Management Office (PMO) which provides the necessary governance, infrastructure and support to transformation programmes; and
  - A stable executive team and Board which has demonstrated the capability to drive sustained change.
44. The strategic and tactical changes the Trust has made have had a direct impact on both quality and performance. These improvements are demonstrated by:
- Care Quality Commission (CQC) reviews showing an improved standard of clinical quality at the Trust, going from 11 areas of concern in 2010 to none in 2012. All other hospitals in the region have had minor CQC concerns at some point during the same period;
  - The Trust meeting its A&E waiting times target in Q2 FY13;
  - The Trust sustaining Hospital Standardised Mortality Rates (HSMR) of less than 100;
  - Decline in mixed sex breaches from 635 (FY12) to one incident of eight breaches in the year to date (to November 2012); and
  - The Trust meeting the 18-week target since October 2012.
45. Whilst the Trust continues to make significant progress, further work is required to fully embed operational improvements to ensure the changes are sustainable and continue to deliver improved performance outcomes. Examples include (but are not limited to):
- The committee structure has been developed and is, in the main, functioning well. Further work is needed to remove the duplication between some of the committees and to establish a more responsive referral process between committees;
  - 18-week performance has been achieved over the past two months. One of the drivers of this was the implementation of weekly performance meetings. The Trust must focus on the actions needed to sustain this performance so it can be embedded into “business as usual”; and
  - Specialty-level governance meetings are not happening in all directorates due to resourcing issues.
46. Through investment in a number of areas (e.g. staffing and operational/clinical services), the Trust’s performance level has improved markedly over the past 18 to 24 months and has done so across a range of quality and safety indicators. The challenge is for the Trust to ensure that it fully embeds the changes it has made.
47. However, this investment is one of a number of drivers behind the Trust’s financial position with many of the costs associated with the operating model being significantly higher than the national average. For example, MSFT spends (as a proportion of its revenue):
- Over six times the national average on Quality and Risk;
  - Over three times the national average in Information Management and Technology; and

- Over twice the national average on HR.
48. The CPT concluded that if a plan could be identified to deliver long term financial and clinical sustainability, then the Trust's operating model is fit for purpose. To that extent, the CPT concluded that MSFT is operationally sustainable.

**Clinical sustainability:**

49. Multiple clinical reviews have taken place at the Trust since concerns about the clinical standard of care were raised in a 2009 Healthcare Commission report that revealed a higher than expected number of deaths at Stafford Hospital.
50. In response to this, the clinicians and management at MSFT have taken considerable steps to drive improvements. The Trust has increased the presence of senior clinical staff, through recruiting more senior nurses and increasing the level of consultant-delivered care. The Trust is also working more closely with neighbouring NHS Trusts, particularly in certain surgical services, with several services now operating as a network across the region.
51. The impact of this effort is tangible and MSFT has demonstrated substantial improvements to the quality of care delivered and their clinical performance – as noted in the findings around operational sustainability.
52. Despite the recent improvements in performance, however, the Trust faces a substantial challenge of scale when comparing the volume of activity at MSFT with other trusts in England. In all services, the volume of activity at MSFT is below the national average and it is evident that, in some services, MSFT is one of the smallest trusts in the country, for example:
- For maternity births, MSFT ranks 135th out of 148 services in England.
  - For A&E attendances, MSFT ranks 132nd out of 150 services in England.
  - For non-elective (emergency) surgical spells, MSFT ranks 133rd out of 166 services in England.
  - For paediatric spells over 1 day, MSFT ranks 116th out of 167 services in England.
53. Patients and GPs can choose where patients are referred for acute care, and it is apparent that activity levels have dropped since the issues highlighted in 2008/09. Regardless of this, the catchment population for MSFT is well below the Royal College Standards (RCS) recommended size of 450,000 – 500,000 for an acute general hospital providing the full range of facilities, including specialist staff and expertise for both elective and emergency medical and surgical care.
54. Small hospitals such as MSFT face challenges in meeting these guidelines due to having lower patient volumes than larger hospitals and, as a result, have less ability to support the number of senior staff required to maintain a consultant presence twenty four hours a day, seven days a week. This is particularly true for acute specialties where consultant presence is required at short notice any time of the day or week.

55. Estimating the catchment population is difficult and there have been a number of different attempts to estimate it. Staffordshire Public Health (SPH) recently reviewed these efforts in an effort to provide clarity on the catchment of MSFT, and noted:
56. "A catchment area refers to the geographical area from which the patients of a particular hospital or service are drawn. A catchment population represents the people who would normally attend the hospital if they needed treatment... Therefore, a catchment population is not simply the total number of people who live in the catchment area."
57. The catchment area for the two Clinical Commissioning Groups (CCGs) that primarily refer patients into MSFT (Stafford & Surrounds CCG and Cannock Chase CCG) has a combined population of 276,000. However not all these people will necessarily be referred to services provided by MSFT, and some may choose to be treated elsewhere. The SPH review estimated that the actual catchment population of the Trust is between 190,000 and 212,000.
58. The CPT notes that there are forecasts which predict a reasonable increase in the local population over the coming 5-10 years. However, it does not believe that these changes will have a material impact on the conclusions with regards to catchment population.
59. With many acute surgical services becoming increasingly specialised, it is likely that the Trust serves a size of population which is insufficient to provide exposure to enough conditions, treatments and procedures for many of its specialist consultants to achieve national standards and maintain their professional expertise.
60. Indeed in some services at present, the Trust is not currently meeting the minimum consultant levels for a twenty four hour, seven day a week service as recommended by the Royal Colleges and other national bodies.
61. Furthermore, recruitment is an ongoing issue in some areas with, at the time the information was gathered, almost one in five consultant posts not filled by substantive appointments – although there are signs that this situation is improving. In many cases, this is due to national shortages caused by increasing specialisation in medical training, but there is anecdotal evidence to indicate that applications are still affected by the historic reputational issues and the ongoing uncertainty about the future.
62. Despite the improvements noted, the Trust is still facing challenges in some services. Since 2009 there have been several clinical reviews by the Royal College of Surgeons - most recently the Cancer peer review of breast services which was conducted in March 2012.
63. Whilst the CQC has lifted any residual concerns about the quality of services at MSFT, there is recognition within the Trust that there are still some cultural issues that need to be addressed. The CPT has observed that the Trust appears to be engaging rigorously and appropriately in performance management of medical staff, and the recent improvements in clinical performance measures do indicate that performance improvement in the Trust is going in the right direction.

64. Bearing in mind the available evidence, the CPT has concluded that although clinical performance has significantly improved in the past 24 months, MSFT is clinically unsustainable over a three to five year period. This is because it will struggle to provide high quality clinical services in the future, and meet national clinical standards, especially for emergency care.

**Financial sustainability:**

65. The first signs of financial difficulty were apparent in FY10 when, in response to well documented criticism of its standards of care, the Trust increased its pay expenditure by £9.1m (9.2%) through the recruitment of additional staff. Further increases in staff the following year put additional strain on the financial position at the same time as the Trust tried to improve its operational and clinical performance.
66. Since becoming a foundation trust in 2008, the retained underlying deficit has deteriorated by over £40m. The planned deficit for FY13 is £15m, with an underlying deficit of £18.8m. The Trust is forecast to deliver a deficit for the foreseeable future with limited opportunities in its current form to sufficiently improve the situation.
67. In the Operational Sustainability assessment, the CPT identified that the costs associated with the operating model are higher than the national average. One other area where the Trust's costs are significantly higher than the national average is its estate costs. The costs associated with managing the estate are more than 6% of MSFT's annual revenue, which compares with a national average of less than 1% for all trusts and just over 1% for all foundation trusts.
68. In order to achieve breakeven in five years the Trust needs to achieve £53m of cost savings, which equates to at least 7% of relevant income in each year. Nevertheless this level of efficiency will still require an estimated total of £73m in extra funding from the Department of Health and local commissioners to sustain the Trust whilst it makes the efficiencies required.
69. The 7% level of cost savings is higher than the average reported to have been achieved by NHS foundation trusts in Monitor's review of FY12 and the findings of the King's Fund Quarterly reviews, with only 5 out of 45 organisations recording efficiencies higher than 7%. There is no evidence to suggest any trust has delivered 7% of savings consistently over a five year period.
70. MSFT has achieved £16.6m efficiencies in FY12 and FY13. The CPT has concluded, and the Trust agrees, that this required level of extra savings and additional income is very unlikely to be delivered and sustained over the five year period.
71. On the basis of the evidence reviewed, the CPT concluded that the Trust cannot achieve financial sustainability within the next five years without significant external intervention. Moreover, without cash support from the Department of Health, the Trust is unable to pay its debts as they fall due and as such is deemed insolvent. The Trust has needed and will continue to require substantial cash support for the next five years.

### **Why is it necessary to appoint a Trust Special Administrator?**

72. The appointment of TSAs is one way in which Monitor can take decisive action to deal with NHS foundation trusts that are either unsustainable in their current configuration or at serious risk of failing to deliver sustainable services. The TSAs must secure the continued provision of the NHS services provided by the Trust in such quantities as the commissioners of those services determine.
73. The Trust's historical clinical failings are widely recognised and the impact of these failures, as well as the financial consequences of rectifying the clinical performance, have resulted in an organisation which is unable to achieve financial balance and which will require significant additional funding from the Department of Health in order to continue to operate.
74. The Trust, working with its commissioners within the local health economy, has not been able to bring about a sustainable financial position. There is no demonstrable track record of delivering radical change to date in the local health economy. Furthermore there is no strategic plan in place to address these significant challenges into the future.
75. There is broad acceptance across the health economy locally, as well as within the wider community of stakeholders including the Department of Health and the NHS Commissioning Board, that there is an urgent need to address the position. The scope of the TSAs, the ability to work across conventional or established stakeholder and organisational boundaries, and the timeframe in which the TSAs are required to develop a solution, means that it is the best mechanism to bring about the required level of change.
76. The initial findings of the CPT suggest that services will have to be restructured in order to provide a clinically robust solution for patients. Previous solutions have stalled due to the lack of a single decision maker. The TSAs, as independent entities, would be able to identify and facilitate the development of a solution.

## Annex – NHS foundation trusts

77. The NHS is guided by the principles set out in *The NHS Constitution*<sup>2</sup>. These include an aspiration to attain the highest standards of excellence and professionalism in delivering high quality care to all and, in doing so, a commitment to provide best value for taxpayer's money and the most sustainable use of finite resources.
78. NHS foundation trusts are public benefit corporations. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central Government to local organisations and communities. Their principal purpose is to provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.
79. NHS foundation trusts are different from NHS trusts in that:
- they are not subject to direction by the Department of Health so have greater freedom to decide, with their governors and members, their own strategy and the way services are run; and
  - they can retain their surpluses and borrow to invest in new and improved services for patients and service users.
80. NHS foundation trusts are accountable to:
- their local communities through their members and governors;
  - their commissioners through contracts;
  - Parliament (each foundation trust must lay its annual report and accounts before Parliament);
  - the Care Quality Commission (through the legal requirement to register and meet the associated standards for the quality of care provided); and
  - Monitor, as their regulator.

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<sup>2</sup> <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2012.pdf>