Title: Trust Special Administration	Impact Assessment (IA)
IA No: 6114	**Date: 20 December 2013**
Lead department or agency: Department of Health	**Stage:** Final
	Source of intervention: Domestic
Other departments or agencies:	**Type of measure:** Primary legislation
Summary: Intervention and Options	**RPC Opinion:** Not applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
n/a	n/a	£0	n/a	n/a

What is the problem under consideration? Why is government intervention necessary?

Under the trust special administrators regime in the National Health Service Act 2006, a trust special administrator (TSA) may be appointed to resolve the problems at a failing trust. The government considers it is necessary for the TSA to have a wide scope in recommending action to address problems at a failing trust, to ensure a sustainable solution. The scope of recommendations which may be made by a TSA (and by implication, which may be accepted by the Secretary of State), has recently been held by the Court of Appeal, to be more limited than the government had believed.

To improve the failure regime, changes and clarifications need to be made to the trust special administrators legislation, in order that it is fit for purpose.

What are the policy objectives and the intended effects?

The policy objective is to put beyond doubt that the remit of a TSA is to make recommendations that may apply to services beyond the confines of the trust in administration where it is necessary for and consequential on primary recommendations about that trust; and that the Secretary of State, for NHS trusts, and Monitor for NHS foundation trusts, have the power to accept such recommendations. The policy also aims to strengthen the requirements for a TSA to seek the support of commissioners affected by their recommendations.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

1) **Do nothing:** This would mean that the solutions the TSA could offer would be restricted, and in those cases where a wider solution affecting other trusts and providers was objectively needed, the TSA would be unable to put forward a sustainable solution. The outcome would be that the trust special administrators provisions in the 2006 Act would be significantly less likely to achieve the policy intent.
2) **Amending the trust special administrators' provisions in the 2006 Act (preferred option):** This option was preferred as it is the most effective way of achieving the policy aim of an effective failure regime. The marginal costs and benefits (the differential impacts) of Option 2 compared to Option 1, do nothing, are assessed in this impact assessment.

Will the policy be reviewed? It will not be reviewed.					
Does implementation go beyond minimum EU requirements?			N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** n/a	**< 20** n/a	**Small** n/a	**Medium** n/a	**Large** n/a
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: ---------- Date: ----------

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period Years 1	Net Benefit (Present Value (PV)) (£m)		
			Low: n/a	**High:** n/a	**Best Estimate:** n/a

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a		n/a	**£1.3m**
High	n/a		n/a	**£2.0m**
Best Estimate	n/a		n/a	**n/a**

Description and scale of key monetised costs by 'main affected groups'

The main costs will fall on DH and are likely to be costs of extending the time the TSA has to complete their draft report, and allowing more time for the TSA to undertake consultation on that report. Using data from two trusts that have recently used the failure regime we estimate these to be an additional £1.3mn to £2mn per TSA report.

Other key non-monetised costs by 'main affected groups'

The amendments may lead to upfront implementation costs that would fall to DH/CCGs if a TSA recommends that changes are needed not only to a trust in administration, but also necessary and consequential changes to other providers. However, given that this will only occur if there are no other viable solutions, these costs are likely to be significantly offset by the earlier realisation of financial benefits (for example through reduced deficit support to the trust in administration).

CCGs may also have increased costs as part of the increased consultation requirement. These are not expected to be significant resource requirements.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	n/a		n/a	**n/a**
High	n/a		n/a	**n/a**
Best Estimate	n/a		n/a	**n/a**

Description and scale of key monetised benefits by 'main affected groups'

There is not a direct monetised benefit, but we do expect there to be substantial non-monetised benefits [please see below].

Other key non-monetised benefits by 'main affected groups'

Given that the failure regime will only be used in exceptional circumstances when a trust is failing, significant cost savings are likely to be realised as a result of securing a sustainable solution , thereby reducing the need for on-going deficits to be supported. Latest estimates suggest NHS providers are currently forecasting a year end deficit for the financial year 2013/14 of around £500mn, although clearly not all of these trusts would be placed into the failure regime. Another key benefit is the patient benefit of improved quality of care as a result of addressing poor clinical standards in failing trusts.

Key assumptions/sensitivities/risks	**Discount rate (%)**	3.5%

1. The key risk is that the greater upfront cost of a quicker process may not be affordable without some change to existing plans.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:						In scope of OITO?	Measure qualifies as
Costs:	N/A	**Benefits:**	N/A	**Net:**	N/A	No	N/A

Evidence Base (for summary sheets)

A. Problem under consideration

1. The trust special administrators regime is one way in which decisive action can be taken to deal with NHS trusts and NHS foundation trusts that are unsustainable in their current form. A failed trust can be put into special administration. A trust special administrator (TSA) is appointed to take charge of the trust at which point the trust's board of directors is suspended (and in the case of NHS foundation trusts also the governors), and the TSA is also required to undertake an enquiry, consult appropriate interested parties, and then produce a report with recommendations that will deliver clinically and financially sustainable services.

2. This failure regime was introduced by the Health Act 2009, and was amended in the 2012 Act to make the regime for NHS foundation trusts compatible with the extended regulatory role given to Monitor to operate the new licensing regime. The failure regime has been used twice: the Secretary of State appointed the TSA at South London Healthcare NHS Trust in July 2012, and Monitor appointed the TSA at Mid Staffordshire NHS Foundation Trust in April 2013. Following its use at these two trusts, it is clear that small changes and clarifications are needed to ensure that the regime is fit for purpose.

3. Use of the failure regime has shown that the statutory timetable would benefit from an extension to allow more time for the TSA to prepare a draft report and to consult on the draft recommendations. There is a power to extend the failure regime's timetable, but experience suggests that the deadlines written into the primary legislation would benefit from an extension for the majority of cases, particularly given the desire for the TSA to seek the support of relevant commissioners to his or her recommendations.

4. The judgement in the Lewisham judicial review held that the TSA's scope to make recommendations, and the scope of the Secretary of State/Monitor, to take decisions, does not extend to action that affects providers other than the one to which the TSA was appointed. South London and Mid Staffordshire have shown that issues of clinical and financial sustainability nearly always cross organisational boundaries. Ultimately, the TSA needs to make the best decision for all patients and taxpayers. The failure regime would have limited use if the TSA could only make recommendations about the trust to which they are appointed.

5. The TSA appointed to an NHS foundation trust is already required by statute to seek support for their draft and final recommendations from all commissioners of the trust in administration. Attendant upon the wider scope for the TSA's recommendations that the amendments would provide for, the requirements on the TSA also need to be strengthened, to ensure that the TSA seeks the support of commissioners of other trusts affected by their recommendations.

6. The failure regime for NHS trusts does not place any requirement on the TSA to seek the support of commissioners for their recommendations. This is a lacuna when compared to the regime for foundation trusts, and there is merit in bringing greater

parity as between the arrangements for NHS trusts when compared with those for foundation trusts.

7. Use of the failure regime has also revealed an anomaly in legislation. The consultation requirements currently placed on clinical commissioning groups and NHS England for local reconfigurations of services are intended to apply only where they institute plans for local service changes (not when it is the TSA-led process). They are therefore inconsistent with the accelerated consultation process that forms part of the TSA regime. Clarification is therefore proposed to dis-apply these usual consultation requirements during the TSA process, where the TSA is already carrying out a consultation. This is similar to existing disapplication of the usual duty to consult on Trusts. In all cases, it is now made clear that this disapplication applies whether the TSA is appointed to an NHS Trust or a foundation trust.

B. Policy background and context

8. Before the 2009 Act, failing NHS trusts had been dealt with in a relatively *ad hoc* way. The intention behind the 2009 Act was to provide for a regime in legislation which would ensure clarity and transparency and ensure that key processes of the regime were applied systematically. For foundation trusts, the provisions of the Health and Social Care Act 2003, provided for a regime in which a trust being dissolved by order could be subject to insolvency procedures under modified statutory provisions for winding up companies. However, it was concluded that it would not be appropriate to apply insolvency procedures to most foundation trusts.

9. The provisions introduced by the 2009 Act enabled the Secretary of State to appoint the TSA to take control of an NHS trust or foundation trust for a temporary period. During this time the TSA was made responsible for ensuring the trust continued to exercise its functions. The TSA was required to produce a report stating the action the TSA recommends the Secretary of State should take in relation to the trust. The TSA was obliged to consult before finalising the report, and the Secretary of State was obliged to make a decision as to what action to take within 20 working days of receiving the report. In the case of foundation trusts, it was for Monitor to initiate the regime by giving a notice to the Secretary of State. On receiving such a notice, the Secretary of State was obliged to make an order de-authorising the foundation trust, returning it to being an NHS trust and appointing the TSA.

10. The failure regime for NHS foundation trusts was amended in 2012 to make it compatible with the extended regulatory role given to Monitor to operate the new licensing regime. Foundation trusts could be put into special administration, no longer being de-authorised prior to the appointment of a TSA. The failure regime for foundation trusts was designed to protect patient access to essential services in the event of a foundation trust going into failure.

11. Following the 2012 Act, the failure regimes for NHS trusts and NHS foundation trusts are similar, but there are differences that reflect the greater autonomy of NHS foundation trusts. The Secretary of State appoints the TSA to an NHS trust, whilst

Monitor appoints the TSA to an NHS foundation trust. The statutory objective of the TSA appointed to an NHS foundation trust is to ensure the continued provision of essential NHS services. The Secretary of State sets the objective of the TSA at an NHS trust at the time of appointment. The TSA of an NHS foundation trust is required by the Act to seek the support of commissioners for their recommendations, whereas there is no statutory obligation on the TSA to an NHS trust to seek commissioners' support. The final report on an NHS trust is submitted to the Secretary of State who decides what action to take, whilst the final report on an NHS foundation trust is submitted to Monitor which decides whether to accept the recommendations, with Secretary of State having the power to veto the recommendations if he or she is not satisfied in accordance with various specified criteria.

C. **Overview of the regime**

12. There are five stages to the failure regime, listed below

- ***Appointment***. The TSA is appointed by an order issued by the Secretary of State, or Monitor in the case of an NHS foundation trust. The TSA has a dual role. Firstly, the TSA exercises the functions of the chair and directors of the trust (and in the case of an NHS foundation trust, its governors), taking charge of the day to day running of the trust for the period he or she is appointed. Secondly, the TSA must make recommendations in relation to the action the Secretary of State or Monitor should take.

- ***Draft Report***. In effect, the task of the TSA is to rapidly assess the issues facing the trust, engage with staff and develop recommendations on the future of the organisation and the services it provides. The TSA must publish a report with draft recommendations within 45 working days of appointment.

- ***Consultation***. There is then a 30 working day consultation on the TSA's draft recommendations, including staff and wider public consultation. Other persons may be consulted by the TSA if directed by the Secretary of State or Monitor (depending on whether the TSA is appointed to administer an NHS trust or a foundation trust).

- ***Final Report***. Following the consultation, the TSA is required to produce a final report with their recommendations within 15 working days. For NHS trusts, that report is submitted to the Secretary of State; for NHS foundation trusts, it is submitted to Monitor.

- ***Decision***. On receipt of the final report on an NHS trust, the Secretary of State has 20 working days to decide what action to take. The Secretary of State must publish a notice of his decision and the reasons behind it, and lay this notice before Parliament. In the case of a report on an NHS foundation trust, Monitor has 20 working days to decide whether it is satisfied that the action recommended in the report would achieve the statutory objectives of special administration, and that the TSA has carried out his/her duties. If Monitor is satisfied with the report, it is forwarded to the Secretary of State who has 30 working days to decide if the commissioners, the TSA, and Monitor have met

their statutory duties and whether certain other key tests are met, relating to whether recommendations in the report would provide for the continuation of services identified in setting the TSA's statutory objectives, whether the recommendations would secure the provision of services of sufficient safety and quality, and provide good value for money . If Monitor or the Secretary of State is not satisfied with the TSA's report, there is a process for re-considering the recommendations. If, ultimately, the recommendations cannot be agreed, the Secretary of State can veto the report. The Secretary of State would then be required within 60 working days to decide what action to take in relation to the trust.

D. Policy objective

13. The policy objective is to create a failure regime and service continuity arrangements that support effective service change and provider restructuring when a trust is in distress, whilst protecting patient access to essential services. The regulatory regime within the NHS is designed to strengthen incentives for trusts to manage risk effectively and to solve problems locally. Monitor and the Trust Development Authority have powers to intervene proactively to mitigate risk, support recovery and prevent failure wherever possible. The failure regime is intended to be used as a last resort, when all other efforts by a trust and its commissioners to develop a viable model of care have been unsuccessful.

14. Issues of clinical and financial sustainability nearly always cross organisational boundaries. To be effective, the TSA needs the power to make, and the Secretary of State or Monitor the power to accept, recommendations that affect other NHS trusts, foundation trusts or other providers where such action is necessary for and consequential on the actions recommended for the trust in administration. NHS trusts, foundation trusts and other providers do not exist in isolation from each other. The failure regime would have limited use if a TSA were limited to making recommendations only about the trust to which they have been appointed.

15. It is important that commissioners are closely involved in developing the TSA's recommendations because of their responsibility for ensuring high quality health services for their local populations. The TSA appointed to a foundation trust is already required by statute to seek support for their draft and final recommendations from all the commissioners of the trust in administration. The government wants to ensure that the TSA of a foundation trust should be required to also seek the support of commissioners of services affected by the TSA's, recommendations that are provided by other trusts.

16. There are currently no requirements for the TSA appointed to an NHS trust to seek the support of commissioners for their recommendations. Commissioners are central to developing and implementing the TSA's recommendations. The clause would introduce an obligation on the Secretary of State to issue guidance on seeking commissioner support for their proposals and involving NHS England. The 2006 Act intentionally makes a distinction between the two types of trust, with the NHS trust

failure regime arrangements having less detailed provision, and we do not propose to alter this. Rather, the amendment introduces a guidance obligation on the Secretary of State, so that guidance to TSAs of NHS trusts must include guidance about seeking commissioner support and the involvement of NHS England.

17. The failure regime must be time limited as it is unacceptable for an NHS provider to continue to fail for an extended time. It has always been intended that the failure regime should be applied to a tight timeline, with deadlines for particular steps in the process written into the primary legislation when the regime was created in 2009, which gave the Secretary of State, and, since the 2012 Act, Monitor a power to agree to extend deadlines where necessary. Experience with use of the failure regime at South London and Mid Staffordshire trusts suggests that certain deadlines written into legislation would benefit from an extension in the majority of cases, particularly given the desire for the TSA to seek the support to their recommendations from relevant commissioners.

18. The failure regime has an accelerated consultation period to help the TSA produce prompt recommendations. The statutory obligations of commissioners (NHS England and clinical commissioning groups), NHS trusts and foundation trusts to involve and consult patients and the public in planning and making service change should not apply in parallel to the consultations already provided for as part of the process of the TSA's report being finalised, as they are inconsistent with the consultation requirements in the failure regime. Disapplication provisions already exist in relation to the consultation obligations on trusts, but the clause updates the provision as it applies to trusts so it is clear that the disapplication relates whether the TSA is appointed to a foundation trust or an NHS trust, and to extend the disapplication to clinical commissioning groups and NHS England.

E. Rationale for intervention

19. The powers of the TSA under the failure regime as currently set out, have been successfully challenged by way of a judicial review of the recommendations made by the TSA who was appointed to South London. To improve the failure regime, and to ensure that the TSA process can lead to the breadth of recommendations needed to address the issues the failing trust gives rise to, changes and clarifications need to be made to the legislation that underpins it. Government intervention is required to ensure that the failure regime is fit for purpose.

F. Monetised and non-monetised costs each option (including administrative burden)

20. It is not possible to robustly monetise the costs and benefits of the amendments due to a lack of evidence on the likely number of failing trusts that might use the failure regime and the impact these might have on whether a judicial review occurs and is successful. We have therefore used costs from two trusts, South London and Mid

Staffordshire, that have been subject to the failure regime to show the likely impact of the amendments and not extrapolated across the NHS.

21. We also expect there to be significant wider financial savings (i.e. due to reduced deficit support to failing trusts) and patient quality of care benefits as a result of a faster process. These are not included in the main body of the impact assessment or extrapolated for the reasons set out above but discussed in the non- monetised section and are likely to be significant.

    The figures used in the quantification are based on

    Cost of initial TSA report (based on South London/Mid Staffs) = £5.35- 10mn

    Increasing time for initial TSA report and consultation = from 120 to 150 days (for NHS Trusts) and from 150 to 180 days for FTs

    Implementation delay due to judicial review up to 2 years

Option 1: Do nothing

22. The costs and benefits of Option 1, do nothing, are implicitly evaluated in this impact assessment, by looking at the marginal costs and benefits of Option 2 over Option 1

Option 2: Introduce the amendments

23. The purpose of these amendments are
    - To make provision to enable the TSA to make recommendations about other providers beyond the trust in administration, where necessary for or consequential on actions recommended in respect of the failing trust
    - Create additional requirements for commissioner support,
    - Extend the timetable for administration, and
    - Correct an omission from the 2012 Act regarding consultation requirements

Monetised Costs

24. The main monetised costs of the amendments arise from extending the time the TSA has to complete their draft report, and allowing more time for the TSA to undertake consultation on that report. There are likely to be costs from the other amendments e.g. costs of additional commissioner support but these are not expected to be significant.

25. Administrative costs are likely to fall on TSA/DH and the additional commissioner support requirements are likely to fall on NHS. The cost of extending the timetable is estimated to be between £1.4mn and £2mn per TSA report and is based on the cost of producing the initial TSA report in South London and Mid Staffs trusts. It is unlikely that these are typical costs and so we have not used these to extrapolate theses costs across the NHS.

Non –monetised costs

26. There is also likely to be a change in the timing and scale of upfront costs incurred by NHS/DH. The purpose of the amendments is to avoid delays to implementing the TSA's recommendations and this may mean up-front costs being higher and incurred sooner rather than later. In the example of South London, the judicial review is

expected to delay implementation and upfront costs by up to two years. This cost has not been monetised but it is recognised the amendment will have an impact and is addressed in the risk section below.

G. Monetised and non-monetised benefits

27. The main monetised benefits of the amendment is the reduced risk of a judicial review against the TSA recommendations based on remit grounds. However, it is unlikely that the TSA would make wider recommendations given the recent ruling against DH in South London. Hence we have not included these savings as example of the monetised benefits.

28. The more significant benefit however is reduced deficit support. Lack of clarity on the number of trusts that might use the Regime means that we have not considered these financial savings as part of our central impact assessment estimates. The savings are, however, likely to be significant. Latest NHS accounts information suggests 37 NHS providers are currently forecasting a year end deficit for the financial year 2013/14 of £517mn, although clearly, not all of these would be placed into the failure regime. Extending the remit of the TSA is likely to reduce this by a currently unquantifiable amount.

H. Rationale and evidence that justify the level of analysis used in the IA

29. It has not been possible to provide robust net present values for the analysis in this impact assessment. Instead we have used costs from recent cases that have used the failure regime to illustrate the likely impact of the amendments and quantified the correct deficit support provided to providers. There are a couple of reasons why we think this approach is justified

    - The two trusts may not be typical of failing trusts that may be subject to the failure regime in the future. It is likely that the two trusts that we have evidence on are amongst the more urgent cases and therefore not representative
    - The number of failing trusts likely to be subject to the failure regime is unknown. We have estimates of the number of trusts currently in financial deficit and their associated financial support. However, it is not possible to confidently predict which of these may be put into the failure regime.. Hence we are unable to

extrapolate reduced deficit support over a number of years to calculate net present values.

I. Risks and assumptions

30. The main risk is that up-front costs in implementing recommendations may escalate because the TSA considers the wider health economy, and be incurred sooner as a result of the amendments. This is mitigated by ensuring the TSA has commissioner support for any revenue consequences and veto of Secretary of State veto on any final recommendations. These costs are also mitigated by the more significant wider costs savings as a result of more timely implementation of the TSA's recommendations.

J. Equalities

31. Section 149[1] of the Equality Act 2010 and the Equality Duty aims to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share a protected characteristic and people who do not;
- Promote good relations between people who share a protected characteristic and those who do not.

32. The TSA is subject to the Public Sector Equality Duty. Statutory guidance published by the Secretary of State for NHS trusts, and Monitor for foundation trusts, requires the TSA to observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act 2010. It requires that the equality assessment should apply to patients, public and staff. It also recommends that the assessment is undertaken early on in the failure regime to allow the TSA to identify, for example, groups with protected characteristics that may be affected and which their draft and final report can take into account.

33. Within their existing powers, the TSA could make recommendations about the trust in administration, that move services making access more difficult for some patients. Enabling the TSA to make recommendations that go beyond the confines of the trust means that services could be moved to other providers within the local health economy, or the TSA could recommend hospitals at the trust in administration could in future provide services currently provided by other trusts. Groups with protected characteristics could be disproportionately adversely affected by any requirement to travel further or for longer to access services (both elective and blue light transportation), because for example they are socio-economically disadvantaged, or rurally isolated communities. The TSA would need to identify groups with protected characteristics as part of their public sector equality duty, to be satisfied their recommendations take account of and mitigate against the risks identified – in particular the needs of disabled people. Strengthening commissioner sign off would

also ensure that the TSA's recommendations deliver high quality sustainable care for all, in particular to ensure enhanced community based services where appropriate.

34. One of the risks of short consultation process in the failure regime is that patients' staff and the public do not have enough time to consider the TSA's recommendations and give a considered response. Groups with protected characteristics may be particularly affected if they find it difficult to access relevant information or produce a written response. The proposed lengthening of the consultation period from 30 to 40 working days would allow more time for the TSA to seek the views of the community that are likely to be affected by the recommendations. In addition, extending the time available to the TSA to produce their draft report from 45 to 65 working days would give more time for the TSA to seek the views of the community, and give fuller consideration of the impact of their recommendations on groups with protected characteristics.

35. The proposal to dis-apply the statutory obligations of commissioners to involve and consult patients and the public in planning and making service change in respect of the failure regime is purely clarificatory. The consultation requirements placed on clinical commissioning groups and NHS England for local reconfigurations of services are inconsistent with the accelerated consultation process that forms part of the Regime. Commissioners are generally expected to consult for a minimum of 12 weeks in cases concerning major acute clinical design, with the provision for referral for local authority scrutiny. One of the principal benefits of the failure regime is the speed it delivers recommendations for clinically and financially sustainable services. The TSA is currently required to consult for 30 working days, with no provision for referral for local authority scrutiny. The TSA has clear requirements to consult those affected – the TSA must conduct a public consultation, must seek a written response from all commissioners of the trust in administration, and hold a public meeting. The Secretary of State may direct the TSA appointed to an NHS trust as to the persons they must consult, and in the case of foundation trusts, Monitor may direct, with Secretary of State having power to direct Monitor as to whom it should direct the TSA to consult. Furthermore, the changes being proposed would strengthen the requirements for the TSA to seek commissioner support for their recommendations (and therefore reflect the views of commissioners' local populations).

36. The clause would clarify that the statutory obligations of commissioners to involve and consult patients and the public in planning and making service change do not apply is respect of the trust special administration regime. Prior to the 2012 Act, primary care trusts' statutory obligations to consult were dis-applied in respect of the trust special administrators' regime. This clause amends the omission in the 2012 Act when primary care trusts were abolished to roll forward this disapplication to clinical commissioning groups and NHS England, as well as trusts**.**