

Monitor

Making the health sector
work for patients

**Securing the future
of services for
patients in Mid
Staffordshire: an
overview of Monitor's
regulatory approach
to a troubled NHS
foundation trust**

Main Hospital

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

Introduction

Mid Staffordshire NHS Foundation Trust (MSFT) is arguably the most challenged part of the National Health Service in England. Staff at hospitals in Stafford and Cannock have made tremendous efforts to improve services since the scandal over poor standards of care was exposed in 2009, and the organisation has been the subject of several major inquiries. However, the independent review commissioned by Monitor last year established that the NHS foundation trust in its present form is clinically and financially unsustainable in the long term. As the sector regulator, our next step was to appoint trust special administrators (TSAs) to find a solution that would secure appropriate hospital services for the local population into the future. The TSAs central conclusion was that the trust should be dissolved as soon as practically possible, and that other organisations should take over the running of the services it previously provided at Stafford and Cannock hospitals.

Monitor is satisfied that the package of measures put forward by the TSAs on 18 December 2013 is the most appropriate solution for the local health economy that can be found in the circumstances. We have worked with our national partners in NHS England and the NHS Trust Development Authority (NHS TDA) to ensure that there will be adequate funding arrangements to implement the plan successfully, and to put in place a new clinical model within the next four years. We accept that the option developed by the trust special administrators will strike the best available balance between access to services (including safeguarding all essential services at their current locations), and ensuring services are of adequate quality and provide value for money for taxpayers. We are therefore recommending their proposals to the Secretary of State.

Monitor's statutory powers with regard to TSAs are set down in the Health and Social Care Act 2012 and are quite specific. For example, we can only accept or reject their recommendations, we cannot amend them. However, the Secretary of State has powers to require the TSAs to amend their report if he feels it does not meet any of his tests as set down in the legislation, including securing the essential services demanded by local commissioners and offering good value for money. He has to make that decision by 26 February 2014. Monitor has written to the Secretary of State advising him that we believe all the relevant tests have been met.

Background

MSFT has had a chequered history since it was authorised in February 2008. Monitor has acknowledged that with the benefit of hindsight it was a mistake to grant the trust foundation status. We didn't have a full picture of the state of care at the trust at the time. We have learned important lessons, and now require an explicit confirmation from the CQC that the standard of care at any applicant trust is of an adequate quality.

Just over a year after authorisation, the care scandal erupted that has since become symbolic of the challenges facing the whole NHS. Monitor found the trust in breach of its terms of authorisation in March 2009. We subsequently worked with a succession of management teams to improve the quality of care for patients. In 2012 the CQC gave the trust a clean bill of health, but Monitor was still worried about the trust's ability to secure these improvements in the long term. Care at the hospitals was safe, but the underlying issue was how to sustain quality over time and in an affordable way.

MSFT has about 300 beds, employs 3,000 staff, and has an annual turnover of about £155m. This is relatively small in NHS terms, and successive management teams at MSFT have been unable to break even financially for many years. In March 2012 the closing deficit was almost £20m, despite extra payments from the local Primary Care Trust worth £4.5m. The trust was losing money so fast that in order to be able to pay its bills that year, the taxpayer was forced to subsidise it by £21m. A comparable bail out was authorised for 2012/13 after the trust again posted a multi-million pound deficit.

This situation could not continue. All this funding has to come out of the NHS budget – every pound spent on MSFT is a pound that can't be spent anywhere else in the NHS. In September 2012, therefore, Monitor decided to send in a team of experts to work with local commissioners and clinicians to find an approach that would protect services for patients and would be sustainable for the future.

The contingency planning team

Monitor asked this “contingency planning team” (CPT) to establish in the first instance whether the trust was clinically, operationally and financially sustainable – and if not, to recommend a suitable approach to establishing an alternative. The key to the team's analysis was an appreciation of the relationship between cost and clinical quality. As well as being one of the smallest trusts in the country in terms of turnover, MSFT is significantly more expensive to run than most others in England. This is partly because of the additional cost of investing in staff to overcome the well-documented care quality problems, but also because fewer patients are choosing to use its services. Numbers of first attendance are ten per cent lower than five years ago. As well as recruiting extra staff, the trust has to take on more and more temporary employees at premium pay rates to maintain staffing levels.

Crucially, there is not enough demand for some clinical specialties (notably obstetrics and paediatrics) to ensure that consultants can adequately maintain their professional skills. It is now widely acknowledged across the NHS that surgeons need to regularly perform a critical volume of operations in order to keep up their clinical skills and operate safely. Therefore, working collaboratively through clinical networks covering several sites is increasingly accepted as a more effective use of

resources than trying to maintain staffing rotas at individual hospitals which have relatively few patients.

The expert judgement of the CPT, published in January 2013, was not only that the trust was financially and clinically unsustainable in its present form, but also that neither the trust nor local commissioners would be able to secure the changes required to deliver sustainable services in future. The team therefore recommended that Monitor use its statutory powers to appoint TSAs to take over the day-to-day running of the trust and take on the task of finding a long-term solution.

The TSA role

This was the first time that an NHS foundation trust had been put into special administration. Accordingly, the board and governors of MSFT were suspended on 16 April 2013 and the TSAs took over responsibility for running the trust. The joint trust special administrators were Alan Bloom and Alan Hudson from Ernst & Young, and Prof Hugo Mascie-Taylor, a consultant geriatrician and former medical director of the NHS Confederation who had previously advised the contingency planning team.

The TSAs consulted widely with local clinicians, staff, patients, residents and their representatives in Parliament and on local councils. They engaged extensively with the public on a series of draft recommendations, and modified their final proposals in light of their findings. It is worth noting that at no stage did they propose the closure of either Stafford or Cannock hospitals: it was always clear that at least some of the services provided at each site were needed at these locations. The key issues that the TSAs considered were: what form of organisation was best suited to run these hospitals, and what pattern of clinical services should be provided to meet local needs.

Their solution to the organisational question is that as soon as practically possible Stafford Hospital should be run by the University Hospital of North Staffordshire NHS Trust (UHNS), based in Stoke-on-Trent, and that Cannock Chase Hospital should be run by the Royal Wolverhampton Hospitals NHS Trust (RWT). This means the existing hospitals will be integrated into separate clinical networks with larger hospitals which have a greater variety of specialties. Both providers confirmed they would be able to use their geographic proximity to run the full range of services the administrators proposed should be retained at Stafford and Cannock.

In coming to a solution on the question of the most appropriate pattern of care, the administrators worked closely with the two clinical commissioning groups (CCGs) run by local GPs that are responsible for purchasing NHS services in the area. The CCGs decided early on what essential services needed to be provided through Stafford and Cannock hospitals in order to meet the needs of the local populations (known as "location specific services"). Based on this minimum required level of services, the administrators sought to find a configuration of services overall that

struck the best balance between access, quality and affordability. In fact, and in part as a result of their consultation, the administrators proposed safeguarding a wider range of services than the CCGs originally said needed to be protected. They took on board the strong feelings of people in the area, and came up with a proposed pattern of services that means nine out of ten patients will continue to access the care that they need at Stafford or Cannock hospitals.

For example, the administrators listened to local campaigners and changed their proposals for maternity services where they now recommend retaining a midwife-led maternity unit at Stafford for women with low-risk pregnancies who want to give birth locally. They also gave assurances that specialist paediatric doctors would be available to treat children admitted to A&E at Stafford, and that the hospital would continue to be able to treat patients requiring critical care. However, the administrators reaffirmed their considered view that there would be too few patients to justify re-opening the A&E department overnight, and that in future some specialist services like routine surgery and out-of-hours emergency care should be provided at other local hospitals with appropriate facilities.

Although this does mean a minority of patients will need to travel to other hospitals in future, the independent clinical advice obtained by the administrators was that these patients will actually receive better care. Seriously ill people requiring emergency care (for example after major accidents) will be taken directly by ambulance to specialist centres at Stoke or Wolverhampton, as many already are. They will be treated as well, if not better, by trained ambulance staff on the journey than they would if waiting in an A&E department that did not have the resources to treat every single form of complicated injury. Similarly mothers-to-be who need expert medical attention from consultants when they give birth would be taken to specialist centres at Stoke, Wolverhampton, Walsall or elsewhere. The majority of patients that the administrators believe can and should travel further in future will be those needing emergency surgery, who will also be better served by consultants at Stoke and Wolverhampton.

Throughout this period the trust special administrators took advice from independent medical experts. In particular, Prof Mascie-Taylor convened a clinical advisory group that included representatives from the medical Royal Colleges, and was chaired by Prof Terence Stephenson, chair of the Academy of Medical Royal Colleges. The TSAs also set up a parallel nursing advisory group chaired by Elizabeth McManus, director of nursing and quality at Chelsea and Westminster Hospital NHS Foundation Trust. Both groups provided assurances that all the recommendations are clinically safe. In a letter to the TSA, Prof Stephenson said: "We believe, on the evidence we have seen, that if implemented properly the TSA model should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff."

Implications for patients and staff

Making changes to local health care services is never easy, or necessarily popular with the general public. Neither does change in a complicated system like the NHS come cheap or happen overnight. Nevertheless it is essential that patients are able to access safe services today, tomorrow and well into the future.

As well as running the trust, the TSAs have worked extremely closely with organisations across the health economy in Mid Staffordshire to design a safe and sustainable model of health care at Stafford and Cannock hospitals. On the basis of their work so far, both as stewards of the institution and architects of an alternative model, we are minded to ask them to manage the transition to the proposed new system.

This is a complicated legal process involving splitting existing corporate assets and handing them over safely to new NHS owners without any interruption in services for patients. It has never been done before with an NHS foundation trust. We anticipate the overall management cost of the contract for the TSAs and their staff over the lifetime of the project will be between £12m and £15m.

The TSAs calculate that their recommendations will ensure secondary care services are delivered in a safe and sustainable manner, yet reduce the cost to the local health economy by £27m a year. However, they were open in their final report that their proposals did not fully address all the financial challenges associated with the services currently provided by the trust. Indeed, they pointed out there was no solution within their legal scope that fully addressed the forecast deficit.

Under the 2012 legislation, the statutory scope of a trust special administrator is restricted to an individual institution and the services it provides. Neither Monitor, nor the TSAs, have powers to compel other organisations at national or local level to take part in this kind of exercise. Yet as the project developed it became clear that the answer to the problems of the trust were as much in the wider local health economy as the institution itself. Although the model proposed by the TSAs will cost less than the current one, and secure safe services into the future, the commissioners have themselves suggested that more work could be done across the local health economy to help reduce the cost even further. We support this proposal.

The significant short-term cost of tackling this problem has to be seen in the context of the long-term cost of doing nothing. The Department of Health now anticipates it will have to commit more than £30m in subsidies this year to shore up MSFT's financial position and enable it to pay staff and suppliers. If the action recommended by the TSAs is not taken, on current trends, the administrators estimate the financial deficit in 2017/18 would be in excess of £40m, double what it was when this work started, and necessitating further annual bail outs. In other words, it is likely the taxpayer would pay £100m or more over three years simply to maintain the status

quo and, of course, there would also be a recurrent expense into the future, draining money that would otherwise be spent on NHS services for patients in other places. The plan put forward by the administrators envisages ploughing roughly the same amount of money into making the necessary changes in the form of a one-off investment that will save resources in the long term and improve the quality of care.

The package to implement the TSAs' proposals will cost £90m over three years, from 2014/15 to 2016/17 inclusive. The largest component of that investment (£32m) will be the cost of funding the ongoing deficit, although this is expected to decrease over time. Another substantial part of these funds (£26m) is earmarked for tackling the ongoing maintenance needs at Cannock and Stafford hospitals, whose fabric has been neglected in recent years.

The Department of Health has agreed to underwrite the bulk of the costs of the transition. In addition, NHS England has agreed to provide an extra £8m to offset the double running costs that will inevitably be involved in winding down MSFT while simultaneously gearing up UHNS and RWT.

The administrators also estimate that the host providers at UHNS and RWT will need to submit business cases to the NHS TDA for capital investment of about £130m to upgrade facilities at all Stoke, Stafford, Wolverhampton, Cannock and Walsall hospitals in order to meet the new demands they will each face. The NHS TDA has assured Monitor that both providers are sustainable as stand-alone organisations, and are expected to be delivering a surplus by the time the transition is complete in 2017/18.

The CCGs warned during the consultation that they would not support any proposal that would leave them with a multi-million pound debt. They have since made clear that the final report has addressed their concerns. They have also been reassured by a commitment from NHS England to provide time-limited support to commissioners of up to £14.87m a year to meet the anticipated funding gap from 2017/18 onwards.

A statement from the Stafford and Surrounds and Cannock Chase Joint Clinical Commissioning Group on 18 December 2013 said: "The proposal to provide our health economy with the financial support to deliver the sustainable clinical model is both absolutely essential and welcome. This will mean that the health economy can work together to create stability for patients, public and the staff, and we as CCGs will need to commission differently in building a health system for the future."

Next steps

This has been and continues to be an extremely trying time for staff at MSFT and the patients that they serve. There is no doubt that the problems of the trust were exacerbated by the reputational damage it suffered as a result of the care scandal. More recently, the uncertainty inherent in the TSA process has affected staff

vacancy levels. As the administrators acknowledged, the trust is highly fragile and it is essential that decisive action is taken in the near future. Monitor's priority in overseeing this process, in our capacity as sector regulator, has always been to ensure that people in Mid Staffordshire continue to have access to the high quality health services they need on a sustainable basis.

The TSAs have done what we asked them to do. They have devised a plan which ensures that the services currently provided by MSFT that local commissioners deem to be essential for patients will be protected into the future, while running the trust themselves efficiently and effectively in the meantime. Monitor is satisfied that the TSAs' proposed future care model is financially robust, and has received assurances not only that the providers who will take over existing services are sustainable, but also that the impact of the acquisitions will be cost neutral. Independent medical and nursing panels have given assurances that the proposed care model is clinically safe and sustainable.

Monitor's board is therefore satisfied that the objective of the trust special administration has been achieved, and on the dissolution of MSFT it will no longer be necessary for the TSAs to remain in place. In taking this decision, the board recognised that the TSAs needed to find a balance between maximising local access to services, ensuring that services are clinically safe, and delivering services within the funding available. In the current circumstances, we believe that the proposed model will achieve this balance through its mixture of networking arrangements where possible and consolidation of services where necessary. However, these recommendations are themselves emerging patterns of care, and over time we expect local commissioners to work with local providers to seek more cost-effective services for their patients while maintaining the access and quality they need.



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