Title: Single Failure Regime **IA No:** DH 6108 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 15/04/2013 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries:**

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

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, One-Out?**	**Measure qualifies as**
N/a	N/a	N/a	No	NA

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

In the past, when poor care was detected, problems have not been addressed as quickly as possible, and effective action is not always taken to ensure that identified issues are resolved.

A critical finding from Robert Francis's report into the failures of care at Mid-Staffordshire NHS Foundation Trust was the significant failures of accountability and transparency in the role of system managers and regulators. Francis found that focus was directed at financial and organisational issues rather than protection of patients and ensuring quality of care.

What are the policy objectives and the intended effects?

A new failure regime, with greater emphasis on quality, will ensure that, where the standard of care is below an acceptable level, firm action is taken until it is properly and promptly resolved. It will deliver a clear and coordinated regulatory approach to identifying and tackling failures.

The intention is to ensure provider Boards adopt as rigorous and comprehensive an approach to maintaining quality as they do to keeping in budget, as highlighted in the Francis report.

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

In response to the recommendations of the Francis report relating to regulatory reform, three options have been considered:

1) Do nothing: This would mean that quality failures would continue to be dealt with as they currently are.

2) A single failure regime: to address any kind of failure with a clear method and clarity of roles of regulators (chosen option)

3) Transfer of functions from Monitor and NTDA to CQC to obtain a single regulator of the health and care system

The preference is for option 2 since, contrary to option 1, it would provide effective and proportionate powers, without restructuring costs and risks of conflict of interest, potentially observable in option 3.

Will the policy be reviewed? It will not be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: _____ Date: Earl Howe

Summary: Analysis & Evidence

Policy Option 1

Description: Single failure regime

FULL ECONOMIC ASSESSMENT

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

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	unquantified			**unquantified**

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

The main costs will fall on the regulators, which operate the single failure regime. As mainly concerned, CQC is currently calculating these additional running costs for its business planning process to be published later this year. The obligation for providers to comply is not expected to be significantly costly, thanks to earlier intervention in case of failure.

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

Key non-monetised costs include the potential alternative costs for regulators and providers of using resources to improve quality of NHS services; other regulatory or clinical activities; the cost of addressing poor care or quality failings providers; the impact on the local economy, and the cost of late intervention to resolve poor quality services.

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

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

It is not possible at this time to quantify, with satisfactory precision,the benefits for patients. It is also uncertain to what extent providers will improve the quality of their services and how this will change over time. Therefore, none of the described benefits have been monetised.

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

Key non-monetised benefits for patients, services users, providers and commissioners are improved quality, increased transparency, greater choice and definition of regulators roles and accountability of providers.

Key assumptions/sensitivities/risks — **Discount rate (%)** n/a

Powers to allow the CQC to instigate a new failure regime. This will mean that in cases where urgent changes are needed to address quality failings, this will be detected quickly, and there will be a clear and time limited process for intervening and tackling problems. The uncertainty is around any potential cost to providers. If reaching quality standards increases their costs, this could lead to financial problems or even their financial unsustainability.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: n/a	**Benefits:** n/a	**Net:** n/a	No	NA

Evidence Base

A. The underlying problem

1. At present, quality problems within providers may not be addressed as quickly as possible. Action is not always taken to ensure that identified issues are resolved promptly and effectively. The Francis Report into the standards of care at Mid-Staffordshire NHS Foundation Trust (FT) identified some significant failures of accountability and transparency of managers and regulators in the period covered by the inquiry. The report highlighted that focus was directed at financial and organisational issues rather than the protection of patients and ensuring quality of care

2. It is clear that action taken to address issues with quality at Mid-Staffordshire FT was not sufficient. Robert Francis attributed the undue focus on financial and organisational issues to 'poor communication, misaligned methods of assessment, and an over-reliance on assurances given by other organisations'.

3. At present, the Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (NTDA) have various powers to intervene in the event of failure. This covers finance, governance and quality. However, the powers that CQC currently has regarding quality failure are relatively blunt – they can issue warnings on the basis of non-compliance with registration requirements or prosecute, or they can close down either individual services or whole providers. For large providers deregistration may not be a credible threat. CQC has never previously exercised this power over an NHS Trust or FT. Monitor and the NTDA have interim steps for enforcement in the event of financial failures, for example to restrict licences or remove the trust board, but this flexibility is not available to CQC for quality failures. Ensuring that providers face equivalent interventions on the basis of financial and quality failures will ensure that providing a high quality service is as important as staying in budget.

4. The intention of this policy is to revise the regulatory framework for providers who are failing on grounds of quality. This means introducing additional steps between the assessment of a provider against essential standards and the ultimate sanction of closing a service or a provider as a whole. This will allow a more flexible, nuanced approach to tackling quality failures that is more proportionate and credible. To reduce duplication for NHS trusts and foundation trusts and to ensure clarity of role for the regulatory bodies, CQC will focus on identifying and exposing quality problems. Enforcement and overseeing specific rectifying actions will be overseen by Monitor for Foundation trusts or the NHS Trust Development Authority for NHS trusts.

B. Policy background and context

5. Over recent years, providers have been given more freedom over how they operate, with increasing transfer of power and control from organisations such as the Department of Health and Strategic Health Authorities (SHAs) to the providers of care. The intention behind this has been to encourage providers to become more innovative and responsive to patient needs and preferences.

6. The first major step was in 2004 with the establishment of NHS Foundation Trusts (FTs), which have greater freedoms over the way in which they manage their organisations and resources. This increases their incentive to innovate, permitting them to thereby raise their income or reduce costs and then improve services by reinvesting any surpluses. When the first FTs were authorised it was intended that all NHS Trusts would eventually become FTs.

7. The Health and Social Care Act (2012) made legislative changes to the way the health and care system operates and provided a framework for moving all NHS Trusts to FT status. The Act abolished Primary Care Trusts and moved commissioning decisions to Clinical Commissioning Groups (CCGs) to ensure greater involvement of clinicians in the commissioning process. This has meant, firstly, that decisions about services are made closer to the individual and, secondly, that providers have more freedom to respond to patient needs and preferences. For this to work effectively, appropriate regulation is needed to ensure that sufficient focus and priority is given to quality of care.

8. In her speech to Parliament on the 9th May 2013, the Queen set out that the Care Bill would:

' Make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; and for connected purposes'.

9. The Care Bill (May 2013) is formed into 3 distinct areas:
   - Reform of Care & Support
   - Response to the Francis Inquiry on failings at Mid-Staffordshire NHS FT
   - Establish Health Education England and the Health Research Authority

10. The Bill follows on from the Draft Care & Support Bill published in July 2012 and takes account of the findings of the public consultation, engagement and pre-legislative scrutiny. It also implements the Government's response to the Dilnot Commission's Report into the Funding for Care and Support and a number of measures adopted in the wake of the Francis Inquiry into the failings at Mid-Staffordshire NHS FT. In particular, the Bill creates a new single failure regime to

ensure that there is the same emphasis on failures in quality of care as there currently is for financial failure. Building on existing policies, the single failure regime develops the roles of the CQC, Monitor and NTDA to provide a simple, flexible process for tackling failures of quality and finance at NHS Trusts and FTs.

C. Role of the regulators involved

NHS Trust Development Authority (NHS TDA)

11. The NHS Trust Development Authority is established by the National Health Service Trust Development Authority (Establishment and Constitution) Order 2012 as a Special Health Authority.

12. The general function of the NHS TDA is to support NHS Trusts in England to deliver high quality and sustainable services to patients, thereby enabling them to become Foundation Trusts (FTs). Where an NHS Trust may be unable to meet the criteria set by Monitor to achieve Foundation Trust status, the NTDA will support it to find a suitable alternative organisational form.

13. The NTDA oversees all aspects of planning and delivery for NHS Trusts, ensuring that trusts provide safe, sustainable, high quality services. It is responsible for oversight of clinical quality, performance and finance, and for developing capacity and capability in NHS Trusts. The NTDA ensures that NHS Trusts meet relevant standards, intervening to support trusts to make sustainable improvements where required. The NTDA will approve organisational transactions and significant capital investments involving NHS Trusts.

14. The NTDA is a Special Health Authority, and operates in accordance with the directions issued to it by the Secretary of State. As NHS Trusts are legally accountable to the Secretary of State, the NHS TDA is able to exercise a wide range of intervention powers on the Secretary of State's behalf.

15. The NTDA is responsible for the appointment and development of chairs and non-executive directors of NHS Trusts.

16. The NTDA will seek and consider advice from Monitor, including advice on what steps an English NHS trust is to take to comply with section 35(2) of the Act as to which Monitor must be satisfied prior to giving an authorisation as an FT.

17. In addition, where the NTDA considers it is in the interests of the health service, it can already advise the Secretary of State to place an NHS trust, which it considers to be either clinically and/or financially unsustainable, into special administration.

Monitor

18. Monitor is an independent regulator that authorises and regulates FTs to ensure that they are well-led and financially robust. Since April 2013, Monitor has also been the economic regulator for healthcare in England with a duty to protect the interests of service users by promoting health care services that are efficient and effective. As such, it sets out conditions that providers must meet to obtain a licence to provide NHS-funded care, and is responsible for ensuring adherence to these conditions, which include meeting minimum quality standards.

19. The 2012 Act requires Monitor to have regard to the need for commissioners to secure access to services within each geographical area in England (section 66 (2)). Monitor will investigate potential breaches of licence conditions and use a Risk Assessment Framework to highlight concerns, assess the risk to the continuity of commissioners requested services and to the governance of FTs.

20. When Monitor identifies that an FT has breached, or is likely to breach, its licence conditions, it will take progressive and appropriate actions to recover the quality and safety of healthcare services, without disrupting the continuity of the services requested by commissioners. Monitor will use a range of powers to intervene at different levels of failure:

- If an FT is in breach of its licence, Monitor can take the following actions:
  1. It can impose requirements on the FT (section 105 of the 2012 Act), and/ or impose a financial penalty. The requirements may include directions to take or not to take specified actions, which may or may not include direction to restore the situation to what it would have been had the breach not occurred;.
  2. It can accept an undertaking from the FT to undertake specified actions to rectify the licence breach (section 106 of the 2012 Act). If the FT fails to meet the terms of the undertaking Monitor can impose requirements on the FT (as in the paragraph above);
  3. If governance is the cause of the licence breach, Monitor may act according to the section 111 of the 2012 Act and impose additional conditions relating to the FT's governance. Monitor may also impose such additional licence conditions where the FT is not taking sufficient steps to ensure compliance with its licence. If those conditions are breached by the Foundation Trust, then, Monitor may remove, suspend, or disqualify one or more directors or members of the Board.

21. Eventually, in the event of extreme failure, Monitor may revoke the licence of the FT, preventing it from operating. In the event of serious failure, Monitor will put in place a contingency planning team to identify services that will need to be protected and determine how to maintain their delivery.

Care Quality Commission (CQC)

22. The Care Quality Commission is the statutory regulator for the quality of health and social care, including in hospitals, dental practices, ambulances, care homes, people's own homes and elsewhere. CQC assesses whether providers registered with CQC meet national standards of quality and safety and are protecting the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

23. Providers of 'regulated activities' must be registered with CQC and comply with registration requirements in order to be able to provide regulated activities. CQC regulates provider compliance with the registration requirements (the sixteen essential standards of quality and safety). To make assessments of compliance, CQC can:

    - make unannounced inspections of services both on a regular basis and in response to concerns
    - carry out investigations into why care fails to improve
    - continually monitor information (national and local, and from the public, local groups, care workers and whistle-blowers)

24. If a provider is deemed to be non-compliant with its registration requirements, CQC can make use of its statutory enforcement powers. These include warning notices that require improvement within a specified period, penalties, suspension or restriction of a provider's activities, or in extreme cases, cancellation of a provider's registration.

25. The CQC takes a proportionate approach to regulation. From time to time a provider may dip temporarily below the bar breaching one or more of the 'essential standards of quality and safety'. Where there are significant, repeated, multiple and/or sustained breaches of registration requirements, it is likely that the provider is experiencing a serious failure, and that there are systemic problems within the organisation.

26. In order to regulate successfully, the CQC works in conjunction with other organisations such as commissioners, other national bodies, and regulators including Monitor and the NHS TDA.

D. What are the policy objectives and the intended effects?

27. The objective is to have a single failure regime, as set out in the Department of Health's reponse to the Francis report, that will deliver a clear regulatory approach to identifying and tackling failures of quality. It is essential that there is a common understanding of provider performance amongst regulatory bodies. CQC would lead on quality surveillance of hospitals looking at quality in the round and not just registration standards but will not be responsible for making the necessary changes where quality failures are identified.

28. The principle that responsibility for dealing with the problem lies with the provider, rather than external bodies, will not change. Only if the provider is unable to resolve the situation itself and problems persist, would Monitor or the NHS TDA then decide to step in, according to their own discretion, to ensure sufficient action is being taken.

29. In these rare cases of clinically unsustainable providers, Monitor would place the provider into trust special administration and ensure that the local population can access a comprehensive range of safe, sustainable health services.

E. The rationale for Government intervention

30. Following the significant failings in quality of care at Mid Staffordshire NHS FT found by the Healthcare Commission in 2009, Monitor immediately commissioned a review of its actions from KPMG, its internal auditors. This concluded that the regulator needed to better align its work with others, requiring better information sharing across the healthcare system and especially with CQC[1]. Monitor began to implement this at the time[2].

31. Moreover, the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, sets out how regulators, commissioners, professional bodies and the Department of Health failed to act together in the interests of patients and high quality patient care. Robert Francis recommended that Monitor's FT functions should be transferred to the Care Quality Commission (CQC) to create a single system regulator for the NHS, reducing duplication and misalignment of regulatory action. This supports the idea of a coordinated interventions framework, embodied by the Single Failure Regime.

---

[1] KPMG, ADVISORY *Learning and Implications from Mid Staffordshire NHS Foundation Trust for Monitor –Independent Regulator of NHS Foundation Trusts*, 5th August 2009, http://www.monitor-nhsft.gov.uk/sites/default/files/KPMG%20internal%20audit%20report_0.pdf accessed on the 25th September 2013.

[2] Monitor website, http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/about-monitor/what-we-do/update-progress-following-the-interna, August 2010, accessed on 2nd October 2013.

32. The National Audit Office advised the Department of Health[3] to set up a coherent and transparent financial support mechanism which outlines when trusts should be supported, or allowed to fail. The Single Failure Regime also seems to be an appropriate response to this request.

33. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, recommended that there should be a single regulator overseeing quality and finance for the NHS. The Department of Health does not agree that there should be a significant transfer of functions from Monitor to CQC as there remains a clear justification for maintaining CQC and Monitor as separate organisations, undertaking distinct roles. Assessing quality and highlighting failures of care should not be conflated with the responsibility for overseeing the turnaround of failing NHS providers. Moreover, a merger of the regulators would have significant transactional costs that can cause a dilutive situation for both regulators. Instead, to achieve the spirit of Francis' recommendation, the Care Bill introduces changes to separate the assessment of providers from the taking of enforcement action, and to ensure that when failures are identified there is a prompt and firm response.

34. As set out in this document the current framework for identifying and addressing quality failure is not considered to be as effective as it could be in tackling and rectifying poor quality of care by providers.

35. The current framework for identifying and addressing quality failure is regulatory in nature and changes to it will be through legislation. Therefore, Government intervention is required to address this.

F. Options under consideration

36. Three options have been considered for how to respond:

a. **Do nothing:** This would mean continuing with the current situation, so that quality failures would be dealt with as they currently are by CQC. Under this option, CQC's powers would continue to be limited to warning notices and the closure of services or of whole providers, without the ability to trigger robust and timely intervention when significant improvement in the quality of care is required.

b. **Introduce a single failure regime**: Under this option, there would be a greater range of tools to use in response to quality failures, which are not currently available to CQC, including a power to trigger special administration on quality grounds. With the knowledge that regulators can employ a broader range of tools with respect to quality failings, the correct

[3] National Audit Office, Securing the future financial sustainability of the NHS, 5th July 2012, pp.13. http://www.nao.org.uk/wp-content/uploads/2012/07/1213191.pdf accessed on the 23rd September.

incentives will be built into the system to ensure that, for providers, delivering a quality service is as important as staying in budget. The aim of this policy is to deliver a clear and coordinated regulatory approach to identify and tackle failures of quality at NHS Trusts and FTs across England for the benefit of all patients. Where quality of care is below an acceptable standard, firm action will be taken until it is properly and promptly resolved.

Rather than transferring functions from Monitor to CQC, as Francis suggests, we intend to have greater clarity over the respective roles of CQC and Monitor/ NTDA. It is important that assessing quality and highlighting failures of care are not conflated with the responsibility for overseeing the turnaround of failing NHS providers. A single regulator, combining CQC and Monitor's existing roles in relation to maintaining quality of care and financial sustainability, would need to balance these dual responsibilities where they conflict and doing so would risk undermining the responsibilities of provider boards to ensure they provide safe care within budget. To reduce duplication, there will be a clear delineation between CQC's role as the assessor of quality and Monitor and NTDA's role in intervening to resolve the problems.

Even if there is a serious quality failure at an NHS Trust or FT, it is currently not often feasible for CQC to close the trust. If, for example, the trust is the sole provider in a relatively remote area, then patients would have nowhere else they can go for treatment. Even if there are alternative providers around, there may be insufficient capacity for the provider (or even an individual service line) to be closed down, and the failure would have to be tolerated in the short term. This in turn serves to reduce the incentive on a provider to improve the quality of its care as there is no realistic threat of intervention. Monitor and NTDA currently have various powers they can and do employ to rectify failure on the grounds of quality, finance or governance. In the case of NHS foundation trusts, Monitor has agreed to follow CQC's lead in identifying quality concerns.

While there does tend to be a link between quality and finance – for example, poor quality may require a significant amount of money to be invested to rectify the problem – this is not perfectly correlated. There can be examples of a provider only being poor on one thing or the other, or there being a long lag time before poor quality leads to a failure of finance. Enabling the regulators to place a failing trust into special administration on the basis of quality failures will ensure that problems are not allowed to persist.

c. **Transferring functions from Monitor and NTDA to CQC as recommended in the Francis report**. This option could reduce the problems created by poor communication and avoid duplications in the respective responsibilities of the regulators involved, but would conflate responsibility for identifying failure and turning around failing trusts. As set out above, we do not agree that there should be a significant transfer of functions from Monitor to

CQC and will not be addressing this option. Moreover, there is an additional direct cost associated with the transfer on functions from Monitor to CQC. A National Audit Office report[4] estimated the cost of each reorganisation of an organisation at £15m, so the additional cost here could be of the order of £30m.

Benefits and costs of each option, and justification for the preferred option

Option 1: Do nothing

37. By definition, the benefits and costs of this option are zero. This is the baseline against which the other options will be assessed.

38. However, doing nothing will mean that failures will persist with significant implications for patients' health and safety. This option has therefore significant costs in terms of quality of life of patients, which have not been monetised.

Option 2: Single failure regime

a. Benefits of introducing the single failure regime

39. The primary benefit of this option is to build the correct incentives into the regulatory system and to improve communication and alignment between the regulators. This would result in a greater emphasis being attributed to the quality of care and improved outcomes for patients.

- *Quicker resolution of quality issues*

40. The clear delineation between the roles of CQC and Monitor/NTDA to deal with quality failure will mean that there is no doubt as to the respective responsibilities of the regulators and how quality failures will be identified and resolved. Whilst there is often a link between quality and finance – for example, where there are problems with quality, more money may be required to resolve them, which could ultimately lead to financial failure or poor management generally could lead to problems on both fronts – this is not perfectly correlated. There are examples of a provider only being poor on one or the other.

41. Under this option, Monitor or NTDA would be able to make use of its intervention powers where CQC has identified unresolved issues with the quality of care. CQC would also receive a new power to direct Monitor to place a Foundation Trust into special administration on quality grounds

[4] National Audit Office, *Reorganising central government*, 2010, http://www.nao.org.uk/wp-content/uploads/2010/03/0910452.pdf , accessed on 24th

as a backstop power if local efforts had failed and Monitor had failed to act. Equivalent arrangements would be made for NHS Trusts.

42. The proposals under option 2 would enable failures in quality to be detected earlier, with a clear method for detection and resolution. Providers would be encouraged to deal with issues early at their own discretion and, because the intervention on quality failings would be similar for finance, this would deliver a strong message to providers that delivering a high quality service is as important as staying in budget.

- *The role of improvement notices*

43. At present CQC can only issues warnings when providers breach essential quality standards. The intention is for CQC to be able to issue improvement notices when there are concerns about current or potential future performance, even if the provider is not technically in breach. Providers would need to respond to the improvement notices within a fixed time period; although the action taken to do so would be at the discretion of the provider. In doing so, services should improve more quickly to the benefit of patients.

44. The Improvement Notice would identify problems, and specify a fixed time for improvement, but it would not dictate the action taken. The assessment taken by CQC, which is not just against registration requirements, may highlight to providers where quality is of a concern to ensure that problems are dealt with whilst they are manageable.

- *Decisions being made on the basis of all available information*

45. The single failure regime is part of an overall set of measures aiming to reduce the likelihood of quality failure in the health and care system, and to deal with them if they do occur.

46. In terms of surveillance, CQC will look at quality in the round and make assessments of providers. This would end the potential confusion about the 'true' performance of providers, related to the relatively strongest focus on finance than quality. Interventions would therefore be better targeted at the providers that are most in need of improvement.

47. This, added to powers for CQC to issue improvement notices and to trigger TSA in extreme cases, should help to ensure that the most appropriate decisions are made. This in turn should help to both save money and to improve the quality of services across the health and care system. This is because compared to the 'do nothing' scenario, there is likely to be earlier, and more appropriate, intervention. Therefore, when there are problems with the quality of services, they will be resolved more quickly, which will serve both to improve quality and potentially to save money,

given that some problems around the quality of services may only be mitigated in the short term through expenditure of extra money.

- *Improved incentives across the system*

48. At present, if there are quality issues within providers that are apparent, the provider may choose not to respond on the basis that the powers for regulators are not as good as they could be. So, for example, if a provider is currently in breach of essential standards then CQC can issue warnings. However, in practice, these warnings may not always have the desired effects, as there may be no realistic possibility that the provider will be closed down – particularly within acute care.

49. Enhancing the powers of CQC, Monitor and the NTDA to intervene on the basis of quality issues would increase the incentive on providers to resolve issues, as there would be more of a credible threat that action will be taken. This could be through the improvement notices, through restrictions placed on the provider through licensing, through the removal of the board or ultimately through the closure of the provider. This would increase the likelihood that the provider will respond. It would also increase the likelihood that the provider increases their focus on the quality of their services, thereby reducing the likelihood of such problems arising in the first place. Both of these incentive effects would serve to improve the quality of services provided, thereby improving patient outcomes.

b. Costs of introducing the single failure regime

50. As there have only been two incidences of special administration so far, one in an FT and the other in an NHS Trust, it is not possible to determine indicative figures for future incidences of special administration; this will depend on the complexity of the NHS Trust or FT, their financial arrangements and the extent of any reconfiguration required.

51. Although they cannot be quantified, the main costs associated with the introduction of the single failure regime have been identified; they will fall on the regulators, who will be operating it. There may also be costs incurred by providers. These are set out below.

    Costs to the regulators: CQC, Monitor and the NTDA may require some additional resource to operate the single failure regime. This includes the costs of reconfiguration and of special administration.

    Costs to providers: The Single Failure Regime results in more action being taken by some providers to ensure that the services they deliver are of the required quality. This may include costs of compliance or may be a reallocation of their budgets.

52. It is not currently possible to determine how many NHS Trusts or FTs will fall into special administration in a given time period, as this will depend on individual financial performance, the new CQC inspection regime and additional pressures which cannot be anticipated at this stage (e.g. severity of winter). To aid an understanding of what this might imply in terms of the nature of costs, we discuss below two case studies which describe the type of costs that were incurred where special administration arrangements were triggered. However these figures **cannot be used to predict the likely costs** of the regime; that analysis will depend on an evaluation of how the different regulators address a future quality failing.

53. Case study 1: The Mid Staffordshire NHS Foundation Trust

The Mid Staffordshire NHS Foundation Trust is one of the two providers that have been put into special administration. This case describes the intervention of quality and economic regulators; and it also shows that quality failures over time drive to financial unsustainability. It therefore supports the assumption made with the single failure regime that earlier and quicker coordinated interventions of regulators –i.e. CQC and Monitor - will have a beneficial impact.

General overview

The Mid Staffordshire NHS Foundation Trust manages two hospitals: Stafford Hospital, opened in 1983, an acute hospital with approximately 300 inpatient beds and Cannock Chase Hospital, created in 1991, which includes around 50 inpatient beds. The FT serves the registered population of two Clinical Commissioning Groups (CCGs): Stafford and Surrounds CCG, and Cannock Chase CCG, which commissions services for a combined population of 276,500, living in Stafford, Cannock, Rugeley and the surrounding areas.[5] It employs around 3,000 members of staff across the two hospital sites and has an annual turnover of about £155m[6].

In February 2008, the Mid Staffordshire Hospitals NHS Trust was authorised as an NHS foundation trust - and became The Mid Staffordshire NHS Foundation Trust – on the basis of compliance with the relevant requirements for governance and financial management. In March 2009, the Commission for Healthcare Audit and Inspection, known as the Healthcare Commission (HCC), – quality regulator of the health care and public health in England and Wales until the 31st March 2009 when it was replaced by the Care Quality Commission (CQC) - published a report criticising poor patient care and the management of the organisation.

From March 2008 to January 2013, a range of intermediate actions were taken by the CQC, Monitor, West Midlands Strategic Health Authority and South Staffordshire Primary Care Trust to

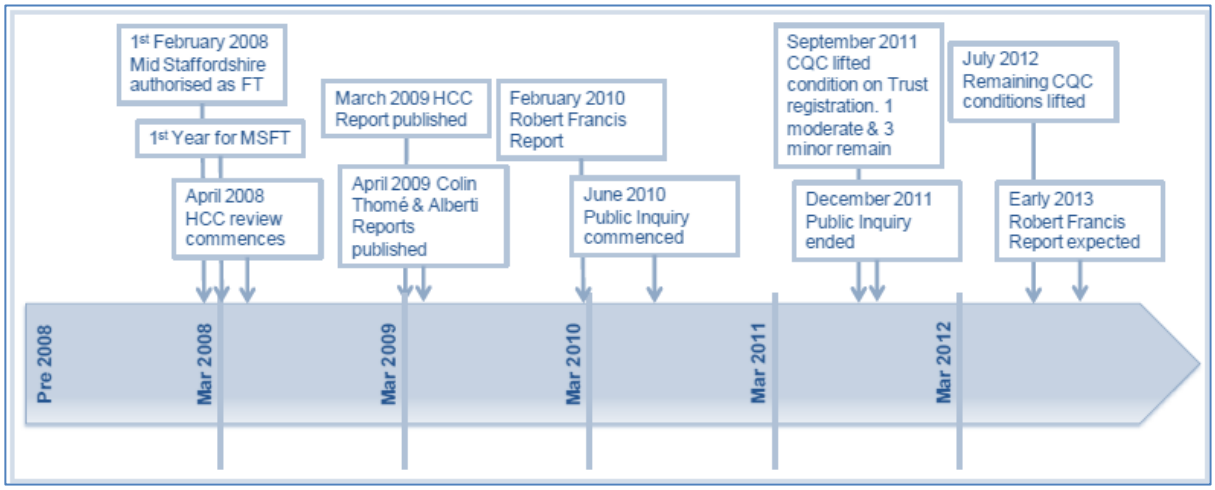
[5] Mid Staffordshire website, http://www.midstaffs.nhs.uk/About-Us.aspx, accessed on 19/09/2013.

[6] Ernst & Young, Monitor - *Contingency Planning Team, Mid Staffordshire NHS Foundation Trust, Assessment of Sustainability,* January 2013, pp.3 http://www.monitor-nhsft.gov.uk/sites/default/files/publications/MSFT%20Sustainability%20Final.pdf

clearly identify failures and intervene at the Mid Staffordshire NHS Foundation Trust. These actions are catalogued in detail in the Francis report. In summary, from April 2008 to March 2009, HCC undertook an investigation into the FT on the basis of high mortality rates and poor patient feedback, which concluded there were systemic problems. Monitor issued an intervention notice in March 2009. It also decided that discretionary intervention was necessary and used its formal powers of intervention to appoint an interim Chair. In October 2012, as it became apparent that the FT was financially unsustainable, Monitor appointed a Contingency Planning Team (CPT) which reported, in January 2013, that, despite significant efforts, the FT was not able to deliver clinically and financially sustainable services in the long run.

Therefore, on the 16th April 2013, Monitor appointed Joint Trust Special Administrators (TSAs) to oversee the running of the Stafford and Cannock Chase Hospitals are operating as usual and patient services continue to be provided in the normal manner.

Figure 1: High Level Mid Staffordshire external reviews from 2008 to 2012



Source: Ernst & Young, 2013

April 2007: Identification of quality failures

Through its programme of analysis of mortality in England, the Healthcare Commission (HCC) became aware by the autumn 2007 that the Mid Staffordshire NHS Foundation Trust (MSNFT) presented a number of apparently high mortality rates for specific conditions or operations and poor standards of care[7]. Following this statistical alert, the HCC requested the Mid Staffordshire NHS FT to provide further information to check whether the high rates were due to problems with quality of care for patients or poor recording of clinical information – as it was claimed by the FT.

[7] Investigation into Mid Staffordshire NHS Foundation Trust, The Healthcare Commission, March 2009, pp.5, https://www.rcn.org.uk/__data/assets/pdf_file/0004/234976/Healthcare_Commission_report.pdf

The trust failed to give sufficient details which led the HCC to decide that a full investigation was required.

March - October 2008: Investigation on The Mid Staffordshire NHS Foundation Trust's A&E

From March to October 2008, the Healthcare Commission focused its investigation on patients aged 18 and over who were admitted as emergencies to the FT. The work was based on further statistical analysis of mortality rates – made by Dr Foster Research Unit at Imperial College London and the Commission's data surveillance team – interviews of staff, patients and relatives, visits to the FT and examination of documents and case notes. The investigation, reported by the Commission in March 2009, showed that since April 2003, the trust's standardised mortality ratio (SMR) had been consistently higher than expected. From 2005/06 to 2007/08, the trust's SMR varied between 127 and 145.

The HCC concluded that, in addition to poor information management, there were systemic problems across the trust's system of emergency care: low level of staff, lack of training, no regular checks by nursing staff of the patients once admitted in A&E, poor handover of patients, lack of equipment, too few beds in some areas, delay in assessment and treatment, failures to report some incidents, opportunities to learn lessons missed etc. In summary, the care and assessment of patients fell below acceptable standards.

March 2009: Monitor issued intervention notice to the FT

Following the receipt of the Healthcare Commission report, Monitor judged that the Mid Staffordshire NHS Foundation Trust was in significant breach of two conditions of its authorisation requirements on the grounds of poor governance and a failure to meet its general duty to exercise its functions effectively, efficiently and economically (section 52 of the 2006 Act)[8]. It decided that intervention was necessary and used its formal powers of intervention to appoint an interim Chair (David Stone), and required the trust to appoint an interim Chief Executive selected by Monitor (Eric Morton). The objective was to put in place strategic and operational leadership to stabilise the Trust and improve the delivery of patient care[9].

Aside of the health regulators' actions, the Secretary of State for Health, Andrew Burnham, announced, on the 21 July 2009, a further independent inquiry into care provided by Mid Staffordshire Foundation Trust to be led by Robert Francis. The first inquiry report was published on 24 February 2010 and confirmed the deficiencies in governance and staff. Moreover, the report assumed that they had started before January 2005.

[8] Monitor, *Mid Staffordshire NHS Foundation Trust: the case for appointing a Trust Special Administrator,* 2013, pp.3.

[9] Monitor, *Monitor issues intervention notice to Mid Staffordshire NHS Foundation Trust*, published on 3rd March 2009, http://www.monitor-nhsft.gov.uk/home/news-and-events/media-centre/latest-press-releases/monitor-issues-intervention-notice-mid-staff, accessed on the 19th September 2013

February 2010 – October 2012: from quality failures to financial unsustainability

The Mid Staffordshire Foundation Trust complied with the recommendations of the HCC, public inquiry and external reports (detailed in the figure 3, pp. 12) and invested significantly in additional staff. Through these investments, the MSNFT's clinical care provided to patients progressed and the CQC lifted its outstanding concerns about quality and safety of the care being provided. However, it started facing a related chronic deficit, which has required significant external financial support from the Department of Health: £21m received in the financial year 2011/12. Despite a new Chair (Sir Stephen Moss) and Chair Executive (Antony Sumara) and attempts to improve its financial situation, the FT's financial unsustainability put it in significant breach of its terms of Authorisation (Act 2006) on both financial and governance grounds[5].

Figure 2 Financial of the Mid Staffordshire Foundation Trust from 2010 to 2012

Currency: £ 000	FY10	FY11	FY12	%change
Recurrent Income	147,361	151,875	152,144	3%
Recurrent Expenditure	(146,311)	(157,506)	(161,592)	(10%)
Underlying EBITDA	**(1,050)**	**(5,631)**	**(9,448)**	**(1000%)**
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)	-	-	-
Underlying Surplus/(Deficit)	**(9,248)**	**(15,606)**	**(19,420)**	**(110%)**
Non Recurrent Income	4,500	6,075	3,216	(29%)
Non Recurrent Expenditure	-	(4,300)	(3,707)	-
Total Surplus/(deficit)	**(4,748)**	**(13,861)**	**(19,911)**	**(319%)**

Source: Monitor, 2013

Explanation of the table 1 (Monitor, 2013):

The first signs of financial difficulty were apparent in 2010 when its deficit reached £4.8m. It occurred as the Trust increased its pay expenditure by £9.1m (9.2%) through the recruitment of additional staff, in response to the Healthcare Commission, Robert Francis and external report's recommendations. Further increases in staff in 2011 to improve its operational and clinical performance put additional strain on the financial position of MSNFT, i.e. its total deficit rise by 43%. The retained underlying deficit has deteriorated by £19.2m from 2010 to 2012 and actually since having FT status in 2008, the FT's retained underlying deficit increased by over £40m. It has increased its total revenue by £4.8m (3%) from 2010 to 2012 due to changes to patient care related income and external support (non-recurrent income) funded mostly by the Primary Care Trust (£13.7m). The FT's total expenditure grew by £19m over the period showing its overall cost base increased at a greater rate than the increase in

income, which was due to its investment its operational and clinical performance. Overall, the FT recorded a deficit of £4.7m in 2010; this then increased in each year to reach a deficit of £19.9m in 2012.

As it became apparent that the FT was not able to sustain both its financial balance and delivery of high quality of care, Monitor decided to appoint a Contingency Planning Team (CPT) in 2012.

October 2012: Monitor appoints a Contingency Planning Team to the FT

The investment in additional staff and equipment had significantly improved the quality of care from 2010; however, the existing organisation at the FT and its absence of strategic plan could not ensure a sustainable future for its service to patients[5]. From October 2012, the CPT, led by Ernst & Young and supported by McKinsey & Company, has been working to develop a long-term plan to ensure that services are provided for local patients on a sustainable basis. The Department of Health has agreed to provide the funding and the work is likely to cost in excess of £2m[10].

In January 2013, the CPT reported to Monitor that, since 2011, the Mid Staffordshire Foundation Trust had made significant progress, through strategic and organisational changes, in establishing its operational sustainability. However, despite these efforts, the Mid Staffordshire Foundation Trust, in its current form, could not be sustainable in the long-term both on financial and quality grounds. Moreover, the CPT did not expect that either the FT or its commissioners would be able to face the challenge required to deliver sustainable services in the future[5]. According to the CPT, the planned deficit for the financial year 2013 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. In the Operational Sustainability assessment, the CPT identified that the estates and operational costs are higher than the national average – i.e. the estates cost increased by 6% per year compared to a national average of 1%. In order to achieve breakeven in 2018, the Trust needs to achieve £53m of cost savings, which equates to at least 7% of relevant income in each year. The 7% level of cost savings is higher than the average achieved by any NHS foundation trusts (Monitor's review 2012).Similarly, the King's Fund Quarterly reviews observed 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. Even if, the Mid Staffordshire FT has achieved £16.6m efficiencies in 2012 and 2013, it agreed with the CPT to say that this required level of extra savings and additional income is very unlikely to be delivered and sustained over the next five years. On this basis, the CPT concluded that the Trust cannot achieve financial sustainability within the next five years without significant external

[10] Mid Staffordshire NHS Foundation Trust, Contingency planning for Mid Staffordshire NHS Foundation Trust – FAQs 1, November 2012, http://www.midstaffs.nhs.uk/getattachment/Get-Involved/Community-Events/MSFT-CPT-FAQs-1-Nov-12-(General).pdf.aspx

intervention. Despite this level of efficiency, the FT 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[11].** Without cash support from the Department of Health, the FT would be unable to pay its debts as they fall due and as such is deemed insolvent, which means that the FT presents a high risk to be unable to provide safe care within its available budget for the foreseeable future and for further identified safety issues in the short, medium and long term and ongoing staffing problems[12].

Subsequently to CPT's conclusion, Monitor decided in February 2013, to use its power to appoint a joint Trust Special Administration at the Mid Staffordshire NHS FT. The appointment of Trust Special Administrators (TSAs) is a 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[13](National Health Service Act 2006). Services of the FT continued to run as normal during the TSAs' intervention.

March 2013: Monitor appoints a Trust Special Administration (TSA) at the FT

In March 2013, Monitor appointed three Trust Special Administrators – i.e. Professor Hugo Mascie-Taylor (experienced clinical practitioner) and two insolvency practitioners, including Alan Bloom (Ernst & Young) – to ensure that the local population will be served by the FT with sustainable and high quality healthcare services. This decision was made with agreement from the health economy locally, as well as within the wider community of stakeholders including the Department of Health and NHS England, that there is an urgent need to address the position[9]. The TSAs have the capabilities to develop the best mechanism to bring about the required level of change. They are able to work on a large scope and across conventional or established stakeholder and organisational boundaries. According to the CPT, previous solutions have been delayed due to the lack of a single decision maker. As independent entities, the TSAs would be able to identify and facilitate the development of a solution. They had been appointed for 45 working days to design, with commissioners and other local healthcare organisations, a way of providing services to patients in the area that is sustainable in the long term[14]. On the 31st July 2013, the TSAs published draft recommendations for the future FT services in Mid Staffordshire. Under their proposals most acute services will remain at Stafford hospital and many other services will be enhanced (A&E, Frail Elderly Assessment service). Some other services will be moved, such as maternity, major emergency surgery and critical care. Overall, 91% of current patient visits will continue to take place locally. Under TSAs draft report, the remaining 9% -approximately 20,000

[11] Monitor, *Mid Staffordshire NHS Foundation Trust: the case for appointing a Trust Special Administrator,* 2013, pp 10

[12] The Trust Special Administration – Mid Staffordshire NHS Foundation Trust, *Trust Special Administrators launch draft report on the future of hospital services in Mid Staffordshire,* 31st July 2013, http://tsa-msft.org.uk/857/ , accessed on the 19th September 2013.

[13] Monitor, *Mid Staffordshire NHS Foundation Trust: the case for appointing a Trust Special Administrator,* 2013, pp16

[14] Monitor, *Trust Special Administrators to Mid Staffordshire NHS Foundation Trust*, 15th April 2013, http://www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-appointment-trust-special-admi , accessed on the 19th September 2013

patients – will be redirected to geographically close providers such as University Hospital of North Staffordshire NHS Trust, The Royal Wolverhampton Hospitals NHS Trust or Walsall Healthcare NHS Trust. However, no agreements have yet been entered into with other providers and no changes will be made until the consultation process has been completed – 1st October 2013 - and Monitor and the Secretary of State for Health have considered the TSAs' final report. The Secretary of State for Health will make a decision by the 31st December 2013. The proposals, as currently stated, are expected to take two to three years to be implemented[8]. **Monitor expects that the Trust Special Administration will cost approximately £6.75m, excluding VAT and expenses.** These costs are approximated and only reflect the situation of the Mid Staffordshire NHS Foundation Trust, the cost for a TSA can vary according to case.

What would have happened under a Single Failure Regime?

The Mid Staffordshire NHS Foundation Trust's case shows that, despite the interventions of the regulators and related efforts from the FT and commissioners, the quality failures caused by systematic problems (detailed above) have led to persistent deficits that made the FT unsustainable. The MSNFT was reliant on external planned support to significantly invest to provide services to the required level of quality.

Under a Single Failure Regime, Monitor would have had the power to appoint a Trust Special Administrator on the grounds of quality failure. It could/would have used its powers to appoint a Trust Special Administration after it has issued its intervention notice in March 2009 in the wake of the HCC investigation. Therefore, it would have saved the cost of intermediate actions: appointment of the interim Chair in 2009 and the commissioning of the Contingency Planning Team in 2012. Moreover, the Department of Health and local commissioners would not have to bail the MSNFT out to that extent; less financial support would have been spent to ensure the continuity of services in the area covered by the FT. Eventually, the Single Failure Regime would have reduced the overall impacts on the FT and its staff, as it would resolved in a shorter period of time the issues.

54. **Case study 2: the South London Healthcare NHS Trust (SLHT)**

The case study 2 aims to give another illustrative example of the appointment of a Trust Special Administration. The SLHT has NHS Trust status and is therefore regulated by CQC and accountable to the NHS Trust Development Authority. The SLHT has been the most financially challenged NHS Trust in England. As it became evident that the trust could not deliver high quality services in a financially sustainable way, it was put into special administration in July 2012, after repeated attempts to sort out its problems over years. Unlike Mid Staffordshire NHS FT, it is not suggested that the single failure regime would

have made a material difference to SLHT and this case study is intended to illustrate the process only.

General overview

The South London Healthcare NHS Trust (SLHT) was created in April 2009 through a merger of three hospital Trusts: the Queen Mary's Sidcup NHS Trust, the Queen Elizabeth Hospital NHS Trust and the Bromley Hospitals NHS Trust. It operated largely out of three main sites: the Princess Royal University Hospital in Farnborough; the Queen Elizabeth Hospital in Woolwich; and the Queen Mary's Hospital in Sidcup[15]. The SLHT serves a population of around 1 million people, predominantly from the London Boroughs of Bexley, Bromley and Greenwich – which account for over 91% of its income – and also from other parts of south and south east London, such as Croydon and Lewisham, and from North West Kent[12]. The South London Healthcare NHS Trust employs approximately 6,300 people and has an annual income of approximately £440m, making it the 28th largest Trust, by income, in the country[16]. The NHS South East London works with six clinical commissioning groups (CCGs).

The Queen Mary's Sidcup NHS Trust, the Queen Elizabeth Hospital NHS Trust and the Bromley Hospitals NHS Trust were merged in April 2009, alongside of service reconfiguration programme called *A Picture of Health*[17], with the expectation that it would facilitate the resolution of long-standing financial concerns, i.e. they all recorded annual deficits every year since 2004/05[18]. On the 31st March 2009, before their merger, they had a total combined debt, arising from accumulated annual deficits, of £149m. However, since its creation, the SLHT has continued to operate at a loss. If some areas have progressed, such as quality of care delivered to patients, the SLHT has failed to reduce its costs sufficiently. For instance, its clinical productivity still remains below comparable providers. Moreover, it is still not integrated as effectively as an organisation as it should be.

In 2013, the Trust was forecast to have debt relating to the accumulation of annual deficits of £207m. This means that since 2004/05 the hospitals that make up South London Healthcare NHS Trust had overspent £356m by March 2013. As it became evident that, despite the several attempts to sort out the problems, the SLHT was unable to secure the clinical and financial sustainability of the services it delivers to its patients, the previous Secretary of State for Health, Andrew Lansley, appointed a Trust Special Administrator (TSA) in July 2012[19]. It was the first time that the Regime

[15] Office of the Trust Special Administrator, *Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London,* January 2013, pp.15. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213341/TSA-VOL-1.pdf accessed on the 23rd September 2013

[16] Laing and Buisson, *Laing's Healthcare Market Review 2010-11,* 2011. London, Laing and Buisson.

[17] Available at http://hspartnership.com/case-studies/a-picture-of-health-acute-reconfiguration/

[18] South London Healthcare NHS Trust, *Annual Accounts*, from 2004 to 2012.

[19] NHS Trust Development Authority, Securing sustainable healthcare for the people of South East London, September 2013, http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA_SLHT_AW.pdf , accessed on the 1st October 2013.

for Unsustainable NHS Providers (UPR) was enacted. The TSA made a set of recommendations to Secretary of State in January 2013. The Secretary of State accepted them, subject to amendments to Sir Bruce Keogh's recommendations on service reconfiguration[20].

Context

2004 – 2009: Identification of financial problem and different attempts to challenge them

In 2004/05, following the emergence of deficits in NHS Trusts in South-East London, the South East London Strategic Health Authority (SHA) undertook a review specifically related to the financial problem of the NHS Trusts in that area. The review, known as *the Service Redesign and Sustainability Project*, concluded that efficiency improvements and service changes would be required to secure sustainability, particularly at four Trusts in deficit: Queen Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust, Bromley Hospitals NHS Trust and university Hospital Lewisham NHS Trust[21].

Following this review, a service reconfiguration programme, called *A Picture of Health,* started in December 2005. It aimed to secure improved, affordable and sustainable health services across the six boroughs in south east London[18].

In the summer of 2007, *A Picture of Health* was redesigned (Financially Challenged Trusts programme, Department of Health, 2007) to address the urgent clinical and financial challenges in the four boroughs: Bexley, Bromley, Greenwich and Lewisham as the NHS organisations appeared unable to develop a strategic plan to turnaround their financial position. The local Primary Care Trusts led the development of suggestions for reconfiguring services and proposed to rationalise the hospital landscape through the establishment of a 'borough' hospital at Queen Mary's Hospital, a 'medically admitting' hospital at university Hospital Lewisham and two 'admitting' hospitals at princess royal and Queen Elizabeth Hospitals[22].

In the autumn of 2007, the National Clinical Advisory Team undertook a review of the proposals for change under *A Picture of Health*, ahead of public consultation. The National Clinical Advisory Team concluded that immediate reorganisation might not be feasible but nevertheless a longer-term goal for the NHS in this part of London.

In July 2008, following the public consultation, the PCTs decided the reconfiguration of services across the four trusts Princess Royal, Queen Elizabeth, Lewisham and Queen Mary's Hospitals. One of the reasons for the continued challenges in South East London is that the final decision

[20] Sir Bruce Keogh, letter to Secretary of State, January 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217008/south-london-healthcare-nhs-trust-bruce-keogh-letter.pdf , accessed on 1st October 2013.

[21] Office of the Trust Special Administrator, *Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London,* January 2013, pp.18. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213341/TSA-VOL-1.pdf accessed on the 23rd September 2013

[22] **Explanatory note**: The 'borough' hospital would not have provided a full A&E service, with the service re-modelled as a primary care-led urgent care centre. The 'medically admitting' hospital would have had an A&E department that can admit patients who may need some emergency monitoring, but would not provide inpatient maternity or inpatient paediatric services (office of the TSA, January 2013)

under *A Picture of Health* did not go far enough to reduce any capacity at any sites and realised expected savings[18].

In March 2009, an independent reconfiguration panel[23] signalled to the Secretary of State its doubts about the financial viability of the PCT's proposals, fearing that all the financial benefits would not be realised. It recommended that this be kept under review as the changes were implemented. This led to the establishment of the merger in April 2009.

April 2009: A merger to face long-standing financial issues

The merger and related creation of the SLHT, on the 1st April 2009, was expected to both support the service changes under *A Picture of Health* and achieve cost and operational synergies across the three Trusts, each of which were facing their own significant challenges[15]. While the merger, alongside these service changes, has delivered some improvements to the quality of care that patients receive, the financial benefits anticipated have not been realised[24] and sustained.

2009 – 2012: Improvement expected at the establishment of the SLHT are not reached

Since April 2009, some areas have progressed but the SLHT has failed to integrate as effectively as an organisation as it should have and has improved insufficiently on the delivery of sustainable cost reduction, e.g. its clinical productivity remains still below comparable providers[18]. Moreover, in January 2011, CQC published a report that identified breaches in regulations covering staffing levels, safeguarding, standards of care, the management of medicines, record-keeping and systems to assess the standards of care. It gave seven days to the SLHT to produce its plans to show how it intends to achieve compliance[25].

By 2013, the financial situation of the SLHT had not improved. Four years since it was set up, the Trust has a debt relating to the accumulation of annual deficits of £207m. This means that since 2004/05 the hospitals that make up South London Healthcare NHS Trust have overspent by £356m[18]. The increase in expenses faced by South London Healthcare NHS Trust and the wider south east London health economy can mainly explained by the financial challenges that have characterised the last few years. The Trust, which was already in a difficult position, had to take a more radical approach – e.g. cutting down services instead of transforming them; relying on temporary staff as the Trust had become unattractive to permanent employees, and worsening the Trust's relations with other NHS organisations and other partners, particularly local authorities. All of these are symptomatic of the failure to address fully the challenges.

---

[23] Independent reconfiguration panel, *Advice on Proposals for Changes to the Distribution of Services between Bromley Hospitals, Queen Elizabeth Hospital Greenwich, Queen Mary's Hospital Sidcup and University Hospital Lewisham and the Associated Development of Community Services*, 31st march 2009.

[24] Palmer, *Reconfiguring Hospital Services, Lessons from South East London,* 2011, The King's Fund

[25] CQC, Care regulator finds South London Healthcare Trust failing to meet some essential standards at three hospitals 14th January 2011. http://www.cqc.org.uk/media/care-regulator-finds-south-london-healthcare-trust-failing-meet-some-essential-standards-three , accessed on the 24th September 2013.

Figure 3 Normalised financial performance of SLHNT (2009-2013)

Currency: £m	2009/10	2010/11	2011/12	2012/13	% Change
Revenue from patient care activities	421.7	407.8	408.8	396.2	(6.0)
Other operating revenue	40.9	30.0	30.1	34.3	(16.1)
Total revenue	**462.6**	**437.8**	**438.9**	**430.5**	(6.9)
Employee costs	(306.9)	(293.8)	(301.7)	(282.2)	(8.0)
Non pay costs	(173.8)	(159.5)	(172.2)	(171.4)	(1.4)
Total operating costs	**(480.7)**	**(453.3)**	**(473.9)**	**(453.6)**	(5.6)
Finance costs	(21.0)	(23.3)	(26.3)	(27.2)	29.5
Public Dividend Capital dividends payable	(9.1)	(8.4)	(8.4)	(8.5)	(6.6)
IFRS Adjustment	4.5	3.4	4.7	4.6	2.2
Surplus / (Deficit) on NHS Control Total Basis	**(43.7)**	**(43.8)**	**(65.0)**	**(54.2)**	19.2
Impairment	(42.3)	0.0	(16.9)	0.0	
Retained Surplus / (Deficit) for the financial year	(86.0)	(43.8)	(81.9)	(54.2)	

Source: *TSA South London Healthcare NHS Trust, 2013*

On the 12th July 2012, following a consultation, the Health Secretary, Andrew Lansley, laid before parliament to Appointment of Trust Special Administrator at the South London Healthcare NHS Trust. It was the first time in England that the Unsustainable Provider Regime (UPR) (section 65I of the National Health Service Act 2006) was to be used[26].

July 2012: The Unsustainable Provider Regime applied to the South London Healthcare NHS Trust

From 16th July 2012, the board of the SLHNT was suspended and a Trust Special Administrator (TSA) (Matthew Kershaw) was appointed to be accountable officer for the Trust and to develop recommendations for the Secretary of State on how to deliver clinical and financial sustainability. As this was the first time the UPR had been enacted, and given the complexity of the challenge in the area, the Secretary of State extended the period allowed for writing the draft report by 30 working days, to 75 working days in total.

Timetable of the Trust Special Administration at the SLHNT – within 75 working days

- **From 16th July to 29th October 2012** (75 working days): *Preparation of Draft Report* – rapid assessment of the issues facing the SLHT, engagement with a range of relevant stakeholders, including staff and commissioners, and development of a draft report including initial recommendations for achieving sustainability.

[26] Department of Health, *South London Healthcare NHS Trust to be put into the Regime for Unsustainable NHS Providers*, July 2012, https://www.gov.uk/government/news/south-london-healthcare-nhs-trust-to-be-put-into-the-regime-for-unsustainable-nhs-providers , accessed on the 24th September 2013

- **From 2nd November to 13th December 2012** (30 working days): *Consultation* – to validate and improve the draft recommendations.
- **By 7 January 2013** (15 working days): *Final Report* – taking on board consultation responses and the health equalities impact assessment, the final report to the Secretary of State should be prepared within.

The TSA's report proposed to implement these main organisational transactions[27]:

- The dissolution of SLHT
- The transfer of Queen Mary's Hospital Sidcup (QMH) to Oxleas NHS Foundation Trust (Oxleas)
- The transfer of a number of clinical services provided at QMH to Dartford and Gravesham NHS Trust (DGT)
- The acquisition of Princess Royal University Hospital (PRUH) by King's College Hospital NHS Foundation Trust (KCH)
- The transfer of Queen Elizabeth Hospital (QEH) to Lewisham Healthcare NHS Trust (LHT)

- **By 1 February 2013** (20 working days) *Secretary of State Decision* – The Secretary of State has to determine what action to take within 20 working days. He must then publish and lay in parliament a notice containing the final decision and the reasons behind it. The Secretary of State has decided that the transactions, led by the NTDA, will have to be delivered by the 1st October 2013.

The DH and NTDA estimate that the **cost of the TSA at the SLNT was around £6.95m**.

From July 2012 to January 2013, the Department of Health recorded the following costs related to the TSA at South London Healthcare NHS Trust:		
• Office of the Trust Special Administrator	£	1,000,000.00
• Consultancy fees	£	4,350.000,00
Total cost TSA incurred by the DH	**£**	**5,350,000.00**

From the 1st April 2013, the NHS Trust Development Authority (NTDA) provides oversight to NHS Trusts, and therefore, is accountable for the TSA.

From April to August 2013, the NTDA recorded the following costs related to the TSA at South London Healthcare NHS Trust:		
. Legal fees incurred by TDA	£	490,000.00

[27] NHS Trust Development Authority, Securing sustainable healthcare for the people of South East London, September 2013, http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA_SLHT_AW.pdf , accessed on the 1st October 2013.

• Accountancy support costs incurred by TDA	£ 892,630.00
• TDA programme costs	£ 214,630.00
Total cost TSA incurred by NTDA	**£ 1,597,260.00**

Source: NTDA, 2013

From March 2013: Developing the TSA's recommendations

In March 2013 the NHS TDA established a TSA Transaction Board to progress the work required to deliver to the transactions by the 1st October.

From April 2013, Mathew Kershaw (first trust special administrator) is been replaced by Caroline Taylor. On behalf of the NTDA, she has worked together with the NHS England, local Clinical Commissioning Groups and neighbouring providers to identify how high quality of care can be sustainably delivered to people in South-East London in future. In order to ensure a safe transition, especially related to the modernisation of the healthcare system (Health and Social Care Act 2012), it has been also decided to expand the reconfiguration process in south east London from three to five years.

During the reconfiguration period, it has been agreed between receivers, commissioners, NHS England and the NTDA that the SLHT will receive a financial support of £466.1m. This is greater than listed in the TSA report (£265.6m, excluding service change), due to a range of agreed amendments to the proposals, such as the exclusion of the service changes in South East London, the increase in the annual investment at each hospital site to support the improvement quality and the extension of the implementation timetable from three to five years[27].

The Total financial support required to implement the transactions

	TSA report	NTDA report
Run Rate	55.3	128.4
Other Revenue	177	201.8
Revenue Sub-Total	232.3	330.2
Liquidity	0	52.8
Operational capital	12.2	42.2
Service development capital	21.1	40.9
Capital and Liquidity Sub-Total	33.3	135.9
Total	**265.6**	**466.1**

Source: NTDA, September 2013

The value for money of the financial support, proposed by NTDA for the TSA at SLHT, has been analysed against both the "Do Nothing" option and the "TSA Recommendations" in the TSA report. NTDA estimates that the Net Present Value (NPV) of the current transactions (NPV: £806.2m over 30 years) shows a clear advantage over the "Do Nothing" case (NPV of (£1328.5m over 30 years) [27]. This justifies the prompt intervention of regulators when a provider is failing.

What would have happened under the single failure regime?

As mentioned earlier in this case study, the single failure regime would not have made a material difference to SLHT as the NTDA, which operates in accordance with the directions issued to it by the Secretary of State, had already the powers to intervene quickly.

In the past, when poor care was detected, problems have not been addressed as quickly as possible and effective action is not always taken to ensure that identified issues are resolved. A critical finding from Robert Francis's report into the failures of care at Mid-Staffs hospital was the significant failures of accountability and transparency in the role of system managers and regulators. Focus was directed at financial and organisational issues rather than the protection of patients and ensuring quality of care.

A new failure regime, with greater emphasis on quality, will ensure that, where the standard of care is below an acceptable level, firm action is taken until it is properly and promptly resolved. It will deliver a clear and coordinated regulatory approach to identifying and tackling failures. The intention is to ensure provider Boards adopt as rigorous and comprehensive an approach to maintaining quality as they do to keeping in budget, as highlighted in the Francis report.

c. Net benefit of Option 2

55. Given the stage of policy development it has not been yet possible to produce a precise estimate of any of the effects, benefits or costs, set out above. It is hard to disentangle the costs of assessing and enforcing quality from the other costs incurred by the regulators and especially CQC. The Department of Health continues to work with CQC, Monitor and NTDA to understand better these costs as the proposals are developed further.

56. Therefore, rather than compare quantified costs and benefits, the discussion above focuses on the benefits and costs described qualitatively only.

57. The direct costs of Option 2 would be incurred by the regulators, especially based only on staff costs within CQC, mainly related to the additional time and efforts to draw the improvement notices. However, it is difficult to be specific on the precise effects even of this, as it is not yet clear how much resource would be required to undertake each function.

58. The benefits also cannot be quantified at this stage. This is because it is uncertain how much of an incentive effect there would be. It is also unclear to what extent providers would respond and improve the quality of their services.

59. On balance, it is considered this option would be net cost beneficial if resources are implemented in a proportionate way. In other words, funding allocated by the regulators to this revised regulatory framework needs to be sufficient for the benefits to result.

60. The biggest area of uncertainty is around any potential cost to providers. As set out above, this could in fact be cost-reducing, but there is the possibility that it increases costs to an individual

provider. If this is the case, it could then lead to financial problems locally, as the provider cannot provide services to the required level of quality without becoming financially unsustainable. That said, if this is the case and the provider cannot offer adequate services within the cost, the regime will allow for a sustainable solution to be developed. In such cases, the single failure regime will improve transparency across the health and care system, thereby highlighting where there are issues which can then be resolved.

Option 3: Transfer of functions from Monitor and TDA into CQC

61. Under this option, CQC would take over key regulation functions from Monitor and NTDA; therefore, CQC, as the only regulators, would assess and enforce the compliance of providers with quality requirements and fundamental standards for clinical and governance, as well as finance control.

a. Benefits, costs and net benefit of Option 3

62. The benefits Option 3 are the same as set out for Option 2, in the sense that more appropriate tools for intervention would help to resolve any kind of failure. Moreover, the duplication of roles and actions is prevented through the mergers of regulators into one organisation. Similarly, benefits will mainly depend on the incentive effect there would be on providers to respond and improve the quality of their services, which is uncertain at this stage.

63. As for option 2, there are thought to be direct costs to the regulator of potentially undertaking more work, and potentially indirect costs resulting from the actions that providers take to improve the quality of their services. There is an additional direct cost associated with the restructuring of the organisations in question. An NAO report[28] estimated the cost of each reorganisation of an organisation at £15m, so the additional cost here could be of the order of £30m.

64. By merging the organisations, there is no delineation between the assessment of quality and the intervention to resolve it. This separation of roles (achieved in option 2) would mean that CQC could make independent assessments without the dual responsibility of needing to intervene to solve them.

b. Comparison of Options

65. Based on the arguments set out above, it is thought that both Option 2 and Option 3 will be preferable to the 'do nothing' baseline scenario.

[28] Available at http://www.nao.org.uk/wp-content/uploads/2010/03/0910452.pdf

66. Given that it is assumed that benefits of Options 2 and 3 are broadly equivalent, the structural change proposed in the option 3 will add an extra cost that is not thought to be justified by additional benefits. Therefore, then Option 2 is preferred since it is estimated to strictly have a higher net benefit compare to option 3 on the basis of the evidence available.

6. Equality Analysis

67. 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.

68. Special Administrators appointed to an NHS Trust or FT are already required to observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act 2010. These duties will be maintained under special administration due to quality failure.

69. We do not expect that the single failure regime will impact negatively upon groups according to the protected characteristics outlined in the Equality Act 2010, nor is the policy expected to widen inequalities. The aim of this policy is to deliver a clear and coordinated regulatory approach to identify and tackle failures of quality at NHS Trusts and FTs across England for the benefit of all patients. Where quality of care is below an acceptable standard, firm action will be taken until it is properly and promptly resolved.

70. Currently, if there is a problem with quality at an acute trust, it would be very difficult for CQC to close the provider or a service line. Notably, in rural areas or for specialist services, closing a provider could mean patients have nowhere else to go for treatment in that area. Even if there are alternative providers around, there may not be sufficient capacity in the area to meet the additional demand. The intention of the failure regime is to ensure that there is a clear and credible plan for intervening and resolving quality problems wherever they exist.

71. We know that some groups of people are more likely to use hospitals and we envisage that the policy will therefore be most relevant to them. The ONS Census data (2011) has shown that for all acute hospital inpatient episodes 38.1% were people over the age of 65, despite this group accounting for only 16% of the UK population. We also know that 70% of all inpatient bed days are taken up by the 15.4 million people in the UK with one or more long term condition.

Addressing failings in quality early will provide the greatest benefit for those using services most often, so this group is likely to be particularly beneficially effected.

72. People who receive care in an NHS hospital should have greater confidence that quality failures will be resolved with greater efficacy. The implementation of this policy will make it clearer for patients, their families and carers, and professionals to understand the distinct roles of CQC and Monitor.

73. The actions taken to resolve identified issues of quality will be at the discretion of hospitals and regulators and commissioners, as necessary and appropriate. Bodies performing public functions, including hospitals, the CQC and Monitor, are also subject to the Public Sector Equality Duty and must pay due regard to it in everything they do. Regulations require listed public authorities to publish relevant information which demonstrates compliance with the equality duty annually and to set objectives to improve their performance every four years.