RCN Policy and International Department
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NHS failure regime

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Introduction

This briefing provides an overview of the current and future approaches to an NHS failure regime.

The RCN is deeply concerned that some organisations in the NHS could fail. Failure could be where:

- Patients cannot be treated safely
- An organization is no longer financially sustainable
- Or both of these

Failure can also occur where there is not sufficient quality of care delivered, however, that care may not be unsafe. But in practice, it is very difficult to define the dividing line between safe and quality care.

We are also now in unprecedented territory of having the first Trust having a Trust Special Administrator appointed (as at July 2012). South London Healthcare Trust is in significant financial difficulties, and yet quality indicators such as mortality (being one of the safest Trusts in the country) and pressure ulcers have improved.[1]

Why are we worried about failure?

The RCN is very concerned about failure in the NHS. That's because our members want to deliver safe, high quality care. Sadly there are still examples of where this does not happen. Nurses are increasingly struggling to do so because of a number of complex and inter-related factors which affect the NHS more generally:

- Increasing demand as the population ages (although some are ageing healthily) and perhaps also as patients expect more
- Drive for efficiency as the NHS budget will not keep up pace with the growth in demand

At the front line they are struggling to deliver safe, high quality care because of inappropriate staffing (too few, and not always an appropriate mix) amongst the myriad other variables which interact: the environment, workforce, systems of care etc.

We also know that having a system which prevents failure, or is speedy when it does happen, is not necessarily easy. That's because the reason for failure is complex.

Pragmatically, we also have to recognize that some NHS providers have been under pressure for some time, and have required additional funding (bail outs) periodically. Put simply, having some providers facing significant deficits is not new. It may be that we are now experiencing a shift in the politics which is more willing to accept large scale changes: closing some hospitals and reconfiguring services. This is partly attributable to a desire for

1 SOUTH LONDON HEALTHCARE NHS TRUST
QUALITY ACCOUNT
20011/12 http://www.nhs.uk/Services/UserControls/UploadHandlers/MediaServerHandler.ashx?id=267&t=634779809562685356

a greater level of transparency to remove the opaque nature of financial settlements in the past. For example, the NAO note that "It is difficult to identify the full extent of one-off funding PCTs are giving NHS trusts and NHS foundation trusts".[2]

How many NHS organisations could fail?

This is a very difficult question to answer, because the full details of each organisations' positions change over time. However, there are some measures which are useful in providing an understanding of the extent of possible failure:

- 20 organisations have self declared that they will not be able to become Foundation Trusts as they are currently configured.[3] Financial sustainability is a key part of Monitors assessment for FT status so this signals that these organisations may be particularly financially challenged
- As at 31st March 2012, 3 FTs have been scored a '1' under Monitors financial risk ratings, where 1 is the highest risk[4]
- At the end of 2011, 9 FTs were designated as being in 'significant breach' of their terms of authorisation[5]
- 34 providers were in deficit at the end of the financial year FY 2011/12 (10 NHS trusts, 21 NHS foundation trusts , and 3 PCTs)[6] and there is particular distress in London

Media reports suggested that up to 92 organisations could 'fail' under failure regime plans (as at 2008).[7] We have not seen that happen in practice, with only one to date being placed under Trust Special Administrator control. Some have commentated that in practice, politicians have been reticent to really get to grips with failure and have a regime which works in practice.[8]

Under the current system, there is some funding to support those Trusts who are in particular financial distress. The NAO estimate that SHAs and PCTs provided £151 million in additional revenue to NHS trusts and £10 million to NHS foundation trusts. A further 15 Trusts could have moved from surplus to deficit without 'one-off' direct support. [9]

What is the current framework to deal with failure?

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[2] National Audit Office, Securing the future financial sustainability of the NHS, 5th July 2011 http://www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx

3 Dixon, A Tackling financial failure – how will the proposed legislation work out in practice? 27th February 2012 http://www.kingsfund.org.uk/blog/financial_failure.html

4 Monitor, Risk Ratings, Current risk ratings for the 143 NHS foundation trusts authorised as at 31 March 2012 http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-performance/actual-performance/risk-ratings#

5 House of Commons Health Select Committee Annual accountability hearing with Monitor14th September 2011 http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1431/143105.htm

6 National Audit Office, Securing the future financial sustainability of the NHS, 5th July 2011 http://www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx

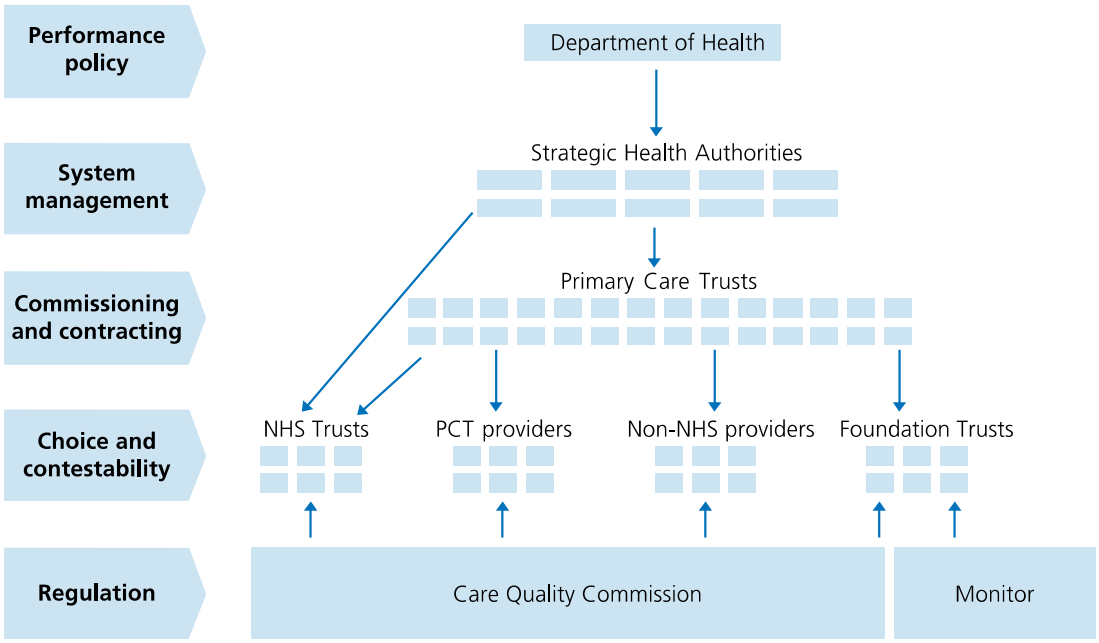
7 HSJ, NHS failure regime: up to 92 trusts may be culled, 18th September 2008 http://www.hsj.co.uk/nhs-failure-regime-up-to-92-trusts-may-be-culled/1852104.article

8 Corrigan, P Health Matters Blog 18th July 2012 http://www.pauldcorrigan.com/Blog/health-policy/dealing-with-failure-is-vital-for-the-nhs-to-succeed/

9 National Audit Office, Securing the future financial sustainability of the NHS, 5th July 2011 http://www.nao.org.uk/publications/1213/nhs_financial_sustainability.aspx

The current framework for failure is part of the broader performance management of those delivering NHS services. This is set out below.

Figure 1: NHS performance regime



Source: Developing the NHS Performance Regime, 2008
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf

The performance regime was also based on 5 key principles, set out in the box below.

Box 1: Principles underpinning the performance regime

1. **transparent** – clear and pre-determined performance measures and interventions;
2. **consistent** – a uniform approach across England and at different levels of the system;
3. **proactive** – thresholds for intervention should identify underperformance at an early stage so that it can be addressed; and action to address significant risk to patient safety should be swift and decisive;
4. **proportionate** – intervention should be related to risk, for example, problems at service level should be addressed through interventions at service level; and
5. **focused on recovery** – initial interventions will focus on recovery and should include action to address the root causes of issues, including 'system-level' risk such as over-capacity or where specific services lack credible alternatives.

Source: Department of Health, Developing the NHS Performance Regime, 2008
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf

However, in practice, the system in 2012 is in a state of flux as it develops shadow organisations in readiness for implementing the reforms set out in the Health and Social Care Act 2012. The RCN has always been concerned that the NHS having to undergo reforms at the same time as meeting efficiency savings under the Quality Innovation

Productivity and Prevention (QIPP) programme (also known as the Nicholson Challenge) would be a distraction.

Failure is a subset of the performance framework: ideally failure would be identified early and avoided through concerted action. However, there has been a failure regime specified in guidance. The Department of Health set out their proposals in 2008.[10], [11] Those proposals recognized that even back in 2008 the Secretary of State already had powers to transfer services and even to dissolve NHS Trusts. The issue was, at that time, that it was unclear the process that would be used to implement these powers.

The DH set out further principles for the failure regime in their response to consultation on the proposed regime in 2009. These are set out below. They also remain in new guidance

on the Trust Special Administrator (essentially the individual who takes control when a Trust is placed into the unsustainable provider regime).[12]

Box 2: Principles underpinning the failure regime

Principle 1 – Patient interests must always come first. The most important consideration is the continuity of safe and effective services.

Principle 2 - State-owned providers are part of a wider NHS system. This was made clear in the draft NHS Constitution. NHS Trusts and divested PCT providers are not free-floating, commercial organizations. Whilst NHS Foundation Trusts are authorised to be run by independent boards and are answerable to a regulator nationally and boards of governors locally, they remain part of the wider NHS. As such, the assests of state-owned providers will be protected, rather than disposed of by the courts.

Principle 3 - The Secretary of State is ultimately always accountable to Parliament for what happens to local NHS services. In exceptional circumstances such as dealing with failed providers, accountability to Parliament should be emphasized.

Principle 4 - The regime for unsustainable NHS providers should take in to account the need to engage staff in the process– retaining staff and maintaining morale within the organisation will be crucial.

Principle 5 - The regime for unsustainable NHS providers must be credible and workable – otherwise there is no value in its specification. In particular, it needs to have transparent and rules based processes to give confidence to provider organizations, such as NHS Foundation Trusts, that it will be used consistently and not so as to interfere with their independence. Critically, these processes also need to be time-bound and ensure rapid decision-making in these exceptional

10 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf
11 Department of Health, The regime for unsustainable NHS providers: Response to consultation, 2009 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093286.pdf
12 Department of Health, Statutory Guidance for Trust Special Administrators appointed to NHS Trusts, 5th July 2012https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf

circumstances.

Source: Department of Health, The regime for unsustainable NHS providers: Response to consultation, 2009
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093286.pdf

At the time that the Department of Health was consulting on the failure regime, the RCN responded and supported the principles (although we did ask that quality be explicitly included). We also said that "*Staff engagement is critical and the RCN calls for ongoing engagement before, during and after a provider is designated as unsustainable. This is vital to minimise a negative impact upon morale and retention. This includes engagement with staff directly affected, appropriate trade unions, and SHAs given the potential impact on the local health economy*".[13]

The failure regime set out a new designation for providers who are consistently underperforming as 'challenged'. Such organizations would also be those who are likely to require support to move towards a sustainable position. That support could be: financial, or could reflect a need to improve the board and/or management and as part of those board decisions, consider reconfiguration of services. The NHS Chief Executive could publicly designate a provider as 'challenged' and the provider could be subject to intervention at the Board level.[14]

Under the failure regime there was an expectation that commissioners would be proactive to both monitor, and take action, where there was underperformance. Commissioners would have the option to use:[15]

- Contractual notices (for example, a performance notice)
- Contractual remedies (for example, a remedial action plan)
- Financial sanctions
- Suspension and termination provisions

The role for SHAs would be to both performance manage commissioners and trusts and to take a wider local health economy perspective.[16]

The role for both Monitor and CQC would be to provide monitoring and reports that others could draw on to inform their performance assessment. CQC and Monitor would also have their own suite of actions that they can take. CQC actions ranging from notices through to closure of services. Monitor can take actions ranging from closer scrutiny to intervening in management and boards of FTs or in the extreme dissolve the FT. Monitors' actions would link to the compliance framework and any failures by FTs to be compliant with the terms of their authorization.[17] Monitor could also trigger a modified insolvency

13 http://www.rcn.org.uk/__data/assets/pdf_file/0019/201673/Consultation_on_a_regime_for_unsustainable_NHS_providers_RCN_Response_FINAL.pdf
14 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf
15 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf
16 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf
17 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf

regime for an NHS Foundation Trust. However, the process was never laid out in legislation and concerns were acknowledged by

the Department of Health about the appropriateness of applying such commercial insolvency processes to FTs. [18]

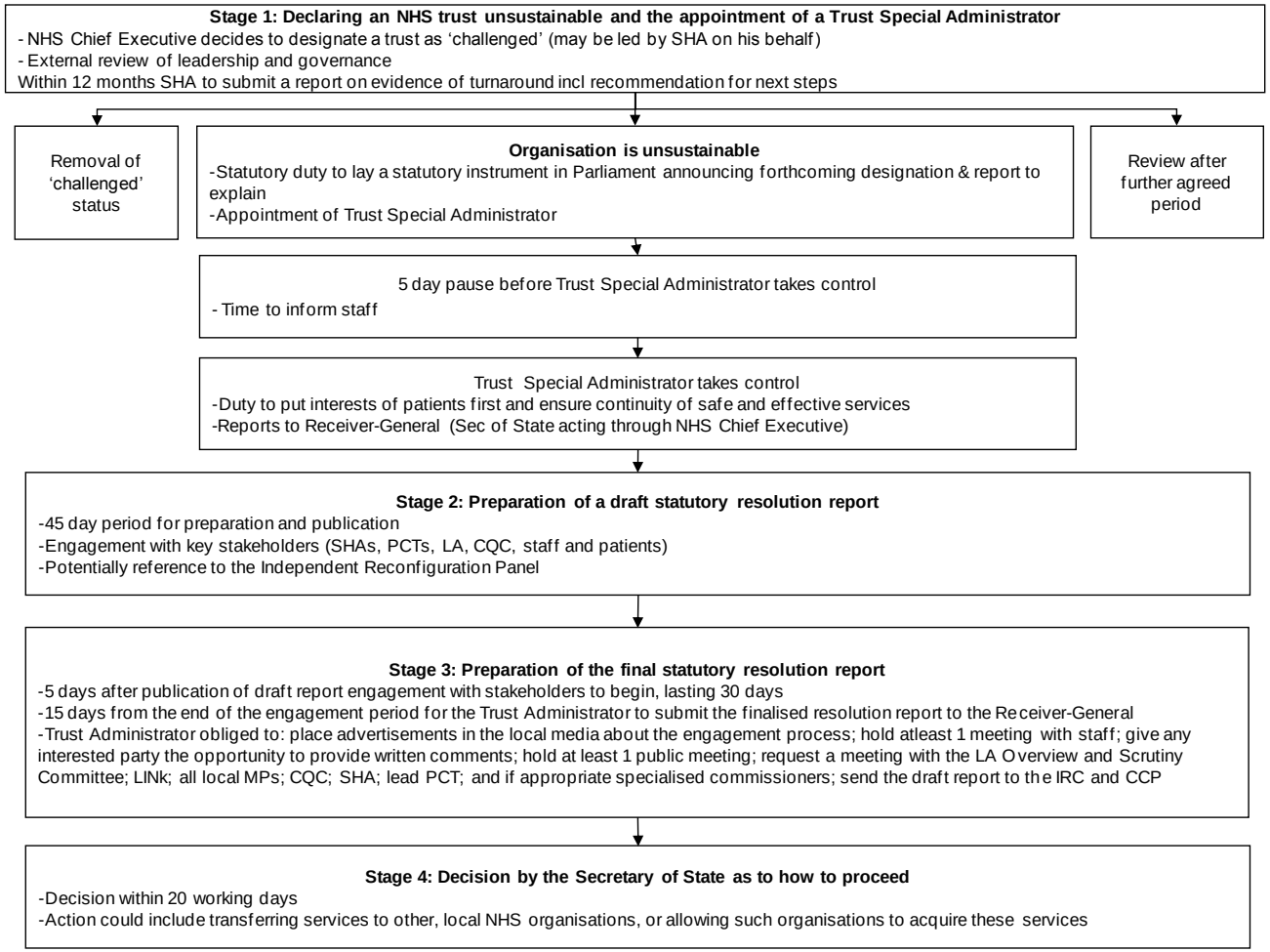
If a provider was persistently failing, then it could be placed 'Under Directions'. This could involve suspensions/removals/appointments to the Board under the oversight of the SHA, acting on behalf of the NHS Chief Executive. The new board could take decisions to:[19]

- Close or dispose of assets
- Franchise
- Takeover by another organization

We set out in our consultation response to the Department of Health in 2009, the stages and steps for the proposed failure regime. We include it below.

18 Department of Health, The regime for unsustainable NHS providers: Response to consultation, 2009 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093286.pdf
19 Department of Health, Developing the NHS Performance Regime, 2008 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf

Figure 2: Flow chart of the failure regime

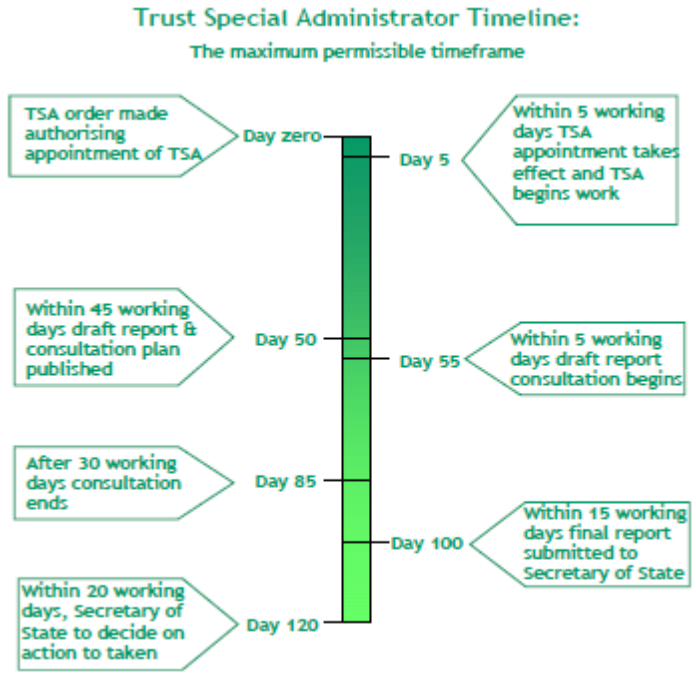


Source: RCN Response to Consultation on a Regime for Unsustainable NHS Providers, 2009
http://www.rcn.org.uk/__data/assets/pdf_file/0019/201673/Consultation_on_a_regime_for_unsustainable_NHS_providers_RCN_Response_FINAL.pdf

A key role is the Trust Special Administrator.[20] Statutory guidance was issued by the Department of Health on the 5th July 2012 for this role.[21]

The timetable for the regime was set out by the Department of Health, and is included below, although an extension could be made if considered necessary.

Figure 3: Timetable as set out by the Department of Health



Department of Health, Statutory Guidance for Trust Special Administrators appointed to NHS Trusts, 5th July 2012https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf

There are also requirements for the Trust Special Administrator to hold specific meetings:[22]

i. at least one meeting with staff and unions;

ii. at least one public meeting to allow anyone with an interest to give their views;

iii. with the SHA or any commissioner to whom the provider provides goods and services that the Trust Special Administrator has requested a written response from; and

iv. any persons that the Secretary State directs the Trust Special Administrator to meet.

20 EXPLANATORY MEMORANDUM TO THE HEALTH ACT 2009 (POWERS IN RELATION TO NHS BODIES—CONSEQUENTIAL AMENDMENTS) REGULATIONS 2010
2010 No. 720 http://www.legislation.gov.uk/uksi/2010/720/pdfs/uksiem_20100720_en.pdf
21 Department of Health, Statutory Guidance for Trust Special Administrators appointed to NHS Trusts, 5th July 2012https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf
22 Department of Health, Statutory Guidance for Trust Special Administrators appointed to NHS Trusts, 5th July 2012https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf

If a commissioner was persistently failing, then the SHA could also decide to change/replace the Board, outsource some/all activities, or allow takeover of the organization by another PCT.[23]

Has it worked?

This is a broad question, and raises issues about how the whole system works. However, with one Trust now under the control of a Trust Special Administrator, it looks like the failure regime will be tested in practice, rather than debated in theory.

The Department of Health also recognized that the failure regime has not prevented "poorer quality and inefficient service provision for NHS patients." 24 Others have also commented that "the failure regime has failed".[25]

What is the future framework to deal with failure?

The Department of Health has provided further detail on the approach to failure that includes changes from the Health and Social Care Act 2012. As before, failure is part of the broader system including the role of:[26]

- CQC and NICE (via Quality Standards) in ensuring quality
- Clinically led approaches to securing access to essential services, overseen by the National Commissioning Board
- Commissioning to include appropriate consultation and involvement, to ensure services are fit for the local context
- Monitor as a sector regulator to support commissioners, by regulating to reduce the chance that providers take actions which would undermine their ability to deliver essential services
- Solutions, if providers are not sustainable in their current form, to be driven by a clinical case for change, agreed by clinical commissioning groups and with consultation with the public and staff
- Avoiding bail outs (essentially sending a strong signal that providers need to become sustainable and would not be able to rely on bail outs in the future).

We would also like to see more explicitly agencies considering human factors.

Under the new approach to be implemented from 2013, Monitor would take a lead when providers are under 'distress'. Monitor would provide support, in discussion with others, to that provider. The Secretary of State could provide financial assistance.[27]

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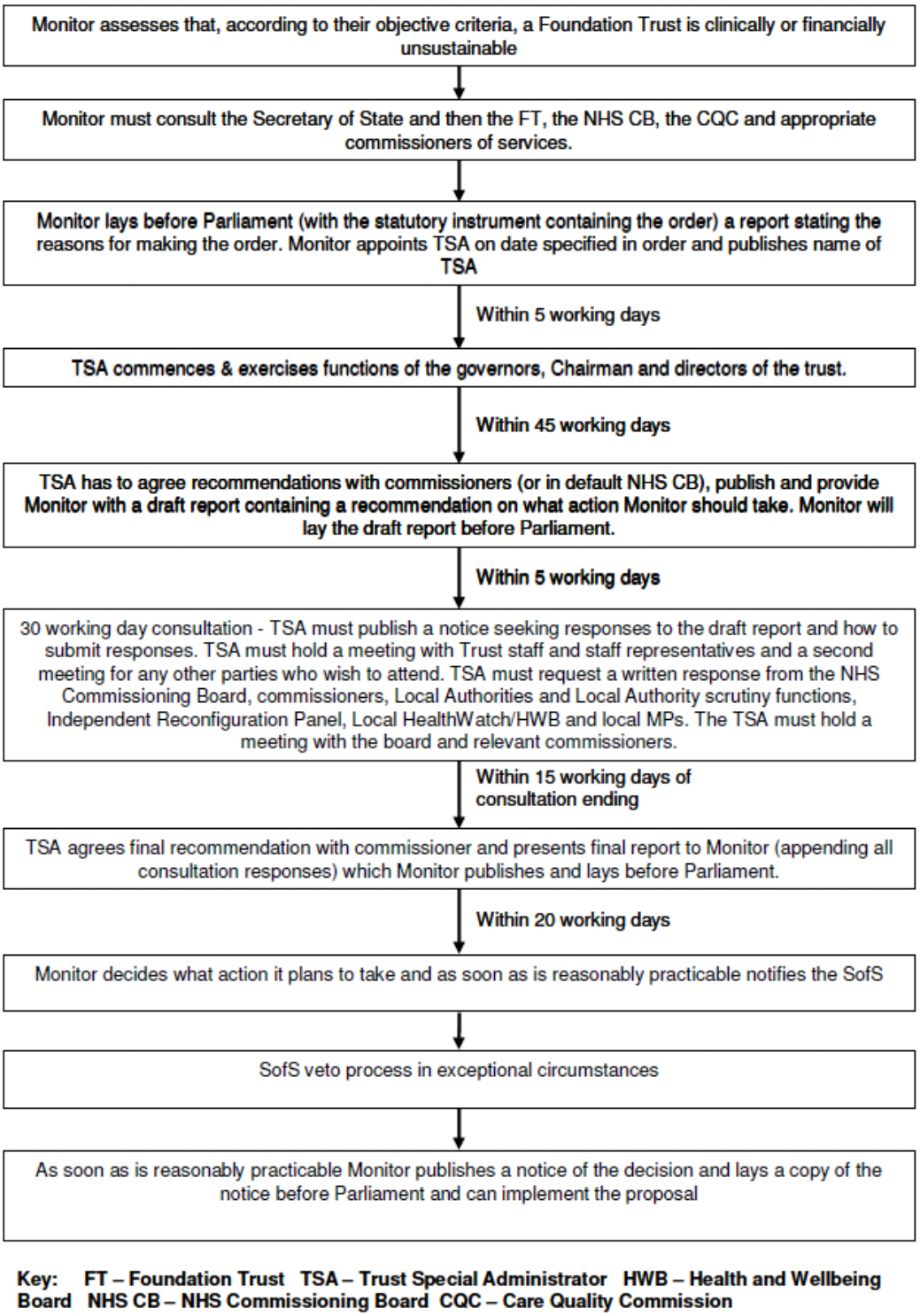
23 Department of Health, Developing the NHS Performance Regime, 2008
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085216.pdf
24 Department of Health, Securing continued access to NHS services:
Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf
25 Kurunmaki, L and Miller, P The failure of a failure regime, From insolvency to de-authorisation for NHS Foundation Trusts, LSE Discussion Paper No 67, March
2011http://eprints.lse.ac.uk/33555/1/CARR_DP_67_Kurunmaki_Miller_FinalProof_22mar11.pdf
26 Department of Health, Securing continued access to NHS services:
Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf
27 Department of Health, Securing continued access to NHS services:

If the provider was still in distress, then Monitor could trigger the unsustainable provider regime and appoint a Trust Special Administrator. The lead commissioner (nominated by the NHS Commissioning Board, or the NHS Commissioning Board itself) with input from the continuity administrator and Monitor would determine which services were essential. [28] The process is set out below.

Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf
28 Department of Health, Securing continued access to NHS services:
Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf

Figure 4: Foundation Trust Unsustainable Provider Regime



Key: FT – Foundation Trust TSA – Trust Special Administrator HWB – Health and Wellbeing Board NHS CB – NHS Commissioning Board CQC – Care Quality Commission

Source: Department of Health, Securing continued access to NHS services: Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf

Some have commented that in practice the new regime is not all that different to the one we have now, what may be different is a greater willingness to make use of it.[29] Others see more potential for transparency.[30]

In addition, there would be a health special administration procedure for private companies that deliver NHS services but become financially unsustainable. This would be based on existing corporate insolvency law. [31] Some have commented that this is in response to the failure of Southern Cross.[32]

Monitor will also be able to set up a standing fund to cover the costs of the failure regime.[33]

Could that work?

It's really difficult to determine how successful the new approach to a failure will be. In part that's a reflection of:

- How well other parts of the system work: if commissioning 'works' it may be able to help prevent failure earlier, if Monitor 'works' in setting appropriate prices in conjunction with the National Commissioning Board, if CQC 'works' in identifying quality failures etc etc. This list could be expanded even further because not all of the new ways of working and approaches are known.
- How the pressures on the NHS change over time.
- How lessons are learnt from the first application of the Trust Special Administration process.

And underlying it all is how individuals and teams work: at every level in the system, particularly how they ensure that they remain focused on patients and their needs.

RCN view

The RCN acknowledges that difficult decisions need to be made. We will be working closely with interested parties as South London Healthcare Trust goes through the unsustainable regime. We stress that the overriding focus should be on continuing to meet the needs of patients in a safe and high quality service.

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29 HSJ, Keeping afloat: how trusts can survive under the new NHS failure regime
http://www.hsj.co.uk/resource-centre/best-practice/finance-and-efficiency-resources/keeping-afloat-how-trusts-can-survive-under-the-new-nhs-failure-regime/5042472.article
30 Health and Social Care Bill NHS Confederation supplementary briefing for MPs on the new 'failure regime' for NHS providers 6 and 7 September 2011
http://www.nhsconfed.org/Documents/Supplementary%20Health%20Bill%20briefing%20from%20NHS%20Confederation%20on%20failure%20regime.pdf
31 Department of Health, Securing continued access to NHS services:
Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf
32 Health Policy Insight, Editor's blog Thursday 1 September 2011: Failure regime for FTs detailed; huge roles for Monitor as 'the new DH'
http://www.healthpolicyinsight.com/?q=node/1218
33 Department of Health, Securing continued access to NHS services:
Technical annex, 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129816.pdf

We also know that staff who are working at South London Health care Trust are facing significant uncertainties and have been working under pressure to deliver the best care that they can, but will understandably be concerned about their future. There is a clear need for engagement to really deliver the intention of not losing staff motivation whilst the Trusts goes through the unsustainable provider regime.

In planning for the future, there need to be very clear and swiftly implemented plans for clinical engagement. This must include the nursing perspective to inform the development of options and the final choices of appropriate solutions to deliver safe, high quality care that is sustainable in the future.

As difficult decisions are taken about the new model(s) of services, we urge that they are assessed against the principles for the NHS, and our own principles to inform decision making.[34] These include: quality, accountability, equality and partnership.

We will keep the policy development, as well as the case of South London Healthcare Trust, under review.

Tell us what you think

This briefing is intended to provide a policy perspective on the unsustainable provider regime and the Policy and International Department would like to receive comments/feedback from as many members as possible on this important issue - policycontacts@rcn.org.uk.

Further reading

RCN, Response to Consultation on a Regime for Unsustainable NHS Providers, 2009
http://www.rcn.org.uk/__data/assets/pdf_file/0019/201673/Consultation_on_a_regime_for_unsustainable_NHS_providers_RCN_Response_FINAL.pdf

And for a focus on patient safety:
RCN Quality and Safety Bulletin:
http://www.rcn.org.uk/development/practice/clinical_governance/quality_and_safety_e-bulletin

And for a focus on human factors:
http://nursingstandard.rcnpublishing.co.uk/archive/article-human-factors-and-online-learning

34 RCN, Principles to inform decision making http://www.rcn.org.uk/__data/assets/pdf_file/0009/78696/003034.pdf