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.

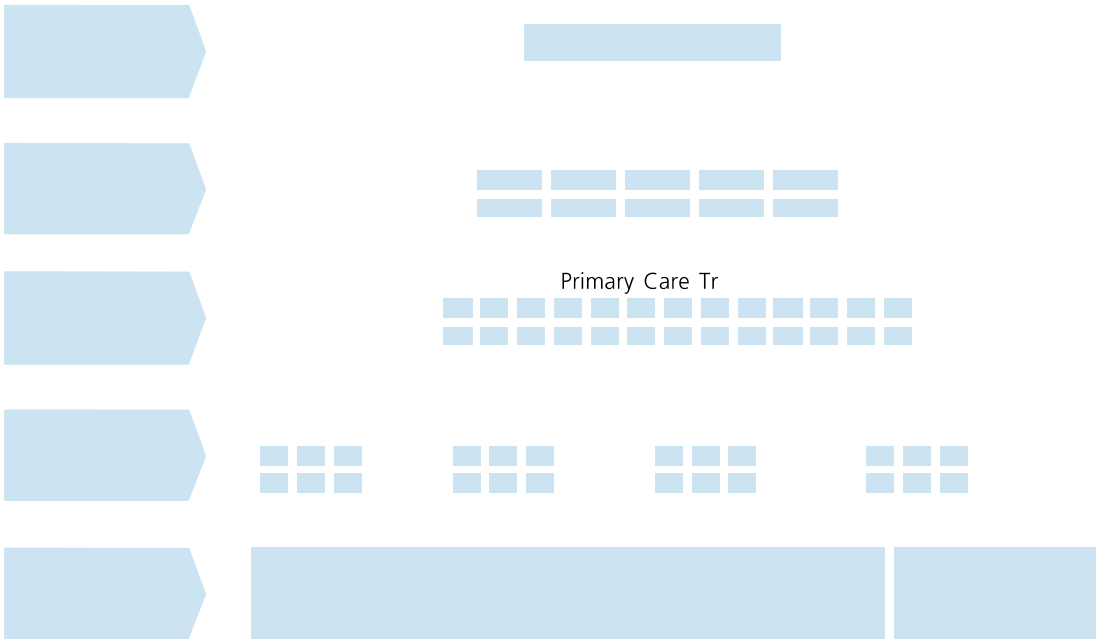
We are also now in unprecedented territory of having the first Trust having a Trust Special Administrator appointed (as at July 2012). South London Healthcare Trust is in significant financial difficulties, and yet quality indicators such as mortality (being one of the safest Trusts in the country) and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

Why are we worried about failure?

a greater level of transparency to remove the opaque nature of financial settlements in the

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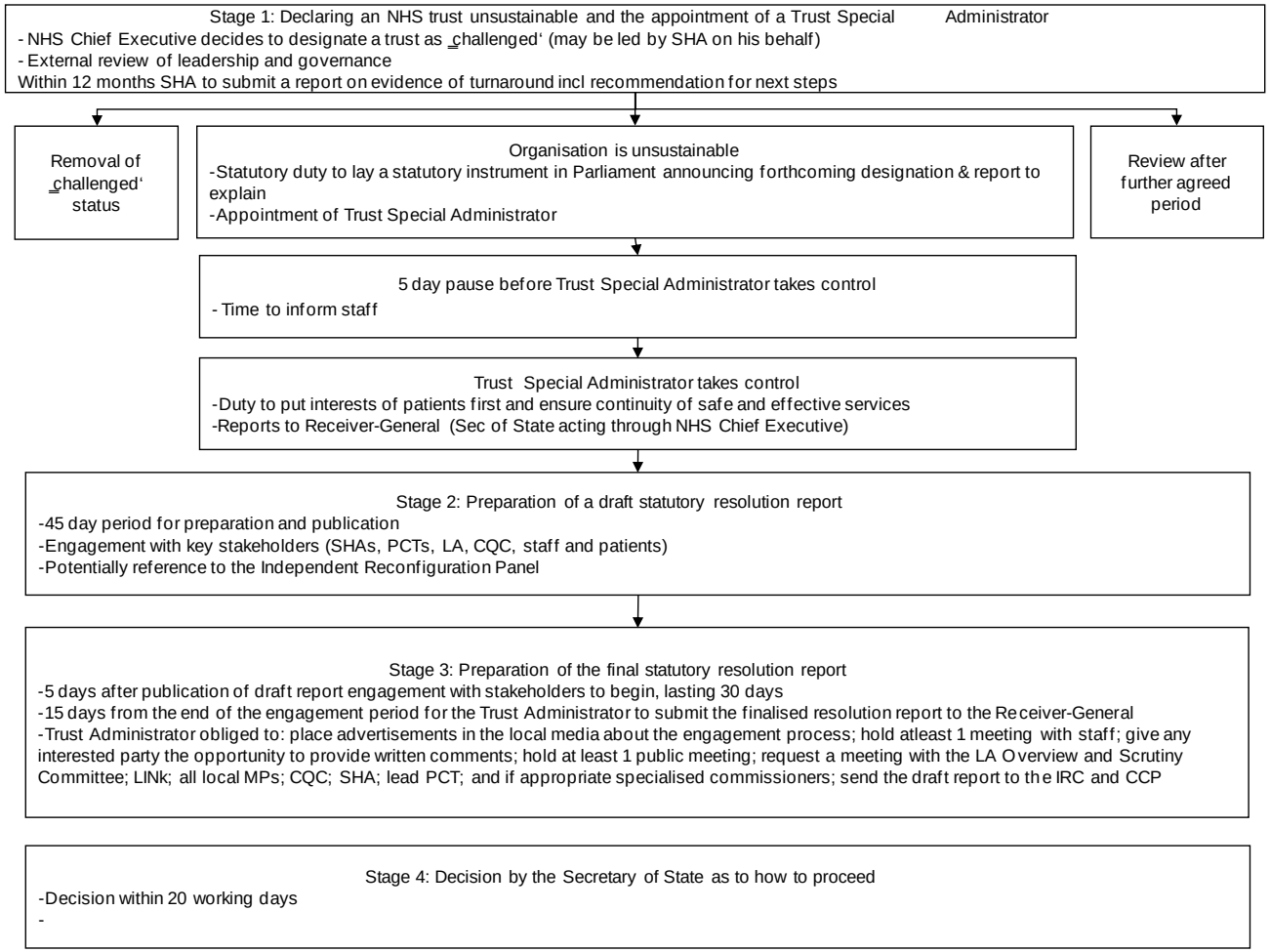
regime for an NHS Foundation Trust. However, the process was never laid out in legislation and concerns were acknowledged by

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,

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

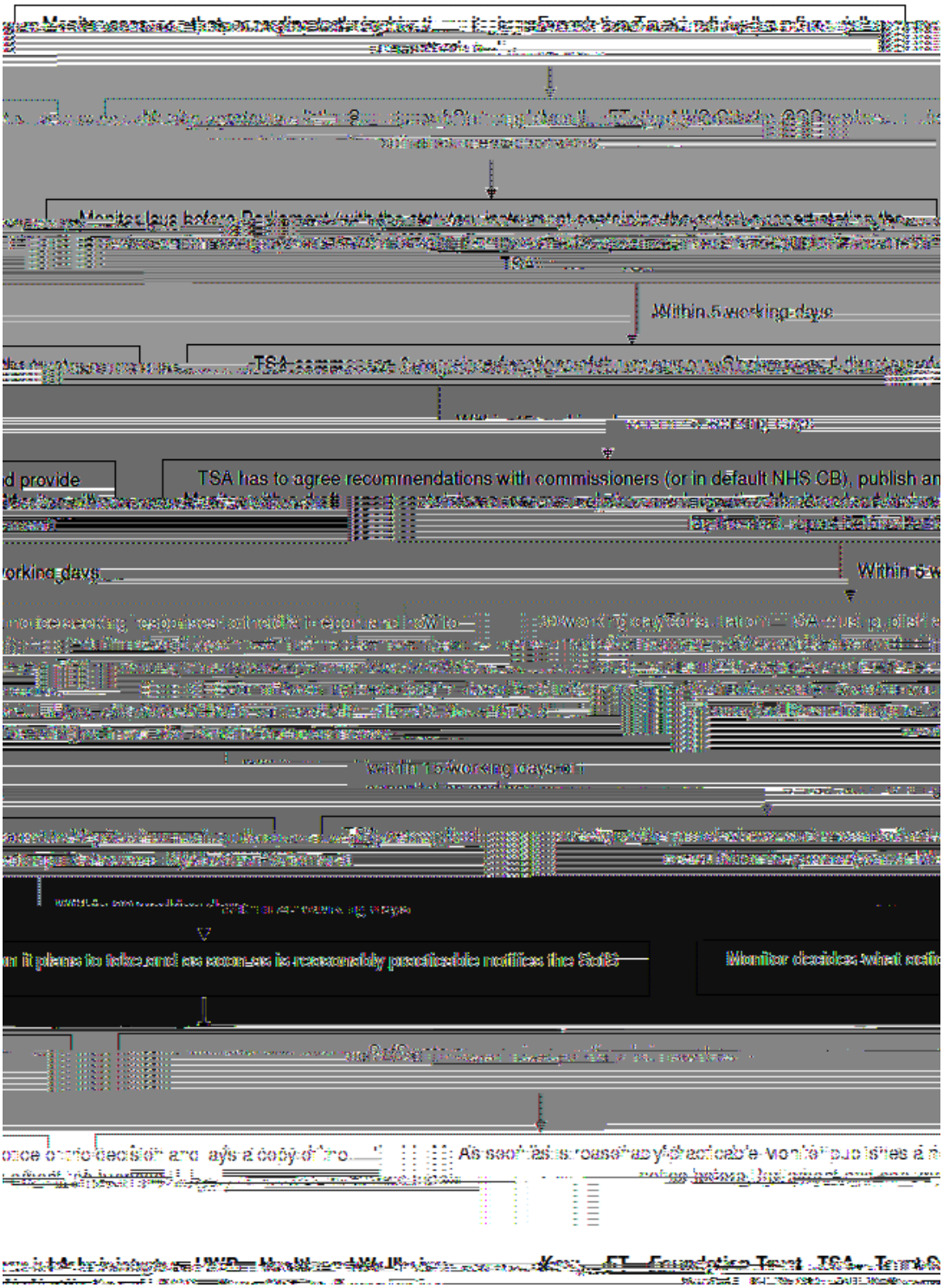
iv. any persons that the Secretary State directs the Trust Special Administrator to meet.

20 EXPLANATORY MEMORANDUM TO THE HEALTH ACT 200r0r G 8H5nW2-8(12(a [( )] TJ ET EMC q 0 -0.0W)6(2-))-12(M)20(O)-8(

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



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

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