STRENGTHENING THE ROLE OF TRUST SPECIAL ADMINISTRATORS
What you said, what we did, what’s been achieved and what still needs to be done

The Government has passed legislation reforming the statutory duties and responsibilities of trust special administrators (TSAs) that are appointed to providers of NHS-funded services in failure. ¹ The NHS Confederation worked closely with members and other stakeholders to bring about and influence these changes, and we will continue to do so as the changes are implemented. This document outlines what we have done over the last two years and how members can get involved as we continue influence on their behalf.

What you said:
- Short-term solutions to long-term financial problems are no longer sustainable.
- Failure should only be seen as a last resort.
- More needs to be done to support organisations in distress.
- Turning around organisations requires a look at the whole system.
- Rules of engagement for crisis-driven change need to be clearer.

What we did:
- Ran a simulation event that tested new reforms for dealing with failure with members.
- Worked with representatives of doctors and patients to bring together views on reconfiguration and build evidence to influence the Government.
- Joined with stakeholders to call for reform to the failure regime and met together with the Care Bill team to give our views.

What’s been achieved:
- Legislation has been passed that includes our recommendations and the changes we were calling for.
- The TSA now has the legal authority to consider the whole system and not just the organisation in failure.
- Timelines for the TSA have been extended to give it more time to produce and consult on recommendations for change.
- Approval is now required from all commissioners affected by the TSA proposals and affected providers, patients and staff must be engaged.

What still needs to be done:
- We have been invited to join a cross-party committee to advise the Department of Health on the guidance for TSAs appointed to NHS trusts.
- We are calling for this guidance to be:
  - clear about what a TSA can and is expected to do
  - realistic about how a TSA should deal with disagreement
  - meaningful in bringing in local views and securing patient involvement.

In the beginning: The Trust Special Administrator

An Unsustainable Provider Regime (UPR) was established in 2009 to deal with the financial failure of NHS trusts. It allowed a trust special administrator (TSA) to be appointed to an NHS organisation in difficulty with the purpose of proposing changes for the Secretary of State’s approval. These changes would aim to secure the sustainability of the organisation and allow it to continue as a going concern. A similar regime was established specifically for NHS foundation trusts (FT) as part of the Health and Social Care Act, which is governed by Monitor alongside the NHS Trust Development Authority that now oversees the UPR.

What we said

We welcomed the development of a failure regime for the NHS:

“Solving financial problems requires a fundamental overhaul of where and how NHS services are provided. Propping up struggling trusts with short term solutions is not the answer. We need to take action before we reach crisis point. We must ensure the rules developed to deal with ‘failing trusts’ are clear and flexible enough to allow organisations to act quickly and tackle problems long before they reach breaking point.” – Mike Farrar, former chief executive of the NHS Confederation, October 2012

What you told us

1. Lack of focus on developing a robust “pre-failure” regime to sit alongside the failure regime and support organisations in distress.

2. Lack of clarity about the rules on crisis-driven change, in particular on recommending whole-system change and engaging local communities.

What we did – influencing the NHS provider licence

Addressing “pre-failure”

Many aspects of the failure regime are contained within the new NHS provider licence, such as the requirements on the continuity of services, meaning that influencing its development was key to improving the failure regime.² As the proposals on this licence developed, we undertook a number of influencing and engagement activities with members and stakeholders to help ensure that it was a useful addition to the regulation of providers and importantly did not duplicate requirements.

We worked with Deloitte’s to run a simulation exercise with members to test the licensing reforms in a neutral setting and help shape how the regulators should respond to the challenges presented.³ Delegates included a wide range of NHS Confederation members with relevant expertise across the whole system and representatives from Monitor, the Care Quality Commission (CQC), the Co-operation and Competition Panel. Deloitte also attended, so the results were directly transmitted to important stakeholders.

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³ The simulation findings were presented in NHS Confederation (2012) - All systems go: testing the new licensing system for providers of NHS-funded care, see: http://bit.ly/1rPhirX
Two important conclusions came out from the simulation event:

1. The failure regime is a last resort; help must be available to deal with distress.
2. Turning around organisations requires looking at the whole system, not just those that are failing.

Addressing the lack of clarity on crisis-driven change

In June 2013, with the Academy of Medical Royal Colleges and National Voices, we published *Changing care, improving quality*, an important report that examined the case for radical, far-reaching change across the NHS, and brought together evidence and views from over 50 face-to-face interviews and a series of workshops and meetings. This was the first time a partnership of patients, clinicians and managers had specifically addressed this issue and symbolised the importance of this joint relationship in understanding the challenges presented by the need for change.

An important part of this work explored views on crisis-driven change and looked to understand how it differed from more proactive change in centralising specialist services and developing out-of-hospital “wrap around” care for patients. We were told by many of the people we interviewed that it was becoming clear that the small window offered by the TSA timetable gave little opportunity to develop plans with the local community, particularly considering that existing forms of engagement are explicitly cut off with the dissolution of the trust’s board and the removal of governors:

“South London was intended to be the process that would set a precedent for reconfiguration and pave the way for future attempts. It turns out to be the exact opposite, as it has set a precedent for preventing future attempts.” – Manager

“The timescales and resources on hand for reconfiguration can make you feel like you’re knitting fog.” – Manager

“There is an obstacle of time. Hit squads solving the problem in minimal time will not help, they will just present plans as a fait accompli.” – Clinician

What we said

*In the Changing care, improving quality report*

We took what we had heard from members and called for greater clarity about the rules of engagement and a clearer sign from Monitor that meaningful public and other stakeholder involvement needed to be retained in the event of a crisis. We highlighted that although Monitor’s guidance to TSAs recognises the difficulty of gaining support for changes that raise public concerns, its recommendations for engaging with patients, staff and the public were too focused on needing to reassure and inform them. We argued that financial failure cannot justify the exclusion of the local community from shaping health services, and that preventing the public from co-producing change in the failure regime will guarantee that it will dissatisfy the local community.

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In a joint letter to Department of Health

In October 2013, we issued a joint letter with the Foundation Trust Network that called on changes to the failure regime following the concerns we heard from our members and the successful judicial review into the TSA proposals for South London Healthcare NHS trust. The letter highlighted the lack of clarity on the legal authority for the TSA to make whole-system proposals, and the need for stronger requirements with regards to consulting local communities. We called on the Department of Health to consider the Care Bill, at that time being considered in Parliament, as an ideal vehicle to address these issues by putting forward Government amendments. We also met directly with the Department of Health with a wider group of stakeholders and reinforced our recommendations to them.

In a comment piece in the Health Service Journal

In an article published in the Health Service Journal in January 2014 Matt Tee, NHS Confederation chief operating officer, outlined the evidence for the changes we were calling for. The article highlighted the importance our members placed on the need to look across the whole system to develop solutions to the challenges providers face and the importance of matching an extended scope of the TSA’s influence with an extension of the responsibilities on them to ensure changes fit with the wider community. This article was cited throughout the Committee Stage of the bill, including by health minister Dr Dan Poulter, shadow health minister Jamie Read and Liberal Democrat MP Paul Burstow.

The changes that have happened

Clause 118 of the Care Bill proposed amendments to the TSA process along many of the lines proposed in the joint NHS Confederation-FTN letter.

Specifically, the bill proposed to make four main changes:

1. It widened the legal boundary for a TSA to recommend changes so that a future TSA could make changes to a local health economy, not just the trust it is appointed to.
2. The timelines for the TSA to make its recommendations and consult with the local community were extended by a total of 35 working days.
3. Department of Health would be required to produce guidance for TSAs appointed to NHS trusts to support them in engaging local providers, commissioners and the public.
4. The legal requirements on other NHS organisations to consult with the local community would no longer apply during the period of the TSA’s appointment.

The Care Act was passed in May 2014 with the above changes mostly in place. Further changes were made to oblige a TSA to consult with any trust (including staff), local authority and local Healthwatch affected by the recommendations.

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7 “Healthcare groups call for greater consultation in the Trust failure regime” – Joint statement of the NHS Confederation, the Royal College of Physicians, the Foundation Trust Network and the Academy of Medical Royal Colleges, see: http://bit.ly/1z22Fur
8 “No NHS hospital is an island when it fails financially” – NHS Confederation HSJ comment piece, January 2014, see: http://bit.ly/1m2k00x
What still needs to be done

The NHS Confederation has been invited to join a cross-party committee established by the Government as part of the final amendments. This committee is chaired by Paul Burstow MP and will meet twice over the next month to advise the Department of Health on the guidance for TSAs appointed to an NHS trust.

At this committee, we will reflect the views that we have heard up to now from members, and in particular, focus on three main points for the guidance:

- **The guidance needs to be clear** – an important factor in the need for new legislation was a High Court decision to overturn a previous TSA’s recommendation relating to whole-system change. The case illustrates the importance of the Government being explicit about the remit of TSAs and what they are and are not expected to do.
- **The guidance needs to be practical** – all administration processes are likely to be difficult and will have come about following an inability to resolve local challenges. As such, the guidance needs to be realistic about the potential for disagreement and must offer practical support for resolving this, or else how to proceed if not.
- **The guidance needs to be meaningful** – crisis-driven change offers a limited window within which to facilitate co-production with patients and the public. TSAs need to be guided to use the time they have to engage with the local community in a meaningful way and to draw on the links that will already exist with providers and commissioners.

Going forward

The Government has listened to and acted on the concerns of our members on the implementation of an NHS failure regime. The changes in the Care Act are a step in the right direction of making changes that put failing local health economies on a more sustainable financial footing.

They are unlikely on their own, however, to be enough. We are keen to continue to emphasise the importance of being more proactive in supporting organisations in distress, to establish a robust pre-failure regime that is in the best interest of local patients and the public. We will continue to engage our members on this issue and will be alive to any concerns they have about the proposed changes as they are implemented.

If you have any issues you would like to raise, or are interested in any of the work identified in this paper, please email Paul Healy at paul.healy@nhsconfed.org. If you would like to be involved in the NHS Confederation's work on this issue in the future, in particular by taking part in our groups and forums, please email Chiara Vivaldi at chiara.vivaldi@nhsconfed.org.

Further reading


“No NHS hospital is an island when it fails financially” - NHS Confederation *HSJ* comment piece, January 2014, see: [http://bit.ly/1m2k00x](http://bit.ly/1m2k00x)