

Monitor

Making the health sector
work for patients

**Review of the
contingency
planning
team/trust special
administration
procedure at Mid
Staffordshire NHS
Foundation Trust:
lessons learned**

Main Hospital

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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1. Summary

Mid Staffordshire NHS Foundation Trust was the first organisation to go through the new regulatory enforcement procedure for NHS foundation trusts that was introduced under the Health and Social Care Act 2012. Monitor appointed a contingency planning team (CPT) to assess the trust's clinical, financial and operational sustainability in October 2012, and on the basis of its report appointed Trust Special Administrators (TSAs) to oversee the management of the trust while implementing a long-term solution for local patients. The outcome, approved by the Secretary of State for Health, was that Mid Staffordshire NHS Foundation Trust was dissolved in November 2014 and most of its services taken over by neighbouring NHS trusts.

Although a viable solution was identified and implemented in this case – and this was done more quickly than has typically been the case where similar changes have been required elsewhere – nonetheless, the work of the CPT and the trust special administration took longer than anticipated, encountered several hurdles, and entailed considerable public expense (see [the published costs reports](#)¹). Throughout the period Monitor continually reviewed the CPT and trust special administration procedures at Mid Staffordshire NHS Foundation Trust and learned important lessons from the experience. Our enforcement team has applied these lessons to commissioning and managing four subsequent cases where NHS foundation trusts have become unsustainable. Three of these involved appointing a CPT, but none has yet required TSAs.

This report describes the lessons Monitor learned from the regulatory procedure at Mid Staffordshire NHS Foundation Trust, the actions we have taken to apply these lessons, and how that experience is informing the pre-emptive approach we now follow to help organisations in struggling local health economies avoid chronic difficulties. The lessons fall under six broad headings:

1. Taking a local health economy-wide approach from end to end
2. Engaging early with national partners and local stakeholders
3. Building consensus locally to avoid the need for a trust special administration
4. Allocating more resources to local communications and engagement
5. Anticipating the needs for sufficient investment in the failing organisation during the process
6. Managing external suppliers more effectively.

¹ www.gov.uk/government/news/final-cost-of-trust-special-administration-at-mid-staffordshire-nhs-foundation-trust

All these points are amplified in detail in the body of this report. However, the single most important lesson that emerged from the experience was an appreciation of the extent to which Mid Staffordshire NHS Foundation Trust's difficulties reflected broader and deeper problems in the local health economy. This insight emerged from the CPT review, and influenced the scope of the TSAs' work from the outset. Essentially it meant that a solution to the problem of a failing institution could not be found and delivered without involving the rest of the local health economy.

Our challenge was that the legislation at that time did not empower the TSAs to make enforceable recommendations affecting any party in a local health economy other than the failing trust. Consequently, developing and implementing a sustainable solution at Mid Staffordshire NHS Foundation Trust depended on negotiating the commitment of all the local parties involved, notably local clinical commissioning groups (CCGs) and the service providers that would in future deliver services previously supplied by the trust. This was time-consuming and expensive. The TSAs had limited options, so the local parties each negotiated from positions of strength, and negotiations took more time and resources than anticipated. The TSAs had to ensure that commissioners would pay for former Mid Staffordshire NHS Foundation Trust services, and that the trusts providing these services in the proposed configuration had the necessary funding. As a result, the costs of the TSAs were more than expected.

The legislation was amended in 2014 to enable TSAs to make recommendations in relation to other providers, but unfortunately any such recommendations are not enforceable. Even under the revised legislation, TSAs would need to secure local commitment to a preferred solution from all the parties involved in delivering it, at a stage when the local health economy's problems would be deeply embedded.

In the light of this experience, Monitor decided it would seek a local health economy-wide approach right from the start of a CPT's involvement with distressed foundation trusts – or even earlier if appropriate. This would mean defining the services at issue as broadly as circumstances require, gaining early commitment from commissioners and providers to implementing a local health economy solution, and assessing the availability of resources to fund the solution at the outset.

Monitor has already started putting this approach into practice. The principle of seeking a local health economy-wide solution underpinned our collaboration with NHS England and the NHS Trust Development Authority (TDA) throughout the Intensive Planning Support Project last year that helped 11 challenged health economies plan more effectively for the future. It is the basis of the informal support we are giving to commissioners in Milton Keynes and Bedfordshire to find a solution to the clinical and financial challenges at both Milton Keynes Hospital NHS Foundation Trust and Bedford Hospital NHS Trust. And it is explicit in the work we have undertaken in The Queen Elizabeth Hospital King's Lynn NHS Foundation

Trust in West Norfolk and Tameside Hospital NHS Foundation Trust in Greater Manchester to protect health and care services for patients.

There is now a broad consensus across the NHS that the problems of individual providers can only be resolved in the context of the wider local health economy. However, there is a limit to what either Monitor or the other two national oversight bodies can do on their own. Although Monitor can and will continue to focus on achieving a local health economy solution when sending in a CPT to look at a troubled foundation trust, for example, we can only do so in so far as this affects the services of the foundation trust subject to the CPT. A Monitor CPT cannot by itself review wider local services that have nothing to do with the particular foundation trust under scrutiny.

This dilemma was recognised by the commitment in the 'Five Year Forward View' that in future Monitor, TDA and NHS England will work together to create a whole systems intervention regime for those local health economies with significant financial or operational issues, where previous or current interventions are not resolving their challenges effectively or quickly enough. This increased direction and support will create the conditions for success in the most challenged health economies, and promote and protect healthcare services for patients in areas struggling with financial or quality problems, or sometimes both. The national partners have now identified the first wave of geographical areas where this 'success regime' will apply – across Essex, north, east and west Devon, and north Cumbria. Here the three partners will work in a more joined-up way to diagnose problems across whole health and care economies, develop solutions to address performance and sustainability issues, and implement the changes required. These interventions will be jointly owned and overseen by all three national bodies. They will put a particular focus on strengthening the capacity and capability of local leadership to work together and drive through the improvements required, for the benefit of local patients. In effect, we will seek to use our oversight levers collectively, rather than independently, to tackle systemic problems affecting a local health economy.

The 'success regime' has therefore built on much existing work, including Monitor's own expertise in contingency planning, sustainability reviews, improvement initiatives and leadership development. Although the regime may be extended to other challenged localities in future, it does not replace these other forms of intervention. Other types of support will continue to have significant value in particular areas and circumstances, and Monitor will continue to use existing regulatory measures where necessary. As the sector regulator, we are also focusing more attention on ways in which we can actively help and support foundation trusts to prevent them getting into serious difficulties in the first place. Meanwhile, we will shortly publish the findings of the CPT appointed to come up with a plan to secure the future of services for patients at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. This trust has been in special measures for several years, and a team of outside experts has been working with it and local commissioners to establish options for sustainable

health and care services in the King's Lynn and West Norfolk area. This will add a further dimension to our broader understanding of the challenges facing local health economies as they seek to maintain services and meet the needs of their patients.

2. Details of the contingency planning team/trust special administration procedure at Mid Staffordshire NHS Foundation Trust

In October 2012, Monitor appointed an independent CPT to Mid Staffordshire NHS Foundation Trust to assess the trust's sustainability from a clinical, financial and operational perspective. In January 2013, the CPT concluded in a report for Monitor that the trust was neither clinically nor financially sustainable in its current form in the longer term. The CPT also concluded that without cash support the trust would be unable to pay its debts as they fell due. It was therefore deemed insolvent.

On the basis of the CPT's conclusions, Monitor appointed TSAs to the Mid Staffordshire NHS Foundation Trust with effect from April 2013. It was the first NHS foundation trust to be placed into trust special administration.

The role of the TSAs was to oversee the management of Mid Staffordshire NHS Foundation Trust – in effect, to take responsibility for running the trust – while consulting on and developing proposals for its future within a limited timeframe. Its proposed solution had to secure the continuity of services provided by the trust that were designated location specific services (LSS) by the local CCGs. The TSAs made draft recommendations in a report provided to Monitor in July 2013. It consulted on the draft recommendations between August and October 2013 and submitted final recommendations in a report to Monitor in December 2013.

In January 2014, Monitor approved the recommendations in the TSAs' final report, which was then submitted to the Secretary of State for approval. In February 2014 the Secretary of State announced his approval of the TSAs' recommendations.

Following the completion of the trust special administration process, from 1 November 2014, services formerly provided by Mid Staffordshire NHS Foundation Trust at County Hospital (formerly Stafford Hospital) and Cannock Chase Hospital have been provided by University Hospitals of North Midlands NHS Trust and The Royal Wolverhampton Hospital NHS Trust respectively (the receiving trusts).

3. Approach to the review

This review has concentrated on learning lessons from how the CPT/trust special administration procedure was applied at Mid Staffordshire NHS Foundation Trust; that is, lessons about the management and execution of the procedure rather than its broader merits or its effectiveness as a policy or the effectiveness of the law that supports it.

The review's findings are based on:

- interviews with project team members
- a Monitor internal audit review of adherence to Monitor's processes for appointing and managing CPT and TSA activities
- a lessons learned session between Monitor and Ernst & Young LLP, the main external provider involved
- a review of existing literature on thoughts and lessons learned (including the findings of a King's Fund-facilitated roundtable review among national bodies).

This review has not sought out lessons learned by other local stakeholders, eg Mid Staffordshire NHS Foundation Trust, receiving trusts and local CCGs. We recognise that their as-yet-unidentified views on the procedure may offer additional lessons for the future.

4. Details of lessons learned

4.1. Take a local health economy-wide approach from end to end

Mid Staffordshire NHS Foundation Trust's cumulative difficulties reflected wider problems in the local health economy. This broadened the TSA process and added to its costs. For instance, although Monitor's formal remit in the statutory procedure is to secure the continued provision of LSS in the locality, in practice at the trust this involved Monitor and the TSAs helping local commissioners to consider how *all* services provided by the Mid Staffordshire NHS Foundation Trust would be provided within the local health economy in the future.

The local health economy-wide nature of Mid Staffordshire NHS Foundation Trust's problems also meant that a sustainable solution depended on making changes to the structure and processes of service providers and CCGs in the wider local health economy. However, the legislation at that time did not empower the TSAs to make enforceable recommendations affecting any party other than the failing trust. Consequently at Mid Staffordshire NHS Foundation Trust, developing and implementing a sustainable solution depended on securing the voluntary commitment of all the local parties involved, notably service providers that were required to acquire services previously provided by the failing trust and the local CCGs that would commission them.

Negotiations were time-consuming and expensive. Both the CCGs and University Hospital of North Staffordshire NHS Trust (UHNS),² as a preferred provider in this case, negotiated from positions of strength because their commitment had to be

² UHNS was integrated into the newly created University Hospitals of North Midlands NHS Trust from 1 November 2014

gained within a legally fixed time limit and there were few alternatives available to the TSAs. Negotiations and due diligence by UHNS duplicated some of the TSAs' analysis and took substantially more than the anticipated time and resources. (The total pre-transaction costs of the three trusts involved came to £13 million,³ although these costs were not met by Monitor.)

The scale of change required by the TSAs' recommendations in Mid Staffordshire NHS Foundation Trust was costly to implement. Local CCGs gave the TSA the go ahead to start consulting on draft proposals for a preferred solution, but their response to that consultation concluded that they could not agree to the draft recommendations because, at that time, the recommendations would not achieve financial balance.⁴ So the TSAs' work extended to ensuring that the CCGs that would pay for services and the trusts that would provide them in the future configuration had the necessary funding. The costs of the trust special administration were more than expected as a result.

Learning from this and subsequent experience, Monitor now takes a local health economy-wide approach right from the start of a CPT's involvement with distressed foundation trusts – even earlier, where appropriate (see 4.3 below). This approach includes the following steps:

4.1.1. Define the services at issue as broadly as circumstances require

Monitor recognises that the objective of trust special administration is to protect LSS for patients. However, we have learned from Mid Staffordshire NHS Foundation Trust, and from subsequent comparable situations where we have been expected to help secure other non-LSS services for local patients, that a broader set of services may need to be considered. Monitor should therefore facilitate a wider discussion and solution in these cases, so far as protection of LSS affects a trust subject to a CPT/trust special administration.

Action: CPTs may facilitate a discussion of services beyond LSS and a solution involving them, where circumstances require. However, Monitor will direct and encourage other LHE stakeholders themselves to commission additional advice and support for work beyond the core scope of the CPT. This could include, for example, commissioning costed options for the delivery of services, which could help to refine the definition of LSS.

³ www.ntda.nhs.uk/wp-content/uploads/2014/10/Paper-G-appendix-A-TDA-Board-MSFT-Transaction-Report-.pdf

⁴ The TSAs were unable to obtain statements of support from all commissioners and therefore sought a statement from NHS England. NHS England wrote to the TSAs on 11 December 2013 confirming that the recommendations in the draft report, as varied after the consultation by the recommendations set out in the TSAs' final report, would achieve the objective set out in Section 65(DA) of the National Health Service Act 2006.

4.1.2. Secure earlier options evaluation by local CCGs and providers

Patients of failed trusts will be better served if the parties involved in a local health economy can develop and implement an LHE-wide sustainable solution as quickly as possible. Amendments to legislation as a result of the Care Act 2014 mean that TSAs can now make recommendations relating to an NHS foundation trust or an NHS trust that they are not administering. Although the amended legislation is as-yet untested, this increase in their powers may make future TSAs more effective. However, a TSA still cannot require stakeholders beyond the failed trust to implement its recommendations.

In future cases, we expect to have gained the commitment of local CCGs and providers to developing and implementing an LHE-wide solution before a trust special administration becomes necessary (see lessons 2, 3 and 4).

Action: Pending any further amendment to the legislation, to accelerate the pace of change in subsequent cases where a trust special administration becomes necessary, Monitor will build in an expectation that the TSAs will encourage and support local CCGs/providers to evaluate and jointly refine the implications of proposed options for providing services. This is to help ensure they are sufficiently prepared to operate effectively in a restructured health economy.

4.1.3. Assess the availability of resources to fund the solution

All the parties involved in implementing the solution at Mid Staffordshire NHS Foundation Trust invested a considerable amount of time agreeing how the requisite funding was to be provided.

Action: To avoid proposing solutions that alternative providers or CCGs do not have enough funding, capacity or capability to implement, TSAs and local CCGs should at the outset of a CPT/trust special administration process estimate the resources necessary to deliver LSS and assess the capability, capacity and funding risks of key stakeholders likely to be involved in delivering any proposed solution. That assessment will be factored into the development of potential solutions and tested with feasible providers. This action has still to be fully implemented formally.

4.2. Engage key staff at national partners and local stakeholders early

Working with the CPT and TSAs at Mid Staffordshire NHS Foundation Trust placed considerable demands on local healthcare organisations. Progress was closely related to the capacity and capability of local commissioners and neighbouring providers involved in negotiating a solution. Several senior staff from their respective national organisations provided help but their approaches to the procedure were not necessarily aligned.

The need to iterate and refine proposals for LSS with local CCGs and to consult widely and extensively with them, other local health economy and national

stakeholders, added considerably to the time it took to secure a solution that could be implemented. As well as adding cost to the process, the uncertainty of the situation made it more difficult than anticipated for the TSAs to maintain business as usual at the trust.

Monitor, TDA and NHS England needed to work collaboratively on the CPT/TSA projects at Mid Staffordshire NHS Foundation Trust. However, the other national organisations did not have the same level of resources as Monitor and the TSAs. Participation by their staff often came 'on top of the day job'. It would have speeded up decision-making and progress if senior staff of these national stakeholders could have been engaged and committed earlier in the process. They could then have expedited matters with those they were responsible for in the local health economy.

Action: When appointing subsequent CPTs, Monitor has sought to understand better up front the capacity and capability of local stakeholders who will need to take part in the projects, and to determine the level of resource and support the local stakeholders may need to contribute effectively to developing and implementing a preferred solution. Monitor has then consulted further with national bodies to encourage them to provide the required resources to local health economy stakeholders.

Action: As outlined in the 'Five Year Forward View', Monitor, TDA and NHS England are working to align their respective local assessment, reporting and intervention regimes for foundation trusts, NHS trusts, and CCGs, complementing the work of the Care Quality Commission (CQC) and Health Education England. This closer alignment will include more joint working at regional and local levels, alongside local government, to develop a whole-system, geographically based intervention regime where appropriate. We are already working in this way on current and recent CPTs. Through the whole systems interventions meetings, we are also establishing a governance framework for formalising a consistent approach to partnership working on other LHE-wide projects in future.

Action: Monitor and any future CPTs and TSAs involved in similar procedures will engage early with senior staff at national level where appropriate.

4.3. Avoid appointing TSAs unless essential by building consensus earlier among local CCGs and providers

The appointment of TSAs had a profound impact on the local health economy. The TSAs' powers and remit can shepherd local stakeholders towards a solution, but in Mid Staffordshire NHS Foundation Trust the trust special administration process was seen by many as challenging and negative. The TSAs' recommendations encountered considerable stakeholder resistance and gave rise to concerns across the local health economy. It took significant resources to resolve these concerns and effect the recommendations. In addition, although the Mid Staffordshire NHS

Foundation Trust TSAs developed a solution quickly, it duplicated some of the CPT's work and revised the clinical model recommended by the CPT.

In light of these experiences, Monitor has reviewed when is the right time to appoint TSAs. We have concluded that it is reasonable if:

- the board of the failing trust is unable or unwilling to drive necessary changes
- local commissioners cannot agree what changes are required
- speed is essential because there are serious safety or financial issues, or
- all parties involved agree and a trust special administration will enable the solution to be delivered quickly.

The first of these factors contributed to the CPT's conclusion that appointing TSAs represented the strongest chance of a successful restructuring at Mid Staffordshire NHS Foundation Trust.

Even where a trust special administration is ultimately necessary to complete a reconfiguration, CPTs can do a lot of the groundwork and consensus-building before the handover. If Monitor appoints TSAs, there must be a real prospect that the trust special administration process will resolve the problem. That will depend on the extent of consensus among local CCGs and providers and their capability to jointly develop and implement a preferred solution: without true consensus, the solution will be vulnerable to renegotiation when contracts between commissioners and providers are renewed for the following financial year.

Monitor has therefore concluded that where conditions permit, it will generally be preferable for the CPT to lead as much of the preliminary assessment work and consensus-building as possible. Given the challenges and additional costs involved in running a trust special administration, we will appoint one only if a more consensual solution cannot be rapidly agreed and implemented.

This approach is similar to what has evolved in the commercial sector.

Administrators are now sparingly appointed to insolvent companies; instead, a solution is often developed between the parties involved – including an insolvency practitioner, purchasers of a business and assets, creditors and managers – without a formal process. Today, a formal process is typically only required to validate a going concern restructuring at its conclusion.

Monitor has no formal powers to implement a preferred solution other than through commissioning TSAs to implement one of the CPT's range of options. So building consensus among local CCGs and providers behind a preferred solution and understanding their implementation capability will be critical to the success of solutions developed without a TSA. We are beginning to build this local health

economy-wide consensus long before a distressed foundation trust becomes unsustainable.

Action: To help build consensus from the outset, Monitor now consults local CCGs and local government (where appropriate) when selecting CPT/TSA suppliers. They take an active part in the CPT in developing a preferred solution, which the local health economy can implement subsequently. This should help to ensure CCGs support any eventual restructuring or reconfiguration and accept the financial and operational consequences, making it less likely that commissioners will withdraw contracts on which a solution may depend.

Action: As a CPT progresses and/or a consensual process is passed to a local health economy to implement, Monitor should constantly keep under review the question of whether and when to appoint a trust special administration in the light of local circumstances, with a bias towards avoiding it unless necessary.

Action: Monitor's enforcement team now supports our regional directors of Provider Regulation to assist in turning around NHS foundation trusts showing early signs of long-term distress. Our aspiration is that taking this pre-emptive approach will avoid the need for either CPTs or TSAs in the medium term. This is one of the objectives of our new Provider Sustainability Directorate (see Lesson 6).

4.4. Allocate more resources to communication and stakeholder engagement

At Mid Staffordshire NHS Foundation Trust, communication with stakeholders was particularly demanding of resources. Unanticipated additional clinical and specialist communications staff were needed to develop and communicate the evidence for change, consult, and secure acceptance of the recommendations. The TSAs who were deployed over an extended period, were often the most senior, experienced members of the team which had an impact on costs.

The amount of Monitor, CPT/TSA team and trust leadership time that must be spent on stakeholder engagement and communications during an enforcement process cannot be underestimated. Effective public engagement is resource and time intensive.

Action: CPT and TSA suppliers are now required to apply adequate specialist resources to communications and clinical engagement in their tenders.

Action: Monitor recognises that a dedicated, experienced communications team is an essential part of such assignments, and all major assignments now include a significant central communications capacity to co-ordinate and support a strategic approach to stakeholder engagement.

Action: The scope of subsequent CPTs has allowed for an increased level of Monitor stakeholder engagement, both with the local health economy and with relevant national bodies.

4.5. Anticipate significant investment in the failing organisation during the process

Mid Staffordshire NHS Foundation Trust was suffering the cumulative effects of under investment. The pace and intensity of the CPT/TSA process therefore applied significant pressure to an already weak organisation. The TSAs and Mid Staffordshire NHS Foundation Trust had to divert additional time, money and resources to under-invested areas to ensure the organisation was able to deliver services safely.

Monitor now appreciates that making sure a failing organisation continues to operate may present unexpected challenges. In particular, retaining and recruiting staff into a failed trust becomes more difficult over time, as does supporting an inadequate IT system, for example. These necessities cost Mid Staffordshire NHS Foundation Trust an unanticipated £3 million to resolve.

Action: Future CPT/trust special administration engagement should require suppliers to provide an assessment of likely risks involved in the continued operation of the trust in question and steps to mitigate them. When appointing future TSAs, Monitor should consider the need for a contingency budget to address problems that are more difficult or extensive than originally expected.

4.6. Manage external suppliers more effectively

The experience of procuring a CPT and TSAs for Mid Staffordshire NHS Foundation Trust taught Monitor valuable lessons about improving the process, which we have reflected in the actions listed below. Our experience also indicates that the three consulting firms that have undertaken trust special administration and subsequent CPTs have also learned and developed more effective ways to provide better value for money. However, the pool of expertise in the independent restructuring sector capable of undertaking a CPT or TSA successfully is still very limited and expensive to use. In view of this, and because we have identified and are building more of the skills needed to undertake a CPT inside Monitor, we are establishing in-house resource within our new Provider Sustainability Directorate.

4.6.1. Avoid discouraging potential suppliers from bidding

At Mid Staffordshire NHS Foundation Trust, Monitor commissioned the CPT and subsequently sought bids from potential TSAs as a separate procurement. We did this so that we could switch supplier for the trust special administration if the need arose. However, alternative TSA suppliers took the view that the firm selected for the CPT would develop considerable intellectual capital, giving it a competitive advantage in the TSA tender, so they did not bid for the TSA. This meant that the incumbent supplier provided all three stages (CPT, TSA and implementation) of the process.

Learning from Mid Staffordshire NHS Foundation Trust suggests that, in some cases, it would be appropriate to engage one supplier at the outset to deliver the CPT, the TSA and the implementation stage, particularly given the risks associated with changing suppliers at the start of the implementation phase. However, in encouraging suppliers to bid for all three stages, we need to ensure we also retain the option to change supplier if necessary to secure value for money.

Action: The scopes in invitations to tender (ITTs) issued for subsequent reviews allow a single supplier to contract to provide all three phases of a project if required. However, they also include break clauses at the end of each phase that can be exercised at each stage if Monitor has concerns about the performance of the current supplier or sees a need to introduce a supplier with skills to match changed circumstances. They can also be triggered by Monitor to stop the CPT process early, when an immediate transition to a TSA is called for, or to conclude the CPT altogether, if appropriate. Monitor believes the ability to trigger a termination ensures that we secure value for money from suppliers. This will be our preferred procurement approach on subsequent appointments.

4.6.2. Avoid duplication between CPT and TSAs

The CPT recommended a clinical model that it concluded would deliver a clinically and financially sustainable future for services provided by Mid Staffordshire NHS Foundation Trust. Although both the CPT and the TSAs came from the same supplier, the TSAs felt obliged to make changes to the CPT's recommended clinical model. This created duplication, stakeholder management issues and extra cost.

Action: CPTs are now limited to developing a range of options or preferred solutions without concluding on a single recommendation.

4.6.3. Strengthen procurement of external suppliers

Mid Staffordshire NHS Foundation Trust was the first NHS foundation trust for which Monitor commissioned a CPT and TSAs. For each element, there were considerable uncertainties surrounding the scope, processes, risks of implementation and methods for reaching a solution. Monitor sought to mitigate the risks of these uncertainties by going through a rigorous procurement process involving a detailed ITT and subsequent oversight of the supplier. Learning from this experience has enabled us to streamline subsequent procurements.

The scope of the CPT tender was based on our knowledge of Mid Staffordshire NHS Foundation Trust which developed during other work we carried out there and in the local health economy. The scope for the first phase of the trust special administration tender (solution development) closely mirrored the legislative requirements. The scope for the second phase (implementation) was informed by the lessons learned from other bodies commissioning the implementation of the recommendations of the TSA appointed to South London Healthcare NHS Trust. Monitor met the

commissioners of that work and the advisory firms involved in the implementation, before drawing up the scope of the Mid Staffordshire NHS Foundation Trust implementation phase.

Our experience of the Mid Staffordshire NHS Foundation Trust procurement and subsequent oversight of the suppliers has enabled us to reduce our management on later cases as our knowledge of suppliers' capabilities has grown. The actions we have taken have led to more efficient procurement, improved the quality of the process and secured better value for money.

Action: Monitor has adjusted procurement, oversight processes and ITT scope to make them more efficient and cost effective. Changes include:

- consultative working with potential suppliers on developing scopes before the release of the ITT
- more focused and hence significantly shorter ITTs and subsequent supplier bid responses
- requirement for bidders to describe their clinical engagement and their investment in communications in their bids
- requirement for key individuals from prospective suppliers (including any key subcontractors to them) who will lead a CPT/TSA to attend formal interview
- provision of extensive formal feedback to all bidders after the selection, to help them build their capability for future bids.

The changes have received excellent feedback from suppliers, some of whom have materially improved their offer. We are continuing to refine and adjust our procurement process.

Action: If we appoint future TSAs, we will provide more detailed guidance on how to meet some of the statutory requirements of trust special administration. This will avoid a new administrator having to develop their own way of meeting them.

4.6.4. Bring some aspects of CPT work in-house

CPT work, often undertaken in close collaboration with TDA and NHS England, has two aspects. First is the analysis of the long-term clinical, operational and financial sustainability of provider organisations. We have determined that we have the necessary skills in-house for this activity. We have already done this kind of work ourselves, for example in Burton Hospitals NHS Foundation Trust, but hope to bring most of it in house in due course. The second aspect of CPT work that we want to bring in house is the development of restructuring options where it has been established that providers are not sustainable in their current form. Again, we have

already been doing some of this work alongside external advisers, for example, in Milton Keynes and Bedford, but would like to develop a stronger in-house capability.

Action: We will further develop Monitor's ability to deliver CPT work in-house by establishing and developing an in-house resource within the new Provider Sustainability Directorate.



Making the health sector
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