



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 1516
SESSION 2010–2012**

13 OCTOBER 2011

Department of Health

Achievement of foundation trust
status by NHS hospital trusts

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Department of Health

Achievement of foundation trust status by NHS hospital trusts

Ordered by the House of Commons
to be printed on 12 October 2011

Report by the Comptroller and Auditor General

HC 1516 Session 2010–2012
13 October 2011

London: The Stationery Office
£15.50

This report has been
prepared under Section 6
of the National Audit Act
1983 for presentation to
the House of Commons
in accordance with
Section 9 of the Act.

Amyas Morse
Comptroller and
Auditor General

National Audit Office

11 October 2011

This report examines the management and reporting processes for the pipeline put in place by the Department to identify and address the obstacles trusts face.

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This report can be found on the National Audit Office website at www.nao.org.uk/foundation-trusts-2011

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Key facts

113

NHS trusts in the 'pipeline' process to become foundation trusts

20

NHS trusts which 'tripartite formal agreements' show are not financially or clinically viable in their current form

28

trusts predict they will submit applications to the Department of Health in April 2013 or later

- 113** the number of NHS trusts that are aspiring to gain NHS foundation trust status by 2014.
- 20** the number of NHS trusts which analysis of 'tripartite formal agreements' (TFAs) shows are not financially or clinically viable in their current form.
- 28** trusts (almost a quarter) predict in their TFAs that they will submit applications for foundation trust status in April 2013 or later.
- £1.47 billion** efficiency savings target for pipeline NHS trusts in 2010-11.
- 78 per cent** of NHS trusts face strategic and local health economy issues.
- 80 per cent** of NHS trusts face financial issues.
- 65 per cent** of NHS trusts face quality and performance issues.
- 39 per cent** of NHS trusts face governance and leadership issues.
- £3.2 million per year** the cost incurred by the centrally resourced team dedicated to supervising and managing trusts' progress through the pipeline including £1.7 million support to trusts to prepare them for foundation status. Additional consultancy costs in 2011-12 are forecast to be £0.3 million.
- £376 million** the estimated loan facility that will be needed across NHS trusts to reach the required levels of liquidity.
- 62 per cent** of trusts in the London region have yet to achieve NHS foundation trust status – the biggest challenge faced by a single region.

Summary

1 Government policy is that NHS hospitals should run their own affairs and be accountable to local people and patients, as opposed to being subject to top-down direction from the Department of Health (the Department). This has been policy since the first NHS foundation trusts were created in 2004 as self-governing NHS providers. To attain foundation trust status requires strengthened board governance, financial disciplines that promote long-term financial viability, and a framework to secure delivery of quality services. The Department sees foundation status as a vital step for hospitals if they are to succeed in an increasingly financially demanding and competitive health service. The Government expects that the vast majority of NHS trusts will become foundation trusts by April 2014, primarily through a locally managed process with national support as needed.

2 When it first created NHS foundation trusts the Department announced that all acute and specialist hospitals should be in a position to apply for this status by 2008. By 1 October 2011 there were 139 NHS foundation trusts, and 113 NHS trusts at various stages in the 'pipeline' towards foundation trust status. The number of authorisations peaked in 2007 and 2008, however, and only 14 foundation trusts had been authorised since the end of 2009. Many of the remaining NHS trusts have more challenges to resolve to achieve foundation status than the early applicants did. These include financial, quality and governance issues within the organisations themselves, and also, for some trusts, more deep-seated and long-standing issues about, for example, size and location, which limits their capacity to deliver health services efficiently and effectively. Trusts now also face the added challenge that across the NHS 4 per cent efficiency savings per annum are required if the service is to achieve its target saving of up to £20 billion by the end of 2014-15.

3 Monitor, the independent regulator of NHS foundation trusts, is responsible for assessing applicants for foundation trust status, and subsequently for regulating them once they are approved. Monitor sets the criteria aspirant trusts must meet, and has made clear that there will be no dilution or weakening of the standard it applies.

4 In its White Paper *Equity and Excellence: Liberating the NHS* (July 2010) the Government announced that it was relaunching the foundation trust process:

“Within three years, we will support all NHS trusts to become foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of a foundation trust...”

Following the pause in the passage of the legislation in summer 2011, the Department has amended the Health and Social Care Bill so an NHS trust may, in exceptional circumstances, continue beyond April 2014 if it is on an agreed timeline towards foundation trust status. This may, for example, involve merger or transfers of services between hospitals, which has to follow set protocols including defined periods of public consultation.

5 From October 2010 the Department has been developing new processes to help progress aspirants through the 'pipeline' towards foundation trust status. A key element in this process has been completion of a 'tripartite formal agreement' (TFA) for each NHS trust. The TFA summarises the main challenges facing each organisation, and the resulting actions to be taken by the trust, Strategic Health Authority (SHA), and the Department. These organisations then commit themselves to taking specific actions, laid down within the document, in line with an explicit timetable. Because of the influence that commissioning intentions have on whether trusts' financial plans are viable, the lead Primary Care Trust (PCT) for each trust has also been asked to endorse the TFA document.

6 The regional distribution of trusts in the pipeline is very uneven. By 1 October 2011, all but one trust in the North East has become a foundation trust. By contrast, in London, only 38 per cent of trusts have achieved foundation status. There are several reasons why trusts have not become foundation trusts. Some trusts had not applied earlier because they had not viewed it as a priority and were not under pressure to do so. Others had applied and failed. Some have never attempted it because they have severe financial, performance and quality issues to address.

7 The actions required to achieve foundation status rest primarily with local trusts' boards and management, supported regionally by their SHAs and nationally, as required, by the Department of Health. The Department intends that, following the abolition of SHAs in April 2013, a new body, the NHS Trust Development Authority will become responsible for progressing the remaining trusts in the pipeline.

8 It is already clear that not all NHS trusts will be able to achieve foundation trust status in their current form. The pipeline process has been useful in bringing out in sharp relief the problems faced by these trusts which are often long-standing and which can only be solved by redesign of how hospital services are delivered within local communities.

9 This report examines the management and reporting processes for the pipeline put in place by the Department to identify and address the obstacles trusts face. Some of the issues can be tackled at local or regional level, but some trusts face challenges that will need strategic national interventions. There are at least 20 trusts, including eight in London, that face complex and substantial problems. These trusts have indicated that the problems they face are so severe that they cannot meet the standard for foundation trust status in their present form. Tackling these problems will require much more radical reorganisation of how healthcare is provided to local people, including mergers and reconfiguration of services, with services contracting or closing in some locations and expanding in others.

10 Our methodology is summarised at Appendix One. We interviewed key Department of Health staff, and reviewed relevant documents including the TFAs for all the trusts in the pipeline. In addition, we visited six NHS trusts and three SHAs, and carried out telephone interviews with senior managers at a further five SHAs.

Findings

The Department's management of the pipeline between October 2010 and September 2011

11 The process of developing and committing to TFAs has made much more transparent the challenges trusts face to demonstrate their long-term viability, and has forced the signatories publicly to accept accountability for addressing them. Some of these issues, though well-known within the local health economy, have lain unresolved for a number of years.

12 It has taken six months to finalise TFAs. The time taken reflects the extent and complexity of the issues faced by some trusts and the degree of effort being taken to ensure they are an accurate assessment of both the challenges faced and the actions required. Different SHAs have been involved to differing extents in drafting the documents. The Department asked for all draft TFA documents to be submitted by trusts in March 2011. There were questions about the quality of some original submissions, and the Department identified a need to develop national responses for trusts with common financial problems. The Department signed the TFAs for the final 46 of the 113 trusts on 30 September 2011 committing trusts to agreed actions, although for some of the most challenged trusts the process of agreeing the set of actions they, their SHAs, and the Department will need to take is not complete.

13 The Department has put in place a national framework to monitor progress against milestones and track risks. Now that TFAs are agreed, progress against timelines will be monitored by SHAs. The Department has asked each SHA to report monthly on progress against milestones and, following discussion with the Department, to agree the level of risk in each case. Ultimately, this information will flow to the NHS Operations Board. If there are concerns about trusts' progress, the SHA will address these through its existing performance management arrangements.

14 The level of resources being devoted to ensuring that TFAs are robust varies considerably between SHAs. The progress of trusts through the pipeline will also require continued investment of staff time and monitoring by SHAs. Those that are most challenged will require the closest scrutiny and support. A number of SHAs have developed robust local performance management systems, for example in the North West and East of England, but these are not universal and there is scope to learn from exemplars. As part of the Government's wider health reforms, the ten existing SHAs were grouped into four clusters on 1 October 2011. The Department and the new clusters are developing a single operating model to manage trusts' performance through the pipeline ahead of the introduction of the NHS Trust Development Authority in 2013.

15 There is no mechanism to measure how much the pipeline process is costing across the NHS. The Department did not specify to SHAs how they should resource the work they do in support of the pipeline, and the level of resources committed has varied. The cost of work being done by trusts in support of foundation trust applications is not known by the Department, partly because financial management decisions are devolved to local management, and also because some of the work would have been necessary anyway to improve trusts' performance in a more challenging financial climate. The process is costing the Department £3.2 million a year. Additional consultancy costs in 2011-12 are forecast to be £0.3 million.

16 The flow of NHS trusts through the pipeline is heavily back loaded. Analysis of milestones in the TFA documents shows that the number of applications, as currently forecast, peaks in April 2013. Beyond that date 15 trusts expect to submit applications to the Department between May 2013 and April 2015. The Department is considering what resources it will need to process applications, and what scope there may be to streamline application processes, but there is a clear risk that bottlenecks will lead to delay. Once endorsed by the Department, straightforward applications can typically require four months to process with more difficult cases taking very much longer. Monitor has already expressed concern to the Health Select Committee about having to deal with a large number of late applications. Trusts with particularly complex problems seeking late application dates will be likely to struggle to meet Monitor's standards by 2014.

17 The Department recognises that NHS trusts face some common obstacles to achieving foundation status, and is carrying out work to provide national support. This work, still in progress, includes:

- considering loan funding to improve trusts' liquidity or to fund capital investment;
- actions to address the cases where a trust's viability is undermined largely by payments required to service one or more Private Finance Initiative (PFI) schemes;
- developing diagnostic tools and support to help trusts improve the quality of local management and strengthen Board capability – an area that Monitor has highlighted repeatedly as a weakness in past submissions; and
- a portfolio of alternative solutions for trusts that cannot meet the requirements for foundation status.

Challenges now faced by the Department, trusts and SHAs in taking forward the actions required by the TFAs

18 Achieving foundation trust status is more difficult because of the challenge of making savings under local cost improvement programmes (CIPs) and the NHS Quality, Innovation, Productivity and Prevention (QIPP) initiative. Trusts are required to make at least 4 per cent year-on-year cost savings over at least the next four years. Many of the trusts in the pipeline will need to achieve greater savings to be able to demonstrate their financial viability.

19 Meeting Monitor's tests of financial viability is a challenge for almost all trusts in the pipeline. The Audit Commission reported that 16 trusts received additional funding from PCTs or SHAs in 2010-11 to help them break even. The Department's assessment of trusts' financial position in July 2011 concluded that as many as 48 trusts were unlikely to meet Monitor's criteria without additional work to address a number of issues, for example:

- **The Department has identified that up to 36 trusts may need access to £376 million of loan facilities to deepen their working capital reserves sufficiently to meet Monitor's standard requirement for a set level of working capital.**
- **The Department acknowledges that external financial support may be needed for a small number of trusts with large PFI schemes.**
The Department's advisers have examined 22 trusts with PFI schemes costing some £763 million a year, and concluded that in most cases the PFI schemes do not in themselves undermine the viability of specific trusts. This initial analysis indicated that up to 6 of the 22 trusts were not viable under any of the tested scenarios, because of the scale of their PFI payments alongside a variety of other financial problems.
- **The level of accumulated debt is identified by 24 trusts (21 per cent) as an obstacle to them achieving foundation status.**

20 Tackling the financial problems faced by some of the most challenged trusts will require direct intervention by the Department, such as long-term loan facilities, debt restructuring, and addressing the affordability of PFI schemes. At this point it is impossible to conclude how many trusts will need this support. The Department has said that some proposals will have to be subject to HM Treasury approval, and any support must also be consistent with Monitor's financial assessment criteria. The Department is still considering how to resolve these issues. To qualify for foundation status trusts must be financially viable even if future performance reflects the pessimistic scenarios in their financial plans. Interventions using public money to increase aspirants' apparent viability would also risk distorting competition and undermining the policy objective to increase hospitals' financial sustainability.

21 Although commissioners are required to sign the TFA to confirm that they support the trust's application, those currently responsible for commissioning decisions – Primary Care Trusts – will increasingly hand over responsibility to new GP led Clinical Commissioning Groups. This creates potential uncertainty about trusts' future income. Trusts and SHAs are engaging with pathfinder Clinical Commissioning Groups around the country but these are inevitably at different stages of preparedness. Firmer commitments from them about their plans for commissioning will be needed to ensure that aspirant trusts' financial projections are robust enough to withstand scrutiny.

Analysis of TFAs shows that, so far, 20 trusts recognise they will not achieve foundation trust status in their present form

22 The process of applying for foundation trust status has identified long-standing issues for 20 trusts which they cannot resolve in their current form. These issues are:

- very high levels of historic debt;
- for a small number of trusts, the ongoing cost of large PFI schemes;
- misalignment between hospital capacity and demand for services from commissioners; and
- imbalance between primary and secondary care.

23 Seventeen of the twenty trusts have already said that they are seeking merger partners among existing foundation trusts or other pipeline trusts or, in one case, with a private sector partner. Such mergers fit within a wider set of established processes around reconfiguration of hospital services, although these involve lengthy public consultations and take time to complete. The Department is developing contingency plans for intervention if trusts fail to identify a viable partner or alternative configuration, and has not yet publicly announced the circumstances under which it would act.

24 In the next few months it is possible that more trusts will declare that they are not viable in their current form. Among the TFAs signed off at the end of September 2011, were a group of trusts whose future as an independent entity depends on the results of further consideration of their financial situation by local trusts' boards, their SHAs, and the Department.

25 Modelling work done by the London SHA on the 18 non-specialist acute trusts in the Capital suggests that at least half cannot become financially viable in their current form. Compared to other regions, London has both the highest proportion, and the largest number, of trusts in the pipeline. They face complex problems individually, but there is also a wider underlying mismatch in parts of London between hospital capacity and demand from commissioners, and an imbalance between primary and secondary care. The SHA is working with all London trusts to identify ways to achieve sustainability in the long term.

Conclusion on the work done to date

26 Based on statements in the TFA documents, the processes the Department has put in place have introduced a new sense of purpose among NHS trusts in the pipeline for foundation trust status. The Department has made it clear that it is not in the business of maintaining back-door subsidies to financially weak trusts with a record of poor care. Even where foundation trust status is a realistic possibility, many trusts will need to substantially improve their performance. This will involve a step change in the quality of local management, together with close performance monitoring, and timely intervention by SHAs, the Department and, in due course, by the NHS Trust Development Authority, if trusts start to miss milestones. There are, however, at least 20 trusts that face such substantial and long-standing problems that they are not viable in their current form. The Department is now in the process of determining, with the NHS, how it will deal with these trusts.

Part One

Moving towards NHS foundation trust status

1.1 The Department of Health's policy is that providers of NHS services should become NHS foundation trusts. To demonstrate that they are ready to do so, NHS trusts must strengthen their board governance, implement financial disciplines that promote long-term financial viability and put in place a framework to secure delivery of quality services sufficient for them to operate in a more competitive economic environment than that faced by NHS trusts.

1.2 This part of the report outlines the background policy framework and describes the process for trusts in the pipeline.

NHS trusts and NHS foundation trusts

1.3 NHS hospitals were established as autonomous bodies known as 'trusts' under the 1990 NHS and Community Care Act. The 1999 Health Act brought them back under the control of the Secretary of State for Health, so that although they continued to function as independent bodies, the Secretary of State has the power to direct them in the exercise of their functions.

1.4 NHS foundation trusts were introduced by the 2003 NHS Health and Social Care Act. Since April 2004, NHS trusts have been eligible for authorisation as NHS foundation trusts. They were intended to be organisations whose accountability was oriented more towards patients and local communities than to the Department centrally. This greater independence had to be earned by passing through a rigorous assessment process designed to provide assurance that the trust is financially sustainable and well governed.

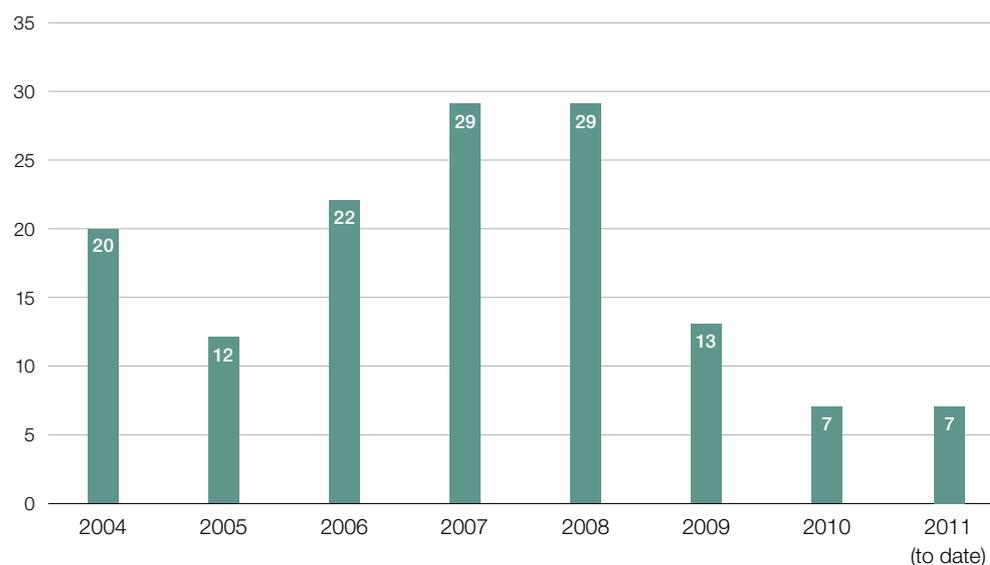
1.5 NHS foundation trusts were given much more financial and operational freedom than other NHS trusts. They remain within the NHS and their financial performance is regulated by Monitor, while their healthcare services are regulated by the Care Quality Commission, as with the rest of the NHS.

1.6 When it first created NHS foundation trusts, the Department announced that all acute and specialist hospitals should be in a position to apply for this status by 2008. By 1 October 2011, there were 139 foundation trusts, leaving 113 NHS trusts still to make the transition. The number of authorisations peaked in 2007 and 2008, but only 14 foundation trusts have been authorised since the end of 2009 (**Figure 1**).

Figure 1

The number of NHS foundation trusts authorised between 2004 and 2011 (to date)

NHS foundation trusts by year of authorisation



Source: National Audit Office

Relaunch of the NHS foundation trust concept

1.7 The Department continues to see NHS foundation trust status as an effective way of embedding sound financial management and high quality governance within NHS providers in order to promote their clinical and financial viability in the long term, while recognising that foundation trust status is not a guarantee of future success. The Government's White Paper *Equity and Excellence: Liberating the NHS* (July 2010) stated that:

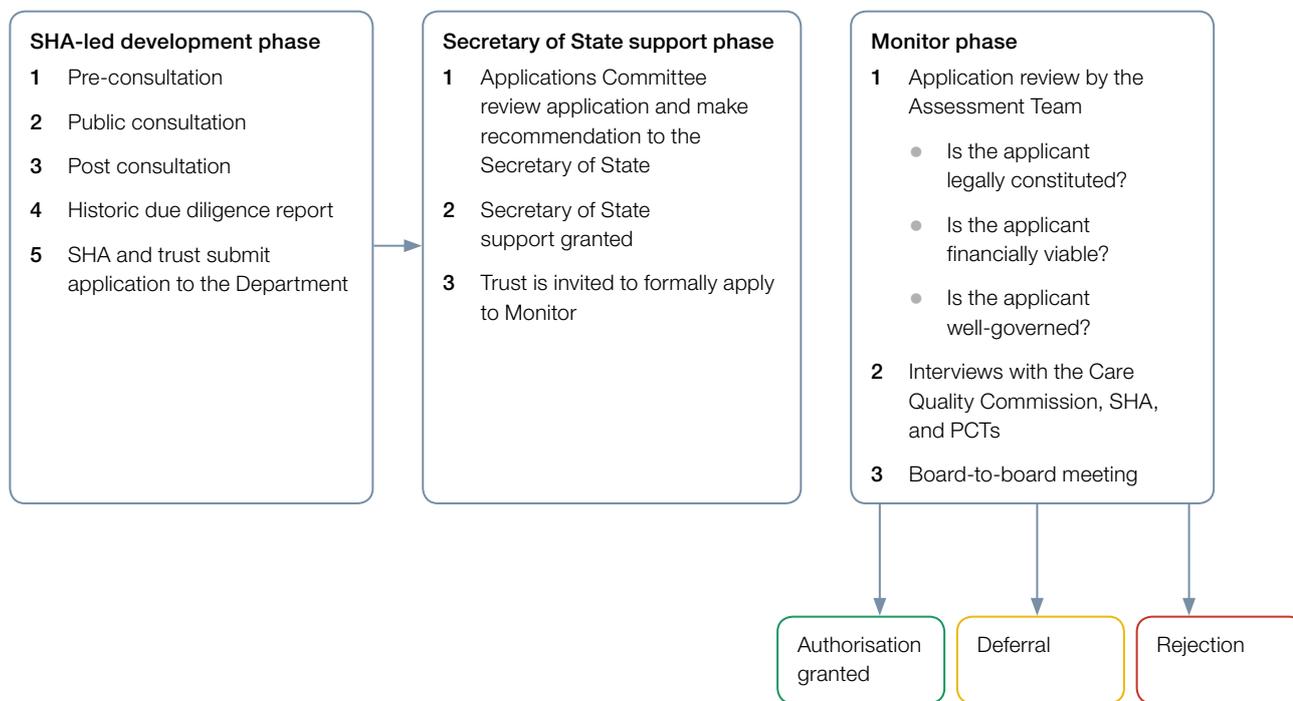
“Within three years, we will support all NHS trusts to become NHS foundation trusts. It will not be an option for organisations to decide to remain as an NHS trust rather than become or be part of an NHS foundation trust and in due course, we will repeal the NHS trust legislative model.”

1.8 The published Health and Social Care Bill (19 January 2011) reinforced this commitment by requiring NHS foundation trust status to be achieved by April 2014, after which it would be legally impossible to continue as a NHS trust. However, following further consultations and subsequent recommendations by the NHS Future Forum of expert advisers, in June 2011 the Government amended its plans so as to allow for ‘exceptional cases’ where the 2014 deadline could be extended.

Criteria NHS trusts must meet

1.9 Monitor is responsible for assessing and authorising applicants for NHS foundation trust status, and for their regulation afterwards. Before submitting an application to Monitor, trusts have to gain the approval of their Strategic Health Authority (SHA) and the Secretary of State (**Figure 2**). Once the SHA is fully supportive of the application, it goes forward to the Department of Health’s Applications Committee which reviews it and advises the Secretary of State on its merits. If approval is secured the trust submits its application to Monitor.

Figure 2
NHS foundation trust application process



Source: National Audit Office

1.10 Monitor assesses each applicant's eligibility for NHS foundation trust status by considering:

- the trust's legal constitution, including its level of public membership and draft constitution;
- the quality of governance, including the quality of the board, and its performance and risk management arrangements;
- evidence on the quality of services; and
- the trust's financial viability, including its integrated business plan, short-term financial health and long-term financial projections.

1.11 Monitor has published analysis that indicates there are five key reasons why, historically, trusts' applications for foundation status have not been successful. These are:

- effectiveness of the trust board – composition and lack of clarity about objectives and performance;
- strategic business planning – inability to think strategically and a lack of clarity and rigorousness in plans;
- service performance – failure to address performance within a reasonable and realistic time frame leading to questions about the board's effectiveness and hence the trust's ability to operate as an autonomous organisation;
- financial governance – lack of confidence in the trust's financial calculations and the underlying drivers of its cost base, including realism about the financial implications of loans and private finance initiative agreements; and
- quality of clinical governance – weaknesses in being able accurately to understand the quality of the care that the trust provides and commitment to continuous quality improvement.

1.12 For applicants now making submissions to Monitor, the process has become more demanding:

- In July 2010 Monitor tightened its assessment criteria for quality of governance in applicant trusts, in response to the tightening financial climate and the lessons learned from failings in patient care at Mid-Staffordshire NHS Foundation Trust.
- In April 2011 Monitor updated the efficiency assumptions it uses to assess applicants' plans, to reflect more challenging economic conditions.

The Department's process for trusts now in the 'pipeline'

1.13 Some NHS trusts have not so far applied to become NHS foundation trusts because they had not seen it as a priority and were not under concerted pressure to do so. Others have delayed application because they recognised they first needed to address financial weaknesses, improve poor performance or complete service reconfigurations, and some had been unable to complete the application process because of weaknesses in their application.

1.14 The Department has developed a structured approach to help the trusts in the pipeline meet Monitor's assessment criteria. All NHS trusts were required to sign a 'tripartite formal agreement' (TFA) with the Department of Health and their SHA. In view of the importance of commissioning intentions to the viability of trusts' financial plans, the lead Primary Care Trust (PCT) which will be buying services from each aspirant trust has also been asked to sign the TFA document to indicate their support. Once agreed, the TFA sets out the journey for each provider and is a public record of the commitments the NHS trust, SHA and Department of Health have made to achieve foundation trust status by a particular date.

1.15 The TFA documents make explicit that accountability for achieving NHS foundation trust status and supporting trusts through the pipeline is shared between all three parties (**Figure 3**).

1.16 The Department has resourced the pipeline centrally by setting up a dedicated team under the National Director of Provider Delivery, reporting to the Provider Development Board. Each SHA has a director of provider development, which in most cases is a dedicated post, working with the National Director in a Provider Executive Group. The cost incurred by the central team within the Department is £3.5 million a year, of which staff costs are £1.4 million, non-staff costs £0.1 million, and consultancy spend forecast to be £0.3 million in 2011-12. The balance of £1.7 million is funding the Department has been providing to trusts for a number of years to prepare them for foundation status, including historic due diligence. The cost to SHAs and individual trusts is unknown.

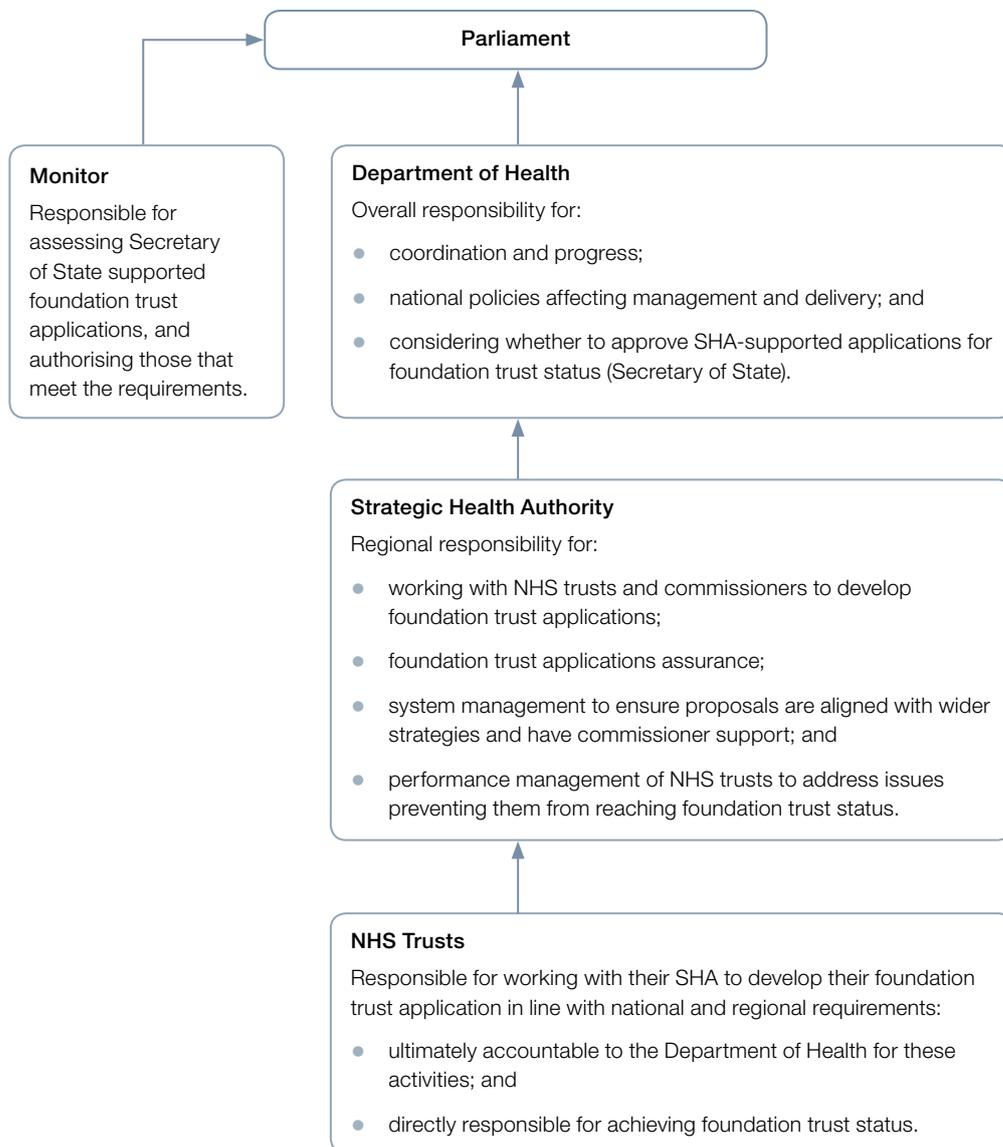
1.17 The Department is establishing an NHS Trust Development Authority, to be legally established in June 2012 and fully operational from April 2013. The new body will be a Special Health Authority. In addition to managing the pipeline, it will be responsible for performance management of all remaining NHS trusts, including their governance and risk, and for public appointments to them.

1.18 Monitor has expressed concern to the Health Select Committee that the pipeline of applications being submitted should be phased and not backloaded, and that the current programme will mean them receiving potentially as many as five applications per month for several years.¹ Even straightforward applications can typically take Monitor four months to process. Negotiations between the Department and Monitor are ongoing as to how best to make sure that the process remains manageable.

¹ Health Select Committee 10th Report, Session 2010-12, Annual accountability hearing with Monitor, HC 1431.

Figure 3

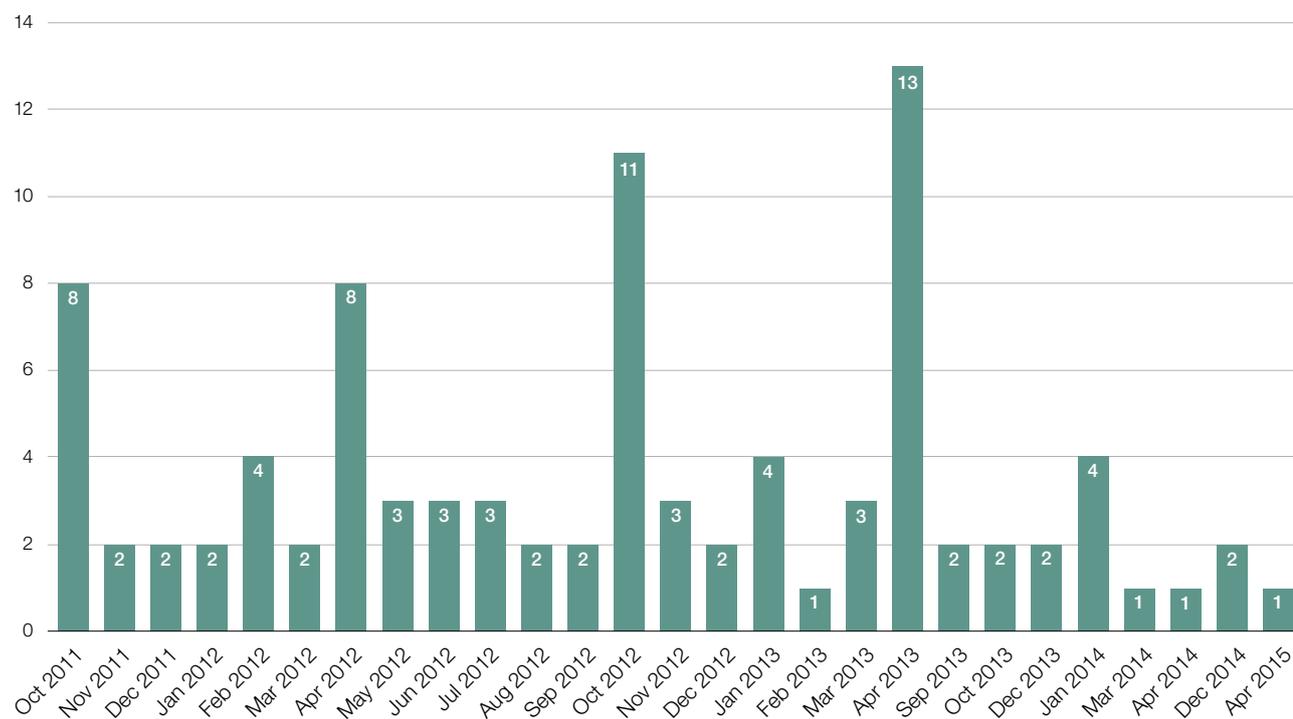
Accountabilities for the NHS foundation trust pipeline



Source: National Audit Office

1.19 It will take several years for the trusts currently in the pipeline to work towards foundation trust status. The dates that trusts are currently forecasting to submit applications to the Department, prior to submission to Monitor, will lead to peaks in October 2011, April 2012, October 2012 and, most notably, in April 2013 with a further 15 expected between May 2013 and April 2015 (**Figure 4**). There are 28 trusts, almost a quarter of those in the pipeline, which currently forecast that they will submit applications to the Department in April 2013 or later, and three trusts have yet to confirm an application date. The Department’s working assumption is that, on current projections, the NHS Trust Development Authority will be responsible for some 60 NHS trusts in the pipeline, including some which by that point will have applications being considered by Monitor. There is a risk, if challenged trusts fail to achieve milestones, that the number of applications submitted late in the process will increase further or that they will fail to reach the standard altogether. The Department recognises this risk and is developing the performance management arrangements and frameworks that it believes will ensure timely action to manage that risk.

Figure 4
Date of planned application submissions to the Department of Health



NOTE

1 This figure excludes 13 trusts that submitted applications to the Department before October 2011, four trusts that plan to merge and will not submit applications separate from potential partner organisations, and three where trusts have not at this stage confirmed an application date in their TFA.

Source: National Audit Office analysis of Department of Health data

1.20 There is more to do in some regions than in others. In the North East, for example, there is only one trust that has yet to become an NHS foundation trust. In five SHA regions, as at October 2011, at least half of all trusts had still to achieve NHS foundation trust status (**Figure 5**).

Figure 5

The number of trusts in the pipeline at 1 October 2011

Region	NHS trusts	Total trusts	Proportion NHS trusts (%)
London	26	42	62
West Midlands	17	30	57
East Midlands	8	15	53
South Central	8	16	50
South East Coast	9	18	50
East of England	13	28	46
South West	10	27	37
North West	14	42	33
Yorkshire and the Humber	7	23	30
North East	1	11	9
Total	113	252	45

Source: Department of Health

Part Two

Issues resolvable locally

Understanding the issues trusts are facing

2.1 After the Government announced its intention to reinvigorate the foundation trust process, in November 2010 the Strategic Health Authorities (SHAs) were asked to give the Department the following information about each NHS trust:

- the expected date for submitting a foundation trust application to the Department;
- the key milestones to submitting the foundation trust application;
- the key issues and risks for each NHS trust; and
- for each issue, what support is required at local, regional and national level to enable trusts to be ready for NHS foundation trust status.

2.2 SHAs placed NHS trusts into one of five categories, describing the scale of challenge they were facing (**Figure 6**). At that date there were a total of 120 trusts in the pipeline.

2.3 The 'tripartite formal agreement' (TFA), process described in paragraph 1.14, was intended to provide a sharper focus on the issues highlighted by SHAs in November 2010, specifically by:

- providing more detail specific to each of the individual trusts;
- helping the Department to quantify the extent to which similar issues are faced by different trusts across the country;
- requiring signatories to the TFAs to take responsibility for actions addressing these issues; and
- setting specific timetables for those actions and ultimately for the achievement of foundation trust status.

2.4 In November 2010 the Department categorised trusts as facing issues in one of four categories – financial, quality and performance, governance and leadership and strategic issues (**Figure 7**). The TFA process hugely increased the proportion of trusts identifying issues in all categories, reflecting the increased rigour and more in-depth analysis of the issues.

Figure 6

SHAs' informal categorisation of NHS trusts in the pipeline, as at November 2010

Category	Number of trusts	Percentage
NHS trusts with no quality, financial or performance issues to prevent them from becoming foundation trusts	42	35
NHS trusts with quality, financial or performance issues requiring external support to make them ready for applying for foundation status	29	24
NHS trusts with major financial issues such as PFI charges or legacy debt making it difficult to achieve foundation status in the near future	17	14
NHS trusts considered not clinically or financially viable in their current organisational form	16	13
Potential Community Foundation Trusts, not yet in operation	16	13
Total	120	100

NOTE

1 Percentages do not sum to 100 per cent due to rounding.

Source: Department of Health

Figure 7

The issues faced by trusts identified by SHAs and trusts

Issues	Assessment made by SHAs in November 2010 (Percentage of all trusts in the pipeline)	Assessment in TFAs, March-September 2011 (Percentage of all trusts in the pipeline)
Financial	49	80
Quality and performance	30	65
Governance and leadership	18	39
Strategic issues	59	78

NOTE

1 The analysis covers 120 trusts in November 2010, 113 trusts for TFAs. Some trusts will feature in more than one category.

Source: Department of Health

2.5 The Department required draft TFAs to be submitted by the end of March 2011. Some initial draft TFAs lacked detail, or were viewed by SHAs or the Department as overly optimistic about what could be achieved, requiring challenge by the SHAs to secure a greater degree of certainty that trusts' diagnosis of issues is complete and balanced, and to test whether the proposed actions were realistic before all the parties were prepared to sign. There was also a pause in the process in parallel with the Government's listening exercise during the passage of the Health and Social Care Bill. The Department finalised the TFAs for the final 46 of the 113 trusts in the pipeline on 30 September 2011, but in some cases conclusions and timetables are subject to decisions yet to be taken by local trusts' boards, their SHAs, and the Department.

2.6 Many of the major challenges identified in the TFAs as requiring action by SHAs and the Department are already well known within the local health economy, reflecting:

- in some cases, historic financial difficulties within the local health economy;
- the need to improve clinical outcomes by carrying out procedures in a smaller number of specialised units;
- the need to improve the patient experience by redesigning services to move procedures from a hospital to a community setting where appropriate; and
- the need to replace facilities which are no longer fit-for-purpose.

Financial issues are a major concern for trusts

Extent of financial issues

2.7 Many pipeline trusts face a range of financial issues, either singly or in combination, including:

- poor current financial position due to failure to manage demand, and/or treatment costs, including scope to achieve efficiencies;
- high annual payments required by contracts signed under the Private Finance Initiative, or the up-front costs of other capital investments;
- repayment of loans received from the Department which might or might not have a fixed repayment period; and
- a shortage of cash to fund day-to-day operations (working capital) or to pay debtors (liquidity).

2.8 While only 6 of the 113 trusts reported a deficit in their published accounts for 2010-11, some 90 trusts reported at least one financial issue in their TFA document. Acute trusts (hospitals) were more likely than other types of trust (mental health and community) to report that they faced financial issues, across all categories (**Figure 8**).

Figure 8
Trusts in the pipeline reporting financial issues

Issue	All trusts (%)	Acute trusts (%)
Current financial position	32	47
Level of efficiencies	58	74
Private finance initiative plans and affordability	19	31
Other capital plans and estate issues	38	41
Loan debt	21	23
Working capital and liquidity	37	40

NOTE

¹ Trusts may be counted under more than one heading.

Source: National Audit Office analysis of TFAs

2.9 The Audit Commission reported in August 2011 that during 2010-11, 16 NHS trusts received additional income totalling £90 million for strategic change or business support, and that the additional income for 12 of these trusts was greater than their reported break-even position. South London Healthcare and Barking, Havering and Redbridge University Hospitals NHS Trusts received additional advances of funds from the Department to fund capital investments, and four trusts received additional loans to improve their short-term financial health.²

2.10 The 2010 Spending Review settlement for the Department requires the NHS to make year-on-year efficiency gains of 4 per cent for the next four years. Trusts are expected to achieve cost efficiencies at the same time as improving their financial position to a sustainable and viable point. For trusts seeking to attain foundation status and that have existing financial difficulties, the challenge will be even greater. In 2010-11, trusts in the pipeline had a combined target of £1.47 billion of efficiency savings. The scale of the challenge means that, if trusts fail to achieve forecast income and expenditure from the outset, they will have to make up the shortfall in future years, increasing the risk that they will not achieve the timetable for foundation status anticipated in their TFAs.

Private finance initiative

2.11 Private finance initiative (PFI) commitments are cited as being an underlying cause for financial difficulties by a number of trusts. In some cases, trusts entered into long-term agreements with private sector partners to build new hospital facilities. The new buildings are privately financed, and the trusts have entered long-term agreements to pay for them through an annual charge.

² Audit Commission, *NHS financial year 2010-11 A summary of auditors' work*, August 2011.

2.12 As at March 2011, a total of 48 trusts in the pipeline had PFI schemes. PFI payments might impact on the ability of trusts to meet authorisation criteria for foundation status because of changes:

- to activity levels with changes in commissioner strategies;
- in the way that trusts are funded for service transitions;
- in the cost of capital and accounting policies; or
- in the requirement to make increased efficiency savings.

2.13 The Department carried out an initial review at the end of 2010, which looked at a sample of seven NHS foundation trusts with PFI agreements, eight NHS trusts with PFI agreements, and five potential schemes under consideration (two foundation trusts and three NHS trusts). The main factor affecting viability was whether trusts could generate a sufficient operating surplus to absorb finance and depreciation charges associated with the PFI, rather than the PFI deal itself.

2.14 In the summer of 2011, the Department asked McKinsey & Company to carry out a more detailed review of the finances of 22 trusts, with PFI schemes that were either operational, under construction or in procurement, where SHAs had decided that the associated costs of the scheme could be a barrier to the trust satisfying Monitor's assessment criteria for financial viability. The 22 trusts have a combined turnover of £7.4 billion with projected total annual payments of £763 million (varying between trusts from 5.6 per cent to 20.1 per cent of turnover), of which 45 per cent is interest payments.³

2.15 The initial analysis found that up to 6 of the 22 trusts were not viable under any of the tested scenarios. The Department is carrying out further analysis of their finances prior to submitting to HM Treasury a business case for refinancing or additional support on a case-by-case basis. Trusts potentially have scope in some cases to manage the situation through:

- identifying new sources of activity;
- rationalisation or leasing of surplus space;
- improving efficiency and productivity; and
- stronger contracting arrangements.

³ Some of these payments are notional, for year one of schemes not yet operational.

Loans and Liquidity

2.16 Monitor's requirements when assessing a trust's financial viability are that it can generate a sustainable surplus by year three of its business plan. Achievement of an acceptable financial risk rating is assessed against five metrics. One of these is that the trust has sufficient liquid reserves to cover a minimum of 15 days' operating expenses, (Monitor call this a 'liquidity risk rating of 3'). In order to help determine additional support that might be necessary to help trusts reach this position, the Department carried out an analysis, based on 2009-10 figures, for the 99 pipeline trusts in existence at 31 March 2010 (excluding community trusts). The analysis showed that up to 36 trusts in the pipeline did not meet the Monitor liquidity risk rating, even with access to 30 days of additional working capital facility. The Department calculated a figure of £376 million as the size of the loan facility that would need to be made available to these trusts in order to meet Monitor's minimum liquidity requirement if their financial situation did not improve in the meantime. The Department is discussing with HM Treasury whether access to the working capital facility could be offered by the Department rather than commercial banks to reduce borrowing costs to trusts. In the case of University Hospital Southampton NHS Foundation Trust, their £10 million share of this facility was made available to them upon authorisation as a foundation trust on 1 October 2011.

2.17 The Department carried out a further analysis of pipeline trusts' financial position in July 2011, and concluded that about half (excluding newly created community trusts) were to a greater or lesser extent likely to require funding in addition to efficiency savings they expected to be able to achieve locally (**Figure 9**).

Figure 9

Assessment of the extent to which trusts have sufficient working capital without additional support

Categories	Number of trusts in each category
Trusts that are likely to meet assessment criteria with their current liquidity, cash and debt	51
Trusts that may require some additional loans	25
Trusts that are very likely to require additional loans or restructuring of their debts (or both)	16
The most challenged organisations requiring case by case review	7

NOTE

1 This analysis excludes newly created community trusts.

Source: Department of Health

Tackling quality issues

2.18 Monitor published amendments to the quality performance threshold in July 2010 and highlighted, in published lessons learned from recent applications for foundation trust status, the importance it expects trusts to attach to continuous quality improvement.⁴

2.19 A high proportion of trusts in the pipeline have service performance issues that may impact on their ability to achieve foundation trust status (**Figure 10**).

2.20 By way of illustration, the Department monitors the performance of acute trusts against key quality of care indicators, for example the 18 weeks referral to treatment standard, and meeting cancer waiting times. The most recent published data, for April to June 2011, shows that for these indicators:

- Four of the seventy acute trusts in the pipeline achieved all five of the referral-to-treatment standards, but five did not achieve any;
- Four trusts did not achieve the standard for a maximum two week wait for a first outpatient appointment for patients referred urgently with suspected cancer by a GP.

2.21 The Department also rates the performance of NHS trusts against performance measures from the NHS Operating Framework. Eleven pipeline trusts were categorised as ‘underperforming’ on user experience (eight in London). On quality of services as a whole, two trusts were classed as ‘challenged’ (the most serious category).

Figure 10

Quality issues among trusts in the pipeline

Issue	Number of trusts	Proportion of trusts in the pipeline reporting this issue (%)
QIPP	43	38
Quality and clinical governance issues	31	27
Service performance issues	35	31

NOTES

1 Trusts may be counted under more than one heading.

2 The Quality, Innovation, Productivity and Prevention (QIPP) programme aims to secure £15-20 million savings across the NHS by the end of 2014-15.

Source: National Audit Office analysis of TFAs

4 Monitor, *Lessons learned from recent NHS foundation trust applications*, 10 January 2011.

2.22 It is primarily the responsibility of local management to develop plans for service improvement, overseen by trust Boards, local SHAs and the independent regulator, the Care Quality Commission (CQC). Analysis of papers considered by the Provider Executive Group indicates that it has initially focused more on financial issues than quality and service performance. Within the pipeline process, NHS North East led a project seeking to better align the Department's performance framework and quality review undertaken as part of the pipeline process with Monitor's compliance framework and standards applied by CQC, and this common approach is now being rolled-out to trusts.

Tackling governance and leadership

2.23 Monitor has highlighted that a common shortcoming in aspirant trusts is weakness in the quality of governance and leadership. The SHAs we spoke to also emphasised that the quality of leadership in individual trusts, including the capability of executive teams, will be critical to addressing financial and quality issues identified in TFAs. For 44 trusts in the pipeline (39 per cent), TFAs identify board capacity and capability, and the quality of non-executive input, as an obstacle to achieving foundation trust status. Nearly 30 trusts indicate in their TFA that they were involved in board development activity.

2.24 The East of England SHA had already prepared an assurance framework to support the SHA's opinion on whether trusts in its pipeline are ready to apply for foundation trust status. The framework includes a set of detailed checklists for assessing board capacity.

2.25 The NHS National Leadership Council proposed in January 2011 development of a diagnostic tool for board development, which the Council expected would need to be applied to around 60 trusts to make them ready for foundation trust status. Subsequently, the Department's Provider Executive Group set up a working group in April 2011 to develop a set of products which boards could use to assess their own readiness for foundation trust status, and to help them address weaknesses identified. The working group includes a representative from Monitor, as well as individuals with senior management experience in trusts and SHAs.

2.26 The Department's aim is to further develop a model governance and leadership 'assurance framework'. The framework will establish a common approach which aspirant trusts, SHAs, the Department and the prospective NHS Trust Development Authority can all use to take assurance. The Department, supported by Deloitte and a range of experts and stakeholders, have developed a draft Board Memorandum on board capability, and self-assessment tools. Draft products for assessing board capacity and capability are being piloted with a view to launch in the near future. Firm decisions have still to be made about how the new products might be rolled-out to other trusts in the pipeline through a list of approved suppliers. The Department also recognises that some trusts will need further professional support.

Performance management

2.27 For interventions to be effective, they must be supported by a robust performance management framework that can identify risks and trigger action in good time. In June 2011, the Department's Provider Executive Group considered proposals for directors of provider development in each SHA to complete a monthly template assessing progress made by the trusts in their region. This would inform discussions between the SHA and the Department, leading to a red/amber/green rating for each trust and for the SHA as a whole. This information will feed into reports for senior management teams in the NHS and the Department.

2.28 The Department anticipates that SHAs will monitor trusts' progress against timelines as part of their normal performance management approach. The Department did not require the ten SHAs to use a standard approach to managing the pipeline, and SHAs will have adopted local mechanisms. As an example, **Figure 11** sets out the performance management framework that has been put in place by NHS North West. Compared with the dedicated resource used by NHS North West, some other SHAs have no resources dedicated full-time to managing their local pipeline, although all have very challenged trusts in their region.

Figure 11

The North West SHA's detailed performance management framework

Key element in the NHS North West performance management framework	Explanation
TFA and accountability agreement	Accountability agreements were introduced by NHS North West to underpin each TFA. The agreement sets detailed milestones, and specific 'covenant tests'.
Reporting and monitoring	Performance against milestones is monitored on a monthly basis. Assessments on a red/amber/green scale feed into the Department's assessment for the pipeline as a whole.
Covenant tests	Trusts are required to notify the SHA immediately if they fail a covenant test. If a covenant test is breached, the trust will be deemed to be under 'special measures' triggering direct SHA intervention.
Transition directors	The SHA has allocated transition directors to provide regular face-to-face support to the trusts assessed as high risk.

Source: NHS North West

2.29 From 1 October 2011, the ten SHAs have clustered into four groups. Each has a director of provider development, and the Department intends that there will be a single operating model in place across all four by the end of 2011.

2.30 The Department has put in place a national framework to monitor progress against milestones and track risks. Once TFAs are agreed, progress against timelines will be monitored by SHAs. The Department has asked each SHA to report monthly on progress against milestones and, following discussion with the Department, to agree the level of risk in each case. Ultimately, this information will flow to the NHS Management Board. If there are concerns about trusts' progress the SHA will address these through its existing performance management arrangements.

Part Three

Issues requiring strategic solutions

3.1 The Department's November 2010 survey of Strategic Health Authority (SHAs) showed that there would be a hardcore of trusts that would need an escalated level of intervention. For some of these trusts, the problems they face cannot be solved managerially at the trust level – they depend on a strategic solution to issues in the local health economy. A common feature is a complex web of problems that often go back many years. Past experience of successful applications does not necessarily offer a solution to the problems faced by the most challenged trusts, for which new approaches will be needed.

Some of the issues trusts face cannot be addressed locally

3.2 There are 46 trusts (40 per cent of the 113 trusts in the pipeline) where sign-off of the 'tripartite formal agreement' (TFA) was not until the end of September 2011. This was either because trusts were required to give more thought to their analysis of the issues or because the process of agreeing the set of actions they and the Department will need to take was not complete.

3.3 Most significantly, 20 trusts were assessed as being not financially and/or clinically viable in their current form, of which all but three are acute hospital trusts. Some of the problems these trusts face in achieving the required standards of financial and clinical sustainability are beyond the ability of either the trust or the SHA to solve in isolation at a local level and will need strategic intervention by the Department.

3.4 Seventeen of the most challenged trusts have already announced that they are seeking alternative solutions through merger with, or takeover by, another NHS trust or NHS foundation trust or, in one case, with a private sector partner, meaning that three remain. Their future, together with a number of others which have classed themselves as 'viable' contingent on external support, depends on decisions taken by the Department with regard to:

- liquidity;
- PFI debt where the scheme has proved to be unaffordable; and
- reconfigurations across the wider local health economy.

3.5 Some of the SHAs and trusts we spoke to explained why reconfiguration of services might be necessary. A common issue is an excess of certain types of capacity due to the centralisation of specialised services, movement of treatment for some conditions out of hospitals into community care, and moves to reduce unnecessary hospital admissions.

3.6 Where reconfiguration is needed, all partners have an important role to play to make sure that services are reorganised successfully:

- The trust must make sure that service performance can be maintained and invest time to communicate with stakeholders and secure the buy-in of clinicians.
- SHAs must make sure that trusts' plans to realise savings by reorganising care pathways and estates are compatible with commissioners' forward plans, especially once clinicians assume commissioning roles. In some areas this will also involve new community trusts, also within the pipeline. SHAs will also have a continuing performance management role.
- The Department is responsible for making sure that the process and criteria for assessing potential reconfigurations is clear, and for providing support to the other parties.

The challenge is greatest in London

3.7 The London health economy presents some particularly challenging issues. Compared with the other nine regions, London has the lowest proportion of trusts that have achieved foundation trust status (38 per cent), and the highest number of trusts (26) still in the pipeline. The SHAs we spoke to in other regions agreed that, while some individual trusts in other parts of the country face similar problems, the concentration and complexity of challenges in London are not replicated elsewhere.

3.8 There are some complex specialist teaching hospitals in London, and individual trusts with local challenges, but also a number of strategic issues. Problems in London are complex, but NHS London's broad assessment is that:

- there are too many hospitals, relative to the population, in parts of the capital, leading to duplication of services;
- in parts of the capital there is an imbalance between primary and secondary care, so hospital accident and emergency departments are too often used by people with relatively minor health problems who should be treated in the community;
- in some trusts there is more capacity, some of which has been funded through PFI investment, than commissioners need;
- PFI contracts limit the flexibility some trusts have to reconfigure their services and they have associated long-term financial commitments; and
- there is still scope for productivity and efficiency improvements in many trusts.

3.9 Within the London pipeline are a group of eight particularly challenged acute trusts. The sign-off of these trusts' TFAs was not completed until the end of September 2011. Seven of these are not expecting to submit their application to the Department of Health before 2013 (the eighth expects to have merged with another trust by then). All eight cited the sustainability of the local health economy as an issue. All but one cited the level of efficiencies required of them, and more than half cited service reconfigurations, current financial position, PFI schemes and loan debts.

3.10 NHS London has developed a model that estimates, for the 18 non-specialist acute trusts in London,⁵ the gap between income and cost, and predicts future viability of trusts in their current configuration based on a range of assumptions about the scope for efficiency improvements and PCT clusters' likely commissioning intentions. The SHA estimates that, even if they achieve productivity savings in the top quartile of their peers or better, at least half of the trusts in the pipeline cannot achieve foundation status in their current form. The SHA is working with all London trusts to identify ways to achieve sustainability in the longer term, and the Department will also need to be engaged in this process.

3.11 These issues are particularly noticeable in the area covered by NHS Outer North East London, which powerfully illustrates the complex task facing the Department around the most challenged trusts, and why solutions in such cases are likely to require the coordination of the future plans of a number of local providers and commissioners. The three acute trusts – Barking, Havering and Redbridge University Hospitals, Newham University Hospitals and Whipps Cross University Hospitals – have assessed themselves, for different reasons, as being not viable in their current form. Barking and Newham are two of the six NHS acute trusts that recorded a deficit in 2010-11. During 2010-11, all three trusts received additional one-off financial help from the Department.

3.12 Aside from the ongoing financial challenges that these trusts face, the future of Barking, Havering and Redbridge is linked to a major strategic reconfiguration of services in the area which has been reviewed by the Independent Reconfiguration Panel and, at the time of our fieldwork, was awaiting a final decision by the Secretary of State, while the other two trusts are discussing a possible merger with Barts and the London NHS Trust. Barking is also currently the subject of an investigation by the Care Quality Commission into the quality of care provided across many of its services.

When intervention is required, solutions will have to be applied on a case-by-case basis

3.13 As noted in paragraph 3.3, some trusts have acknowledged their lack of long-term viability and have started to set out plans in their TFA documents to merge with partner foundation trusts, for example. Some trusts that continue to pursue a foundation trust solution for the moment will ultimately be unable to achieve foundation status, because they cannot achieve the progress milestones they set out in their TFA and assessed under the performance management system, or they cannot gain Departmental or Monitor approval at their respective stages of the process.

⁵ The study did not look at all London trusts in the pipeline.

3.14 The Department has identified a number of potential interventions which could, subject to consultation and local and national political support, be used to tackle the problems faced by the most challenged trusts (**Figure 12**). These ideas are at an early stage. The Department is still developing, within the pipeline ‘process’, an agreed mechanism to deal with issues which cannot be resolved by trusts and SHAs locally. The most challenged trusts will need potentially complex, locally-tailored interventions. The Department has not yet identified solutions for all such cases including, ultimately, a publicly understood ‘failure regime’. The Committee of Public Accounts has made it clear, however, in their report on the Health Landscape, that it is imperative the Department puts in place clear and transparent policies for dealing with failure of commissioners or providers to ensure patients are protected and value for money is assured.⁶

Figure 12

Examples of potential interventions which may be needed to address strategic issues

Potential intervention	Explanation
Strengthening the management team from within the NHS	Appointment of a strong board with proven NHS management experience, with a short-term contract to address the issues the trust faces. Strengthening of boards has been an ongoing process across NHS trusts, prompted partly by new chief executives and partly by SHAs.
Appointment of an external management team	The team would have a contract to deliver the financial, quality or performance improvements needed to make the trust ready for foundation trust status.
Operating franchise	The franchisee would take full responsibility for operating the trust, with scope to make whatever operational changes are needed to prepare the trust for foundation trust status.
Acquisition by, or merger with, an existing foundation trust or other NHS trust	Some trusts are already exploring this option in response to the issues identified in their TFAs. There might be instances where the Secretary of State would have to intervene to order compulsory takeovers or mergers.

Source: Department of Health

Appendix One

Methodology

Our methodology was designed to obtain an overview of the pipeline process from the perspective of the three primary signatories to the tripartite formal agreements: the Department of Health, Strategic Health Authorities and NHS Trusts. We visited three SHAs and six NHS trusts. The trusts we selected were chosen to help us understand how trusts are approaching different challenges and obstacles to achieving foundation trust status. They are not representative of the population of NHS trusts in the pipeline as a whole.

Methods

Interviews with Department of Health officials

We carried out face-to-face interviews with key officials responsible for:

- directing the pipeline process;
- evaluating 'tripartite formal agreements' (TFAs);
- developing central support for boards and executive teams; and
- developing the Department's strategy for managing PFI debt among aspirant trusts.

Document review

We reviewed key papers at the Department of Health, including:

- papers provided to the Provider Executive Group and other analyses of pipeline trusts carried out by the Department;
- draft analysis of the extent of PFI debt;
- NHS London modelling of acute trust finances; and
- draft tools to support board development.

Quantitative analysis

We carried out summary analyses of:

- published financial accounts for all 113 trusts in the pipeline for the four years 2007-08 to 2010-11; and
- signed TFA documents.

Purpose

To develop an understanding of:

- the Department's role in the pipeline process;
- the Department's approach to evaluating TFA documents; and
- the approach the Department is taking to providing central support to SHAs and trusts in the pipeline.

To understand:

- governance arrangements for the pipeline process; and
- the tools and other central support for SHAs and trusts the Department is developing.

To assess and understand:

- the extent and nature of financial issues faced by trusts; and
 - the extent and nature of issues identified by trusts in the TFA documents.
-

Methods	Purpose
<p>Semi-structured interviews with Strategic Health Authorities</p> <p>We carried out face-to-face interviews with senior managers in three SHAs:</p> <ul style="list-style-type: none"> ● NHS London; ● NHS West Midlands; and ● NHS North West. <p>In addition, we carried out telephone interviews with:</p> <ul style="list-style-type: none"> ● NHS Yorkshire and Humberside; ● NHS South East Coast; ● NHS South West; ● NHS South Central; and ● NHS East of England. 	<p>To understand:</p> <ul style="list-style-type: none"> ● SHAs' role and responsibilities in the pipeline process; ● how SHAs are supporting NHS trusts; and ● SHAs' views of the support they need from the Department of Health.
<p>Visits to NHS trusts</p> <p>We carried out semi structured interviews face to face with senior managers at six NHS trusts:</p> <ul style="list-style-type: none"> ● South London Healthcare NHS Trust; ● Barking, Havering and Redbridge University Hospitals NHS Trust; ● University Hospital of North Staffordshire; ● The Shrewsbury and Telford Hospital NHS Trust; ● St Helens and Knowsley Teaching Hospitals NHS Trust; and ● The Pennine Acute Hospitals NHS Trust. 	<p>To understand:</p> <ul style="list-style-type: none"> ● NHS trusts' role and responsibilities in the pipeline process; ● how trusts are approaching obstacles to achieving foundation trust status; and ● trusts' views of the support they need from SHAs, the Department of Health, and commissioners.
<p>Consultation with other stakeholders</p> <p>We discussed the issues with colleagues at:</p> <ul style="list-style-type: none"> ● the Care Quality Commission; and ● Monitor. 	<p>To understand:</p> <ul style="list-style-type: none"> ● key stakeholders' perspectives on the risks and challenges to be managed in the pipeline process; and ● how key stakeholders are engaging with the Department of Health within the pipeline process.



Design and Production by
NAO Communications
DP Ref: 009720-001

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