The King's Fund

Ideas that change health care

Financial failure in the NHS

What causes it and how best to manage it

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1 Introduction

The case for having a well-understood, transparent and automatic regime for dealing with financial failure is clear. First, it should return a struggling organisation to financial good health or find an alternative way to provide services to patients. Second, its existence should provide incentives to other organisations not to fall into similar financial difficulties and thus help to improve NHS efficiency more widely. Without such a system there is a danger that the NHS is pushed into providing 'bail-outs' that prop up inefficient services and blunt incentives for efficiency.

However, it has proved hard to design and implement such an approach in the NHS. The 2009 Health Act set out a new system for handling financial failure which the 2012 Act built on. This introduced the role of trust special administrator (TSA) that would take over a failed organisation with the dual role of running it while also finding a sustainable long-term solution for its services.

The TSA model was arguably designed for a landscape of generally financial robust organisations with a few limited cases of financial difficulties. Instead the NHS faces a rising tide of financial distress that has meant an increasing number of organisations have had to rely on central Department of Health support. This has increased the emphasis on 'pre-failure' interventions and led to a wider array of support and sanctions being placed on struggling organisations. At the same time, the focus in many areas has begun to switch from struggling organisations towards struggling local health economies. This recognises that sometimes both the cause and solution to one organisation's financial difficulties lie in making changes in commissioning or in the organisation of other providers. Within this context, it has become increasingly difficult to identify what constitutes financial failure rather than financial underperformance.

This report describes the current financial state of the NHS and the drivers of financial failure before setting out the approaches used to avert financial failure or to deal with it once it occurs. We finish with some recommendations for the future.

2 The current financial health of the NHS

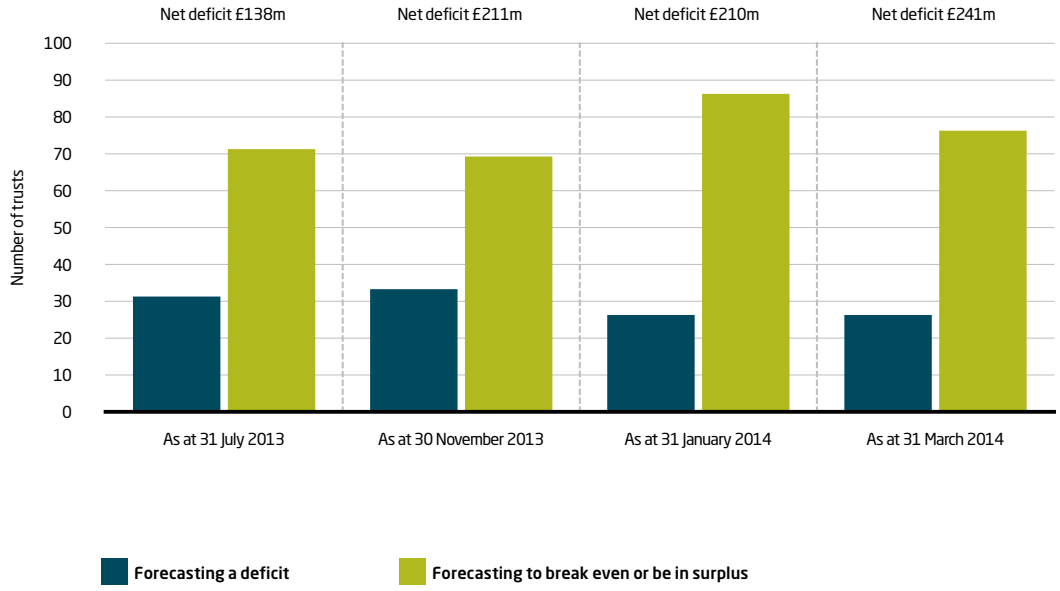
The NHS has faced an unprecedented and sustained slowdown in spending growth in recent years. Until 2013/14 the system appeared to manage rather well in releasing efficiency savings, meeting demand and in maintaining quality of care. However, in 2013/14 both on finance and on performance the first signs of real stress began to appear. Some providers were put into special measures because of failings in the quality of care, but many more faced overspends. This section sets out the latest financial performance information.

Current financial position in NHS trusts and foundation trusts

2013/14 was a challenging year for both NHS trusts and foundation trusts.

The NHS Trust Development Authority (TDA) reported a net deficit for NHS trusts of £241 million in 2013/14 (draft accounts), compared with a planned net deficit of £76 million at the start of the financial year. Twenty-five NHS trusts finally ended the year (2013/14) in deficit (**Healthcare Financial Management Association 2014**). This represents just over 25 per cent of all NHS trusts in England, compared with just 5 per cent in 2012/13. Although the number of NHS trusts forecasting a deficit fell as the year progressed the overall size of the deficit increased, indicating a pattern towards fewer, bigger deficits (*see* Figure 1, overleaf).

Figure 1 Financial performance of NHS trusts



Source: NHS Trust Development Authority (2013; 2014d, e ,f)

Monitor reported a gross deficit for NHS foundation trusts of £307 million in 2013/14, compared with a planned gross deficit of £190 million at the start of the financial year. Forty NHS foundation trusts ended the year (2013/14) in deficit (*see* Figure 2, opposite). This is just over 27 per cent of all NHS foundation trusts in England, compared with 14 per cent in 2012/13. In contrast to NHS trusts, the net foundation trust position has been driven more by declining surpluses than rising deficits (Monitor 2014e).

Financial reports from the NHS TDA and Monitor for the first few months of 2014/15 show a further deterioration in the financial position. The NHS trust sector reported a net deficit of £300 million for the four months to 31 July 2014, compared with a planned deficit of £224 million, and 33 NHS trusts (34 per cent) are now forecasting deficits for 2014/15 (NHS Trust Development Authority 2014b). A report by Monitor on the first quarter 2014/15 described 'unprecedented financial and operational pressure' on the foundation trust sector resulting in a net deficit of £167 million, compared with a planned deficit of £80 million. This net figure included deficits at 86 foundation trusts (close to 60 per cent of the total) adding up to £227 million (Monitor 2014h).

Figure 2 Financial performance of foundation trusts

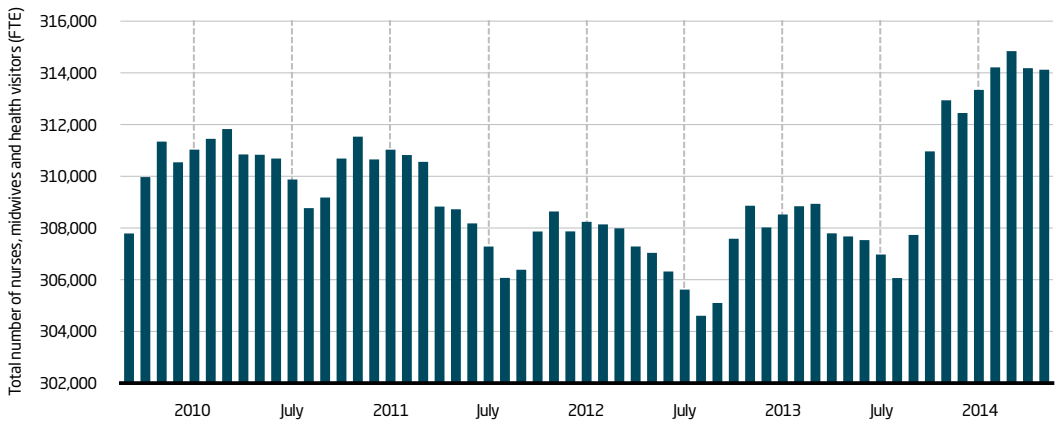
Source: Monitor (2013a,b,c, 2014f,g)

Part of the deterioration in financial performance is likely to be due to providers being unable to find sufficient efficiency savings. Increases in demand across the NHS – whether in emergency admissions, GP referrals or elsewhere – all need to be met if service standards are to be maintained. For many organisations the balancing act between finance and performance is becoming impossible to maintain. Monitor cited 'demand pressures, the need to maintain care quality and the under-delivery of planned cost improvement programmes' as reasons for the large overall deficit in the foundation trust sector in early 2014/15 (Monitor 2014h).

Growing staff numbers are another factor behind the increasing financial pressure on trusts. The impact of various reports on the quality of care provided by the NHS – from the Francis Report on Mid Staffordshire hospital (Francis 2013), to Sir Bruce Keogh's inquiries (Keogh 2013) and Don Berwick's review (Berwick 2013) and a revitalised Care Quality Commission (CQC) – appears to have led to renewed growth in the number of nurses. Between August 2013 and March 2014, the number of nurses, midwives and health visitors employed by the NHS grew by nearly 9,000 (2.9 per cent), bucking seasonal trends and boosting the nursing workforce to its highest level ever (*see* Figure 3).

While this increase will hopefully help to deliver better services, there is a difficult trade-off with budgets as hospitals face continued pressure on their finances (Appleby *et al* 2014b). Indeed this led Monitor to comment on Foundation Trusts, 'staff numbers have increased 4.1 per cent (24,000), compared with 1.4 per cent (8,000) in the plan and 2.4 per cent last year, despite generally lower activity and revenue growth this year. This suggests at least some part of this growth in headcount is attributable to other factors, such as the impact of the findings of Keogh and Francis on clinical staffing levels' (Monitor 2014g). Difficulty with recruitment and retention of permanent staff means that many trusts are relying on temporary staff to maintain these levels. Monitor has highlighted this as a particular factor in the growth in expenditure across the foundation trust sector, noting that spend on contract and agency staff in the first three months of 2014/15 was double the planned figure (Monitor 2014h).

Figure 3 Total numbers of full-time equivalent qualified nurses, midwives and health visitors



Source: Monthly NHS Hospital and Community Health Service (HCHS) Workforce Statistics in England – March 2014, Provisional statistics www.hsic.gov.uk

Overall assessment

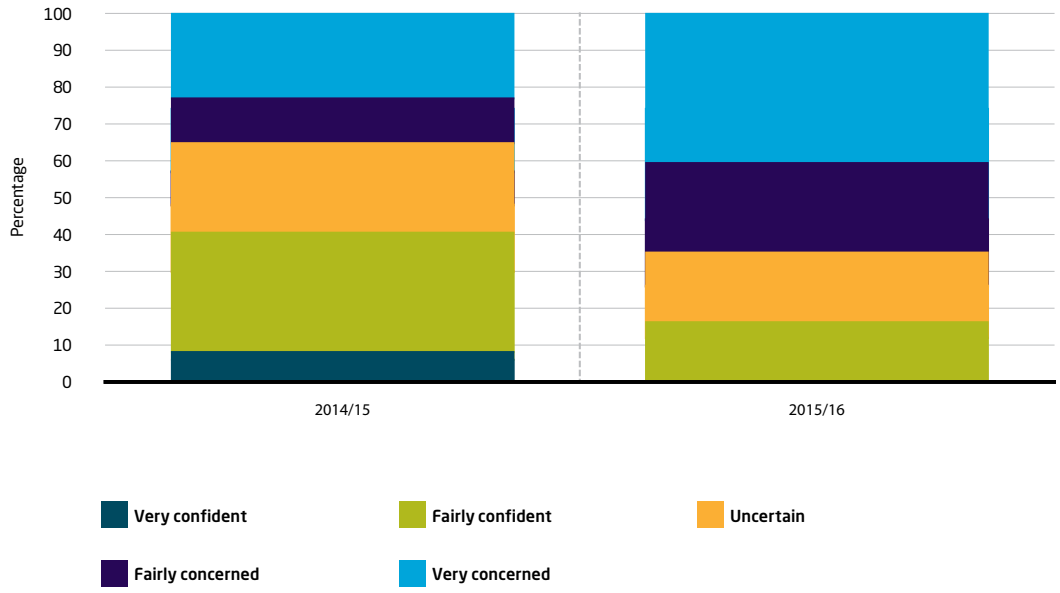
- The dramatic slowdown in funding growth for the NHS since 2010/11 (and prospects for near-zero real growth for some years to come) has re-emphasised the need to get the greatest value for every pound spent. On current plans it is clear that financial pressures are increasing and are unlikely to diminish in the near future.

- Savings are becoming harder to achieve, and demand for services is growing.

- The 2013/14 financial year ended with around a quarter of trusts and foundation trusts in deficit. The use of previous years' surpluses by many trusts and the draw-down of money carried over from 2012/13 at national level to offset higher than planned spending in some areas helped to keep budgets more or less in balance across the NHS as a whole. With net deficits in the NHS trust and foundations trusts sectors significantly larger than planned for the first months of 2014/15, this year already looks rather worse than last.

- The evaporation of the large annual underspend the NHS has produced since 2006 means that any improvement in performance in 2014/15 must come with effectively no growth in real term spending. With GP referrals, emergency admissions and accident and emergency attendances continuing to rise, it is difficult to see how the NHS will manage this pressure, even without renewed staff recruitment aimed at raising quality of care. Figure 4, which is based on a survey undertaken in March this year, shows how confident finance directors are that they will be able to balance the books. This does not take into account the further decline identified in recent reports by the NHS Trust Development Authority (2014b) and Monitor (2014h), and it is likely that confidence is now even lower.

Figure 4 Confidence in achieving financial balance in 2014/15 and 2015/16



NB: Sample size = 74 (out of 249). Survey carried out in March 2014. Trust finance directors' question:
'Looking ahead, how confident are you that your organisation will achieve financial balance in 2014/15... and in 2015/16?'

Source: Appleby *et al* (2014b)

3 What drives provider financial failure?

This section looks at the factors driving financial failure. While focusing on money, in some cases finance, quality and wider organisational failure are all interlinked and this appears to occur particularly when there are weaknesses in leadership, management and governance. We begin by looking at this common driver of failure before moving on to consider other factors more associated with financial failure alone. While weaknesses in leadership appear to explain some of the difficulties individual organisations have fallen into, it is these other factors that are likely to lie behind the current surge in financial distress across the NHS.

Weak leadership, management and governance

Weak leadership and poor governance are a recurrent feature of failing organisations, financial failure and failures in the quality of care (Walshe 2003; Audit Commission 2006; House of Commons Health Committee 2006; Monitor 2014g). As Dorgan *et al* have demonstrated (Dorgan *et al* 2010) management practices are strongly related to a hospital's quality of patient care and productivity outcomes.

The importance of leadership and governance is not limited to skills and capabilities of managers. It has been repeatedly underlined (Higgins 2001; Dorgan *et al* 2010; The King's Fund 2011; Care Quality Commission *et al* 2014) how essential active clinical engagement is in the management and oversight of an organisation. This is as true for financial good health as for quality of care. The Audit Commission notes that in cases of financial failure, 'it is striking how often clinical leaders… have become disengaged from the core management processes of the organisation' (Audit Commission 2006) and the converse also applies; where financial recovery was beginning, this was closely linked to stronger clinical engagement and the importance of genuine clinical ownership of the financial situation could not be overstated.

The Audit Commission (Audit Commission 2006) has identified three key governance issues that can contribute significantly to the risk of failure:

- inadequate calibre of leadership – particularly the chair, chief executive and finance director
- lack of board cohesion and inability to challenge – compounded by high turnover of board directors, both executive and non-executive, impeding the board's ability to work as a team
- the board's 'eye being off the ball' – typically as a result of merger, a large building project or other big strategic project.

Higgins also identified failures in systems and processes including planning and performance management. Governance weaknesses can be compounded by weaknesses in the quality of performance monitoring and forecasting. For example, budgets that are not supported by robust financial analysis or implementation plans and therefore have little credibility within the organisation (Audit Commission 2006), or incomplete quality dashboard data and little triangulation with external forms of assurance (Keogh 2013).

A common response to poor performance is the removal of the chief executive and/or others from the senior leadership. Given the importance of leadership this may seem an appropriate response. However, it is also clear that stability in senior leadership is a common feature of high-performing organisations and rapid turnover at the top can become part of the problem rather than the solution (Ham 2014b). Equally, even a well-led organisation will struggle if confronted by a toxic combination of low funding, high demand and a poorly aligned local health economy.

Weak leadership or governance are to some extent internal issues. Even in times of relatively low financial pressures such weaknesses can still lead to deficits. However, the NHS is certainly not in a period of easy finances and the increasingly hostile external environment can expose other issues, though many of these will not have been caused by the current leadership and are not necessarily under its control. We now look at some of these external factors.

Other causes of financial failure

Palmer (2005) identifies a further set of underlying causes of deficits, including: 'legacy costs' particularly associated with past capital investment; 'stranded capacity' for example associated with the shift of activity from hospital to the community; and the design of national 'Payment by Result' (PbR) tariffs.

Legacy costs

Palmer argues that the average cost of provision for each hospital trust is a legacy of past investment and service delivery decisions that cannot readily be reversed, and the fixed nature of the national tariff means that trusts with high legacy costs will be disadvantaged.

This has often been linked to the presence of large private finance initiative (PFI) schemes. A good example is Peterborough and Stamford Hospitals NHS Foundation Trust. The PFI cost for 2013/14 was £40.4 million making the trust's estate costs very high at 22 per cent and £22.2 million above the Department of Health's current 'approval threshold' benchmark (PWC 2013). As a result, the department announced it would provide additional support for up to seven organisations it had identified as having excess PFI costs, including Peterborough and Stamford (Department of Health 2012). However, more recent work by Monitor (Monitor 2014a) found PFI to be linked to improved financial performance, indicating that in general, newer hospitals are reaping the benefits of better design indicating that these seven are the exception rather than the rule. However, this means 'legacy' issues still apply to those with potentially out-of-date facilities.

Stranded capacity and costs

There has been concern that falling levels of hospital activity, for example due to the 'care closer to home' principle, may threaten financial stability. Under PbR net losers of activity will see reductions in income and rises in their unit costs which, given a fixed national tariff and capped commissioning budgets, will leave a funding gap unless trusts can diversify their income sources outside the NHS. Palmer calls this 'stranded capacity' and the associated costs as 'stranded costs'. However, there has been no such fall in activity in recent years at a national level, rather providers are struggling to deal with rising numbers of patients within constrained budgets although the Better Care Fund was intended to lead to falls in emergency

admissions in 2015. However, the risk of such stranded capacity for providers can mean that proposals that are good for the local health economy generate financial problems for acute providers and the resulting lack of progress leads to poor financial (and clinical) outcomes.

The payment and pricing system

The efficiency factor applied to the tariff year on year means that the larger the proportion of tariff income the tougher the financial challenge for a trust (Monitor 2014a) and hospitals have faced a real cut in PbR prices of 6.3 per cent between 2010/11 and 2014/15 (Appleby *et al* 2014a). In addition, though sometimes patchily enforced and despite recent revisions, the marginal tariff for emergency admissions can increase the gap between trusts' costs (driven by increasing activity) and their incomes. For many trusts this rate does not reflect the cost of meeting additional demand, and the financial impact can be significant (Foundation Trust Network 2013). Decisions on tariff reflect the overall challenge to the NHS on finance: simply raising the tariff is not an answer as it would mean commissioners (with their capped budgets) can buy less from providers.

In addition, the national tariff is an average even if it does attempt to take account of local variation in costs, eg, between more expensive care delivery in central London when compared to outer London and indeed the rest of England. However, apart from a relatively narrow set of input prices, ie wages, PbR does not take into account other factors that can make it difficult to provide high-quality care at tariff. Although the configuration of services or other factors such as rurality may increase costs, these are excluded. Only recently has Monitor allowed 'local' variations to prices, which we return to in the next section.

This increasing mismatch between the funding available and the demands on the system is of course also felt in services not paid for by PbR, such as mental health and community health services, even if, to date, their financial performance has tended to be better than that of acute hospitals.

Relationship between provider, commissioner and the local health economy

Trusts in financial difficulty often have a belief that problems are externally created and beyond the organisation's control. The Audit Commission (Audit Commission 2006)

suggested that 'the effect is to render the organisation and its management as relatively powerless in the short-term and not in charge of its own destiny'. This can be triggered by a belief that a trust is not being paid fairly by its local commissioner. It is interesting to note that Monitor identified differences between commissioners and providers in a number of their compliance notices (Monitor 2014d), and an independent review of the financial difficulties experienced by Heatherwood and Wexham Park Hospitals NHS Foundation Trust described a poor and deteriorating relationship between the trust and the local commissioner (Verita 2011). This can be compounded when commissioners are themselves underfunded when measured by the clinical commissioning group (CCG) allocation formula (or primary care trust (PCT) formula before the reforms). It may be difficult for operators in a health economy to make difficult decisions on services when these decisions would not be needed if the area was receiving its 'fair share' of NHS spending.

More broadly, the sustained slowdown in NHS spending since 2009 means many local health economies are struggling to meet demand and maintain quality within their budgets. To date, most of the financial pain has been felt by providers rather than commissioners. Proposals such as increases to tariff can redistribute the pain but are not likely to reduce it for the NHS as a whole given the financial constraints on commissioners, unless the changes succeed in aligning incentives across the health economy and this is complex to achieve. Individual providers can face the consequences of wider weaknesses in the local health economy whether from poor primary care, lack of co-ordination across care pathways and providers or, indeed, from cutbacks to social care. This can mean in turn that the solution to a provider's financial difficulties lies in co-ordinated action across a health economy. This will be one factor driving the NHS TDA's assessment that 12 existing NHS trusts are unsustainable in their current form with most looking to be taken over by, or merge with, another nearby provider (NHS Trust Development Authority 2014c).

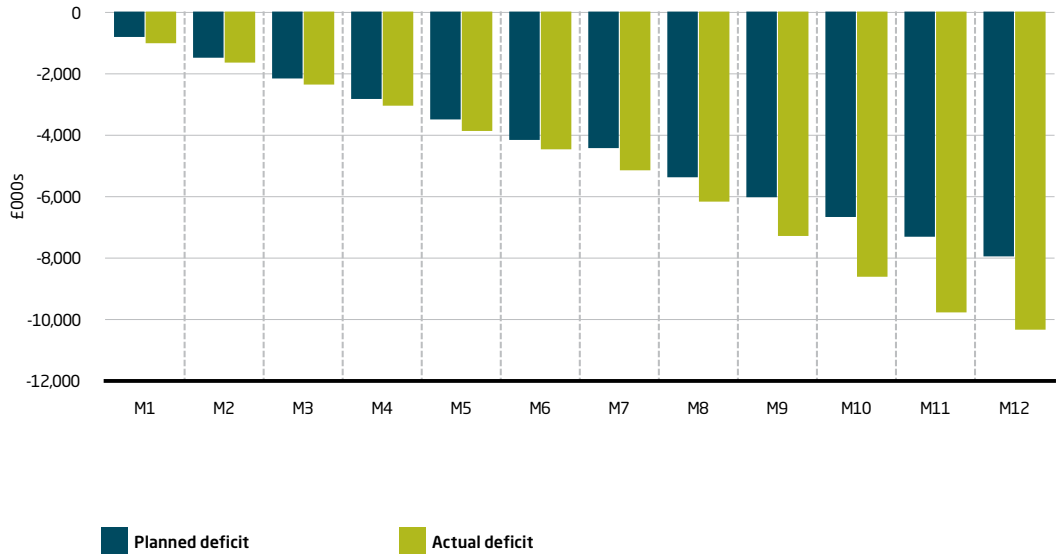
The interaction between special measures and financial distress

Following the publication of the Keogh report (2013), five NHS trusts and six foundation trusts were placed in special measures in July 2013. A year later these trusts have been re-inspected by the Care Quality Commission (CQC) to see what improvements in quality and safety have been made. Of the original group only two – George Eliot Hospital NHS Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust – were recommended to be taken out of special measures completely.

A recent analysis (Calkin 2014) revealed that trusts in special measures are predicting a collective deficit of almost £140 million this year. According to this analysis, five of the 11 trusts in special measures plan to end 2014/15 with deficits equivalent to between 10 and 12 per cent of their turnover. Many of the trusts say increased expenditure on nursing to improve the quality of care is a key factor in their financial position. This is consistent with the CQC's review which found the inadequate ratings on safety and caring were often due to low staffing levels (**Care Quality Commission *et al* 2014**). However, as discussed later, it is not always easy for struggling organisations to recruit substantial extra staff.

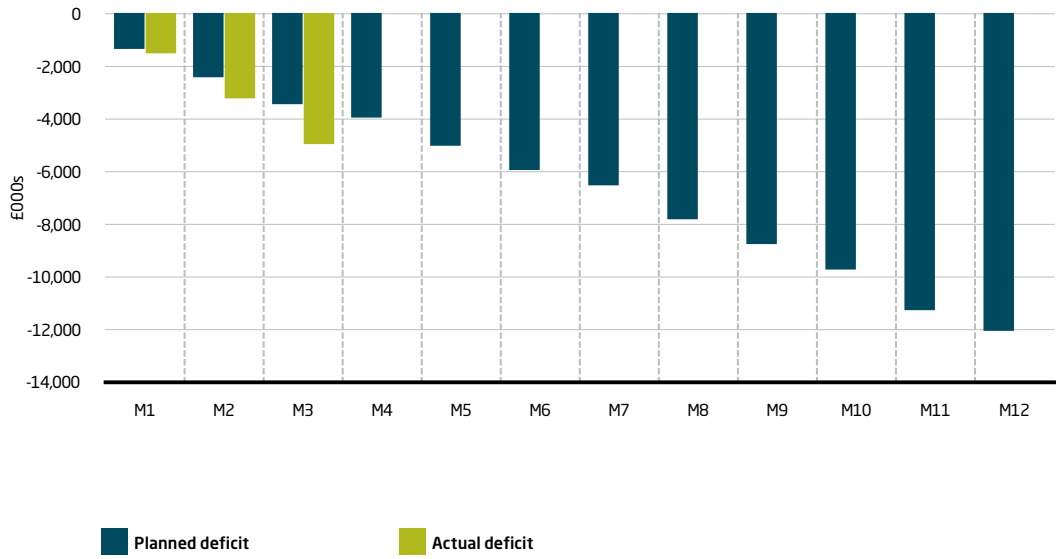
Being taken out of special measures as quality of care improves may indeed come at the cost of increasing deficits. Hence George Eliot Hospital ended 2013/14 with a deficit of £10.2 million against a plan of £7.9 million, and forecast a further £12 million deficit for 2014/15 (*see* Figures 5 and 6). The trust cites 'continuing cost pressures related to additional capacity used and higher than planned levels of agency staff' as the reason.

Figure 5 George Eliot Hospital NHS Trust – 2013/14 financial position



Source: George Eliot Hospital NHS Trust (2014b)

Figure 6 George Eliot Hospital NHS Trust – 2013/14 financial position



Source: George Eliot Hospital NHS Trust (2014a)

The other provider to be taken completely out of special measures, Basildon and Thurrock University Hospitals NHS Foundation Trust, moved in 2013/14 from forecasting a surplus of £0.1 million to an actual deficit of £9 million, with a further substantial deficit forecast for 2014/15 (Basildon and Thurrock University Hospitals NHS Foundation Trust 2014b,c). It pointed to 'an investment in quality… which had, at its heart, the recruitment of an additional 200 nurses' (Basildon and Thurrock University Hospitals NHS Foundation Trust 2014a).

When caught between an apparently clear conflict between quality of care and financial balance, so far the conflict is being decided in favour of the former. Returning to financial balance in such circumstances – and with no respite from increasing NHS expenditure in sight – will be very challenging.

Conclusion

We have entered a period in the NHS's history when even the best-managed organisations are struggling to avoid financial distress. Further, some of the drivers of this distress are not immediately within the control of a single organisation or are complex; this has already led the NHS into a more nuanced response to financial distress than was intended by the 2012 Act.

4 Managing failure

Avoiding failure in the first place

Many of the systems and processes applied by Monitor and the NHS Trust Development Authority (TDA) are specifically designed to avoid failure and, if they do not succeed, to prepare the way for alternatives. Monitor's approach both for NHS foundation trusts and for independent sector providers is based on its risk assessment framework (Monitor 2014i). This sets out a set of tests applied to essential NHS services (Commissioner Requested Services) which aim to 'identify any signs of a provider getting into financial difficulty early enough for all concerned to take steps to safeguard essential NHS services'.

These continuity of service tests lead to a risk rating of between 4 (no evident concerns) to 1 (significant risk) with escalating intervention from Monitor as the level of risk increases. For foundation trusts these ratings are combined with a further set to ensure good governance, which itself provides further assurance against failure.

The NHS TDA applies a similar methodology that escalates from level 5 (standard oversight) up to level 1 (special measures) (NHS Trust Development Authority 2014a). Many tools used to manage failure are available by the time a provider has reached 'high risk' under either the TDA or Monitor model. For example, under special measures a trust could:

- be required to develop an improvement plan
- be subject to a capability review of its leadership
- lose elements of its financial autonomy
- be required to take on an improvement director appointed by NHS TDA
- be required to partner with a high-performing organisation.

This set of interventions generally targets weaknesses of leadership, whether of capability or sheer capacity. However, as they focus primarily on the failing organisation itself they are less well able to tackle broader health economy relationships and misalignments and, as such, may leave a core group of providers that cannot deliver financial balance without more co-ordinated intervention and support.

Financial support and tariff

When an NHS organisation can no longer pay its bills, this does not mean that these bills – including salaries for staff – don't get paid. Rather, a range of financial assistance is available to ensure that there is no interruption in services. Until introduction of the 2012 reforms, much of this support, often referred to as 'planned support', is believed to have been channelled by strategic health authorities (SHAs) and primary care trusts (PCTs) to trusts, although the extent and frequency of such support was not transparent. Though by its nature sometimes difficult to identify, the National Audit Office (NAO) estimated that in 2011/12, SHAs and PCTs provided some £161 million of additional revenue to support providers (National Audit Office 2012). In addition, the NAO estimated there was a further £274 million of non-recurrent support, although some of this second funding stream will represent local agreements on financing new services rather than support for struggling organisations. One of the objectives of the 2012 Act was to end 'bail-outs' and instead deal directly with the underlying challenges facing trusts in deficit. However, the most immediate impact was to transfer the responsibility for providing finance from commissioners back to the Department of Health in the form of loans or Public Dividend Capital. In fact, even before 2013 the Department of Health did provide some Public Dividend Capital to NHS trusts and NHS England has continued to provide some moderate support to trusts, making available £60 million to the NHS TDA in 2013/14 (NHS Trust Development Authority 2014f).

Loans

The Department of Health can choose to make loans to troubled organisations. It has long provided loans through the Foundation Trust Financing Facility to foundation trusts looking to finance capital investment. Loans can now be made to both trusts and foundation trusts through the re-named Independent Trust Financing Facility (ITFF). These can still provide finance for capital investment

but can also provide cash for other purposes. The critical restriction is that organisations must be able to show they can meet the interest on loans and repay the principal and for some this will mean showing they have a turnaround plan that can return the organisation to financial health.

Public Dividend Capital (PDC)

Organisations cannot always reasonably repay loans and as a backstop – and again through the ITFF – the Department of Health can provide PDC to ensure an organisation has sufficient cash. Under normal circumstances PDC is not repaid although a dividend is payable on the outstanding PDC. In the five years from 2006/07 to 2011/12, the Department of Health provided PDC to 21 organisations (National Audit Office 2012) but the number has since risen sharply. In 2012/13 12 organisations received revenue PDC because of financial difficulties (NAO 2013) rising to 31 organisations receiving 'interim deficit support' in 2013/14 (Department of Health 2014a). In theory the ITFF could refuse to issue PDC if an organisation had no recovery plan, however, as this would result in an NHS organisation failing to pay some of either its salaries or other bills, it has never happened. This means that no NHS trust or foundation trust has ever truly 'failed' in the way that private sector organisations have done, and reinforces the need for 'pre-failure' regimes as applied by Monitor and the NHS TDA to avoid, as far as possible, reaching this point.

Though financial support of one form or another is intended to be short-term, this is not always the case and there are examples where NHS organisations have received support over many years. This both underlines the difficulty for the NHS in having a truly credible exit strategy in relation to large providers and can also make it more difficult to persuade local stakeholders that difficult decisions are necessary to achieve financial balance.

Increases in tariff for specific organisations

The 2012 Act allows increases to the national tariff for specific organisations if they can prove providing essential services is uneconomic (Monitor 2014c). This may be with or without the agreement of commissioners, but in all cases it needs Monitor's agreement. Monitor is currently considering a first set of such tariff modifications and it includes, for example, a request from the University Hospitals of Morecambe Bay NHS Foundation Trust for a £17 million increase in its prices (Dowler 2014).

Though this seems like a straightforward method to fund organisations facing unavoidable cost pressures and thereby avoid deficits, this is not the case. This is because commissioners themselves must live within cash-limited budgets and raising the prices they pay will mean they can buy less, if not necessarily from the trust benefiting from the increase in tariff, then from other local organisations.

Turnaround, contingency planning teams, whole health economy interventions

Even if loans, PDC or other financial support mean hospitals can pay their bills while in deficit, it is on the basis that financial performance must improve over time, and support comes with the expectation of a successful recovery plan. However, in many cases, organisations are not left to themselves to develop and implement these plans.

Turnaround teams were used with some success the last time many NHS organisations ran into deficit in 2005 (although the widespread deficits were already apparent in 2004). This earlier experience with overspends came at a time of rapid growth in NHS spending and, apart from a more limited number of deeply indebted organisations, was soon corrected despite around a third of NHS organisations overspending in 2005 (**The King's Fund 2006**). For many organisations with small deficits financial discipline was relatively easy to reassert, while those with more deep-seated deficits were provided with intensive support through turnaround teams. In 2012/13 this appeared to have been successful; almost all of the 2005 turnaround trusts had achieved financial balance, even if for some this was through merger. The same was true of a further group identified as being in 'extreme difficulty' by the Health Select Committee (**House of Commons Health Committee 2006**). However, from the perspective of 2014 the picture is far less positive (*see* Table 1). Many of these organisations – even in their new merged form – have since fallen back into difficulties. This is evidenced in two ways: first, auditors can refer trusts to the Secretary of State for failing to meet their break-even duty taking one year with another and for failing to have a robust plan to restore their finances (**Audit Commission 2014**). Second, financial performance can be tracked through the risk ratings from Monitor and the NHS TDA. Many organisations in Table 1 that were managing to break even or run surpluses in 2012/13 are falling back into deficit in 2014/15. This underlines both how much more difficult the financial context has become for many providers, and just how challenging it can be to find a long-term solution to persistent underlying problems.

Table 1 2005/06 and 2012/13 year-end finances of 2005 turnaround trusts and trusts in 'extreme difficulty'

Organisation	2005/06			2012/13		2014/15 status
	Financial position (£000s)	Position as % of turnover	New organisation (if relevant)	Financial position (£000s)	Position as % of turnover	
Barnet and Chase Farm NHS Trust	-8,994	-3.6%		639	0.2%	Auditor referral to Secretary of State. Subsequently taken over by the Royal Free London NHS Foundation Trust.
Brighton and Sussex University Hospitals NHS Trust	-11,290	-3.7%		3,325	0.5%	NHS TDA oversight rating 4 'material issue' as at 31 January 2014.
George Eliot Hospital NHS Trust	-7,294	-8.8%		32	0.03%	Auditor referral to Secretary of State.
Mid Yorkshire Hospitals NHS Trust	-15,000*	-5.2%		-21,839	-4.7%	Auditor referral to Secretary of State.
The Shrewsbury and Telford Hospital NHS Trust	-12,142	-6.4%		81	0.03%	Auditor referral to Secretary of State.
University Hospital of North Staffordshire NHS Trust	-15, 059	-5.0%		235	0.05%	Auditor referral to Secretary of State. Planned acquisition of Stafford Hospital after dissolution of Mid Staffordshire NHS Foundation Trust.
Surrey and Sussex Healthcare NHS Trust	-40,281	-27.8%		254	0.11%	Auditor referral to Secretary of State.
West Hertfordshire Hospitals NHS Trust	-26,785	-12.8%		1,904	0.68%	NHS TDA oversight rating 4 'material issue' as at 31 January 2014.
Hammersmith Hospitals NHS Trust	-18,484	-4.3%	Imperial College Healthcare NHS Trust	9,025	0.9%	NHS TDA oversight rating 2 'emerging concerns' as at 31 January 2014. Rating was improving.

Organisation	2005/06			2012/13		2014/15 status
	Financial position (£000s)	Position as % of turnover	New organisation (if relevant)	Financial position (£000s)	Position as % of turnover	
The Royal West Sussex NHS Trust	-13,298	-13.5%	Western Sussex Hospitals NHS Foundation Trust	5,034	1.4%	Monitor Risk Rating 3 'no evident concerns'.
South Tees Hospitals NHS Trust	-21,396	-6.7%	South Tees Hospitals NHS Foundation Trust	14,840	2.79%	Monitor Risk Rating 2 'material risk' and subject to enforcement action.
Queen Elizabeth Hospital NHS Trust	-19,289	-14.5%	South London Healthcare NHS Trust	-44,718	-10.16%	South London Healthcare NHS Trust dissolved and Queen Elizabeth Hospital subsequently passed to Lewisham and Greenwich NHS Trust.

Source: House of Commons Health Committee (2006)

***Projected year-end by Department of Health** **Source:** Department of Health (2013b)

Although the phrase 'turnaround' is no longer used, many of the tools now adopted by local health economies and national bodies have similar features, particularly the provision of external support and expertise to help an organisation develop and potentially implement a plan to restore its finances. In the current system this can include partnering with a high-performing organisation that can then share its skills and capabilities with the struggling organisation. However, in 2005/06 the NHS was also benefiting from continued significant increases in funding and the number of trusts that required intensive turnaround was relatively few. No such significant increase in NHS funding is expected in coming years and the number of organisations in severe difficulties is already high. As of 30 July 2014, Monitor alone has already placed 10 foundation trusts in its highest risk rating and made them subject to enforcement action, more than the number of providers in turnaround in 2005 (Monitor 2014b).

Where a provider has got into difficulties through weaknesses in its own leadership such tailored support can help it return to financial health as there is nothing fundamentally unsound with its business. This does not mean that the current leadership of an organisation is at fault: it can take time to turn round an organisation's finances and quality of care and too high a turnover in leadership

will hold back recovery rather than help it. However increasingly the challenges facing NHS organisations are more deep-seated and require co-operation across commissioners and multiple providers. In such cases providing additional support to the provider alone may miss the point if services are misaligned across the health economy.

Two new interventions are available that attempt to work across organisations. First, in 2014 NHS England, Monitor and the NHS TDA provided funding to help 11 challenged health economies develop plans that tackled these underlying issues (NHS England 2014). The funding largely provided consultancy support and could be considered a form of 'turnaround' for the whole local health economy. The results of this new programme have not yet been announced.

Second, where the risk to essential services looks high (risk level 1), Monitor can appoint a contingency planning team (CPT). The CPT works with both the provider and commissioners to consider options for local services and although its focus is on restoring the financial viability of the foundation trust, these teams also work closely with commissioners to develop potential alternative service configurations and provide a view on how the necessary changes may be implemented. CPTs have been used in Mid Staffordshire, Peterborough and Stamford and will report on Queen Elizabeth Hospital, King's Lynn. Again, with only two completed examples it is early days to assess the success of the CPT model and it is important to note that the CPT can be a prelude to the appointment of an administrator.

Trust special administrator (TSA)

The NHS does have an administration regime and this is sometimes referred to as the 'failure regime'. This reflects its original status as the final stage for an unsustainable provider – the point at which other action has not been successful and it has formally 'failed'. The regime was first set out in the 2009 Act, revised in the 2012 Act (this extended its scope to include NHS foundation trusts, for whom the regime follows a slightly different legal process) and again in the 2014 Act. It has been used twice, beginning in July 2012 at South London Healthcare NHS Trust and then again in April 2013 at Mid Staffordshire NHS Foundation Trust.

The key elements of the regime are (Department of Health 2013a):

- **Appointment of the TSA**, either by the Secretary of State (NHS trusts) or Monitor (foundation trusts). The TSA replaces the chair and directors of a trust or the governors of a foundation trust and exercises day-to-day control of the organisation. In addition the TSA must develop recommendations on how the problems of the organisation can be resolved.

- The TSA then has 65 working days to develop its **draft report** followed by a 40 working day public **consultation** on the draft recommendations.

- Following the consultation the TSA has 15 working days to produce a **final report** which goes to the Secretary of State (trusts) and Monitor (foundation trusts).

- On receipt of the report, the Secretary of State has 20 working days to make a **decision**. Monitor also has 20 days and, if it agrees with the report it then goes to the Secretary of State who has a further 30 days. The Secretary of State can veto the report on specific grounds but if they do so more than once they must then decide within 60 days what alternative action to take.

The Secretary of State and Monitor can extend the deadlines and did so during the processes at South London and Mid Staffordshire, although subsequent revisions to the regime in the 2014 Act have increased the basic timescales.

The regime in some way mirrors the administration regime used in the private sector and was intended to provide a clear, rules-based and quick resolution to 'failure'. The experience with the two TSAs to date has, however, underlined both the complexity and the exceptional nature of the NHS that makes 'failure' so difficult to deal with. In the first case, the decision to dissolve South London Healthcare NHS Trust was successfully challenged in the courts on the grounds that the overall package made recommendations on a neighbouring provider which was outside of the scope of the legislation at the time (the regime has since been amended by the Care Act 2014). In the second case at Mid Staffordshire NHS Foundation Trust the process has again been threatened with legal challenge and the TSA solution also relies on an ongoing subsidy from NHS England. We set out below why finding sustainable solutions can be so difficult. These factors apply to many if not all alternatives to resolve financial failure when this requires more than a change of leadership in the failing organisation.

Whole health economy solutions

When administrators are appointed in the private sector, their objectives are threefold (PWC 2014):

- rescuing the company as a going concern

or failing that

- achieving a better result for the company's creditors as a whole than would be likely if the company were wound up (liquidated) without first being in administration

or failing that

- realising property in order to make a payment to one or more secured or preferential creditors.

Critically, the administrator acts in the interest of the company's creditors and not for customers or alternative suppliers unless, of course, they also happen to be creditors.

However, in the NHS altering services at one provider is almost bound to have a knock-on effect, either for patients or commissioners or for surrounding organisations, and these impacts matter. For example, closing a service at a failing organisation may save that organisation money, but from the perspective of the wider NHS, it only does so if the surrounding hospitals can treat the redirected patients more cheaply than the 'failed' organisation. If not, the problem is simply passed on. A by-product of keeping NHS costs down by running hospitals with very low levels of spare capacity is that few providers can absorb large numbers of redirected patients without a long lead time in which to invest and develop their services. Therefore if the NHS 'market' was allowed to identify which providers were to fail, someone would need to develop a plan for how to handle the consequences of failure before anyone actually went out of business, and get other local providers to agree it.

In addition, with the NHS as a whole facing a major funding challenge, it may be in some areas that the only way to restore a provider's finances is through a complex plan involving changes to primary care, community health services and social care as well as other nearby acute providers. The formal powers of Monitor, the NHS TDA and the trust special administrator apply primarily to providers once they are rated at risk or are placed into the failure regime. This can create a challenge if the real issue lies within the wider health economy, of which the provider's distress is only a symptom rather than the cause.

The need for interaction across multiple bodies at local level is mirrored at a national level. The 2012 reforms left a complex web of relationships across the Department of Health, NHS England and clinical commissioning groups (CCGs), Monitor, the NHS TDA and the Care Quality Commission (CQC). As the response to distress reaches beyond a single organisation, these national bodies increasingly have to agree a shared approach. Recognition of this need is growing and one of the goals of joint work commissioned by NHS England, Monitor and NHS TDA in 11 troubled health economies is to bring commissioners and providers together (NHS England 2014). Indeed the five-year strategic plans requested by the national bodies in December 2013 also adopted a local health economy approach, although it is not yet clear what the outcome of these new approaches has been.

Skills and capacity

Key to the Monitor and NHS TDA risk ratings is an assessment of an organisation's leadership capability; a theme that is also reflected in the 'well-led' domain in the CQC's assessment methodology. This is well founded given the importance of leadership and governance in the stability of an organisation. Providing additional support, replacing individual leaders, or in the case of the TSA regime replacing the entire leadership, are all elements of the turnaround toolkit. In addition, the Dalton Review is also looking at ways high-performing organisations can help weaker organisations improve and builds on some existing examples of 'buddying' between organisations (Department of Health 2014c). Given the evidence on the importance of clinical leadership and engagement this must apply also to medical and clinical staff.

However, leading major change programmes, including reconfigurations, requires enhanced skills not only in the organisation in question but often right across the local health economy, and it may be difficult for even the best leaders to compensate

for weaknesses in partner organisations. These weaknesses may be around skills or simple capacity (not least for commissioners who must also live within tight running cost controls). An individual's usual 'day job' can make it difficult to contribute the substantial resources over long periods of time which designing and implementing a plan usually requires.

Alongside issues of capability and capacity across the local health economy, the 2012 reforms have removed the system leadership role of the strategic health authorities. Within the reformed system it is no longer clear who is responsible for developing and co-ordinating a 'plan' when one is needed. While commissioners may seem the obvious candidate, they can lack the scale and coverage required given commissioning is now split between multiple CCGs (which on average are smaller than PCTs) and NHS England. They are, of course, also relatively new organisations and do not have the direct leverage over providers that Monitor and the NHS TDA have. Once in administration, the TSA can, by default, provide some of this organising or convening focus even if this was probably not the initial intention behind the model. Outside of the TSA model, the lack of a clear system leader looks problematic when large-scale change is required (**Ham *et al* 2013**).

The importance – and difficulty – of providing leadership can be particularly serious as organisations become threatened. At the most extreme, once an organisation is in administration, the challenge of recruiting and retaining good staff is understandably hard as the organisation may only have a short shelf life and its leaders (the administrators) by definition are not there for the long-term. Critically, organisations struggling with their finances must avoid also failing on clinical safety and quality.

Time and money

In the private sector there is a limit to how much time, money and appetite there is for turning around a failing organisation's finances. This is because simply closing the business is always an alternative to struggling on. However, as set out above, 'closure' in the NHS is no guarantee of improved financial performance if patients simply transfer to another (potentially just as expensive) organisation for treatment and given that alternative providers must have sufficient capacity to absorb any influx of transferred activity.

Apart from the issues of co-ordination across a local health economy, turning around deep-seated finance and performance issues can take both time and money.

- First, as set out in **Appleby *et al* 2014b**, complex change in the health service can rely on developing, implementing and then reaping the gains of new models of care. In most cases it is neither quick nor costless to introduce such new services. Finances can only improve after the newly organised services can realise the savings that they can get through delivering better health or better management of patients and thus reducing capacity.

- Second, even where the root causes of financial or performance problems lay within a single organisation, these have been caused by, or contributed to, poor morale and a culture of disengaged staff, and it can take time to turn around a negative culture. One of the enabling factors behind many high-performing organisations is stability in leadership (**Ham 2014b**), a luxury that many organisations – especially struggling ones – are denied due to the rapid turnover in senior leadership.

Engagement with staff, the public and politicians

Many people care passionately about their local hospital and are quick to rally to its defence when its services or staff are threatened. Even where change appears to be necessary, persuading them that difficult choices must be made is not easy. The same can be true of staff, although engaging them early in developing and delivering necessary changes, rather than imposing these from the top, can help significantly (**Ham 2014a**).

Financial failure can be particularly challenging as many people would be happy to see an increase in spending on the health service to maintain services and are not happy to see money as the motive for unpopular changes. Perhaps unsurprisingly, when confronted by vocal local opposition politicians have a poor track record in backing change and 'bail-outs' can appear a relatively attractive solution. This means that attempts to handle financial failure and its consequences by using a technocratic or rules-based system as in the private sector is very challenging unless those rules find a way to recognise and engage with the public and politicians.

Given the depth of feeling, lengthy local engagement cannot guarantee that stakeholders will support the necessary changes. However, accelerating the process and attempting to override or limit opposition is unlikely to be the answer as even the most watertight of proposals can unravel when politicians are put under pressure. Even the TSA process with its clearly defined deadlines and statutory consultation period has been threatened by judicial review in both of its uses and, in Mid Staffordshire, the recommendations were effectively subject to a significant caveat by ministers such that the door remained open to a consultant-led maternity service remaining at Stafford Hospital (Department of Health 2014b).

Engagement can be made easier. In particular:

- Engagement takes time and resources and needs careful planning, from the logistics of venues and translators to proper integration of the engagement into the design of the recovery programme, whether for staff or, when necessary, with the public. Both foundation trust governors and members should play an active role and offer an established route for wider engagement.

- Complex black box economic modelling that does not speak the language of clinicians (and sometimes the public) is more likely to engender a lack of trust than be persuasive. Keeping clear clinical from economic benefits can also be important to maintain trust.

- Lastly, as noted before, the NHS sometimes does not allow enough time in change processes. This can mean, for example, closing an old service as the new one opens. This places great reliance on the trust people have in these new services and does not allow them to experience them before removing the old service. Where feasible, some degree of double running can help get greater local support.

Mergers and franchising

In the NHS one of the commonest responses to sustained financial difficulties has been to merge the organisation into another, in the expectation that the new larger organisation will be more able to make the changes necessary for sustainability, whether these imply changes of personnel, back-office efficiencies or reconfiguration.

Despite their popularity, the evidence on the success of mergers and takeovers in terms of delivering the benefits they promised, or indeed, any benefits at all, is perhaps surprisingly negative (*see*, for example, Fulop *et al* 2002; Kjekshus and Hagen 2007; Gaynor *et al* 2012). This is not limited to the NHS or indeed the health sector – managements appear to consistently underestimate the difficulties and overestimate the benefits of merging organisations. Part of the challenge is that many mergers assume a reconfiguration that is intended to release savings and yet the merger itself does not necessarily overcome the difficulties such reconfigurations face. As not all mergers fail, the NHS needs to be more discriminating in determining when merger is an essential part of a recovery plan and when it is a potentially expensive distraction.

In February 2012 Hinchingbrooke NHS Trust became the first NHS organisation to have its management franchised to a private sector operator, Circle, following a competitive procurement process. Whatever the merits of the case in Hinchingbrooke the model does not yet appear to have found wider favour and no other organisation has been franchised out. As yet this remains an isolated example in the NHS.

5 Conclusion

There is a common view that the NHS has no robust way of managing provider failure. However, taking a wider perspective this apparent lack has ensured that patients continue to receive essential services and that the NHS has not needed to carry significant excess capacity just in case a provider closes or downsizes. Those disappointed should also recognise that there is no magic solution for financial failure in the health service and this has never been truer than in 2014, when a rising tide of financial distress is spreading across the NHS. This means we need to distinguish between those essentially robust providers struggling in an exceptionally hostile financial environment and those with more fundamental problems that would remain at best marginal even in easier times.

Identifying weak leadership and then correcting it should be the easy step when managing failure; both the tools to diagnose weakness and the powers to replace leaders are in place. If these methods have not always been as successful as they could be, that may be because organisations have looked for a quick fix. Such an approach can lead to rapid turnover in leadership, with successive leaders or teams not being given sufficient time to materially change performance. Fundamentally, good leadership must also encompass clinicians alongside other professionals. Rapid turnover can too easily become part of the problem rather than the solution, especially where the signal is sent out that working for a challenged provider can be a short-term and career-limiting decision.

In the context of 2014, the leadership challenge is growing as the wider finances of the health service deteriorate. For increasing numbers of organisations, simply supporting or replacing the leadership will not be sufficient. Instead, as local health economies try to manage their long-term finances they need to address a number of difficult issues:

- **Defining the relevant local health economy**
  Patients already move between different providers at different stages of their care. In some cases, there are credible high-quality providers who could take over some services either because they are already nearby or because they could enter the market. Defining the boundaries of the health economy and what is in its scope will itself partly determine the solution and getting it right can be difficult. Sometimes this will mean avoiding too great a focus on the failed organisation itself rather than on other elements of the health economy that may provide the solution.

- **Establishing the diagnosis and linking it to the solution**
  This may appear straightforward but under pressure to deliver quick results the link can be lost. For example, a provider may face high demand because of weaknesses in local GPs. However, transforming local primary care can appear too hard and too slow and instead of confronting the underlying issue, a redesign of secondary care is looked to as the alternative.

- **Understanding the economics of reconfiguration and transformation**
  Recent work from Monitor found no strong relationship between scale and efficiency. This underlines the fact that a merger or reconfiguration designed to achieve greater size is far from guaranteed to improve performance. Detailed understanding of costs at specialty level is likely to be needed to be confident that intended savings are really achievable. Both for reconfiguration and transformation, services also need to be given enough time to put in place new services or pathways.

Alongside ensuring that the diagnosis and the potential answer are well understood at local level, we need to remove the barriers to change and strengthen the enablers at national level. This means:

- **Managing NHS finances at national level**
  Reports on the first few months of 2014/15 (NHS Trust Development Authority 2014b; Monitor 2014h) show substantial deficits across the NHS trust and foundation trust sectors. This does not represent a sudden deterioration in the quality of leadership in the NHS, but rather a sharply worsening financial context that is dragging too many into deficit, too quickly. The tariff efficiency factor, and in particular the marginal rate for emergency admissions at a time of increasing admissions, are also significant factors in the growing distress. At the highest strategic level, the government needs to ensure sufficient resources are available to the NHS to deliver quality services. At present, it must also clearly distinguish between those organisations that are financially sustainable into the long-term and those that are not. The approach to these two groups needs to be fundamentally different, even if both, at present, require financial support.

- **Creating a supportive financial framework for change**
  NHS organisations have always been provided with short-term finance when they are in difficulty. While this is necessary, the NHS needs to develop a more sophisticated approach to finance so that it can clearly separate 'emergency' finance from supporting investment that brings about transformation and places a health economy on a sustainable financial path. At present there is a danger that emergency support can become an alternative to change, and equally that areas cannot access funds for transformation until they are in a financial crisis. Additional support for transformation – including double running – can make change more palatable to the public and to politicians as it can provide the chance to prove that the new services are better than the old. We have argued elsewhere for a transformation fund (Appleby *et al* 2014b) and the case remains good when dealing with financial failure.

- **Allowing realistic timetables for recovery**
  Whether turning round a negative culture within one organisation, or working through the complexities of the local health economy, bringing about change can take time. Implementing change will also come with a potentially long timetable. As long as there is confidence in a recovery plan and its milestones, organisations and their staff should be allowed the time to bring about change. Allowing sufficient time may also have implications for the financial framework, allowing a greater focus on ensuring long-term sustainability and the investments needed to reach it, and moving away from annual cash injections that focus on the symptom (a cash shortage) and not what drives it.

- **Providing strategic leadership**
  With the disappearance of strategic health authorities, the NHS lacks a focal point with the authority to bring all the players in a health economy to the table and in complex local health economies this can present a clear gap. National organisations need to consider how, between them, they can provide this leadership or enable it at local level.

- **Finding a balance between the public and politicians and the need for change**
  The public cares deeply about the health service in general and about local hospitals in particular. Delivering change will always be difficult and in a democratic society politicians cannot ignore this strength of feeling even if they want to. Where difficult change may be required it is essential to design an approach that explicitly and flexibly handles the deep public and political concern.

This combination may appear to make what is an already slow process by private sector standards even slower. However, the NHS (rightly) works under more constraints than the private sector. There is no point in taking quick action that reduces a problem in one area only to create a new one for commissioners or other surrounding providers, or to establish quick fixes that only unravel over time. This will also be important as the NHS opens up to more independent sector providers: where they provide essential services to patients, allowing them to 'fail' (in a private sector sense) will be just as unacceptable as allowing an NHS provider to 'fail'.

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Richard initially trained as an economist and spent five years in academia before joining the Department of Health as an economic adviser. Following this he spent a period of four years as a health care specialist at McKinsey & Co.

Richard returned to the Department of Health in 2003 where he undertook a number of roles including Senior Economic Adviser, Director of Strategy, Director of Financial Planning and Chief Analyst, and finally Director of Finance, Quality, Strategy and Analysis. In 2013 he moved to NHS England as Chief Analyst before leaving to join The King's Fund.

Candace Imison became Deputy Director of Policy at The King's Fund in January 2009. Since joining the Fund she has published on a wide range of topics including polyclinics, community health services, workforce planning and referral management.

Candace came to The King's Fund from the NHS where she was Director of Strategy in a large acute trust. She worked on strategy at the Department of Health between 2000 and 2006. Candace joined the NHS in 1987 and has held a number of senior management and board level roles within NHS providers and commissioners. She is currently a non-executive director of an acute trust in South West London.

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Joni Jabbal joined The King's Fund as a policy officer and researcher in July 2013. She contributes to the Fund's responsive policy work, focusing on models of care, quality regulation, and tracking the performance of the English health and social care system.

Previously, Joni worked at the Royal College of Physicians, focusing on the impact of the NHS reforms, developing new models of urgent and emergency care services, and leading the RCP's public health work streams. She has also worked as a senior policy executive at the British Medical Association.

Joni has a particular interest in incentives and behavioural outcomes in health care settings, researching the intrinsic motivation of junior doctors in England. She has also published work on the commissioning structures in the new NHS and on the development of urgent and emergency care services for the future.

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Ideas that change health care

Even the best managed organisations in the NHS face a struggle in the current financial situation. The case for having a well-understood, transparent system for dealing with financial failure is clear, so why has it proved so hard to design and implement such a system?

Financial failure in the NHS: what causes it and how to manage it describes the current financial state of the NHS and the drivers of failure. It points out that 2013/14 was a challenging year for both NHS trusts and foundation trusts, with signs of real stress in both finance and performance. Some providers were put into special measures but many more faced overspends. Our analysis of what drives financial failure suggests that weak leadership and poor governance are a recurrent feature, but other drivers include legacy costs, the payment and pricing system and problems in the wider health economy.

The report suggests a number of ways in which failure can be managed at both local and national level. The first step is to address the leadership challenge, not going for the 'quick fix' solution but rather encouraging leaders to work with the wider local health economy to identify both the problems and the potential solutions. At a national level it is important to:

- be clear that many factors contribute to financial failure, some of which are not under the control of one organisation
- agree a shared approach to dealing with financial challenges
- separate 'emergency' finance from supportive investment that brings about transformation
- allow realistic timetables for recovery
- provide strategic leadership at a local level.

NHS organisations must be able to manage failure in a way that addresses the underlying causes and increases the chance of a sustainable solution.

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