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Managing financial difficulties in health economies: lessons for clinical commissioning groups

Research report

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About this work programme

In the face of severe spending constraints and an ageing population, the need for the NHS to find efficiencies has never been more urgent. Our work programmes on efficiency and productivity, and on commissioning, are assessing the scale of the financial challenge facing the NHS and how this can be met, and looking at new and more effective ways of commissioning health and care services.

The analysis in this report is the first output from a project on the financial performance of local health economies. This will be of interest to all NHS organisations, but particularly to clinical commissioning groups (CCGs), who arguably face the greatest challenge in managing their finances while establishing themselves and addressing local health and care needs. The second part of the project uses financial modelling to determine the main factors linked to the level of financial performance: the findings from this phase will be published in spring 2014.

Beyond this, the Nuffield Trust aims to monitor the financial performance of CCGs, in order to help them navigate their own financial challenges in a climate of austerity.

Find out more at: **www.nuffieldtrust.org.uk/our-work/efficiency-productivity**

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Executive summary

With rising costs and demand for services, alongside a budget that is set to flat-line in real terms until at least 2014/15, the NHS is set for a difficult decade. The £20 billion productivity challenge that was identified in 2009 looks likely to be extended into the second half of the decade as the economic and fiscal outlook remains challenging. At the same time that the NHS faces unprecedented budgetary constraints, the system is undergoing an extensive reorganisation, with the bedding down of a new commissioning structure, in the form of clinical commissioning groups (CCGs) and NHS England, and a new regulatory framework and regime. The bodies involved, particularly CCGs, need to rise to the challenge of performing as new organisations, while dealing with ever-tightening budgets.

Although the scale of the current financial challenge is unprecedented, this is not the first time that the NHS has struggled with financial constraint. Even in periods of high financial growth, the NHS has had difficulty balancing the books. In 2006, during a time of significant real-terms increases in spending, 104 NHS organisations were put into the Department of Health's 'turnaround' programme, which was set up to help them address financial difficulties. In the years following 2006, some health economies continued to struggle to balance their books, while others consistently made surpluses.

A Nuffield Trust project, developed in partnership with the Audit Commission and NHS Confederation, set out to gather learning from the experience of those in turnaround and to explore why some health economies were more successful than others in balancing their finances in subsequent years. Although much of the learning will be applicable to all NHS organisations, we have focused on the lessons for CCGs, who arguably face the greatest challenge in managing their finances while establishing themselves and addressing local health and care needs.

We undertook interviews with managers who were in post in organisations experiencing turnaround in 2006, exploring their perceptions of factors that contributed to the initial deficit, what helped and hindered their attempts to reach financial balance, and the learning they would pass on to emerging CCGs and others in the health system.

The interviews revealed a range of reasons identified as contributing to the deficits. The most common included:

- policy-driven pressures such as the introduction of Payment by Results and foundation trusts
- primary care trusts (PCTs) being too small (pre-2006) to influence providers or build the capacity and capability to execute their duties effectively
- historic financial commitments, such as private finance initiative contracts
- inadequate allocations which meant some areas were underfunded
- weak or inadequate governance and performance management processes

- unproductive or antagonistic relationships with stakeholders across the health economy and a culture of blame within troubled organisations
- instability of leadership and management caused by frequent changes in senior personnel (particularly in PCTs).

Approaches to tackling deficits did not differ significantly between case study sites and it seems that *what* was done to resolve the issues was less important than *how* the health economy went about addressing the problem. The economies that turned around most quickly appeared to be more skilled at balancing a series of tensions. Our analysis suggests ten key lessons primarily for CCGs as they grapple with difficult financial futures:

1. Identify and assess the reasons for financial problems as they arise and avoid attributing difficulties solely to external pressures (for example, resource allocation, over which there is little control.
2. Strive for strong and stable leadership to ensure consistency and aid development of relationships – although some level of change, if well timed and well managed, can bring fresh ideas and momentum.
3. Foster constructive relationships between providers and commissioners, while being mindful of the dual roles of competition and cooperation.
4. Work together with other CCGs to ensure financial risks are managed effectively – this may involve developing a complex matrix of commissioning arrangements.
5. Invest in management capacity and capability, whether provided in-house or bought in from commissioning support units or elsewhere, to ensure internal governance and financial processes are efficient and effective.
6. Ensure that where support and input are purchased from external suppliers that CCG members are involved in the process and feel they own the resulting plans and strategies.
7. Invest considerable effort in engaging with members of constituent practices to ensure GPs fully understand the role they play in the financial health of their CCG, and feel that they have ownership and influence.
8. Engage with the public (this will be critical when difficult decisions need to be made, particularly about service closures) and take other health and social care organisations along with any major change to ensure they are managed effectively.
9. Organisational development, although important, should be balanced with an outward-facing, strategic, whole-economy perspective.
10. Develop a long-term financial strategy as well as dealing with immediate pressures. The financial health of CCGs will depend, in some cases, on significant service change, which requires strategic thinking.

As CCGs and the wider NHS architecture take shape, it will be crucial that learning from the previous era is heeded. The challenges faced by CCGs should not be underestimated as they will be facing a greater financial challenge than their predecessor PCTs.

What this study suggests is that effectively managing finances is a careful balancing act between short-termism and strategic planning; between challenge and collaboration; and between an internal and economy-wide focus. It will also be important for policy-makers and NHS England to ensure that CCGs are given the support and tools to implement the learning identified.

This research report precedes a further study that is examining the trends in deficits and surplus in the NHS using quantitative data. The aim of the analysis set out here is to identify what factors are considered by NHS managers to be associated with financial performance.

“ effectively managing finances is a careful balancing act between short-termism and strategic planning; between challenge and collaboration; and between an internal and economy-wide focus

1. Introduction

The NHS is currently facing an unprecedented financial situation. The 'Nicholson Challenge', first set out in 2009, identified the need to make £15-20 billion in efficiency savings by 2015. Ever since, the health service has been under pressure to close this productivity gap, which is driven by a combination of rising demand and rising costs. Recent analysis has found that the financial challenge may continue for much longer than previously anticipated and suggests that the NHS is actually facing a decade of austerity (Roberts and others, 2012).

Although unprecedented in scale, this is not the first time the NHS has faced a difficult financial situation. In 2004/05, despite year-on-year real-terms increases in funding, a number of NHS organisations overspent. By 2006, 104 organisations were formally put into the Department of Health's 'turnaround' programme (National Audit Office, 2007). In an early analysis of the reasons for such financial failure, the Audit Commission found a high degree of consistency between those organisations experiencing difficulties. The Audit Commission, writing in the midst of the crisis, also suggested that, if lessons could be learnt from such failures and acted upon, the risk of future occurrence could be reduced (Audit Commission, 2006). The situation facing the NHS currently looks set to be considerably more challenging than in 2006 as no-growth budgets will mean that there are unlikely to be any surpluses to shift to areas of deficit. Nor can a rising tide of resources be used to overcome them.

“ Although unprecedented in scale, this is not the first time the NHS has faced a difficult financial situation

It was with such thinking in mind that we undertook this project. Returning to the period 2006 to 2010, we set out to explore both why health economies began to fail in 2004 to 2006, and how they responded to their respective financial challenges. Crucially, we wanted to explore why some struggling health economies continued to experience financial difficulties while others managed to turn themselves around relatively quickly and maintain financial balance. This analysis has taken two forms. First, we have explored the experiences of health service leaders who were in organisations in turnaround in 2006, how they responded in the immediate period after 2006 and how they sought to reach or maintain financial balance in the subsequent four years. The aim of this work was to gather pertinent learning for emerging clinical commissioning groups (CCGs). Second, we are currently undertaking financial modelling to determine whether there is any significant association between certain contextual factors and financial performance.

In this research report we detail the findings of the first element – the experience of managers – and seek to identify useful learning to assist those in the NHS grappling with tightening budgets. Findings from the second element will be published in the spring of 2014.

2. Context

All NHS organisations, with the exception of foundation trusts, have a statutory responsibility not to overspend and, as such, are required to manage their budgets within tight financial constraints and complex accounting and funding rules. However, not all are able to contain their spending within available funds and, as such, each year some report a one-off overspend and others a recurrent one. The current financial challenge in the NHS (as well as the rest of the public sector) is prominent in policy discourse and organisational plans. However, it is important to note that this is not the first time that the NHS has faced a difficult financial situation in recent years. Indeed, in 2006, numerous NHS organisations were carrying significant deficits.

2.1 2006: the turnaround process

In 2005/06, the NHS as a whole overspent by around one per cent of its budget (£547 million in nominal prices), with a number of organisations falling into significant deficit (House of Commons Health Select Committee, 2007). This was the first time the NHS had overspent since 1999/2000 (Department of Health, 2006). Table 1 illustrates the gradual rise in the extent of deficits and in the proportion of NHS organisations carrying a deficit.

Table 1. NHS deficit 2001/02 to 2005/06

Financial year	Surplus/(deficit) reported in audited accounts (£m – nominal prices)	Per cent of NHS organisations with an overall deficit
2001/02	71	8
2002/03	96	12
2003/04	73	18
2004/05	(251)	28
2005/06	(547)	31

Source: House of Commons Health Select Committee, 2007; adapted from National Audit Office data

The deficits, although a relatively small percentage of the overall NHS budget, were of concern because they occurred at a time of sustained financial growth and were unevenly distributed across the country, with some organisations generating a surplus that partially off-set the deficits. The Department of Health's own analysis also highlighted a concern that 'sound financial management was seen as less important than delivery in other performance areas by both NHS bodies and the Department of Health' (Department of Health, 2006). A House of Commons Health Committee report into the NHS deficits concluded that the deficits were not new but were

brought to the fore by a change to the financial rules which no longer allowed an underspend on capital expenditure to be used to subsidise current spending (House of Commons Health Committee, 2006). The same report also concluded that the size of deficits had been growing steadily due to a combination of the funding formula, poor central management and poor local management.

The then Secretary of State pledged to bring the NHS back into financial balance by the end of 2006/07. To facilitate this process the Department of Health set up a 'turnaround' programme. Established in February 2006, the aim was to help 104 PCTs and NHS trusts address their financial difficulties (Department of Health, 2006).

The National Audit Office's report on the summarised NHS accounts for 2006/07 reported that the NHS had been successful in its attempts to reach financial balance. At the end of the financial year 2006/07, the NHS had achieved a net surplus of £515 million (National Audit Office, 2007). However, further analysis has revealed that organisations were financially supported, with the result being that nearly all broke even on paper at least. This redistribution of funds masks the underlying position of organisations.

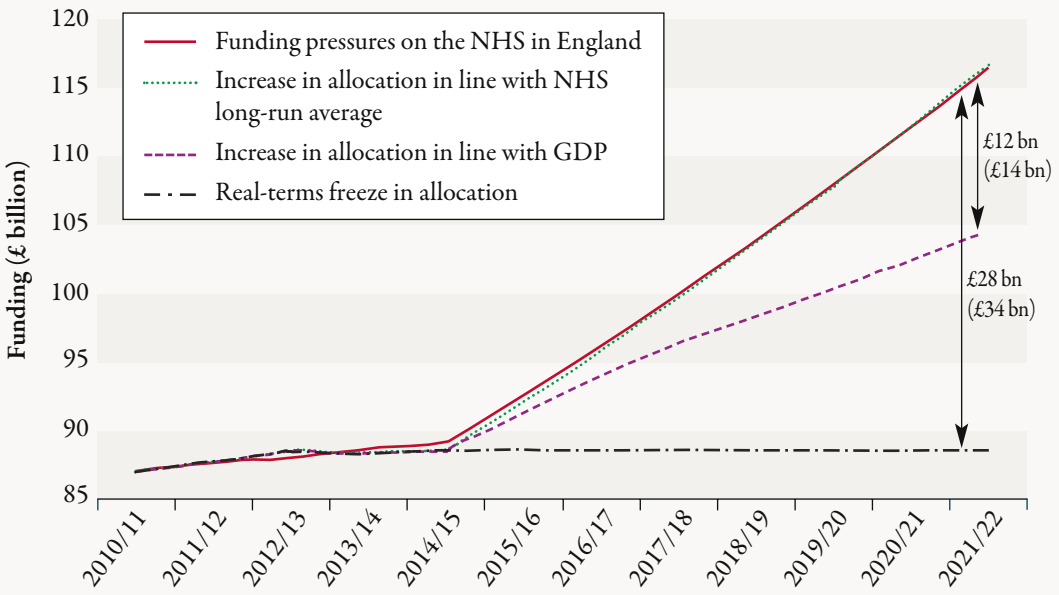
PCTs had a statutory duty not to allow their spending to exceed their annual allocation – known as the revenue resource limit (RRL) – and so sometimes received non-recurrent in-year adjustments to their revenue resource allocations. This had the effect of allowing PCTs to meet their financial duties. The intention was to help the NHS to cope with local difficulties by 'plugging' overspends at the year-end with short-term fixes through revenue transfers from under-spending PCTs, usually in the same strategic health authority (SHA) area. This shifting of funds made the system less transparent and added a layer of uncertainty about the underlying financial position of organisations. It also distorted the impact of the funding allocation formula. This non-recurrent funding took different forms and titles, such as 'service level agreement' or 'planned support', and didn't need to be repaid in future years. Other types of non-recurrent funding took the form of cash 'loans' from one trust to another trust to enable providers to pay bills and staff in order to keep the service running.

2.2 Looking forward

The NHS experienced a period of significant financial growth for the ten years following 2000. That came to an end with the worldwide financial downturn and the Coalition Government's subsequent commitment to reduce the fiscal deficit. As a result, all public sector budgets have, and continue to be, squeezed. Health has been relatively protected from the cuts so far, with the government promising no real-terms cut to the health budget. However, the near-zero per cent real-terms increase in the health budget for the foreseeable future may well feel like a cut on the 'front-line' when faced with rising demands, particularly after a decade of sustained increase. In 2009, the Chief Executive of the NHS, David Nicholson, projected a gap between funding and cost pressures of around £15-20 billion by 2015 that would need to be met through productivity gains. In order to meet this gap in funding by 2015, all organisations were required to set Quality, Innovation, Productivity, Prevention targets. However, the UK economic and fiscal situation looks likely to remain challenging for some time and the period of austerity is set to continue beyond 2015.

Even if the current productivity challenge is met by 2014/15, modelling suggests that the English NHS could face a further funding gap of up to £28 billion by 2021/22 if spending is frozen in real terms (Roberts and others, 2012). In order to close the gap, funding would need to grow in line with the historic average for the NHS (four per cent a year) – this scenario is highly unlikely given announcements to continue with total public sector spending cuts to 2016/17 (Roberts and others, 2012).

Figure 1: Projected funding gap



Note: The funding gap for PCT-commissioned NHS services in England is displayed together with the estimate for the departmental expenditure limit, in brackets.

Source: Roberts and others, 2012

The likely prolonged period of financial uncertainty will pose challenges for providers and commissioners alike. The newly established CCGs face particular challenges – they are developing their new organisations and taking on extended responsibilities, at the same time as managing increasingly tight budgets. Trusts, similarly, continue to face an uncertain future as they struggle to generate sufficient income and savings to cover costs. It is important, therefore, that all NHS organisations learn from what has gone before. This report explores how senior NHS management responded to financial difficulty in the period following 2006, in order to identify pertinent learning for CCGs.

2.3 Financial performance of NHS organisations: what does the literature tell us?

The existing literature on factors influencing the financial status of PCTs and other NHS organisations in England is rather limited.

In one of the more in-depth pieces of work on this issue, the Audit Commission identified the main reason for financial failure in those organisations with the most significant deficits as 'the absence of adequate financial leadership and the failure of good financial governance' (Audit Commission, 2006). The research highlighted three major problems with board leadership: inadequate calibre; a lack of cohesion often compounded by high turnover; and the distraction of other business (such as a merger or a large capital project). Importantly, the report states that financial failure is too often seen as separate from organisational failure and that financial issues can, in fact, be indicative of other problems in an organisation. Further causes of financial problems were found to stem from inadequate information and a belief that the organisation was not in control of its own destiny; instead citing external factors, including their resource allocation. This failure to grasp their own financial situation, asserts the Audit Commission, led to many organisations in significant difficulty relying on short-term fixes, such as asset disposal, borrowing and the use of non-recurrent funding. Such short-term solutions disguised underlying financial circumstances and enabled organisations to continue to operate without addressing the root causes (Audit Commission, 2006).

A later paper by Hellowell and Pollock (2007) suggests that the cause of deficits in NHS organisations lies not just with local management and governance, but also with national policies such as Payment by Results and the private finance initiative (PFI). The study concludes that the cost of PFI contracts for most trusts is greater than the capital they are provided with through the NHS payment system, and that this has led to the emergence of financial deficits. While Payment by Results tariffs for acute hospitals include an element for capital, the percentage tends to be lower than the capital costs actually incurred by organisations with PFI schemes (8.3 per cent of trust income, compared with the 5.8 per cent embedded within Payment by Results).

However, Asthana and Gibson (2005) argue that financial deficits are better explained by inadequacies in the resource allocation formula. They demonstrate that the resource allocation model discriminates against particular communities. According to them, 'NHS funding provides insufficient resources for rural areas, for comparatively affluent areas, and most particularly, for areas that are both rural and affluent'. Badrinath and others (2006) add weight to this analysis. Their study involved a descriptive comparative study using data from 58 PCTs; 29 in greatest financial surplus and 29 in greatest deficit in the English NHS based on Department of Health figures from 2004/05. Their findings suggest that the PCTs in financial deficit appeared to be different in population from the PCTs in surplus: the population density of PCTs in deficit was almost seven times lower than that of PCTs in surplus. Like Asthana and Gibson, they concluded that PCTs in deficit tended to serve relatively affluent and rural areas. Moreover, their study also found that PCTs in deficit received on average £205 less per resident population, and £123 less per registered population, than PCTs in surplus.

A report by the Department of Health's chief economist in 2007 looking at the causes of deficits suggested that there was a clear pattern to financial performance, with the most significant deficits in 2004/05 being contained within a 'cone-shaped area above a line from Bristol to Southampton and below a line from Bristol to the Wash' (Department of Health, 2007). This report suggests that changes in accounting procedures which disallowed the transfer of resources from areas of surplus to those of deficit explain why deficits emerged during this period. The analysis suggested that three factors had contributed to the deficits: first, in certain areas staffing levels increased to above those consistent with national targets; second, targets such as the four-hour A&E wait revealed weaker than anticipated performance in secondary care and led to cost pressures; and third, the management in these poorly performing areas was put under particular pressure and weaknesses in that management (as highlighted by the Audit Commission, and discussed above) meant that the situation was not addressed satisfactorily (Department of Health, 2007).

This brief overview of the literature suggests there is no single narrative about why NHS organisations experience financial difficulties. Our research aims to build on, and add to, the existing evidence and to explore more recent reflections from senior managers.

3. Methods

For this element of the work, primarily qualitative methods were used to explore the experience of senior NHS managers. The research team selected six health economies as case study sites. All sites had at least one organisation in turnaround in 2006. Half the sites recovered financially and half remained in a difficult financial situation.

The project involved three distinct steps:

i. Site selection

ii. Data collection

iii. Analysis and validation.

i. Site selection

'Health economies' were the core unit of analysis for this work. The method for defining a health economy attempted to calculate the totality of NHS spending on health care for the population living within a PCT boundary (as PCTs were organised before their abolition in April 2013). We decided that, because financial problems can manifest in providers and commissioners, a focus on one or the other might distort the true position. We constructed health economies around PCT base units by first listing the top acute providers according to how much a PCT spent on them. We then looked at the providers to check which PCTs accounted for the majority of their income. In most cases, the providers that the PCT had considered to be its main providers had also considered that particular PCT as its main source of income. In cases where a PCT commissioned a significant proportion of care from more than one acute provider, the expenditure on all those providers was included in the health economy 'unit'.

Financial performance of a health economy is defined as the aggregate surplus or deficit of the PCT commissioner, PCT provider arm, and NHS trust or foundation trust (apportioned to PCTs on the basis of commissioning spend as described above) less non-recurrent financial support. The valuation of the surplus or deficit takes account of funds transferred between PCTs by the SHA and funds allocated to foundation and NHS trusts. The financial data were obtained via Freedom of Information requests to the Department of Health. This allowed us to arrive at the underlying financial position by taking the reported annual over- or under-spend and adjusting it for any non-recurrent funding or top-slices. The cumulative financial position between 2006/07 and 2009/10 was the basis of this analysis. The cumulative position was considered most appropriate in order to mitigate the effects of individual good or bad years skewing the overall performance.

Using our constructed health economies as the base unit, we identified a long list of sites where at least one organisation had been included in the Department of Health's turnaround programme following financial difficulties in 2005/06. The progress of each health economy was tracked to 2009/10 in terms of the combined cumulative financial out-turn of the PCT and its designated acute providers.

From this initial long list of health economies, we were able to divide sites into two categories: those that had reached cumulative financial balance and those which were still (in 2011), in cumulative terms, carrying a deficit. Based on the literature, we hypothesised that contextual features such as age or deprivation of population, location or rurality, might be perceived by interviewees as factors in explaining deficits. Within those categories, we split sites into broad geographic categories: north England, south England and London. In order to reach a short-list of six from this longer list, we tried to ensure a spread across a number of contextual features. Efforts were made not to choose health economies with particularly unusual or extreme features (for example, extremely rural) in order to maximise the learning potential for a wider audience.

Table 2. Site selection criteria

Factor	**Criteria**
Financial performance	At least one organisation in the health economy started in turnaround in 2006/07 and whose cumulative position by 2010/11 was deficit *Or* At least one organisation in the health economy started in turnaround but improved and achieved financial balance/surplus (in cumulative terms) by 2010/11
Geography	London North England South England
Socio-demographic	Deprived/affluent High/low proportion of older people
Supply market	Monopoly provider Competitive secondary provider market
Wider context	PCT reconfigured/not reconfigured in 2006

ii. Data collection

In order to understand the context and to identify particular issues in each of the health economies, a rapid review of key documents was undertaken. The document review was used to build up a portrait of each case study site, to identify key staff, and to understand any significant reconfigurations/mergers. Key documents included annual reports, Audit Commission reports, Care Quality Commission/Healthcare Commission annual reports and Department of Health quarterly reports. The document review enabled the research team to focus and tailor each set of interviews to ensure that we explored relevant issues.

In each of the six case study sites, semi-structured telephone interviews were carried out in early 2012 with health service leaders in both the PCT and the main acute provider(s) (as defined in the site selection section described above). Where staff had changed, the current staff member in the appropriate position was contacted in the first instance and then, where possible, their predecessors were approached. In each health economy, members of the senior management team (such as chief executives, finance directors, chairs and commissioning managers) who were in post at the PCT between 2006 and March 2012 were contacted, where they could be traced. Similarly, those occupying senior management positions (for example, chief executives, finance director, director of performance) at the PCT's main acute provider(s) between 2006 and March 2012 were contacted.

The exact profile of staff interviewed in each site depended upon the particular structure of the organisations and the ability of the research team to trace former staff – in some cases, six or seven people had occupied one post over the period of interest. Every effort was made to contact all of them but, at times, this proved impossible.

Table 3. Number and role of interviewees

Role of interviewee	**Number of interviewees**
Chief executive	15
Finance director	6
Director of commissioning/strategy/performance	4
Professional executive committee chair/ practice-based commissioning lead	4
Non-executives (chairs and chairs of audit committees)	3
Total	**32**

iii. Analysis and validation

Interviews were recorded and detailed notes made according to a pre-agreed template. All interview notes were analysed according to a coding framework and key themes identified.

In order to validate the findings of the interviews, we ran a break-out session at the NHS Confederation conference in June 2012. This offered an opportunity for managers and clinicians to reflect on their own experiences and to help us validate the key findings and identify the main lessons for CCGs and NHS England. The discussions that took place at this session are not reported directly in this report, but the structure and content of the write-up has been influenced by this seminar.

3.1 Limitations of the research

As with any research of this type, this project was subject to a number of limitations and it is important to acknowledge these. First, the research team was limited by time and resource which had an impact on the number of interviews that could be undertaken. Second, we were able to interview only those people who a) we could trace and b) were willing to speak to us. Therefore, there may have been an element of self-selection within the sample of interviewees. We were undertaking this research at a time of considerable change in the NHS and many organisations were merging and being dissolved. As such, many people in relevant posts had left their organisation or had been made redundant. Third, we were asking people to talk about events that took place more than six years ago. We sought to mitigate the impact of these limitations by talking to a number of people from the same organisation and by referring back to the key documents for certain facts – this provided some level of triangulation. In addition, as described above, early findings from the interviews were presented to, and discussed by, a range of health service managers at a session at the NHS Confederation conference.

To preserve anonymity, certain details have been left out of the site descriptions. In attributing quotes, we have indicated which site the respondent came from and if they represented the PCT or a provider. The PCT category includes GPs and Professional Executive Committee chairs.

4. Case study sites

Six sites were chosen as case studies. All sites had at least one organisation in turnaround in 2006. Sites A, B and C turned around their financial situations in the period after 2006. Sites D, E and F remained in financial difficulty to 2010/11 (according to our analysis, as described in the methods section).

Case study site	Geographical profile			
	Location	**Population (approx)**	**Rurality**	**Socio-economic status**
A	South England	600,000	Largely rural	Mix of very affluent and relatively deprived
B	London	300,000	Mostly urban	Very mixed in terms of affluence; multicultural; large inequalities in life expectancy
C	North England	500,000	Urban	Ranks centrally in terms of deprivation
D	London	200,000	Urban	Mixed
E	North England	300,000	Largely urban	High levels of deprivation
F	South England	750,000+	Largely rural	Relatively affluent

Case study site	Organisational profile			
	Reconfigured in 2006?	**Acute providers?**	**Divested community services?**	**Socio-economic status**
A	Yes: formed of a number of smaller PCTs	One dominant early wave foundation trust (FT)	Not by the end of 2011	Mix of very affluent and relatively deprived
B	No	One main provider that achieved FT status in 2011	2010	Very mixed in terms of affluence; multicultural; large inequalities in life expectancy
C	Yes: formed of a number of smaller PCTs	One large early wave FT which also serves a number of other PCTs	2011	Ranks centrally in terms of deprivation
D	No	Host to one main provider but commissions 35 per cent of activity from provider outside its boundaries (neither have FT status)	2010	Mixed
E	No	One main large provider (not FT) that also serves a number of other PCTs	2011	High levels of deprivation
F	Yes: formed of a number of smaller PCTs	PCT commissions from several acute trusts within its borders and outside. Three of its providers are FTs (its largest provider achieved FT status in 2011)	2009	Relatively affluent

Case study site	Financial profile			
	Purchaser	**Provider(s)**	**Purchaser**	**Provider(s)**
A	PCT in turnaround 2005/06; in balance by end of 2006/07	Provider financially healthy throughout	PCT in turnaround 2005/06; in balance by end of 2006/07	Provider financially healthy throughout
B	PCT in turnaround in 2005/06; achieved balance by 2007/08 although with historic debt which was eventually written off	Provider financially healthy throughout	PCT in turnaround in 2005/06; achieved balance by 2007/08 although with historic debt which was eventually written off	Provider financially healthy throughout
C	PCT in turnaround in 2005/06; recovered by 2007	Provider financially healthy throughout.	PCT in turnaround in 2005/06; recovered by 2007	Provider financially healthy throughout.
D	PCT in turnaround in 2005/06; PCT improved but remained finely balanced	Main provider in turnaround in 2005/06; provider remained in deficit	PCT in turnaround in 2005/06; PCT improved but remained finely balanced	Main provider in turnaround in 2005/06; provider remained in deficit
E	The PCT was financially healthy throughout	The main provider was in turnaround in 2005/06. Its position improved but it remained in deficit	The PCT was financially healthy throughout	The main provider was in turnaround in 2005/06. Its position improved but it remained in deficit
F	The PCT was in financial turnaround in 2005/06. The PCT remained in financial difficulty	Several main acute providers were in financial difficulty in 2005/06. Two remained in financial difficulty	The PCT was in financial turnaround in 2005/06. The PCT remained in financial difficulty	Several main acute providers were in financial difficulty in 2005/06. Two remained in financial difficulty

5. Identifying the causes of deficits

In this section we explore the reflections of past and present managers on the causes of the financial difficulties in their local health economy. During each interview, participants were asked why they thought their case study site had fallen into deficit. Almost all interviewees' diagnosis of why their local health economy had experienced financial difficulties was unique. This suggests that health economies had not reached a common understanding of the causes of the problem. Responses often differed from site to site, and also between interviewees from the same site. Most notably, there was often a significant divergence between accounts offered by commissioners, and those offered by providers in the same site, suggesting that a whole-economy diagnosis of the causes of the problem had not been undertaken.

> Almost all interviewees' diagnosis of why their local health economy had experienced financial difficulties was unique. This suggests that health economies had not reached a common understanding of the causes of the problem.

However, there were also issues that were raised by more than one respondent. For example, individual interviewees from the same organisation and who were employed concurrently would often offer similar analyses of how financial problems in their area had developed, even if this view was not shared by those from other organisations, or those employed by the same organisation at a different time. This would suggest that individual organisations often built up a shared narrative of why their health economy was experiencing difficulties, but that such a narrative did not always cross organisational boundaries or endure over time.

Thematic analysis of the interview data reveals seven broad perceived reasons for the initial financial difficulty (see Box 1 overleaf):

Box 1. Main causes of financial difficulties, according to the interviewees

1. **Policy driven:** relates to factors associated with national policy, such as Payment by Results and the purchaser/provider split.
2. **Commissioning structures:** issues associated with the commissioning function of PCTs (for example, being too small to exercise power over providers and lacking the right skills to execute their duties effectively).
3. **Historic financial commitments:** those sites with large PFI contracts cited their financial obligations as being central to their difficulties.
4. **Inadequate allocation:** the fact or perception that a health economy's allocation was inadequate.
5. **Governance and performance management:** weaknesses within organisations in terms of processes and accountability, which meant that the right data was not always being scrutinised by the right people at the right time.
6. **Relationships and culture:** difficult or antagonistic relationships between stakeholders (usually between the commissioner and main acute providers, but also with local authorities) leading to an inability to generate constructive dialogue across the health economy. A culture of blame also featured, whereby staff would consistently blame an external factor or another organisation for the issues faced by their own organisation.
7. **Leadership and management:** instability of leadership and management with frequent changes in senior personnel.

5.1 Policy-driven factors

Interviewees in all of the sites pointed to systemic issues as having triggered the original slide into deficit. By systemic issues, we mean those factors inherent to the system over which health economies had no control such as the introduction of Payment by Results and foundation trusts.

The introduction of Payment by Results[1] was cited by both PCT and provider respondents from three sites (A, E and C) as contributing to financial difficulties within their health economies. Provider respondents from site E felt that Payment by Results put them at a disadvantage because, in more recent years, they had not been fully reimbursed for excess emergency activity,[2] thereby – in their view – unfairly

1. Payment by Results in context: 'Payment by Results began in a small way in 2003/2004, was extended in 2004/2005, and, for the majority of trusts, included only elective care in 2005/2006. In 2006/2007 the scope of Payment by Results was extended to include non-elective, accident & emergency, outpatient and emergency admissions for all trusts. 2007/2008 marked a year of consolidation with no significant changes to the tariff. The financial impact of Payment by Results has also been introduced gradually, with a four-year transition path which came to an end in 2008/2009. In 2009/2010, the national tariff for admitted patient care and outpatient activity was for the first time underpinned by the Healthcare Resource Group version 4 (HRG4) currency, which was specifically designed for payment purposes.' (Department of Health, 2010).

2. In 2010/11, a marginal rate of 30 per cent of tariff was introduced for emergency admissions above a baseline. In addition, from 2011, providers have not been not paid for further treatment where patients are readmitted for the same condition within 30 days of discharge (see Health Finance Managers Association, 2011, for explanation of marginal tariffs).

penalising them for what they perceived as poor demand management by primary care. Conversely, PCT respondents from sites A and C felt that the new payment mechanism was unfairly weighted to the benefit of providers, especially early-wave foundation trusts. As one respondent put it:

> *As a result of that early adoption of foundation status, the PCT agreed to tariff arrangements that weren't, I think, financially sensible. And as a result, it led to the PCT taking on significant financial debts.* (Site C, PCT)

In site C, respondents felt that the establishment of an early-wave foundation trust was at the heart of the PCT's problems. This came "with a sizable dollop of financial support" from the local PCTs and a political imperative for the trust to be seen to succeed.

One respondent from site F suggested that, because they were dealing with two early wave foundation trusts, they were "exposed to full Payment by Results" before other health economies. For some time, site F "abandoned" Payment by Results in favour of block contracts that they perceived as easier to manage. One provider in site F recognised the pressure that Payment by Results put on PCTs:

> *It* [Payment by Results] *makes relationships more difficult. It drives you [the hospital] to deliver more, count more, code more… sometimes at* [the] *expense of the financial position that the commissioner finds themselves in. In a cash limited service… if one organisation gets more… it means that another will get less.* (Site F, provider)

It is not clear why our case study sites felt they were adversely affected by these factors that were common across the system, where other health economies managed to remain in balance during these changes. It also does not explain why four of our case study sites, which included no foundation trusts at the time, fell into deficit nor why two of our three sites that had early wave foundation trusts (A and C) managed to regain financial balance quickly and maintain it.

5.2 Commissioning structures

Interviewees from five out of six of our case study sites saw the size, number and maturity of the commissioner organisations as among the main reasons for their health economy's financial difficulties. For example, interviewees from sites A, C and F argued that prior to their reorganisation in 2006, the PCTs in their respective health economies were too small and too numerous. This structure, it was argued, created various problems. First, the small size of the PCTs gave commissioners little overview of the health economy as a whole and, correspondingly, little ownership over the inherent problems. This meant that growing financial problems were not identified until relatively late and often by the SHA; for example, "not until around 2005" (Site C, PCT).

Respondents also argued that the size of the PCTs significantly limited their analytic capacity and purchasing power, seriously impeding them in the commissioning of services. This was compounded, it was argued, by the sheer number of PCTs. As one respondent from site C put it:

> *the PCTs began to develop in slightly different ways and develop slightly different debts and began to see less and less ability to control the power [of the providers]...* [Each was] *going in a different strategic direction and demanding different things.* (Site C, PCT)

Interviews with PCT managers revealed a strong perception of a cohesive and powerful provider landscape. The vocabulary used by these interviewees in this respect included phrases such as "all-powerful" acute and foundation trusts, and the local health economy being "dominated by providers".

For some respondents, a contributory factor in this power dynamic was the institutional age of the commissioner, with the PCT being an "immature organisation" (Site D, PCT) when compared to the local acute trust. This rhetoric was disputed by interviewees from provider organisations, who argued that the commissioners actually hold the power in a health economy as "the people with the money always have the upper hand" (Site D, provider).

Commissioners and providers alike pointed to insufficient provision of community and social care in the local health economy as a cause. For example, respondents from sites B, C and F all argued that a lack of community and social care meant patients stayed too long in hospitals, that "too little step down care led to bed blocking" and there was a "reliance on hospital care to meet social care needs", leading to a large continuing care bill. Although recognising the need for greater provision, commissioners struggled to address the issue. As one respondent from site B put it:

> *At board-to-board meetings, the PCT used to repeatedly say that the only things they could do to change and improve things was to change primary and community care and the only way they could do that was by taking activity away from the hospital.* (Site B, provider)

As with the policy-driven factors above, the commissioning structures were not unique to our sites and many other small PCTs across the country managed to remain in balance despite the same challenges. This suggests that some of our sites were blaming external factors beyond their control rather than managing the challenges they faced effectively.

5.3 Historic financial commitments

A health economy's historic financial obligations – that is, their financial commitments dating back to before 2006 – were often perceived as contributing to a slide into deficit. Two of our sites had PFI buildings and both pointed to their repayment plans as being a direct cause of financial difficulty. Respondents from site F, for example, cited a "large PFI" arrangement, held by an acute trust in the health economy as putting pressure on the PCT as the hospital attempted to "grow its way out of trouble" (Site F, PCT).

Similarly, respondents from the main provider in site D also argued that the need to service PFI payments contributed substantially to their financial insecurity, arguing that they were otherwise both "very efficient" and "high performing". Data reveal that site D's expenditure on PFI was over five per cent of its income in 2006/07 and site F's expenditure was around 1.5 per cent of its income in 2006/07 – both figures were above the national median of expenditure on PFI in that year (0.9 per cent). While

such commitments no doubt put pressure on the organisations affected, it is not clear that they entirely explain their deficits as the repayments would have been factored into business cases and it could be argued that the task of management is to run their organisation within the financial envelope available. The impact of PFI is being further explored in the subsequent quantitative analysis that will be published by the Nuffield Trust in spring 2014.

5.4 Inadequate allocation

Respondents from three out of the six sites (Sites A, D and F) cited the "inadequate" allocation of funds from the Department of Health to the local health economy as being a root cause of their difficulties in 2006. Sites D and F believed that the allocation explained their continuing financial struggles:

> *The problem is the allocation formula … what the acute providers were saying they needed outstripped the allocation of the PCTs.* (Site F, PCT)

However, respondents from two other sites (B and E) were more circumspect, arguing that the budgetary deficits in their local economies were experienced at a time of significant fiscal growth. Moreover, several respondents argued that, regardless of the initial allocation, managers had a responsibility to ensure that their organisation's expenditure matched its income. As one put it:

> *My approach was always to say – 'listen, you've got what you've got...*[and] *it's in our gift to get back into balance'.* (Site D, PCT)

It is interesting to note here that, while some interviewees questioned the allocation formula, almost none pointed explicitly to wider contextual factors such as age or rurality as being important. The literature suggested that these issues were significant in terms of their impact on allocations. As with commissioning structures and policy-driven factors, there appeared to be a tendency in some sites to blame factors beyond the organisation's control for their financial difficulties.

5.5 Governance and performance management

For a number of interviewees, an important contributory factor to their organisation's deficit was a lack of proper internal procedures. One recurring theme was a lack of proper accountability and governance. A respondent from site A, for example, argued that the former PCTs were "ticking the right governance boxes" but that "the systems were flawed", concluding that "you don't get into that level of deficit by accident" (Site A, PCT).

Respondents from sites B and D argued that poor commissioning procedures were to blame. These included poor "housekeeping", a lack of internal controls, little evidence-based decision-making or statistical analysis, no effort at performance monitoring within the PCT and no contractual levers to curtail spending or even markers to flag over-performance within an acute contract. Respondents from sites B and F felt that the PCT concentrated on "major strategic solutions" at the cost of the "here and now". Indeed, perceived financial mismanagement on a day-to-day level was a common theme across all sites, with one interviewer saying simply "they didn't have a grip on their finances". In one of the sites where the provider was in financial difficulty, interviewees cited a lack of clear accountability structures within the hospital (Site B, provider).

For some, however, such failings were often the result of insufficient technical capacity and/or financial capability on the part of the commissioner, especially in comparison with providers. For example, one respondent from site C argued that the PCT in their health economy was always at a disadvantage because it did not have the ability to monitor costs generated by the provider in real time, and hence could never properly curtail activity. As they put it:

> ... [Providers were always able to] *spot activity and bill for it...* [But] *there was a six month lag before the PCT knew about it... for example, say a GP sends* [a] *patient to [an outpatient clinic], PCT incurs a cost, hospital clocks it and bills it, PCT finds out about it six months later when they get the spreadsheet – so we could see a huge rise in dermatology because the hospital has set up a new dermatology service which has sucked in activity. PCT would only know about it later...* (Site C, PCT)

5.6 Relationships and culture

One of the major issues cited by respondents from all sites was organisational culture. Respondents from PCTs and providers alike argued that health economies had fostered a culture where providers over-performed on contracts, where GPs over-referred and over-hospitalised, and PCTs often failed to manage demand sufficiently. Frequently, interviewees talked about the "blame" for the situation lying with others in the health economy. For example, respondents from site D's PCT argued that the acute trust in their area habitually over-performed in emergency care to cover its own PFI costs. Conversely, interviewees from the provider, and some from the PCT in site C, argued that local GPs were the root cause; often too ready to send patients to the acute trust, leading to a system that was "over-hospitalised and over-referred" (Site C, provider). Both practices were attributed to cultures and norms that had built up over years. As one respondent put it:

> *Most doctors have been trained in* [site C] *and tend to work 'the* [site C] *way', which tends to default towards hospital services.* (Site C, PCT)

Interviewees from three sites (B, D and E) argued that the financial difficulties in their area could be attributed in part to poor primary care and, in particular, poor demand management by GPs and PCTs. An interviewee from site B argued that this was as much cultural as anything else, since GPs were "naturally very single minded about patient care" and, as a result, resisted any efforts to introduce demand management strategies. Another interviewee at the same site offered a similar perspective:

> *GPs don't see* [demand management] *as their job. It will always be a very difficult thing for a GP to bring about because they never want to deny treatment to a patient if they think they need it.* (Site B, PCT)

A common claim from a variety of interviewees (from PCTs as well as providers) was that the PCT often failed to take responsibility for their own problems. As one put it:

> [There was a propensity] *to externalise the problem.* [There was] *no internal acceptance of responsibility, no ownership... it is always the hospital over-performing, or GPs referring too much, or the social care...* (Site B, PCT)

Other respondents – this time from site D – talked of a "victim mentality":

> *The PCT felt like a victim and blamed the trust...it didn't 'own' the problem... Even when they recognised it was a problem, they blamed others.* (Site D, PCT)

One interviewee from the provider in site D talked of staff regarding overspending as "a victimless crime" (Site D, provider).

On a related note, respondents from two sites (B and D), also spoke of a general inertia and passivity in the PCT, where poor performance (internal or external) was largely left unchallenged. A respondent from site B, for example, said: "they had a mind-set where they were powerless – even though it was a period of considerable financial growth".

Another issue raised by multiple sites (A, B, C and F) was the failure of PCTs to collaborate with other commissioners in their area, or more widely, in the years preceding 2006 (when three of our sites comprised several smaller PCTs). Respondents variously said that: "no-one really trusted anyone… so there wasn't really… cooperative working that would have made that arrangement [with the foundation trust] far more successful" (Site C); that the PCTs "didn't work together to challenge the trust" (Site A); and that the PCT became "a by-word for being physically and strategically distant... Not known for working collaboratively or collegiately" (Site B). According to some interviewees, part of this was a response to sharp practice on the part of the provider. As one interviewee from site F put it:

> [The acute] *trusts were able to play* [the PCTs] *off against each other...* [to] *exploit differences in contract management (agree different contracts with different triggers and thresholds) which meant they could resist pathway redesign... PCTs talked about trusts* [as trying to] *'divide and rule'.* (Site F, PCT)

Most respondents recognised that a certain degree of tension between purchaser and provider was entirely right and proper. Indeed, a respondent from site A argued that relationships in their health economy had become "too cosy" and "not challenging" enough. However, a more common narrative (in four out of the six sites: B, C, D and F) was that the relationship between purchasers and providers was too antagonistic, and a contributing cause to their health economy's poor financial performance:

> [The PCT] *were at strategic loggerheads with the hospital...* [They had] *got into a mind-set that the hospital was evil – even the non-execs...* [It was a belief that permeated] *every level of the organisation, from the chair on down...* (Site B, PCT)

Respondents often put this kind of tension down to a lack of understanding between the PCT and the provider and, in particular, a failure on the part of providers to appreciate the perspective of the PCT. PCT respondents from site C, for example, argued that the "foundation trust did not understand the financial problems in the PCTs". PCT respondents from site A pointed not just to the foundation trust as not understanding the issues but also to local GPs who, they said, remained "unaware of the issues" (Site A, PCT).

An interesting perspective on this problem was offered by one respondent from the PCT in site B:

> *I don't think the hospital was any more predatory than a good hospital should be. It was very good at claiming, under the rules what was owed to them – nothing more.* (Site B, PCT)

The problem, the respondent argued, was that the PCT could not find a way to have a productive relationship with the hospital, while recognising that both were ultimately acting in their own self-interest. This measured view was unusual among interviewees, most of whom described an antagonistic relationship with their counterparts.

5.7 Leadership and management

The make-up and performance of staff was seen as an issue to at least some degree in all sites. Respondents saw a failure of leadership as a significant factor in case study sites' slide into financial deficit. A common thread here was a general failure of management to actively address the problems in their organisation or area. One respondent from site A argued that management did not "grasp the nettle"; a respondent from site D described management as "rudderless". For others, the problem was that senior managers tended to be too idealistic. As one respondent from site B put it, "[the organisation] suffered from being visionary rather than effective" (Site B, PCT).

Some argued that, in the case of PCTs, the calibre of leaders was often a by-product of their size. One interviewee from the PCT in site F said that the pre-2006 PCTs in their area were "too small to all have quality leadership". In most cases this was not restricted to chief executives but included senior leaders in general – from chairs, to non-executives, to finance directors.

> *The calibre of the staff was low, because small organisations don't tend to attract the best staff... they tend to go for big organisations with power and good systems.* (Site C, PCT)

Another common theme was the turnover of staff particularly at the highest levels (chief executive, finance director, chair). This was a particular feature of PCTs, with providers enjoying more stable senior leadership. One interviewee from the provider in site B claimed that, in the time that they had been working in the area, the acute trust had only had one chief executive, whereas the PCT had had 'nine or ten' – actually an exaggeration, with the correct figure being five. This was seen as a problem because it made it difficult to forge long-term relationships between the commissioner and providers.

However, it is also important to note here that, for some respondents, one of the reasons their health economy fell into deficit was the relatively low churn of staff. For example, one respondent from site A argued that low staff turnover prior to the PCT merger had led to a sense of "stagnation" in their area, contributing to its relatively poor financial performance.

6. Responding to the deficit: what helped and hindered?

Interviews sought to explore the factors that senior leaders felt helped and hindered their attempts to return their respective health economies to a sound financial footing. Actions taken to address financial difficulty appeared to take a relatively consistent form across all sites, whether successful or not: as all were in the official 'turnaround' programme, they were assigned a turnaround director or team and were required to produce a turnaround plan. In addition, all sites attempted to manage activity, mostly by setting up referral management centres/protocols and through the use of benchmarking in general practice, and all, to varying levels, addressed internal governance issues.

Perhaps where the approaches diverged was in the extent to which a whole economy view was taken. Although all sites talked about addressing issues within their own organisations, the sites that turned around quickly appeared also to focus on relationships with other local organisations. Sites that continued to struggle appeared more likely to have pursued solely short-term goals at the expense of taking a longer-term strategic perspective in the period immediately following 2006.

Rather than revealing a single formula for regaining financial balance, our analysis suggests that the success of struggling health economies in turning around their financial fortunes depended on how effectively they navigated a series of tensions. Of course, these tensions varied according to context, but thematic analysis identified some common trends. These are explored below.

6.1 External input: ensuring it is 'owned' locally

All sites had external help in the form of a turnaround director or team during 2006. Some brought in further external expertise during subsequent years. Respondents generally found this external input to be helpful – with the exception of some staff in two PCT sites (A and D) who felt that the turnaround team or director was not sufficiently directive or "made little difference" (Site A turned around quickly and site D remained in difficulty). In other sites, interviewees reported that external input helped to bridge barriers between commissioner and providers, and helped to escape a cycle of blame. As one interviewee reported:

> [company x's input] *was very helpful because you had some fairly strong organisations with various different views all… I suppose, avoiding the blame bit about well it's your fault and, you know, it's why this hasn't happened or x, y and z hasn't happened… They brought interesting perspectives, they were able to benchmark data to show where we were at odds with others and to provide that external facilitation.* (Site F, PCT)

Another interviewee from site E described the turnaround director as a "broker":

> [name] *was a really effective broker… particularly within the hospital, putting together the programme office and running the turnaround.* (Site E, provider)

However, interviewees stressed the importance of embedding this external support. Respondents from site C complained that their initial turnaround plan was "imposed by the SHA" and consequently "owned by very few people and certainly not providers" (Site C, PCT). Subsequently, a new plan was developed, which was generally felt to be owned by the health economy.

Summary: External expertise can be helpful in improving organisational discipline and brokering difficult discussions. However, for change to endure, plans need to be owned and embedded by individuals in the site.

6.2 The importance of leadership: stability without stagnation

Leadership emerged as a key theme in this piece of work. Interviewees routinely stressed both the importance of high-calibre leaders and stability of leadership, and this was echoed in the Audit Commission's own analysis in 2006 (Audit Commission, 2006).

All PCTs experienced at least one change in leadership in 2006 (three as a direct result of reconfiguration) with some PCTs experiencing upwards of six chief executives and finance directors in subsequent years. Such a change was sometimes found to be helpful in bringing in a fresh perspective. Indeed, respondents in site A warned about the dangers of "stagnation" – there had been very stable leadership across all organisations in the economy in the run-up to 2006 and some interviewees asserted that the management had become somewhat complacent, with the result that financial issues had not been addressed. An injection of "new blood" from outside the health economy was felt to bring new ideas and a new culture.

On the other hand, many interviewees argued that too much change in senior leadership could be problematic. Interviewees in site F pointed to a change in senior leadership at a crucial point in their efforts to turn the economy around as a contributing factor in their difficulties. Accounts from this site suggest that the economy was initially recovering but then declined once more when several members of the PCT's senior team left, leaving the organisation with an interim chief executive for around a year. PCT and provider interviewees talked about "problems creeping back in" and the PCT losing "its grip on finances" during this time (Site F, PCT). Respondents from sites B and D also referred to constantly changing senior leadership as a challenge, with providers acknowledging that the turbulence was problematic for them too. One commented:

> *I think in their* [the PCT's] *defence, a lot of it was because everything kept changing. You spend so much time on that process, and you lose all the corporate memory and you have to rebuild relationships with people like ourselves. But to me that was* [a] *more fundamental issue than whether or not they had financial problems.* (Site F, provider)

Summary: High-calibre leadership is essential when steering a health economy out of financial difficulty. Stability of leadership is advantageous in maintaining financial balance and not allowing a deficit to arise; however a lack of change for long periods can risk stagnation.

6.3 Commissioning at the right scale

Interviewees from both PCTs and providers talked about the size of PCTs as an important factor not just in explaining their difficulties, but also in the success of turning health economies around. Three of our case study sites were reconfigured in 2006, having been created from at least three smaller PCTs – two of them turned their financial situations around very quickly, one remained in difficulty. Without exception, all PCT interviewees from these sites commented that the reorganisation of PCTs into fewer larger PCTs aided their recovery for a number of reasons. Some interviewees felt having a single larger PCT was beneficial insofar as it allowed the board to have an overview of the whole (or at least a large portion of) health economy. Two PCTs (Sites A and C) credited this as central to their efforts to get a grip on the financial situation because it provided them with a single set of information.

Interviewees also argued that larger commissioning units helped to rebalance the relationship between commissioner and provider. Prior to reorganisation, interviewees in PCTs suggested that providers had been able to use their size to their advantage during contract negotiations – as one respondent put it, providers could "play one PCT off against another" (Site C, PCT). Reorganisation allowed the PCT in site F to benchmark across a wider area, helping it to "spot bad behaviour" in providers (Site F, PCT).

Having a single, large purchaser rather than multiple, smaller PCTs was seen as advantageous by some respondents from acute trusts, who claimed it was easier to deal with fewer commissioning organisations. One provider in site F said that working with a single PCT facilitated longer-term planning, by better ensuring the relationship between the organisations remained consistent.

Larger purchasers were also considered to facilitate economies of scale, improved commissioning practices, and were better able to attract high-calibre staff. Some respondents argued that their site's failure to move to a single organisational structure quickly contributed to their ongoing financial troubles. For example, despite formally being a single PCT, site F retained a locality structure for some time, having initially been formed of a number of PCTs. Interviewees said that this led to competition between different commissioning units and to the replication of scarce skills.

Summary: Commissioning units need to operate at scale in order to effectively balance the relationship with providers and to benefit from economies of scale. Collaboration across commissioners also offers an overview of the financial situation and therefore enables more effective management of risk.

6.4 Inter-organisational relationships: striking the right balance between collaboration and challenge

Many interviewees said that efforts to improve their financial position were aided by a sense of collaboration across the whole health economy, underpinned by constructive relationships, particularly between commissioner and provider.

Sites A and C (the fastest to turn around), for example, made deliberate efforts to work across the health economy and to foster collaboration early on in the turnaround process. One interviewee from site A's PCT remarked that the "solution is in collaboration". Similarly, the chief executive of the PCT in site C made it a priority on joining the newly-formed organisation in 2006 to change relationships with providers.

Respondents from sites D and F (both remained in difficulty) also recognised a need to foster better collaborative relationships, but admitted that they failed to do so early enough. In site F, relationships between commissioner and providers were described as "strained" and the language used during interviewees pointed to long-standing hostility: PCT respondents talked about providers "growing their way of trouble"; one interviewee from a provider commented: "I think the PCT tried [to play the providers] off against one another" and another interviewee at one acute trust suggested the PCT suffered from a skills gap. Efforts were made in recent years to foster cross-economy relationships in site F:

> *there was a recognition… back in 2008 that, rather than developing our own initiatives and efficiencies, there is a system to sit down and have a robust conversation about what the financial problems were in the system as a whole… it teased out what the problems were for the system as a whole.* (Site F, PCT)

Interviewees in sites that successfully turned their economies around also emphasised the need for collaboration beyond just hospitals and commissioners. Indeed, they stressed the importance of building links with local authorities, GPs, patient representatives and the wider public.

One note of warning, though, was offered by respondents from sites B, C and E, who argued that while good relationships are important, there still needs to be some challenge and tension to prevent relationships from being too cosy. As one respondent put it:

> *There have always been tensions between commissioners and [the hospital] for as long as I can remember. But if there wasn't a tension you'd wonder if we were doing our job properly.* (Site E, PCT)

Summary: Deficits are more effectively tackled through a whole economy approach, underpinned by relationships that are collaborative but not cosy.

6.5 Maintaining internal focus without losing sight of the whole economy view

Interviewees stressed a need for strong internal governance and processes as a first step in addressing financial deficit. Indeed, troubled organisations in all sites undertook some level of internal restructuring/development. The aim of much of this activity was to establish robust accountability structures, tight financial governance, high-quality data systems and sufficient in-house capability and capacity. However, a message from the interviews is that, while "getting one's house in order" is important, it must not happen at the expense of a whole economy perspective.

Both sites D (provider and PCT) and E (the provider) acknowledged that they initially took an overly insular approach to their deficits and that this was not helpful in achieving a sustainable solution. Interviewees from site D reflected that both the PCT and hospital became very introspective, looking internally for solutions at the expense of working together to address the problems. Similarly, the hospital in site E tended to "look within its four walls" for answers to its problems. The insular approach in site D was blamed by some interviewees for the slow development of relationships, as described in the section above.

The other approach that was felt to be unhelpful was a focus on data to the exclusion of other factors. While analysing activity statements from providers is clearly a key part of the commissioner's role, some PCTs in our case study sites began to analyse every single transaction. This was described by one interviewee as "a waste of time" by a PCT representative in site C. Similarly, former employees of the PCT in site D reflected that the efforts to verify data resulted in an approach that focused purely on transactional issues and failed to bring about needed service change:

> *A whole industry built up around checking data, rejecting stuff that didn't have the right postcode… it focused much more on the transactional aspects of running the system than it did improving the health of the economy.* (Site D, PCT)

Summary: Developing strong internal processes and governance is essential, but this must happen alongside, not at the expense of, a strategic and outward-looking approach.

6.6 Planning for the longer term: balancing short-term goals with long-term strategic change

A key pressure facing all the organisations interviewed was the need to bring about rapid turnaround. This forced a short-termism which, some interviewees reported, was not always helpful in addressing underlying causes of the deficit. The annual financial cycle in the NHS was cited by some as creating constant pressure for short-term solutions and that the requirement to meet short-term targets often meant that the need for longer-term strategic change was not addressed.

When reflecting on the focus of efforts to rebalance budgets in the immediate period following introduction of the turnaround programme, the majority of interviewees described a relatively short-termist approach. A few recognised the shortcomings of this, but argued that the pressure to rebalance books immediately forced such a focus. Several interviewees said that there was insufficient time to undertake service

reconfiguration and that actions which produced immediate savings (for example, cutting the workforce, training or estates) were favoured.

> *If you're given a requirement at the beginning of the year to deliver a financial reduction by the end of the year, reconfiguration will take too long to deliver that.* (Site F, provider)

> *We actually took 500 staff out, some on a non-recurrent basis, to deliver a surplus.* (Site F, PCT)

Making short-term cuts to training and estates had been the dominant approach in the PCTs that came together to form PCT A in 2006, and was a key feature of approaches to address the financial situation in sites D and F. In site A, the new PCT leadership changed this way of thinking in 2006. Similarly, a change of leadership in site D also reversed this trend, but not until much later (2010). As one member of staff from the PCT in site D commented:

> *You get what you pay for. If you put staff in rotten facilities with rotten technology, they don't perform well.* (Site D, PCT)

According to interviewees in site D, "the pressure to turn around too quickly runs the risk that things quickly collapse again" (Site D). This interviewee suggested that turnaround in the NHS takes at least two years. Respondents in PCTs A and C similarly stressed that "turnaround is easy but maintenance is harder" (Site A, PCT).

Furthermore, in the rush to bring about rapid turnaround, interviewees felt that the underlying causes of the deficit were not properly explored and understood. Site A's PCT reported that, prior to the leadership change in late 2006, attempts had been made to address the financial problem but they were unsuccessful because they had not identified the causes. Similarly, informants from site B reported that the financial situation got worse and that part of the problem was that there had been a failure to get at the underlying causes of the original difficulties. Interviewees talked of the pressure to balance the books within the year and suggested that this was the focus rather than understanding how it came about to begin with. Respondents from sites A, B, and D, for example, all argued that almost no effort was made to identify the cause of the deficit. As one from site B remarked:

> *No one at [health economy B] could diagnose the source of the problem – they weren't able to work out what drove the overspend.* (Site B, PCT)

Failure to unpick and understand the causes of deficits appeared to have been facilitated, partially, by the movement of non-recurrent or additional income across the NHS. As explained in the context section, it had been common in the NHS to shift money from areas of the system in surplus to those areas in deficit. The result was that, on paper, nearly all NHS organisations balanced their books annually. The availability of such non-recurrent income masked the underlying positions of many organisations and, according to some interviewees, allowed them to continue to operate without having identified the causes of the original problem. Establishing exactly how much non-recurrent funding an organisation has received is difficult, but interviewees in four sites reported having received some such funding. There also appeared to be a tendency in some sites to blame factors beyond the organisation's control for their financial difficulties and that this behaviour distracted from any attempts to diagnose issues that could be controlled or managed effectively by the organisation.

Summary: While there is pressure to meet financial targets in the short term, addressing underlying causes of deficits requires careful diagnosis of the problem and long-term strategic change.

6.7 Clinician, staff and public engagement: ensuring change is 'owned'

A clear message from the interviews was the importance of engaging clinicians, management staff and the public in any change and, in particular, ensuring that GPs both 'own' the financial problem and see it as something that they can control. All sites admitted to having struggled in some element of engagement and some sites recognised its importance relatively late in the process of addressing their financial difficulties. Interviews suggested that staff and public engagement is difficult and can take time but, if done in a timely manner, can be beneficial to overall efforts to turn around the financial situation. Part of the challenge in at least four of the sites (A, B, D and E) was in bringing about a culture change within the troubled organisation from one of blame or externalising the problem, to one where everyone within the economy understood that they have a role.

The former chief executive of site C's PCT said they prioritised GP engagement early on in the turnaround process, recognising the need to begin conversations with local practice-based commissioning in order to address concerns about elective, non-elective and prescribing spend. The chief executive added that money was invested in practice-based commissioning and, while it took a while to develop, they began to see an impact by 2008 (roughly two years after the turnaround process began). GP engagement also came late in site A; practice-based commissioning had been seen as PCT-led and slow and bureaucratic, and it was not until 2009 that GPs began to take ownership.

> *It's about ownership.*[As a GP]*, every time I sign a prescription, every time I make a referral, I'm spending money.* (Site A, PCT)

The PCT chief executive in this site blamed historically poor relationships between the PCT and GPs for the slow culture change among GPs. Although site A turned around relatively rapidly, several interviewees said that GP engagement in subsequent years had been central to maintaining financial balance.

The challenge of engagement of GPs and others was keenly felt in site B. Again, poor PCT–GP relationships were blamed and former PCT staff suggested there was little clinical leadership at the PCT. A similar story emerged in site F where frequent changes in structures and leadership made relationship building difficult. Some suggested that organisational change and a pressure to turnaround quickly (see above) inhibited their ability to properly engage stakeholders.

Summary: Staff, clinician and public engagement is difficult and time-consuming, but it is crucial for bringing about change and maintaining financial balance.

7. Discussion: implications for CCGs beyond 2013

The period from 2006 to 2010 was one of significant financial growth for the NHS with total spending increasing in real terms by an average of seven per cent a year (Appleby and others, 2009). Despite this context of growth, numerous health economies experienced financial deficits and difficulties, and some continued to struggle financially after 2010. Our analysis has attempted to explore what senior health service leaders understood to be the principal reasons for the original problems and to understand why some areas managed to regain financial health while others continued to struggle.

This study adds weight to many of the themes that have emerged in the literature published from 2005 to 2007, which pointed to internal issues of leadership and governance, combined with the pressures of national policies, as explaining financial difficulties in health economies. What this research adds is a recognition that the ability of senior leadership to navigate a series of tensions determines whether or not attempts to rebalance the economy are successful.

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While contextual factors can present challenges, they do not appear to completely explain the success or otherwise of health economies. The literature suggests that the allocation formula may disadvantage some areas and some interviewees perceived this as a factor, although others argued that the culture of an organisation could overcome such challenges. Previous studies have also pointed to national policy as leading to deficits. Some sites cited policy issues as being at the root of their problems, but these were common to all health economies, not just those in financial difficulty. Others maintained that early wave foundation trusts put particular pressure on health economies but, again, other areas managed to maintain balance in the face of such developments and, indeed, the presence of one or more foundation trusts does not appear to have disadvantaged two of our sites in regaining balance.

In some sites, there appeared to be a tendency to attribute difficulties to external factors beyond the control of the organisation and this took the focus away from what could be achieved locally with effective management. The lack of a single narrative within each of the six health economies also suggested a failure in some cases to undertake a process to diagnose and understand the cause of the financial difficulty. Some interviewees recognised this failure but justified it by citing short-term pressures or a lack of cooperation on the part of other members of the health economy.

A principal observation from our research is that there was no single set of activities that appeared to lead to financial stability following 2006. Indeed, most sites undertook a similar combination of activities: all focused on demand management and on developing internal structures and processes; and, at some point during the period in question, all looked outwards across their health economy in order to develop relationships with other organisations, with varying degrees of success. Instead, success appeared to rest on the ability of senior management to perform a 'balancing act' between what may have seemed like conflicting approaches and factors. None of these issues or balancing acts will be unfamiliar to experienced managers but this shared wisdom provides a rich seam of learning, primarily for CCGs, as the reforms take root.

7.1 What can CCGs learn from the past?

CCGs are facing numerous challenges, and learning from the past is important. It is likely that public sector budgets will continue to contract. This spells tough finances for all organisations in the NHS and the need for even tighter financial management for CCGs. As both leaders of CCGs and partners of GP practices, many members of CCGs are grappling with financial pressures both as a commissioner and as a provider, adding a greater level of complexity to financial management than that experienced in the period from 2006 to 2011.

A principle of the current NHS reforms is that clinical leaders have a significant impact and influence on the system. For this to be realised, CCG boards need to exhibit strong leadership and effective management skills. Many of those in senior positions in CCGs do not necessarily have a great deal of leadership experience, so there is a real challenge for them to develop the appropriate skills and provide a consistent level of strong leadership at the same time. Keeping GP members engaged and on board with change and organisational development needs a particularly effective form of leadership (see Naylor and others, 2013, for more discussion).

Stable leadership, particularly during the critical first years of operation, is essential in fostering a constructive culture among GP members. Retaining high-quality leaders may be a challenge, particularly given the pressures facing the clinical members of CCG governing bodies who will be facing a steep learning curve in terms of management, leadership and governance in addition to continuing to manage their clinical practices and the inevitable conflicts of interest and potential divided loyalties that their dual roles will generate. Previous experience from PCTs suggests that frequent changes to senior leadership can be detrimental to attempts to keep a grip on finances. However, CCGs should also bear in mind the risks of stagnation and recognise that change in leadership can be beneficial if introduced at the right time. Investment in the leadership of CCGs needs to be a priority for policy-makers at a national level.

Critical to the effective working of CCGs is their ability to develop constructive but challenging relationships with providers, health and wellbeing boards, Local HealthWatch, public health, social care, the wider local authority and local area teams. Our research suggests that, given the financial climate, CCGs need to be highly skilled in developing relationships that are challenging but not antagonistic if they are to successfully address the long-recognised imbalance of power between providers and commissioners (Smith and Curry, 2011). This will be all the more critical where CCGs plan to decommission or radically reorganise services.

The system does not necessarily facilitate collaboration between providers and commissioners, so a significant challenge for CCGs is in demonstrating the potential mutual benefits to secondary care clinicians and their organisations. In some areas, a CCG may need to forge relationships with multiple bodies and the governing body will need to recognise the value of investing in those relationships. CCGs also need to carefully consider the relative roles of competition and cooperation, and be able to use the most appropriate approach when required, developing an appropriate relationship with providers. Being able to hold effective discussions about financial and service issues across all local health and social care bodies is important for CCGs wanting to gain common understanding of priorities and develop workable plans. This is likely to require significant investment of time, which of course is at a premium for those involved in running CCGs.

Another key message from our research is that PCTs got into financial difficulty partly as a result of being too small to wield power and influence in the system. When introduced, CCGs were allowed to form organically with no minimum size specified, although anecdotal evidence suggests that some very small CCGs were strongly encouraged to merge. There are 211 CCGs with populations ranging from just under 70,000 to around 900,000, with a median population of 226,000 (NHS Commissioning Board, 2012). This compares to the previous arrangement of 151 PCTs with a median population of 284,000 (Naylor, 2012). Prior to 2006 when the deficits emerged, there were 303 PCTs with an average population of 160,000 (Martin and others, 2008), with the number being reduced to 151 in the period 2006 to 2010.

As many CCGs have smaller populations and smaller footprints than their immediate predecessors, it is imperative that CCGs collaborate and work together to ensure that commissioning decisions are made at a scale that is most appropriate for the service in question. Although CCGs do not commission as wide a range of services as predecessor PCTs, maintaining an overview of the financial health of a total locality will help to avoid the situation that arose in 2005/06 where PCTs commissioning from the same providers could have diverging financial situations. Having a streamlined approach across a number of CCGs will help commissioners to challenge the prevailing power of providers in the system and facilitate more productive working relationships across health economies. It is possible that regional commissioning support units (CSUs) and the local area teams of NHS England might play an important role in facilitating these relationships. CSUs also have the potential to provide strong, shared back-office functions as well as to maintain an overview of the wider financial picture that individual CCGs may lack.

Having a streamlined approach across a number of CCGs will help commissioners to challenge the prevailing power of providers in the system and facilitate more productive working relationships across health economies.

One of the issues identified by PCT staff was the asymmetry of information between commissioners and providers, with commissioners disadvantaged by lengthy time lags in the receipt of acute data. Although less of an issue in recent years as data feeds

have become faster, CCGs still need to ensure they have the appropriate capability and capacity in data analysis and management if they are to hold providers to account effectively. The public inquiry into the quality of care at Mid Staffordshire NHS Foundation Trust (Francis, 2013) highlighted the need for commissioners to be in a position to hold providers to account, not just for activity but also for quality, and CCGs need to ensure they have the systems in place to do so.

As it is unlikely that CCGs have in-house all the skills required to operate effectively, they will be buying in varying degrees of support from external commissioning support services. CCGs will need to know how best to use that support and to ensure that any changes that are introduced as a result of it are felt to be 'owned' by members. Previous research indicated that PCTs did not always have the appropriate expertise to use external support effectively (Naylor and Goodwin, 2010) and CCGs should heed this learning. Our interviews also pointed to the risks of external input not being properly embedded in the local context, so CCGs need to be particularly vigilant in this area. Many CSUs will be staffed largely from the former PCTs, so have potential to provide CCGs with a rich source of information and understanding about the local context.

With all the tasks that CCG governing bodies have to accomplish as they take on their full responsibilities, there is a risk that engagement of member practices, the public and others may not be a high priority. Our case study sites all underlined the importance of taking the public, clinical and managerial populations along with change. The current financial challenge means that CCGs will need to take some difficult decisions about service reconfiguration and possible closures, and it will be crucial that these decisions are made in the context of proper dialogue between all stakeholders. Acute reconfiguration and closures are already underway (for example, South London and North West London) and CCGs need, and be allowed, to play a central role in facilitating change that ensures the needs of their populations are met and that the changes are understood by all parties. Engagement takes time and resource and should be seen as a core duty of CCGs, not an added extra. Particularly crucial is the CCGs' ability to engage with their GP membership. PCTs reported struggling to engage with GPs and CCGs will need to work hard to embed a sense that every GP has a part to play in ensuring the financial performance of their CCG. Although CCGs will have fewer formal levers than PCTs to influence GPs as providers as their contracts will be held by NHS England rather than by the CCG, they are much better placed in terms of common purpose, persuasion and peer review. They may also have some financial incentives to influence GP behaviour (see Naylor and others, 2013).

A major risk during the early months and years of CCG existence has been and will be that these new organisations are focused on their own organisational development. The scale of the organisational development challenge for these CCGs became obvious in a simulation exercise run in late 2010 (Imison and others, 2011). Of course, it is essential that CCGs become viable organisations with robust governance processes, clarity of accountability and strong engagement among members. Indeed, our research emphasised the need to ensure that internal processes and policies are in place and operating effectively. However, it is also important that at the same time as focusing inwards, the CCG also maintains a strategic view across the whole health economy. Our research suggests that keeping a grip on the finances requires a dual approach.

CCGs, as statutory bodies, will have a requirement to break-even on an annual basis. They, therefore, face the pressures that their predecessor PCTs experienced to pursue

short-term fixes to immediate financial problems. Our research suggests that, while balancing the books annually is an important duty, developing a strategy for the longer term is also essential. A long-term strategy for maintaining financial balance should seek to effectively identify potential pressure points in the system and to bring about appropriate change.

Finally, the last point of learning that CCGs should heed is the need to identify mounting problems and the cause of any financial issue. During the course of our research, it emerged that not all health economies had properly diagnosed the causes of their financial difficulties post-2006 and that this appeared to contribute to the difficulties in maintaining balance. CCGs should take time to properly understand the causes of any difficulties in order to ensure they tackle the right issues and to avoid the tendency to simply blame external factors beyond the control of the CCG. What this research and much previous analysis has pointed to is the importance of managerial capability in unpicking the causes of financial difficulties and getting to grips with the issues that need to be addressed.

Box 2: Ten lessons for CCGs

1. Identify and assess the reasons for financial problems as they arise and avoid attributing difficulties solely to external pressures (for example, resource allocations) over which there is little control.
2. Strive for strong and stable leadership to ensure consistency and aid development of relationships – although some level of change, if well timed and well managed, can bring fresh ideas and momentum.
3. Foster constructive relationships between providers and commissioners, while being mindful of the dual roles of competition and cooperation.
4. Work together with other CCGs to ensure financial risks are managed effectively – this may involve developing a complex matrix of commissioning arrangements.
5. Invest in management capacity and capability, whether provided in-house or bought in from commissioning support units or elsewhere, to ensure internal governance and financial processes are efficient and effective.
6. Ensure that where support and input are purchased from external suppliers that CCG members are involved in the process and feel they own the resulting plans and strategies.
7. Invest considerable effort in engaging with members of constituent practices to ensure GPs fully understand the role they play in the financial health of their CCG, and feel that they have ownership and influence.
8. Engage with the public (this will be critical when difficult decisions need to be made, particularly about service closures) and take other health and social care organisations along with any major change to ensure they are managed effectively.
9. Organisational development, although important, should be balanced with an outward-facing, strategic, whole-economy perspective.
10. Develop a long-term financial strategy as well dealing with immediate pressures – the financial health of CCGs will depend, in some cases, on significant service change, which requires strategic thinking.

8. Conclusion

This research provides insight into the causes of, and reactions to, financial difficulty and the types of factors that have helped and hindered health economies in addressing deficits. It has built on the existing literature and further added to our understanding of the behaviours and approaches of senior leaders who face a challenging financial situation. It has offered some valuable lessons for CCGs as they take on their full responsibilities.

The challenges facing CCGs should not be underestimated. There is a need at a national level to recognise these challenges and to support CCGs. While their potential ability to better engage with clinicians across the health system may offer them greater legitimacy in the eyes of the public and providers than their largely managerial predecessors, CCGs face a very complex future. Not only are they grappling with constrained commissioning budgets, but they are also managing financial pressures as providers of GP services. Indeed, there are already reports of some CCGs forecasting large financial deficits in their first year (*Health Service Journal*, 2013).

“While their potential ability to better engage with clinicians across the health system may offer them greater legitimacy in the eyes of the public and providers than their largely managerial predecessors, CCGs face a very complex future.

Given the permissive policy around minimum CCG size, many will be operating at a smaller scale than their former PCT, which may further limit their ability to challenge providers and hold them to account. Although some are employing individuals from the former PCT, many will suffer a loss of collective memory and it will be essential that they draw on the expertise and knowledge of their local CSU.

CCG leaders are on a steep learning curve in terms of leadership and management skills, and NHS England needs to ensure that they are sufficiently supported and given access to appropriate training. Important in retaining good leaders, CCGs need to feel reassured that they have the freedom and autonomy to make decisions that are suitable for their local populations. This is particularly important as the NHS goes through a prolonged period of austerity and all that that may entail. Being able to engage with local populations, local GPs and other health and social care organisations is central to the success of CCGs.

While our research offers some valuable lessons for emerging CCGs, it has not been possible to review all the factors that may explain financial performance in health economies. This is, in part, the subject of a further piece of quantitative work which is using routine data to examine what factors, if any, are associated with the financial performance of health economies. This work will be published in the spring of 2014.

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