



EXIT, MERGER AND RECOVERY: DEALING WITH NHS PROVIDERS IN DIFFICULTY

To explore the issues involved in dealing with NHS providers in difficulty, the Nuffield Trust held a series of seminars led by experts in this field. The experts were Andrew Cash, Director General of Provider Development in the Department of Health; Mark Goldman, Chief Executive of the Heart of England NHS Foundation Trust; and Bill Moyes, Executive Chair of Monitor.

This report is a synthesis of the seminars, prepared by Professor Chris Ham, chair of the series and adviser to the Nuffield Trust. The seminars were held during February 2007.

Report summary

The main conclusions of this report are:

- taking action to prevent financial difficulties by recognising the warning signs, engaging appropriate experts, and intervening to avoid escalation is critically important
- Monitor's experience demonstrates the value of a rules based intervention regime that makes explicit what is expected of Foundation Trusts, and the consequences that will follow from failures of performance
- a menu of options is available for dealing with financial difficulties, including cost reductions, the use of loans, the sale of assets, and service reconfigurations; taken together these options make up the NHS recovery regime
- in the case of serious financial failures, there is also the option of merger by acquisition, and the experience of the Heart of England NHS Foundation Trust and Good Hope NHS Trust, described in this report, is the first case in which merger by acquisition has been used

- market exit and insolvency need to be real options in order to create an incentive for Foundation Trusts to improve, but as yet there is no agreed exit regime, nor is there clarity about what insolvency means in the case of Foundation Trusts
- the NHS and Monitor face challenges in enabling the government to meet its objective of enabling most NHS Trusts to become Foundation Trusts by the end of 2008, especially in the case of providers with large deficits
- in some circumstances, it may be appropriate to create Foundation Trusts encompassing a number of hospitals in an area; as in the case of mergers, this will need to be reconciled with the requirement for patients to be able to choose between competing providers
- the Health Care Commission, and the proposed new regulator of health and social care, need to work closely with Monitor on the safety and quality of health care, and in the process ensure that issues related to financial failure do not take precedence over concerns for quality and safety

About the Nuffield Trust

The Nuffield Trust is one of the UK's leading independent health policy charitable trusts. It promotes independent analysis and informed debate on UK health care policy and acts as a catalyst where fresh ideas and information are devised and developed through a programme of activities within four policy themes: Policy Futures; The Changing Role of the State; Public Health; and Quality.

The Policy Context

The programme of health reform in England has focused on extra spending linked to targets and performance management to bring about improvement. The government is now seeking to drive change bottom up through the actions of patients and providers, rather than top down through directives from Whitehall.

To this end, patient choice and competition between providers are being given greater emphasis, supported by payment by results and practice based commissioning. The aim is to create a 'self improving' system in which there is less reliance on targets and performance management and a stronger dynamic within the NHS for staff and the organisations they work for to be responsive to patients and efficient in the use of resources.

As a result of choice and competition, some providers are likely to attract additional patients and income, while others may be faced with a reduction in demand for their services and challenges in balancing their budgets. These challenges are compounded by changes to the financial regime that have brought about greater transparency in the financial position of NHS organisations and removed the scope for using brokerage and other mechanisms to obscure the true funding position of these organisations.

The Department of Health has made use of turnaround teams from the private sector to offer support to the NHS organisations faced with the biggest deficits. These teams have worked with the organisations concerned to agree actions to be taken to reduce deficits, and to support them in implementing these actions. Turnaround teams are likely to have a continuing role as the NHS works towards the target of a net surplus of £250 million in 2007/08.

The view from the centre

There are 229 NHS Trusts in England, acute and mental health, and as at 1 May 2007 65 have achieved Foundation Trust (FT) status. The Department of Health expects that up to 100 will have become FTs by December 2007, rising to a maximum of 170 by December 2008. There are also 152 PCTs in England

and many have significant provider functions. The expectation is that PCTs will increasingly concentrate on their commissioning role and a variety of models will emerge for their provider functions. These include community FTs and social enterprises.

The context for handling NHS providers in difficulty is one of transformational and transactional change. Transformational change derives from a number of sources including the white paper, *Our Health, Our Care, Our Say*, and the vision of strengthening prevention, providing care closer to home, and offering more support to people with long term conditions. The transactional changes are represented by payment by results, the development of commissioning, and the development of new models of service provision. In addition, patients are being offered a wider range of choices, and providers are competing for patients in the emerging health care market.

The Department of Health's priorities are the 18 weeks target, reducing MRSA and other hospital acquired infections, narrowing health inequalities, promoting health and well being, and achieving financial health. There is also an increasing focus on achieving efficiency improvements. 2007-08 will be a relatively stable year with a roll over of the current tariff arrangements and their extension to rehabilitation and diagnostics. 2008-09 will be the transformational year with the return to historic levels of growth. The aim is that primary care based commissioning will then be in place and that the last big target (of 18 weeks) will have been achieved.

Major change will be needed in 2008-09 as competition increases. There could be a reduced demand for DGH services as out of hospital care expands. Dealing with spare capacity may then be a bigger issue than coping with under capacity. With all providers registered with the proposed national regulator for health and social care, and tighter funding linked to stronger commissioning, there is an increased possibility of provider failure.

Provider failure could lead to de-registration, loss of contract and, in the case of FTs, insolvency. It is important that this is well managed with a transparent and fair support, intervention and failure regime



across all types of provider. As part of this, commissioners need to ensure continuity of services for patients. The issues are likely to be particularly challenging for those NHS Trusts that do not achieve FT status and have the most serious financial problems (see below).

Support and intervention need to be triggered by early awareness of problems. In many cases, intervention through turnaround teams and other means will lead to recovery. There is a menu of other options available for dealing with difficulty, including service reconfiguration, partnerships (including mergers and acquisitions), franchise, sale or long term lease of assets, finance (including loans) and closure of services.

Failure should be rare but real enough to create incentives to continuously improve.

Insolvency may occur when FTs are unable to meet their liabilities or secure further loans to allow them to continue. There is a need to agree what happens in the aftermath e.g. how to ensure continuity of essential services for patients which is a commissioner responsibility. The Department of Health's consultation document on the future of regulation stated that work was in hand to prepare secondary legislation to establish an insolvency regime for FTs. As the document noted:

'We expect to lay regulations in 2007 that will:

- allow for the protection of essential NHS assets and services*

- establish a transparent regime for creditors and potential creditors of NHS foundation trusts*

- provide recourse and protection for the creditors of a failed NHS foundation trust*

- reflect the important role of Monitor in overseeing NHS foundation trusts'.*

(Department of Health, 2006, pp. 48-49)

The Experience of Monitor

Monitor has adopted a graded response in dealing with difficulties in FTs. In the first stage, the aim is to understand the causes of difficulty. In the second stage, Monitor seeks to work with the FT's board to develop and implement a recovery plan. In the third stage, it intervenes to bring about change and improvement.

The causes of financial failure fall into three main categories. These relate to structural issues e.g. too many sites; operational inefficiency e.g. low productivity; and poor management e.g. lack of controls. Monitor's compliance approach seeks to identify problems early and ensure they are addressed rapidly. Monitor has helped to turnaround three FTs within 12 months of problems being detected. These were Bradford, Peterborough and the Royal Devon and Exeter.

In all three cases, substantial deficits have been turned into sustainable surpluses, with a significant loss of posts. Monitor is also working with UCLH which is making real progress in tackling a deficit of £36 million in 2005/06.

Based on its experience, Monitor has developed an action matrix (page 4) linking the areas in which cost can be reduced and the operational levers for bringing about cost reductions. As the matrix shows, areas of

Bradford

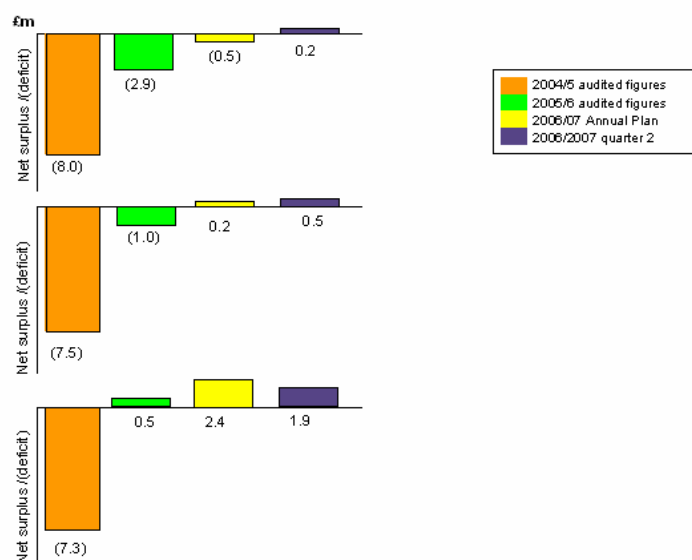
- Turnover - £220m
- Approximately 6% (300) reduction in headcount

Peterborough

- Turnover - £155m
- Approximately 10% (330) reduction in headcount

RD&E

- Turnover - £242m
- Turnaround includes 90% reduction in agency spend and 3% like for like reduction in headcount



high impact in the short term include:

- decreasing pay costs by improved vacancy control, reduced management posts and reduced agency usage, and
- decreasing non-pay costs by improved office supply purchasing, reduced furniture costs, rationalised estate costs, and improved IT effectiveness

In the long term, a relentless and focused approach to delivering greater efficiency is needed to achieve substantial and sustained cost reductions.

The Action Matrix

		Operational levers			<div>High</div> <div>Medium</div> <div>Low</div>
		Increase revenue	Decrease pay costs	Decrease non-pay costs	
Cost areas	Corporate	<ul style="list-style-type: none"> – Contract monitoring – Remove discounts – Improve coding – Increase training or research income 	<ul style="list-style-type: none"> – Increase vacancy control – Reduce management posts – Reduce agency usage 	<ul style="list-style-type: none"> – Improve office supply purchasing – Reduce furniture costs – Rationalise/reduce real estate costs – Examine IT effectiveness 	
	Clinical directorates	<ul style="list-style-type: none"> – Develop new services – Grow existing services – Increase private patient income 	<ul style="list-style-type: none"> – Decrease ALOS – Improve pathway management – Improve theatre utilisation – Increase ward productivity 	<ul style="list-style-type: none"> – Increase use of generics – Standardise medical consumables – Prevent/reduce negligence costs 	
	Clinical support	<ul style="list-style-type: none"> – Provide pathology services – Provide CSSD services 	<ul style="list-style-type: none"> – Improve pathology productivity – Improve radiology productivity 	<ul style="list-style-type: none"> – Outsource contract monitoring 	
	Site costs	<ul style="list-style-type: none"> – Increase rental income – Increase parking charges 	<ul style="list-style-type: none"> – Market test and outsource hotel services (cleaning, catering, laundry, facilities management) 	<ul style="list-style-type: none"> – Improve procurement of hotel services (cleaning, catering, laundry, facilities management) 	

Boards are responsible for addressing failures in governance, clinical quality and service performance. Monitor's approach relies on self certification. Where a board cannot confirm it is achieving standards and targets and managing risks, it is required to set out the reasons why and the steps being taken to address the issue. Monitor then assigns a risk rating for finance, governance, and mandatory services. Governance risk ratings are based on seven elements: legality of constitution, representative membership, board roles and structures, cooperation, service performance, clinical quality, and other risk management processes. NHS FTs' risk ratings are reviewed by Monitor and published on its website.

Heart of England NHS Foundation Trust and Good Hope NHS Trust: a case study

The Heart of England NHS FT has been involved in providing management support to Good Hope Hospital NHS Trust since November 2005.

Good Hope has had a troubled history affecting both quality of care and finances. Its management was franchised to the private sector but for various reasons this did not work. At the end of the

franchise, Good Hope was still draining money out of the patch. Heart of England NHS FT felt it had an obligation to patients and to its business to step in and offer support.

Non-financial failure covers governance e.g. failures of controls or processes; service delivery e.g. failure to meet targets or standards; and clinical quality. Monitor is the only organisation with power to intervene in an NHS FT and it looks to bodies such as the Healthcare Commission to take the lead in investigating clinical and service failure.

Heart of England would not have offered support just to solve the financial problems of Good Hope. It had to be the right thing to do in the context of Heart of England's existing strategy. Effectively, Good Hope and Heart of England have engaged in a partnership, and Heart of England has now acquired Good Hope with the new organisation coming into being on 8



April 2007. Monitor has been involved as a critical friend in the process.

Heart of England's strategy derived from work with local PCTs and was consistent with the *Working Together for Health* project. This project arose out of contact with Kaiser Permanente in California and the aim of developing services outside the hospital. Heart of England was interested in building on *Working Together for Health* and using the opportunity of supporting Good Hope to show what could be achieved.

One of the attractions of the partnership was the greater mass of services provided across the two trusts and the bigger population served. This created an opportunity to develop new tertiary services, and not just to protect what already existed. A major benefit had been forcing Heart of England to look closely at what it does and drive out inefficiencies. Monitor has been looking over the shoulder of the FT as this has happened.

Heart of England was awarded a management contract to run Good Hope Hospital. Over an 18 month period a turnaround from a loss of £6m to a surplus of £1.7m was achieved. This resulted from a combination of efficiency, closure of a ward and a theatre, income growth through better financial procedures e.g. coding, invoicing and some gains from tariff. There was an additional arbitration on income at year end 2005/06 which brought gains in 2006/07 as well as over activity in 2006/07 which brought some additional income.

There was no blueprint to guide the partnership and the acquisition. Heart of England has created the process along the way. One of the lessons had been the need for a strong and sympathetic board to lend its support. Another lesson was the importance of Heart of England having a strong team of managers able to lead change and improvement across the two organisations. The experience had shown that it takes many months to see results, and it is all about 'the art of the possible'. In the process, Heart of England had found it knew its own business better than the big four firms of accountants.

The Heart of England board was clear that the acquisition should not weaken its strong financial position, for example through the use of its surplus to buy out the deficit at Good Hope. An alternative had to be found. The DH, SHA and Monitor worked together to agree a package of measures to support the acquisition. The package included the issue of £18m of public dividend capital to finance Good Hope's debt, rather than covering the debt through a loan.

The advantage of this to Heart of England is that, although public dividend capital attracts a dividend and is owed to the Secretary of State, it does not have a fixed repayment period. Determining the accounting arrangements was complex with Monitor and the DH/SHA having different views on the accounting rules. The experience had underlined the lack of understanding in SHAs of FTs as businesses e.g. that risk transfer costs money. The final agreement was based on the SHA being held responsible for paying interest on the additional public dividend capital that was issued to cover the Good Hope debt (Mooney, 2007).

The new organisation is well placed to take forward the adaptation of the Kaiser Permanente approach in *Working Together for Health*. Alongside the acquisition of Good Hope by Heart of England FT, the PCTs in the east and north of Birmingham have merged. There is a real opportunity for synergy between the new PCT and the FT working across a larger health economy.

The experience of merging Heartlands Hospital and Solihull Hospital in the 1990s had generated important learning that had helped in the partnership with Good Hope. Heart of England FT is one hospital on two sites (Heartlands and Solihull) and Good Hope will become the third site. A lot of work had gone into reviewing clinical services and agreeing the rationalisation of services between the three sites. This had been led by clinicians.

A major organisation development programme had been undertaken to reduce the risk of failure from cultural differences between the merged organisations. The chief executive was personally involved in the programme. Good Hope had regained confidence as

an organisation as its finances and performance had improved.

Emerging Issues

Drawing on the presentations made at the three seminars, and the contribution of participants, the following issues emerged:

Preventing failure

Recent experience underlines the importance of taking action to prevent financial difficulties by recognising the warning signs, engaging appropriate experts, and intervening to avoid escalation. This includes:

- ensuring that NHS boards are aware of their responsibilities and are exercising effective oversight and stewardship
- strengthening the finance function, particularly through the appointment of experienced and able finance directors, and
- engaging clinicians in improving performance.

Monitor's initiative on service line economics is one way of engaging clinicians by enabling them to see the contribution that their services make to the financial performance of their organisations.

Also important is the role of commissioners in preventing financial failure. NHS providers depend critically on developing mature relationships with their principal commissioners in which the intentions of commissioners are understood and the consequences worked through jointly, especially where major changes in services are planned. Organisational instability among PCTs and the uneven development of practice based commissioning have not been conducive to the emergence of such relationships.

Rules based intervention

When financial difficulties do occur, the experience of FTs demonstrates the value of an explicit rules based intervention regime. Monitor has developed and refined this regime since its inception with the result

that FTs are clear what is expected of them in terms of financial and non-financial performance and the consequences that will follow from failures in performance. The FT regime involves a graded response extending from work to understand the causes of difficulty through advice and support and ultimately intervention by Monitor in the case of significant failures. Intervention may include sending in auditors to analyse the causes of difficulty and action to replace board members (as, for example, happened in the case of Bradford where the chair was removed and replaced by an interim chair pending substantive appointment by the board of governors).

Recovery regime

The experience of Monitor and the Department of Health through the turnaround teams suggests that a menu of options is available for dealing with financial difficulties as part of an emergent recovery regime. In many cases, recovery will be achieved by action within the organisations experiencing difficulties, involving both short term and long term measures as described in the Action Matrix above. In essence, this is how deficits have been handled in most cases in the past, with action being focused on detailed recovery plans agreed between NHS organisations and the agencies regulating their performance (Monitor in the case of FTs and SHAs in the case of NHS Trusts).

In some circumstances, the organisations concerned may require loans linked to recovery plans to enable them to achieve turnaround. The Department of Health is using this approach with a number of financially challenged NHS Trusts. Depending on the causes of difficulty, it may also be necessary to sell some assets and undertake service reconfigurations. Other potential options include allowing interest on public dividend capital to be deferred and writing down the value of public dividend capital, subject to agreement with HM Treasury on the use of these options.

In the case of FTs, access to private funding may be an option, subject to the development of an appropriate insolvency regime (see below). In extreme circumstances, it might be appropriate to consider the sale or lease of an FT to the private sector.



Mergers and Acquisitions

The case study of Heart of England FT and Good Hope NHS Trust is the first example of how a merger by acquisition has been used to address financial failure. While it is unlikely that this option will be the main way of dealing with providers in difficulty, it does offer an approach that is likely to be relevant where similar circumstances apply i.e. where an NHS organisation with a record of strong financial performance is able to engage in partnership with and ultimately acquire a neighbouring organisation with a history of weak financial performance.

In this case, merger occurred through acquisition with the agreement of the board of Good Hope NHS Trust and the support of the Heart of England FT board. This eased the transition to a new organisation. In other circumstances, the more complex route of formal merger, involving the dissolution of the trusts concerned and resulting in the creation of an entirely new body, may need to be pursued. It remains an open question as to whether the boards of organisations with a record of strong performance would be willing to go down this path.

One of the questions that arises from the merger of Heart of England FT and Good Hope NHS Trust is the impact this and future mergers may have on patient choice and provider competition. The benefits of creating a smaller number of NHS organisations able to achieve high levels of performance have to be weighed against the risk that monopoly or near monopoly providers may dominate the market. To make this point is to underline the need to develop explicit competition rules that can help to inform future mergers and acquisitions as they emerge.

Exit and Insolvency

As yet, there is no explicit exit regime in place to deal with providers for whom recovery or merger is not appropriate.

The need to develop an exit regime and a way of handling financial failure and insolvency was acknowledged in the Department of Health's consultation document on regulation. As the regime is developed, it will be necessary to agree a definition of what insolvency means for NHS FTs, and how this differs from financial difficulties that can be addressed other than through the insolvency route.

While it is important not to exaggerate the extent to which insolvency will occur, it is equally important for insolvency to be a real option in order to create the incentive for FTs to continuously improve. A clear insolvency regime is also needed to provide reassurance to commercial lenders.

A related issue is how to deal with NHS trusts with such large deficits that it is unlikely that they can take the action necessary on their own to become FTs (see box). The Department of Health is currently exploring this issue in discussion with SHAs with a view to finding ways of dealing with these deficits while enabling progress to be made to Foundation Trust status. One of the challenges in this process is to maintain access to services and protect the Secretary of State's position as banker.

NHS Trusts that are financially challenged

Barking, Havering and Redbridge Hospitals NHS Trust
Bromley Hospitals NHS Trust
Hinchbrook Health Care NHS Trust
North Bristol NHS Trust
Queen Elizabeth Hospital NHS Trust
Queen Mary's Sidcup NHS Trust
Royal Cornwall Hospitals NHS Trust
Royal United Hospital Bath NHS Trust
Royal Wolverhampton Hospital NHS Trust
Surrey and Sussex Healthcare NHS Trust
The Lewisham Hospital NHS Trust
The Royal West Sussex NHS Trust
University Hospitals Coventry and Warwickshire NHS Trust
West Middlesex University NHS Trust
Weston Area Health NHS Trust
Whipps Cross University Hospitals NHS Trust

Source: Department of Health (2007)

Pace and Direction of Change

One of the challenges going forward is to meet the government's objectives for the health reform programme while at the same time ensuring that NHS providers have the leadership and capabilities needed to perform successfully. Specifically, the aim of enabling most NHS providers to become FTs by the end of 2008 has to be reconciled with the ability of NHS boards to exercise effective oversight and stewardship in a much more challenging economic context and where traditional NHS financial practices such as brokerage are no longer an option. There will also be challenges for Monitor in dealing with the workload involved in assessing applications and in overseeing the performance of a larger number of FTs.

Also important is the need to ensure that the services provided by FTs make sense in relation to future service strategies. In a number of areas, it is likely that hospital services will be reconfigured to better meet the needs of local populations, and it may be more difficult to bring about service changes if FTs have been created to protect and develop a particular set of

services without regard to the wider consequences. Where circumstances permit, it may be appropriate to create FTs encompassing a number of hospitals in an area, to facilitate reconfiguration within FTs themselves, thereby avoiding the need for mergers by acquisition or dissolution. It is not clear whether such an approach can be reconciled with Monitor's assessment process and the criteria that are used to determine whether an NHS trust is fit to become an FT.

Non-financial Failure

This report has focused particularly on providers in financial difficulty. Failures in contract performance and in safety and quality may also occur, and these will be dealt with by commissioners and by Monitor or the Healthcare Commission as appropriate. The government's plans for the future of regulation envisage a continuing separation between Monitor and its responsibilities in relation to FTs, and the proposed new regulator of health and social care and its responsibilities in relation to all providers as far as quality of care is concerned. It will be important for Monitor and the proposed new regulator to work closely together in the future. It is equally important that issues related to financial failure do not take precedence over concerns for quality and safety.

Conclusion

It is now two years since Palmer (2005) dissected the challenges facing the NHS in dealing with hospital failure. While some progress had been made since then in developing more rigorous and robust processes, particularly through the work of Monitor in relation to FTs and the steps taken by the Department of Health to deal with the financial challenges facing NHS Trusts in 2006-07, there is more work to be done to develop the recovery regime and to devise an exit regime, including arrangements for insolvency.

A clear message from this report is that prevention is better than cure and that effort now needs to be focused on using the lessons from the experience of Monitor and the turnaround teams to avoid serious financial difficulties emerging in future. This includes strengthening the role of NHS boards, bolstering the finance function, and engaging clinicians in improving



performance. The report also underlines the value of developing a rules based intervention regime and clarifying the options that will be used to support recovery. An exit regime needs to be articulated alongside the recovery regime to deal with the rare but important cases where NHS organisations are no longer viable.

As this work goes forward, it will be important to allow for the challenges of applying a more transparent and business like way of dealing with financial difficulties and failure in a highly visible service like the NHS. If, as has been suggested, dealing with financial difficulties entails, among other things, reconfiguring some services, selling assets, and merging organisations to ensure continuity of services, then this will require careful handling with the public and other stakeholders. A core tension in the health reform programme is how to reconcile a system in which markets play an increasing part and yet where decisions are still driven by politics (Ham, 2007).

The way in which the issues discussed in this report are resolved will provide important clues on the resolution of this tension.

Chris Ham is professor of health policy and management at the University of Birmingham and an adviser to the Nuffield Trust.

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H Mooney (2007) Is it new hope for 'No Hope' as cliffhanger reaches final reel? **HSJ** 11 January, 14-15

K Palmer (2005) **How should we deal with hospital failure?** King's Fund, London