

NHS  
market  
futures

# HOW SHOULD WE DEAL WITH HOSPITAL FAILURE?

Facing the challenges of the new NHS market

Keith Palmer

This paper is one in a series of papers examining the emerging NHS market. Other papers in the series address critical issues such as regulation and the future of primary care. The series will make an important contribution to the debate about the direction in which the NHS is now moving.

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## Foreword

We launched our NHS Market Futures programme earlier this year to help clarify where current health reforms are heading and to consider what opportunities and challenges they present.

The new market in health care that is emerging is the product of a series of complex and ongoing policy developments. These include devolving decision making to a local level, offering greater choice to patients, bringing in new providers from the private and voluntary sectors, and introducing a set of new incentives to drive up productivity and efficiency.

No one can yet be sure what these far-reaching changes will produce in combination, but we can begin to identify further measures that may be needed to refine or amend the changes if the best interests of patients are to be served.

Our series has been examining three broad areas of the new health care market – primary care and commissioning, regulation, and the role of incentives across the whole system. We have attempted to describe some of the difficult policy challenges faced by the NHS and to offer some options for the way ahead.

It has also become clear that the reforms are throwing up specific issues that so far have not been fully considered but which, if not handled well, have the potential to damage patient care and undermine the changes.

One such issue is the topic of this paper – how should we deal with hospitals that fail in the new market? How can we ensure that patients

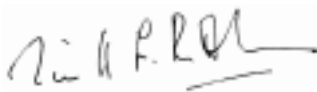
have a real choice of hospital, including one that is local and of high-quality?

In spite of unprecedented increases in funding, parts of the health service are facing serious financial difficulties and all the signs are that this year will be more difficult than the last. The trouble is that the new market incentives will inevitably create further instability as a by-product of trying to stimulate improved efficiency and responsiveness.

In this paper, Keith Palmer – one of our Senior Associates – points out that hospitals' financial problems are not always the result of inefficiency or poor management. He considers the impact of market forces on hospital finances and ways of managing the instability that results – both by heading off failures before they occur and by introducing a regime to manage failures that cannot be averted.

In later publications we will pull together recommendations relating to some of the other changes taking place across the health service in England to offer some practical solutions.

If you would like to be kept up-to-date with this programme, or wish find out more about any other aspect of the King's Fund's work, please sign up for email updates at [www.kingsfund.org.uk/updates](http://www.kingsfund.org.uk/updates).

A handwritten signature in black ink, appearing to read 'Niall Dickson', with a horizontal line underneath.

Niall Dickson  
Chief Executive



## About the author

**Keith Palmer** is a Senior Associate at the King's Fund. His other current involvements in the health sector include non-executive Director of Guy's and St Thomas' NHS Foundation Trust, Chairman of the Camden and Islington LIFT Strategic Partnering Board, member of the Foundation Trust Financing Facility Credit Committee, Trustee and Treasurer of Cancer Research UK and non-executive Director of the International Virtual Medical School (IVIMEDS).

For many years Keith held senior positions in a major UK investment bank. Among other things, his work involved the design of failure regimes for the energy and water utility companies.

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## Introduction

More than 25 per cent of NHS trusts in England reported financial deficits in 2004/5. A significant number had large deficits exceeding 10 per cent of their total income (National Audit Office/Audit Commission 2005). In reality, this is just the tip of a financial iceberg because reported deficits include ‘financial assistance/brokerage’, which is the NHS mechanism for obscuring the magnitude of underlying deficits. At some trusts, underlying deficits are known to exceed 25 per cent of their total income.

These significant deficits arise even before the NHS reforms ‘bite’ in earnest. In mid-2005 most of the reforms – payment by results (PbR), practice-based commissioning, patient choice and independent sector provision – had not been fully implemented. Their full impact lies in the (near) future. Patient choice will shift income from one hospital trust to another as money follows the patient. PbR will increase deficits at hospital trusts in which average costs exceed the (Market Forces Factor-adjusted) national average for the same services. (The Market Forces Factor (MFF) is an adjustment to the tariffs to take account of non-controllable regional cost variations.) Independent sector provision will reduce demand for certain NHS trust services and therefore their income. Practice-based commissioning may further reduce demand for hospital services and the ‘care closer to home’ agenda is intended to reduce demand for admitted hospital care (Department of Health 2004). The impact of these reforms will be – indeed is intended to be – to create winners and losers (Palmer 2005). A significant proportion of trusts currently in deficit can expect their deficits to get bigger as a result. A perfectly plausible prediction is that within the next few years as many as 20 per cent of all hospital trusts in England will have large and persistent deficits – these trusts face the prospect of failing.



Statements by Ministers and the Department of Health (DH) have encouraged the belief that hospital trusts that are unable to restore financial balance within a reasonable period of time will be allowed to fail. The thoughts underlying these statements appear to be the following:

- deficits arise because of poor management and inefficient operations
- allowing trusts that do not deal with their deficits to fail sends strong signals to all trust managements to act to restore financial balance and avoid failure.

However, what exactly is meant by allowing a hospital to fail is less than clear. The statements often seem to imply that failing hospitals face closure.

The key question that arises is – how should we deal with hospital failure? To answer this question we need to consider the following:

- Is it true that all hospital trusts with large persistent deficits are inefficient and poorly managed?
- How can we be sure that patients in failing hospitals will not suffer?
- Can failing trusts really be allowed to close and what would be the implications for continuity of provision of essential services in the locality?
- What are the implications for the ability of patients to choose and for the equity of provision of services?
- What failure regime will apply and how will it reconcile potentially conflicting financial pressures with patient interests?
- Will the failure regime provide the level and pattern of services required to deliver the ‘care closer to home’ agenda?

Currently, the Department of Health and strategic health authorities (SHAs) performance manage NHS trusts to ensure that they meet mandatory access and financial targets. The organisation Monitor (the independent regulator of foundation trusts) monitors the financial performance of foundation trusts. The deficits of NHS trusts are funded by the DH via opaque mechanisms, which allow them to continue to operate and pay the bills despite continuing deficits. Foundation trusts can fund their deficits by borrowing so long as they do not breach their prudential borrowing limits (PBLs).

There is currently no failure regime for NHS trusts and the regime created for foundation trusts is incompletely specified. Earlier in 2005 the DH consulted on proposals for a failure regime but they have not, as yet, published definitive conclusions. The draft proposals were silent on a number of important issues discussed in this paper. The ongoing review of health and social care regulation is addressing economic regulation of health care and is expected to address the questions around failure raised here. Monitor has recently published the paper *Developing an Effective Market Regulatory Framework in Healthcare* (Monitor 2005), which refers to its role in addressing failure but does not discuss the issues. Therefore, a thorough analysis of the issues seems timely.

This paper takes a close look at the questions listed above.

In particular, it addresses:

- what we mean by ‘deficits’ in the NHS, and asks why some trusts incur deficits while others do not
- how private sector businesses deal with failure, describing the financial distress regime and failure regime applicable in the private sector, and asks whether there are relevant lessons for the NHS
- how we should deal with financial distress and failure of NHS trusts and foundation trusts, describing a financial distress regime and a failure regime appropriate for the NHS.

## Deficits and their causes

### What do we mean by ‘deficit’ in the NHS?

The NHS gives a special and unusual meaning to the term ‘deficit’ because of the way that it is funded. For NHS trusts, the only source of capital finance is the government. Capital advances are called Public Dividend Capital (PDC). Trusts are required each year to pay in full a so-called dividend on PDC, whose annual amount is specified as a percentage of the book value of PDC – in other words, a fixed return on total capital employed. Although the PDC is regarded by the government as public sector equity and the return on PDC is called a dividend, in reality PDC has the characteristics of debt and the dividend on PDC (despite the name) has the characteristics of interest on debt.

An NHS trust is said to be in income/expenditure balance when income from all sources equals the sum of operating expenditure, capital depreciation and the dividend on PDC. Put another way, income/expenditure balance is achieved when the operating surplus exactly equals the dividend on PDC. An NHS trust incurs an income/expenditure *deficit* when the operating surplus is less than the dividend on PDC. An example is given in Box 1 (see opposite) where the operating surplus is 10 and the dividend on PDC is 20, giving an income/expenditure balance of –10, that is, a deficit of 10.

The term ‘deficit’ has a different meaning when used by private sector companies. The capital that they employ will typically be a combination of debt and equity. Whereas interest payments on debt are a deduction from operating surplus to derive net profit (or loss), the dividend payable to shareholders is not. Therefore, a private sector company incurs a deficit (that is, a loss on profit-and-loss account) only if its

**BOX 1: DEFINITION OF DEFICIT FOR AN NHS TRUST**

|                   |  |
|-------------------|--|
| Income            | = (activity volume x average tariff) + non-tariff income   |
| Expenditure       | = current operating costs + depreciation + dividend on PDC |
| EBITDA*           | = income – current operating costs                         |
| Operating surplus | = income – current operating costs – depreciation          |

Income/expenditure balance:

Operating surplus = dividend on PDC

Dividend on PDC = required % return on PDC employed

**Example**

|                            |                                  |
|----------------------------|----------------------------------|
| Income                     | = 200                            |
| Operating costs            | = 170                            |
| Depreciation               | = 20                             |
| Dividend on PDC            | = 20                             |
| EBITDA                     | = (200 – 170)                    |
|                            | = 30                             |
| Operating surplus          | = (30 – 20)                      |
|                            | = 10                             |
| Income/expenditure balance |                                  |
|                            | = (10 – 20)                      |
|                            | = –10 (that is, a deficit of 10) |

*\*EBITDA means earnings before interest, tax, depreciation and amortisation.*

operating profit (equivalent to the operating surplus in the NHS) is less than the interest payable on debt. Examples are set out in Box 2 (see p 6) using the same numbers for operating surplus (that is, +10) as in Box 1.

**BOX 2: DEFINITION OF DEFICIT FOR A PRIVATE SECTOR COMPANY**

EBITDA = income – current operating costs  
(same as NHS trust)

Operating surplus = income – current operating costs – depreciation  
(same as NHS trust)

Net (pre-tax) profit = operating surplus – interest on debt  
(but no deduction of dividend on equity)

**Example: Case 1**

Income = 200

Operating costs = 170

Depreciation = 20

Interest on debt = 5

EBITDA = (200 – 170)  
= 30

Operating profit (equivalent to surplus in the NHS)  
= (30 – 20)  
= 10

Net (pre-tax) profit (equivalent to income/expenditure balance in the NHS)  
= (10 – 5)  
= +5

**Case 2**

Income = 200

Operating costs = 170

Depreciation = 20

Interest on debt = 0

EBITDA = (200 – 170)  
= 30

Operating profit (equivalent to surplus in the NHS)  
= (30 – 20)  
= 10

Net (pre-tax) profit (equivalent to income/expenditure balance in the NHS)  
= 10 – 0  
= +10

In case 1 of Box 2 (see opposite), the private sector company is assumed to have financed part of its capital with debt and has to pay interest of 5 in the period, leaving in this case a profit of 5 accruing to equity providers. The company reports a net profit (surplus) of +5, even though it earns exactly the same amount of operating surplus as the hospital trust in Box 1 (see p 5), which is reporting a deficit of 10. In case 2, the private sector company is assumed to have no debt. In this case it would be reporting a (pre-tax) profit equal to the operating profit, that is +10, while the hospital trust in Box 1 (see p 5), which generates the same operating surplus, would be reporting a deficit of 10. The private company has fallen short of its target to earn a desired return on debt and equity, but this is not regarded as causing it to incur a loss. In contrast any hospital trust that fails to earn the full target return on the PDC is deemed to be in deficit – a much more demanding financial target than applies to a private sector company.

## **Why do deficits arise?**

It is important to understand why deficits arise. Is it correct – as many suggest – that they are always an indicator of inefficiency and poor management? This is certainly one important cause, but it is not the only one. There are at least four distinct underlying causes of NHS and foundation trust deficits.

### ***Differential efficiency and productivity***

Some of the observed dispersion of trust costs around the national average undoubtedly does reflect underlying differences in their efficiency and productivity. The introduction of average-cost PbR tariffs will – and is intended to – put pressure on above-average cost trusts to improve their efficiency and productivity. If their (MFF-adjusted) average costs remain above the national average they will incur deficits.

### ***The design of PbR tariffs***

The introduction of average-cost PbR tariffs will have ‘introductory’ and ‘sustained’ effects (Palmer 2005). Their introduction will redistribute

revenue across trusts, broadly causing above-average cost trusts previously in balance to move into deficit and those already in deficit to incur larger deficits. Correspondingly, below-average cost trusts previously in balance will tend to move into surplus. As NHS trusts are not allowed to retain surpluses, they can be expected to seek to increase current spending within the year to minimise the reported surplus at year end.

Further magnification of financial imbalances, consequent upon the introduction of PbR tariffs, should be expected under the following circumstances.

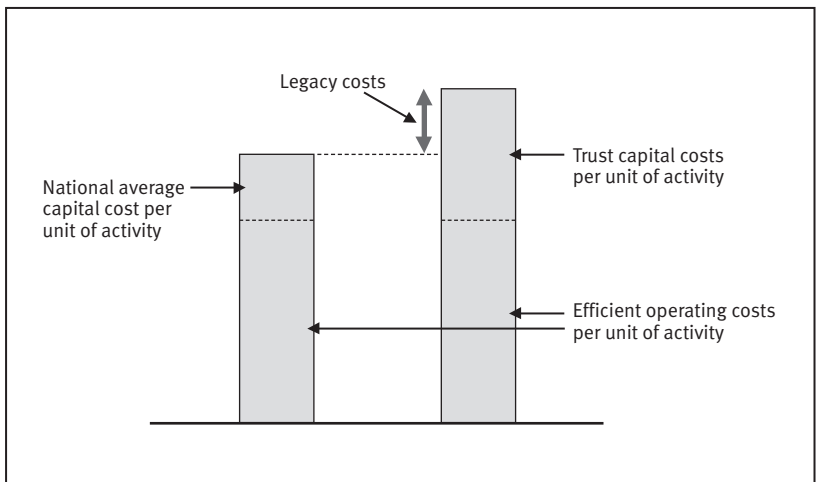
- If the reference cost data used to compute the tariffs are incompletely or inaccurately reported, or they are inadequately ‘cleaned’ to remove unrepresentative ‘outliers’; if the case mix adjustment tools are imperfectly calibrated; and/or if the MFF imperfectly adjusts for non-controllable regional cost variations. These circumstances will all tend to generate surpluses and deficits across trusts – even when they are of equivalent efficiency and productivity. Part of the financial imbalances will reflect imperfections in the design of the tariffs rather than differences in the efficiency of the providers. The version of PbR tariffs used in 2004/5, applicable to early adopters (the first wave of foundation trusts), exhibited all of these characteristics. The draft tariffs set for 2005/6 perpetuate some of them.
- If there are ‘technical economies of scale’ in the provision of hospital services, even well-calibrated tariffs based on national average costs will favour larger trusts at the expense of smaller ones – even if they are equally efficient. Smaller efficient trusts will be more likely to incur deficits than larger efficient trusts. The evidence for whether there are significant economies of scale across hospitals of different size and comparable efficiency and similar activity mix in the UK is inconclusive.

Some of these effects can be eliminated as the design of PbR tariffs improves. However, some of them are inherent in the approach and will persist even if trusts are efficient and when tariff design flaws are eliminated.

### ***Legacy costs***

The current average cost of provision for each hospital trust is a legacy of past investment and service-delivery decisions that cannot readily be reversed. The capital costs per unit of activity of ‘sunk’ capital at a particular trust may be well above or well below the average capital cost per unit of activity for the NHS as a whole. These costs – the depreciation and capital charges (the dividend on PDC) – must be shown as costs on the income/expenditure account for the remaining life of the assets. They are what they are and cannot be managed down (very much). Whenever a trust’s actual sunk fixed costs per unit of activity are higher than the national average, PbR tariffs will not fully reimburse those costs. The unrecovered costs are referred to here as ‘legacy costs’ (see Figure 1, below). Trusts with significant legacy costs

**FIGURE 1: LEGACY COSTS**





will incur deficits, even if operating efficiently, so long as PbR tariffs are set equal to average-costs, unless trust-specific adjustments to the tariffs are made, for example via MFF adjustments.

One example of legacy costs is Private Finance Initiative (PFI) unitary charges. The average fixed costs per unit of activity embedded in the unitary charge are, in many cases, higher than the average fixed costs recoverable through the tariffs. This cannot be interpreted as ‘proof’ that PFI is not value for money. It is a reflection of the fact that new build – however funded – often has higher long-run marginal costs per unit of additional activity than the average costs of older capital investment. There has never been a test of the ‘productivity’ of capital measured as the capital cost per unit of additional annual activity. Nor would such a measure obviously be appropriate unless it took into account the quality improvements embedded in new build. In such circumstances unless a special case-by-case adjustment is made to the tariffs applicable to these trusts, they will incur a continuing deficit even if the rest of their operations are managed efficiently. Moreover, this cost is both a cash cost and an income/expenditure charge. (For more about legacy costs in the NHS, see Appendix, pp 42–5.)

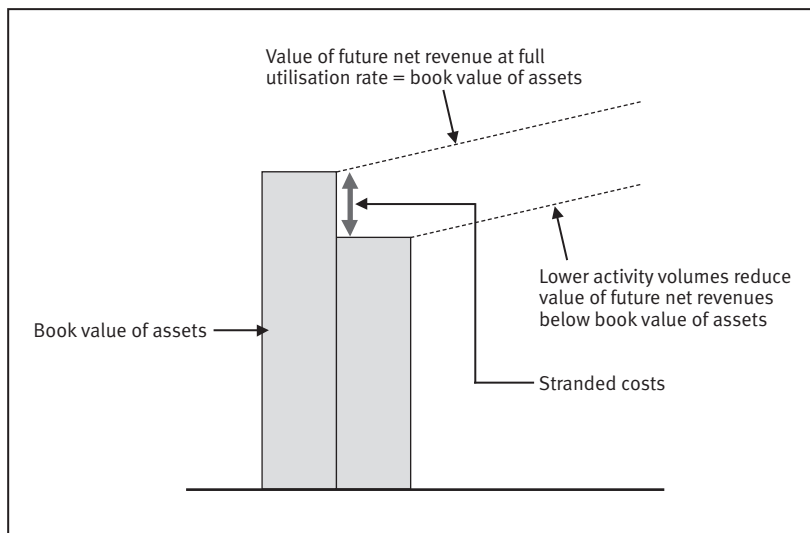
### ***Activity/income shifts and stranded costs***

Patient choice, independent sector provision and, if successfully implemented, the ‘care closer to home’ agenda will all tend to change the level and pattern of demand for hospital services across the NHS. As PbR is an activity-based payment system, this will also change the level and pattern of income accruing to NHS and foundation trusts. Net winners will see an increase in demand for services and a consequential increase in capacity utilisation. Conversely, net losers will see a reduction in demand and a fall in capacity utilisation in some services. In a cash-limited NHS with fixed prices, the total volume of activity that primary care trusts (PCTs) can purchase is fixed. Net losers will not be able to act to improve capacity utilisation, because there will be no more money to pay for extra services. Part of the existing capacity will

‘sit there’ under-used. This under-utilised capacity is referred to here as ‘stranded capacity’ and the associated costs as ‘stranded costs’. (For more about stranded capacity and stranded costs in the NHS, see Appendix, pp 42–5 and Palmer (2005).)

There is a lot of evidence that a significant amount of stranded capacity already exists in parts of the NHS today. Many hospital trusts have tacit or explicit agreements with their PCTs not to provide more elective services than the PCTs can afford. These agreements offer little funding of activity growth beyond what is necessary to meet the waiting time targets and the growth in emergency care. Many hospitals could quickly increase activity quite significantly in some services if the purchasing power of PCTs were greater. The over-provision of acute hospital capacity in London has been known for many years (Tomlinson 1992; Pickles 2004). In London and other parts of the south-east of England, work undertaken by several SHAs indicates that capacity to provide some services is as much as 20 per cent greater than the volume of activity that their PCTs can afford to purchase (*Health Service Journal* 2005a, 2004). Further evidence of stranded capacity is cited in the appendix (see pp 42–5).

Moreover, there is good reason to expect that the amount of stranded capacity will increase. Waiting lists get shorter because the rate of provision of services is greater than the rate of additions to the lists. When spending by commissioners on hospital care stops growing significantly (probably in 2008), the capacity available to provide services is likely to exceed demand. There is then likely to be an even larger amount of stranded capacity in the NHS. It may well be that the problem of stranded capacity will be greater in the south of England, because PCT funding allocations are being rebalanced in favour of the north of the country to offset a historical bias in favour of the south. Consequently, imbalances between PCTs’ purchasing power and available capacity may be even greater in the south in the future (Pickles 2004).

**FIGURE 2: STRANDED COSTS**

Stranded costs arise when the capital costs incurred in providing capacity cannot be fully recovered out of future income because the capacity is under-utilised. This is illustrated in Figure 2 (see above). When capacity is installed there is an expectation that the future net revenue from using the capacity at a target utilisation rate will be sufficient to meet both the operating costs and the capital charge (depreciation and dividend on PDC). If actual utilisation turns out to be below target because of a downward shift in demand, future net revenue will be lower and therefore insufficient to meet the capital charge in full unless the marginal costs can be reduced as much as the reduction in marginal revenue. The true value of the capital invested will be lower than the book value.

NHS and foundation trusts facing such a reduction in demand for their capacity clearly must respond by seeking ways to either increase revenue or reduce costs. Increasing service income is not an option

across the NHS as a whole because demand is fixed by PCTs' purchasing power and the fixed PbR tariffs. The other option is to rent or sell the excess capacity to others (if practicable). Even if these options do prove to be feasible, the alternative-use value of surplus capacity embedded within a hospital site will often be lower (sometimes much lower) than the book value of the assets. In many cases, trusts with stranded costs, even if operating efficiently and having done everything possible to create value from their excess capacity, will continue to incur income/expenditure deficits and the book value of the assets will exceed their true value. (The concept of stranded costs is a familiar one in other industries when there are rapid and unanticipated shifts in demand and significant sunk fixed costs.)

### ***Conclusions***

The conclusions of this section are clear. NHS trusts may certainly exhibit persistent deficits because they are inefficient and/or poorly managed. However, some of them will incur persistent large deficits, even when they are operating efficiently and are well managed, because they must pay for the legacy costs and stranded costs and/or because of imperfections in the design of PbR tariffs. When the causes of deficits are in large measure legacy and/or stranded costs, the deficit can be eliminated only if controllable costs are reduced below the efficient level. This will often result in an undesirable deterioration in the quality of patient care.

## Dealing with failure in the private sector

There are relevant lessons for the NHS in the way that the private sector deals with financial distress and failure. The road to failure in the private sector is marked by four stage posts. Stage 1 is the emergence of unplanned under-performance against internal targets and external expectations. Stage 2 is reached when persistent major under-performance is reported that needs urgent radical management action. Stage 3 is reached when the company exhibits signs of financial distress. At this point the company is unable to finance its business without involuntary re-negotiation of its loans with lenders and/or a new issue of shares at a very low price. Stage 4 – the end of the road – is failure, meaning insolvency and the commencement of bankruptcy proceedings.

### ***Stage 1***

At stage 1, management will respond by addressing the causes of under-performance. It is typically caused by lower than planned sales and/or higher than planned unit costs. Typical restorative action involves efforts to boost sales (for example, by cutting prices and/or increasing marketing expenditure) and/or cost cutting to improve margins. Under-performance on operating account usually forces the company temporarily to increase borrowing, which is repaid over the medium term as performance improves.

### ***Stage 2***

If there is persistent major under-performance, management must develop an urgent restructuring plan targeting recovery of profitability over several years. A typical restructuring plan will involve some or all of the following:

- sharp cost reductions in the core business; often a restructuring charge is made in the first year (reducing earnings in that year) and

the restructuring programme is implemented over two to three years (resulting in an improvement in earnings in the medium term)

- sale or closure of non-core or under-performing parts of the business
- strict capital rationing, leaving more cash flow to finance restructuring and moderate the increase in borrowing
- changes in the senior management team sought by shareholders when they have lost confidence in the team's ability to address the problems effectively
- an increase in long-term borrowing and voluntary re-scheduling of existing debt to defer financial costs until the restructuring is complete and the finances stronger
- a cut (or complete cessation) of the dividend with the cash saved used to finance restructuring
- new equity may be raised to strengthen corporate finances (sometimes at a deep discount to the market price)
- a write-down of the balance sheet value of assets and liabilities.

### ***Stage 3***

A company reaches stage 3 – financial distress – when it has exhausted access to all voluntary additional sources of finance and is forced to seek involuntary debt re-negotiation. The financial distress ‘trigger’ is usually breach of loan covenants. Responding to financial distress involves the re-scheduling of existing debt with deferral of principal repayments and, *in extremis*, conversion of debt to equity (on terms that typically massively dilute the value of previously issued equity).

As the price of agreeing to re-negotiate the debt, lenders will exercise their rights to impose many tough conditions designed to protect the value of their outstanding loans. In addition to increased interest margins and fees, these will usually include some or all of the following:

- a change of some or all of the senior management team and/or the non-executive directors
- agreement to a business plan involving further stringent cost-reduction measures, minimum discretionary investment and

disposal/closure of under-performing businesses; the business will be 'run for cash', with the aim of paying out lenders as a priority

- no resumption of dividend payments until the 'work-out' of re-scheduled debt is complete
- possibly the sale of the business as a going concern to the highest bidder.

In almost all cases this sort of restructuring requires a major write-down of the value of assets and liabilities in the balance sheet, reflecting the permanent diminution in the expected value of future cash flows. The actions taken to force the company management to address the problems come from shareholders (the owners) and lenders acting in accordance with company law and lenders' contractual rights.

#### ***Stage 4***

If a restructuring plan cannot be agreed, or is agreed and then fails, the company may fail – that is, be declared insolvent – in which case the private sector failure regime comes into play. The provisions of the Insolvency Act govern the process. Typically an administrator will be appointed by the courts to administer the provisions of the Act. The primary responsibility of the administrator is to protect the interests of the company's creditors. It will seek to maximise the realisable value of the business and to distribute the proceeds according to the priority ranking of creditors – usually senior lenders, then subordinated lenders, trade creditors and shareholders, with the shareholders being last in line. The administrator is independent of all the parties and has complete control of the business.

By far the most common resolution of insolvency proceedings is the sale of some or all of the business as a going concern to a new owner. This is because sale as a going concern will normally maximise value, capturing any remaining goodwill. Closure and piecemeal sale of the depreciated fixed assets will rarely be in the interests of creditors, because the value realised is almost always less than sale as a going concern.

In certain private sector industries with their own regulator, for example the privatised utilities, the independent regulator has statutory powers to act to protect consumers in the event that a licensee should suffer financial distress or fail. The regulator does not have to wait until a licensee becomes insolvent to act. The regulator's powers typically enable it, in essence, to approve or reject a proposed financial restructuring and to require a licensee, in certain limited circumstances, to transfer (sell) the regulated business as a going concern to another party acceptable to the regulator. These provisions ensure that customer service is not prejudiced should a licensee become unable to finance its operations.

Table 1 (see p 18) summarises the salient points of the financial distress and failure regimes that apply in the private sector. The powers to act during the pre-failure period derive from the Companies Act, contract law and the terms of the loan agreements. The parties that are empowered to act are the shareholders and lenders, whose rights are determined in the statutes and the loan agreements. Their key objective is to avert failure. Where there is an industry regulator, it may have narrowly defined rights to act ahead of lenders and shareholders to protect customers.

When a private sector company does fail, the Insolvency Act conveys the powers to deal with insolvency. The appointed administrator acts independently of all the other parties in accordance with the provisions of the Insolvency Act. However, where there is an industry-specific regulator, it may have specific powers to moderate the actions that the administrator is entitled to take.

Key points about the private sector financial distress and failure regimes, relevant for the discussion about the NHS, include the following.

- Restructuring plans to improve medium-term performance almost always make the income/expenditure (profit and loss) statement worse in the short term.



**TABLE 1: KEY FEATURES OF A PRIVATE SECTOR FAILURE REGIME**

|   | <b>Financial Distress</b>   | <b>Failure</b>   |
|---|---|--|
| <b>Powers</b>                               | Companies Act<br>Contract law<br>Industry regulation law<br>(if any)  | Insolvency Act<br><br>Industry regulation law<br>(if any)  |
| <b>Parties that act to address problems</b> | Lenders<br>Shareholders<br>Industry regulator   | Administrator<br><br>Industry regulator  |
| <b>Actions</b>                              | Lenders/shareholders force solution to avert failure within legal and contractual rights<br><br>Industry regulator has powers to act to protect customers | Administrator assumes control of company<br><br>Industry regulator retains powers to protect customers |

- Restructuring often involves closure of certain parts of the business but very rarely complete closure of a company.
- Additional debt finance is almost always needed to fund the restructuring plan. This may take the form of additional debt and/or deferral of payments of existing debt.
- A cut (or complete cessation) of the dividend is an almost universal feature of most restructuring plans.
- A write-down in the value of assets and liabilities is very common, reflecting the permanent diminution in the value of the restructured business.
- Insolvency is a relatively rare occurrence because the owners, the lenders and the regulator have strong incentives to act to avert failure.

- Before failure it is the owners and lenders that act to avert failure. Once failure is triggered, an independent administrator is empowered to act. Where there is an industry-specific regulator, it often has specific powers to act before and after failure – but only to protect customers.
- The cost of failure in competitive industries is borne by the owners (shareholders) and to a lesser extent by lenders, but not customers. In monopoly industries the regulator acts to ensure that, in these industries too, it is the owners and lenders that bear the costs, not the customers.

## Dealing with failure in the NHS

### **What do we mean by hospital ‘failure’?**

In the private sector a company is said to have failed when it becomes insolvent – meaning that it is unable to pay its creditors and has exhausted access to all sources of funding from lenders, trade creditors and shareholders to keep it going. Once it is declared insolvent, the private sector failure regime comes into play.

In the NHS it is less clear what we mean by hospital ‘failure’. NHS trusts are owned and funded wholly by the state. When they incur deficits, the financing shortfall can be provided only by additional funding from the state. The state can always ‘afford’ to finance the deficits but it may decide not to do so. If the state, acting through the Department of Health, were to decide that it was not willing to finance the deficit, the trust would be unable to pay the staff and others, and would have to cease providing services and close (and even then the state would remain responsible for closure costs, for example redundancy and pension entitlements). In practice, given the imperative of retaining health services for the public in the locality of the failing trust, the DH has little option but to keep funding the deficits of failing trusts. Therefore, the reality is that a NHS hospital trust fails only when the DH says that it has failed. There is a need for an objective test of what constitutes failure and a clearly specified failure regime that applies to trusts that are deemed to have failed.

### **How should we deal with failure in the NHS?**

A key lesson from the private sector is that failure is the end of the road. We need mechanisms not only to deal with failure but also to head it off before it happens – if at all possible. These mechanisms must not only restore financial viability but also protect the quality of current patient

care and ensure that the level and type of services available in the future in the locality continue to meet patient needs.

The NHS is ill placed at present to deal with the financial destabilisation caused by NHS reform. To address the deficiencies, action is required on three levels:

1. a more flexible financial regime for all NHS trusts to facilitate adjustment to emerging financial imbalances
2. a financial distress regime to apply to trusts with large and persistent financial deficits – deemed to be in financial distress – before they fail
3. a failure regime to apply to trusts that are deemed to have failed.

The DH will need to define a financial distress threshold – which if exceeded would trigger the financial distress regime – and a failure threshold – which if exceeded would trigger the failure regime. The financial distress threshold might be, for example, when a trust's deficit exceeds, say, three per cent of total income for two consecutive years. Financial failure could be deemed to have occurred if there was material failure to achieve milestones and targets set out in the restructuring plan agreed with the trust prior to failure.

### **A more flexible financial regime**

NHS trusts have very limited scope to manage their way out of a deficit in the short term. The volume of activity that they can sell is not readily influenced and prices are fixed either in PCT contracts or nationally (when PbR is fully in place). The wages and salaries bill – typically about 60 per cent of total costs – is fixed within-year except for some flexibility around the employment of temporary/agency staff.

Unlike private sector firms, NHS and foundation trusts must pay the dividend on PDC in full, and they have no access to borrowing and no retained earnings or cash flow to draw on to finance adjustment and restructuring. Nor are they permitted to use the depreciation provision

to fund restructuring costs. They are required to balance income and expenditure exactly in each year, at the same time meeting increasingly demanding access targets (*see* Box 3, below). (The financial regime for NHS trusts is described in more detail in Palmer 2002).

If NHS trusts and foundation trusts reduce activity they will generally be worse off under PbR because their income will be reduced by more than their costs. Often NHS trusts with large deficits are forced to resort to measures such as freezes on hiring and reductions in discretionary spending on everything other than that which is necessary to meet the ‘must do’ waiting time targets. The result all too often is that some reduction in the deficit is achieved at the cost of deterioration in the quality of patient services and distraction from achieving greater productivity improvement over the medium term. In practice, it is impossible to restore financial balance with these ad hoc responses when the deficit is very large (as it already is at a significant number of trusts).

### **BOX 3: CURRENT ‘RULES OF ENGAGEMENT’ FOR NHS TRUSTS**

#### **Operations**

- Volume of activity is not readily influenced
- Prices are fixed for the year but change annually in unpredictable ways because of opaque tariff-setting methodology
- Employee remuneration is fixed nationally
- Significant costs, for example, land/buildings, pensions and so on, are fixed

#### **Financial**

- Dividend on PDC must be paid in full every year – another fixed cost
- Earnings or cash flow cannot be retained and capital finance cannot be used to fund revenue expenditure
- No access to borrowing to finance unplanned deficits
- Mandatory annual income/expenditure balance (NHS definition)

Foundation trusts have significantly more financial flexibility than NHS trusts. They are not required to achieve annual income/expenditure balance and they can retain surpluses to invest in services and/or to create reserves to deal with unanticipated financial shocks. They do have access to (capped) borrowing to finance adjustment and greater freedom to use cash flow as they see fit. However, they too are required to pay the dividend on the PDC in full every year. Nevertheless, overall they are much better placed than NHS trusts to adjust to unplanned deficits by adopting a medium-term adjustment plan and funding it by borrowing.

There is much that can – and should – be done to improve the efficiency and productivity of all NHS and foundation trusts over the medium term. Measures to improve productivity fall into two broad categories:

- those that can be realised within a single trust
- those that can be realised only by rationalising services across hospital trusts and/or across the primary care/acute sector boundary.

Measures within a single trust include improving clinical processes (further reducing length of stay, better utilisation of assets and staff, increasing day-case rates, and so on), improving procurement, improving the flexibility of working practices and reducing corporate costs. Examples of measures to rationalise services across trusts and across the primary/acute care boundary include consolidation of specialist services, more care in a non-hospital setting and more community-based nurse-led care. All of these measures have the potential not only to reduce costs across the NHS but also to improve the quality of patient care. However, as in the private sector, implementation of these measures takes time and costs money. The inflexible financial regime currently applying to NHS trusts makes it very difficult for them to develop, implement and finance medium-term restructuring plans that incorporate such measures, especially when they already have large deficits. Moreover, some actions of benefit to patients and to the NHS as a whole, for example, more care in the

community, may increase the deficits of individual trusts (making them very reluctant to adopt those actions).

If productivity-enhancing restructuring is to take place, NHS trusts need to operate within a more flexible financial regime. Short-term cost cutting displaces and frustrates medium-term improvement. Increased financial flexibility would be achieved if the following changes to the financial regime applicable to NHS trusts were implemented:

- allowing a portion of the dividend on PDC to be deferred in certain circumstances for a maximum period (say, three years) with the deferred amount repayable in future with interest
- allowing NHS trusts access to a working capital facility (from the NHS Bank, for example), the size of which should be capped and use of which would incur an interest rate high enough to discourage undisciplined recourse to it; NHS trusts in deficit would be allowed to use the facility only to finance implementation of an agreed restructuring plan that was designed to restore medium-term financial balance
- allowing NHS trusts to retain surpluses and reinvest them in service provision and/or to create reserves; this would strengthen the incentives on NHS trusts to improve efficiency and productivity (as it has already done in foundation trusts).

The first of these changes should also apply to foundation trusts. The second and third of them already do.

With these changes, NHS trusts would be much better placed to manage their financial position while also achieving greater improvements in productivity than would otherwise have been possible. Concerns that such changes would take the pressure off trusts to restore financial balance and end up costing more money than is available in the DH budget are unlikely to be justified. The changes to the financial regime will facilitate adjustment and should accelerate realisation of greater productivity improvements than would otherwise have occurred – resulting in a higher standard of patient care and more robust

finances in the medium term. Failure by a trust to use the increased flexibility to adjust to unplanned deficits, causing them to breach the financial distress threshold, would lead them directly into the financial distress regime.

## **A financial distress regime**

### ***NHS trusts***

Currently there is no effective financial distress regime for NHS trusts. Trusts that incur large deficits are exhorted by the DH and their SHA to restore financial balance and meet the access targets. Although much short-term cost cutting takes place (sometimes to the detriment of patients), the deficits remain large in quite a few cases. The SHA may change the senior management of the trust but this does little good if the underlying causes of the deficit are beyond the control of management. As the trust cannot close, the DH inevitably ends up having to continue to fund the deficits.

The problem is that the current SHA-led process rarely starts with a thorough diagnosis of the underlying causes of the deficits or allows for measures necessary to deal with them permanently. There is little recognition that restoration of financial balance in the medium term may involve making the deficit bigger in the short term, or that, in certain circumstances, financial restructuring of the trust's balance sheet and provision of additional funds to finance implementation of the restructuring plan are likely to be required.

Here it is proposed that there should be a financial distress regime that addresses these shortcomings. All NHS trusts with deficits that exceed a pre-announced financial distress threshold would become subject to this regime. They would be required to commission a diagnostic evaluation of the causes of their deficit and to develop, and have approved by the SHA, a medium-term restructuring plan that would both restore medium-term balance and improve the quality of services available to patients and the public in the locality.



The restructuring plan should always include detailed and specific measures to improve efficiency and productivity and to rationalise services in line with expected demand for services by patients. In many cases this will involve trusts reconfiguring services and may involve providing new types of services in new ways and at different locations. The restructuring plans should not be just about cost cutting. The restructured trust should be able and required to contribute to delivery of the wider health strategy in the locality.

Where the diagnostic evaluation shows that a trust is faced with significant legacy and/or stranded costs, it may be necessary and appropriate to take steps to deal with them, with possible steps including the following:

- fund the legacy costs through an additional MFF payment directly to the trust
- recognise the diminution of value of public assets by writing down the value of the assets and of the PDC in the trust's balance sheet; this will automatically reduce the annual dividend on PDC and contribute to restoration of financial balance
- recognise the existence of legacy and/or stranded costs by allowing certain trusts to continue to run a deficit and funding it with additional (deferrable dividend) PDC
- (if not already done) permit trusts to defer payment of some or all of their dividend on PDC, and require them to use the retained resources to finance restructuring.

These financial restructuring steps are conceptually very similar to those that accompany operational and financial restructuring when a private sector company is in financial distress.

It is clearly not straightforward to untangle the controllable part of the deficit from the part that is genuinely the consequence of legacy and stranded costs. Financial restructuring of this sort should be

contemplated only when it forms part of a ‘difficult’ and aggressive restructuring plan. Serious efforts to address the underlying problems might include measures to:

- close certain services where sufficient demand no longer exists and reduce capacity of others, and/or
- merge clinical services across trusts operating under common management when this is judged a more cost-effective and patient-responsive way of providing the services, and/or
- expand outpatient services and care in the community to address the ‘care closer to home’ agenda (even though this may increase the trust’s deficit in the short and medium term), and/or
- merge trusts where the failing trust on a stand-alone basis cannot expect to be viable even after services and financial restructuring, and when this offers the best outcome for patients.

The write-down of assets and the PDC costs the DH nothing. High legacy and stranded costs have already been incurred and are being paid for by the tax-payer. The write-down simply recognises that those costs are already being borne by trusts and, if each of them must achieve financial balance, their full sunk costs must be funded.

The restructuring plan will need to include a financing plan that shows the amount, sources, and terms and conditions of funding to be made available to finance the restructuring costs and the (reducing) trust deficits. Possible sources of finance include deferral of the dividend on PDC, borrowings (from the NHS Bank) repayable with interest over a defined period and/or additional PDC (preferably of the deferrable dividend variety).

Concerns that the proposed financial restructuring measures might relax pressure on trusts to improve efficiency and/or that they would cost more money are likely to prove misplaced. If trusts have large deficits today and no plan of action to improve things, it is unlikely that deficits

will get smaller quickly – and the DH has no option but to continue to fund the deficits, however large they are. Agreement on a challenging but achievable restructuring plan to eliminate the deficit over the medium term, involving actions that improve productivity and are good for patients and which support the wider NHS strategy, is likely to elicit a strong positive response from boards, staff and the public. Although ‘one off’ costs may increase in the short term, over the medium term the recurrent costs of service provision should be lower – and patient services better – than they otherwise would have been, and the total costs to the NHS should go down.

Trust boards should be required to sign off the restructuring plan in the knowledge that they will be held accountable for its delivery. The board and the staff should be made aware that failure to achieve the milestones and targets set out in the restructuring plan will lead them directly into the failure regime.

The main differences between the current approach to dealing with trust deficits and the proposed financial distress regime are that:

- the latter would be used to drive change in the way that services are provided across the sector
- the medium-term framework would facilitate clinical and financial performance improvement as well as deficit reduction
- the financial restructuring would deal permanently with non-controllable legacy and stranded costs
- the operational and financial plan would provide a disciplined framework within which progress in achieving restructuring targets could be monitored
- failure to deliver the agreed restructuring plan would have ‘dire’ consequences for the trust, hence efforts to avert failure would be much greater.

### ***Foundation trusts***

The current position of foundation trusts incurring financial distress is very different to that of NHS trusts. Monitor has statutory responsibility

for monitoring the financial performance of foundation trusts. It has developed clear definitions of what constitutes financial distress (although it does not use the term) and a graduated, transparent response to financial distress as circumstances worsen. It can (and does) require foundation trusts in financial distress to prepare and implement restructuring plans and has certain powers to act (notably to fire the board) if it judges this to be necessary. Moreover, foundation trusts already have much of the financial flexibility suggested above for NHS trusts. In particular, they do not have to achieve annual income/expenditure balance, they can retain surpluses and they have access to financing up to limits agreed with Monitor, which are linked to their financial performance.

However, Monitor does not currently have the power to agree to adjustments in the balance sheets of foundation trusts in order to recognise the existence of legacy and/or stranded costs or to agree a deferral or cut in the dividend on the PDC. Nor is there a clear process, in the event of foundation trusts becoming financially unsustainable (which in their case is when they have reached the limits of their PBL), for dealing with failure of foundation trusts.

## **A failure regime**

Once an NHS or foundation trust enters the failure regime, it should lose control over its destiny. That sanction is the strong incentive required to make sure that the trust and SHA do everything possible to implement the restructuring plan and avert failure. Drawing on relevant parallels in the private sector, this section describes what the failure regime should look like for NHS and foundation trusts.

### ***Appointment of an NHS administrator***

The DH should appoint an NHS administrator to intervene to deal with any NHS trust when it is deemed to have failed by virtue of persistent failure to reach restructuring and financial milestones set out in an agreed restructuring plan. In the case of foundation trusts, the failure

regime would be triggered and an NHS administrator appointed if a financially distressed foundation trust breached its PBL.

The NHS administrator should be required to operate within guidelines set out either in legislation or in regulations set by the Secretary of State for Health. Unlike in the private sector, where maximising value for creditors is the primary criterion guiding the administrator's actions, in the health economy there are clearly wider considerations. Possible criteria to guide the actions of the NHS administrator might be to:

- protect the quality of patient services going forward
- preserve patient choice in the locality
- preserve essential services in the locality
- ensure compatibility with the aims and intended outcomes of the NHS strategy, for example, care closer to home
- restore financial balance as quickly as possible, consistent with complying with the guidelines taken as a whole.

One question that comes to mind is – who should the administrator be? The role is one that neither can nor should be performed by the DH itself. But nor is it a role that can be performed without close knowledge of health service issues. Two options suggest themselves: either the administrator could be a new appointment or the powers and duties could be vested in the economic regulator. The problem with the second option is that, whereas there is an economic regulator for foundation trusts (Monitor), there is currently no economic regulator for NHS trusts. Nor can Monitor, as things currently stand, be responsible for managing the failure of trusts that are not foundation trusts. Although there is a policy intention to give all NHS trusts the chance to become foundation trusts by 2008, in practice many of them are unlikely to meet the required financial and other criteria, and some could fail as NHS trusts before they qualify for foundation trust status. Therefore, there is a need for an administrator who can deal with failure of both NHS and foundation trusts. Whoever performs the role, the administrator should be independent in the same way that Monitor, the economic regulator of foundation trusts, is independent.

The NHS administrator would have powers to direct the failed trust to take steps to deal permanently with financial imbalances and to restructure services in a manner consistent with the guidelines set out by the statute or regulations. However, to the extent that the proposed steps would involve additional cost to the public finances, the administrator would have to seek approval from the government (that is, the ‘owner’) before proceeding. Any proposed restructuring plan would normally have to be subject to patient and public consultation.

### ***Failure resolution options***

Acting within the guidelines set by the DH, the NHS administrator would be charged with imposing on the failed trust the most appropriate failure resolution solution. The options available to the administrator can be grouped into three categories:

1. restructuring of the trust on a stand-alone basis
2. closure of the trust
3. transfer of the trust as a going concern to another party such as another NHS or foundation trust, or an independent provider.

In some situations it may prove possible to devise a solution based on the appointment of new management and more aggressive implementation of the restructuring plan – while retaining the trust as a stand-alone organisation. It is very likely that, in some cases, restoration of financial balance and retention of the quality of services to patients will require a write-down of asset and PDC values and access to additional finance to fund restructuring and transitional deficits.

Total closure of a trust will be appropriate only when it can be shown that it can be achieved in a manner consistent with the guidelines. This is unlikely to be the best option from a patient perspective in most situations. Moreover, in all but a tiny number of cases, as in the private sector, total closure will rarely be the best financial option because the alternative-use value of a closed hospital will only rarely exceed its value as a going concern operating on a smaller scale or in a different way. Although total closure will always be an option that has to be

considered, it is unlikely to happen very often. (Local opposition to closure and the associated political fall-out are another reason, in practice, why closure will rarely occur.) Other options are clearly going to need to be considered.

The third option is to transfer the failing trust to another party as a going concern. There will be many cases where the financially most attractive option, and the one with the greatest benefits for patients, will be a ‘merger’ with another trust. Why?

- There are often significant additional benefits to be had from integrated management of clinical services across sites.
- There are often additional opportunities to reduce costs while offering a better service to patients.
- A merger with a trust that has a strong management team and a good track record will often give greater confidence that the restructuring plan will be successfully implemented.

Mergers of failing trusts with either another NHS trust or a foundation trust can happen only if they are preceded by a financial restructuring of the failing trust (often requiring a write-down of assets and the PDC) and access by the acquiring trust to additional committed finance that is sufficient to fund the restructuring costs and transitional deficits. Without these steps no NHS or foundation trust can contemplate merger with an organisation that has a large, persistent and structural deficit.

Would mergers between NHS or foundation trusts and failing NHS trusts raise competition issues? There are no conventional competition issues because prices are fixed (so there is no scope for a monopolist to raise them). Would mergers impact adversely on patients’ ability to choose? Not if the guidelines prescribed that mergers must not limit patient choice. If the merged trusts were located in parts of the country where there are many alternative providers of contestable (elective) services,

there would be little cause for concern about the withdrawal of those services. If this were not the case, the administrator could set as a condition of merger that specified protected services must be retained. (This is a power that Monitor already has in respect of foundation trusts.) In many cases successful mergers offer the best prospect of better services and no diminution of choice for patients where trusts are otherwise failing. The merged trust could not only be required to continue to offer protected services locally, but also be asked to agree as a condition of merger to increase provision of community-based services. Moreover, the merger solution will often maximise the value of the failed trust.

Another option is to sell the failing trust to a provider in the independent sector. As with the merger or stand-alone restructuring options, this will require a coincident or prior financial restructuring of the failed trust that leaves the prospect of a financially sustainable business following transfer. In addition, the independent operator will want to see a profit to compensate for the risks that it will incur. Therefore, this option will often prove to be more expensive for the DH than a merger unless the cost reductions achievable by the independent provider are significantly greater than can be achieved by an NHS or foundation trust (without adversely impacting on the quality of care). As there are likely to be fewer opportunities to exploit cross-site service rationalisation for an independent provider, this option may not prove to be the most attractive in many cases.

### ***Key features of proposed financial distress and failure regimes***

The key features of the proposed financial distress and failure regimes are summarised in Table 2 (see p 34). It is unclear (to me) whether the DH currently has the powers to implement the failure regime for NHS trusts, or whether new legislation would be required. Monitor does have the statutory powers to deal with failure of foundation trusts, although it currently lacks a number of key levers. In the proposed



financial distress regime for NHS trusts, SHAs would be given additional powers to act when the financial distress threshold was crossed. The NHS administrator would act to deal with failure of NHS trusts and foundation trusts when the failure threshold was crossed. The NHS administrator could either be a single new appointment to deal with all NHS trusts and foundation trusts; or Monitor could act as the administrator for foundation trusts and a separate appointment be made to deal with NHS trusts; or, with suitable amendment of Monitor’s powers and duties, it could perform the role of NHS administrator for NHS trusts and foundation trusts.

TABLE 2: KEY FEATURES OF A PROPOSED NHS FAILURE REGIME

|   | Financial distress   | Failure   |
|---|--|---|
| <b>Powers</b>                               | NHS direction (NHS trusts)<br><br>Health and Social Care Act (foundation trusts)   | ?<br><br>Health and Social Care Act (foundation trusts)   |
| <b>Parties that act to address problems</b> | SHAs (NHS trusts)<br><br>Monitor (foundation trusts)   | NHS administrator (NHS trusts)<br>NHS administrator/Monitor (foundation trusts)   |
| <b>Actions</b>                              | SHA forces solution to avert failure. DH approval sought for actions that impose extra costs on public finances (NHS trusts)<br><br>Monitor has powers to act to protect patients. DH approval sought for actions that impose extra costs on public finances (foundation trusts) | NHS administrator assumes control of organisation. DH approval sought for steps that impose extra costs on public finances (NHS trusts and foundation trusts) |

## **The consequences of hospital failure**

What will be the consequences of hospital failure? As things currently stand, the consequences for patients of hospital failure are unlikely to be good. NHS trusts seeking desperately to reduce their deficits in the short term will have to choose between acting in ways likely to be detrimental to patient interests or failing to reduce the deficit (thereby leaving the costs of failure with the tax-payer) or both.

What would be the consequences, for trusts, patients and the NHS as a whole, if a financial distress and failure regime along the lines outlined here were put in place? There would be a clear process whereby first, trusts would be given additional flexibility to restore financial balance; second, they would know that if they crossed the financial distress threshold, they would be subject to new powers available to the SHA to agree or impose a medium-term restructuring plan; and third, they would know that if they failed, they would become subject to the failure regime under which circumstances they would lose control over their fate. The NHS administrator would have the power to impose a solution that would balance patient interests and financial considerations in accordance with guidelines set by the DH. There would be stronger incentives acting on trusts to sort themselves out, hence failure would be more likely to be averted. And if trusts did fail, there would be an outcome that addressed patient needs, was consistent with the wider NHS strategy and that offered a better prospect of more rapid return to financial balance.

## Conclusions

A significant minority of NHS and foundation trusts are already incurring large deficits. The impact of the NHS reforms will be to magnify financial imbalances at a significant number of trusts. It is a realistic expectation that within a few years more than 20 per cent of all hospital trusts will incur large and persistent deficits, with the real risk that quite a few of them will fail.

It is often assumed that trusts that incur deficits are inefficient and poorly managed. In fact trusts incur deficits for a variety of reasons, only one of which is inefficiency and poor management. Others include:

- inappropriate design of PbR tariffs
- high legacy costs, meaning irreversible sunk capital costs, the fixed costs of which per unit of activity are higher than the national average
- stranded capacity costs, which arise when utilisation of existing capacity is lower than planned because of unanticipated shifts in demand and income across trusts.

Legacy costs and stranded costs will cause trusts to incur deficits even if they are efficient and well managed.

There are some relevant general lessons for the NHS that can be learned from looking at how financial distress and failure are dealt with in the private sector. These include the following.

- Restructuring to improve medium-term performance almost always makes the income/expenditure position worse in the short term.
- Restructuring often involves closure of certain parts of the business.
- Additional finance and a cut or complete cessation of the dividend are almost always required.

- A reduction in the value of assets and liabilities in the balance sheet, reflecting a permanent diminution in their value, is very common.
- Failure is usually resolved by selling the business as a going concern at a discount to book value, rather than closure.
- The price of failure is largely paid by the owners, lenders and employees, not by the customers.
- Failure is dealt with by an independent administrator who intervenes to deal with it, acting under powers conveyed by the insolvency legislation.

How should we deal with failure in the NHS? A key lesson from the private sector is that failure is the end of the road. We need mechanisms not only to deal with failure but also to head it off before it happens. Moreover, in the NHS appropriate mechanisms must not only restore financial viability, but must also protect the quality of patient care and ensure that the level and type of services available to patients locally in the future continue to meet their needs.

The NHS is currently ill placed to deal with the financial destabilisation intentionally caused by NHS reform. To address the deficiencies there is a need for:

- a more flexible financial regime for all NHS trusts to facilitate adjustment to emerging financial imbalances
- a financial distress regime to apply to trusts with large and persistent financial deficits before they fail
- a failure regime to apply to trusts if and when they do fail.

The current financial regime for NHS trusts is too inflexible to enable adjustment without risking harm to the quality of patient care. Undue focus on short-term cost cutting displaces and frustrates medium-term improvement. Increased financial flexibility would be achieved, without

eroding pressures for financial discipline and with better patient outcomes, if the financial regime were amended to:

- allow part of the dividend on the PDC to be deferred in certain circumstances for a maximum period
- allow NHS trusts access to a capped working capital facility (from the NHS Bank) to be used to finance an agreed restructuring plan
- allow NHS trusts to retain surpluses and reinvest them in service provision, thereby strengthening the incentives to improve efficiency and productivity.

Foundation trusts already have much of this financial flexibility. However, they, like NHS trusts, must pay the full dividend on the PDC every year, and there is no established mechanism for adjusting the value of their PDC to reflect a permanent diminution in the value of their assets, should it occur.

NHS trusts with deficits that exceed a pre-announced financial distress threshold should become subject to the NHS financial distress regime. They would be required to submit, and have approved by the SHA, a restructuring plan that sets out in detail how medium-term balance is to be restored while also improving patient care. Where it can be demonstrated that there are legacy costs and/or stranded costs and that the restoration of medium-term balance requires an adjustment to the balance sheet value of assets and the PDC, the DH should be willing to agree to balance sheet adjustments and transitional funding in return for radical restructuring. This should be contemplated only when actions are proposed that will deal permanently with financial imbalances, such as:

- closure of certain services where sufficient demand no longer exists
- merger of clinical services across trusts operating under common management, for example organisationally integrated managed networks
- expansion of community care services as an alternative to admitted hospital care

- merger of trusts where a trust on a stand-alone basis cannot expect to be viable even after financial restructuring and mergers offer the best patient outcomes.

Failure by an NHS or foundation trust to achieve the agreed restructuring and financial targets would trigger the NHS failure regime. Once a trust enters the failure regime it should lose control over its destiny. That is the sanction that is necessary to ensure that trusts make every effort to implement the restructuring plan and avert failure. If a trust fails, an independent NHS administrator would be appointed to intervene in the failing trust. Unlike in the private sector (where the administrator is concerned with maximising residual value), the NHS administrator should be required to operate within guidelines set by the DH, which address patient needs as well as restoration of financial balance. Possible criteria to guide the actions of the NHS administrator might be to:

- protect the quality of patient services going forward
- preserve patient choice in the locality
- preserve essential services in the locality
- seek to make outcomes supportive of the wider NHS strategy
- restore medium-term financial balance.

In practice the options available to the NHS administrator to deal with failure are limited. Total closure will rarely be an option if the criteria set out above are to be met. Practical options are likely to be:

- major restructuring of services at the failed trust combined with a write-down of assets and liabilities and transitional funding (and usually a complete change of the board), with the restructured trust continuing on a stand-alone basis
- merger with another NHS trust or foundation trust when there are clear patient benefits and financial savings that can be achieved by merger, not otherwise available to the trust on a stand-alone basis
- franchising of the failing trust to an independent operator after financial restructuring.

All feasible solutions are likely to have to recognise a permanent diminution in the value of public capital and the need for transitional funding during implementation of the restructuring. In many cases merger with another trust will be the solution that best addresses patient needs and maximises improvement in the finances of the failing trust.

When publicly owned trusts fail, it can only be the tax-payer or patients who pay the price of failure. The proposed failure regime must ensure that solutions can be imposed that minimise the future costs of failure to the tax-payer while also ensuring that it is not the blameless patients of the failing trust who pay the price of failure.

As things currently stand, the consequences for patients of hospital failure are unlikely to be good. NHS trusts seeking desperately to reduce their deficits in the short term will have to choose between acting in ways likely to be detrimental to patient interests or failing to reduce the deficit (thereby leaving the costs of failure with the tax-payer) or both.

What would be the consequences, for trusts, patients and the NHS as a whole, if a financial distress and failure regime along the lines outlined here were put in place? There would be a clear process whereby first, trusts would be given additional flexibility to restore financial balance; second, they would know that if they crossed the financial distress threshold, they would be subject to new powers available to the SHA to agree or impose a medium-term restructuring plan; and third, they would know that if they failed to deliver the restructuring plan targets, they would become subject to the failure regime in which the NHS administrator would impose a solution. There would be stronger incentives acting on trusts to avoid financial distress and, even more so, failure. This would strengthen the resolve of trust boards and management to deliver the agreed restructuring plan, thereby improving patient services and restoring financial balance

more quickly than would otherwise have been the case. Moreover, if trusts did fail, the failure regime would operate to impose a solution that addressed patient needs as well as financial pressures. The consequences of failure for patients would be much better than they promise to be if current arrangements are not changed – quickly.



## Appendix: More about legacy costs, stranded capacity and stranded costs

This appendix explains in more detail the nature of legacy costs, stranded capacity and stranded costs.

### Legacy costs

Legacy costs are an inevitable consequence of any move from a resource allocation system where average costs were not central to the process, to one where activity is paid for at prices set equal to adjusted national average costs. In the recent past, local prices paid by primary care trusts (PCTs) for hospital services were essentially cost-plus and were set without any reference to the national average cost per unit of activity per annum. Likewise, capital funding was not allocated by reference to capital productivity, that is the extra patient services per pound of capital investment. For example, Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) schemes – while subject to ‘value for money’ tests (to make sure that they are at least as cost-effective as the public sector alternative) – were not (and are not) evaluated in terms of whether their annual capital costs (depreciation plus dividend on public dividend capital or PDC) were expected to be no greater than the national average capital costs. It should therefore be no surprise that some hospitals have inherited legacy capital costs arising from past capital investments where the annual capital charge is greater than the allowance for capital costs embedded in the average cost PbR tariffs. Equally, some hospitals will have inherited legacy costs that are lower than the national average.

Hospitals with higher average capital costs than the national average will not fully recover those costs out of the PbR tariff revenue even if efficiently managed, unless an explicit uplift is provided in the trust’s Market Forces Factor (MFF), for the following reasons.

- PbR tariffs are set equal to national average costs. The tariffs include a capital charge equal to the national average capital charge across all NHS trusts. This is computed as the depreciation and dividend on the PDC per unit of activity for all capital employed in providing NHS services in England.

It is therefore an average across all hospitals of varying age, quality and capital productivity. If a hospital has inherited higher-than-average capital costs it will under-recover from tariffs the amount of revenue needed to pay their actual capital charges. Consequently, they will have a deficit on their income/expenditure account even if operations are efficient.

- The depreciation provision is computed after indexation of the capital stock using the approved NHS methodology. If a hospital trust incurs actual capital cost increases that are greater than the index allows for, this too will give rise to revenue under-recovery and the emergence of a deficit, even if well managed, unless the MFF adjustment adequately compensates for this.

The problem of legacy costs arises because they are sunk and irreversible. However, there is also a problem with new proposed capital investments, for example new PFI hospitals and LIFT schemes. If the costs per unit of output are higher than the amount that is recoverable in the tariffs, undertaking the investments will worsen the income/expenditure balance in the future. The only available choices for the trust contemplating such investments are to:

- not proceed (in which case patients do not get the enhanced services)
- absorb the higher non-recoverable costs by cutting costs below the efficient level (with potentially adverse consequences for patients)
- get trust-specific financial support from the DH for the extra costs
- incur an additional deficit.

### ***Stranded capacity***

The following is the evidence for the existence of stranded capacity:

- There are widespread reports of PCTs seeking to cap payments to hospital trusts to avoid incurring deficits. This is particularly the case in the south of England where PCT funding allocations are under pressure because the DH is seeking to reverse a historical funding bias in favour of the south. This is compressing the volume of activity that PCTs can afford to purchase leading them, in turn, to try to control payments to hospital trusts. As a result, hospital trusts have under-utilised capacity in some services while suffering supply constraints in others.
- Hospital trusts have been increasing the effective capacity of their services by reducing average length of stay and increasing day-case rates. This has increased the capability of hospitals to provide services. This tendency will

strengthen when PbR is fully in effect. However, PCTs have not been able to afford to purchase all the extra services that the hospital trusts are now capable of providing.

- The emergence of under-used capacity and financial deficits has caused many trusts and SHAs to close capacity in an attempt to manage financial pressures. Examples abound in the pages of the *Health Services Journal* (2005a, 2005b, 2005c, 2005d, 2005e, 2004) and elsewhere in the press. A few examples are:
  - closure of 500 beds in London in 2005
  - reports from Southampton that capacity in certain hospitals is about 20–25 per cent more than is required
  - reports from Surrey and Sussex SHA that capacity of hospital trusts in some services exceeds effective demand (that is, what PCTs can afford to purchase) by up to 25 per cent
  - reports from several London SHAs of similar percentages of excess capacity for certain services.

### Stranded costs

Stranded capacity exists because the purchasing power of commissioners (PCTs) is insufficient to pay for all the services potentially available at the prices set in the tariffs. In a true market, prices would be bid down and the ‘surplus’ capacity would be used at a lower average price and higher capacity utilization. With fixed prices this is not possible.

If we start from the position where the level and pattern of demand for existing hospital capacity and the PbR tariffs are just sufficient to generate the revenue to pay the capital charge relating to that capacity, then the book value of the assets in the trust’s balance sheet will be an accurate reflection of their true value.

If a hospital then suffers a reduction in demand for that capacity, causing utilisation rates to fall (because of, for example, the impact of practice-based commissioning, patient choice, independent sector provision and/or the shift of hospital care into the community), there will be an immediate reduction in net revenue unless marginal costs can be reduced as much as marginal revenue. Certain hospital costs are fixed even in the medium term. A permanent reduction in capacity utilisation can lead to a permanent reduction in future net revenues

and therefore a reduction in the true value of a trust's assets and liabilities below their book value. If the trust is required to pay in full the dividend on the PDC relating to the book value of the PDC, then it will incur a deficit even if it is operating efficiently.

Note that legacy costs and stranded costs are quite distinct although trusts often suffer from both. Legacy costs reflect high sunk costs for planned volumes of output. Stranded costs reflect higher than expected unit costs because of unplanned shortfalls in capacity utilisation rates.

How can there be long waiting times and excess capacity at the same time? Although there are long waiting times for some procedures at most hospitals, there are many services where activity could be increased using existing capacity but where there is no remaining PCT purchasing power, nor likely to be in the future. This surplus capacity imposes costs on the tax-payer and should be eliminated. However, the restructuring required to reduce total costs over the medium term will increase costs in the short term.

The problem of stranded capacity and stranded costs – already quite evident today – can only get worse after 2008. Waiting lists and waiting times will come down rapidly as the large increase in resources for the NHS is narrowly focused on expanding capacity in certain services to meet these targets. Falling waiting lists and waiting times can occur only when the annual rate of supply of services exceeds the annual demand – taking patients off lists faster than they are being added. This is being achieved partly through more productive use of existing capacity and partly by adding new capacity to the system. When waiting times have been reduced to the level set in the targets and when the growth in real resources in the NHS flattens off (probably in 2008), there very probably will be too much capacity relative to demand at that time. If prices remained fixed (at current levels), this excess capacity would be apparent as even lower utilisation rates of capacity and greater stranded costs. If tariffs are reduced in real terms by more than the currently planned 1.7 per cent per annum, more activity could be purchased with the same PCT budgets but there would be much greater cost pressures on trusts and more of them would incur large deficits and risk failure. If marginal prices (that is, prices paid for extra activity in excess of base levels) were flexible downwards, then it would be possible to increase the total volume of activity within a fixed budget with much less risk of systematic financial failure of trusts.

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