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The Failure of a Failure Regime: From Insolvency to De-Authorisation for NHS Foundation Trusts

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Abstract

This paper examines the failure of a 'failure regime' for NHS Foundation Trusts. More particularly, it considers the proposals to create a failure regime for NHS Foundation Trusts that were set out in the Health and Social Care Act 2003, and that drew explicitly on the Insolvency Act 1986. These proposals were subsequently abandoned in favour of a regime based on a notion of 'de-authorisation'. This case is of considerable interest, as the category of failure has come to saturate public life, while the ideas and instruments for conceptualising and calculating failure have not received the attention they deserve. This paper suggests that failing and failure do not have the objectivity and inevitability often associated with them, and that both are formed out of a set of calculative practices and financial norms that allow complex processes of mediation between domains and desired outcomes. It is important, we argue, to analyse the roles played by metrics such as ratio analysis and risk indexes, for it is through these that this mediation takes place. It is important also, we suggest, to explore that happens when attempts are made to model 'failure regimes' for public services on ideas and instruments designed for the corporate world. Further, we argue that it is important to examine the co-creation of new entities, and of the failure regimes for regulating those entities. We suggest that the case examined here has implications that go beyond the domain of healthcare, and that it highlights important issues concerning the role that 'exit' models can play in the regulation of public services.

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[1] This paper was initially written for the CARR/Score Workshop, 'Organizing, Shaping and Creating Markets', Stockholm Centre for Organizational Research, Stockholm, 16-17 April 2010. The work conducted for this Discussion Paper was part of the programme of the ESRC Centre for Analysis of Risk and Regulation. The authors wish to thank the three anonymous reviewers, Andrea Mennicken and Mike Power for their comments and encouragement with this project.

> In the new environment of patient choice and competition, it is almost inevitable that some providers will fail. Indeed, it is desirable that this is the case, in order to enable major reconfigurations where necessary and to bring about real accountability. System exit is essentially irreversible financial failure and is therefore an economic result. Such financial failure may have its roots in other forms of failure (for instance, clinical or governance) but it is only the financial impact that can cause insolvency and thus exit (Monitor 2005: 25)

Introduction

The category of failure has come to saturate public life in ways that both pre-date and go far beyond the recent financial crisis and its ramifications for public services. In the mid nineteenth century, failure was deeply personal, encapsulated in the term 'loser' and other associated terms (Sandage 2005). This notion of failure brought together the economics of capitalism and the economics of personhood. The various attempts on both sides of the Atlantic during the nineteenth century to figure out whether and how to forgive failure were not only economic and legal matters, but profoundly cultural (Mann 2002). The redefinition of insolvency as economic rather than moral, as arising from risk rather than sin, entailed a 'democratising' of failure, an acknowledgment that failure was something available equally to all citizens, an acceptance that the vicissitudes of capitalism could lead to personal failure even despite hard work.[2]

In recent years, the category of failure has been democratised further. No longer restricted to the personal and the corporate world, it can now encapsulate almost any public service, whether education, healthcare or social care.[3] The language of failure today dominates regulatory regimes, the entities they seek to regulate, and indeed much of the debate concerning the performance of public services. This language of failure goes hand in hand with a set of metrics and devices for calculating failure, for assessing the performance of organisations, determining whether there are problems and if so how severe they are, setting out what might be done to address the problems identified, and pronouncing on the moment of failure itself. It is difficult to separate this language and these metrics of failing and failure from that of markets and marketisation. Exit, rather than voice, has become the preferred option for dealing with decline and decay (Hirschman 1970). In so far as public services are designed increasingly according to the rules of the market game, the entities providing them now have to be allowed to fail according to the same rules. At least in principle, bankruptcy law is equally applicable to

[2] S. Sandage describes the relatively enduring Bankruptcy Act of 1867 in the United States as the first comprehensive bankruptcy law in American history, and comments on it in the following terms: 'National bankruptcy promised a kind of national citizenship' (Sandage 2005: 215). The civil war, he suggests had altered the terms of political and economic identity in ways that expanded the constituency of failure.
[3] On 'failing schools', see for instance G. Paton (2010).

the provision of healthcare and the corporate world. And the regulation of these very different domains is circumscribed by the aspiration in a liberal society to ensure transparent and equitable arrangements for identifying failings and pronouncing on failure, yet without giving rise to a limitless expansion of the domain of regulatory intervention.[4]

Notwithstanding the ubiquity of the language of failure, and the panoply of regulatory regimes now dedicated to adjudicating on it, sociologists, organisation theorists, and management researchers have largely neglected the phenomenon in recent years, while accountants have typically confined themselves to seeking to develop and refine predictive models, albeit with little success.[5] When the issue of failure has been addressed by social scientists, this has largely been on the basis of a view of failure as something objective and immutable, an inescapable outcome of an underlying economic reality. Our perspective differs, and has more in common with recent developments in cultural history (Balleisen 2001; Mann 2002; Sandage 2005), although we focus particularly on the various instruments for calculating failure, and how these have been made available to all in recent years.[6] We suggest that the moment of organisational failure does not have the objectivity and inevitability often associated with it, and that it is itself formed out of a set of calculative practices and financial norms, which allow complex processes of mediation between domains and desired outcomes. It is, we argue, important to examine these metrics and instruments – such as ratio analysis and risk indexes – through which this mediation takes place.[7] It is important also, we argue, to distinguish between failure and failing, a distinction internal to regulatory and policy discourses, and subject to the same processes of judgment, interpretation and mediation. Both notions, we suggest, can operate as organisational and regulatory recourses, giving rise to demands for further resources or regulation in order to combat deficiencies and decline.[8] We suggest further that it is important to explore what is at stake when attempts are made to model failure regimes for public services on ideas and instruments designed for the corporate world. And we argue that it is important to examine, in the context of intensely regulated public

[4] Halliday and Carruthers (2007) consider the issue of corporate insolvency regimes, and describe this as a global phenomenon driven by the interaction between 'lawmaking' at the national level and 'norm making' at the global level.

[5] An interesting exception is Meyer and Zucker (1989), although it is worth noting that this was written over two decades ago, and to our knowledge has not been extended since by others. While written in a more 'realist' frame than the current paper, Meyer and Zucker's notion of 'permanently failing' (or poorly performing) organisations effectively challenges the notion of failure as a given and objective event. For a thoughtful overview of the early management literature on failure, see Whetten (1980). On ratio analysis and related issues, see Dev (1974) and Miller and Power (1995).

[6] An interesting parallel, relating to the emergence of accounting technologies and the control of mass credit within the department store in the early decades of the twentieth century, is provided in Jeacle and Walsh (2002).

[7] On the use of ratio analysis, as applied to the corporate world, see Miller and Power (1995).

[8] Power (1997), examining the phenomenon of auditing, speaks of the 'dialectic of failure'. By this he means that efforts to audit, and indeed to regulate more generally, always fail, and this failure is the condition for further attempts at control. This process or dialectic, he argues, has contributed to the creation of new institutional structures, such as the Auditing Practices Committee (Power 1997: 26).

services, the interaction between the creation of new entities, and the creation of new failure regimes for regulating those entities. While others (e.g. Espeland and Sauder 2007) have emphasised how public measures such as rankings can produce 'reactivity' on the part of those who are ranked (i.e. altered behaviour such as redistributing of resources, redefining of work, and increased gaming), our focus is on the attempt to co-create both the regulatory regimes and the entities they are designed to regulate and assess.

We explore this set of issues by examining the domain of healthcare in England, and more particularly the failure regime that emerged in tandem with the newly created entities called 'Foundation Trusts'. The domain of healthcare is of particular interest. For, while all bodies of expertise have the capacity to generate 'enclosures' – relatively bounded locales within which their power and authority is concentrated and defended – the domain of healthcare can be viewed as an exemplar (Rose and Miller 1992). We consider the procedures that were set out in the Health and Social Care Act 2003, and how these have been subsequently debated and modified. For these proposals sought to create a failure regime for NHS Foundation Trusts that drew heavily on the Insolvency Act 1986. We explore firstly the multiple and possibly competing aspirations that were associated with the idea of 'democratising' failure. Secondly, we examine the various metrics for calculating failing and failure, including ratio analysis and risk indexes, which were drawn upon and mobilised by the newly created Independent Regulator as a way of assessing the financial health of Foundation Trusts. Thirdly, we consider the complex process of seeking to make the new failure regime operational, with particular emphasis on the consultation process that took place during 2004 concerning the secondary legislation to enact the insolvency aspects of the proposed failure regime. Fourthly and finally, we consider the process of 'rethinking failure' that took place as the modified insolvency regime failed to materialise, and a new 'de-authorisation regime' came to take its place. Instead of a failure regime that would have focused largely on the valuation and transfer of the assets of *failed* entities, we see the emergence of a regime for identifying *failing* and poorly performing entities as well as *failed* entities, a regime that, in assessing ultimate failure, seeks to place the financial position of the entity alongside other conditions such as the health and safety of patients and the quality of services provided.

In conclusion, we consider some more general features of the 'democratisation' of failure regimes that this example illustrates. We explore the tensions that underlie the attempt to model a failure regime for public services on a mixture of ideas and instruments designed for the corporate world, aspirations for local accountability, and the retention of central control. We consider also the interaction between the creation of new entities, and the creation of new failure regimes to regulate those entities, in so far as the new entities were themselves created by the same legislation that created the regulatory instruments

and rationales.[9] We argue that the example of creating and seeking to regulate NHS Foundation Trusts demonstrates that the moment of organisational failure is much more complex than the language of realism suggests, formed as it is out of a complex of calculative practices, entity claims, expert judgments and negotiation (Miller and Power 1995). We suggest it is important to examine how the adjudication of failing and failure comes to be 'mediated' through a diverse set of metrics, such as ratio analysis and risk indexes. Developed many decades earlier, and for the corporate world rather than public services, these metrics continue to provide much of the calculative infrastructure that underpins the failure regime for NHS Foundation Trusts, almost irrespective of the to-ings and fro-ings surrounding the legislative details that seek to set in place the failure regime.

Democratising failure

On 30 April 2003, Alan Milburn – then Secretary of State for Health – delivered a speech to the Social Market Foundation on the subject of healthcare provision. He stated as follows:

> NHS Foundation Trusts will be built on the values and principles of community empowerment, of staff involvement, and of democratisation. Indeed the way they will work draws on some of this country's best traditions of mutualism and co-operation. They draw too on international experience of greater independence improving performance in hospitals across Europe (Milburn 2003).

Over a year earlier, Milburn (2002) had set out the aspirations that underlay this new organisational initiative. Invoking Nye Bevan's notion of 'serenity' – knowing that we will be cared for when we are ill – Milburn endorsed wholeheartedly the founding values of the National Health Service. But he argued that, while its values are correct its structures are wrong. The NHS, he argued, was a product of the era in which it had been formed. It was monolithic and bureaucratic, and was run like an old style nationalised industry controlled from Whitehall. Top-down control, he argued, stifled local innovation and did not put patients first. The balance of power, he went on to say, had to shift in favour of the patient. The notion of patient choice was fundamental here:

> Choice will fundamentally change the balance of power in the NHS. Hospitals will no longer choose patients. Patients will choose hospitals (Milburn 2002a).

[9] On the interrelation between regulatory processes and regulated entities, see Kurunmäki and Miller (2010).

A new organisational form was needed, he argued, in order to bring about this change.[10] NHS healthcare did not need to be delivered exclusively by line-managed NHS organisations. It could, instead, be provided by a multiplicity of providers, albeit working according to a national framework of standards and inspection, and subject to the principle of healthcare being available free of charge at the point of delivery. The task of managing the NHS would, henceforth, become one of overseeing a system rather than an organisation. Innovation would be secured by a promise: the better the performance of the organisation, the greater freedom it will enjoy. A new type of independent not-for-profit entity would be created, a sort of 'third way' in healthcare. Appealing to arguments on both the Left and the Right, he spoke of the case for 'new forms of organisation such as mutuals or public interest companies within rather than outside the public services and particularly the NHS' (Milburn 2002a). He went on to label this new type of entity a 'foundation hospital', indicating that over the coming months the legal, financial, governance and accountability issues raised by such a development would be examined.

By May 2002, a name for this new type of entity had been found (Milburn 2002b). Those hospitals that were to be freed from day to day interference from Whitehall, that were to be given local flexibility and freedom to improve services for patients, were to be called 'Foundation Trusts'. Milburn (2002b) announced the plan to legislate to 'enshrine in statute the freedoms and responsibilities that NHS Foundations Trusts will have'. These new types of organisations for providing healthcare would be free-standing legal entities, no longer directed by the Secretary of State. They would occupy the middle ground within public services, located between state-run public services and shareholder-led private structures. And, as central control over day to day management ceased, so should local community input be strengthened. NHS Foundation Trusts, Milburn (2002b) argued, 'will have the ability to develop governance arrangements that enable patients and the public to play a more effective part in the running of the NHS at a local level'. As free-standing entities, they would be held to account through the commissioning process, rather than through day to day line management from Whitehall. They would, for instance, have the freedom to retain proceeds from land sales to invest in new services for patients. They would have greater freedom to decide what they can afford to borrow, and they would be able to make their own decisions about future capital investment. They would also be given more flexibility with regard to pay, allowing 'additional rewards for those staff who are contributing most' (Milburn 2002b). Exercising these freedoms, Milburn argued, would give NHS Foundation Trusts autonomy comparable to that which is commonplace for hospitals elsewhere in Europe.

In March 2003, the Health and Social Care Bill was introduced to Parliament. On 20 November 2003, the Health and Social Care Act was passed. This set out, in the dry

[10] On the aspirations for NHS Foundation Trusts, see Day and Klein (2005), particularly section I; see also Klein (2003, 2004).

language of legislation, provision for the twin creation of NHS Foundation Trusts as 'public benefit corporations', and a body corporate known as the 'Independent Regulator of NHS Foundation Trusts'.[11] The 'authorisation' procedures for NHS Trusts to become Foundation Trusts were set out, together with the effect of authorisation. The Act also detailed various financial matters, including the power of the Secretary of State to give financial assistance, together with principles concerning prudential borrowing, public dividend capital, authorised services, private healthcare, the protection of property and the financial powers of Foundation Trusts.

In addition, and most importantly for the purposes of this paper, the Act set out – in an entire section headed 'Failure' – the procedures for dealing with NHS Foundation Trusts that were considered to be failing, and what would happen in the event of actual failure. This specified the powers of the regulator in circumstances where an NHS Foundation Trust was considered to be significantly contravening or failing to comply with any term of its authorisation or any requirement imposed on it. In such circumstances, the regulator would be entitled to require the trust, directors, or board of governors, to do specified things or indeed not do specified things, and within a specified period. The regulator would also have the power to remove any or all of the directors or members of the board of governors, and appoint interim replacements; this power included the authority to suspend a director or member of the board of governors from office, or disqualify an individual from holding office for a specified period.

Under a heading titled 'Voluntary arrangements', the regulator was given the power to require an NHS Foundation Trust's directors to make a proposal for a voluntary arrangement with its creditors. In addition, the regulator was given the power to require an NHS Foundation Trust's directors to obtain a moratorium on its business prior to the approval of a voluntary arrangement.[12] Under a heading titled 'Dissolution etc.', the Secretary of State was given the power, in certain specified circumstances, to dissolve an NHS Foundation Trust by order. The power could be exercised where an NHS Foundation Trust fails to comply with a notice under previous sections of the law, or where it fails to implement a voluntary arrangement, and where the regulator considers that, despite the exercise of its powers under previous sections of the legislation, the goods and services of the NHS Foundation Trust remain at risk. Procedures for dissolution included the power to issue an order to transfer, or provide for the transfer of, any property or liabilities of the trust to another specified body. In the case of dissolution, the application of these powers included provision for ensuring that the essential goods and services which the Foundation Trust continue to be provided, whether by the Trust itself or another body.

[11] Health and Social Care (Community Health and Standards) Act 2003, Chapter 43, paragraphs 1.1 and 2.1.
[12] These provisions regarding 'voluntary arrangements' were drawn directly from Part 1 of the Insolvency Act 1986.

Democratising failure – the aspiration to make failure available to all, including healthcare providers – was a bold endeavour. It meant allowing individual organisations to exit or fail, while ensuring that the provision of services did not. It entailed an attempt to resolve the tensions between the tripartite aspirations of local and democratic accountability and mutualism, an 'exit' or insolvency model based on the corporate sector, and the retention of at least a residual form of central control in order to guarantee the continued provision of services. Even without the likely tensions between these three poles, there was still the task of making a new accounting entity, and making a new regulatory regime in parallel. This process of co-production turned out to be challenging enough in itself. We turn in the next section to consider the proposals that emerged for making the notions of failing and failure calculable. In the subsequent section, we examine how the notion of failure was to be made operable, in particular through proposals for secondary legislation which sought to enact the insolvency aspirations of the failure regime.

Calculating failure

Even before the Regulator formally came into being on the 5 January 2004, the Department of Health had engaged McKinsey & Company to develop models to assess applicants' financial health, and to advise further on the applications process.[13] At the inaugural Board Meeting of the new Regulator on 14 January 2004, the Board agreed that this was a sensible course of action. On the 16 of January 2004, the Secretary of State for Health announced that he had approved 24 NHS Trusts to apply to the Regulator for authorisation as NHS Foundation Trusts. The Executive Chairman of the Regulator wrote on the same day to the Chief Executives of the 24 Trusts explaining what they would need to send to the Regulator in order to apply formally. Meetings were arranged with the Chairs and Chief Executives of the 24 Trusts in London and Leeds to start to build links with the applicants, and to explain how the Regulator planned to assess applications.[14] At this stage, the requirements for an application (which also triggered the shadow governance arrangements) had been kept to the minimum necessary to satisfy the legislation, although applicants had been informed that more material would be required by the Regulator in due course.

On 21 January 2004, McKinsey & Company made a presentation to the Board to explain the work they were undertaking on behalf of the Regulator. They stated that they were conducting an audit of preparedness amongst applicants, the NHS, the Regulator and other bodies, and that they were interviewing key players. They stated that their initial findings had emphasised the importance of a rigorous and robust application process, one that focused primarily on the assessment and management of financial and governance

[13] Foundation Trust Regulator Board minutes, 14 January 2004.
[14] Foundation Trust Regulator Board minutes, 21 January 2004.

risks. The Board agreed that the Regulator's role must focus on risk management, whilst creating space for Foundation Trusts to develop new opportunities and guarding their independence. The Board also agreed that applicants needed to look very carefully at getting their governance arrangements right. The Board agreed to look at NHS Foundation Trust governance issues in detail at their next meeting.

McKinsey & Company also described to the Board the work which they were doing to develop a model for assessing applicants' business plans, i.e. their plans to deliver the service development strategy, operate viably as an NHS Foundation Trust, and manage short and medium term risks.[15] They reported that Foundation Trusts applying for authorisation faced potentially serious financial risks, not least the possible impact of the implementation of the new Payment by Results regime, which put in place a new funding mechanism for hospitals based on set national tariffs.[16] There were also concerns about the readiness of Primary Care Trusts to sign up to contracts to ensure that income to support the service development strategy could be guaranteed.

At the July 2004 Board Meeting of the Independent Regulator, an oral briefing was provided on compliance and annual risk assessment. By this time, there were already 20 Foundation Trusts, and the Secretary of State had just forwarded a further 24 applications. This meant that, by the end of the year, as many as 40 Foundation Trusts could be in existence, based on the high success rate till that point.[17]

Meanwhile, the annual risk assessment process was being prepared. On the financial side, it was proposed that this would be based on key metrics such as liquidity, borrowing, and performance against financial projections provided during the application process. A balanced scorecard approach was suggested, to generate an annual risk rating which would determine the monitoring regime for the forthcoming year. On the compliance side, priorities fell into two distinct areas, namely compliance and building relationships with other regulatory bodies and other interested parties across the health sector. The aim was to have a full compliance regime in place by the spring of 2005, following a formal consultation process in the autumn. The intention was for the Regulator and the Healthcare Commission[18] to consult simultaneously on the Regulators' compliance regime, and the Healthcare Commission's new performance assessment scheme

[15] At the June Board meeting, it was reported that McKinsey & Company had been appointed as 'Strategic Consultants to the Regulator' (Foundation Trust Regulator Board Minutes, 2 June 2004).
[16] On Payment by Results, see Kurunmäki and Miller (2008).
[17] Of the original set of 24, only 4 had been deferred, of which 3 would ask for final decisions during 2004. Foundation Trust Regulator Board Minutes, 26 July 2004.
[18] The Healthcare Commission, previously known as the Commission for Healthcare Audit and Inspection, was created under the Health and Social Care (Community Health and Standards) Act 2003 with a statutory duty to assess the performance of healthcare organisations, award annual ratings of performance for the NHS and coordinate reviews of healthcare with others. On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, took over the Healthcare Commission's work in England.

respectively. It was proposed that the draft consultation document would be considered by the Board in September. The Board considered it of paramount importance that the roles of various bodies – the Regulator, the Healthcare Commission, Strategic Health Authorities, and Primary Care Trusts – with respect to Foundation Trusts be clearly defined and delineated. To this end, it was suggested that a short paper to the Department of Health should be prepared during August, for discussion at the September 2004 Board meeting. The Board noted that it was content with the broad focus and direction of what was proposed, although it was also noted that it was clear that ongoing Board discussions about the nature and level of regulatory engagement were required.

At the same meeting, the issue of interim monitoring was considered. Given the time required to design a full monitoring regime, and consult on it prior to implementation, the Regulator had put in place interim monitoring arrangements. These would remain effective until the launch of the full compliance regime in early 2005 and had been published on the Regulators' website.[19] The stated overriding objective of the Regulator was to assess and mitigate potential risks to the delivery of Foundation Trusts' obligations under their terms of authorisation. This was to be sought by obtaining information on finance and governance, and assessing risk in these areas based on criteria similar to those used in the assessment process. The Regulator would then wish to be satisfied by the Board of Directors of the Foundation Trust that the risks identified were being addressed effectively. It was felt that monitoring risk in this way would allow Foundation Trusts to operate in the autonomous manner envisaged in the legislation. Two instances were cited concerning existing Foundation Trusts, where issues had been identified, and these were being pursued in cooperation with the Executive teams of the Trusts in question.

The issue of interim monitoring was discussed further at the 10 September 2004 Board meeting, when a draft compliance consultation document was also discussed.[20] It was noted that both the Independent Regulator, named 'Monitor' in August 2004, and the Healthcare Commission were separately producing material on how they would operate their respective compliance frameworks. The aim was, if possible for the two organisations to consult at the same time so that stakeholders could see how the separate systems interrelated, and what was expected of them in terms of a broader compliance system. The aspiration was that Foundation Trusts would be primarily responsible for self-governance, and that subject to satisfactory compliance this would allow Monitor to step back and focus its efforts on those cases where particular problems had been identified. As regards the draft compliance document, the Board noted that it was broadly content with it but asked for some further work to be carried out in three particular areas. Firstly, it was suggested that Monitor's compliance philosophy should be made more prominent, and that relatedly the document should make clear that high standards would

[19] Noted in Foundation Trust Regulator Board minutes, 26 July 2004.
[20] Noted in Foundation Trust Regulator Board minutes, 10 September 2004.

lead to a lighter touch being applied by Monitor. Secondly, work was needed on what constituted a 'significant failure' as set out in Section 23 of the Health and Social Care Act, and the document should offer some examples. Thirdly, there should be more material on the dissemination of good practice, giving examples and praise where appropriate.

The Board meeting of 29 September considered the 'final draft' of the compliance consultation document on a page-by-page basis, noting somewhat ominously that the 'implications of Foundation Trusts' independence were now becoming more apparent to them'.[21] The discussion noted that the Department of Health was comfortable with the proposed approach, and the Board approved the document, while allowing the Executive Chair the right to make any necessary minor amendments prior to publication.

The consultation document was published in November 2004, with the following portentous statement concerning Monitor's 'compliance philosophy':

> NHS Foundation Trusts are in the vanguard of the shift from a centrally managed NHS to a healthcare system which is intended to be responsive both to the needs of the patient and the wishes of the local community. NHS Foundation Trusts have been given significant freedoms. […] These freedoms also carry important responsibilities. Individually, NHS Foundation Trusts are accountable for their success or failure. They must operate effectively, efficiently and economically. So while they can retain surpluses, they can also become insolvent (Monitor, 2004)

This meant that a successful NHS Foundation Trust could expect to be given considerable latitude to exercise its freedoms. For instance, it might only have to report its financial position to Monitor every six months. However, and while endorsing the mantra of 'light touch' regulation for successful and well-governed entities, it was stated bluntly that there would be intensive and rapid intervention, should that be needed, in order to ensure services to patients are safeguarded. The legislation, it was noted, gave Monitor extensive powers to intervene in the event that an NHS Foundation Trust is failing to comply with its authorisation. However, it made clear that Monitor was 'not in a position to provide failing NHS Foundation Trusts with financial support' (Monitor 2004, paragraph 1.1)

To begin with, this meant that Monitor would operate a relatively tight monitoring regime that would not differentiate materially between NHS Foundation Trusts. Over time, as some Foundation Trusts demonstrated a track record of compliance with their authorisation, Monitor would ease the degree of monitoring. This meant, in practice, that most NHS Foundation Trusts would be likely to be required to report quarterly, although

[21] Monitor Board meeting minutes, 29 September 2004.

in cases where the risks of non-compliance with the terms of authorisation could not be managed, monitoring would be in-depth and probably monthly.

Risk management by Foundation Trusts themselves was at the heart of this monitoring regime. Monitor's intention was that, after two consecutive years without significant concerns being identified, each NHS Foundation Trust would be able to undertake its own risk assessment, using tools and criteria specified by Monitor. Information provided in the Annual Plan would be used by Monitor to assess the scale of risk that an NHS Foundation Trust faced in three respects: finance, governance, and mandatory services. The diagram in Appendix A sets out the elements of the Annual Plan Monitor proposed to ask NHS Foundation Trusts to submit. Financial risk would be assessed using a scorecard, combined with 'informed judgement on the robustness of the business plan assumptions' (Monitor 2004: para 2.1.4). The financial scorecard used to generate the risk rating is described in Appendix B, and has four principal components: achievement of plan, as per Annual Plan projections; underlying performance; financial efficiency; and liquidity. Each component would be broken down into a set of specific metrics which would be rated 1 (low risk) to 5 (high risk), and compared to a grid of standard values. Appendix C sets out the monitoring implications of each rating. A rating of 1 would indicate no cause for regulatory concern on any of the assessed components, and would result in bi-annual monitoring. A rating of 5 would suggest a high probability of significant break of the terms of authorisation in the short term unless remedial action was taken, resulting in potential for intervention under section 23 of the Act.

The momentum that was maintained during the first year of existence of the Independent Regulator was impressive. Not only did the Regulator rapidly endorse the decision by the Department of Health to appoint McKinsey & Company as consultants who were to advise on the metrics needed to assess the performance and risks of Foundation Trusts, and initially also to assess those that applied for authorisation. An outline of the recommended metrics was produced equally promptly, even if these bore a striking resemblance to those metrics already in use in the corporate world.[22] And, within the very first month of operation of the new regime, the Secretary of State for Health had approved 24 NHS Trusts to apply to the Regulator for authorisation as NHS Foundation Trusts, while a similar number of eager applicants were waiting in the wings. Meanwhile, procedures for interim monitoring were being devised, so as to be able to deal with those applicants that were approved prior to the details of the new failure regime being put in place. All this took place in the context of a continuing optimism about the prospects for 'light touch' regulation which would embed freedom and responsibility in equal proportions within Foundation Trusts.

[22] On the spread of such metrics, see Power (2007). For details on the metrics, see Laitinen (1991); Moses and Liao (1987); and Tamari (1964).

A working definition of the notion of 'significant failure' still remained an aspiration, however. While risk-based regulation was embedded rapidly in the new failure regime, the notion of failure itself proved more complex to operationalise in the healthcare context. It is to the latter that we turn in the following section, with particular attention to the proposals for secondary legislation to enact the insolvency aspects of the proposed failure regime.

Making failure operational

Despite opposition from the British Medical Association to the 2003 legislation that introduced NHS Foundation Trusts,[23] many eligible hospital trusts had applied for immediate 'authorisation', as indicated in the preceding section. Many that were not eligible started work right away on preparations for such an application. In parallel, and somewhat ironically given that 'authorisations' were being granted while the details of the failure regime were still being worked out, work was taking place on how to make the legislation operable. In particular, consultation began in March 2004 on proposals for secondary legislation for the establishment of a 'failure regime' for NHS Foundation Trusts. The proposed failure regime, as set out in the 2003 legislation, appealed directly to the 1986 Insolvency Act, yet it was also suggested that modification to this was needed in order for it to apply to the newly established Foundation Trusts. Fifty organisations were consulted as part of the process, and 28 responses received. As the consultation document stated at the outset:

> The Secretary of State will not guarantee the debts of an NHS Foundation Trust except in the specific case of a PFI [Private Finance Initiative] contract. In the event of the financial failure of an NHS Foundation Trust, the Independent Regulator will initiate a failure regime, which will ensure that essential NHS services continue to be provided. The Act contains powers to create, by secondary legislation, a specific 'stand alone' failure regime for NHS Foundation Trusts. The regime will be established through application and modification of Parts I and IV of the Insolvency Act 1986 ('the Insolvency Act') which relate to voluntary arrangements and winding up respectively. The NHS Foundation Trust failure regime will be based on well-established insolvency procedures for companies but with modifications applied to allow for the protection of essential NHS services and assets (Department of Health 2004: para 1.2).

The document went on to set out the proposals for the secondary legislation to establish this 'failure regime'. Central to these proposals was the principle that NHS Foundation Trusts would not be subject to direction by the Secretary of State for Health. Instead,

[23] House of Commons Health Committee (2003), Appendix 7 (FT11). See also British Medical Association (2003).

Foundation Trusts would manage their own budgets, have freedom to retain surpluses, and be able to access a wider range of options for capital funding than that available to NHS Trusts, although borrowing limits would be set. The Independent Regulator of NHS Foundation Trusts would oversee the Foundation Trusts, and would have responsibility for authorising, monitoring and regulating them. These responsibilities would neither replicate the Secretary of State's powers of direction, nor would they entail a role in their day to day running. Instead, the Regulator would set terms of authorisation, like a licence, for each NHS Foundation Trust, detailing the conditions under which they would operate. This would authorise a Foundation Trust to provide goods and services for purposes related to the provision of healthcare, some of which would be designated as mandatory. In accordance with the liberal principle of governing through freedom, the regulator 'is expected to give NHS Foundation Trusts maximum freedom to operate, while safeguarding the interests of NHS patients and the wider NHS' (Department of Health 2004: para 2.9). But, the regulator would be given power to intervene where a Foundation Trust is in significant breach of its terms of authorisation, including where a Trust 'fails' financially, or where it breaches its terms of authorisation through a failure of clinical standards as determined by the Secretary of State (Department of Health 2004: para 2.9).

The responsibilities of the Regulator included responsibility for acting in the case of *failing* entities. For instance, under section 23 of the Act, the Regulator was given the power to require an NHS Foundation Trust, the Directors, or the Board of Governors to do, or not do, specified things within a specified period. Put differently, the Regulator might require the Trust to 'take action with a view to averting the failure of an NHS Foundation Trust' (para 2.14). As the consultation document went on to state: 'In most cases, timely intervention by the Regulator should avert the failure of an NHS Foundation Trust' (Department of Health 2004: para 2.15).

But, while 'failure' included both financial failure and quality of care, the new failure regime proposed focused largely on the former:

> The regime will be established through application and modification of parts of the Insolvency Act. The NHS Foundation Trust failure regime will be based on well-established insolvency procedures for companies but with modifications. The modifications will reflect the different natures of companies and NHS Foundation Trusts. For companies, in the event of financial failure, the primary requirement is to ensure equity and fairness for all creditors. For NHS Foundation Trusts the requirement is to ensure first and foremost the continuation of essential NHS services, while also providing protection for creditors (Department of Health 2004: para 2.16)

Central here was the use of the 'voluntary arrangement' procedures, as set out in the Insolvency Act 1986. This means that an entity facing financial difficulties could reach

an agreement with its creditors to pay its debts either in full or in part over an agreed period, with additional provision for a moratorium which prevents creditors from taking action to seize assets to recover their debts during the specified period. The aim of applying and modifying these provisions of the Insolvency Act to NHS Foundation Trusts was to give Trusts facing financial difficulties the opportunity to reach an agreement with creditors to avoid financial failure, and to safeguard the continued provision of NHS services. While a 'voluntary arrangement', according to the proposals, could only be triggered by the Regulator, it was also suggested that directors or creditors of NHS Foundation Trusts could approach the Regulator to suggest that an NHS Foundation Trust is in financial difficulty, and that the Regulator should exercise its power to initiate the failure regime. The timetable for the consultation process envisaged that the Department of Health would lay before parliament later that year generic proposals for the secondary legislation, including provision to apply in modified form those parts of the Insolvency Act 1986 that pertained to voluntary arrangements. At the same time, the Department of Health declared its plan to publish a ministerial statement 'to set out the detail of the failure regime for NHS Foundation Trusts' (Department of Health 2004: para 2.24).

The newly formed Independent Regulator commented as follows on the consultation document at its Board meeting of 20 April 2004:

> … the Regulator needed to work up a clear policy on monitoring/compliance which would establish what sorts of failure would trigger intervention by the Regulator including financial failure, clinical failings, problems with governance, etc.[24]

In its formal response to the Department of Health consultation document,[25] Monitor commented generally that the failure regime assumed that the Independent Regulator would possess detailed knowledge of the Foundation Trust's situation, whether financial or otherwise. Monitor stated that it could not confirm that the compliance regime would provide the Independent Regulator with sufficient information to implement the failure regime.

More specifically, the response commented on two issues. On the 'failure regime' itself, it was suggested that, while the powers of the Independent Regulator to intervene were clearly not limited to financial matters, 'the majority of the Consultation Paper is written very much with financial failure in mind'.[26] While acknowledging that financial failure was the most likely scenario in which its powers would be invoked, it asked for

[24] Monitor Board meeting minutes, 20 April 2004, para 12.
[25] For Monitor's response to consultation document see Department of Health (2004b) from Independent Regulator.
[26] For Monitor's response to consultation document see Department of Health (2004b), paragraph A (p. 2) of its letter (Independent Regulator).

clarification that the proposed failure regime should apply to both financial and non-financial failure, if that was what was intended. The response also addressed the role of the Regulator, and its power to intervene. Noting the general duty to exercise its functions 'effectively, efficiently and economically', the Independent Regulator voiced unease that failure of a Foundation Trust to meet a financial commitment could mean that the Regulator would be obliged to consider intervention every time such an event occurred. Relatedly, concern was expressed at the requirement to intervene to avert failure, which would have gone against the very spirit of freedom on which the creation of Foundation Trusts was based. On this issue of a requirement to intervene in order to avoid failure, the Independent Regulator commented as follows:

> If the Regulator is tasked with proactively preventing breaches of the Terms of Authorisation, it will need to micromanage every Trust.[27]

The concern regarding the balance between financial and non-financial failure, and the danger that the former might dominate, was voiced by a number of other bodies. The Royal College of Physicians of Edinburgh, while accepting the need for a failure regime, commented that the proposals were 'almost solely concerned with arrangements for financial failure', and asked whether there were any plans for dealing with a Trust that fails on quality of care issues. The Association of Business Recovery Professionals, which represents authorised insolvency practitioners as well as 'turnaround practitioners', suggested that the whole subject needed to be given further thought, in particular with respect to provision to ensure that mandatory health services continue to be provided. Health Link, a not-for-profit company seeking to represent the interests of patients, argued strongly that the proposals related exclusively to the financial aspects of failure, and did not define adequately what was meant by the protection of services. The submission from Guy's and St Thomas' Hospital NHS Trust made a similar if somewhat broader point, suggesting that the consultation document did not make clear what criteria would apply when the Independent Regulator is considering whether it is necessary or desirable to issue a 'failure' notice requiring the instigation of voluntary arrangements and winding up:

> We believe it is desirable to and in the interests of NHS Foundation Trusts, creditors and all stakeholders alike, for criteria or guidelines to be published setting out what the Independent Regulator will take into account when determining whether he will issue a notice requiring the directors to make a company voluntary arrangement proposal to creditors. We do not believe that the criteria need be either extensive or complicated.[28]

[27] For Monitor's response to consultation document see Department of Health (2004b), paragraph B (p. 2) of its letter (Independent Regulator).
[28] For Guy's and St Thomas' Hospital NHS Trust's response to consultation document see Department of Health (2004b).

While presuming that conventional financial tests – such as balance sheet liabilities exceeding assets, or a trust being unable to pay debts as they fall due – would be applied, this comment highlighted the lack of clarity within the proposals even with regard to the financial aspects of the failure regime. Here, according to a number of commentators, it was unclear what would trigger the failure regime. For instance, King's College Hospital NHS Trust commented that it was not within the powers of the directors, at least as proposed, to commence insolvency proceedings. Accordingly, they suggested, it would be inequitable to apply the strictures of the Insolvency Act in their entirety without granting the directors the powers it affords them. East Somerset NHS Trust asked for clarification with regard to the role of the Healthcare Commission in identifying an NHS Foundation Trust as a failing organisation. And Sheffield Teaching Hospitals NHS Trust sought further information what exactly the Independent Regulator would take into account when issuing a notice requiring the directors to make a voluntary arrangement proposal. In a rather sardonic tone, they remarked that 'We have only been told that he will do so when he considers it necessary or desirable to do so.'[29] The submission went on to ask for further information on whether there will be a specific definition of insolvency within the proposed legislation, and whether any such definition would 'take account of factors relevant to operational management within the NHS environment'.[30] There was considerable concern, suggested the Sheffield Trust, that factors beyond the control of the Foundation Trust, particularly pertaining to demand management, were not taken into account in the current insolvency legislation. A precise explanation was needed, they suggested, given the way in which the proposal document used interchangeably notions of insolvency and failure regime on the one hand, and references to failure to meet quality care standards on the other.

The definition of failure, and how and when a failure regime might be triggered, gave rise to considerable concern among those commenting on the proposals. But the issue of who needed to be protected elicited perhaps even greater concern. The submission by King's College NHS Trust commented bluntly on the issue of balancing the rights of members and the rights of creditors, as follows:

> This balance appears to have been lost in translation into the context of a foundation trust, leaving the creditors to drive the liquidation in their best interests.[31]

The submission from Addenbrooke's NHS Trust added local and other stakeholders to the list of those that should be given greater consideration. As they pointed out, empowerment of local and other stakeholders was central to the aspirations of the Act

[29] Sheffield Teaching Hospitals NHS Trust's response to consultation document see Department of Health (2004b).
[30] Ibid.
[31] King's College NHS Trust's response to consultation document see Department of Health (2004b). Here, attention was drawn specifically to S101 of Part IV of the 1986 Insolvency Act.

creating Foundation Trusts. To that extent, 'it seems strange to effectively disenfranchise members at this stage in the life of the trust by giving them no opportunity to participate in this consultation.'[32] Health Link, unsurprisingly, echoed this sentiment very strongly:

> … we are concerned that no patient groups were specifically invited to comment. Foundation Trusts in a public sector service are a wholly new concept and it is unlikely that adaptations from the commercial insolvency system will be wholly successful unless the public and patient interest is adequately represented.[33]

The response from Health Link went on to argue that continuity of care and continued access to services, were extremely important to patients. The patients' stake, they stated, should be recognised in their appropriate involvement in the failure regime, which was not currently the case. They asked how the interests of patients would be balanced with the interests of commercial debtors, citing the instance of the run-up to financial failure when the risks to patients are the greatest. Patients, they suggested, are left bearing the risk of failure so they must be involved in mitigating it.

The Association of Chartered Certified Accountants (ACCA), equally unsurprisingly, argued in the other direction, suggesting that the proposed regime could appear unattractive to trade creditors.[34] A 'better balance' was needed, they argued, between safeguarding the core business of the Trust and respecting the rights of creditors. But the ACCA also drew attention to the importance of making allowances for the 'public benefit' nature of the Trust concept. On this point, they elaborated as follows:

> It is important, however, that the new legislation acknowledges the fundamentally different objects and purposes of Foundation Trusts on the one hand and commercial organisations on the other – differences which have implications for what the responsibilities of Trust directors should be. It must be borne in mind that many of the provisions in insolvency law, as they affect directors, are based on the premise that directors of insolvent companies owe a duty of care to their companies' creditors, rather than to the companies' other stakeholders, including shareholders. We query whether the government really expects the directors of Foundation Trusts which are in financial difficulties to put the interests of Trust creditors above the interests of all other stakeholders, and to make the directors personally liable for the Trust's debts if they do not do so.[35]

Citing the example of a significant outbreak of infection, they pointed out that the directors may take the decision to close part of the hospital in such circumstances. This

[32] Addenbrooke's NHS Trust's response to consultation document see Department of Health (2004b).
[33] Health Link's response to consultation document see Department of Health (2004b).
[34] Association of Chartered Certified Accountants's response (ACCA reference TECH-CDR-379. DOC) to consultation document see Department of Health (2004b), p.2 of its letter.
[35] Ibid. p.8 of ACCA document.

would temporarily halt income flows, putting the organisation at financial risk, but the decision would have been taken out of the necessity to safeguard public interests. Putting the dilemma rather starkly, the ACCA commented that the primary obligation of the directors of NHS Foundation Trusts is to provide healthcare, and in certain circumstances this may mean taking action that creates a financial risk.[36]

Many others needed to be protected too, it seemed. For instance, the City of London Law Society felt that the government should provide indemnity for the costs/liabilities of the nominee/supervisor, along the lines provided for administrators under the railway administration, and for interim lending to keep a Trust afloat pending resolution of any voluntary arrangement. The Association of Business Recovery Professionals felt similarly, remarking that a prudent insolvency practitioners would be unlikely to accept appointment without an unlimited indemnity from the Secretary of State. The same body felt more generally that, in so far as the Secretary of State can act very much as he likes, even if most of the creditors disagree, there was considerable scope for injustice and general discontent. And the Finance and Leasing association added finance providers to the list of those who needed protection.

To these concerns was added a host of other issues that made even more complex the task of devising a failure regime appropriate to the distinctive entity status created for NHS Foundation Trusts. A number of commentators remarked, for instance, on the absence of an 'administration' process as per the 1986 Insolvency Act, and by special application to the railways. The City of London Law Society described the procedure of 'administration' as 'a creative, flexible and useful rescue/insolvency tool', and recommended that its exclusion be reconsidered.[37] They went on to remark, not without irony, that it was not clear why the secondary legislation had not been introduced at the outset, a point echoed by the Finance and Leasing Association. The result of this two-step procedure, it suggested, was that there may not actually be any secondary legislation formally in place at the time of failure of a Trust. Further, and notwithstanding the proposal by the Department of Health to issue a 'ministerial statement', it went on to state in prescient terms that 'the absence of secondary legislation could prove permanent'.[38] The temporary or permanent absence of secondary legislation would have the consequence that a creditor would have no other recourse than to sue or seek to enforce any security it might hold. The promised ministerial statement, it added, was of uncertain legal status.

A further concern voiced by many was the application without amendment of the 'wrongful trading regime' found in section 214 of the Insolvency Act. The only action that directors of a Trust would be able to take to minimise loss to creditors would be to

[36] Ibid., p. 8 of ACCA document.
[37] City of London Law Society's response to consultation document see Department of Health (2004b).
[38] Ibid.

approach the Regulator to suggest that the Trust be wound up. But, in so far as the wrongful trading regime does not apply to the Regulator, it would offer little protection to creditors of Trusts. This point was echoed by a number of the submissions from NHS Trusts.[39] To those concerns were added the strong suggestion from many of the submission from NHS Trusts to disapply the proposed provision requiring directors to contribute to the debts of a failed Foundation Trust.

With freedom goes responsibility. This is an enduring refrain within liberal modes of governing. But here it was paired with an additional requirement: safeguarding the interests of patients and ensuring continuity of care within the context of a novel public benefit entity that was to be made subject to existing corporate insolvency legislation, albeit in modified form. The consultation process surrounding the proposed secondary legislation gave some indication of the scale of the challenge facing the Department of Health in its attempt to make principles of flexibility and freedom fit with the wish to provide for transparent and equitable arrangements for dealing with failing, failure and exit. As this section has demonstrated, the very definition of failure itself remained problematic, as did the balance between financial failure on the one hand and non-financial failure (regarding quality of care for instance) on the other. There was a lack of clarity as to what precisely would trigger intervention by the regulator. And, unsurprisingly, there was a clamour of voices as to who needed to be protected by the legislation. Predictably, patients and creditors were depicted as having potentially conflicting aspirations and needs, but there were others too who apparently needed to be protected. For instance, directors were held to need protection, and even the insolvency practitioners themselves were thought to need protection, if a viable insolvency regime was to be put in place. But there was still more. A multitude of 'technical' details to be worked out, concerning for example, whether the notion of 'administration' was applicable in this instance, how existing contracts that had been entered into prior to the proposed secondary legislation would be treated, and whether the 'wrongful trading' regime was appropriate in this instance. Even without the benefit of hindsight, the consultation process during 2004 on the proposed secondary legislation demonstrated that making a failure regime for NHS Foundation Trusts based on existing insolvency legislation was a highly fraught endeavour.

Rethinking failure

Making a new accounting entity is challenging enough. Making the regulatory regime for that entity at the same time is doubly challenging. If one adds to that the challenge of making or adapting the instruments for identifying and assessing the failings and failure of such entities, one begins to appreciate the scale of the task that faced those who

[39] See for instance, submissions from City Hospitals Sunderland NHS Trust, Doncaster NHS Trust, Guy's and St Thomas' Hospital Trust, and Sheffield (Department of Health 2004b).

embarked on the project of creating a regulatory regime for NHS Foundation Trusts. Notions of social construction and co-emergence may make sense as analytic categories, but they do not necessarily make a good basis for public policy and regulation.

It is therefore perhaps unsurprising that the aspiration to democratise failure itself failed. A little less than five years after the passing of the 2003 Health and Social Care Act, the acknowledgement of this failure was made public, even if the admission appeared in stages. On 4 June 2008, the Department of Health published a document titled 'Developing the NHS Performance Regime'. That document reaffirmed the need to establish a failure regime for state-owned providers, such as Foundation Trust hospitals, that would reflect the Government's commitment to ensuring service continuity while protecting public assets, yet allowing individual organisations to fail. This dilemma had been present from the outset, although initially it was viewed as a potentially productive tension. By 2008, and in light of a lack of development of a substantive failure regime for NHS Foundation Trusts, the tension was seen as much more fraught. Continuity of service provision was by that point being viewed increasingly as in stark contrast to maximising value to creditors as in the private sector.

By September 2008, a consultation document was published, setting out the Government's proposals for a statutory regime for 'unsustainable' NHS providers including NHS Trusts, NHS Foundation Trusts and Primary Care Trusts. Such a regime was intended for those organisations that were 'underperforming', 'seriously underperforming', or 'challenged'. While such an approach would, it was hoped, reduce the number of organisations that actually fail, it would not eliminate them. A regime was thus still needed to deal with cases of organisational failure. The consultation document acknowledged openly that no real progress had been made in this respect since the 2003 legislation:

> The unsustainable provider regime supports the Monitor intervention regime and the pipeline of NHS Trusts applying to become NHS Foundation Trusts. It provides a practical answer to the question, unresolved since the conception of NHS Foundation Trusts in 2002, of what happens when an NHS Foundation Trust fails. The Health and Social Care Act 2003 (now consolidated into the NHS Act 2006) envisaged an insolvency procedure with significant commercial aspects, but the Department has never found an appropriate way to give a workable effect to that and has never laid the relevant regulations. (Department of Health 2008: para 13)

The document went on to say that discussions of organisational failure in the NHS often took financial failure as the principal point of reference, and assumed that it was both possible and desirable to transpose onto the NHS a model of insolvency that included

significant commercial elements. Such a premise should now be discarded, the document stated.[40] In uncharacteristically frank terms, the consultation document stated:

> After careful consideration, the Government has concluded that it is not appropriate to apply this quasi-commercial insolvency process to NHS Foundation Trusts or indeed to other state-owned providers (Department of Health 2008: para. 50).

The response document to this consultation was published in January 2009 (Department of Health 2009a), alongside the first introduction of the Bill that subsequently, and in a modified form, became the Health Act 2009.[41] In place of an insolvency process, the proposed new sections enabled Monitor to issue a 'notice' to the Secretary of State, which would require the Secretary of State to make an order that the failed Trust would cease to be a Foundation Trust and a public benefit corporation, and would become a National Health Service Trust. A 'de-authorised' Foundation Trust would thus become an NHS trust under the Secretary of State's powers of direction, and a Special Administrator would be appointed to take control of the trust. Transitional arrangements were to be put in place to allow the continuation of commercial arrangements that had been entered into using Foundation Trust freedoms, and to ensure continuity of services. This 'de-authorised' status differed from the powers that had been put in place in the 2003 Health Act. Under that legislation, the Secretary of State – at the request of Monitor – could have made an order to dissolve the trust, transfer property or liabilities to other NHS bodies, and apply the provisions of insolvency legislation relating to the winding up of companies to the trust, in order to deal with outstanding liabilities, etc. But, those provisions did not give either Monitor or the Secretary of State the power to 'de-authorise' a Foundation Trust, or to return it to ordinary NHS trust status.

A further consultation, announced in July 2009[42] followed. This consultation referred to the recent events at Mid Staffordshire NHS Foundation Trust, events that were considered to have demonstrated a 'gap in the regulatory architecture' of NHS Foundation Trusts – between the existing powers of Monitor to intervene, and the unsustainable provider regime. The investigation by the Healthcare Commission into the (financially well performing) hospital in Stafford had begun in April 2008, after complaints from residents regarding the standard of care provided were reinforced by statistics showing an unusually high death rate. The investigation was carried out between March 2008 and October 2008, and in March 2009 the Healthcare Commission published a highly critical report that received widespread media attention (Healthcare Commission 2009). The report concluded:

[40] Six reasons were set out. See Department of Health (2008: para 50).
[41] Further detail on how the wider performance framework would work for NHS trusts was published in April 2009, and is included in Department of Health (2009b).
[42] Department of Health (2009c).

> In the trust's drive to become a foundation trust, it appears to have lost sight of its real priorities. The trust was galvanised into radical action by the imperative to save money and did not properly consider the effect of reductions in staff on the quality of care. It took a decision to significantly reduce staff without adequately assessing the consequences. Its strategic focus was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards (Healthcare Commission 2009: 11)

The report summarised as follows:

> This was a small trust trying to support a range of specialties. It had become a foundation trust and improved its finances. However, it did not have a grip on operational and organisational issues, with no effective system for the admission and management of patients admitted as emergencies. Nor did it have a system to monitor outcomes for patients, so it failed to identify high mortality rates among patients admitted as emergencies. This was a serious failing (Healthcare Commission 2009: 10)

The report by the Healthcare Commission was followed by the announcement in June 2010 of a full public enquiry.[43]

These investigations into the events in Mid Staffordshire were considered to have given rise to widespread public concern, and a loss of confidence in the Trust, its services and its management. However, concerns were not limited to this specific trust, but to the system as a whole. Further amendments to the forthcoming legislation were seen to be required in order 'to maintain public confidence in the NHS' and 'to protect the foundation trust brand' (Department of Health 2009c: 5). The consultation document stated as follows:

> In very rare circumstances, foundation trusts may not live up to the high standards that were conditional on them achieving foundation trust status in the first instance. Significant failings may result in such a loss of public confidence that the organisation should lose the right to continue as a foundation trust that can operate autonomously (Department of Health 2009c: 5)

The amendments proposed in the consultation document included two changes. Firstly, Monitor should be able to consider de-authorising an NHS foundation trust which is seriously failing to comply with its terms of authorisation or any requirement(s) imposed on it under any enactment. This amendment indicated that de-authorisation should be

[43] On 9 June 2010, the Health Secretary Andrew Lansley announced a full public enquiry into the 'commissioning, supervisory and regulatory bodies in the monitoring of Mid-Staffordshire NHS Foundation Trust', to be chaired by Robert Francis QC and to report by March 2011 (Lansley 2010).

applicable more widely, and not only to trusts considered 'fundamentally unsustainable'. The document stated as follows:

> [...] situation in the Mid-Staffordshire has demonstrated that we need to be able to apply deauthorisation to a wider set of circumstances, as failure may not only occur in trusts that are 'structurally unsustainable' (Department of Health 2009c: 5).

The Minister of State, Department of Health, Mike O'Brien, when introducing these amendments to the Lords in October 2009, emphasised the need of a wider remit for de-authorisation:

> The clauses relating to trust special administrators already enable Monitor to trigger de-authorisation of a foundation trust that is no longer sustainable [...] in its current form. [...] The proposal under consideration today is a further, distinct piece of the jigsaw. It enables Monitor to trigger de-authorisation when – and this is very rare – a sustainable FT has breached any term of its authorisation or a statutory requirement and the breach is so serious that it justifies that step. A power to de-authorise makes it clear that foundation trusts must maintain the high standards expected of them and gives a strong signal to the public that organisations must earn the right to continue as foundation trusts.[44]

The amendments sought to establish a framework that would require Monitor to consider, when aiming to identify failure, the health and safety of patients, the quality of services provided, the financial position of the trust, and the way in which it is being run. To ensure full and proper consideration of these issues, the amendments proposed that Monitor be required to publish guidance setting out in detail the factors that it will take into account, as well as to consult key stakeholders to obtain their views.

A second, and significantly more controversial amendment to the bill was the introduction of a new section that would allow the Secretary of State for Health to write to Monitor requesting it to consider the de-authorisation of an NHS foundation trust. The tension between local accountability supported by independent regulation and the retention, or regaining, of central control in the name of 'democratic accountability', was evident in the speech given by the Minister of State, when introducing the proposed amendment:

> In addition to highlighting the need for such a de-authorisation process, the Mid Staffordshire experience highlighted issues of democratic accountability. While Monitor is responsible for the regulation of foundation trusts, the Secretary of State is ultimately accountable to Parliament for the overall provision of NHS

[44] Health Bill (Lords), 12 October 2009, Column 47.

> services. Monitor's operational independence is a vital component of the regulatory framework, and one that we should seek to maintain, but when considering the most serious risks to patients the Secretary of State should have the ability at least to express formally his view. To enable that, the amendments propose that the Secretary of State will be able to request formally that Monitor considers de-authorising a foundation trust.[45]

In such a situation, it was considered essential that the Secretary of State and Monitor be able to act quickly and transparently. The Minister of State went on to state:

> We therefore propose that if Monitor believes that a differing course of action is preferable, it will be required publicly to explain its decision, either within a default of 14 days or within such further time as the Secretary of State deems appropriate to the particulars of the case. If there is a case for a longer period, Monitor may ask for that and the Secretary of State will be able to consider it and take a view as to how long it should be.[46]

On 12 November 2009, and despite significant opposition to these new 'intervention powers' – on the grounds that it might allow political pressure to be exerted on the regulator, which would be contrary to the original intentions behind the setting up of an independent regulator – the Bill received Royal Assent and became the Health Act 2009.

With this step, the new de-authorisation regime came into force, replacing the insolvency model that had been at the heart of the original 2003 legislation. The attempt to democratise failure by allowing organisations but not services to fail, and by making failure and exit an option for public services, thus encountered its limits. In place of a corporate model based on the notion of insolvency, there was a rethinking of what constitutes failure, how it could be identified and made operational in the context of healthcare, and whether what was required was a greater emphasis on identifying *failing* healthcare providers, so as to prevent actual *failure*.

Conclusion

Our aim here has not been to adjudicate on this protracted process of seeking, and ultimately failing, to invent an insolvency-based failure regime for a public service. Our interest rather is in what it tells us about the process of seeking to further 'democratise' the economic notion of failure by extending its remit to healthcare. In so far as the category of failure now saturates public life and the assessment of public services, it is instructive to examine the complexities and ultimately the limits of applying corporate

[45] Health Bill (Lords), 12 October 2009, Column 49.
[46] Health Bill (Lords), 12 October 2009, Column 49.

models in unfamiliar and even alien contexts. We have argued that social scientists have neglected the issue of failure in recent years, and in particular have given insufficient attention to the complex of ideas and instruments that are associated with it. We have sought to help remedy this deficit, by examining the attempts to design an insolvency-based failure regime for the newly created entities called Foundation Trusts, and the eventual abandonment of such a regime in favour of one based on the notion of 'de-authorisation'. We have examined the tensions that underlie this attempt to design a failure regime based on a mixture of ideas and instruments drawn from the corporate world, aspirations for local democratic accountability, and the retention of central control.

A number of points emerge from this case. Firstly and most generally, this episode demonstrates the importance of considering the interrelation between the making of the new entity and the making of the regulatory regime for that entity, as well as the sheer complexity of making a new entity that can be readily separated from the system in which it is embedded (Kurunmäki 1999). We know from previous studies that there can be 'reactivity' between a regulatory regime and those subject to it. But the implications of the episode addressed here go further, and point to the importance of examining the co-creation of the entity itself. Put differently, if the making of markets and the allowance for exit from the market game are intrinsically related, these in turn are dependent on the creation of appropriate entities and appropriate regulatory regimes. While this co-creation was never envisaged as an easy task, it was not regarded as insuperable, even if it turned out to be so in this instance.

Secondly, this example has demonstrated the importance of distinguishing between failing and failure, a distinction that is central to and internal to regulatory and organisational discourses and dynamics, and which highlights as others have done that adjudicating on both is much more complex than the language of realism makes appear (Miller and Power 1995). The case addressed here has shown how both failing and the moment of failure itself, are subject to a variety of conditions and calculations. These can potentially defer the moment of failure, and can make both 'failing' and 'failure' into organisational and regulatory recourses, giving rise to demands for yet further regulation, further resources, new or altered institutional frameworks, and no doubt much more. An event such as the recent, and still ongoing, financial crisis demonstrates the complex interplay between the notions of failing and failure, as a variety of actors and instruments come together to pronounce and predict. This is of particular interest in the context of a liberal society where the notion of 'light touch' regulation remains to the fore, notwithstanding its demonstrable limitations.

Thirdly, we have examined the metrics and instruments – such as ratio analysis and risk indexes – through which the adjudication of failing and failure is mediated, and how these can give visibility or prominence to a particular register or logic of organisational

functioning, often at the expense of others.[47] Developed several decades earlier, and for the corporate world rather than public services, the instruments considered here continue to provide much of the substance of the failure regime for NHS Foundation Trusts even within the new 'de-authorisation' model. Indeed, at least at present, it seems as if the use of these financial metrics for assessing the performance of key healthcare providers in England may well be the most enduring legacy of the initiative examined here. Put differently, the calculative infrastructure of accountancy and risk management seems able to travel freely, and appears set to outlive the specific circumstances of its creation in the corporate world.[48]

Fourthly, policy makers would do well to reflect on the failure to devise an insolvency-based failure regime for NHS Foundation Trusts that we have documented in this paper. For it illustrates the dilemma that Hirschman (1970) highlighted several decades ago: the limits of relying excessively or primarily on one mechanism (whether exit or voice) as a means of addressing organisational decline and decay, notwithstanding the original and multiple aspirations behind the creation of Foundation Trusts. Hirschman recommended widening the spectrum of policy choices, and cautioned against allowing the schism between economics and politics to occlude policy options. His words of caution remain surprisingly timely for those currently seeking to design regulatory and 'failure' regimes for a range of public services. In the case of schools in England, for instance, recent developments suggest that failing and failure continue to be conceived primarily in non-financial terms (Department for Education 2010).[49] When the term failure is applied to universities, however, it is now couched primarily in financial terms, and in a manner not dissimilar to that initially proposed for Foundation Trusts, even if there is no explicit reference to insolvency legislation. The recent Browne report on higher education funding for universities in England, for instance, defines 'instititutional failure' according to the 'going concern' precept, and does little more than gesture in conventional corporate terms to the possibility of exploring mergers and takeovers as a way of dealing with those institutions that are deemed to fail according to such criteria (Browne 2010: 46, 50). Debates concerning the Browne report have to date, largely and understandably focused on the financial implications for individual students, while ignoring the implications of foisting on universities a framework for dealing with failure that, at the very least, lacks detail.

[47] One example of such different logics or registers and which would merit further study, is the tension or trade-off between efficiency (defined as high or increased bed occupancy rates) and clinical quality (defined as low or reduced rates of healthcare associated infections). For instance, in July 2004 it was suggested by Professor Barry Cookson from the Health Protection Agency that reducing bed occupancy rates to 85% would help stop the spread of MRSA. On the issue of bed occupancy rates and their possible impact on infection rates more generally, see for instance: Committee of Public Accounts (2009); National Audit Office (2009); House of Commons (2008).

[48] On the use of risk-based methods in a very different context – the attempt to create an EU-wide insurance market – see the proposals in 'Solvency II' (*Official Journal of the European Union* 2009).

[49] Ironically, however, whereas achieving Foundation Trust status for healthcare providers was conditional on assessments of high performance, those schools specially targeted at present for academy status are ones that are deemed to exhibit low performance (Department for Education 2010: 12, paragraph 16).

Fifth, and finally, the case we have considered here raises a number of more general issues for further study, notwithstanding its focus on one highly specific example. It is tempting to see the case as little more than a clash between the financial logic of insolvency and the clinical logic of care quality. This has no doubt been important and possibly even decisive in the abandonment of attempts to devise an insolvency-based regime, given the timing of the events at the Mid Staffordshire NHS Foundation Trust.[50] Put differently, 'hybridisation' has limits in some contexts.[51] But the attempt to create new entities called Foundation Trusts, together with a new regulatory framework, brought into play additional logics or discourses, with regard to aspirations for local accountability and related governance arrangements, notions of mutualism, as well as ongoing and more general ideas of choice and consumerism in the field of healthcare. This highlights the importance of attending not only to the instruments for calculating failure, but the multiple ideas and aspirations that typically surround them. And it reinforces the importance of examining the discursive or cultural idioms within and through which the category of failure is itself articulated. As noted at the outset of this paper, the notion of failure has been substantially reframed over the past 150 years, and there is no inevitability to the current predilection for defining failure as primarily an economic event. If, as we have suggested in this paper, the category of failure has been 'democratised' in recent years, and made 'available' to all, its precise meaning and the ways of identifying and instrumentalising it can take many different forms. The task for researchers and policy makers alike is to understand and analyse what happens when different notions of failing and failure are put to work within different failure regimes, in widely differing contexts, and with varying effects.

[50] On these, see for instance Healthcare Commission (2009).
[51] On the notion of hybridisation, see: Kurunmäki (2004); Kurunmäki and Miller (2008, 2010).

Appendices

Appendix A

Source: Monitor: Compliance Consultation – Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their Authorisation and for intervening in the event of failure to comply, November 2004, p.10.

Diagram 1: Annual Plan

	Element	Description
Finance	• **Financial projections** (Appendix D1)	• Actual results against plan for the previous year with a commentary explaining variances • 3 year strategic outlook including updated risk analysis • Projections for the next 3 years (Income & Expenditure, Balance Sheet and Cash Flow)
	• **Financial commentary** (Appendix D2)	• Commentary on the 3 year plan, including rationale for key assumptions and sensitivity analysis applied to projections
Governance	• **Membership report** (Appendix D3)	• Membership data including present and projected membership by constituency • Commentary on membership strategy
	• **Board statements** (Appendix D4)	• Certification that all significant risks have been identified • Certification that effective risk and performance management processes are in place, and all issues raised by external assessments/audits have been addressed • Certification that Board is satisfied with Board roles, structures and organisational capacity • Certification of continued compliance with Authorisation
Mandatory Services	• **Commentary** (Appendix D2)	• Summary of any major changes in the service development strategy • Reference, as needed, to mandatory service agreements listed in the annual update to Schedules 2 and 3 of the Authorisation

Appendix B

Source: Monitor: Compliance Consultation – Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their Authorisation and for intervening in the event of failure to comply, November 2004, pp.13–14.

Diagram 3: Indicators used to derive financial risk rating

Financial criteria	Weight, %	Metric to be scored*	Rating categories 1	2	3	4	5
Achievement of Plan	25	• EBITDA** achieved, % of plan in previous year	100	80	60	25	<25
Underlying Performance	25	• EBITDA Margin, %	10	8	4	0	<0
Financial Efficiency	25	12.5 • Return on assets excluding dividend, %	5	4	2	-3	<-3
		12.5 • I&E surplus margin net of dividend, %	2	1	0	-3	<-3
Liquidity	25	12.5 • Days cash on hand (including committed facilities)	35	25	15	10	<10
		6.25 • Debtor days	15	20	40	50	>50
		6.25 • Creditor days	33	40	50	60	>60

Financial risk rating is weighted average of financial criteria scores

*All metrics will be derived from year 1 of the projections, except EBITDA achieved as a % of plan for the previous year
** EBITDA: Earnings before interest, taxes, depreciation and amortisation. EBITDA will be adjusted for any 'one off' non recurring revenue or cash.

Once the scorecard has generated a preliminary score of 1 through 5 for each metric, the relevant weighting will be applied to generate an aggregate, whole number rating of 1 to 5 for financial risk. A series of overriding rules will then be applied. These rules are listed in Diagram 4.

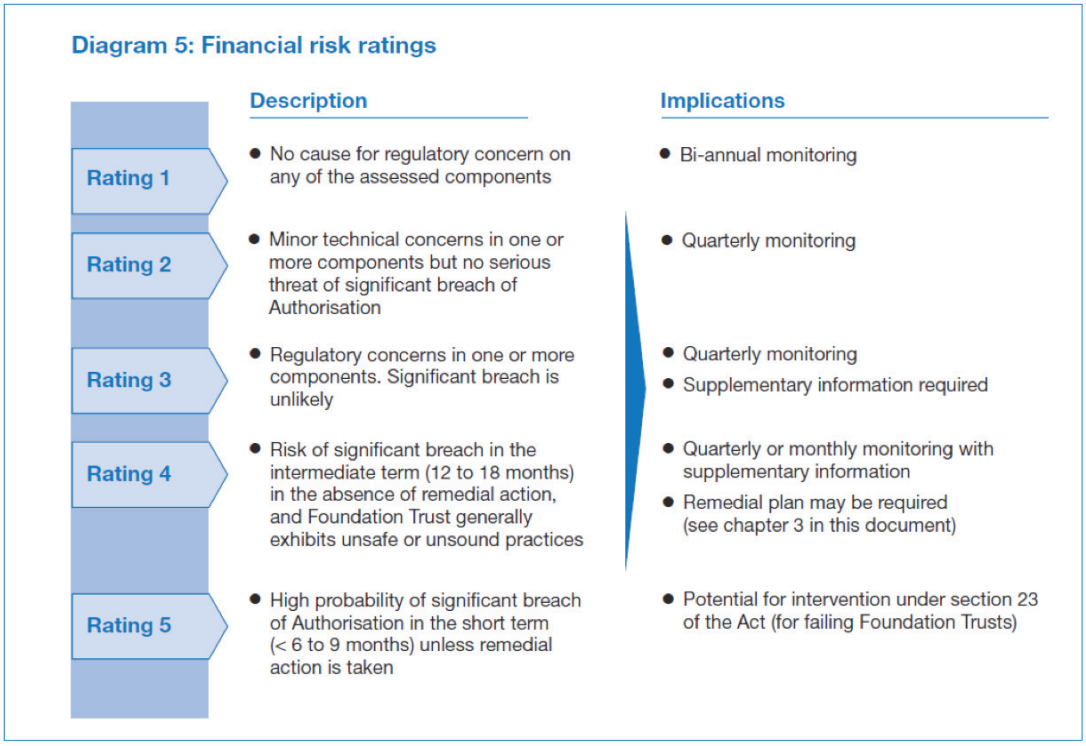
Diagram 4: Rules used to adjust financial risk rating

Situation	Rating Rule
• Plan not submitted on time?	• 3
• Plan submitted not complete and correct?	• 3
• PDC* dividend not paid in full?	• 4
• Lowest ranked metric a '5'?	• 4
• One financial criterion at least '4'?	• 3
• Two financial criteria at least '4'?	• 4
• Unplanned breach of PBC**?	• 4
• Previous year annual score worse?	• No more than 2 points above previous year

* PDC: Public Dividend Capital
** PBC: Prudential Borrowing Code

Appendix C

Source: Monitor: Compliance Consultation – Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their Authorisation and for intervening in the event of failure to comply, November 2004, p.15.



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