Dealing with financially unsustainable providers

How will the failure regime work?

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Acknowledgements: The authors would like to thank Claire Mundle for research assistance in preparing this paper and reviewers who provided helpful feedback on earlier drafts.

Introduction

The financial pressures in the NHS are being felt particularly harshly by acute hospital trusts. A number of trusts and foundation trusts have been rated as at financial risk, and some trusts have declared themselves not financially sustainable as currently configured. These trusts will therefore not be able to achieve foundation trust status and alternative solutions are being sought. In the past, the Department of Health has bailed out financially unsustainable organisations. In the future, if foundation trusts are not able to balance their finances they will be declared 'unsustainable' and will go into administration. The rules that govern this process are often referred to as the 'failure regime', although the formal term used in government documents is the 'continuity of services framework'.

This briefing describes the scale of the problem to be tackled, explains why a failure regime is required in the NHS, outlines how the failure regime for NHS trusts (currently being applied in South London) works and how the failure regime for foundation trusts introduced by the Health and Social Care Act 2012 will work in future. It concludes with a discussion of key issues that need to be resolved if providers of acute services to the NHS are to be put on a financially sustainable footing.

This briefing will not deal with quality failure, although in practice financial and quality failure may go hand in hand. The Care Quality Commission may intervene when quality failure is identified and may require services to be closed down. However, the Care Quality Commission does not have available to it a comparable regime to that applying to financial failure.

What is failure?

The obvious signs of possible failure are persistent financial deficits. However, these deficits may arise for a number of reasons. The appropriate action will depend on which of these apply.

In the simplest cases, persistent deficits may be attributed to poor financial and clinical management. In these cases, the introduction of outside experts or a change of management, supported by short-term loans to cover financial losses while the problems are being addressed, may be sufficient to deal with the situation.

More difficult cases can arise when the problems seem so severe that change of management is unlikely to be sufficient. For example, in London and other large conurbations there may be a number of trusts providing a similar range of services, not all of which are viable in financial and clinical terms. In this situation, the solution may lie in fundamentally changing the services provided – for example, relocating more specialised services to fewer hospital sites or community settings and/or closing one or more hospital sites.

However, in those parts of the country that are reliant on a single provider, this solution may not be acceptable as patients would have too far to travel for treatment if local services were withdrawn and no acceptable alternatives were made available to them. In these circumstances, persistent losses would be regarded as inevitable and a subsidy would be required to maintain at least some of the services.

Why do we need a failure regime?

A failure regime is needed for a number of reasons. First, the government no longer wishes to bail out inefficient and unsustainable providers. In the past, hospital and other trusts incurred deficits, but these deficits were usually met from central funds to allow trusts to continue to provide services. The system for providing such financial support, and the criteria used were opaque and not subject to effective external scrutiny (Palmer 2005). By 2005/6, 190 NHS bodies had reported deficits, some for more than one year in a row. The Department of Health responded by requiring these bodies to develop recovery plans, and a National Programme Office was established in 2006 to oversee the turnaround process. The total NHS budget was top-sliced to the tune of £450 million to fund these continuing deficits.

Despite efforts to reduce deficits, central funds have continued to be made available to cover deficits for some NHS trusts and to bring the NHS overall into financial balance. Without clear rules about how to deal with persistent poor financial performance and the consequences for trusts, there is no incentive for NHS trusts to tackle the problem. Resources that could otherwise be spent on higher quality care continue to be diverted to supporting financially unsustainable trusts. The government has now made clear that it no longer wishes to prop up inefficient services in this way (Department of Health 2011).

Such subsidies could be seen to advantage NHS trusts over other organisations competing for NHS-funded care. Since 2002, a competitive market in NHS services has evolved. Patients are increasingly offered a choice of hospital, and new private sector providers have entered the market. A new payment system – Payment by Results – has been introduced for hospital services. This sets the price for individual operations at the average cost of providing them across the NHS as a whole, thereby putting financial pressure on all trusts with higher than average costs. An efficiency element has been introduced affecting all trusts whereby the price of hospital services (or tariff as it came to be known) is set below the expected rate of cost inflation. As a result, the real price has been reduced on an annual basis, putting trusts under more financial pressure.

For a more competitive market to work, it is argued there must be consequences for inefficient providers and those who do not attract patients. Again, this requires a mechanism by which providers that lose business are allowed to fail and exit the market.

The current scale of the problem

NHS trusts can achieve foundation status only if they convince Monitor that they are financially sound. When the coalition government came into office, only a minority of acute trusts had achieved foundation trust status. The coalition government has decided that all trusts should achieve foundation trust status by 2014.

As of 1 October 2011, there were still 113 NHS trusts in various stages of preparation for foundation trust status. Of these, 20 have self-declared that they cannot reach foundation

trust status in their present form because of high levels of debt, misalignment of capacity and demand, imbalance between primary and secondary care or severe private finance initiative problems. Of these 20, 17 are seeking mergers, all but one with other NHS trusts or foundation trusts, and one or two are considering private sector partners. Since October 2010, all trusts seeking foundation trust status have had to prepare a tripartite formal agreement between the trust, the relevant strategic health authority and the Department of Health, setting out the challenges they face and the actions they would take to deal with them. Examination by strategic health authorities of the tripartite formal agreements has suggested that there may be more trusts that may have to declare they are non-viable.

The Department of Health has acknowledged that as many as 36 NHS trusts will need access to loan facilities costing £376 million to deepen their working capital reserves and it has already decided to make extra finance available for a small number of trusts with a high level of unavoidable costs resulting from their private finance initiative (PFI) contracts. Recently Peterborough and Stamford Foundation Trust received an injection of what is termed public dividend capital to prevent it running out of cash, but no date has been specified for its repayment.

More generally, a recent report from the National Audit Office (2011) suggests that almost all the trusts in the pipeline will find it hard to meet Monitor's criteria for financial viability. Four out of five face financial difficulties and a similar number need to tackle strategic issues. Two out of five acknowledged that they needed to strengthen their governance and leadership if they were to succeed in achieving foundation trust status.

The latest national monitoring report (Department of Health 2012e) identifies 12 acute or ambulance trusts that are performing below par in respect of finance: six of them, all in London, were placed in the most serious category. The situation in London was further emphasised in a report from NHS London (NHS London 2011), which found that even if trusts managed to achieve an unprecedented level of cost savings, underlying deficits would remain. Its overall conclusion was that only 6 out of the 18 trusts concerned are financially viable in the long term. In addition, 15 foundation trusts (out of a total of 144) finished 2011/12 in deficit and at least 4 were judged by Monitor not to be viable in their current form.

The financial context in which NHS providers currently running deficits have to bring their finances into balance is a difficult one. The NHS was set the challenge of making £20 billion of savings over four years from 2011/12 onwards, the so-called Nicholson Challenge. This led to demanding cost reduction targets for all NHS providers far higher than have been achieved in the past. Monitor's review of foundation trust performance in 2011/12 reported that more than half had missed their savings plan targets (Monitor 2012b).

Commissioners are also seeking ways of reducing spending on hospital services: in the case of elective operations by introducing treatment thresholds; and in the case of emergency cases by aiming to reduce the need for hospital admissions through better organisation of services in the community. However, many hospital costs are fixed in the short and medium term and some, such as PFI payments, in the long term, so any loss of business cannot easily be offset by reducing costs.

In summary, as the financial squeeze on the NHS tightens, the prospect is that a number of NHS and foundation trusts will not be able to survive in their present form.

Dealing with failure

In the 2009 Health Act, the Labour government introduced a failure regime to deal with those trusts unable to reach financial balance. However, this regime was not activated until this year, when the current government announced that the South London Healthcare NHS Trust would be put into the unsustainable provider regime (Department of Health 2012c).

A separate failure regime, building on that for NHS trusts, was introduced for foundation trusts in the Health and Social Care Act 2012. In addition, the Act set out a similar regime to apply to private sector providers of services to the NHS. In both instances, the main purpose of the Act's provisions is to ensure that patients do not lose access to essential services if a provider runs into financial difficulty. In this section we describe the failure regime that applies to NHS trusts currently and will apply to foundation trusts and licensed private providers in future.

- **NHS trusts**

In 2007 the Public Accounts Committee recommended that the government should establish a failure regime, and provision was made for such a regime in the 2009 Health Act.

This Act provided for the appointment of a trust special administrator to advise the Secretary of State on what action should be taken when a trust fails. These statutory provisions formed part of a broader framework, the NHS performance regime, for dealing with poor performance in respect of finance, quality and safety of care, operational performance and user experience. The performance regime provided for poorly performing trusts to be categorised as 'challenged' if their financial difficulties could not be quickly resolved. If so, they were required to prepare a remedial plan and their performance would subsequently be closely monitored by the relevant strategic health authority and the Department of Health. If this process was not successful then the failure regime was triggered. In the case of a foundation trust, this would lead to de-authorisation and reversion to NHS trust status. (This option was removed by the 2012 Act.)

The Department of Health (2012d) has now decided that the failure regime should be merged with the tripartite formal agreement regime into a single process. Trusts are now assessed according to their performance against a set of financial and quality indicators as either: 'performing'; 'performance under review'; or 'underperforming'. Strategic health authorities are expected to take appropriate action in relation to the last group.

The Department of Health is aiming to put the onus on trust boards to come up with solutions. Currently, trusts' progress against their targets is being monitored by strategic health authorities. In April 2013 this responsibility will pass to a new organisation – the NHS Trust Development Authority – which is currently being established to take over responsibility for NHS trusts from strategic health authorities and the Department of Health (Department of Health 2012a). Its functions will include:

- performance-managing NHS trusts, including taking over responsibility for the pipeline
- providing assurance – in association with the Care Quality Commission, the NHS Commissioning Board and clinical commissioning groups – of their clinical quality, governance and risk management
- making appointments to trust boards, with a view to strengthening their capacity for leadership
- supporting the development of local solutions to the problems facing individual trusts and, as appropriate, brokering a national solution such as debt write-downs or injections of additional liquidity.

The failure regime has recently been applied to the case of South London Healthcare NHS Trust. This organisation was a merger of three previous trusts and had been in deficit for seven years. Efforts to turn it round have proved unsuccessful and it had not made progress towards a successful foundation trust application. Its deficit of £65 million in 2011/12 was the largest in the NHS.

The regime sets a tight timetable for the trust special administrator's work. In the South London case this means the administrator will issue a draft report by October, followed by consultation, and that a decision about the trust's future will be reached by 4 February 2013 at the latest. This is 145 working days after the appointment of the administrator (on 16 July 2012) and includes an extra 30 days that were added to the process at the discretion of the

Secretary of State to allow for the responses to a planned consultation in Orpington to be taken into account. This timetable is in sharp contrast to the drawn-out processes that have typically accompanied proposals for service change in the past (Imison 2011).

- **Foundation trusts**

The government has found it difficult to develop a failure regime for foundation trusts. The proposals put forward in the first draft of the Health and Social Care Bill were withdrawn and new proposals put forward in September 2011. However, these proposals were modified as the Bill passed through parliament. As a result, the new regime – Trust Special Administration – set out in the Health and Social Care Act 2012 has some similarities to the 2009 regime but also important differences.

The key features of the new regime are outlined below.

- The Act removes the option of de-authorisation of foundation trusts; the government intends that all NHS trusts will achieve foundation trust status or be dissolved (eg, through takeover by an existing foundation trust).

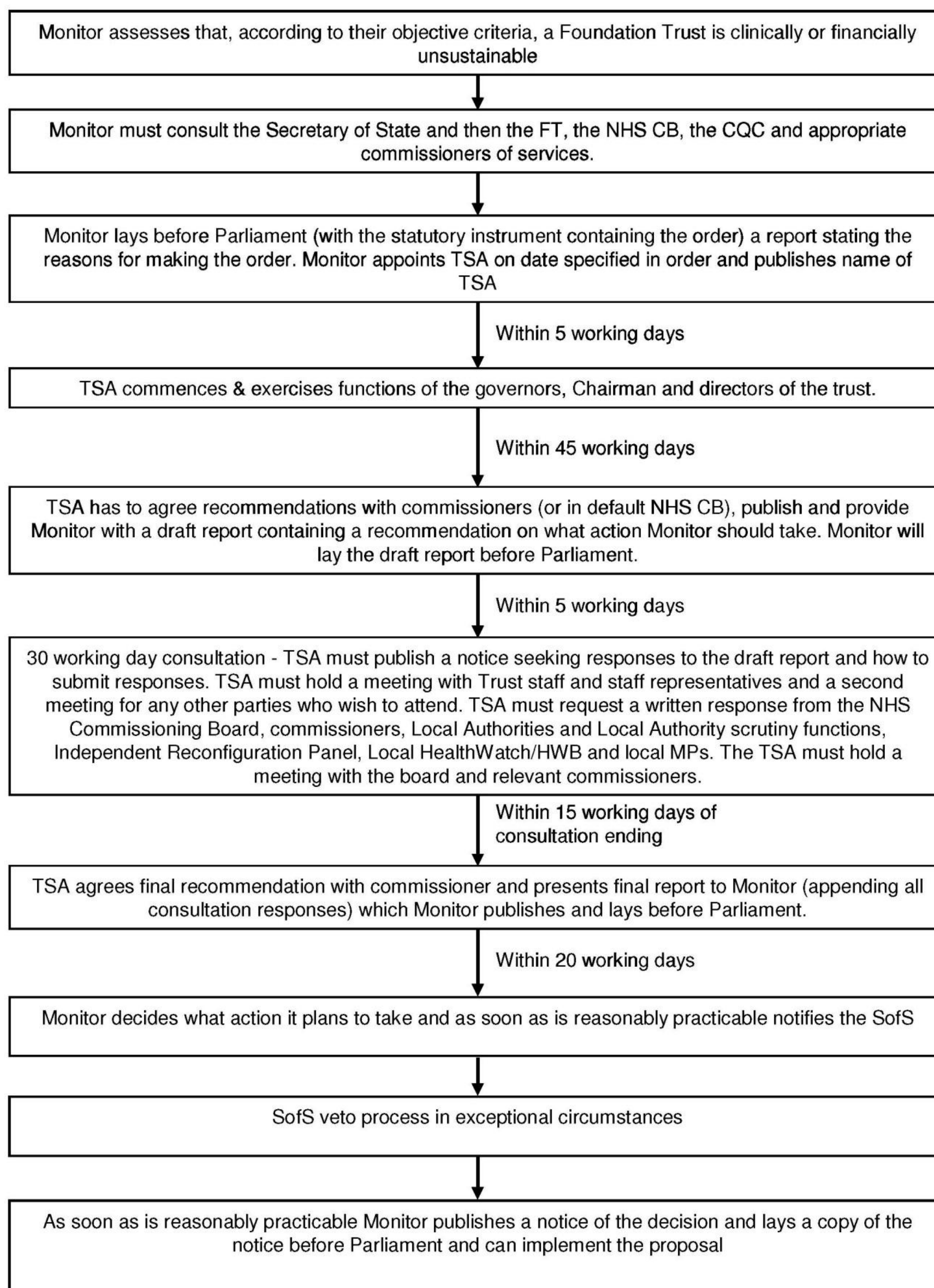
- Monitor, if it is 'satisfied that an NHS foundation trust is, or is likely to become, unable to pay its debts' may lay an order before parliament for the foundation trust concerned to be placed into trust special administration. This involves the appointment of a trust special administrator, who must, unlike under the NHS trust regime, be an insolvency practitioner. The administrator is required to draw up proposals with the aim of ensuring continuity of those services which, if not provided, would cause significant harm to the health of patients or increase health inequalities. The responsibility for defining these services lies with local commissioners and, in some circumstances, the NHS Commissioning Board, which is responsible for commissioning specialised services at national or regional level.

- The administrator's proposals might involve complete dissolution of the trust concerned and the transfer of its assets and services to other organisations. The resulting plan, after consultation, is to be submitted to Monitor for approval and then subsequently to the Secretary of State.

- Once a trust is in special administration, Monitor is empowered to provide financial assistance to maintain services until a long-term solution is found and implemented. The Act allows Monitor to do this by maintaining a fund, financed through a levy on both providers and (subject to secondary legislation) commissioners, from which such assistance can be provided.

  The Act prescribes a timetable for the trust special administration regime (see figure below). The timetable includes: 45 working days to propose a course of action; 30 working days for consultation; 15 working days to revise the report after consultation; 20 days for Monitor to decide whether to approve it; and 30 working days for the Secretary of State to agree with or reject it.

The foundation trust unsustainable provider regime



Source: Department of Health (2011)

The Act does not, however, prescribe the process or timetable leading up to Monitor's decision to make an order to appoint a trust special administrator. Ahead of failure, Monitor has a duty, through the Act, to monitor the financial risk of foundation trusts providing essential services (those that would be protected by the failure regime). If it considers a trust at risk, it must inform the NHS Commissioning Board and the Care Quality Commission and publish a list of all trusts it considers to be at risk or requiring a variation in the tariff. This might, it is hoped, force commissioners and the trusts concerned to take steps to improve the situation before failure is unavoidable.

Monitor may support providers when they are in financial distress but have not yet reached crisis point, by, for example, appointing a turn-round team or requiring trust management to take specific actions to address its difficulties. The Act also requires the co-operation of providers and commissioners and other third parties, including any that Monitor may appoint to 'assist with the management of the licence holders' affairs, business and property'.

It is left to Monitor to determine how it may assess risk and intervene ahead of failure. A recent consultation document (Monitor 2012c) sets out Monitor's initial thoughts on how its risk assessment framework will operate. This builds on the framework currently applied to foundation trusts but develops it by introducing new financial metrics, indicators of operational efficiency and indicators of financial management.

Monitor proposes to designate different categories of risk – 'normal', 'concern', 'distress' and 'financial failure' – with different levels of intervention for each category of provider.

- **Normal -** No action needed.
- **Concern –** Monitor may investigate whether a provider may be in breach of continuity of services licence and may collect extra information to allow the situation to be monitored more closely.
- **Distress –** Monitor may consider whether it should issue a notice under continuity of services licence conditions and, if so, require the provider to co-operate with an expert team appointed to assist with contingency planning. The team's tasks would include defining what services should be protected if the provider were to enter the special administration regime.
- **Financial failure –** When a provider is considered to be in financial failure (because it is, or is likely to become, unable to pay its debts), Monitor would initiate the special administration process as described above.

To reduce the risk of failure, the consultation document (Monitor 2012c) proposes that all licensed providers should 'adopt and apply systems and standards of corporate governance… [which would provide]… reasonable safeguards against the risk of the licensee being unable to carry on as a going concern'. Licensees will also be required to have regard to guidance from Monitor and also to Monitor's risk rating of their business.

- **Private sector providers of NHS-funded care**

Under the 2009 regime no provision was made for failure on the part of private firms supplying NHS services. Reflecting the government's general policy of encouraging a market in health care services open to both public and private providers, the 2012 Act provides for a separate insolvency-based health special administration regime to be developed for private sector providers. The detail of the health special administration regime will be set out in secondary legislation. However, the main elements of health special administration will be similar to those set out for foundation trusts.

As in the foundation trust failure regime, the private sector provider regime will involve the appointment of a health special administrator at the request of Monitor. The health special administrator will, as for foundation trusts, aim to secure the continued provision of health care services provided for the purposes of the NHS by the company. The administrator may recommend the transfer of the provider as a going concern or the transfer of some or all of its assets to another licensed provider. Although the administrator is required to have regard to the interests of shareholders, the objective of maintaining continuity of service takes priority. As with foundation trusts, the administrator may request financial assistance from Monitor to keep services running until a long-term solution is found.

The consultation paper proposes conditions that would restrict providers' ability to dispose of assets used for commissioner-requested services – so that an incoming special administrator would have the necessary assets to ensure continuity of services – and that they ensure that

they have the necessary resources – human as well as physical – to maintain such services for 12 months. To anticipate failure, Monitor proposes to use the risk assessment framework described above (the details of which will be consulted on later this year) that would provide the basis for issuing a notice to any provider if it considers there is a risk it cannot continue as a going concern. The notice would require the provider concerned to co-operate with a team of specialists to work out how commissioner-requested services could best be protected. Monitor proposes, however, to withdraw licence conditions proposed earlier, relating to degree of indebtedness, imposition of a cash lockup (eg, where a parent company is in distress) and restrictions on lending and investment.

The Department of Health and Monitor will be consulting on how other aspects of the failure regime will operate including the continuity of service regime for companies, the definition of essential services, the operation of the risk pool and the methods to be used for calculation of the tariff. It is therefore not easy to predict in advance how the regime will operate in practice.

Issues

The failure regimes for existing NHS trusts, for foundation trusts and private sector providers raise a number of challenging issues.

The 2012 Act gives power to Monitor to anticipate and, if possible, prevent failure through its ability to monitor the ongoing situation and to require trusts to take specific actions. This is the appropriate response if failure is due to poor management and Monitor, by virtue of its continued role in overseeing the governance of foundation trusts, is well placed to deliver it.

The Act also provides for special tariffs to be established if high costs result from the specific circumstances of the provider concerned, ie, its mix of services, scale or location. This is the appropriate response where high costs are not the fault of the current management, but of the objective conditions they face.

Whether or not a trust is financially viable depends closely on the tariff for its services. As noted above, the current tariff has been used to impose a downward pressure on costs. Monitor, which, together with the NHS Commissioning Board, takes over the responsibility for tariff setting, will need to ensure that future tariffs are not set at such a level that a large number of trusts will not be able to remain solvent.

It must also ensure that the tariff accurately reflects the costs of all trusts, particularly those with specialised services, atypical mixes of patients or other special factors such as remote locations or local labour costs. Recent research recently carried out for Monitor by PricewaterhouseCoopers (2012) has revealed that the existing tariff often does not closely reflect trusts' costs, in part because some key cost determinants such as case mix are not taken into account. As a result, the difference between good and poor performance may lie in the way that trusts are paid rather than their own capacities to manage their business.

The provisions of the Act focus mainly on the individual trust but the solution may lie in the wider health economy. For example, poor primary care or poorly developed community services can lead to excessive levels of emergency admissions (Imison *et al* 2012). Alternatively, local hospital services may not be of sufficient scale to guarantee high quality at a reasonable cost so solutions may involve neighbouring health economies. In both cases the solution would require taking a view across the whole of the local health economy or even more widely if some services had to be centralised to promote higher-quality care. In other words, financial failure may require reconfiguration of services over a wide area.

Special administrators may include reconfiguration proposals in their plans for maintaining continuity of services. But agreement between providers, commissioners and local authorities is still likely to be hard to reach. The process for reconfiguration is often long and difficult. As we have argued elsewhere (Imison 2011), there is a need to make changes to the current

processes involved in making service changes. As things stand the process is at odds with the rapid timetable set out for the administration process.

The evidence to support commissioners in determining which services are 'essential' and should be retained is patchy. For example, there is only limited evidence on the health and other consequences of longer travel times on which such judgements could be based. The importance of continuity will vary from service to service – at one end there are long-stay mental health patients (where maintenance of placements is highly desirable) and at the other straightforward electives (where travel to an alternative provider might be easy). It will be much harder to determine how maternity and emergency care – the usual areas of major contention – should be treated. Monitor has published draft guidance on how these issues should be tackled (Monitor 2012a).

There is also a risk that the failure regime will become the first rather than last resort, if planned reconfigurations of services ahead of financial failure are not made easier and quicker. The Act requires Monitor to notify the NHS Commissioning Board and the relevant clinical commissioning groups when services are at risk due to problems with the configuration of services and to publish all such notifications. In turn the Board and clinical commissioning groups are required to have regard to such notifications. However, the Act does not set out what form their response to this information should take. Abolition of strategic health authorities and primary care trusts, both of which play a major role in managing reconfigurations, means that, unless the Board steps in, there is no organisation in a position to take the lead when failure of one trust requires change involving other trusts and, possibly, private sector providers as well.

In addition, these provisions do not acknowledge the fact that in practice clinical commissioning groups are unlikely to have the capacity and the knowledge base to carry out the analysis required to determine what should be done in the event of threatened financial failure and to manage the complex processes involved in seeing through service reconfiguration.

Even under the present system for managing reconfiguration, the process can drag on. Experience shows that it can take many years for a solution to emerge which satisfies all interested parties, not least because there is a statutory requirement for consultation with the public as well as local authorities. Given the number of parties (particularly where several clinical commissioning groups are involved) agreement as to the form any reconfiguration should take might be difficult to reach. The Act gives the NHS Commissioning Board a role in resolving differences at local level but this offers no assurance that in practice the process of determining what should happen will not be an extended – and hence expensive – one.

The Department of Health has recently published proposals for consultation (Department of Health 2012b) relating to health scrutiny by local authorities that would require both the NHS and local authorities to publish timescales relating to when they expect to be ready to make decisions and for indicative timescales to be published in guidance. However, as long as these remain indicative the risk of a protracted process remains.

If reconfiguration is not expedited there is a risk that trusts will be jettisoned into the failure regime. This will put the trust special administrator in a difficult position. The administrator's powers are restricted to dealing with a failing trust or private provider and must be discharged within a strict timetable. It is hard to see how that can be reconciled with the need to find a broader-based solution.

There is a risk that insufficient analysis is undertaken to identify the underlying causes of persistent deficits. It is important that a thorough and deep analysis of the 'business' is undertaken before an administrator is appointed. Given the short timescale available to the

administrators, it is unlikely, even if there is consensus about which services to preserve access to, that they could generate solutions that have eluded a succession of senior NHS managers. The financial viability of individual service lines is not well understood in the NHS (Foot *et al* 2011) and the apportionment of fixed overheads is always a matter of some dispute. Clinical interdependencies between services are also contested and the evidence to support these arguments is not clear cut, although there is increasing evidence and experience to support the possibility of medical and surgical intakes being separated. It is, therefore, hard to see how administrators will be able to determine which services they can safely transfer to other sites or providers, those which can be run independently on the existing site and those which will need to remain under unified management on the same site. Disentangling this in an environment where the evidence is contested will be difficult. Much therefore depends on the ability of Monitor to anticipate failure through its governance functions and for contingency plans to be developed at the 'distress' stage before special administration.

It will be important to see how these issues are addressed in the case of South London Healthcare NHS Trust and to identify what further actions will need to be taken by the NHS Trust Development Authority in the case of trusts and Monitor in relation to foundation trusts and private providers. Wherever possible they must act to prevent failure, but where it is necessary the resulting service configuration needs to be not only clinically and financially sustainable, but also have the support of local clinicians and the public.

Conclusions

Given the current economic situation and the financial pressures on the NHS, more organisations are likely to find themselves financially challenged. It is no longer acceptable to keep providing an open-ended public subsidy to these organisations without a clearer justification for doing so and a plan for how they will be put on a more sound financial footing. The public may well question why the government cannot bail out hospitals when money was found to bail out banks. There are at least two reasons: first, the requirements of fair competition; second, and perhaps more important, these funds could be spent elsewhere with potentially greater gains in health. It is for these reasons that the NHS needs a clearer process for dealing with financial failure.

While the provisions and rules set out in the Health and Social Care Act 2012 for foundation trusts and the Health Act 2009 for NHS trusts provide a clear process and timetable for an individual trust, they are less well designed to respond to failures that require changes across a wider area. Further changes are needed to ensure planned reconfigurations can be implemented in a timely way.

In the end all decisions and proposals by the special trust administrators will require the support of both commissioners and the government. Under the 2012 Act the administrator's proposals may be rejected by the Secretary of State and some form of continuing subsidy offered to keep failing trusts as going concerns. Indeed, whether an organisation is actually deemed to be in failure – ie, unable to pay its debts – will depend on decisions by the Department of Health to inject funds to keep a persistently troubled foundation trust afloat or not. The process for making such a decision is not yet clear.

The government has shown determination in tackling these difficult and long standing financial issues by bringing in the administrators in South London. They will need to show courage to back the changes the administrator may recommend.

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