CIRCLE’S NHS FAILURE

Where now for the private sector?

Is Circle’s defeat in running Hinchingbrooke Hospital a learning curve or the death knell for private sector management of NHS services? Matthew Limb consults experts from all sides of the debate

Circle’s decision to withdraw from its contract to run Hinchingbrooke Hospital in Cambridgeshire will have an immediate impact, says King’s Fund chief executive, Chris Ham.¹ “I think this sounds the death knell for private sector companies to take on management franchises.”

He says part of the lesson is there is “no money to be made out of taking on struggling hospitals, at least for the foreseeable future.”

Such hospitals, especially district general hospitals like Hinchingbrooke that lack the “diversity of income” of bigger hospitals, require time and “herculean effort” to be put back on their feet.

Ham tells The BMJ, “If you’re being offered the opportunity to run a challenged hospital with a history that goes back many years, with issues around quality as well as finance and you’re approaching it with a commercial, private sector mindset it’s not a difficult calculation to make.

“I think already we’ve got evidence that Serco and Virgin are having second thoughts about whether they want to be in a market like the NHS, where there is so much evidence of financial distress.”

Stephen Collier, the former boss of private provider BMI Healthcare, chairs the NHS Partners Network, which represents independent sector providers of NHS services. He predicts all parties—private sector and NHS—will steer clear of franchising “this side of a general election.”

But, he suggests the “doability” of franchising in the current environment is “more a political question than a results question,” or at least that these are separate considerations.

He explains, “It’s a setback [for the model], but I don’t think it’s the end of the road. The wider point is, whether you look at this from inside the NHS or outside we can’t continue as we are, so there has to be space to bring in different models."

For Nigel Edwards, chief executive of the Nuffield Trust think tank, it seems NHS officials have already “gone cold” on this particular idea—he cites the “dropping” of proposals for other NHS hospitals to go through the process. But he cautions, “Never say never.”

The 2013 review by David Dalton, chief executive of Salford Royal NHS Foundation Trust, that urged NHS organisations to consider adopting new organisational forms, including franchising, to help drive improvements in the quality of NHS services, suggests the proposition still has legs.²

So how does its author see it? “I still think it is too early to jump to any conclusions. We need to understand better how to create the right balance of risk management and incentives associated with these types of contracts."

Dalton says, “One contract with one provider in one locality in Cambridgeshire does not mean in itself that there is a problem with one organisation managing another.

“We see failures regularly in NHS organisations, which are disguised by spending £600m of taxpayers’ money last year propping up their balance sheets.”

The thrust of the Dalton review was that all providers should reassess how to deliver high quality and affordable care and then determine the organisational models which best suit them.

He says, “If we were to look at Hinchingbrooke now, I am sure that there should be consideration of new models to create shared back office functions, to create single, shared service agreements for some of their elective services and to pursue integrated services for long term conditions and urgent care.”

Edwards says the Dalton review has made available a “wider set of tools,” including the possibility of creating provider chains and hospital acquisitions. This could give providers more freedom to radically change services or systems than do management contracts. “We will see takeovers of hospitals by other managing bodies,” he says.

However, the NHS, as it looks to access fresh ideas, expertise, staffing options, and other approaches from elsewhere, may find the private sector’s gloss, magical to some, less pristine.

Edwards says, “If your problem isn’t solvable it’s not reasonable to expect the private sector to solve it just because it’s private.”

BMA council chair Mark Porter says, “What has happened in Hinchingbrooke shows that the responsibility of running a critical public service can never be handed over, and so the insistence on private providers as a potential solution to problems facing Hinchingbrooke was always misguided.”

However, Nick Bosanquet, professor of health policy at Imperial College London, says it would be a “great mistake” if the case was taken as a warning against all collaborations.

Rather than sounding the death knell of partnerships with the private sector, he says “what it means is we want to design collaborations so there is a mutual benefit and stability.”

Clinical involvement

Will the model favoured by Circle of putting doctors and other healthcare staff more in charge also lose some of its allure?

Ham suggests it shouldn’t on the basis that “bad cases don’t make good law.” He explains, “We absolutely need great clinical leadership and much more effort to involve doctors...
and other clinicians in leadership roles, but that doesn’t mean you then abandon, as a board or as an executive team within a trust, your responsibility for providing leadership.

“It’s getting the balance right between much more clinical leadership and management on the one hand and what you expect people in senior leadership roles to do on the other hand. I don’t know the detail of Hinchingbrooke, but maybe they got that wrong.”

None of the analysts I spoke to could really judge the true picture of clinical, staff, or management engagement and performance under Circle and what this means for the private sector extending or holding back its reach.

The Care Quality Commission’s latest investigation uncovered serious failings at Hinchingbrooke, particularly in emergency and medical care services, leading to it being rated “inadequate” and put into special measures. 1 2

Edwards says, “Some of the implications of the regulatory report suggest maybe there were some weaknesses—that they’d stripped out a lot of middle management.” Circle may either have “overdone that” or he suggests, perhaps jokingly, “just discovered what it was managers were doing.”

He adds, “I wouldn’t draw any strong conclusions. It takes a long time for a new management system to bed in.”

Collier says, “I certainly don’t think it in any way implies that engagement with clinical professionals is part of the reason why it didn’t succeed.”

Nick Boyle, a consultant surgeon at Hinchingbrooke, is head of business development and sits on the trust’s executive board. Boyle, like the majority of the hospital’s staff is an NHS employee. He admits that Circle’s decision to withdraw was a “setback, in the short term” for the private sector’s involvement in the NHS but “not the end of the story.” He said, “I think the vast majority of people who think seriously about the NHS and believe in it realise it has got to change and reform if it is to survive. I think that what has happened in Hinchingbrooke over the last two or three years could have provided one possible model.”

Boyle was saddened that the issue of the management franchise had become politicised. “The majority of hospitals in the UK today are running deficits. The whole NHS structure is under enormous strain—in Cambridgeshire, Peterborough hospital is requiring a subsidy of £1m a week. The idea that profit automatically means a drain on services is absurd.”

Diane Bell, who uses Hinchingbrooke as an outpatient in cardiology and for emergency care, was also in a position professionally to take a closer view on how Circle operated. She was director of strategy for Bedfordshire clinical commissioning group last year when it awarded a £26.5m five year contract for integrated musculoskeletal services to a Circle led consortium.

Bell, a public health consultant who now works for the for profit health organisation COBIC, says Circle understood the need for both cultural and health system change to move more towards patients being involved and better supported in their care.

“They also got the fact that clinicians need to be freed up to help redesign the system to allow patients to have that empowerment,” she says.

“I think Circle had the right ideas, the right concepts, but the funding model wasn’t going to support them to invest and do what they needed to do,” she says.

Financial questions
Collier says that as Circle settled into “what you might call the hard yards” under its contract, it became subject to “exactly the same pressures and challenges as any other NHS trust or foundation trust but without access to public dividend capital.”

Whether this case sounds the death knell or not, anyone considering future private sector deals will have much to chew over—the CQC findings following on from the 2013 Commons Public Accounts Committee report that was highly critical of the franchise, inadequate oversight, and failure to secure value for money for taxpayers. 3

Allyson Pollock, who is professor of public health research and policy at Queen Mary, University of London, says the costs of the whole episode must be examined afresh as there were many warnings about the precariousness of the contract.

“The big problem now is we’ve got the Health and Social Care Act, which abolished the ‘duty to provide,’ and one of the most telling things is Jeremy Hunt hasn’t been around,” she says.

“So unless there is urgent legislation to remedy this, to restore the duties and powers of the secretary of state, and above all to restore the duty to provide, this isn’t the end of the story.”

Ham says he originally thought that the experiment was “worth pursuing” as long as the contract was well managed and “sufficiently robust” at the outset.

He explains, “I guess nobody predicted at that stage that the tariff would be cut in the way it has been cut so that there would be less money flowing to small hospitals like Hinchingbrooke, which are clearly much more reliant on tariff income than bigger hospitals are, or indeed that the CQC regulatory regime would have the impact it’s clearly having on a much larger number of hospitals across the NHS, whether they’re run by the NHS or by the private sector.”

Ham says he presumes the people who were heading Circle at the time thought the chance of achieving efficiencies and “releasing resources” over the 10 year term was a “risk worth taking” to see if it would lead to other contracts. “Clearly that was not a soundly based judgment, and you have to ask questions about the people from the NHS side who were prepared to sign the contract along those lines as well.”

Bosanquet adds: “I think it was a very positive effort to find a new dynamic, a new role for a hospital which had had 20 years of problems, but it was probably too ambitious in the business model. There was a lot of starry eyed optimism, and the people who negotiated the original contract are no longer in the same positions with Circle, so there’s been change on all sides.” He says the affair should be treated as a learning curve. “If we are to have services redesign there are going to be more examples where the redesign doesn’t work as well as examples where the redesign does work.”

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