Assembling Calculative Infrastructures

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ABSTRACT

Much has been made of economising. Yet social scientists have paid little attention to the moment of economic failure, the moments that precede it, and the calculative infrastructures and related processes through which both failing and failure are made operable. This chapter examines the shift from the economising of the market economy, which took place across much of the nineteenth century, to the economising and marketising of the social sphere, which is still ongoing. We consider a specific case of the economising of failure, namely the repeated attempts over more than a decade to create a failure regime for NHS hospitals. These attempts commenced with the Health and Social Care Act 2003, which drew explicitly on the Insolvency Act 1986. This promised a 'failure regime' for NHS Foundation Trusts modelled on the corporate sector. Shortly after the financial crash, and in the middle of one of the biggest scandals to face NHS hospitals, these proposals were abandoned in favour of a regime based initially on the notion of 'de-authorisation'. The notion of de-authorisation was then itself abandoned, in favour of the notion of 'unsustainable provider', most recently called also the Trust Special Administrators regime. We suggest that these repeated attempts to devise a failure regime for NHS hospitals have lessons that go beyond the domain of healthcare, and that they highlight important issues concerning the role that 'exit' models and associated calculative infrastructures may play in the economising and regulating of public services and the social sphere more broadly.

Keywords: calculative infrastructures, economising, failure, NHS, hospitals, neoliberalism

INTRODUCTION[1]

Infrastructures come in many differing guises, as researchers from a variety of disciplines have shown. The ubiquity, materiality, indeterminacy and politics of information infrastructures have been demonstrated in a very fruitful interaction among scholars working in adjacent fields, including the sociology and history of technology, and information science (see e.g. Bowker & Star, 2000; Star, 1995; Star & Ruhleder, 2001). As Star (1999: 378) points out, much of the ethnographic study of information systems implicitly involves the study of infrastructure. Accounting is often at the heart of such information systems. As Star (1999) would say, struggles with infrastructures are built into the very fabric of accounting work. Accounting scholars, over the past thirty years or so, have studied the mundane devices that make up a particular set of infrastructures, namely calculative infrastructures that lay claim to objectivity and neutrality. Early studies attended, for example, to the statistical infrastructure put in place in France as a precursor to the development of national income accounting after World War II (Miller, 1986), the changes in private sector accounting and in the role of the intendants and associated information flows during the 'Colbert period' of Louis XIV's reign (Miller, 1990), and the more general roles of accounting and statistical infrastructures in the governing of economic life (Miller & Rose, 1990, 2008). More recently, accounting researchers have focused on the roles of international accounting and auditing standards in market-economic reform (Mennicken, 2008, 2010), the significance of managerial infrastructures during accounting origination (such as the origination of impact accounting in higher education) (Power, 2015), accounting as a "mediating instrument" linking science and markets in the microprocessor industry (Miller & O'Leary, 2007), the making of a calculative infrastructure for forgiving and forecasting failure (Kurunmäki & Miller, 2013), and the roles of accounting in facilitating platform organisation (Kornberger, Pflueger, & Mouritsen, 2017).

Our interest in what we term 'assembling calculative infrastructures' is threefold. First, we are interested in the assembling of a particular calculative infrastructure for failure in the case of NHS hospitals in the UK, and the rethinking of the notion of failure that this entailed. Second, we examine the ways in which nascent and established calculative infrastructures reciprocally enable the assembling of a wide variety of actors and entities.

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[1] This chapter builds on Kurunmäki, Mennicken and Miller (2018): 'Économicisation et démocratisation de la faillite: Inventer une procédure de défaillance pour les hôpitaux britanniques.' *Actes de la recherche en sciences sociales* 221-222: 80-99.

Third, we ask how such calculative infrastructures enable intervening, the governing of the domains which they purport to know and to act upon. This highlights the political dimension of calculative infrastructures and the extent to which they not only enable interventions, but in doing so, establish a particular conception of the objects and objectives of government.

Following Foucault (Veyne, 1978) and Star (1999), we conceptualise calculative infrastructures as relational phenomena (see also Star & Ruhleder, 2001, and the chapter by Reilley & Scheytt in this volume). As the historian Paul Veyne highlighted, for Foucault it was not a matter of starting from the study of objects, but of analysing the sets of practices that fashion and form the objects which become the correlate of historically specific sets of practices (Veyne, 1978: 218) (cited in Mennicken & Miller, 2014, p. 19). As Veyne also remarked, this places relations at the heart of the analysis, and it highlights a key methodological injunction of Foucault's: to accord primacy to the relations that link actors, instruments, and ideas (Veyne, 1978, p. 236). This means attending not only to the devices that instrumentalise the real, but analysing their interdependence with the multiple rationalities and codes that seek to prescribe how the real is to be programmed (Mennicken & Miller, 2014, p. 19). Calculative infrastructures, including accounting infrastructures, are inherently epistemological, they intertwine operational and ideational aspects of governing. Accounting infrastructures do not only make ideas about markets, efficiency and economic rationality operable; They also animate and shape economic thinking itself, ideas and models of market making, economic organising and actorhood (see here also the contribution by Juven to this volume).

In this chapter, we are particularly interested in studying how calculative infrastructures demonstrate the constitutive (or performative) dynamics of economisation, as well as its possible limits. We examine the designing of one highly specific calculative infrastructure: the attempts over more than a decade to devise a failure regime for National Health Service (NHS) hospitals in England. We use the term 'calculating failure' to describe the transformation and economisation of both the ideas and the instruments of failure as deployed in this instance. We use the term 'calculative infrastructure' to designate the relatively stabilised chain of accounting calculations and associated narratives, calculative technologies, rationales and ideas that come to appear necessary for the assessment of both failing and failure (Kurunmäki & Miller, 2013: 1101).

In itself, this is an intriguing example of an attempt to subject public hospitals to a financial discipline that turned out to be more rigorous than that applied to banks. This contorted process began prior to the financial crash, continued throughout its aftermath, and is still ongoing.

Initially, it appeared to its protagonists as relatively straightforward, in so far as the corporate model of bankruptcy was considered largely transposable to the public sphere, albeit with a bit of tinkering. But, as the process unfolded, and particularly in the light of the near collapse of the global banking sector which coincided with the eruption of one of the biggest scandals regarding care quality to beset the NHS, things became increasingly complicated. We chart the protracted toings and froings of this process as it tells us much about marketising and economising and the role of a particular calculative infrastructure for the thinking and doing of failure. In doing so, we de-naturalise failure, deprive it of its self-evidence. For, of all the things that are 'made up' in this world, that come into being hand in hand with the ways in which they are named (and in this case calculated), failure is a perfect illustration of what Ian Hacking has called dynamic nominalism (Hacking, 2002).

It is remarkable that, despite more than three decades of research into the ways in which calculative infrastructures and their associated rationales shape the economy and the entities that inhabit it (see e.g. Callon, 1998; Hopwood & Miller, 1994; Power, 1994) and a similar amount of time devoted to analysing 'New Public Management', social scientists have paid very little attention to the category of failure, both generally and in the particular setting of the public sphere.[2] This is especially puzzling, as an economised category of failure now saturates public life. While much has been made recently of economising, and the extent to which it has been paired increasingly with marketising (Çalışkan & Callon, 2010; Kurunmäki, Mennicken, & Miller, 2016; Miller & Power, 2013), the calculative infrastructure for thinking and acting on failure has been largely overlooked.

The lack of research analysing calculative infrastructures that shape how failure is understood and acted upon is particularly regrettable as the possibility of exit takes us to the heart of economising and marketising. It takes us also, perhaps, to the limits of 'actually existing' neoliberalism (Davies, 2014), in so far as that is characterised by a fundamental tension between expanding the reach of market-based principles, while also expanding the scope of government through a vast apparatus of regulatory intervention, often and ironically in the name of increasing competition. This tension is critical, for without a relatively orderly regime for exit, market principles are ultimately unable to operate. Yet, allowing or facilitating the possibility of exit for service providers goes hand in hand with the imperative, in most cases in the public sphere,

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[2] There are of course notable exceptions, such as Halliday and Carruthers' (2009) work on bankruptcy or Meyer and Zucker (1989) on permanently failing organizations. For a thoughtful overview of the early management literature on failure, see also Whetten (1980). On the use of ratio analysis, as applied to the corporate world, see Miller and Power (1995).

to maintain services. Attending to the category of failure and the assembling of a calculative infrastructure for thinking, rethinking, and calculating failure, focuses our attention on the often overlooked 'how' of both economising and marketising. It directs attention to the assembling of the calculative infrastructure and the ideas on which they depend, and the co-construction of the entities to be regulated and the bodies that are to regulate them.[3]

Failure, we suggest, is an archetypal 'variable ontology object' (Kurunmäki & Miller, 2013, p. 1101) (Latour, 1993, p. 85). The actual moment of failure has none of the objectivity and inevitability often attributed to it. That moment emerges within and through an assemblage of calculative practices, expert claims and pronouncements, legal procedures, financial norms and risk assessments, and much more. Together, these make up a more or less stabilised infrastructure for the thinking and doing of failure, allowing a multitude of potentially conflicting interactions among a wide variety of actors, aspirations and instruments that illustrate only too clearly the conditionality of performativity (Butler, 2010, p. 399; Kurunmäki et al., 2016). A whole host of actors and instruments are brought into play, and have to achieve a significant degree of stability, before the moment of failure can be pronounced. Before that can happen, there is an open-ended yet not limitless set of negotiations and interpretations.[4] The more these are stabilised, the more real becomes the possibility of failure, until the moment that failure is pronounced. And when that happens, the realities of poverty, hunger, eviction and much more, present themselves uncompromisingly, but this is a reality that is an outcome, not something that announces and imposes itself without assistance.

The rethinking and remaking of public services according to the notions of failure and exit has a long pre-history. For even in the corporate sphere, it required a fundamental shift in how failure was understood, how it could be 'forgiven', and how the act of forgiving could be made operable, as Scott Sandage and others have shown. In the mid nineteenth century, failure was deeply personal, encapsulated in the term 'loser' and other associated terms (Sandage, 2005). 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.[5] In the U.S., the passing on

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[3] See here also Espeland and Sauder (2007) who have emphasised how public measures such as rankings can produce 'reactivity' on the part of those who are ranked.
[4] Power (1997) speaks in this context of the 'dialectic of failure'.
[5] Sandage describes the relatively enduring Bankruptcy Act of 1867 in the United States as the first comprehensive bankruptcy law in American history.

the same day in 1867 of the Bankruptcy Act and the Reconstruction Act felicitously paired the birth of failure with the birth of freedom.[6] Or, as Sandage puts it, 'liberty and slavery' gave way to a new measure of human worth: 'success and failure' (ibid., p. 223) (see also Mann, 2002). The birth of freedom was also the birth of failure, for in a fair race, losers have only themselves to blame. Failure considered as an economic event also offered possibilities. For, if failure could be forgiven, this facilitated re-entry into the market game.

It is the attempt to design a calculative infrastructure that would operationalise this economised notion of failure in the sphere of public services, with its attendant possibility of exit, that we consider here. We focus on a particular example, but suggest that it has much wider relevance. For, in recent years the category of failure has been extended to encapsulate almost any public service, whether education, healthcare, prisons, or social care. The idea of failure and the language of failure today dominate regulatory regimes, the entities they seek to regulate, and indeed much of the debate concerning the performance of public services. The contemporary language of failure, when applied to public services, entails a profound rethinking of failure, a deeply epistemological process. It goes hand in hand with the deployment of a set of metrics and devices for calculating potential failure, for determining whether there are problems and if so how severe they are, setting out what might be done to address the problems identified, and if they are sufficiently severe pronouncing on the moment of failure itself. Exit, rather than voice, has become the preferred option for dealing with severe 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, for those promoting these reforms, bankruptcy law is equally applicable to 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.[7]

We explore this set of issues by examining the domain of healthcare in England, and more particularly, the calculative infrastructure for the rethinking and doing of failure that emerged in tandem with the newly created entities called 'Foundation Trusts'. Created on 5

[6] Congress approved both the Bankruptcy Act and the Reconstruction Act of 1867 (the first of four major provisions for readmitting former Confederate States) on the same day: 2 March 1867.
[7] Halliday and Carruthers (2009) consider the issue of corporate insolvency regimes, describing this as a global phenomenon driven by the interaction between 'lawmaking' at the national level and 'norm making' at the global level.

July 1948, Britain's National Health Service (NHS) was the first comprehensive healthcare system to be based on the principle of free and universal entitlement to State-provided medical care, rather than on the insurance principle with entitlement following contributions. With current expenditure approximately £120 billion, and expenditure in its first year of operation approximately one tenth of that (at current prices), there have been concerns ever since its inception about expenditure being out of control (Klein, 2013, p. 25). We consider here a highly significant moment in the recent history of the NHS, namely the procedures that were set out in the Health and Social Care Act 2003, and how these have been subsequently debated, operationalised and modified. These proposals sought to create a 'failure regime' for NHS Foundation Trusts that would draw heavily on the Insolvency Act 1986, something that *prima facie* appears at odds with the founding principles of the NHS.

We explore first the multiple, and possibly competing, aspirations that were associated with the idea of economising failure in the domain of healthcare. Second, we examine the calculative infrastructure, including ratio analysis and risk indexes, that was largely borrowed from the private sector by the newly created Independent Regulator as a way of assessing the financial health of Foundation Trusts. Third, we consider the consultation process that took place during 2004 concerning the secondary legislation, in an attempt to enact the insolvency aspects of the proposed failure regime. Fourth and finally, we consider the still ongoing process of 'rethinking failure' that took place as the modified insolvency regime failed to materialise. A series of somewhat opaque terms were devised as part of the attempts to try and operationalise the much-vaunted failure regime. These included 'De-Authorisation', 'Unsustainable Provider', and 'Trust Special Administrator' regimes to deal with cases of failure. Most recently, a 'single oversight regime' has been developed, that focuses not only on the financial robustness of the entity, but on the health and safety of patients and the quality of services provided.

In conclusion, we suggest that this case has important lessons not only for our thinking about the assembling of calculative infrastructures, and the roles they may reciprocally play in assembling a wide variety of actors and entities. We suggest it also has important lessons for the politics of infrastructures, the roles of infrastructures in rethinking processes of organising, and in the governing of economic life. A focus on the design and redesign of infrastructures for the rethinking of failure in healthcare helps us problematise and scrutinise the relational dynamics between organising, economising and marketising (see here also Juven's chapter in this volume). It directs attention to the 'how' of neoliberalism, and the

fundamental tensions that it embodies. Further, it allows us to explore the potential limits of neoliberalism, economisation, and marketisation, albeit for one specific case.

Economising failure

> 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.[8]

Attempts to develop a calculative infrastructure that would enable regulators to identify, calculate and deal with financial failure in public services, predate the recent financial crisis with its litany of failures, and extend beyond corporate failures and the potential failure of entire national economies. Following a century and more of attempts to devise corporate financial failure regimes, the category of failure now has an even larger territory. The notion of exit has become the watchword for those seeking to assess and regulate in the name of markets. Economising is busy conquering a new territory, and we need to understand and analyse how that is happening. We examine the shift from the economising of the market economy, which took place with great difficulty across much of the nineteenth century, to the economising and marketising of the social sphere, which is still ongoing. We examine how a particular conception of failure or exit was to be made available to all, and how this was to be achieved by the travelling of ideas and instruments from the corporate to the social sphere.

In this context, the domain of healthcare is of particular interest to us. 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 (see also Rose & Miller, 1992). The NHS was formed out of the nationalisation of 1,000 hospitals owned and run by a large variety of voluntary bodies, and 540 hospitals operated by local authorities, together with the integration of general practitioners. Throughout its life, the NHS has faced the twin dilemmas of balancing central and local control, while reconciling public accountability and professional autonomy (Klein, 2013, pp. 9-10). Yet, in all the discussions over the several years that preceded the creation of the NHS, one of the most striking features is the lack of any

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[8] Monitor (2004) *Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their authorization and for intervening in the event of failure to comply*. London: Monitor, p. 4.

consideration of the financial implications (ibid., p. 26). The assumption was that the cost of the NHS could be calculated simply by extrapolating pre-war healthcare expenditure. Also, it was assumed that healthcare expenditure would be more or less self-liquidating. Put simply: once people's ailments were cured, there would be little or no need for healthcare expenditure. At the very least, healthcare expenditure should remain constant or even decrease (Gebreiter, 2015).

Within the very first year of operation, these assumptions began to be questioned. Only four months after the NHS was launched, the original estimate of £176 million for 1948-49 was revised upwards to £225 million, requiring the Minister of Health to petition Parliament for the additional funding. The following year, the cost of the NHS had increased to £359 million, again requiring the Minister of Health to petition Parliament for a large supplementary estimate (Gebreiter & Ferry, 2016). An article in the *British Medical Journal* in 1950 suggested that healthcare costs had 'got completely out of hand'.[9] Another declared that 'the National Health Service is heading for bankruptcy'.[10] Articles in *The Lancet* and *The Accountant* spoke in very similar language (Gebreiter & Ferry, 2016). Controlling the cost of the NHS became one of the most pressing issues in the early 1950s. Charges for dentistry, spectacles, and prescriptions were introduced in 1952, with the aim of containing spending within the limit of £400 million set by the Chancellor of the Exchequer.

In 1956, the Guillebaud Committee (set up in 1952) reported that much of the apparent increase in spending was due to general price inflation, rather than extravagance or inefficiency. That said, as Klein remarks, and notwithstanding this retrospective partial vindication, the 'days of financial innocence for the NHS were over' (Klein, 2013, p. 26). In 1948, Bevan had proclaimed to doctors that: 'My job is to give you all the facilities, resources, apparatus, and help I can, and then leave you alone as professional men and women to use your skill without hindrance.' Two years later, he was complaining to the Cabinet that doctors had gained too much control over hospital management committees, and were 'pursuing a perfectionist policy without regard to the financial limits which had necessarily to be imposed on this Service as on other public services' (cited in Klein, 2013, p. 27).

Accounting, and in particular costing, was appealed to as part of the solution. In the early 1950s, the Ministry of Health commissioned four reports on hospital costing, which

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[9] 'Cost of NHS', *British Medical Journal*, Vol. 1, No. 4654 (March 18, 1950), p. 656.
[10] 'A Failing Policy', *British Medical Journal*, Vol. 2, No. 4691 (December 2, 1950), pp. 1262-1263.

paved the way for the nationwide introduction of a departmental costing system in April 1957 (Gebreiter, 2015, p. 187). A departmental hospital costing system, modelled on those used in industry, would, it was hoped, improve efficiency, economy, and cost control. A series of leading articles in *The Accountant* also called for the introduction of a departmental costing system, as a way of 'checking this enormous expenditure' (Gebreiter & Ferry, 2016, p. 728). Despite this initial optimism with regard to the roles of accounting, departmental costing was soon criticised for its inability to account for the cost implications of clinical decisions. The control of expenditure, which overall was on an upward trend from the 1960s until the 1980s, was at this time largely through macro-budgets. Starting with the Cogwheel Report of 1967, there were suggestions that doctors ought to become more conscious of the costs associated with their choices, and there were some experiments such as the introduction of clinical budgets at Westminster Hospital. But such experiments remained restricted to a small number of sites during the 1970s (Gebreiter, 2015, p. 188).

In October 1983, the publication of a 25 page document, subsequently known as the Griffiths Report, was to transform the management of the NHS and the roles of accounting within it. This 'Report of the NHS Management Inquiry' was led by Sir (as he became subsequently) Roy Griffiths, managing director of one of the country's largest supermarket chains, Sainsbury's. It involved only four people, and took a mere six months to complete its work. Many people were consulted, although it took no formal evidence. The Report spoke of 'institutional stagnation', argued that it was 'extremely difficult to achieve change', and lamented 'long delays in the management process'. The answer, it proclaimed, resided in general management, and budgets. The aim was to highlight to clinicians the cost implications of their decisions. As a result, management budgets were trialled at four test sites across England, but these received only a 'lukewarm' reception by clinicians. In 1986, the government had to abandon the label 'management budgets', as scepticism among clinicians turned into outright hostility. Further experiments followed, albeit rebranded as the 'resource management initiative'.

If economising the management of hospital-based healthcare through the introduction of budgets proved unsuccessful, largely due to the challenges of aligning clinical and financial rationalities, then it seemed to politicians that other more radical measures were needed. More specifically, it seemed to Margaret Thatcher and her close cabinet colleagues[11] that

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[11] As Klein (2013) remarks in *New Politics in the NHS*, Margaret Thatcher explicitly repudiated consensus-seeking as a desirable form of political strategy, and also repudiated the traditional instrument of consensus-

hospitals should be given greater independence, and the newly celebrated consumers of healthcare (which meant GPs at that time) should be given greater power in the form of GP budgets which allowed them to 'purchase' the hospital care they wished for their patients. Thus took shape the notion of the 'internal market', intended to promote greater efficiency within the framework of a non-market public service committed still to the aim of providing healthcare to all those that needed it. The twin mechanisms devised came to be termed 'GP fundholding', and 'hospital trusts'. The financial health of the latter entities would depend, or so it was claimed, on their success in obtaining contracts from consumers, i.e. GPs.

The proposals were greeted with uproar from both the British Medical Association and the Labour Party, working in an unusual sort of unspoken alliance. The Labour Party claimed that the Government's strategy was to destabilise the NHS and replace it with a commercial organisation. The British Medical Association argued that the proposals would seriously damage patient care, and that they ignored the underfunding of the NHS. Huge advertisements paid for by the BMA on hoardings in public places depicted a giant steamroller with the legend: 'Mrs Thatcher's Plans for the NHS'. The newspapers carried full-page advertisements with the message: 'The NHS. Underfunded, Undermined, Under Threat'. Even GP surgeries were provided with pamphlets prepared by the British Medical Association, which asked among other questions: 'Do you want the cheapest treatment or what is best for you?' (Klein, 2013, p. 153). As Klein remarks, political and professional voices spoke with a rare unanimity, claiming that the Government was seeking to replace the primacy of the patient with the primacy of the pound, and that this would force doctors to subordinate the search for health to the search for solvency (ibid.).

The rationale for the internal market reforms was that patient choice and competition between providers would drive improvements in the NHS. The creation of Hospital Trusts, following the NHS and Community Care Act 1990, laid the foundations for the creation of Foundation Trusts, a new type of semi-autonomous entity, just over a decade later. Likewise, GP fundholding laid the foundations for the creation of Clinical Commissioning Groups following the Health and Social Care Act 2012. Cost accounting, in the form of Reference Costing (a national average cost, calculated for all Healthcare Resource Groups), acted as an intermediary, in so far as it provided the equivalent of a market price (the reimbursement rate) for the clinical services that were provided by hospitals. And an 'independent regulator'

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forming, namely Royal Commissions. Her review of the NHS that gave rise to the document Working for Patients was carried out by a Cabinet Committee of only five persons.

called Monitor was created to assess and authorise applications for Foundation Trust status, as well as evaluate their financial performance subsequently. A felicitous outcome of this arrangement was that the Secretary of State would no longer be answerable for day-to-day operations. Reciprocally, and in theory, hospitals would be insulated from ministerial pressures prompted by individual cases.

Creating new entities

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.[12]

Over a year earlier, Milburn had set out the aspirations that underlay this new organisational initiative.[13] 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. Patients should choose hospitals, rather than hospitals choosing patients.[14]

A new organisational form, underpinned by a new regulatory regime and calculative infrastructure, was needed, he argued, in order to bring about this change (on the aspirations for NHS Foundation Trusts see Day & Klein (2005), particularly section I; see also Klein, 2003; Klein, 2004). 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

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[12] Milburn, A. (2003) *Speech to the Social Market Foundation*, 30 April 2003.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4031877>
[13] Milburn, A. (2002b) NHS Foundation Hospitals, 22 May 2002.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4000768>
[14] Milburn, A. (2002a) *Redefining the National Health Service*, 14 January 2002.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4000711>

principle of healthcare remaining 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 (Giddens, 1998). 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'.[15]

By May 2002, a name for this new type of entity had been found.[16] 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'. 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. 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'.[17]

On 20 November 2003, the Health and Social Care Act was passed. This set out, in the dry 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' (to be called 'Monitor' with effect from 9 August 2004, and

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[15] Milburn, A. (2002a) *Redefining the National Health Service*, 14 January 2002.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4000711>
[16] Milburn, A. (2002b) *NHS Foundation Hospitals*, 22 May 2002.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4000768>
[17] Milburn, A. (2002b) *NHS Foundation Hospitals*, 22 May 2002.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/MediaCentre/Speeches/Speecheslist/DH_4000768>

hereafter referred to in this chapter as the Regulator).[18] The role of the Regulator was both to 'authorise' NHS Trusts to become Foundation Trusts, and to ensure that those trusts so authorised adhered to the terms of their authorisation.

In an entire section headed 'Failure', the Act set out the procedures for dealing with NHS Foundation Trusts considered to be failing. Section 23 specified the powers of the Regulator in circumstances where aNHS Foundation Trust was considered to be significantly contravening, or failing to comply with, any term of its authorisation or any requirement imposed on it.[19] The Regulator could require the trust to do, or not to do, specified things within a specified period. It could also 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. Sections 24 and 25 of the Act outlined further possibilities pertaining to 'Failure'. These included provision for 'Voluntary arrangements' (consistent with the provisions set out in the Insolvency Act 1986, Part 1) and for 'Dissolution'.[20] The latter gave The Secretary of State 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. It also included provision for the dissolution of the trust, while modifications to the Insolvency Act 1986 included securing that the goods and services which the Foundation Trust had been providing, continue to be provided, whether by the Trust itself or another body.[21]

Economising failure in this way was a bold endeavour. It meant allowing individual organisations to exit or fail, while ensuring that the provision of services continued. 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, with a corresponding calculative infrastructure created in parallel. This process of co-

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[18] Health and Social Care (Community Health and Standards) Act 2003, Chapter 43, paragraphs 1.1 and 2.1.
[19] Health and Social Care Act 2003, Section 23.
[20] Health and Social Care Act, 2003, Sections 24 and 25.
[21] Health and Social Care Act, 2003, Section 26, and "Sections 24 and 25: supplementary"

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.

Calculating failure

Even before the Regulator formally came into being on 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.[22] On 16 January 2004, the Secretary of State for Health announced that he had already approved 24 NHS Trusts to apply to the Regulator for authorisation as NHS Foundation Trusts. 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. The first ten Foundation Trusts were authorised with effect from 1 April 2004, less than three months after the Regulator formally came into being. Three months later, on 1 July 2004, a further ten authorisations were announced.[23]

On 21 January 2004, McKinsey & Company made a presentation to the Foundation Trust Regulator Board to explain the work they were undertaking on behalf of the Regulator. They also described to the Board the work which they were doing to develop a model for assessing applicants' business plans.[24] They reported that Foundation Trusts applying for authorisation faced potentially serious financial risks. These risks included 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 (Kurunmäki & Miller, 2008). At this meeting, the Board agreed that the Regulator's role must focus on risk management. At the July 2004 Board Meetingof the Regulator, an oral briefing was provided on compliance and annual risk assessment. By this time, there were already 20 Foundation Trusts, and it was expected that by the end of the year as many as 40 Foundation Trusts could be in existence.[25]

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[22] Foundation Trust Regulator Board minutes, 14 January 2004.
[23] Monitor Annual Report, 2004, p. 5.
[24] 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).
[25] Only one application was refused at this stage: Nuffield Orthopaedic Centre NHS Trust (Monitor Annual Report 2004, p. 5).

The governing of these new entities was to be enabled through an annual risk assessment process which involved the creation of a new calculative infrastructure for individual Foundation Trusts. On the financial side, it was proposed that the risk assessment 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 that would determine the monitoring regime for the forthcoming year. 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 (charged with responsibility for care quality)[26] to consult simultaneously on the Regulator's compliance regime, and the Healthcare Commission's new performance assessment scheme, respectively.

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 their website.[27] The stated overriding objective was to assess and mitigate potential risks to the delivery of Foundation Trusts' obligations under their terms of authorisation. The issue of interim monitoring was discussed further at the 10 September 2004 Board meeting, when a draft compliance consultation document was also discussed.[28] The Board noted that it was broadly content with the draft document, but asked for further work to be carried out in three particular areas, one of which pertained to the question of what constituted a 'significant failure' as set out in Section 23 of the Health and Social Care Act.

The Board meeting of 29 September considered the 'final draft' of the compliance consultation document, noting somewhat ominously that the 'implications of Foundation

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[26] 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 organizations, 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.
[27] Noted in Foundation Trust Regulator Board minutes, 26 July 2004.
[28] Noted in Foundation Trust Regulator Board minutes, 10 September 2004.

Trusts' independence were now becoming more apparent to them'.[29] The discussion noted that the Department of Health was comfortable with the proposed approach.

In November 2004, a consultation document was published. This included the following statement concerning the Regulator's 'compliance philosophy':

> While well-governed NHS Foundation Trusts will operate mainly through self-governance, those without demonstrated strong governance will be more actively monitored to ensure compliance with their Authorisation.[30]

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 the Regulator 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 the Regulator extensive powers to intervene in the event that an NHS Foundation Trust was failing to comply with its authorisation. However, it made clear that the Regulator was 'not in a position to provide failing NHS Foundation Trusts with financial support'.[31]

Risk management by Foundation Trusts themselves was at the heart of this monitoring regime. The Regulator'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 the Regulator. Information provided in the Annual Plan would be used by the Regulator to assess the scale of risk that an NHS Foundation Trust faced in three respects: finance, governance, and mandatory services. A set of metrics was specified, with low risk being rated 5, and high risk 1. A rating of 1 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. Indicators used to derive a Foundation Trust's financial risk rating included metrics derived from EBIDTA (earnings before interest, tax, depreciation and amortisation), to indicate the extent of achievement of plan and underlying performance. Indicators also

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[29] Monitor Board meeting minutes, 29 September 2004.
[30] Monitor (2004, p.4) *Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their authorization and for intervening in the event of failure to comply*. London: Monitor.
[31] Ibid., para 1.1

included return on assets as well as income and expenditure surplus margin metrics to assess financial efficiency, and ratio calculations to evaluate the liquidity of a Trust's assets. The overall financial risk rating (on a scale of 1 to 5) was calculated as a weighted average of the scores (see Figure 1 below).[32] As already noted, the implications of this overall rating for the extent of monitoring, and even possible intervention, were severe. The speed at which all of this was achieved was remarkable, not least as the detailed specifications for authorisation still remained to be specified. That said, the metrics used were not exactly novel, bearing as they did, a striking resemblance to those already in use in the corporate world.[33] Yet, a working definition of the notion of 'significant failure' still remained little more than an aspiration. While the principle of 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.

Take in Figure 1

Making failure operational

Despite opposition from the British Medical Association to the 2003 legislation that introduced NHS Foundation Trusts,[34] 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, work was taking place on how to make the outstanding sections of 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

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[32] Ibid., p. 13.

[33] On the spread of such metrics, see Power (2007). For details on the metrics, see Laitinen (1991), Moses and Liao (1987), Tamari (1964), and Dev (1974).

[34] House of Commons Health Committee (2003) *Foundation Trusts. Volume II, Minutes of Evidence and Appendices*. HC 395-II. London: The Stationery Office, Appendix 7 (FT11). See also British Medical Association (2003) Press release: 'BMA warns that foundation hospitals may increase health inequality'. 21 January 2003 <http://web.bma.org.uk/pressrel.nsf/wlu/ SGOY-5HUMJ5?OpenDocument&vw=wfmms>

Trusts. Fifty organisations were consulted as part of the process, and 28 responses received. As the consultation document stated at the outset:

> 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.[35]

The document went on to set out the proposals for the secondary legislation to establish this 'failure regime'. In accordance with the liberal principle of governing through freedom, and in line with the consultation document, the Regulator 'is expected to give NHS Foundation Trusts maximum freedom to operate, while safeguarding the interests of NHS patients and the wider NHS'.[36] 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.[37]

Among those who sent their responses to the consultation document was the Regulator, who commented as follows 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.[38]

In its formal response to the Department of Health consultation document,[39] the Regulator commented on two issues in particular. On the 'failure regime' itself, it was suggested that, while the powers of the Regulator to intervene were clearly not limited to financial matters, 'the majority of the Consultation Paper is written very much with financial

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[35] Department of Health (2004a) *Consultation on proposals for secondary legislation to be made under the Health and Social Care (Community Health and Standards) Act 2003 to establish a failure regime for NHS Foundation Trusts*. 15 March. London: Department of Health, para 2.9.
[36] Ibid., para 2.9.
[37] Ibid., para 2.9.
[38] Monitor Board meeting minutes, 20 April 2004, para 12.
[39] For Monitor's response to consultation document see Department of Health (2004b) *Consultation responses* [to *Consultation on proposals for secondary legislation to be made under the Health and Social Care (Community Health and Standards) Act 2003 to establish a failure regime for NHS Foundation Trusts*]. London: Department of Health. <http://webarchive.nationalarchives. gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4082318> (from Independent Regulator).

failure in mind'.[40] While acknowledging that financial failure was the most likely scenario in which its powers would be invoked, it asked for 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 Regulator voiced unease that failure of a Foundation Trust to meet a financial commitment could mean that they would be obliged to consider intervention every time such an event occurred. They commented as follows:

> If the Regulator is tasked with proactively preventing breaches of the Terms of Authorisation, it will need to micromanage every Trust.[41]

The concern regarding the balance between financial and non-financial failure, and the danger that the former might dominate, to the detriment of patients and/or mandatory services, was voiced by a number of other bodies, including The Royal College of Physicians of Edinburgh, The Association of Business Recovery Professionals, Health Link (a not-for-profit company seeking to represent the interests of patients), and Guy's and St Thomas' Hospital NHS Trust.

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, these comments highlighted the lack of clarity within the proposals even with regard to the financial aspects of the failure regime. According to a number of commentators, it was unclear what would trigger the failure regime, i.e. what might result in the dissolution of a Foundation Trust. A calculative infrastructure had been put in place that made it possible to identify financially failing trusts. Yet, it was not clear when failing would lead to failure. If 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, the issue of who needed to be protected elicited perhaps even greater concern. The submissions by King's College NHS Trust, and Addenbrooke's NHS Trust, commented bluntly on the need to balance the rights of members, creditors, patients and local stakeholders. [42] [43]

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[40] Ibid., Department of Health (2004b), paragraph A (p. 2) of Monitor's letter (from Independent Regulator).
[41] Ibid., Department of Health (2004b), paragraph B (p. 2) of Monitor's letter (from Independent Regulator).
[42] King's College NHS Trust's response to the consultation document; see also Department of Health (2004b). Here, attention was drawn specifically to S101 of Part IV of the 1986 Insolvency Act.
[43] Addenbrooke's NHS Trust's response to the consultation document; see also Department of Health (2004b).

Health Link echoed such sentiments very strongly, noting that no patient groups were specifically invited to comment. [44] The Association of Chartered Certified Accountants (ACCA) argued in the other direction, suggesting that the proposed regime could appear unattractive to trade creditors.[45] But the ACCA also drew attention to the importance of making allowances for the 'public benefit' nature of the Trust concept, which they pointed out was fundamentally different from a commercial organisation. [46]

To these concerns was added a host of other issues that made even more complex the task of devising a failure regime and calculative infrastructure 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 similar to 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.[47] They went on to remark, in prescient terms, that 'the absence of secondary legislation could prove permanent'.[48]

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. A calculative infrastructure embracing the principle of risk-based regulation had been established, with financial risk

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[44] Health Link's response to consultation document; see also Department of Health (2004b).
[45] Association of Chartered Certified Accountants' response (ACCA reference TECH-CDR-379. DOC) to consultation document; see Department of Health (2004b), p.2 of its letter.
[46] Ibid. p.8 of the ACCA letter.
[47] City of London Law Society's response to consultation document; see also Department of Health (2004b).
[48] Ibid.

metrics at its core. These metrics encouraged, and even required above all else, a focus on the financial condition and management of hospitals that were considered to be performing poorly. However, the notion of failure itself proved difficult to operationalise. 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. The making of a failure regime for NHS Foundation Trusts based on existing insolvency legislation, and the possibility of exit, was proving to be a highly fraught endeavour. Although a calculative infrastructure for the identification of financially failing hospitals had been established, this calculative infrastructure struggled to align the financial rationality that it promoted with the clinical rationality and *raison d'être* of hospitals. Further, it struggled to operationalise, in the context of a complex healthcare system, the processes that would follow from the strictly corporate model of bankruptcy that had inspired the reforms in the first place.

Rethinking failure

Making a new accounting entity is challenging enough, particularly given the fundamental tensions at the heart of the proposals. Making the regulatory regime for that entity at the same time proved to be doubly challenging. If one adds to that the challenge of making or adapting the instruments for identifying and assessing the failings of such entities, and devising procedures for cases of actual failure, one begins to appreciate the scale of the task that faced those who embarked on the project of creating a regulatory regime for NHS Foundation Trusts based on the notion of exit.

It is perhaps unsurprising that the aspiration to economise failure through the application of corporate insolvency principles and practices to NHS hospitals 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.

In September 2008, a further 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 actual failure. The consultation document acknowledged openly that no real progress had been made in this respect since the 2003 legislation:

> 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.[49]

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.[50] 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.[51]

The response document to this consultation was published in January 2009,[52] alongside the first introduction of the Bill that subsequently, and in a modified form, became the Health Act 2009.[53] In place of an insolvency process, the proposed new sections enabled

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[49] Department of Health (2008) *Consultation on a Regime for Unsustainable NHS Providers*. 10 September 2008. London: Department of Health, para 13.

[50] Six reasons were set out. See Department of Health (2008) *Consultation on a Regime for Unsustainable NHS Providers*. 10 September 2008. London: Department of Health, para 50.

[51] Ibid., para 50.

[52] Department of Health (2009a) *The Regime for Unsustainable NHS Providers: Response to Consultation.* 16 January 2009. London: Department of Health.

[53] 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) *The NHS Performance Framework: Implementation Guidance*. <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/ digitalasset/dh_098526.pdf>

the Regulator to issue a 'notice' to the Secretary of State, that 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. This 'de-authorised' status differed from the powers that had been put in place in the 2003 Health Act, which allowed the Secretary of State – at the request of the Regulator – to make 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.

A further consultation was announced in July 2009.[54] This consultation referred to the shocking events at Mid Staffordshire NHS Foundation Trust, events that were considered to have demonstrated a 'gap in the regulatory architecture' of NHS Foundation Trusts. The investigation by the Healthcare Commission into the (financially well performing) hospital in Stafford had begun in April 2008, after many complaints regarding the standard of care provided were reinforced by statistics showing an unusually high mortality 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.[55] The report concluded:

> 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.[56]

The report by the Healthcare Commission into Mid Staffordshire NHS Foundation Trust was followed by the announcement in June 2010 of a full public enquiry, which reported in February 2013.[57] The preamble to the report spoke of the 'appalling suffering of many

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[54] Department of Health (2009c). *Consultation on De-Authorisation of NHS Foundation Trusts*. 27 July 2009. London: Department of Health.

[55] Healthcare Commission (2009) *Investigation into Mid Staffordshire NHS Foundation Trust*. March 2009. London: Healthcare Commission.

[56] Ibid., p. 11.

[57] 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. See Lansley, A. (2010) 'Health Secretary Andrew Lansley's oral statement on 9 June 2010'. London: Department of Health. <http://www.dh.gov.uk/en/MediaCentre/Speeches/ DH_116653>

patients', and the consequences of 'allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.'[58]

These multiple investigations into the events at 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'.[59] The amendments sought to establish a framework that would require the Regulator 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. 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 the Regulator requesting it to consider the de-authorisation of an NHS foundation trust. This proposed amendment highlighted the tension between local accountability supported by independent regulation and the retention, or regaining, of central control in the name of 'democratic accountability'. 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 make financial failure and exit an option for public services, encountered its limits. There was a rethinking of what failure meant, no doubt influenced significantly by the Mid Staffordshire scandal, and possibly also by the massive state bailouts provided in order to shore up the UK banking sector. In place of a corporate model based largely or wholly on the notion of insolvency and exit, there was a significant broadening of what counted as failing and failure, and changes to the ways in which they could be identified and made operational

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[58] Francis QC, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.*. London: House of Commons. Vol. 1, p. 9.
[59] Department of Health (2009c). *Consultation on De-Authorisation of NHS Foundation Trusts*. 27 July 2009. London: Department of Health, p. 5.

in the context of healthcare. Subsequent developments reinforced this broadening of what counts as failure. These included the removal in the 2012 Health Act of the 'de-authorisation' option, in favour of allowing the appointment of a 'special administrator', as well as the provision in the 2014 Care Act for the Care Quality Commission to instruct Monitor to appoint a special administrator where the care quality regulator observed a serious failure to provide services of sufficient quality. With these further steps, the rethinking of failure was consolidated and stabilised, and the place of exit within the regulatory regime for hospitals was diminished. Failure was no longer to be viewed as wholly or largely a matter of financial failure.

Conclusion

We have examined in this chapter the fundamental tension between expanding the reach of market-based principles which seek to autonomise and localise decisions, while expanding the scope of central government to regulate and intervene when things go wrong. The notion of exit, the possibility of failure, takes us to the heart of these issues. It takes us beyond the incessant measuring and comparing of performance and highlights the difficulty of applying corporate models in an unfamiliar and even alien setting. Put differently, 'hybridisation' has limits in some contexts.[60] Our analysis demonstrates the immense complexity of making a new entity that can be readily separated from the system in which it is embedded, and doing so while also making up the regulatory regime for that entity.[61] And it demonstrates the fundamental importance, in all this, of the calculative infrastructure of accounting and risk management, along with the associated and additional logics or discourses that have surrounded this initiative (see here also the contributions by Reilley & Scheytt and Juven in this volume).

The assembling of a calculative infrastructure that would support the operationalisation of failure in terms of exit modelled on market ideas proved difficult to realise. However, this does not mean that hospitals were not economised, or that re-organising in the name of the market was abandoned. Risk and financial performance metrics provided trusts and the regulator with a calculative infrastructure that placed financial discipline at the core of hospital management. The establishment of that infrastructure was animated by a

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[60] On the notion of hybridization, see Kurunmäki (2004); Kurunmäki and Miller (2011); Miller, Kurunmäki and O'Leary (2008).
[61] On the issue of making an accounting entity, see Kurunmäki (1999).

market rationality and, as the Mid Staffordshire scandal demonstrates, largely de-coupled from infrastructures aimed at the assurance of patient safety and care. Our case sheds critical light on the possibility of assembling (and 'hybridising') different logics of organising (e.g. market, caring, and state logics). We highlight the tension between local accountability and autonomy on the one hand, and the retention of central control in the name of 'democratic accountability', on the other. Such tensions take us to the limits of 'actually existing' neoliberalism (Davies, 2014). They also make us aware of the immense challenges faced when assembling calculative infrastructures that embrace multiple and often competing logics or rationalities.

Attending to the category of failure, and the assembling of a calculative infrastructure for thinking and rethinking failure, focuses our attention on the 'how' of both economising and marketising. Failure, we have argued, has none of the objectivity often associated with it (see also Miller & Power, 1995; Miller & Power, 2013). Rather, it is a cultural idiom that was redefined as an economic category across much of the nineteenth century. Today, it has an even larger territory as it is being applied increasingly to a wide variety of public services. Operationalising the notion of exit continues to be a major challenge for those seeking to devise a failure regime for hospital trusts in England, as does the devising of a stable calculative infrastructure for identifying failings. Yet that has not prevented corporate models of failure from being touted as appropriate for universities in England, as in the recent Browne report on higher education.[62] The failure to devise a failure regime for hospitals in England based on corporate insolvency legislation, should provide a lesson for those that would seek to extend such models into other domains. It should also encourage social scientists to pay greater attention empirically to the notions of failure and exit, and the calculative infrastructures that support them.

Acknowledgements

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[62] Browne, J. (Lord) et. al. (2010) *Securing a sustainable future for higher education: an independent review of Higher Education funding and Student Finance,* p. 46, 50.

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FIGURES

Figure 1: Source: Monitor: Compliance Consultation - Consultation on Monitor's proposed regime for monitoring compliance by NHS Foundation Trusts with their authorization and for intervening in the event of failure to comply. London: Monitor, November 2004, p. 13.

Diagram 3: Indicators used to derive financial risk rating

Financial criteria	Weight, %	Metric to be scored*	1	2	3	4	5
			Rating categories				
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.