

OVERVIEW

How could a flagship healthcare institution renowned for superb patient care find itself facing a financial crisis so severe that its very future was at risk? When the U.K.'s independent hospital regulator, known as Monitor, hired Alvarez & Marsal Europe, this was the very basic, yet extraordinarily complex, question at hand.

In the summer of 2004, Bradford Teaching Hospitals, designated by Monitor as one of England's first "foundation" hospitals under a new government program to recognize leading organizations and trusts, suddenly became stricken with an acute liquidity crisis. The surprising news sparked headlines and a wave of political controversy as officials struggled to comprehend how Bradford's financial condition could have deteriorated so far, so fast and within just months of being awarded foundation status.

Working with a great sense of urgency, A&M's senior team of UK-based turnaround and restructuring professionals discovered that certain events compounded pre-existing operational problems, rapidly causing a severe decline in Bradford's financial condition. Through a meticulous, hands-on approach, A&M analyzed complex financial, operational and clinical processes to develop a detailed analysis of strengths, weaknesses, risks and potential solutions, which it presented to Monitor in November of 2004.

With an increasing number of healthcare entities faced with the challenge of navigating a changing healthcare landscape, the experience shows the value of an approach that identifies the true root causes of financial and operational problems as the first step on the path to reform and provides a useful roadmap for other hospitals to follow.

TROUBLING PROGNOSIS

To get to the bottom of Bradford's financial problems, A&M first needed to understand how the hospital functioned on a day-to-day basis, with the goal of identifying links between operational deficiencies and poor financial performance. The process required interviewing managers and operations heads of clinical departments to determine how they managed resources and led their



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divisions. Who was responsible for what tasks? What type of interaction was taking place between departments? Were functions centralized or decentralized? What was the ratio of nurses to occupied beds? What specialties were in the most demand? How were waiting times for certain procedures being managed? Then the team began pouring over the financial records in an effort to clarify the financial morass.

FINANCIAL AND OPERATIONAL WEAKNESSES

No reliable cash or profit forecasts existed and the current balance sheet was unreliable; no one knew the true measure of Bradford's financial trouble. Developing an accurate financial forecast and cash flow analysis was a daunting challenge. Within days, however, A&M's investigation confirmed that the most likely profit and cash deficit was nearly three times the initial projection of £4 million.

Bradford's budgeting processes were deeply flawed. Poor accounting controls and procedures produced insufficient information and an unreliable balance sheet. This greatly increased the risk of financial misstatements and shortfalls resulting from unexpected expenditures.

Operationally, it was difficult to evaluate the effectiveness of individual departments. Costs were budgeted on "best case" scenarios, not on realistic projections of actual levels of activity. As a consequence, no one, for example, could account for the reason Bradford had increased output in one surgical specialist by only 10% after increasing its capacity in that area by 30%. Were there too many doctors? Not enough demand? Too many specialists and not enough generalists? An inadequate number of theaters? No one knew the answer.

Compounding an already puzzling financial picture, every budget had cost savings built into it, as mandated by healthcare authorities. But Bradford had no plan in place for actually achieving those savings. Departments were instructed to save money, but never told how. Not surprisingly, the circumstances made it impossible for the hospital to stay within budget targets.

ACCOUNT AND INVENTORY MANAGEMENT

Bradford's antiquated invoicing and accounts receivable functions were found to be similarly dysfunctional. A decentralized invoicing system made it difficult for the hospital to reconcile charges with services rendered. It was nearly impossible to obtain an accurate profile of outstanding debtors because the Primary Care Trusts (PCTs), the entities charged with reimbursing hospitals for patient services, were challenging the accuracy of the charges. The accounts payable process had similar problems, and because multiple entities within the hospital could cut checks, some bills were paid twice.

Bradford also lacked an efficient procurement and inventory management structure, leading to significant waste and over-spending. While some good systems were in place, they were rarely enforced. A&M, for example, discovered that a special type of anaesthetic, which should have been restricted to use in children and at-risk patients, was the second most administered drug in the hospital and used by anaesthetists for the majority of patients. The hospital was paying too much to administer an unnecessary drug and had no effective control system in place to prevent it from happening.

TRANSITION TO PAYMENTS BY RESULTS

Another key contributor to Bradford's troubles was a transition to a system known as "payment by results." In the past, if hospitals under-budgeted, they could ask for, and would typically receive, additional government funding. Under the new, fact-based system, however, hospitals only would be paid for specific services provided, mirroring processes commonly used in the United States and other countries. Shortly after the new system took effect, Bradford found itself continuously at odds over denied claims with the PCTs. In the past, the hospital had essentially relied on the PCT to resolve operating shortfalls, rather than seek to remedy any internal operational issues that were contributing to the problems.

A&M's analysis of the denied claims showed that many had been rejected because of incorrect treatment codes. Further investigation found that the hospital had made administrative staff, rather than consultants, responsible for reviewing clinical notes and submitting codes for payment. Not surprisingly, because untrained eyes were reviewing the clinical information, much of the data provided to the PCT was inaccurate. In an extreme case, one specialty area had a coding error rate near 50%. As a result of errors in the coding process, recovery income efforts were more difficult, income was lost and, in many cases, the severity of some illnesses remained undocumented, leading to seemingly unjustified increases in clinical costs.

LESSONS LEARNED

While A&M did not prepare a turnaround plan based on its assessment, the team's investigation yielded a clear analysis of the root causes of Bradford's problems and potential ways to remedy those problems. Among the possible solutions A&M identified were:

- Reengineering the financial function to ensure accurate and useful information is provided to decision makers. This would include replacing antiquated systems, improving the interface between various operations, analyzing the relationship between revenue and expenses by department, independently assessing the recoverability of reserves, developing more meaningful reporting and forecasting packages, and centralizing the cash flow forecasting and invoicing processes.
- Eliminating cash flow deficits by developing a plan that deals with the realities of the payments by results system, ceasing to look to the PCTs to resolve operating shortfalls, and developing a meaningful turnaround plan.

Alvarez & Marsal's Performance Improvement Approach

1 Understand Opportunities and Challenges:

Alvarez & Marsal helps to create an atmosphere in which a fact-based analysis and positive change can take place. A&M's hallmark due diligence approach begins in every instance by establishing a credible and fact-based financial and operational assessment on which to develop informed decisions and actions.

2 Collaborate and Listen:

A&M's specialized team of turnaround and healthcare executives objectively scrutinizes the socio-economic, clinical and political landscapes against a backdrop of industry best practices to quickly develop and communicate to key constituencies a thorough picture of hurdles and opportunities.

3 Plan and Partner:

Working closely with administrators, consultants and other authorities, A&M develops an execution-oriented and strategic plan that builds on the organization's key strengths while targeting key weaknesses to address quickly.

4 Build Consensus:

The key to implementing change is forging consensus among constituents in order to ensure that operational and/or financial turnarounds and cost-reduction initiatives can be activated. A&M believes this is a critical success factor.

5 Support and Guide:

Performance improvement initiatives require solid leadership to execute change efficiently and effectively, and to minimize organizational disruption and anxiety. A&M supports existing administration and authorities with solid implementation expertise and, when required, provides interim management services.

- Enhancing clinical income by developing internal control and reporting processes to ensure that reimbursement for all services is provided.
- Improving the coding system to ensure a reliable basis for management. Amongst other advantages this could lead to improved reimbursement for procedures performed. This would require increasing participation at all levels, particularly among clinicians, providing proper education and training to coding staff, implementing a verification system, and linking consultant performance to the success of coding and documentation, among other initiatives.
- Utilizing the improved data to develop operating statistics to be used as day-to-day management tools by the Operations Directors. These tools are widely used in the United States to balance resources (costs) with the real level of demand (revenue).
- Rebuilding the relationship with PCTs by putting aside historical disagreements, so that they do not hinder the ability to obtain accurate payments. In addition, internal processes should be developed to systematically review denied claims to determine whether additional information could result in additional reimbursement, and new procedures should be implemented to check supporting documentation.
- Strengthening processes that enable purchases to be tightly controlled and minimize waste.
- Increasing accountability by having the board become more proactive and challenging toward the management team, ensuring profitability by putting in place a predetermined set of operating performance measures, and employing best practices to balance resources with demand.

The road forward for Bradford and other hospitals facing similar challenges need not be paved with disruption. A bright future lies in the ability to use an informed and complete fact base to implement a well-rounded plan for operational and financial reform. Identifying problems is only the first step. Success lies in executing meaningful change and there are no shortcuts. To achieve sustainable progress, revenue estimates must be prudently constructed, costs must be budgeted on a realistic basis without the traps of unidentified cost savings, responsibilities must be clear, early action must be taken, and a system of meaningful accountability must be in place.

As in every turnaround situation, leadership must face difficult realities, recognize the need for urgency, and adopt an attitude that will support a process of reform over time. This is the underlying bedrock on which healthcare institutions like Bradford will be able to establish an operational and financial foundation that can handle today's complexity and future changes to the country's healthcare system. In the end, the national ability to continue to deliver top quality patient care year after year depends on it.

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