Response to ‘Choosing the Right Direction’, a public consultation document on the future of health services in West Hertfordshire.

14 July 1998

AM Pollock
D Price
J Shaoul
D Gaffney

Word document: hertnew5.doc
INTRODUCTION

This report is based on an analysis of the formal consultation document, ‘Choosing the Right Direction’, earlier consultative material, supplementary information supplied by the health authority and listed on the contents page of ‘Right Direction’, and a series of interviews with local clinicians and managers, CHCs, and a regional official. We have examined the consultative document, ‘A declaration of intent to submit a case for consultation on merger’, [WHHA, 1998], and its preferred option to merge Mount Vernon & Watford Hospitals and St. Alban’s & Hemel Hempstead NHS Trusts in April 1999. We have also visited three of the local hospitals.

The local authorities’ written response to the informal consultation by West Hertfordshire Health Authority (WHHA), ‘Moving Forward’, raised concerns about the failure to underpin the proposals with a needs assessment and financial investment details. These deficiencies and shortcomings were acknowledged by the health authority chief executive during an interview with local authority researcher (D Price) when the chief executive promised to make good that deficiency.

The report is in two parts. Part 1 provides a general assessment of WHHA’s strategy. Part 2 provides detailed comments on the main aspects of ‘Right Direction’.

---

1 West Hertfordshire Health Authority and NHS Trusts. Choosing the Right Direction: A Public Consultation Document on the Future of Health Services in West Hertfordshire; June 1998. Referred to throughout this paper as ‘Right Direction’. 
PART I
GENERAL ASSESSMENT

‘Choosing the Right Direction’ describes as a clinical gain its preferred option of cutting acute service provision and closing local hospitals2. However, the Authority fails to substantiate this claim because it does not show how all current users’ health care needs will be met, what new investment will be needed or how it will be funded. It fails even to substantiate the projected economic benefits of its rationalisation plan because it does not specify the level of closure which will be needed to make new investment affordable. In other words, the Health Authority has not provided the evidence to transform service cuts into gains of any sort. This central incoherence makes the document both confused and confusing.

All the options in ‘Choosing the Right Direction’ involve cutting services and closing hospitals

The document describes the cuts under the preferred option as service gains

But it does not provide evidence of gain or give details of the new system of community-based care which is intended to replace hospital beds

At the heart of the policy are proposals to close at least three of the area’s four acute hospitals and their attendant services and relocate what remains on one site. What is driving the policy? What does the policy involve? Will the Authority be able to cope? And will it get out of deficit?

What drives the policy?

The decision to close hospitals is being driven by a deficit created by the Government’s capital charging policy

That policy affects all health authority areas but it is highly disadvantageous to West Hertfordshire

West Hertfordshire Health Authority is closing hospitals in order to solve a financial deficit. But that deficit has nothing to do with local health services. It is a deficit created by the Government’s deliberate decision to charge for capital. This policy impinges more heavily on some health authority areas than on others. In West Hertfordshire the policy is highly disadvantageous

---

2 West Hertfordshire Health Authority and NHS Trusts, Choosing the Right Direction: A Public Consultation Document on the Future of Health Services in West Hertfordshire; June 1998; Appendix 4, pxiv.
because its local trusts have incomes which are low relative to the value of the capital on which the charge is being levied.

The NHS Confederation recent survey of NHS trusts and health authorities in England and Wales showed that 30% were in deficit to the tune of 123 million (50% response rate). The cause of the deficit is a system of charging ('capital charges') introduced by the last government in 1992 in order to improve efficiency in the public sector by imposing a levy on NHS-owned assets (land, buildings, and equipment) employed in providing health care. The charge or 'financial target' is set at 6% of assets employed.

Capital charges affect trusts differently because the level of payment is not related to income but to asset value. The crucial factor affecting the affordability of capital charges is the relationship between income and assets (the income to assets ratio). Trusts with high asset values relative to income will have to devote a larger proportion of income to capital charges than trusts with asset values low relative to income. Trusts must make an adequate surplus on the revenue received from purchasers (health authorities and fundholders) if they are to pay the capital charges and stay out of deficit. For some trusts the system is highly disadvantageous and many trusts fail to make the surpluses required to cover capital charges.

The two acute trusts in West Hertfordshire are among those in difficulty. Both have incomes which are low relative to their assets when compared with the national average. In common with many other trusts in similar positions, the two Hertfordshire trusts are unable to generate sufficient surpluses on their income to match this level of payment. Table 1 shows that in 1996/7 St Albans and Watford Trust needed to make a surplus of 7.5% of income to cover the capital charges of 4.14 million. It only made a surplus of 1% i.e. 0.55 million. Watford and Mount Vernon faced similar difficulties in that they made a surplus of only 2% or 1.72 million. It need to make 5.16 million or 6% to break even. As a result both Trusts went into deficit.

<table>
<thead>
<tr>
<th>Income to asset ratio</th>
<th>Total income</th>
<th>Total assets</th>
<th>Income to assets ratio</th>
<th>Capital charge (£m (% income-surplus needed))</th>
<th>Actual Surplus (£m (% income))</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Hertfordshire Trusts 1996/7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Alban's and Hemel Hempstead Trust</td>
<td>55</td>
<td>69</td>
<td>0.797</td>
<td>4.14 (7.5%)</td>
<td>0.756 (1%)</td>
</tr>
<tr>
<td>Watford and Mount Vernon Trust</td>
<td>86</td>
<td>92</td>
<td>0.93</td>
<td>5.16 (6%)</td>
<td>1.944 (2%)</td>
</tr>
</tbody>
</table>

Capital charges lie behind West Hertfordshire's drive to close beds, wards, and hospitals. A similar story is repeated around the country. Asset bases which are not affordable under the capital charging system and current
income streams are targeted for disposal. The mechanism is rather like the old windows’ tax. But as inexorable as the logic may seem, it is quite another thing to suggest that a health service so curtailed is a better one any more than a room with fewer windows is improved. What then does West Hertfordshire’s closure policy amount to and what evidence of improvement is there?

What the policy involves

‘Right Direction’ proposes to close at least three and possibly all four of West Hertfordshire’s acute hospitals

It proposes to cut the number of acute hospital beds within the area by 50%

It does not say what the alternative provision will be or if there will be any

It does not plan provision for all West Hertfordshire residents or all current users of local services

The Health Authority’s preferred option proposes to cut both the number of hospitals and the general level of acute hospital provision.

Under West Hertfordshire’s preferred option (Option B) at least three, and possibly all four, of the area’s acute hospitals will be closed and replaced by a single general hospital on one of three sites (Watford, Hemel Hempstead, or Langleybury) and by unspecified community provision on some retained estate. The single site option also involves reducing the complement of acute beds available to local providers by 50%.

The logic behind the single site option is simply that two trust incomes paying for services using one set of acute facilities sounds as if it should be cheaper, although, as we point out below, this depends on the value of the future asset base and the size of the future income. Building a new asset base whilst retaining parts of the old one can push up the value of the asset base increase the deficits and lead to more closure.

In the circumstances, it is significant that a trust merger consultation is being undertaken in West Hertfordshire at the same time as the service review. Trusts mergers are being widely promoted around the country as means of saving on administration. However, administrative costs can be saved in other ways (for example, by direct management!) and the more likely explanation is that merger is a step on the way to service rationalisation. It can also make incremental closure more easily managed in the event of continuing deficit problems.

The authority attempts to justify the proposed level of service cuts by recalculating the volume of hospital activity for which it has to provide. It reduces the apparent scale of activity in four ways:
1. it assumes that in future there will be less caseload in total;
2. it does not plan capacity for people who live outside the district but who currently use West Hertfordshire's services;
3. and it assumes that its residents will travel further for care and that more will go out of district (between 4,000 and 9,000 more episodes of care involving West Hertfordshire residents will be undertaken outside the district under the proposals)
4. it excludes W Herts residents who obtain treatment out of area in neighbouring health authorities (24% of all residents were treated outside W Herts in 1996/7)

By these means the W Herts health authority caseload of 87,994 in 1996-97 is reduced to one of just under 63,000 for the purposes of the plan. But this is illusory: it represents a partial acute strategy because it does not plan for all W Herts residents or all current users of West Hertfordshire’s hospitals. No details are given of the provision that will be made, if any, for those excluded from the plan.

W Herts is planning a local service which will accommodate just 75% of the caseload which is currently treated. Local acute hospitals will have 50% of current capacity. The Health Authority describes this as a ‘new system of health care’. However, no details are given of the scale of investment needed to provide alternative care for those displaced from acute hospital beds nor how that investment will be funded.

Can West Hertfordshire cope with the closures?

What does the authority say about the need for health care provision? If it is going to claim that service closure means improvement, then it is here that the proof should be found.

In fact, there is no needs analysis. The partial strategy assumes a fall in caseload when the national trend shows growth. It takes no account of inflows from other districts so we have no way of knowing what the out-of-district needs are. And it assumes increases in outflows to other districts, whereas we know that at least two neighbouring health authorities (Brent & Harrow and Hillingdon) are planning for a decrease in the number of patients coming from out of district. In any event, neither we nor the neighbouring trusts have any way of telling what the needs of these transferred patients are.

The bed cuts, too, run counter to national evidence. The Secretary of State for Health only last month announced an increase of 3,000 acute beds to meet the current crisis in capacity in acute hospitals. Evidence of waiting lists and ‘trolley waiters’ suggests that West Hertfordshire has shortages of its own but no systematic attempt has been made by the Health Authority to look at existing levels of stress. Indeed, we were told by the Authority that the exercise was unnecessary.
In common with similar plans elsewhere, the Authority also relies on projected productivity gains to justify the contraction in capacity. Productivity gains means treating more patients with fewer beds and resources and is measured as throughput of patients and reflected in higher rates of bed occupancy.

National data suggests however that the NHS has reached saturation in terms of bed occupancy and throughput and that further productivity gains will not be achieved except by denying some groups of patients access to care.

Two pieces of evidence are cited in support of the productivity projections. The first, a management consultant’s report on a trial ambulatory care system, purports to show that earlier discharge is feasible and will reduce the need for hospital beds\(^3\). However, this study was limited to economic rather than clinical evidence. It does not provide evidence of clinical gain. The second, an “audit” reputedly showing that “up to half of all patients” in “[local] general medical or elderly ward[s]… did not need to remain in an acute bed”, [p53] was not contained within the library of additional material and this vital piece of evidence has not so far been traced.

No attempt is made to estimate the need for community-based health care in the event of the closure of half the hospital sector and no precise undertakings are given about funding new community services.

**The financial analysis**

The Authority’s financial analysis is deeply flawed. Each of its options involves partial asset disposal coupled with new investment. But if the Authority undertakes new capital investment and retains some of the old estate, will it get out of deficit (remembering that getting out of deficit is the logic behind the rationalisation of the acute sector)? Our own financial analysis suggests that it may not and that new investment could push up the deficit necessitating more asset disposal and service cuts, and allowing less investment in alternative community provision.

---

\(^3\) Agenda item 6, West Hertfordshire Health Authority meeting?
The key points of the analysis are:

The rationalisation options all involve combining new investment with retained estate.

But the costs of new investment are seriously underestimated and the size of the retained estate is not defined.

Meanwhile trust income will reduce because the health authority is planning to reduce the volume of caseload it purchases and has not planned to accommodate current caseload from neighbouring health authorities.

This is likely to produce a worsening of the income to assets ratio and an increase in the deficit.

Accordingly, the financial gains of rationalisation are not demonstrated.

All the options in 'Right Direction' involve rationalising acute services by retaining some of the old estate and developing new facilities on different sites. The amount and the values of the land to be disposed of and the value of the retained estate are not shown.

Under Option A, Watford and Hemel Hempstead are retained as acute hospitals whilst Mount Vernon and St. Albans are retained with reduced services. Under option B, depending on the location of the single site acute facility, either three or all four of the existing acute hospitals would be downgraded to community hospital status. In the event of centralisation at either Watford or Hemel Hempstead, downgrading at the three other sites would be coupled with substantial new investment on the single acute site. In the event of a single site at Langleybury, a wholly new acute hospital would be developed and estate retained at the other four sites. In none of these cases is the value of the retained estate specified.

National data on the costs of PFI hospitals also show that the costs of the new investment are seriously underestimated. It is notable that W Herts provides no evidence to support the estimated capital implications of the single site options. The estimates range from £87m for a new 600-bed hospital at Langleybury to £22m for an extra 300 beds at Hemel Hempstead (figure 28, p.96). Compared with other similar schemes in England, most new builds are considerably more expensive, especially under PFI. A single site, single phase, PFI hospital for Norfolk and Norwich is quoted at £214m for 809 beds and North Durham with 454 beds cost 96 million.

As we have seen, it is capital values upon which the trusts have to pay capital charges. Values will increase as new investment is added to old estate even where the increments of new capital are off-set by disposals of old assets. Land disposal on its own does not substantially affect asset value, which is largely a
function of buildings and equipment. Netting land sales off the cost implications [figure 17, p.73] will be insufficient. Moreover no details are provided of the sites or buildings earmarked for disposals, their condition, or their values or of the sites to be retained.

The probable trend towards higher asset values will occur in a context of falling income because the proposals involve purchasing less hospital care (only about 72% of existing caseload) from the rationalised acute service. This has potentially disastrous implications for the deficit. We have shown that capital charges cause deficits when income to assets ratios are disadvantageous. West Hertfordshire’s rationalisation policy has the potential to increase the deficit it is seeking to cure by increasing the value of the asset base whilst at the same time reducing the income it can generate. Such a pressure would raise the real possibility of complete closure of some of the downgraded sites.

Increased revenue pressure of the type described above would seriously affect the Authority’s capacity to fund alternative community hospitals by requiring complete closure of one or more of the downgraded sites as well as the diversion of income from the community back into the acute sector. The Authority has failed to demonstrate the financial benefits of its proposals.

Conclusion and recommendations

West Hertfordshire Health Authority does not provide evidence to support its claim that the closure of half the local acute hospital sector is either a clinical or an economic gain; it does not make a serious attempt to define the services which it will substitute for the closed hospital beds; and it has failed to show how the new system of health care will be funded.

We recommend:

1. that the local authorities reject options A and B

2. that the local authorities seeks clarification of the points listed in the appendix to this report

3. that were West Hertfordshire to proceed with the proposals in ‘Right Direction’ without providing further information the local authorities seek a judicial review of the consultation process on the grounds of insufficient information.
Appendix

Questions to be put to West Hertfordshire Health Authority

1. Health care needs

1.1 How does the health authority intend to fund and provide for the 26% of caseload not included in its acute services strategy? What are the future activity projections and service needs of these residents?

1.2 What is the basis of the health authority’s projection of a 6% reduction in caseload currently treated by local providers?

1.3 The health authority anticipates shifting 6-14% of the W Herts caseload currently treated by local providers to neighbouring health authorities. What evidence of surplus capacity is there in neighbouring health authorities? What are the implications for access? Which groups and services will be affected and what are the revenue implications?

1.4 What income will remain after the extra district caseload has been funded and what impact will this have on the viability of the providers?

1.5 What plans have neighbouring health authorities made to accommodate the 20% of caseload treated by local providers but which are no longer included in the acute services strategy? How has West Herts incorporated these acute strategies into its own partial acute strategy?

1.6 What will the impact on the financial viability of local providers be following the loss of revenue from W Herts and neighbouring health authorities?

2. Acute and community beds

2.1 What evidence is there that the new system of healthcare under the network of care option (Option B) will provide appropriate care?

2.2 What new facilities and services will be provided in the community and how will they be funded and staffed?

3. The hospitals

3.1 What is the age, nature, and condition of the estate at each of the sites included in the review?

3.2 What are the proposals for each hospital in respect of staffing, facilities, services, and estate, and how will each hospital be funded?

4. Finance

4.1 For each of the options, what is the value of the retained estate and the new investment at each site, and what income is projected for each site?
PART 2
DETAILED COMMENTS ON 'RIGHT DIRECTION'

1. Health care needs

The Right Direction contains considerably less detail than Moving Forward. Given the deficiencies which were highlighted during the informal consultation and which were acknowledged by the Chief Executive, C Reagan, this must be a cause for grave concern.

During the course of the interviews with Health Authority staff it became clear that WHHA's stated position is that a needs analysis was unnecessary and there is a belief that there was not a problem with unmet need (although a senior GP referred to 'trolley waits' and other manifestations of shortage).

A rational solution to problems of health care provision in a health authority area should at the very minimum start with an analysis of trends in caseload by type of admissions, purchaser flows and provider volumes by health authority of residence. The formal consultation document contains no analysis of need, the sources of data for the estimates of caseload are not cited and no dates are given for the baseline activity (fig 26 p91). We have reviewed the estimates given in the Right Direction against the data provided from other sources.

Main points about the treatment of health care need in 'Right Direction’

<table>
<thead>
<tr>
<th>There is no needs analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is a partial acute strategy because it does not deal with all of the current caseload</td>
</tr>
<tr>
<td>It assumes that more WHHA residents will be treated outside the area</td>
</tr>
<tr>
<td>It assumes a fall in caseload</td>
</tr>
<tr>
<td>It closes beds when national policy is to re-open them because of the crisis in acute hospital capacity</td>
</tr>
</tbody>
</table>

Activity levels

Activity is measured as finished consultant episodes or FCEs. A consultant episode is the basic building block of hospital activity and is defined as the time spent under the care of a particular consultant within one health care provider. Activity can be expressed as caseload. W. Herts hospitals treat patients from outside the WHHA area as well as those from within and because some W. Herts residents are cared for in hospitals outside the area it is important to track the movement of patient into local Trusts as well as of all W. Herts residents.
When planning acute services it is customary to analyse trends in admissions over a number of years, health authority flows, provider caseload and to relate admissions to need. The health authority has done none of these things.

Instead WHHA has used one year's admission figures to establish what it believes is the need for hospital provision in W. Herts. It has then modified these figures by making some far-reaching but unsupported assumptions about trends and its responsibilities for patients cared for by W. Herts providers.

<table>
<thead>
<tr>
<th>Why we say the Health Authority has not looked at health care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No analysis of trends in:</td>
</tr>
<tr>
<td>admissions</td>
</tr>
<tr>
<td>health authority flows</td>
</tr>
<tr>
<td>provider caseloads</td>
</tr>
<tr>
<td>No analysis of emergency and elective flows</td>
</tr>
<tr>
<td>No waiting list figures</td>
</tr>
<tr>
<td>No analysis of the relationship between admissions and need</td>
</tr>
<tr>
<td>No information about where WHHA residents or patients from outside the area will go after hospital closure</td>
</tr>
</tbody>
</table>

Most significantly it has assumed without warrant a 6% reduction in future caseload and it proposes to purchase health care for less than three-quarters of the current caseload.

<table>
<thead>
<tr>
<th>What the Health Authority says about needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no unmet needs for health care</td>
</tr>
<tr>
<td>There will be a 6% reduction in caseload compared with 1996/7</td>
</tr>
<tr>
<td>It need only but acute care for 72% of its existing acute caseload</td>
</tr>
</tbody>
</table>

Analysis of the figures drawn from the Authority's consultant's report show that cross-border flows are significant. The purchaser population was divided as follows:
Table 1
Acute FCEs involving WHHA residents, by place of treatment, 1996-97

<table>
<thead>
<tr>
<th>Caseload in 1996/7 by place of treatment</th>
<th>FCEs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHHA residents treated in local trusts</td>
<td>66,911</td>
<td>76</td>
</tr>
<tr>
<td>WHHA residents treated in non-local trusts</td>
<td>21,083</td>
<td>24</td>
</tr>
<tr>
<td>Total FCEs undertaken on WHHA residents</td>
<td>87,994</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Arthur Andersen, p10

The provider population was divided as follows:

Table 2
Activity levels in all local trusts, by area of origin, 1996-97

<table>
<thead>
<tr>
<th>Caseload in local trusts 1996-97</th>
<th>FCEs</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-WHHA residents treated in local trusts</td>
<td>17,100</td>
<td>20</td>
</tr>
<tr>
<td>WHHA residents treated in local trusts</td>
<td>66,911</td>
<td>80</td>
</tr>
<tr>
<td>Total caseload in local trusts</td>
<td>84,011</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Arthur Andersen, p10

The total caseload treated in local trusts was divided among the trusts as follows:

Table 3 W Herts acute hospital activity 1996-97, FCEs by acute trust

<table>
<thead>
<tr>
<th>Caseload in local trusts</th>
<th>FCEs</th>
<th>Staffed Beds Sept. 1997</th>
<th>Staffed Theatres</th>
</tr>
</thead>
</table>

Source: Arthur Andersen, p10
Table 4 "Baseline Activity" : WHHA’s planning base

<table>
<thead>
<tr>
<th>Projected caseload source and date unknown</th>
<th>Elective FCEs</th>
<th>Emergency FCEs</th>
<th>Day Cases</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemel</td>
<td>2,918</td>
<td>17,459</td>
<td>3,355</td>
<td>23,732</td>
</tr>
<tr>
<td>Watford</td>
<td>2,225</td>
<td>17,204</td>
<td>7,040</td>
<td>26,469</td>
</tr>
<tr>
<td>St Albans incl. Harpenden</td>
<td>1,745</td>
<td>1,014</td>
<td>5,717</td>
<td>8,476</td>
</tr>
<tr>
<td>Mt. Vernon</td>
<td>2,553</td>
<td>582</td>
<td>1,146</td>
<td>4,261</td>
</tr>
<tr>
<td>Total</td>
<td>9,411</td>
<td>36,259</td>
<td>17,258</td>
<td>62,958</td>
</tr>
</tbody>
</table>

Where will WHHA residents go now?

The Right Direction is based on only 72% of WH Herts acute caseload for 1996/7 i.e. it has an acute services plan only for those residents currently receiving acute services from the four local acute providers listed in table 3 and 4. The strategy does not take into account the 24% of acute caseload from WH Herts which flows out to other acute providers (table 1). The acute services strategy does not include the 17,100 cases flowing in from outside the district which makes up 20% of the workload of the four acute providers (table 2). The strategy gives no time scales.

WH Herts is planning acute services for the 76% of residents which attend the four providers listed above. It is important to note that WH Herts anticipates an overall reduction in the number of cases to be treated of 6% from 66,911 in 1996/7 to 62,958. It also anticipates that local providers will treat 6-14% fewer WH Herts cases with these additional cases being accommodated out of district.

There are seven points to note:
1. This is neither an acute strategy for the health authority nor for the local providers;

2. The health authority is planning acute services only for 72% of the caseload it currently purchases for i.e. it is a partial acute strategy;

3. Neither the local health authority nor local providers have taken into account the needs of residents from outside W Herts which currently comprise 20% of local caseload. This is in sharp contrast to the informal consultation;

4. The health authority anticipates a 6% reduction in the caseload which is currently treated by local providers from 66,911 in 1996/7 to 62,958;

5. The health authority is assuming that 6-14% fewer cases will be accommodated by local W Herts providers and that between 4,100 and 9,000 extra cases will have to be treated in hospitals outside W Herts. This means that there will be less income for local acute providers. No attempt has been made to determine the nature of this caseload nor the services to be provided nor whether there will be access and availability at neighbouring hospitals. Moreover the two neighbouring health authorities (Hillingdon and Brent and Harrow) are planning acute services on the basis of fewer patients flowing in from W Herts;

6. The health authority is basing its partial acute strategy on a 6% reduction in 1996/7 caseload even after taking into account the increase in cross border flows resulting from a single site option;

7. The health authority has presented its projected activity [p91] on the basis of the current configuration of services rather than its proposed options.

Questions to ask about health care needs

1. How does the health authority intend to fund and provide for the 28% of caseload not included in its acute services strategy? What are the future activity projections and service needs of these residents?

2. What is the basis of the health authority’s projection of a 6% reduction in caseload currently treated by local providers?

3. The health authority anticipates shifting 6-14% of the W Herts caseload currently treated by local providers to neighbouring health authorities. What evidence of surplus capacity is there in neighbouring health authorities? What are the implications for access? Which groups and services will be affected and what are the revenue implications?

4. What income will remain after the extra district caseload has been funded and what impact will this have on the viability of the providers?

5. What plans have neighbouring health authorities made to accommodate the 20% of caseload treated by local providers but which are no longer included in the acute services strategy?
6. What will the impact on the financial viability of local providers be following the loss of revenue from W Herts and neighbouring health authorities?

There is a suggestion by one CHC chief officer that WHHA's caseload modelling is part of a wider picture in North Thames Region and that caseload transfers amongst health authority areas are being directed by region to solve local deficits. We have been unable to confirm this with region who would only say that they had agreed a strategy with WHHA.
2. Acute and community beds

<table>
<thead>
<tr>
<th>What the Health Authority says about bed numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the preferred option bed numbers will be reduced by 56% - 60%</td>
</tr>
<tr>
<td>Additional beds will be bought outside the area</td>
</tr>
<tr>
<td>Total available bed complement will be no more than 52% of current provision</td>
</tr>
</tbody>
</table>

The number of beds proposed for the preferred single site option is between 560 and 610 compared to the present level of 1,397 (296 closed). Under Option B there will be a reduction of between 54% and 60% in the acute bed complement. The health authority document includes a proposal to buy in additional care from providers in neighbouring health authorities, up to 50 from Barnet General, 45 from the QE II and 50 from Luton and Dunstable, depending on the location of the single site option. However the available acute bed complement will be no more than 730 or 52% of current provision i.e. residents will have access to 50% fewer beds. There are no clear proposals for community beds.

The reduction in beds is justified by:

1. new patterns of healthcare treatments which are less dependent upon in-patient care and presuppose facilities and the cash to pay for them will be available in the community;
2. more efficient use of resources (p76) which they admit will mean an increased workload for fewer staff;
3. increased out of area flows;
4. and anticipated decrease in caseload (see activity analysis).

Apart from raising issues of access and whether neighbouring hospitals have capacity (Barnet General is already experiencing serious difficulties with its PFI) we question whether this radical downsizing is appropriate. Nationally current policy direction is to reverse bed closures and the crisis in acute hospital capacity has now been recognised. Even taking into account the acute beds which the health authority hopes to purchase from out of the area the health authority is still proposing to halve the number of beds and is only planning acute services for 72% of the current caseload (FCEs). This will demand a dramatic increase in productivity or throughput and will necessitate a change in casemix to higher percentage of day cases and easier elective cases.

Questions to ask about acute and community beds
1. What evidence is there that the new patterns of services will provide appropriate healthcare?

2. What new facilities will be provided and how will they be funded?

3. What productivity targets have been established for the acute and community sectors?

4. What redundancies will be required in the acute sector and what extra staffing will be required in the community sector?
3. The future of the four acute hospitals

Services at all three hospitals must change under the two options put forward by the Health Authority.

Under Option A:

- Watford will retain some acute services but may lose inpatient children’s and women’s services, inpatient urology, pathology, ophthalmology, and breast cancer diagnostic unit.
- Hemel Hempstead will retain some acute services but may lose inpatient children’s and women’s services, inpatient urology, pathology, ophthalmology, and breast cancer diagnostic unit.
- St Albans will lose all elective surgery and medical admissions but retain a minor injuries clinic.
- Mount Vernon will lose all elective surgery, acute medicine, and medical admissions but retain a minor injuries clinic and cancer services for the next 10 years. The long-term future of two of its three specialist services will remain under review but oral and maxillofacial surgery will be moved to Northwick Park.
- Harpenden will lose all inpatient beds.

Under Option B:

- Watford would become the site of the single acute hospital for the area or be downgraded to a community hospital in the event of single site developments at either Hemel Hempstead or Langleybury.
- Hemel Hempstead would become the site of the single acute hospital for the area or be downgraded to a community hospital in the event of single site developments at either Watford or Langleybury.
- St Alban’s will function as a community hospital only and might have some post-acute inpatient beds.
- Mount Vernon will function as a specialist hospital only for the next ten years, but the long-term future of two of its three specialist services will remain under review and oral and maxillofacial surgery will be moved to Northwick Park.
- Harpenden might become a community hospital.

Quite plainly, if the Health Authority asserts that there are no alternatives beyond the two options it is putting forward, then a prior decision has been taken to downgrade or close at least three acute hospitals. Approximately half of the St Alban’s site has already been sold and two of its three remaining wards are subject to a summary closure decision made last winter and temporarily deferred. The St Alban’s Total Purchasing Project (TPP) is expecting that the resource will come under the control of local GPs and the community trust upon implementation of the 1997 White Paper. The ward closures are indicative of a strategy already in place. They were deferred pending the present consultative exercise. The relevant local authorities should therefore note that 'Right
Direction' is likely to be deemed to be consultation on the ward closure proposals.

The fate of Mount Vernon has been determined jointly by WHHA and Hillingdon Health Authority, which together are seeking to relocate caseload to other hospitals within their areas, and by a cross-regional development group which has concluded that cancer services should remain on the site for the next 10 years.

WHHA devotes chapter 8 to the future of Mount Vernon's specialist services and its statutory duties to protect and develop them. The proposals for specialist services are identical in the WHHA and Hillingdon documents. Both authorities propose that oral and maxillofacial surgery should move to Northwick Park but that plastic surgery, burns, and cancer services should be retained pending the cross-regional review of cancer services to be published in September 1998. Since this review is said to have been inspired by proposals to withdraw all acute medicine, care of the elderly, and elective surgery from the site, and has already reached a conclusion, there is an implication that the changes to local services have already been determined.

The WHHA proposals for Mount Vernon's non-specialist services are in marked contrast to Hillingdon Health Authority's. Under Hillingdon's proposals, which are also out to consultation at the moment, inpatient services for non-acute medicine and care of the elderly, medical day care, medical outpatient services and the minor injuries service will all remain on the Mount Vernon site, although all acute medicine will be withdrawn¹. Will these services be available to WHHA residents and if so, how will they be funded?

The service reductions at Mount Vernon by both Hillingdon and WHHA suggest that Mount Vernon will cease to be financially viable. Taken together these proposals look like an attempt to achieve hospital closure in two stages. If Hillingdon's and WHHA's preferred options are implemented, we would expect Mount Vernon to close within ten years. There is anecdotal evidence to suggest that closure could be scheduled within the next five or six years (the implementation period of the larger capital investment proposals under consideration) and that a policy of destabilising staff has already begun.

The proposals for Harpenden Memorial Hospital (p26, fig. 9) are too indeterminate to comment upon.

Questions to ask about acute hospital closure

1. What precisely are the proposals for each of the hospitals in the area?

2. How will each of the hospitals be funded under the proposals?

¹ Hillingdon Health Authority, 'A contract with Local People', 1998, p32.
4. Capital accounting and the financial deficit

Total assets (land, building, and equipment) were £215m in 1996-97. If we take this to be the net relevant asset base, the financial target of 6% laid down in 1989 amounted to £12.9m. The surplus required to meet this target would have been £258m had the authority been achieving the national average surplus of 5% of income. This was £16m more than the actual income of £242m. But the overall surplus was only 3% and income is set to decline because of the deficit. In other words, the asset base is underfunded and has been since trust formation. Comparisons with other trusts' average prices, like the one attempted on page 89 fig 25 and now in wide circulation are beside the point because the problems arise not from running costs but from the asset to income ratio.

The proffered solution to this underfunding is entirely formula driven and could have been predicted when the hospitals opted for Trust status. In fact, reducing the estate was the declared objective of introducing the system. But this means that chronic underfunding is driving the change, not a rational healthcare perspective. The proper solution is planning and a coherent investment relative to healthcare needs. This is precisely where the health authority has failed.

The deficit is generated by the two acute hospital trusts. Horizon, the community health trust, is also in deficit but there seem to be a very different set of issues involved and the deficit is small. The following analysis is restricted to the two acute trusts which account for most of the problems and to the proposed Langleybury site which could bring new deficit problems of its own.

(i) St Albans and Hemel Hempstead

<table>
<thead>
<tr>
<th>St Alban's and Hemel Hempstead financial summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined income (1997) £55m</td>
</tr>
<tr>
<td>Surplus earned on income - 1%</td>
</tr>
<tr>
<td>Total assets £69m</td>
</tr>
<tr>
<td>Financial Performance Target - 6% or £4.14m,</td>
</tr>
<tr>
<td>requiring a surplus of 7.5% on 1997 income</td>
</tr>
</tbody>
</table>

These relatively small hospitals have a combined income of £55m. High external purchasing has reduced the surplus to a mere 1% income, insufficient to cover

---

2 The net relevant asset base used to calculate the 6% financial target performance is actually lower than this. Total assets provide a reasonable approximation.
3 We believe that the current average surplus is less than 5%.
4 External purchasing includes outsourcing i.e. competitive tendering, management consultancy, pharmaceuticals, etc. Outsourcing is best used for highly specialised services using expensive equipment, services subject to unpredictable or uneven demand, or where it is possible to access
Interest and capital charges. The government essentially waived payment on the Public Dividend Capital, but even so the trust ended up with a deficit of £1.797m in 1997.

The trust has already rationalised activities between 2 hospitals and sold land at St Albans. Despite a large increase in FCEs, costs have not been passed on to purchasers, a problem reported by other hospitals. Clinical negligence and an income not keeping pace with inflation are other sources of deficit. St. Alban's plans to break even by 2000 by making savings on capital charges, reducing overheads via estate management, and concentrating A & E at Hemel Hempstead.

With total assets of £63m the trust requires a surplus of £4.14m, equivalent to 7.5% of income. But it actually makes a surplus of only 1%. Since the trust cannot increase income from the Health Authority, the options are to reduce costs (sack 147 or 10% staff) or reduce the asset base. If we assume an income of £55m income (although this is likely to decline) and a cost reduction to produce a surplus of 5% of income (broadly, the national average), then the asset base must still be reduced to £45.8m to eliminate the deficit. In other words, even with efficiency savings the asset base will still have to be reduced.

(ii) Mount Vernon and Watford

<table>
<thead>
<tr>
<th>Mount Vernon and Watford financial summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined income (1997) £86m</td>
</tr>
<tr>
<td>Surplus earned on income - 2%</td>
</tr>
<tr>
<td>Total assets £93m</td>
</tr>
<tr>
<td>Financial Performance Target - 6% or £5.16m, requiring a surplus of 6% on 1997 income</td>
</tr>
</tbody>
</table>

This trust has an income of £86m and a rising deficit. Again, the main problem is that external costs are increasing, leaving insufficient to cover other costs. The earned surplus is only 2% of income leaving a net deficit after interest of £2m.

The trust's financial review noted increased activity levels in all areas apart from outpatients and a change in case mix towards more complex cases. There had in fact been a 19% increase in workload and 7% increase in cancer care. Part of the increased activity was due to changed patterns of GP purchasing in neighbouring

---

A steep wage gradient. But outsourcing is now being used across the board. Increased outsourcing increases the burden of fixed costs on the remaining revenues after paying external costs. One effect of this is to give the impression that labour's share of value is increasing because it is becoming relatively more expensive. But this effect is in fact a statistical artifact arising from a declining income and rising external costs. As fixed costs rise, Trusts have to increase income or decrease staff.
health authority areas. Again, cost inflation had been greater than the inflation uplift. Their plan was to close the A&E at Mount Vernon and move it to Watford. Contracts with purchasers had not been signed at June 1997 leaving a contracting gap of £8m and an interim service reduction was instituted focusing on theatres and beds.

Trust assets of £93m require a surplus of £5.16m, or 6% of existing income, very much higher than existing 2%. To achieve the necessary surplus means sacking 140 staff (5%) or reducing the asset base by £21m to £72m. The asset base would have to be substantially lower if they cannot reduce costs to get a 5% surplus.

(iii) Langleybury

The proposed single site at Langleybury will or could involve the retention of some or all of the existing hospital sites at Watford, Hemel Hempstead, St Alban’s, and Mount Vernon (as well as some provision at Harpenden and Potters Bar) [p.26]. The combined asset value of this estate is not given. However, the capital cost of the new hospital is estimated at £87m. This is probably a considerable underestimate. Taking current hospital building under the private finance initiative as a guide, the final cost is likely to be in excess of the combined value of the two existing trusts (£141m). The total asset value must be even higher given the proposed retention of old estate at the other four main sites. Given that income to the new hospital will be less than the combined income of the two existing trusts (because only 72% of existing activity is being purchased), the single site development at Langleybury will have an income to assets ratio even more disadvantageous than any of the existing trusts. It is in fact already in deficit on the drawing board. The same problem arises under the Watford and Hemel options.

Questions to be asked about capital accounting and deficits

1. Why has the Health Authority not acknowledged that West Hertfordshire’s deficit problems arise from the capital charging system and chronic underfunding?

2. How does the Authority propose to fund any of the single site options whilst at the same time retaining old estate at the other main hospital sites and getting out of deficit?
5. Destabilisation of NHS

Both of the options presented by WHHA entail a reduction in service although the authority only chooses to offer a list “Where savings could be made” for the local acute option. [Right Direction, p17] The implications of increases in waiting lists and the sale of NHS assets has attracted a good deal of private sector attention. According to one senior GP, the private sector is already making approaches to GP consortia about asset sales and referrals. “It’s going to be quite a jungle with all these shortages”, he said.

The Health Authority chief executive accepts the implications of this strategy. Under the preferred option, NHS elective surgery will function as a safety net for those who cannot afford to go elsewhere. Changes of this type can only serve to deepen the funding crisis of the NHS, leading to the alienation of yet more services and assets from the NHS.

Questions to ask about the destabilisation of the NHS

1. Is the Authority relying on private sector capacity to make good local NHS shortages?

2. Should the Authority be planning to make NHS provision a ‘safety net’?
6. The legality of the consultation exercise

In our view, a legal challenge could be mounted against this consultative exercise on the grounds that consultation is only on a general principle and because inadequate information has been supplied.

The proposals as they stand entail transferring anywhere between 4,100 and 9,000 finished consultant episodes to neighbouring health authorities and reducing access to acute care for whole groups of patient. **This will particularly affect the elderly.** But neighbouring authorities are undertaking reviews of their own, as is the regional health authority. There is therefore no guarantee that their facilities will remain unchanged. It is plainly unwise to plan health care provision on this basis and in the circumstances we question whether the authority is proposing to provide comprehensive care as laid down in the 1977 Act. At the very least, any reliance on others to provide alternative cover would have to be based on some form of co-operation. However, both Hillingdon and Brent and Harrow are planning for the opposite contingency, a reduction in caseload from WHHA, and we are advised that Brent and Hillingdon providers have not been approached by WHHA to see if they have the capacity to cater for this extra caseload.
SUMMARY AND RECOMMENDATIONS

Sustaining two general hospital sites and downgrading three others will only solve the financial problems if there are also extensive cuts in the asset base, services, and staffing, but this policy will not deliver suitable healthcare services for the community. Concentrating facilities at one site will neither solve the financial problems nor deliver suitable healthcare services for the community.

1. We recommend that these options are rejected.

Both of the options presented by WHHA entail a reduction in services. There is a lack of clarity about the nature of the services to be provided and foregone under either option. The favoured option, Option B, is based on centralising acute care on one site rather than two. However, Option B appears to give the health authority the flexibility to pursue any one of three alternatives without further consultation. These alternatives are a new greenfield site to be built under the PFI, or alternatively the retention of either Watford or Hemel as an acute DGH.

The preferred option, Option B, envisages a greater than 50% reduction in the number of acute beds in the area and assumes that local providers will treat 20% less caseload than currently.

It is important to look at the proposals to reduce acute capacity in W Herts against a backdrop of rising waiting lists, rising emergency admissions and an increase in the number of acute beds over the last two years. More recently Frank Dobson has signalled his intention to reopen 3,000 acute beds as a result of the waiting list initiative and in recognition of the high rates of bed occupancy and general saturation in the NHS.

2. We therefore recommend that the local authorities express their concern that:

i) the health authority has no overall acute services strategy and is not planning acute services for its entire population i.e. that this is only a partial acute strategy for 72% of the caseload it currently purchases:

ii) the health authority and local providers, in sharp contrast to the informal consultation, have not attempted to quantify the needs and levels of services required for the 20% of caseload that comes from neighbouring health authorities:

iii) the health authority assumes an increase in caseload to hospitals outside West Herts of between 4,100 and 9,000 extra cases (p73) but provides no evidence of the availability of capacity, services, and funding to accommodate the caseload:

iv) the health authority assumes a 6% real reduction on 1996/7 in the total caseload it currently purchases from West Herts providers even
after taking into account the increase in cross border flows resulting from a single site option:

v) the health authority sets out its projected activity (p91) on the basis of the current rather than the proposed configuration of acute services.

Given the failure of the health authority to meet the standards of rationality and value for money,

3. we recommend that the local authorities and the public should require:
   i) information to be provided about the nature of the estate, its age and condition, at all of the sites.
   ii) further clarification of the WHHA claims that the West Herts Trusts are more expensive than a comparable hospital, of the figures in the table on p89 (which do not match trusts’ published accounts), and the basis of the comparator;
   iii) further details about how and where displaced caseload of WHHA residents and cross border flows from neighbouring health authorities will be accommodated and funded;
   iv) and that the health authority make good their failure to provide adequate documentation of need, how needs are met, and future projections of health care need.

In view of the fact that the average ratio of income to assets for trusts in England in 1996-97 was 74/68 or 1.088 and that St Albans and Hemel Hempstead had an income to assets ratio of 55/69 (0.797) and Watford and Mount Vernon had 85/92 (0.93), it is not surprising that these trusts have difficulty in achieving their financial targets.

4. We therefore recommend that WHHA issue a statement recognising that the real financial problem for WHHA trusts arises from lack of income relative to their capital base.

Because the health authority is consulting only on the general principles of a new system of care for which it neither provides evidence of support nor detailed investment proposals,

5. we recommend that were WHHA to proceed on this basis the local authorities seek a judicial review of the consultative process and the legality of the proposal to plan hospital services for only a part of the local population.