Summary of key points and issues raised at the meeting convened by the five councils with West Herts Health Authority (WHHA) on October the 16th 1998

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WHHA is proposing a strategy of cutting costs in the hospital sector in order to free investment for the primary and community sectors. There are two basic questions for the health authority to answer: what evidence is there that these financial objectives will be met under the proposals and will the new service configuration adequately provide for local needs?

The health authority’s responses at the meeting of 16 October confirmed that there was little or no analysis behind its proposals and considerable confusion within them. Several new admissions were made but these served only to highlight the inadequacy of the authority’s planning base. Accordingly, neither question could be answered.

KEY FINANCIAL POINTS

1. The WHHA have devised their proposals without analysing the causes of deficit. They have conceded for the first time that capital charges were a significant cause of deficit.

Since 1991 NHS Trusts’ sole statutory obligations are financial. NHS Trusts are required to break even having made a return of 6% of their asset base and after paying the interest on their loans. The return, which is part of the system of capital charges, is paid for out of the annual revenue the Trust receives to pay for patient care and clinical services. In the private sector such a return is known as ‘the return on capital employed’ and is the surplus or profit of the enterprise. On average NHS Acute Trusts pay 8-10% of income as capital charges. Around 65% of income pays for staff wages and the rest goes on consumables such as drugs.

If NHS trust income is low relative to its asset base it will fail to break even and go into deficit because income to asset variations are not reflected in the capital charge funding formula. In 1996-97, 25% of NHS Trusts in England were in deficit having failed to break even (NHS (England) Summary Accounts 1996-97).

In 1996/7, the WHHA deficit was £3 million while the two local acute Trusts had a deficit of £4 million. On October 13th, 1998 at a meeting called by St Albans Council the WHHA chief executive attributed the deficit to increased activity and staff costs. On October 9th London Health Economics Consortium (LHEC) acting as advisor to the health authority also dismissed the importance of capital charges. However during the meeting called by the five councils on October 16th, the Director of Finance for the health authority agreed that capital charges were a significant cause of the deficit and were compounded by the capitation target i.e. income was insufficient for the asset base. Table 1 shows the impact of capital charges in 1996/7 - neither of the local acute Trusts could break even.
as their surplus was too small to cover capital charges. The deteriorating financial position began in 1995 when capital charges were fully implemented.

2. WHHA admitted that their proposals implied an increase in capital costs because they would lead to an increase in the size of the estate. However, this impact on costs had not been analysed.

LHEC in its September report to the health authority suggested that the objective of the single site option was to reduce the fixed costs and size of the asset base but noted that the green field site option would require capital expenditure of £150 million. The new site will however have only 510 - 640 beds i.e. half the current capacity of the combined two acute Trusts (1125 beds, according to Government figures).

The health authority at all the public meetings has promised to retain current estate including Watford, Hemel Hempstead, St Albans and Harpenden. The chief executive in correspondence with Councillor Anne Shaw (August 12th) stated that the value of this estate was £111 million. At various public meetings the health authority has stated that 45 - 70% of estate would be retained. The question is where the income to support these sites is to come from since the future income of these sites will have been switched to out of area Trusts and the new single site option. Income can only be found at the expense of other community services including the community trusts and primary care.

On October 16th the health authority admitted to the five councils for the first time that the overall cost of the asset base would rise but hoped that this would be offset by the economies of consolidating services on one site. This will mean staff and service reductions but the volume of cuts is unknown because the cost implications have not been worked out. In a labour intensive industry such as health care the opportunities for economies are very limited.

3. The meeting confirmed that there will be a loss of local trust income following the closure of specialist services at Mount Vernon under a new regional plan. However, neither the financial impact nor the service implications of this change have been examined.

The regional plan to withdraw specialist services from Mount Vernon over the next five to ten years will result in a direct loss of income to Mount Vernon and Watford Trust and increase its financial deficit. It can be no coincidence that the five to ten year timescale of the region and the health authority’s proposed radical reconfiguration of services are the same.

At the meeting of October 16th the health authority stated that current caseload for specialist services in Mount Vernon is the equivalent of 120 beds. It informed the five councils that this caseload would no longer be provided locally
under the network of care or 'single site’ option B but would be purchased out of 
area. It is essential that local residents and their representatives understand 
where care will be purchased, what caseload is involved and what the impact on 
local providers will be of the withdrawal of specialist income.

The loss of specialist services is curious given the current commitment to local 
access and the national models which recommend pursuing hub and spoke 
models of care e.g. cancer. Given the recent change in regional boundaries the 
health authority should state what the implications of these changes are and 
which region will be planning regional specialty services on their residents' 
behalf.

4. The implication that the health authority is planning for a major 
programme of redundancies among clinical and ancillary staff has not been 
spelt out. Nor have the implications for clinical services been examined.

Trusts can in theory adjust their cost base in four main ways (by increasing their 
income through increased activity, by disposing of assets, by liquidating their 
asset base altogether, or by cutting labour). However, WHHA trusts are reducing 
caseload and increasing their asset base. They must therefore cut labour in 
order to cut costs. If the authority opts for PFI the impact will be even greater.
One estimate (see item 5, below) suggests that up to 1000 medical posts are lost 
for every £200m of capital investment.

The withdrawal of specialist services and accompanying loss of income from 
Mount Vernon and Watford Trust will aggravate the deficit and destabilise the 
Trust. We suggest that the haste with which the health authority has drawn up 
proposals to merge the two local acute Trusts, Mount Vernon and Watford Trust 
and St Albans and Hemel Hempstead Trust (ostensibly to save on administrative 
costs, although the proposed savings are very small indeed) is in part driven by 
the perceived need for further consolidation and disposal of assets.

5. WHHA refused to acknowledge that their proposals had serious 
implications for trust financial viability. However, reducing trust income whilst simultaneously increasing the asset base will affect trust stability.

West Herts health authority preferred option is a single acute site. This 
suggests that the health authority thinks that even with the merger of the two 
Trusts the financial viability is still in question.

The two Trusts currently have an income of £141 million, an asset base of £161 
million and 1125 acute beds. (20% of its caseload and an unknown proportion 
of its income comes from out of area). The health authority were unable to 
provide actual numbers of total beds at the meeting on October 16th.
The critical issue is whether there will be sufficient Trust income required to support the single site option with its increased capital costs and reduced income. Trust income will fall for three reasons. First, the health authority is proposing to transfer specialist caseload accounting for 120 beds of current provision to (unspecified) out of district providers. Second, it proposes to shift general acute caseload equivalent to a further capacity of 135 to 170 beds away from the local acute Trusts to out of area providers. (We note that the health authority at the meeting of 16th October gave a figure of £6 million as the estimated cost of reproviding 135-170 general acute beds elsewhere but were unable to provide details of caseload). This figure seems very low, given that the two Trusts' combined income of £141 million to support 1125 beds. Moreover, the health authority will not have the advantage of the economies of block contracts to leverage reductions in prices from external providers. Third, the health authority says that it is committed to more community beds to accommodate some of the 40% of current caseload that the health authority deems 'inappropriate admissions' to the Trust currently. The location, staffing and funding of these beds has not yet been identified. All these additional service changes will have to be met from the current revenue of the two Trusts.

How can a more expensive asset base be serviced by a marked drop in income? It is important to note that the cost of capital to the single site Trust will almost double under a PFI. The cost of capital is included in prices or unit costs or cost per case comparisons which are now required by the government as part of its national benchmarking exercise. The increased cost of capital and decline in income will make the new single site Trust uncompetitive compared with other providers out of the area. Increased costs will be at the expense of labour and clinical services since in the absence of assets to dispose of these will be the only areas where economies can be found. According to Newchurch & Company, advisors to the DoH on PFI: 'An incremental investment of £200 million might... require productivity improvements leading to perhaps 1,000 job losses... and is probably only achievable by reducing the number of doctors and nurses... in the local healthcare market.' (Newchurch & Company, PFI Futures: capital investment after the White Papers, London, March 1998).

In the event that the new greenfield site does not come to fruition and the Health authority decides to go for a single site option at either Hemel or Watford, the issues remain the same. How does the health authority support a trust with a reduced income and increased asset base?

**B HEALTh CARE NEEDS**

1. The health authority conceded that they had failed to clarify the population for which they were planning.

The authority acknowledged that there was confusion about whether their plans referred to West Herts residents or to patients of West Herts trusts. They were
therefore unable to specify the population for which the proposed 510-640 bedded hospital would cater, its caseload or its income.

2. The meeting confirmed that 28% of the population were not being moved to the new pattern of care.

The authority conceded that more than a quarter of local residents would not be exposed to the new model of health care since those for whom services would subsequently be outside the health authority area would continue to gain admission to hospital at the current rate.

At the meeting at St Albans the chief executive stated that Choosing the Right Direction applied to all patients. However when questioned on October 16th it became clear that the care of the 28% of residents going out of area would continue unchanged. The health authority were unable to provide data at the meeting of residents going out of district or the income and costs of the contracts. We find it curious that the health authority is prepared to risk the care of 72% of its residents with a radical reconfiguration while expecting the remaining 28% to rely on current forms of delivery? It seems unfortunate that these residents should be excluded from the benefits of the health authority vision. We would expect an analysis of the health care needs of the 28% of residents currently and future projections of caseload and income and provision

3. The authority conceded that its community provision target was speculative and that because of doubts about the financial implications community services could be cut. However, Choosing the Right Direction appeared to contain a commitment to expand them.

The authority is proposing to reduce the size of the acute hospital sector by approximately half and provide for some of this displaced caseload in the local community and out-of-area. However, not only is it unable to specify the volume, caseload, and financing of this alternative provision, it admitted at the 16 October meeting that community services might contract because of the financial pressures created by the single site option. Social services would be irresponsible to endorse any radical reconfiguration without understanding the implications for their own severely constrained budgets of any shift in caseload from the health authority.

4. The Director of Public Health provided evidence of an increase in hospital admissions locally during the last 4-5 years. However, neither he nor the authority has yet produced evidence to show that their proposals to reverse that trend are either feasible or reasonable.
The authority has so far been unable or unwilling to produce the evidence which it claims demonstrates that about half the inpatients in its acute hospitals are there inappropriately. Moreover, in August 1998 the authority was forced to reopen closed beds because of shortages created by increased emergency admissions. At the meeting of 16 October the authority was unable to say how many beds had been reopened. In the absence of evidence about unnecessary admissions and in a situation of acknowledged bed shortage, we can only conclude that the statutory body with responsibility for the health care needs of the local population has adopted a careless attitude towards its duties by proposing drastic bed cuts.

Central to the network of care option is a substantial switch in caseload from local hospitals to out-of-area providers and the primary sector. However, no analysis is offered of the primary and community sector’s capacity or willingness to undertake the extra work or of the capacity of out-of-area providers.

5. A Strategic Outline Case (SOC) has been published without the financial framework and needs analysis in place to justify this investment.

We note that the authority has failed to provide a ‘do nothing’ or ‘do minimum’ option. Option A is not a ‘do minimum option’ since in addition to making major changes to acute services it also asks the public to decide where £7 million cuts should fall suggesting that they be implemented across community and primary care services.

Recommendation 1

Given the lack of information to judge the consultation, we recommend that the health authority withdraw its consultation documents and present a ‘do minimum’ option based not on the total deficit of the Trusts but the deficit of the health authority.

The authority should remember that the Trusts are independent financial bodies and not directly managed by the health authority and therefore the responsibility for managing the deficits falls to the Trusts. This would allow the health authority and the Trusts to present openly and transparently the causes of the deficits and the implications of the reconfiguration of specialist services and future closure of Mount Vernon for local NHS services, local councils and social services and local people. It would also allow greater transparency in discussions about where savings and service reductions will fall.

Recommendation 2
In the event of the authority refusing to conform to good practice by providing a ‘do minimum’ option, then it must at the very least be required to provide the following information to support its case:

i) the value of the new single site, its projected income and caseload. If additional beds are to be provided at the new site to cater for out-of-district caseload, the health authority must also show what the increased cost of the asset base will be, the additional caseload and external incomes the Trust will receive;

ii) the value of retained estate and projected caseload and income at St Albans, Harpenden, Mount Vernon and Watford;

iii) the value of community services, current caseload and income, future value, income and caseload;

iv) the size and quantity of caseload currently provided for out of area. Future caseload capacity and income required;

v) the impact on social services including any future capital and revenue expenditure implications.