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Blaming the victims: the trust special administrator's plans for south east London

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What this report shows

Major service closures, staff redundancies and the sale of NHS land and hospitals across South East London will occur as a result of the Secretary of State (SOS)'s decision in January 2013 in the light of the report of the trust special administrator (TSA) for the South London Healthcare NHS Trust (SLHT) whom he appointed in July 2012. In our report, we show that these closures, redundancies and sales are the result of the government not acting in the interests of the health service as required by Parliament when triggering the TSA regime. The TSA has made no public health case for downgrading services and has provided no sound evidence for the policy.

Instead, as our analysis of the TSA regime for SLHT shows, another process of financially driven service change devised by government and of a type criticised by the Francis inquiry in Mid-Staffordshire has taken place.

Blaming the victims: government policies and the financial situation in South East London

- Service change has been driven by the exorbitant, increasing, yet unclear, cost of the SLHT's long-standing PFI deals - £89 million and 18% of Trust turnover according to the SoS in July 2012, £69 million or 16% of Trust income according to the TSA report in January 2013.
- The PFI cost to the Trust is increasingly unaffordable because the annual charge is indexed to inflation. The growing PFI funding crisis has been exacerbated by underfunding of PFI charges through the national tariff.
- Government policy has also undermined Trust income by reducing the prices paid by commissioners for hospital attendances and admissions (the national tariff) and as a result of an efficiency programme known as the QIPP.
- Its policy of allowing Foundation Trusts (such as Guy's and King's) to retain surpluses, and requiring commissioners to return surpluses to the Treasury, has denied SLHT access to funds that were originally ear-marked for all patients and residents using the NHS in South East London.

These national government policies have combined to make up a financial deficit – for the SLHT, and elsewhere - which distort resource allocation and which the TSA regime has chosen to resolve locally.

Some of these drivers are acknowledged by the TSA report, but it goes further in asserting that underperformance is in part due to mismanagement including excess spend on locum costs and agency staff. However, the evidence for this claim is unclear; SLHT expenditure on staff and numbers of staff fell by 1.7% and 2.3% respectively between 2009-10 and 2011-12.

The TSA reports on financial underperformance and operational and managerial inefficiency make a number of productivity criticisms including the costs of lack of

integration and low income per consultant and other staff. However, we show that the data and methods behind these claims are mainly derived internally, have been insufficiently analysed and cannot be verified.

The TSA has ignored the health care needs of the people of South East London

The TSA's solution to the crisis created by central government involves major service cuts not based on an assessment of the reasonable needs of the local population for the services in question.

- Standard needs assessment involves analysis of patient flows, changes in referral patterns and activity, bed capacity, staffing and bed norms modeled against need. However, the SoS has accepted TSA recommendation in the absence of this analysis.
- TSA recommendations nonetheless involve major service change. They include recommendations to reduce the SLHT budget by £74.9m between 2013-4 and 2015-16; to reduce medical and nursing staff costs 16.4% and 17.2% respectively over the same period and to reduce bed capacity in South East London over five years by a total of 14.3%, which according to TSA amounts to a reduction of 579 available beds (operational (131) and mothballed (448)).
- It is a serious omission to recommend service closures and staff and bed reductions without evidence to explain how patients' needs will be met in future or how quality and safety will be safeguarded.
- The risks of this policy are high given that acute activity and admissions in South East London continue to rise year-on-year in all acute Trusts. Acute elective and emergency admissions rose by 21% between 2005-06 and 2011-12. Over the same period the number of general and acute overnight beds fell by 17%. As a result, bed occupancy has been at unsafe levels for the last three years.
- The situation in South East London reflects the national picture. Across England as a whole, staff redundancies and bed and service closures have accumulated year-on-year so that today the NHS (in England) now has one of the lowest ratios of beds and staff per head of the population in the OECD. In 2010, there were 3.0 hospital beds per 1,000 population in England compared with an OECD average of 4.9 hospital beds per 1,000.
- The TSA report does not consider the freedom of foundation trusts such as Guy's and King's to generate up to half their income from private patients. Half the beds, staff and services remaining in the NHS could be dedicated to private patients and no longer available to the NHS. The TSA has made no analysis of what this means for patient care or of how beds and staff are used currently.
- Whilst the TSA report recommends ''community reprovision", we have found no evidence of this new provision and no explanation of how it will be provided and resourced. This is of considerable concern because experience of PFI-driven closures over two decades demonstrates that promised 'community reprovision' does not materialise. There is no

evidence that enhanced community provision will reduce hospital admissions.

- The TSA has used productivity measures and targets as a substitute for planning and access. But it should be noted that (a) travel times are not a proxy measure of the public's use and need for services; (b) MORI opinion polls, such as the one conducted by Deloitte, are not a substitute for public health planning; (c) productivity measures are not a measure of access or need: they are subject to gaming and bias by Trusts.

We have serious concerns about the data and methods used by the TSA in his estimates of productivity and efficiency. Most of the data are not in the public domain and are not verifiable.

Conclusion and recommendations

The major closures, redundancies, sell-offs and service reconfigurations that will follow the TSA regime for the SLHT do not serve patients, whose needs have been, at best, down-played and at worst ignored. PFI is playing a major role in service closure. In the case of Lewisham hospital, there can be little doubt that the government is sacrificing a thriving local hospital in order to protect the interests of bankers, shareholders and corporate stakeholders. In the case of SLHT, the victims are being blamed for the consequences of government policies to promote PFI, deflate the national tariff, and require efficiency savings, all of which involve misallocation of funds originally ear-marked for NHS services in the area. The real victims here are the people of South East London and those who work in and use the health services there. If the Secretary of State implements the TSA recommendations, the public health consequences are likely to be catastrophic.

We recommend that:

(1) application of the TSA regime to the SLHT should be revoked and the case reconsidered afresh, having excluded the effect of government policies on the financial performance of the Trust;

(2) the TSA regime should not in the future be applied to Trusts whose financial under-performance results from government policies;

(3) Department of Health statutory guidance with respect to the TSA regime should be amended so as to require that (a) proper and reasonable public health needs assessment provides the basis for future recommendations in South East London and elsewhere, (b) all data and methods are in the public domain, and (c) the TSA conforms to service planning standards which:

- do not use productivity measures and targets as a substitute for planning and access
- do not use travel times as a proxy measure of the public's use and need for services
- do not use MORI opinion polls as a substitute for public health planning
- do not use non-standard data, methods and definitions;

(4) the Department of Health and the Treasury should investigate the financial terms of PFI contracts, to make these terms available for public scrutiny and where necessary to renegotiate contracts; in default of which Parliament should act to require them to do so;

(5) the National Audit Office, the Care Quality Commission, and the House of Commons Health Committee should as a matter of urgency consider investigating the cost and quality of external consultants' reports to the TSA.

Introduction

The trust special administrator (TSA) was appointed by a statutory order on 16 July 2012 in response to a "long-standing history of underperformance, particularly around financial management and access standards, and a consistent inability to deliver high quality services whilst balancing income with expenditure." [1]

The order with respect to South London Healthcare Trust (SLHT) was made under Chapter 5A of the National Health Service Act 2006, which permits the TSA "to exercise the functions of the chairman and directors of the South London Healthcare National Health Service Trust."[1]

No powers or duties are specified with respect to the functions of the chairman and directors of NHS organisations that are not part of SLHT.

Under TSA recommendations to address the deficit, SLHT is expected to reduce total available beds by 90-100 beds, and medical and nursing staff by 16.4% and 17.2% respectively.[2](page 49, figure 18-page 51)

Major reconfigurations of this type should be accompanied by detailed service plans and based on clear planning assumptions. They require careful consideration of how needs will be met and where patients will in future be directed.

However, despite the publication of statutory guidance in July 2012, the House of Commons Public Accounts Committee concluded in October 2012 that the Department of Health "was not able to explain clearly what would trigger a trust being placed into the failure regime, and how decisions would be made about the future of a trust in financial difficulty." Nor was the department able to explain the process for South London Healthcare NHS Trust, which at the time was already in special administration.[3]

The committee also highlighted the connection between PFI and special administration:

> "A number of trusts in financial difficulty have PFI contracts with fixed annual charges that are so high the trusts cannot break even. Paying these charges is one of the first calls on the NHS budget and the Department is liable for supporting all PFI payments because it underwrites the Deed of Safeguard given to contractors. It already expects to have to find £1.5 billion to bail out seven trusts facing problems with PFI repayments over the remaining life of their contracts - equivalent to £60 million a year."[4]

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[1] Explanatory Memorandum to the South London Health Care National Health Service Trust (Appointment of Trust Special Administrator) Order 2012 No. 1806

[2] South London Healthcare NHS Trust, Office of the Trust Special Administrator. *Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London. Volume 1.* January 7, 2013

[3] House of Commons Committee of Public Accounts. Department of Health. *Securing the future financial sustainability of the NHS. Sixteenth Report of Session 2012–13.* 22 October 2012, 3.

[4] Ibid.

This departmental liability figured prominently in the TSA final report. "[T]he [proposed] changes are necessary," the TSA wrote, "if the Government wishes to cease the substantial cash support it currently has to give to the Trust to maintain its operations."[2]

The statement suggests that financial considerations are driving service change. However, the Francis inquiry into substandard care at Mid Staffordshire Hospital warned against the prioritisation of financial considerations and recommended "evidence-based tools for establishing the staffing needs of each service" coupled with "convincing evidence" of the case for change.[5]

The Francis view is echoed in statutory guidance, which requires that "patients' interests must always come first" under the special administrator system.[6] Furthermore, the power given by Parliament to the Secretary of State to trigger the TSA regime can "only" be exercised if he or she "considers it appropriate in the interests of the health service" [7].

Thus, whilst the Secretary of State cannot be held to a purely objective standard, neither does he or she have entirely free rein. The Secretary of State must reason fairly and rationally, and include an assessment of the reasonable needs of the local population for the services in question. Such needs are clearly an integral part of the "interests of the health service".

We show that by not undertaking an assessment of the reasonable needs of the local population for health services the TSA put the Secretary of State in breach of his functions.

Chronology and key documents for SLHT

Jul 2012	Statutory Instrument 2012 No.1806. The South London Healthcare National Health Service Trust (Appointment of Trust Special Administrator) Order 2012, July 11, 2012
	Statutory Instrument 2012 No.1824. The South London Healthcare National Health Service Trust (Extension of Time for Trust Special Administrator to Provide a Draft Report) Order 2012, July 11, 2012
	Explanatory Memorandum to 2012 No.1806 & 2012 No.1824
	Written Ministerial Statement, Department of Health. South London Healthcare NHS Trust. July 12, 2012
	South London Healthcare NHS Trust. The case for applying the regime for unsustainable NHS providers. July, 2012
	Department of Health. Statutory Guidance for Trust Special Administrators appointed to NHS Trusts. July 2012
Nov 2012	South London Healthcare NHS Trust, Office of the Trust Special Administrator. Draft report – securing sustainable NHS services. November, 2012

[5] Ibid:69.
[6] Department of Health, 2012. *Statutory Guidance for Trust Special Administrators appointed to NHS Trusts,* 7. Available at: https://www.wp.dh.gov.uk/publications/files/2012/07/statutory-guidance-trust-special-administrators.pdf
[7] NHS Act 2006, s.65B(2)

Jan 2013	South London Healthcare NHS Trust, Office of the Trust Special Administrator. Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London. Volume 1. January 7, 2013
	NHS Medical Director Letter to Secretary of State January 30th. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156291/south-london-healthcare-nhs-trust-bruce-keogh-letter.pdf.
	Secretary of State for Health. South London Healthcare NHS Trust: Notice of decision by Secretary of State. January 31, 2013

On 7 January 2013 the TSA made recommendations to the Secretary of State for Health. On 30 January 2013 Sir Bruce Keogh wrote to the Secretary of State saying 'the recommendations are likely to lead to improved care'.[8] On 31 January 2013 the Secretary of State approved the recommendations.

The TSA recommendations involve reductions in the SLHT budget of £74.9m over the period 2013-2016, 61.8% of which will come from payroll cuts.[2(figure 18-page 51)] Service closures and reductions include:

1. Sale of SLHT estates: three areas of the QM Hospital Sidcup and Orpington Hospital will be disposed.[2(pages 57,59)]
2. Closure of a total of 579 beds over five years including 90-100 acute beds in South London Health Care Trust [2(page 49), 15(Appendix K-page 54)]
3. Reductions in medical and nursing staff in South London Health Care Trust of 16.4% and 17.2% respectively between 2013-14 and 2015-16.[2(page 51)]
4. Lewisham Hospital to close its A&E department, 24/7 adult surgical and medical emergency departments, obstetric unit, critical care unit and two inpatient departments (paediatric and complex surgery).[2(figure 38-page 90)]
5. SLHT will be dissolved a) QMS will be merged with Oxleas NHS Foundation Trust b) QEH and LEW will form a new NHS Trust (c) PRUH will merge with King's College NHS Trust.[2(page 28)]
6. After SLHT has been dissolved the Department of Health will write off its debt and will provide direct support the PFI operators in order to cover excess costs of the PFI contracts of QEH and PRUH. [2(page 60)]

We examine the analysis that underpinned the TSA recommendations and which provided the rationale for Secretary of State approval.

Organisations responsible for planning or approving reconfiguration in SE London

According to the TSA, CCGs are responsible for planning primary care and community services whilst the administrator is responsible for planning acute services:

[8] NHS Medical Director. Letter to Secretary of State. January 30, 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/156291/south-london-healthcare-nhs-trust-bruce-keogh-letter.pdf.

> "Developing primary care and community services is core to the CCGs' intentions and the delivery of their activity projections, and it forms a secure platform for the TSA's review of hospital-based services. But, with the TSA's remit being to bring forward recommendations for securing clinically and financially sustainable services, it was the nature and disposition of acute services that needed to be fully explored."[2]

Six CCGs[9] prepared a community strategy as part of the process:

> "The TSA team worked with commissioners, clinicians and other stakeholders to understand how the quality of service provision by the NHS in south east London could be improved and secured within the available financial resources. This included the CCGs developing a strategy for community-based care, which outlines their aspirations for primary care and community services, integrated care and planned care services."

A "strategy for community-based care in south east London" is published as appendix O to the TSA final report. However, insufficient planning and investment data are included.

We were unable to locate community planning data on CCG websites. Indeed, three[10] of the six websites were inactive when accessed via URLs on the NHS England directory of CCGs and directed us instead to a British Library archive. No documents could be retrieved.

A recent BMJ editorial highlighted that there is no evidence that good community-based care or increasing expenditure leads to reduction in admissions, especially in the frail elderly.[11]

[9] Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark.

[10] Bexley, Greenwich and Lewisham.

[11] D'Souza S. Preventing admission of older people to hospital. *BMJ* 2013;346:f3186

Part 1: Government policies and the financial situation in SE London

Increases in costs

According to the Department of Health, the main argument for the restructuring of SLHT "is its long-standing history of underperformance (…) since there has been a consistent inability by the trust to deliver high quality services whilst balancing income with expenditure over the last seven years"[12]

The department claimed that as a result SLHT "in 2011-12, incurred the largest financial deficit of any of the 248 NHS provider organisations in England, at over £65 million".[12] and that "[t]he Trust is spending over £1m per week more than its income".[13]

According to the Secretary of State and the TSA, PFI annual costs are the main driver of deficits in the SLHT although the accounts of the figures and numbers of PFI differ.

In his explanatory memorandum to parliament, the Secretary of State stated:

> "one of the major pressures in SLHT's financial position is the £89m annual cost of servicing the debt of its five [sic] PFIs, 18% of the Trust's annual turnover is spent on contracts." [14]

However, according to the TSA the PFI charge is £69 million each year or 16% of income, but the year is not provided.[15]

SLHT has six PFI schemes including two large schemes in Queen Elizabeth Hospital (QEH) and Princess Royal University Hospital (PRUH).[16]

The TSA does not give an account of total capital costs as a percentage of income. Had it done so, around £8.5 million 'public dividend capital' (interest paid to the Treasury each year as part of the capital charging regime) would have been added to the total.

Although TSA acknowledges that affordability pressures have been present since PFI contracts were signed, it did not explain that PFI costs are rising year by year nor why they are rising. In fact, PFI costs take an increasing share of income each

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[12] Written Ministerial Statement, Department of Health. *South London Healthcare NHS Trust*. July 12, 2012

[13] Lansley A. Letter to South London Healthcare Trust's staff. July 2, 2012

[14] Explanatory Memorandum exec summary., paragraph 6; and see paragraph 53 and 54

[15] South London Healthcare NHS Trust, Office of the Trust Special Administrator. *Draft report – securing sustainable NHS services.* November 2012

[16] SLHT has six PFI contracts in total across its three main hospital sites (Queen Elizabeth Hospital – QEH, Princess Royal University Hospital – PRUH, Queen Mary's Hospital Sidcup – QMS). Two of these contracts are used to pay the development of PRUH in Bromley and QEH in Greenwich. The other four are smaller contracts for the running of equipment and other services for the hospital buildings.

year because they are indexed to inflation (and so increase in absolute terms) and because overall income is falling.

This tendency was built into PFI deals from the beginning. In our earlier study of PFI and capital charges, we show that in 1998-9 Greenwich Healthcare devoted 2.1% of its revenue to paying for capital before PFI and 16.2% in the first year of the PFI.[17] In Bromley, 7.0% of revenue was devoted to capital before PFI and 10.7% in the first year of PFI.

The original higher cost has been exacerbated by the linkage of PFI payments to the retail price index (table 1) which shows that Bromley PFI unitary charge rose more than six-fold since between 2000-01 and 2012-13 and that by 2031-2 it will have risen almost twenty-fold.

Table 1: The effect of indexation on the PFI unitary charge at Princess Royal University Hospital Bromley and Queen Elizabeth Hospital Woolwich, 2000-01 to contract close

PFI Scheme	**Unitary payment 2000-01 (£m)**	**Unitary payment 2012-13 (£m)**	**Unitary payment at contract close (£m)**
Princess Royal University Hospital (PRUH) - Bromley	5.8	39.0	94.1 *
Queen Elizabeth Hospital (QEH) - Woolwich	18.2	27.9	61.3 **

Note: (*) unitary payment in 2031-32 (**) unitary payment in 2029-30
Source: HM Treasury 2011 PFI signed projects list

These payments, which are dictated by government policy and have been approved by the Treasury, involve a diversion of the patient care budget and are unsustainable.

The growing PFI funding crisis has been exacerbated by underfunding of PFI charges through the national tariff.[18]

PFI affordability problems can only be resolved by the sale of NHS assets, the diversion of income to PFI or renegotiation of the contracts.

PFI is also part of the finance costs reported below by TSA, but TSA has not defined or disaggregated the PFI and other costs to show their components and assumptions.

Table 2 shows that SLHT operating income and operating costs dropped by 6.9% and 13.3% respectively between 2009-10 and 2012-13. SLHT finance costs (related to the two major PFI projects in PRUH and QEH) increased by 29.5% during the same period with an average annual increase rate of 9.1%.

[17] Allyson M Pollock, Jean Shaoul, Neil Vickers. Private finance and "value for money" in NHS hospitals: a policy in search of a rationale? BMJ 2002;324:1205–9
[18] Allyson M Pollock, David Price, Moritz Liebe. Private finance initiatives during NHS austerity. BMJ 2011;342:d324

Table 2: South London Healthcare Trust financial performance 2009-10 – 2012-13 (in £million)

	2009-10	**2010-11**	**2011-12**	**2012-13**	***2009-10 – 2012-13 % change***	***2009-10 – 2012-13 average annual growth rate***
Total operating income	462.6	437.8	438.9	430.5	*-6.9%*	*-2.3%*
Total operating costs	523	453.3	490.8	453.6	*-13.3%*	*-4.2%*
Finance costs *	**21.0**	**23.3**	**26.3**	**27.2**	***29.5%***	***9.1%***
Total financial deficit	-81.4	-38.8	-78.2	-50.3	*-38.2%*	*4.5%*
Net deficit **	-43.7	-43.8	-65.0	-54.2	*24.0%*	*10.7%*

Notes: (*) Finance costs are principally related to the two whole hospital PFIs located at PRUH and QEH (**) Net deficit is the adjusted for the impact of impairment deficit
Source: Office of the Trust Special Administrator. *Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London. Volume 1.* January 7, 2013

Reductions in income

NHS income has been reduced by the return of underspends to the Treasury.

The NHS underspent by £1.7 billion in 2011-12, of which all but £0.3 billion was returned to the Treasury despite a 2010 promise made by David Nicholson, NHS England chief executive, that it would all be ploughed back into the health service.[19,20] According to the House of Commons Health Committee, underspends averaged £2 billion a year between 2007-8 and 2009-10 but it is not known how much of this surplus was retained by the Treasury.[20]

Deficits arise in individual trusts because of high costs of capital, falling income and changes to reimbursement. So long as costs are not pooled (shared across the whole NHS), a policy of breaking even at trust level will result in the closure and sale of NHS assets.

Five central government policies are responsible for deficits at trust level. They are:

I. Foundation trust policy, which allows surpluses to be retained by foundation hospitals. In South East London, Guy's foundation trust made and retained a total surplus of £39 million over three years (2008-9 – 2010-11).[21](figure 2, page 3)

II. The requirement on CCGs to return surpluses to the Department of Health. In 2011-12 the six South East London CCGs which buy care from the four acute trusts Guy's, King's, Lewisham and SLHT in South East London returned £31 million.[21](figure 3, page 4)

[19] Nigel Hawkes, 'Only a fifth of £1.7bn NHS underspend will be carried into next year's budget', British Medical Journal, 10 July 2012.
[20] House of Commons Health Committee. Public expenditure on health and care services, 12 March 2013.
[21] South London Healthcare NHS Trust. The case for applying the regime for unsustainable NHS providers. July, 2012

III. The exorbitant costs of PFI. PFI has first call on NHS resources. It requires special subsidies and subventions of billions of pounds taken from other parts of the NHS to make the policy affordable. PFI liabilities are a major cause of income reduction and deficit. However, PFI liabilities cannot be resolved by selling off PFI assets because the public sector is contracted to make payments to the private sector for thirty years or more and asset sales do not remove this liability. Therefore, non-PFI hospitals are closed and land is sold off. This has been the case since the first PFI deals were signed off in the NHS. The alternative, contract renegotiation, has still to be seriously considered by the Department of Health despite urging by the Public Accounts Committee.[22] The option was not considered by the TSA.

IV. The impact of National Tariff deflation. Reductions in Trust income are due to tariff deflation, ie, reductions in the amount paid under the new tariff and new policies which reduce the amount paid for Accident and Emergency and maternity care.

V. Quality Innovation Productivity and Prevention (QIPP) savings of £20 billion by 2015 are centrally imposed savings which are to be achieved through the tariff and at local level through adjustments to CCG allocations.

Table 3 presents the QIPP (Quality Innovation Productivity and Prevention) savings that the SE London CCGs have to deliver over a three-year period to 2015-16. According to these data, South East London CCGs must achieve QIPP cumulative savings of £110million, £30 million of which will be reinvested for quality improvements in acute care. Therefore the net QIPP saving that South East London CCGs must deliver until 2016 is £81million.

These three-year planned savings are expected to exert additional pressure over the already constrained SE London acute NHS trusts' budgets.

Table 3: Quality Innovation Productivity and Prevention (QIPP) savings for South East London CCGs over the period 2013-14 to 2015-16

		£million
QIPP savings acute care	A&E	3.6
	Outpatient care	14.4
	Elective care	25.2
	Non-elective care	28.8
	Total acute	72.0
QIPP savings non-acute care		39.0
QIPP total savings		**111.0**
Investment to deliver acute QIPP		30.0
QIPP net savings		**81.0**

Source: Office of the Trust Special Administrator. *Appendix M Finance, Capital and Estate Evaluation*. January, 2013

[22] House of Commons Committee of Public Accounts. Department of Health: Securing the future financial sustainability of the NHS, Sixteenth Report of Session 2012–13, 22 October 2012.

TSA account of operational efficiencies

The TSA report argues that a key driver for the SLHT's annual deficit has been its operational and managerial inefficiency, partly due the overuse of locum and agency staff.[2(page 41)]

Table 4 shows that the TSA has misrepresented the overall position. TSA own data show that total number of staff (temporary and non-temporary) and overall payroll costs decreased by 2.3% and 1.7% respectively, between 2009 and 2012.

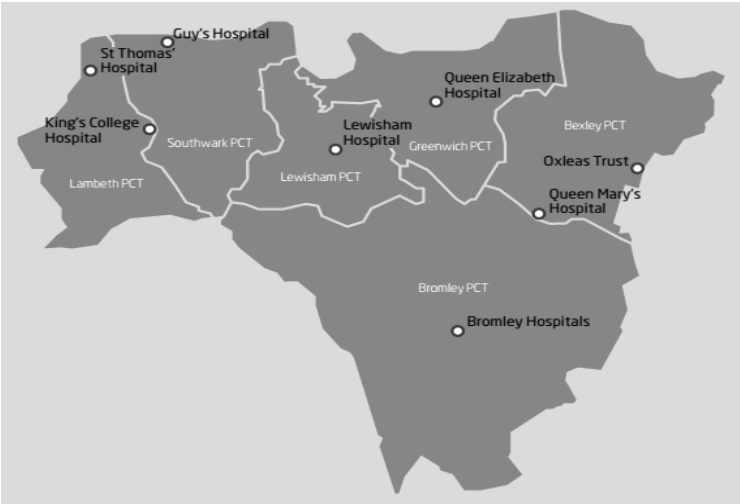
Table 4: South London Healthcare Trust number of employees and staff cost, by temporary and non-temporary staff

		2009-10	**2010-11**	**2011-12**	***2009-12 % change***
Total, excluding bank/locum/agency staff	*n employees*	5,771	5,431	5,367	*-7.0%*
	£million	268.2	259.5	262.2	*-2.2%*
Bank / locum / agency staff	*n employees*	742	1,067	995	*34.1%*
	£million	38.7	34.3	39.5	*2.1%*
Total staff	*n employees*	6,513	6,498	6,363	*-2.3%*
	£million	306.9	293.8	301.7	*-1.7%*

Source: South London Healthcare Trust. *The case for applying the regime for unsustainable providers - South London Healthcare NHS Trust.* July 2012

Part 2: TSA has ignored the health care needs of the people of South East London

The South East London (SEL) health economy consists of: a) six small PCTs commissioning services for a population of about 1.8 million people b) two major teaching and research hospital trusts (Guy's and St Thomas' and King's College Hospital) c) Lewisham Healthcare NHS Trust and d) South London Healthcare NHS Trust (SLHT).[23] SLHT came into existence on 1 April 2009, after the merger of three hospital Trusts – Queen Mary's Hospital Sidcup NHS Trust (QMS), Queen Elizabeth Hospital NHS Trust (QEH) and Bromley Hospitals NHS Trust.[2] Today, SLHT operates largely out of three main sites: Princess Royal University Hospital (PRUH) in Farnborough, near Orpington; QEH in Woolwich; and QMS in Sidcup.



The TSA recommendations require major hospital and service closures

i) TSA Bed Closures

The TSA has misrepresented the scale of proposed bed closures. Bed plans published in Appendix K of the TSA draft report (November 2012) involve closure of 131 operational and 579 total available (operational and mothballed) hospital beds across the South East London Acute NHS Trusts by 2017-18.[15(Appendix K-page 54)] However, these projected bed closures are not disclosed in the TSA final report (January 2013). Instead, the TSA refers to the closure of 90-100 acute beds in SLHT by 2015-16.[2(page 49)]. In reality, at least 579 total available beds will close with the sale and disposal of hospital sites.

The TSA has provided no evidence of bed modeling or need or activity to support its proposals. Bed definitions do not accord with national data.

[23] Palmer K. *Reconfiguring hospital services. Lessons from South East London.* UK: The King's Fund 2011

Table 5 (based on data published in Appendix K of the TSA draft report) shows that according to TSA plans, SEL Acute NHS Trusts will lose 3.6% of their operational hospital beds and 14.3% of their total bed capacity by 2017-18. Almost half (41%) of available beds at Lewisham will close, and over a quarter of beds at Guy's (27.7%) by 2017-18.

Table 5: Hospital Beds in South East London Acute NHS Trusts, current and projected (data set out in the draft TSA Report - Appendix K)

	Current Bed Provision 2012			**TSA Recommendations for 2017-18**			
	Total available	Moth-balled	Operational	Available Beds required in 2017-18	Change in number of operational, (available) beds	*% change of operational beds*	*% change of total available beds*
Lewisham	419	129	290	246	-44 (-173)	*-15.2%*	*-41.3%*
PRUH	587	7	580	626	46 (39)	*7.9%*	*6.6%*
QEH	532	1	531	532	1 (0)	*0.2%*	*0.0%*
ST Thomas'	968	54	914	849	-65 (-119)	*-7.1%*	*-12.3%*
Guy's	379	70	309	274	-35 (-105)	*-11.3%*	*-27.7%*
KCH	928	0	928	928	0 (0)	*0.0%*	*0.0%*
QMS	240	187	53	19	-34 (-221)	*-64.2%*	*-92.1%*
Total	**4053**	**448**	**3605**	**3474**	**-131 (-579)**	***-3.6%***	***-14.3%***

Source: Office of the Trust Special Administrator. *Appendix K Finance, capital and estates appendix.* November 2012

ii) TSA staff reductions

TSA recommends reducing SLHT budget by £74.9m over the period 2013-2016 (a 14.2% decrease in the Trust's current total operating expenses). Of this, 61.8% is to be met from payroll cuts in medical, nursing, scientific and non-clinical staff (table 6).

Table 6: Proposed reductions in budgets for South London Healthcare Trust, by cost category and site, over the period 2013-16

By cost category	£million	*% change compared to current cost base*
Medical staff	14.8	*-16.4%*
Nursing Staff	16.9	*-17.2%*
ST&T Staff	4.5	*-12.2%*
Non clinical Staff	10.1	*-20.2%*
Supplies	14.9	*-20.7%*
Other	13.7	*-91.3%*
Total	**74.9**	***-14.2%***
By site	£million	*% change compared to current cost base*
Queen Elizabeth Hospital	32.3	*-15.9%*
Princess Royal University Hospital	30.9	*-15.1%*
Queen Mary's Hospital	11.7	*-14.1%*

Source: Office of the Trust Special Administrator. *Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London. Volume 1.* January 7, 2013

TSA does not explain how cost reductions of this scale will affect numbers and categories of staff, nor how services and quality of care are to be safeguarded. But as Francis pointed out, staffing levels are key to quality.

iii) TSA recommendations for service change are not supported by a planning base

TSA has provided no planning base to support the financial targets or the major reductions in beds and staff. TSA reports have provided no detailed plan supported by evidence of how patients' needs will be met or where patients will go. Major service reconfiguration is always accompanied by strategic plans and a needs assessment. Below (table 7) we identify the types of data routinely found in previous NHS business cases and DoH planning documents associated with major service change and we show that TSA has conducted no analysis of needs to show the impact of service reconfiguration.

Table 7: Planning data that should accompany any major health sector reconfiguration and whether found in TSA reports

Planning data for health sector reconfiguration			*Data in the TSA reports*
Demographic Indicators (by local authority areas and by CCG areas)	Population by sex and 5 year-age groups		No
	Births by local area authorities and by CCGs		No
Epidemiological Indicators (by local authority areas and by CCG areas)	*Mortality indicators*	Deaths by age groups, sex and specific causes	No
	Morbidity indicators	Disease specific prevalence and incidence / Sociodemographic measures	No
Provision of Services (Current and projected)	*Hospital and Community Services*	Acute Beds number by specialty and per 100,000 population	No
		Medical Equipment by category	No
		Nursing Homes / Residential Homes (number of beds per 100,000 population)	No
		Day Centres	
	Staffing WTE and per !00/000	GPs	No
		Community Nurses by category	No
		Community Psychiatric Nurses	No
		Occupational therapists	No
		Physiotherapists	No
		Hospital staff per 100,000 population	No
		Medical hospital staff by specialty and training status	No
		Nursing hospital staff by specialty and training status	No
		Scientific and therapeutic hospital staff by specialty	No

		Technical and Administrative hospital staff by specialty	No
Utilisation of Services (current and projected patient flows)	*Hospital Services*	A&E attendances per 100,000 population	No
		Elective admissions by specialty	No
		Non elective Admissions by specialty	No

As table 7 shows, there has been no analysis or modeling of demographic needs, patient flows, or community provision. There is no detailed account of community reprovision. Experience from other PFI driven closures is that promised community provision does not materialise.

Furthermore, there is no modeling of the impact of service closures and staff cuts on quality of care and access to services

TSA asserts without evidence that increasing community provision will meet population health care needs and prevent hospital admissions. However, the community strategy (Final Report appendix O) has insufficient data for planning and needs assessment.

iv) TSA conflates productivity with planning

TSA has chosen to reduce the concept of the population's current and future health care needs to questions of provider performance, quality and public opinion, and to reduce the concept of access to travel times (table 8) and patient experience. This approach is not consistent with the duty to provide or secure a comprehensive health service.

Table 8: Performance Indicators used for the evaluation of SLHT

Indicators used by TSA report	***Data Sources used***
2010-11 & 2011-12 Care Quality Commission (CQC) evaluation	No reference
Overall Average Length of Stay	Internal (TSA, SLHT) data
HRG Average Length of Stay	Internal (TSA, SLHT) data
Referral to Treatment Time (RTT) and A&E wait time	Internal (TSA, SLHT) data
A&E wait times	Internal (TSA, SLHT) data
Readmission Rate compared to peer group average	Dr Foster health and medical quides
Prevention and treatment of venous thromboembolism	No reference
Prevention of infection	No reference
Quality Score (composite measure of 20 clinical indicators collected nationally)	Internal (TSA, SLHT) data
Income per medical staff	Internal (TSA, SLHT) data
Income per scientific staff	Internal (TSA, SLHT) data

MORI opinion polls such as the one conducted by Deloitte on patients' views of services are not a substitute for public health planning

Hospital productivity measures do not substitute for planning and are not a measure of the population's access or need. They are subject to gaming and bias by Trusts. Travel times on their own are not a measure of need or access.

We have serious concerns about the data and methods used by TSA in their estimates of productivity and efficiency. Most of the data and methods used appear to be internal and have not been published and are not in the public domain. They cannot be substantiated or verified. The data definitions and methods used to estimate beds, staff, activity and productivity do not reconcile with national reported definitions for the sector.

v) What TSA did not take account of in South East London Acute Trusts

The TSA recommendations did not consider trends in bed closures, rising admissions, rising bed occupancy resulting from previous service reconfiguration. Between 2005-6 and 2011-12, 17% of the general and acute beds closed in SE London Trusts (figure 1). However, over the same period the number of general and emergency admissions has risen by 21% (figure 2). The result is that, bed occupancy is at critical levels and in excess of 90% in many trusts (table 9). This suggests that there are serious problems with patients having to be boarded out and put on inappropriate wards thereby jeopardising safety and quality of care.

Figure 1: Trends in bed closures over time in South East London NHS Trusts

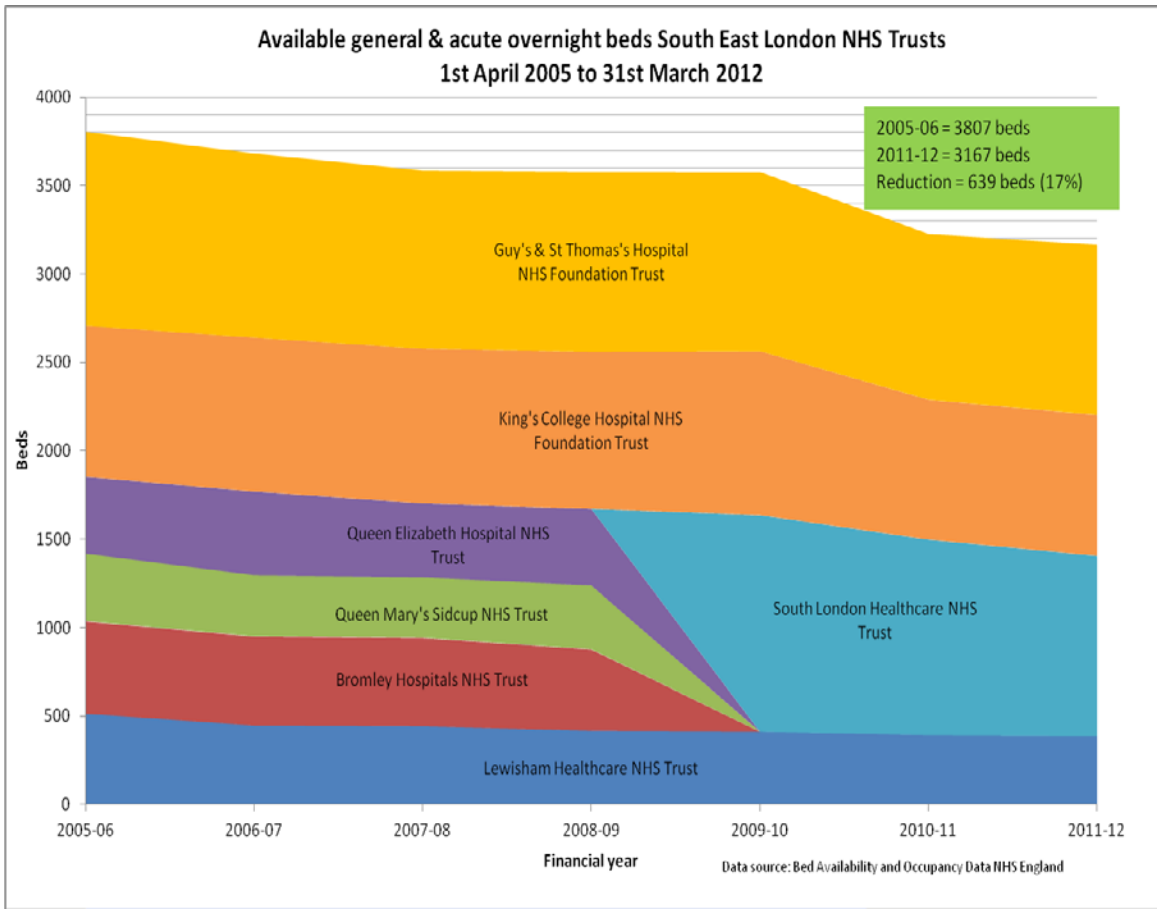


Figure 2: Patient admissions in South East London NHS Trusts

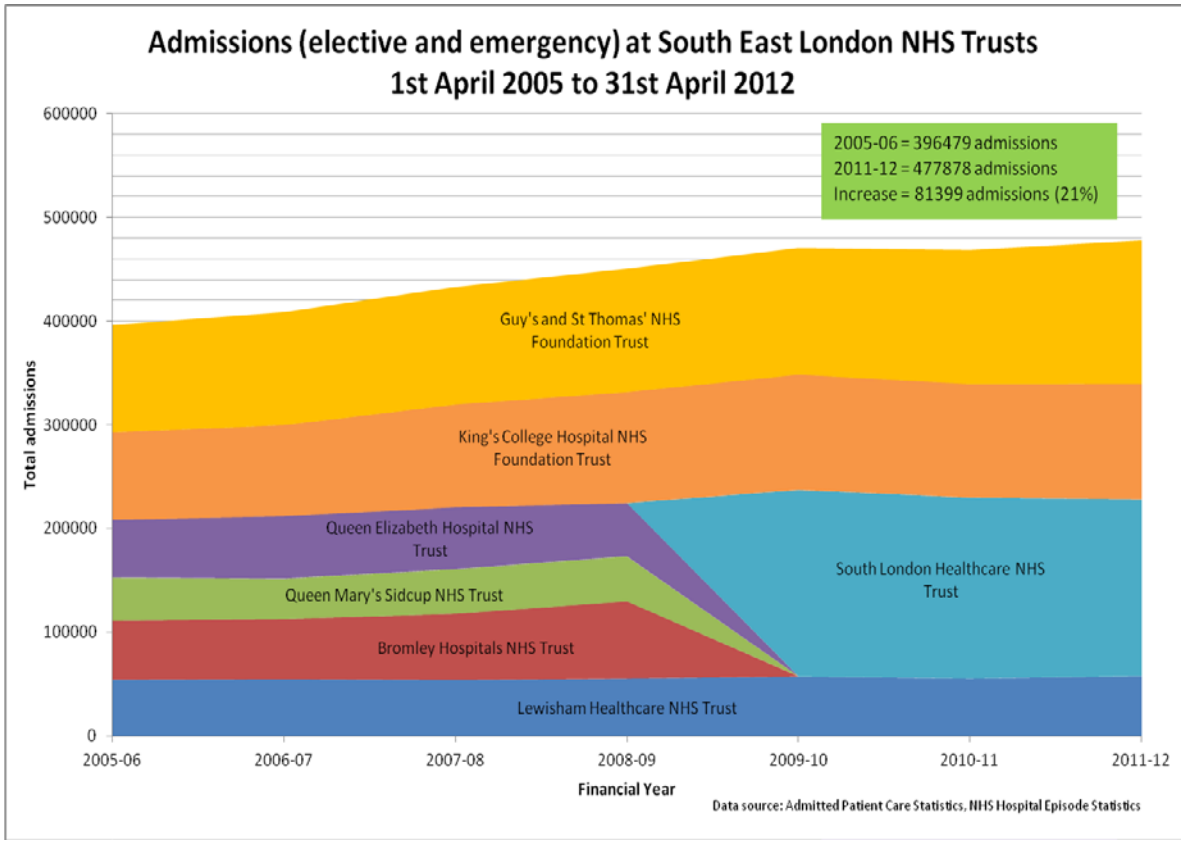


Table 9: Occupancy rates general and acute beds, South East London NHS Trusts, 01 April 2001 to 31 March 2013

NHS Trust	Financial Year											
	2001 -02	2002 -03	2003 -04	2004 -05	2005 -06	2006 -07	2007 -08	2008 -09	2009 -10	2010 -11	2011 -12	2012 -13
Guy's & St Thomas' Hospital	80%	80%	79%	78%	79%	77%	77%	80%	81%	81%	80%	83%
King's College Hospital	90%	91%	91%	87%	89%	90%	92%	92%	84%	90%	91%	94%
Queen Elizabeth Hospital	95%	84%	87%	87%	87%	82%	95%	98%				
Queen Mary's Sidcup	84%	83%	86%	86%	85%	95%	96%	92%				
Bromley Hospitals	82%	90%	91%	94%	91%	95%	92%	85%				
SLHT									92%	90%	90%	90%
Lewisham Healthcare	95%	89%	90%	88%	87%	86%	89%	86%	85%	89%	91%	90%

Data source: Bed Availability and Occupancy Data NHS England

Conclusion and recommendations

The major closures, redundancies, sell-offs and service reconfigurations that will follow the TSA regime for the SLHT do not serve patients, whose needs have been, at best, downplayed and at worst ignored.

Our review of the TSA evidence base confirms that the reconfiguration is being driven by financial not by clinical considerations. It also shows that deficits are the consequence of national policy not local inefficiency.

The Francis inquiry into substandard care at Mid Staffordshire Hospital highlighted how "no thought seems to have been given in any part of the system […] to the potential impact on patient safety and quality" when savings in staff costs were made.[24]

The same may be said of the TSA report. Its authors have failed to show that a financial crisis created by national policies can be resolved locally without detriment to patients. The TSA and other officials who are party to the proposals are therefore complicit in a process of financially driven service change of a type criticised by the Francis inquiry in Mid-Staffordshire.

However, where Francis found that in Mid Staffs "no thought seems to have been given in any part of the system […] to the potential impact [of cost cutting] on patient safety and quality"[25], in South East London patients, doctors, nurses and officials, including clinical directors at Lewisham Hospital, are queuing up to condemn the plans as ill-thought out and dangerous. The Lewisham Trust Board also came out against the proposals to close acute and maternity hospital services.[26]

In failing to put patients first and to plan service change on the basis of an assessment of the reasonable needs of the local population for health services, the TSA has elected to override these concerns and to disregard public health data.

At SLHT the unsustainable provider regime and Trust Special Administrator intervention is the first of its kind. The process involves reduced levels of consultation compared with routine service change and facilitates accelerated closure of NHS facilities. The Secretary of State should establish new and better procedures based on public health planning and the recommendations of the Francis Report.

PFI is playing a major role in service closure. In the case of Lewisham Hospital there is no doubt that the government is sacrificing a much needed and thriving local NHS hospital in order to protect the interests of bankers, shareholders and corporate stakeholders. In the case of SLHT, the victim is being blamed for the consequences of government policies to promote PFI, deflate the national tariff,

[24] The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary. Stationery Office, 2013:42.
[25] Ibid.
[26] Lewisham Healthcare NHS Trust Board. Response to the draft report of the office of the Trust Special Administrator for South London Healthcare NHS Trust: "securing sustainable NHS services". December 12, 2012

and require efficiency savings, all of which involve misallocation of funds originally ear-marked for NHS services in the area.

The real victims here are the people of South East London and those who work in and use the health services there. If this decision goes ahead, the public health consequences may be catastrophic.

We recommend that:

(1) application of the TSA regime to the SLHT should be revoked and the case reconsidered afresh, having excluded the effect of government policies on the financial performance of the Trust;

(2) the TSA regime should not in the future be applied to Trusts whose financial under-performance results from government policies;

(3) Department of Health statutory guidance with respect to the TSA regime should be amended so as to require that (a) proper and reasonable public health needs assessment provides the basis for future recommendations in South East London and elsewhere, (b) all data and methods are in the public domain, and (c) the TSA conforms to service planning standards which:

- do not use productivity measures and targets as a substitute for planning and access
- do not use travel times as a proxy measure of the public's use and need for services
- do not use MORI opinion polls as a substitute for public health planning
- do not use non-standard data, methods and definitions;

(4) the Department of Health and the Treasury should investigate the financial terms of PFI contracts, to make these terms available for public scrutiny and where necessary to renegotiate contracts; in default of which Parliament should act to require them to do so;

(5) the National Audit Office, the Care Quality Commission, and the House of Commons Health Committee should as a matter of urgency consider investigating the cost and quality of external consultants' reports to the TSA.