5 Lessons for the NHS in England

The King's Fund 2011

There are six key lessons that the rest of the NHS can learn from the South East London sector's experience with hospital reconfiguration.

First, reconfiguration of services across hospital sites is likely to be the only way that some trusts can achieve financial balance while avoiding an unacceptable deterioration in the quality of care, given the cold financial climate, which is here for at least the next five years. All NHS hospital trusts in England will be subject to intense pressures to reduce costs by at least 15–20 per cent. Commissioners must restrain the unprecedented growth in hospital admissions because there will not be sufficient funds to pay for activity if it continues to grow at current rates. There can be no more 'trading out of deficits' or 'topping up' of trusts' non-tariff income.[45] Hospital trusts will be forced (after a decade with no productivity improvement) to achieve sustained productivity improvement at unprecedented rates.[46]

Other trusts in England will discover that rapid growth of productivity and slow growth of activity results in excess capacity and stranded costs, and that large cost savings can be achieved only if excess capacity is eliminated. They will also discover that large cost savings, without changes in the way that services are provided, will cause deterioration in the quality of care, and in some cases, make essential services unsafe.

There are particular risks facing the many NHS trusts that are entering the cold climate with weak finances and continuing to provide below average quality care. It is highly likely that, without reconfiguration, the existing quality gap between best and worst performers will widen further and, in some cases, a downward spiral of falling income, growing deficit and declining quality will cause hospitals to fail. More situations like those at Queen Mary's, Sidcup, and Mid Staffordshire NHS Foundation Trust, where standards of care were jeopardised by the drive to cut costs, cannot be ruled out.

The most obvious parallels with the situation in South East London are elsewhere in London, where the challenges facing non-foundation trust district general hospitals (DGHs) are very similar.[47] In those situations as well, reconfiguration across hospital sites will often be necessary to sustain quality of care and financial balance; and the greatest benefits for patients are likely to come from reconfiguration along patient pathways. Second, the large deficits and high legacy debts of some financially challenged trusts are caused, in part, by under-funding of fixed capital charges in Payment by Results (PbR)

45 Despite the efficiency factor in tariffs, average prices paid to hospital trusts have not fallen in real terms because extra payments have been made for non-tariff activities (Audit Commission 2010).
46 Over the past decade, there has actually been a *decline* in NHS productivity (Audit Commission 2010).
47 The picture in North East London is very similar to South East London. Queen's Hospital, part of the Barking, Havering and Redbridge University Hospitals NHS Trust, is a whole-hospital PFI site with serious financial and quality of care problems – the former caused in part by under-funding of its PFI-related capital charges, and the latter induced by the urgent need to address its financial problems. Also in North East London, Whipps Cross University Hospital NHS Trust, Newham University Hospital NHS Trust and Homerton University Hospital NHS Foundation Trust are being encouraged to reconfigure services across broadly similar DGHs, and potentially to merge, as a response to financial problems and issues around quality of care. *See* Whipps Cross University Hospital NHS Trust (2010).

tariffs.[48] Increased funding for trusts with higher than average capital charges, and reduced funding for those with lower than average capital charges, would reduce deficits in the former and surpluses in the latter – at no net cost to the NHS. Funding per patient to pay for staff and drug costs would be more equitable. Financial imbalances across hospital trusts would be reduced and therefore *the pressure for reconfiguration across hospital sites would reduce*.

There would also be less financial 'leakage' from the NHS. Currently, the aggregate unspent surpluses of foundation trusts (amounting to several billion pounds) are not available to finance the deficits of financially challenged trusts. Yet a part of the foundation trusts' aggregate surplus results from over-funding of capital charges, not efficiency gains. Rebalancing of funding for capital charges would reduce this leakage and, by reducing the chronic deficits of those trusts with high capital charges, enable more of them to acquire foundation trust status sooner.

Third, reconfiguration should focus on achieving the best patient outcomes and patient experience for all NHS patients, and on narrowing the quality gap between the best and worst performers. This is best achieved by designing reconfiguration to drive accelerated adoption of best practice models of care (as reflected in national service frameworks (NSFs) and other guidance) in as many services as possible. This requires a significant change in the way emergency and network services are currently provided, from a system where all hospital trusts provide a full range of broadly similar secondary services to one in which there is greater differentiation of roles along patient pathways.

Although mergers between DGHs providing broadly similar services can bring about worthwhile quality improvements and cost savings, they cannot bring about the major improvements in patient outcomes that accelerated adoption of best practice in network services will deliver. Reconfiguration along patient pathways can be acheived only with the involvement and commitment of specialist/tertiary providers as well as DGHs. The planned shift of non-admitting hospital services into non-hospital settings should be subject to rigorous review. Re-providing services in the same way in non-hospital settings is unlikely to improve quality or reduce costs. Since rapid productivity improvement is expected to create excess estate on hospital sites, it will often be both clinically more beneficial and cheaper to locate new or expanded services within hospital trust boundaries. However, there *is* an urgent need to develop new models of out-of-hospital care that aim to keep patients out of hospital for longer. Unless these models are developed and rolled out quickly, demand for hospital services will grow at an unaffordable rate and/or will be 'choked off' by arbitrarily denying patients referrals to appropriate care.

There are good evidence-based reasons why, in some services, larger units serving a wider catchment area produce better patient outcomes and are more cost-effective.[49] It follows, therefore, that there are good reasons why consolidation of those services onto fewer hospital sites can be expected to drive up quality and drive down costs. Examples cited in this report include A&E, maternity and neonatal services, hyper-acute stroke units and heart attack centres – but there are many others.

Fourth, competition and choice in contestable services may inadvertently cause deterioration in the quality of essential services provided by financially challenged trusts, and therefore widen the quality gap between the best and worst performers. Market forces alone will rarely drive trusts into voluntary agreement to reconfigure in ways that will improve quality and reduce costs. In most cases, the most likely outcome is that

48 According to data listed on the HM Treasury website, as at February 2010, more than 60 acute trusts had current signed PFI projects. Most of them will have higher than average capital charges as a percentage of MFF adjusted income.
49 See Harrison and NHS Evidence (forthcoming).

financially challenged trusts will suffer a downward spiral of continuing financial deficits, deterioration in the quality of care and a further widening of the quality gap.[50] The NHS will have no alternative but to continue to fund these deficits or allow the trusts to fail. Few, if any of them, will ever become foundation trusts. This conclusion is important in view of the considerable emphasis placed by the coalition government on 'making the market work'.

Fifth, strong commissioning of emergency and network services across a large catchment area is necessary to bring about major improvements in patient outcomes, for all patients. Individual primary care trusts (PCTs) in London are too small to drive major service change and have limited ability to do so. In South East London this was the case even when they joined forces to form larger joint commissioning groups. Moreover, PCTs need the support of the strategic health authority (SHA) to drive successful implementation of major service change and, to achieve this, the SHA will usually need to bring about organisational change. The coalition government's decision to transfer commissioning responsibility from PCTs to smaller GP consortia will further weaken commissioning levers to effect service improvement across trust boundaries in emergency and network services. GP consortia will have even less expertise and commissioning experience than PCTs; information asymmetries will be even more pronounced; and understanding of how to shape the 'quasi-market' will be even less developed. Since GP consortia will be much smaller than PCT joint commissioning groups, and SHAs are to be scrapped, it is unlikely that GP consortia will be successful in driving major service improvement in emergency and network services.

Recent successes in stroke and trauma services highlight the potential of strong commissioning to markedly improve patient outcomes in ways that are cost-effective, especially in emergency and network services. This raises the important question of whether strategic planning of non-elective and emergency services to deliver best practice care for all patients is to take place in future. If so, who will be responsible for making it happen? Since, for the reasons given above, GP consortia are unlikely to be able to fulfil this role, the new NHS Commissioning Board will need to be given the statutory powers and the capability to perform it effectively; and its powers will need to extend to all hospital providers, not just financially challenged trusts. If the NHS Commissioning Board is not given appropriate powers, then the system will gravitate closer to a pure 'market forces' model – with the adverse consequences noted above.

Sixth, the best available means of bringing about reconfiguration along patient pathways will often be to support acquisitions of financially challenged trusts by high-performing foundation trusts. Those foundation trusts which have existing networks of care and high performance ratings will often be best placed to drive accelerated adoption of best practice models of care, bringing much better patient outcomes for all patients served by the enlarged trust. Acquisitions of 'failing' trusts, by foundation trusts or anyone else, are the logical outcome of competition and choice in health care services. They are also the most practicable means by which the NHS Commissioning Board can use strong commissioning powers to effect desirable service reconfiguration locally. Concerns about adverse impacts on quality of contestable services arising from reduced competition if acquisitions do go ahead should be weighed against the deterioration in quality and loss of opportunities to improve quality if they do not.

However, acquisitions of financially challenged trusts (by foundation trusts or anyone else) will remain a purely theoretical option unless the Department of Health/NHS provides transitional funding to pay for the large, one-off restructuring costs and agrees

50 The existing large variations in quality of care are highlighted in 'The NHS Atlas of Variation in Healthcare' (QIPP Right Care 2010).

to refinance legacy debt (in ways compatible with competition law). The net cost of doing so is likely to be much less than the cost of continuing to fund the deficits of financially challenged trusts so that they can continue providing sub-standard care until they fail, and then picking up the pieces.

The government has some tough decisions to make. It can decide to leave the problem to be sorted out by the market, with predictable adverse consequences for patients (especially those served by financially challenged trusts) and the taxpayer; or it can give the NHS Commissioning Board strong levers to commission strategically, across a whole sector, those services that cannot sensibly be commissioned locally. A further option is to support and facilitate high-performing foundation trusts to acquire financially challenged trusts as a means of bringing about desirable service reconfiguration that drives up quality and drives down costs. Given the scale of the challenge presented by the cold financial climate, these decisions have to be made soon.