

Patient and Public Involvement Forum
East Birmingham

Good Hope Hospital & the Health Care Market



European Services Strategy Unit

(Continuing the work of the **Centre for Public Services**)

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Contents

Introduction	4
1. The Marketisation of the NHS	6
2. Options appraisal and planned savings	9
3. Potential impact of cuts and reconfiguration	11
4. Recommendations	15
References	

Introduction

This report was commissioned by the Patient and Public Involvement Forum, Eastern Birmingham, to feed into a public debate on the Service Changes to Good Hope Hospital in March 2006.

The purpose of this report is to provide a critical commentary on the main proposals in, and potential consequences of, the Foundation Development Plan. In addition, to provide an overview of the government's marketisation strategy for the NHS which will impose new financial and operational difficulties, risks and costs for the Good Hope Hospital (GHH).

Context

Good Hope Hospital is not alone in facing a financial deficit – the NHS is forecast to have a £800m deficit (based on January figures) with about 20 hospitals facing severe financial problems. The scale and cause of the financial problems varies between trusts.

Good Hope signed a three-year franchise agreement with Tribal Secta in August 2003, the NHS's first franchise management partner. Tribal "pledged to work with staff to ensure Good Hope Hospital NHS Trust is a top-performing, three-star NHS trust by the end of its initial three-year franchise agreement" (Tribal press release, August 2003). They planned that "Good Hope should become the flagship for building a true private/public sector partnership approach to improving performance within the NHS.....Throughout our franchise, our priority is to transfer our skills and expertise to both the people and the organisation. Ideally we want to reach a position where franchise support will no longer be required, and it can be 'handed back' to the trust's management team in a stronger, more successful position" (ibid).

The contract was terminated early in December 2005. The PricewaterhouseCoopers financial review states that a review of the franchise agreement with Tribal has been undertaken by external audit. Although unseen by PwC, it is "highly critical" of the arrangement. Given the disparity between the 2003 aims of the agreement and the reality of GHH's position in 2006 there would appear to have been systemic failure.

Interim management agreement

The Good Hope NHS Trust signed an agreement with the Heart of England NHS Foundation Trust (HEFT) to provide interim management support from 1 November 2005. Dr Mark Goldman, the chief executive of HEFT, also became the chief executive of the Good Hope Hospital. The Birmingham and Black Country Strategic Health Authority supported the agreement. HEFT will also provide senior staff to assist Good Hope in obtaining Foundation Trust status by 2008. Good Hope remains an independent NHS Trust.

Foundation Development Plan

Good Hope launched a Foundation Development Plan in late February 2006, prepared jointly with HEFT, which assessed the financial situation and examined two options:

Option 1: Good Hope stands alone with a full Accident and Emergency service.

Option 2: Good Hope merges with HEFT, retaining a full Accident and Emergency service at Good Hope.

The financial assessment included a Financial Review by PricewaterhouseCoopers. The worst-case scenario predicts a financial gap of about £47.5m. The 2005/06 financial deficit is forecast to be £7.1m but could rise to £13.8m. The deficit for 2006/07 is estimated to be £21.8m based on no savings achieved. In addition there is a historical deficit of £12.1m. Good Hope has a statutory duty to recover its cumulative deficit over a five-year period which ends on 31 March 2007.

1. The Marketisation of the NHS

Choice, competition, commissioning, contestability and outsourcing are being mainstreamed in the NHS and health and social care economy. These policies are being implemented in the NHS in several ways:

Patient choice – By 2008 all patients will have a choice of at least four providers of healthcare services and will be able to choose and book.

Payment by Results - Payment for hospital treatment has switched from local negotiated block contracts to a national tariff of over 1,000 procedures, each with a Health Resource Group code. Hospitals are paid only for operations and procedures performed. It forces hospitals to operate like businesses. If they perform an operation at less than the national tariff they retain the difference, but if their costs are higher than the tariff the hospital they will be forced to cut costs, do more operations to generate additional income, or terminate the service. The system is designed to make money follow patients and to spur competition between hospitals. A Market Forces Factor, consisting of staff, buildings and land indices, is used to adjust the national tariff to give the local price for each Trust.

Commissioning - The fitness for purpose review of Primary Care Trusts launched in summer 2005 is targeted to deliver £250m savings via a 15% cut in management costs, reducing the number of Trusts from 303 to less than a hundred. PCTs were originally required to become commissioning-only bodies by December 2008, with up to 250,000 staff facing transfer to a new employer as services are transferred to other providers when the government 'opens up the primary care market' (Department of Health, 2005). However, the government was forced to retract this requirement and timetable but clearly this remains an objective.

Practice-Based Commissioning: GP practices have the right to hold an indicative budget from the Primary Care Trust so that they can directly commission services. A move from a historical to a weighted capitation based budget is agreed locally.

Outsourcing - An NHS survey revealed £2.3bn of services procurement with £795m outsourced (NHS PASA, 2003). NHS commissioning organisations have been informed that a minimum of 15% of activity should be outsourced by 2008.

Outsourcing elective surgery to the private and voluntary sectors:: The NHS Treatment Centre programme was divided into NHS and privately-run centres. The Department of Health commissioned 530,000 operations from 34 private sector-run Treatment Centres plus two supplementary contracts for 9,000 orthopaedic patients. The government has guaranteed patient volumes and the private sector's start-up costs are recognised in the pricing structure. If patients chose not to use the private treatment centres resulting in under-utilised resources, the private sector still gets paid under the guaranteed volume agreement. Other elements of health service outsourcing include:

- The management of some NHS-run Treatment Centres may be outsourced in the £3bn second wave contracts for a further two million operations announced in May 2005.

- Outsourcing of NHS Walk-in Commuter Centres and GP surgeries - two GP practices in Derbyshire have been outsourced to UnitedHealth (USA) and the company announced plans to establish 'super-surgeries' across the UK over the next five years.

Foundation Hospitals - The increasing commercialisation of Foundation Hospitals is clearly evident in Foundation Trust Network (FTN) documents, the alliance of Foundation Hospitals. The Network wants greater autonomy from government targets, a 'hands off' approach by the regulator (Monitor), removal of the cap on the number of private patients they can treat, to provide primary care services, and to be allowed to "develop a reach beyond health". Patients' needs can be met by adopting "the Debenham model of providing branded boutiques" (sic) (Foundation Trust Network, 2005).

Private Finance Initiative and NHS Local Improvement Finance Trust (LIFT) - The Department of Health has used the private finance initiative almost exclusively for NHS investment. 80 Prioritised Capital Schemes have been approved since May 1997 with a capital value of £17.2 billion plus 47 Non-Prioritised Schemes over £10m with a capital value of £1.2 billion. In contrast, just six publicly funded Prioritised schemes have been approved with a capital value of £500m plus another six non-prioritised schemes with a capital value of £117m (Department of Health, 14 December, 2005). Massive cost increases have plagued private finance initiative projects in the NHS. The capital costs of twenty-two schemes increased an average 117% between the original capital cost at the Outline Business Case and the latest capital value in 2005.

NHS Local Improvement Finance Trust (LIFT): LIFT is a £1bn programme to renew the primary care and social services infrastructure such as GP surgeries, health centres and one-stop-centres. It has a different structure from 'normal' private finance initiative schemes. The Department of Health and Partnerships UK (51% owned by the private sector) established a national joint venture company, Partnership for Health, which facilitates local joint ventures (LIFTCo's), in which the private finance initiative contractor has a 60% stake with Partnerships for Health and local stakeholders (usually Primary Care Trusts) each having a 20% stake. LIFTCo builds and refurbishes premises which it leases to primary care trusts, general practitioners, dentists, pharmacists and social care/voluntary organisations. Clinical services may be included in future LIFT projects.

Community care commissioning and TUPE avoidance: Many local authorities systematically reduced in-house provision of social care by using 'spot contracts', in other words using 'commissioning officers' to drip feed individual care packages to the private and voluntary sector rather than using 'block contracts' as staff left or retired. This avoided a TUPE transfer of staff since individual care packages do not legally constitute an 'economic entity'. Since no staff were transferred, there was no obligation on private and voluntary sector providers to maintain local authority terms and conditions.

Of course there is a cost to this type of 'modernisation' at least £670m on one-off costs to date plus £425m additional annual costs for health service modernisation alone, excluding the significant extra costs of PFI projects.

This process is also being mainstreamed in other public services in a five-stage marketisation process

- Commercialising services – services are changed so that they can be specified and packaged in a contract, thus extending outsourcing and offshoring.
- Commercialising labour – the reorganisation of work and jobs to maximise productivity and assist transfer to another employer.
- Restructuring the NHS for competition and market mechanisms – hospitals and other facilities are compelled to compete against each other, funding is changed to follow patients, public bodies are reduced to commissioning functions creating opportunities for private finance and partnerships.
- Restructuring democratic accountability and user involvement – service users are treated as consumers; services and functions are transferred to quangos; arms length companies and trusts and privately controlled companies are established within public bodies.
- Embedding business interests and promoting liberalisation internationally – business is more involved in the public policy making process and promotes national, European and global liberalisation of public services.

The marketisation of public services will have profound consequences for patients, the public, staff, the NHS and primary care (see www.centre.public.org.uk/outsourcinglibrary and New Labours Attack on Public Services, Dexter Whitfield, Spokesman Books, Nottingham, 2006).

This is the context in which the Good Hope Hospital will be operating.

2. Options appraisal and planned savings

Options appraisal

The Foundation Development Plan used a set of criteria by which to assess the two options for GHH. The criteria were scored and weighted (in brackets)

- Better access to services (15%)
- Improved clinical quality of services (15%)
- Improved environmental quality of services (5%)
- Developing existing services and/or providing new services (15%)
- Improved strategic fit of services, including regeneration (10%)
- Meeting national, regional and local policy imperatives (15%)
- Meeting training, teaching and research needs (10%)
- Making more effective use of resources (10%)
- Ease of delivery (5%)

Apart from the scores for the two options no further details were provided. The scoring and weighting of criteria is often subjective and open to criticism. The criteria served a particular purpose in assessing two limited and essentially financial options. However, some comments on the scope of the criteria are needed because they will reinforce other comments made in this report.

Firstly, there are significant differences and conflicts between the national, regional and local policy imperatives with local priorities often being overridden by centralised decision making. Embracing them in one criteria obscures these conflicts and contradictions.

Secondly, no equalities component is apparent either in contributing to reducing health inequalities, service provision or employment. There is no indication that the costs and benefits and potential adverse impact on equality groups have been fully investigated.

Thirdly, there are no criteria which takes account of the impact on employment, both on GHH staff and any knock-on effects for those employed in the subregional health and social care economy.

Finally, some three-quarters of the savings were common to both options making the 'ease of delivery' criteria less relevant.

Planned savings

Table 1 summarises the proposed costs savings and reductions in the Foundation Development Plan. They are divided into four groups – savings of £5.9m, cost reductions totalling £9.75m, productivity and utilisation reductions (for example bed reductions) of £3.9m and further clinical reconfiguration reduction of £1.5bn giving a total of £21.0m.

Table 1: Planned savings at GHH

Cost savings and reductions	£000
Savings	
Cark parking	480
Staff catering	50
Charging for disabled car parking	80
Staff residences	100
Outcome of arbitration over income with BBC Strategic Health Authority	5,200
Sub Total	5,910
Cost reductions	
Management Cost Savings	1,700
Shared Services	2,125
Estate rationalisation (Education Centre and Sheldon Unit)	600
Staffing review (80 posts)	1,600
Budgetary management (1% saving for 3 clinical groups, management of cost pressures, drugs procurement)	3,725
Total cost reductions	9,750
Productivity and utilisation	
Bed reduction and review (close 1 st ward and 2 nd ward and transfer elderly rehabilitation care to PCT)	2,125
Theatres (vacate Vanguard mobile and move to 7 funded theatres)	1,500
Review of unprofitable services	0
Review of medical staffing	250
Total Productivity and utilisation	3,900
Further clinical reconfiguration	1,500
Total	21,060

Source: Foundation Development Plan, Good Hope Hospital NHS Trust, 2006.

The savings in Table 1 do not include an assessment of the implementation costs, redundancy or demolition costs, the timing of savings and risk. The figures do not take account of the 2006/07 Payment by Results (PbR) guidance which the hospital's initial assessment shows a gain of £0.7, £2.3m and £4.0m respectively in the three year period beginning in 2006/07.

However, the Department of Health has since withdrawn the national PbR tariff because of 'underlying errors in the calculation'. This has left all NHS Trusts and PCTs unable to finalise business plans for 2006/07. It raises further questions about the 'security' of GHH's initial assessment on the potential gains from PbR over the next three years. Other factors not taken into account include future costs pressures and a deliverability assessment for 2006/07.

3. Potential impact of cuts and reconfiguration

Introduction

This part of the report considers the potential impact of the combination of the implementation of patient choice and payment by results, the reorganisation of PCTs and refocus on commissioning rather than provision, the proposals to transfer some acute services to primary care, coupled with the expansion of the private sector's role in delivering healthcare.

Healthcare market impact

An assessment of the Market Analysis (Section 3) in the Foundation Development Plan indicates that the strategy:

- **Understates the potential impact of market forces** on the financial and operational stability of the Good Hope Hospital.
- **Lacks an analysis of Good Hope's market position**, for example, what role it will have in the local/regional health care 'market' and how it addresses local priorities. It avoids a 'one-size-fits-all' being imposed on the Trust.
- **Understates the level and effect of increased outsourcing** of healthcare services and activity by national contracts with private and voluntary sector providers and as PCTs move to a commissioning only role. One PCT has already attempted to outsource the commissioning function. Although the procurement process was stopped when a health minister made adverse comments, it is likely to reappear at some stage.
- **Markets and competitive regimes encourage contractors to maximise their income** and are likely to be used by GHH's competitors, putting pressure on GHH to do likewise. '**Gaming**' techniques exploit loopholes in payment systems, ineffective monitoring and inspection, contract variations, and focus on high income activities. They include up-coding – recording additional unnecessary diagnoses and procedures, or selecting the most expensive diagnoses; discharge and readmission of patients to attract additional payments for a single spell; inappropriate admissions (for example, from accident and emergency); deliberately keeping patients in hospital for more than 48 hours to attract the full tariff; misclassifying patients into specialist healthcare resource groups that are funded through separate arrangements (Health Service Journal 13 October 2005).

Eighty per cent of PCTs and practice-based commissioners surveyed by the NHS Alliance consider that the PbR system encouraged gaming by providers to maximise income (Health Service Journal, 23 February 2006). 67% of respondents were commissioning under PbR of whom thirty per cent claimed to have specific evidence of gaming with a further 53% were suspicious but lacked evidence.

- **Understates the likely level of organisational turmoil** within the NHS, and public services generally, as a result of reorganisation and reconfiguration within the NHS. This is almost certain to result in more conflict between NHS organisations as they seek to protect their position and implement strategies.
- **Admits there is a lack of hard data and information.** The Foundation Development Plan reports that “the information GHH has its market share and its existing and new customers (patients) is very limited. There are no formal business development or management functions which has resulted in limited business and commercial focus on attracting and developing new opportunities or defending GHH market share.” (para 3.4)
- **Diversion of resources into managing the market rather than patient care:** The PricewaterhouseCoopers report summarises a series of financial crises and shortcomings at GHH in recent years. However, the achievement of the Foundation Development Plan will not be the end of the matter in terms of additional demands on GHH’s financial capacity (including capability). PricewaterhouseCoopers financial review commented on the ‘leanness’ of the finance department.

The health care market make demands on NHS Trusts and Foundation Hospitals to develop new skills and capabilities in order to compete in the commissioning process and to maximise income/minimise costs through PbR. It requires each market participant to have up to date intelligence and reliable information both externally and internally. But given GHH’s financial situation, building up the hospital’s financial capacity to compete in the market can only be at the expense of resources for patient care.

- **Patient power – patients have a critical role** – they can use Patient Choice to select (or not) to use the Good Hope Hospital for their healthcare needs. A health warning needs to be added about various polls which purport to show ‘that patients will favour independent sector providers and are prepared to travel’. As with all market research opinion polls generally, much depends on how much the respondents understand the context, the options and the how the questions are structured.

Impact assessment

The relocation of specialties from one hospital to another or to community provision often has knock-on effects for patients, staff and services which should be identified at the planning stage. GHH should adopt an impact assessment methodology to assist in developing and assessing strategies. Patients, particularly the elderly, and staff may face increased travel costs and time.

Commissioning

Part of the financial crisis is caused by the funding gap between the actual number of operations and services provided by GHH and the actual level of operations and services commissioned and paid for by the PCTs. PricewaterhouseCoopers regard this as ‘contract overperformance’ and identifies a £4.2m gap. The PCTs are disputing GHH invoices for this work.

The commissioning process also needs to take account of real world provision of services. There is a danger that assumptions may be made about the provision of

community-based services when in fact they are still at the planning stage. There could be a significant time gap between approval and actual provision.

Patient and user charges

The marketisation of health care is almost certain to result in hospitals using the 'freedom and flexibility' of Foundation Trust status or 'market conditions' to increase charges to patients through a variety of means such as 'added value' enhancements. The proposal to charge people with disabilities to park at the Good Hope Hospital is an early indication of the approach to maximising income directly from patients and will naturally be strongly opposed by patient and community organizations and the trade unions.

Health and social care economy perspective

There has not been sufficient time and resources in the preparation of this report to investigate the extent to which health and social care organisations plan and maximise production and supply chains in the regional health and social economy. Some regions, for example, London, North West, East of England and Yorkshire and Humberside have analysed and developed strategies to maximise local and regional supply chains at a time when procurement efficiencies are driving national and international sourcing of supplies. This should be addressed in further stages of the Foundation Development Plan.

Employment

In June 2005 the GHH employed 2,843 full and part time staff (or 2,270 Full Time Equivalents, FTE) - see Table 2. As part of the financial strategy, GHH sought to reduce staffing levels to the 2004/05 average of 2,446 FTE. A vacancy freeze also commenced in 2005. The financial strategy required a reduction of 80 full time equivalents or 100 jobs. By 31 December 2005 GHH staffing level had been reduced to 2,471 FTE, a shortfall of 25 FTE or 31 jobs. A further disestablishment of posts, redundancies and redeployment with continuing controls over bank and agency expenditure were planned.

Table 2: GHH staffing level

Staff Group	Number of jobs	Whole time Equivalents
Ancillary	266	177.5
Estates	19	18.3
Admin & Clerical	548	429.8
Trust managers	104	101.3
Medical and Dental	249	224.2
Nursing and Midwifery	1,223	974.5
Allied health professionals	156	129.6
Scientific & professional	24	18.2
Technical	254	196.8
Totals	2,843	2,270.4

Source: Good Hope Hospital NHS Trust: Annual Report 2004/05.

General managers were responsible for identifying job cuts but had a set of principles including having a minimum impact on service delivery and patient

care, did not adversely affect targets, planned savings were delivered, costs were minimized and staff treated fairly.

However, the Foundation Development Plan does not indicate in which services and functions the staff reductions were made or are planned to meet the staff reduction target. It is essential that this information and any further changes to staffing levels is publicly available so that trade unions, patients and community organisations can assess the degree to which the distribution of job losses is equitable and assess the impact on services.

GHH as a business

The government's modernisation agenda in general, and the Department of Health's reforms specifically, require hospital to become stand alone businesses increasing adopting commercial operating values. The Foundation Trust model further consolidates this approach.

Consultation with patients, staff and public

It will be essential for the Trust to fully consult and involve patients and staff on all changes to services and reconfiguration of the hospital, including new developments. Given the scope of the financial crisis and the level of cuts and savings required to reduce the deficit, the hospital can ill-afford to alienate the very people it will be increasing relying upon to *choose* the Good Hope for healthcare.

Governance

The Foundation Development Plan addresses the issues of management accountability but does not make any reference to enhancing democratic accountability in the interim management arrangement with HEFT.

4. Recommendations

- Further examine GHH's ability and capacity to deal with the information and intelligence needed for the choice, contestability, commissioning, competition and other market mechanisms in the health care market.
- The GHH should adopt an impact assessment methodology for examining the full effects of further cost reductions and policy changes.
- GHH must make a commitment to full consultation and involvement of patients organisations, staff and trade unions in the reconfiguration of services and further development stages of the Foundation Development Plan.
- The GHH should avoid imposing new or substantially increased charges on patients.
- The GHH should make full information available on where job reductions have taken place or are planned together with a gender, ethnicity, grade, part-time/full-time breakdown.
- The GHH should consider its role in the regional health and social care economy in the way it implements savings and cost reductions in order to minimise adverse impacts.
- PPIF should publish information to patients which describes how the health care market will operate and the consequences and knock-on effects of decisions made by patients and their advisers.

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