The People's Inquiry: One Year On

Evidence presented by Dr Tony O'Sullivan (TS) Paediatrician, Lewisham & Greenwich NHS Trust

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Queen Elizabeth II Conference Centre, Broad Sanctuary, London SW1P 3EE, Shelley Room

Present:

Roy Lilley (Chair; RL); Dr Louisa Irvine (LI); Naledi Kline (NK); Dr John Lister (JL); Professor Sue Richards (SR); Polly Toynbee (PT), Frank Wood (FW).

(Also Roger Steer (RS).)

RL:
Our purpose this morning is in the context of what we wrote a year ago on our recommendations is to have your reflections on where we are and your experiences and your comments and your advice.

TS:
I will be guided by you about what you find interesting but I have four areas I was going to suggest we could discuss. One was a reprise of South-East London post the TSA court case. The other was comments of my own experiences about commissioning and tendering. The third comments on the local impact of PFI. The fourth was comments about community based care which is the flagship policy that is said to be the way out of jail and to replace hospitals with another form of care. So those are my four headings. I don't know if you have any other questions that you wanted to ask me.

RL:
I think we'd be very interested to have your comments on those four headings which is a very comprehensive overview and then perhaps we can have a discussion.

TS:
The first point I'd like to make is that in the process of the TSA regime the main thesis was that Lewisham Hospital would close which would be about 150 beds out of the system. That fell by the wayside, that's been done so we won't go through that, and then Lewisham Healthcare trust took over Queen Elizabeth Hospital which was one of the three component parts of the South London Healthcare Trust.

Now, when Queen Mary Sidcup was closed there was a risk analysis of the impact and there was a proposal that there would be about 80 beds needed in the system, for example at Queen Elizabeth Woolwich, to take up the impact of patient diversion from Sidcup. But no extra beds were provided because that was regarded as a sine qua non – there would be no more beds, in fact they would be reduced.

My point here is that in February of this year, 2014, within less than 5 months of our taking over Woolwich we had a CQC inspection. So on the one hand the trust was very concerned that we were going to be inspected so soon, given the traumatic disruption of Lewisham services and low morale at Queen Elizabeth at a merger. But in fact we then welcomed it, because we thought we felt we'd rather air all the problems immediately.

One of the major CQC findings was that the Queen Elizabeth emergency department's acute pathway was not fit for purpose: and the subsidiary finding was that the QE had far too few beds. I

think they quoted 75 or 80 beds were needed in order to unjam the log jam of patients pouring into the A&E not being able to be admitted to wards backing up into the ambulances in the car park and then fines being imposed for those.

So, far from the proposal that 450 beds could be lost from the local South East London health economy, the CQC said that as of that moment the local health economy didn't have enough beds. So our trust got a phone call from Jeremy Hunt in July, and it turns out so did seven or eight of the trusts that were likely to suffer from the winter pressure problems – and therefore that would be rally high publicity in the run-up to the general election in May.

So our chief executive received a phone call from Jeremy Hunt in person, and I think it went something like this:

"We realise you've taken on another hospital and the lots of work you've had to do, thank you very much, but sort out the winter pressure problem by the end of October."

Actually, although it was a huge amount of disruption, the trust has created two wards of 50 beds and is trying to get 25 beds of key inter-base care opened in Greenwich and we've already found 50 in the next few weeks.

I find that just ironic really, that there is an absolutely enormous amount of time and money wasted. The main Trust Special Administrator plan for South London Healthcare Trust was going to take 20 years to pay back. The investment to close Lewisham Hospital was going to cost £200 million, and our estimation is it would take 20 years to just break even on that and actually the whole thesis was wrong.

I am only saying that because I think it's really important that re-configuration is thoughtful, is evolutionary, and is based on reality. Whereas the whole thesis was we need to save money, we will close the hospital and we will invent a reason to justify that – which is 'community based care'. Perhaps we will come back to that later.

At the moment both A&Es have at one time or another been on diverts because they can't cope with demand. Queen Elizabeth Hospital and Lewisham Hospital have been on diverts at one time or another in the last few days. Just two evening ago I was in Children's A&E and they were talking about that day, when they had had ambulances backed up in Lewisham, and delay of patients transferring from the ambulance into the A&E. For that short period, the hospital is going to be fined £10,000 for 10 breaches of ambulance transfers. So that isn't an answer to your problem.

PT:
Were you given extra money to set up these new 50-beds?

TS:
The Trust Decelopment Authority did support that to some degree but I don't know the details. There's winter pressure funds which is mainly for the ongoing recruitment of staff, agency staff and so on, but the actual capital expenditure, there is some money for that but that's not my point. My point is that it was absolutely vital for patient safety to create beds, at a time when we've lost hundreds.

RL:
The key issue it seems to me is the contradiction between the planning which was carried out 'before' and the CQC's conclusion after. So that's the real contradiction.

TS:
We had to re-design the A&E physically, we've created a clinical decision unit for medical and surgical assessment, an assessment unit for surgical cases, in order to try and get as many people, adults, out of hospital and not admitted. So we've redesigned the whole pathway and that could have better been done at another time of course.

LI:
The risk assessment before the Queen Mary's was due to close said that another 80 beds would have to be created somewhere, before Queen Mary's closed, and that actually never happened.

TS:
The point about commissioning and tendering is really a personal story if it's not too parochial. I just find it dispiriting, the amount of time involved.

I'm a paediatrician. I'm also Director of Children's Services for another few weeks and the amount of time I spend in meetings where the main topic of conversation is money is just extraordinary. We discuss our financial budgets, going round and round in circles. We discuss our cost improvement programme. We have to produce a cost improvement programme to present it the Trust Development Authority or else we will be in breach. They are a lot of the time fanciful. Children which is the smallest clinical division and we can't take pro rata cuts, and neither can the hospital.

The trust budget is about £420 million a year, perhaps a little bit less. The 'must do' from the trust development authority is that we save £112 million from that over the next 5 years. That's 25% approximately. So the budgets that we are supposed to make are to represent savings in one form or another of between 4.5 and 6% year on year, and they are cumulative.

In that context, commissioning and tendering is actually the fastest growing body of employees. I don't mean in absolute numbers. We obviously try to recruit nurses for safe staffing levels, but 4 years ago we had a Director of Business and Strategy and we had somebody working for her who was relatively good at contracts in the early days of contracting where the local authority and the PCT might say 'please can you redesign community phlebotomy' or something, and they would be going back to the NHS which was saying redesign your service.

In that sense I think if you can call that commissioning that's OK, that's a sensible conversation between the people that hold the budget and the responsibility for the good of the community, informed by public health and the providers that are providing the services. I don't see anything wrong with that negotiation. But increasingly, rapidly over the last 2 years, and in particular since the Health and Social Care Act came into force, more and more service contracts are being put out to tender and I am spending weekly now hours and hours of time.

Children's Services have been put out to tender by Bexley Commissioners [CCG], who are extraordinary. If there's a range of machismo and ignorance they would be at the extreme end of ignorance of commissioning but high on machismo. So they've under-invested in children's services for quite some time, but their starting point in tendering children's services was that they would expect any person applying for this to cut 20% from the budget and over the next 5 years to absorb 4%-ish flat-rate NHS inflation costs. In my mind that was about a 40% cut that we were expected to put in a tender for, and the other twist on that is that they are expecting the cut to be differentially at the hospital end, rather than the community.

So when it comes to children it's just not possible to put a package together that is safe or good for children. That includes everything from safeguarding, to children's centres, to disability, to child protection, to the acute reception in the A&E. It covered all of that. On the other hand if we don't bid, are we laying the NHS open to a private bid from someone who comes in gung-ho and says 'we can do this'?

PT:
Is there any private bid, do you know?

TS:
Private bidders are at the moment reluctant locally. The process hasn't finished yet. The other part of this is that Greenwich is also tendering children's services so that we have a small team of myself and our service manager and we're spending this time getting really dizzy working out how to put out professional bids to two tenders at once. In Greenwich I don't know if they've got any private interest. Some private companies have come a cropper on community based services.

PT:
Do you think it's right not to bid though, to stand up and say this is an outrageous proposal, we won't bid?

TS:
We've considered that in Bexley. There are different forms of contracting as well. They are using a private contractor model in Bexley so the prime contractor is Oxleas Community Foundation Trust. They do want to put in this bid because they are currently the holders of the community services and they want us to be an ally with them which means risk sharing if it goes pear shaped. Our trust is now being very cautious and we may back out. But that's to be seen.

RL:
I'm just conscious of the time. You're half way through your time and we've still got the local impact of PFI and the community based care.

TS:
Ok, well the point about the expansion of resources to deal with this is that the team of two has now got an additional Head of Strategy, a Business Manager for workforce, a Business Manager for tendering, a Business Manager for contracts, we've brought in training on tendering, a firm of excellent consultants, and in addition to that we've spent about £8 million on consultancies in the last 2 or 3 years. That is a lot of money. Whilst I am not criticising our trust, because we are trying to survive, I do think it's wrong.

PT:
What do you think the value, the cost, of that staffing is?

TS:
Well, I'm not very good at that. I would say salaries are at least £200,000 and may be £300,000, I don't know. I was just thinking that if you multiply that across the whole NHS that's a lot. The positive aspect is that at one point in our management team we complained about the bringing in of consultancies. We've had McKinsey, Deloitte, Price Waterhouse Cooper, 20-20, probably all of them. The clinicians find them exhausting because they take all your time and then they actually regurgitate Dr Foster stuff at you, and then you have to then disentangle it: then they walk away leaving you with a Powerpoint.

We argued that we shouldn't have that, we should have our own capacity. To some extent I welcome investing in our own staff rather than McKinsey. On the other hand, they are spending their time playing the game of tendering and arguing with commissioners about ridiculous timescales and so on. That's all I wanted to say on that. What we need is intelligent planning of the health service with skilled management, public health relative needs assessment and engagement of commissioners.

A shorter point on PFI locally. I was interested in the discussion before of course. Queen Elizabeth Hospital and Princess Royal University Hospital were two of eight hospitals that were deemed as having unrealistic PFI contracts by the Department of Health. So prior to the TSA it had already been agreed that Queen Elizabeth would receive a subsidy to try to level the playing field if that's the right expression.

So in 2013-14 a subsidy for the QE PFI was £12.2 million out of an interim payment of £29.2 million. By the end of 2029-30 the subsidy will have increased. The Department of Health said in an FOI return it would increase at the RPI rate of 2.5% and it would go up therefore to £22.1 million. The interim payments however would go up to £61.3 million.

I am not a mathematician or a finance person but I worked out that the PFI rate was exponentially increasing far faster than the RPI, so that at the end of this initial contract 2029-30 the gap over and above the subsidy will have grown to £18.8 million. Over the course of the period from 17 years to the 2029-30 the trust will have had to pay out £141.3 million over and above what it would have paid if the subsidy were linked to the escalating PFI. Sorry if that was dense!

(See Figure 1.)

[Figure 1]

RL:
And it is interesting because all PFIs are looked at by the Treasury. Community based care?

TS:
Just one other thing. A fact that I found shocking is that the lease to the QE Hospital was given to the PFI company for 125 years. So when you were talking about why can't you let a hospital that isn't working go to the wall and look for the long-term benefit of what would be a good health service for the local community, you would have that site owned privately by lease for a further 95 years after the end of the 30 year contract.

My last point was about community based care. All the clinicians I know would be very pleased for their patients or their mother or their son or whatever to be looked after in the community – if it were safe and good and if it were appropriate. However, the development of community based care is very rudimentary.

I know locally that the GPs are extremely worried about the standard of district nursing at the moment. From my own profession, the community children's nursing team are under-resourced and you've really got to invest for a safe pathway of care before you can start doing this and that's beginning to be a part of the process. Even [former NHS Chief Executive Sir] David Nicholson has said that – but only after he had left his job, not before.

[New Chief Executive of NHS England] Simon Stevens was implying the same thing, that if you are pursuing this vision of community based care you've got to invest in it before you start closing

hospitals. I still think that there's a real risk of looking to close a major hospital in South-East London and that would be because of the PFI issue. The target would be Lewisham again.

During the [Trust Special Administrator] TSA process and since I have been quite involved as a clinician going to meetings and trying to argue at the table about what is a good and clinically effective model of care. I have been involved in the South-East London commissioning strategy project, that's for six CCGs in South-East London. I have commissioned a project for a 5-year strategy which is a must-do for NHS England. Again, clinicians were rounded up to go to meetings just because of the TSA. This is more measured, it's over a longer period of time and I think they feel that they do have to get it right this time. But their starting point is 20% less money.

PT:
The 20% - that's for the community or the whole health economy?

TS:
For the health economy. When you come up with a row of suggestions in blue-sky thinking sessions you are asked 'which of these would deliver 20% more productivity, 20% savings, 20% less staff or what else?', you are asked to pin that down and that's not possible.

I am interested however in good and safe care and when we were at risk of losing Lewisham we went to Salford which is a major hospital with a very, very good reputation. For historical reasons it doesn't have a children's inpatient ward. The reason for that is that the local inpatient children's provision was in two small children's hospitals, Pendlebury and Booth Hall.

At a certain point in time in the Manchester reconfiguration, which actually took 10 years (and some people said it was much better done), those hospitals closed down. So therefore there was debate about whether to open up an inpatient ward at Salford, and they said no they wouldn't. What they did do however is, knowing that sick children would still turn up at Salford A&E which is a major A&E, they set up a 12-bedded short-stay unit adjacent to, and just through a door from the children's part of the A&E. They staffed it with consultants and a nurse consultant, emergency nurse practitioners. It was outside the training schemes because it was experimental.

They also invested in community nursing. The community nursing team is a very interesting model. They share their shifts, they do shifts in the short-stay unit and then help the discharge of children home and the same nurse may see them the next morning. So they do a late in short stay and an early in the community and to me that is quite an exciting model and they have lots of good ideas working with GPs.

However, it was expensive, and in the reconfiguration across the whole of Manchester they actually brought in 90 community children's nurses into that team across Manchester. Which is not so very far from South-East London in size, it's a little bit bigger. South-East London is about 1.65 million people, and that Manchester area is about 1.9-2 million.

So that's very interesting. It follows the model for me of the 1970s and closing mental health wards and having care in the community. That was more expensive. It was better, but it was more expensive than mental health institutional care. Ask questions of the people running the TSA regime (which was McKinsey) and asking people now running South-East London for their estimate of what community care costs – and they do not know. I'm afraid that is a huge gap and so I have offered to get the figures from Salford and we'll work out what community based care costs in Salford. But it's not cheap, and at the very least it should be something that's evolutionary and not threatening for the local stability of the service.

King's is a foundation trust in our patch, and for different reasons they (as a provider with the freedom of the foundation trust) wanted to unblock beds in order to bring in tertiary work. They employed a private company, Home Care, and a team of seven nurses. They were then able to start visiting children two, three, four times a day. Not very many from before but they could take ill children home from A&E or short stay or post surgery, take them home much quicker and nursing care in the home at a level that just isn't funded by the NHS but it could be.

LI:
So if they wanted to get hold of more tertiary work it was worth it for them to invest?

TS:
Yes. They say their investment in that nurse team which was partially subsidised but it paid for the extra work in the short term. It's a provider-led, inward-looking solution and it actually weakens the argument for NHS-provided care.

RL:
Time's up now but I just wanted to know if anyone's got any questions or comments.

PT:
Absolutely fascinating. Really valuable.

RL:
It's a wonderful insight into the chaos. It does bring it into sharp perspective for us. There was something I wanted to just raise with you, I'm not sure if you will have had the opportunity to read it but in the Dalton Report which is just out – it's an old-fashioned report that will probably be eclipsed by Simon Stevens 5-year forward view – but Dalton actually calls for a moratorium on the part of Monitor and the CQC for organisations that are in reconfiguration. So when you were giving your interesting anecdote about the CQC turning up it just made me think I wonder if the CQC should have a bigger role in re-configuration?

TS:
The extraordinary thing about the CQC was that they thought that we'd been merged from the moment the Health Secretary made the announcement. They thought we'd been merged for a year, and they initially wouldn't accept explanations about 'we know this problem and we've got a plan but we've only just made the plans up'. Quality of care is important and they should have a role in safe transition.

LI:
It's so frightening to think 450 beds could be cut from the health economy in South-East London. It's the thoughtlessness of those plans that we had to fight and it was £5 million that was spent on the whole TSA process; that's £5-6 million – a large amount of the plan was found to be unlawful. And what are they spending that money on if they don't spend it on people who do proper health-needs assessments and proper lawyers?

RL:
It's a year since we last spoke. Can you sum up perhaps in two or three sentences where you think we are a year later?

TS:

I think we're in a scary place. The vision of community based care is further undermined by more cuts in social services: more have yet to happen than have happened already. So the majority of the cuts are to come, and that is a key to a large part of it, certainly for care of the elderly – more so than for children.

So that vision of 'we don't need beds and we don't need hospitals' has to go. It just has to be laid to rest. I have enormous faith in NHS staff for thinking their way through the problem, but the market where the tariff doesn't pay well enough for a basic local district general hospital has to be revised.

PT:
Do you think that's finally got through? There's been a change in the culture in the last year, as ambulances have backed up everywhere people are saying we can't cut beds?

TS:
I think it's beginning to get through and I was surprised at the CQC when it came out with a recommendation and that was a relief. So that was why in the end we were pleased that the CQC had come along.

SR:
A very quick question. Could you Tony, not necessarily now but afterwards, put some sort of figure on the cost of the time being spent by clinicans on contracting and tendering?

NK:
What about the proposal of 7-day working, for GPs and community staff that are not working 24 hours (because I don't think the community children's nursing team does). What impact is that going to have on children's services?

TS:
Twenty-four hour, 7-day a week working escalates the pay bill enormously. In the Greenwich tender we were asked to consider 7-day working, but with no change in funding to take account of the fact that if you work on a Saturday instead of a Monday you're paid whatever, time and a half. So the provision could go down if you are doing 7-day working. I haven't seen any economic analysis of the costs of 7-day working so far.

RL:
Bruce Keogh has dropped this hasn't he?

TS:
Well the commissioners haven't dropped it.

RL:
There's an election coming, expect a bump! Thanks very much for your time.