The People's Inquiry: One Year On

Evidence presented by Trevor Shipman (TS) Financial Director Central and North West London Foundation Trust

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Present:

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

RL:
Trevor, welcome back. We know what you are going to do, you are going to take us through the finances. We're very anxious to hear what you are going to tell us this morning.

TS:
Finances, and I also want to touch on mental health and community services.

One of the observations I would make myself about finances at the moment, but actually this has been reinforced, is that over the last year the pressures being felt by providers are substantially greater than those being felt by commissioners.

For commissioning of services, and it's not just in my own trust, I was talking to colleagues, particularly those outside the acute sector where we have no tariff, the commissioners start with 'here is your last year's contract, here is the national deflator and we want to take 2% out as an efficiency on top of that, and we want take specific schemes in addition to that to take funds away'.

SR: What's the national deflator, sorry?

TS:
For the last 3 years in funding NHS services providers have had target savings to make, the first part of which were to cover their own inflation. So it would be to cover pay inflation, non-pay inflation. So if for example the target efficiency is 4%, 2.9% of that might be going to cover internal inflation. But 1.1% is what comes out of the contract at the beginning. So the commissioners are getting the same levels of activity (or more) – but for 98.9% of what they paid the previous year.

In our trust's case, last year we had a current savings target of 7.2%; 4% of that was the underlying efficiency. The balance of that is a "QIPP": Quality Improvement, Productivity and Prevention schemes which commissioners are required to deliver on top of that.

When I say the pressure is on providers, I am not saying it's exclusively on the providers, but it's far more on us than maybe the commissioners because the commissioners start contracting with 'this is how we're shifting costs across'. If I use two of our commissioners – West London CCG, which is the old Kensington & Chelsea PCT plus North Westminster – they are planning this year to make a surplus of approximately £26 million. It was £30 million but is now £26 million.

Central London CCG's last board papers talked about a surplus of £10 million. Not all CCGs are in surplus. Some CCGs such as Brent are looking to break even. Other CCGs are looking to break even though I actually query whether they will make it. But it certainly feels that it's more that way.

That's not to under-estimate that some funds are going from the CCGs to trusts, to support their current financial position. So in North-West London where there is a major workstream around *Shaping a Healthier Future*, funding has gone to trusts to support their underlying financial position as part of that plan. But it certainly feels that way.

This week, yesterday, I was at a meeting where we were told that London as a whole is in surplus. I know the scale of a lot of deficits, I don't know all of them. Unfortunately I don't have the time to be looking at all the board papers, but actually the deficits are significant. Our deficit at the moment stands just shy of £5 million.

PT: And that's new? You never used to be?

TS:
No, I've been on the trust now 10 years, and we've been saying we had 15 years of surplus. We've never had a deficit. I was talking to the Finance Director at South-London and Maudsley yesterday who was saying they were in a similar position. This is not about not making the savings. It's this additional QIPP requirement that is causing the lion's share of it.

LI: How all these trusts be in deficit if you say London as a whole is in a surplus position?

TS:
The commissioners are in surplus. The commissioners are under pressure from NHS England [NHSE] to keep surpluses, so that the whole sector is as close as possible to balance or in as surplus. The challenge for all of us is that we work in health economies, how do we ensure that health economy is financially viable? I believe that the work that is being done currently between NHSE, Monitor and the Trust Development Authority [TDA] is more focused on that than in the past. I believe that is essential.

Outside London, I've been doing work with Milton Keynes and Bedfordshire, which are two health economies that are very challenged both in terms of the commissioners and providers. It's very much been on the basis of what we need is economically and financially viable health economies, with the providers and commissioners viable. I don't think we're there yet, but we are going in the right direction. How we get over the next 18 months to 2 years will be the biggest challenge financially.

This coming year we have got lots of additional pressures. The commissioners are looking at additional pressures because of the transfer of money to local authorities in the Better Care Fund. I won't comment much on the Better Care Fund, only because I don't think anyone is really clear on how that will be effectively used.

RL: We can't find anybody that will give us any evidence!

TS:
I've sat in many meetings earlier in the year with local authorities, commissioners, and trusts, where we debated the Better Care Fund at its early stage. There was a lot of good engagement. Gradually, the meetings dwindled and the local authority representation disappeared. Not 100% but certainly less than at the beginning. Some of the challenges I think around better care fund is how that can be seen to be improving matters within the whole health and social care economy.

I was reflecting back when you were talking earlier about PFI. Some of these things are not new. So back in 1998 we had the first tranche of winter pressures money. The Royal Free and UCLH, I was at

UCLH in those days, agreed to put our money into Camden Council to allow them to provide twilight social care, because one of our problems was that our A&E on Friday nights got blocked up with people who we couldn't discharge because we didn't know that if they went home there was somebody who could knock on their door and say 'are you ok?'.

So we took that decision, and never mind the Better Care Fund (and a query at that stage how legal that was – we found a way of making it legal – it certainly wasn't on the radar). At the moment I think every jury is out on the Better Care Fund and that will be across the board. Some health communities will be very strong but I am not convinced that in most of the London health communities I know how strong that will be.

PT:
But you are providing community services, so why are you having to give money to local authorities when you yourself are doing community work?

TS:
No, the CCGs are giving the money. For local authorities, and Hillingdon is a case in point, most of the services that they looked to put together were community services. So a large part of district nursing.

RL:
The whole idea of the Better Care Fund is to get people home safer and keep them there for longer isn't it? But the worrying thing is that we've had in this session of evidence, when we ask 'what about the Better Care Fund?', people will say 'Well, what about it?'. It seems to have disappeared.

TS:
The concern, particularly from the commissioners, is will this be used in the way in which it is supposed to be used? I think it will be more by the time we've got to the end of the process, with a lot of to-ing and fro-ing to make sure more of it was going back into the health sector rather than all in social care.

RL: I am conscious of the time. Don't forget to talk to us about mental health.

TS:
Mental health in London. Across London in the last 12 months, we've seen huge pressures around mental health. The pressure from commissioners, and with the support of trusts over the last few years has been to reduce the number of in-patient beds for mental health patients. There were many patients, and still are many patients, sitting in mental health beds who shouldn't be there, whether that's in London trusts or whether that's been directly funded by commissioners away in Northamptonshire and in St Andrews (a private facility, which I would query as a charity) or in similar facilities.

What's happened is the number of beds available for acute mental health has reduced across London. It's reduced across the country, but in London we've seen huge pressures. Once we have closed beds we as a trust haven't completely closed the facilities. So we've had most of one ward occupied by other trusts' patients in these last 12 months in the way of enabling them to manage their throughput.

But there's been a lot of patients sitting in the private sector funded by the NHS, a lot more than there has been in the last few years. Part of the problem on the wards is not just the case of increased demand, but because the patients that were less acute now being better treated in the

community, so those that are left on the ward are sick. We are finding that the amount of stress on the staff on these wards is far greater than it was.

RL:
On the subject of shipping people out to the private sector, it was pretty much always the case that the private sector specialised in high-end schizophrenia, difficult and disturbing offender services, things like that. I was talking to Clare Gerarda recently, and she was telling me that there are trusts in London that are shipping people all over the place, but not necessarily in the ITU end.

TS:
No. Even those that have gone out. Part of the whole basis of mental health is not that you are going to have mental disease for the rest of your life. You can recover. The extent you will recover will vary, and we have a team working for the commissioners and local authorities going around the country and bringing patients out of some of these institutions, because they were put there and forgotten. Being forgotten, they have not necessarily had the right care, they've certainly not had treatment. We've even brought patients back out of those facilities straight into supported living in a house. They were sitting there at very high end, expensive units and they don't actually require that.

PT: And you'd been paying for that?

TS:
No, we've saved for the commissioners. Because we've got the expertise within the trust we've saved commissioners £22 million in the last 3 years by bringing people out of these facilities. Not to bring them out for the savings, but bringing them out to enable people to have treatment and get back into their own home or to be in some sort of supported accommodation.

RL:
Can you say, is it too early, or can you say something about the Home Secretary's announcement that juveniles won't be held in police cells any more?

TS:
We see less of that in our area than most parts of the country. What we have as a policy is we have specific policies on some of our adult wards. It's not best treatment but in an emergency we have a policy which enables a child to be held on an adult ward with additional staffing.

We've had more problems outside London with this than in London. For most of the boroughs we work in a good relationship with our local police as well which helps greatly, because they know what our level of tolerance is for dealing with this.

One of the big problems, and it's interesting how the private sector/charities can get on the band-wagon, is we've looked at creating our own in-patient facility, funded by the trust, to enable us to take up some of these cases: tier 4, the highest level of need of these adolescents.

The rate which NHS England pay for these places made it an uneconomic venture. Meanwhile St Andrews is currently building in Northampton the largest adolescent unit in Europe, with a school. I've just seen the groundwork's going down this week. Because they clearly can see that there is a way that they can fund the build and also survive on NHS funding.

PT: But why can they do it and you not? It's the same per capita isn't it?

TS: It's the same per capita. I think part of it may well be on whatever rates they are able to borrow the capital to do this development. It is a completely new build. They already provide this service in a much smaller unit elsewhere on the site.

JL:
Last year we heard from Martin Baggaley from South London & Maudsley [SLaM], and also from the union there which had taking up the question of the funding for forensic cases, adult forensic cases, from NHS England, which was below the actual costs in NHS services because SLaM gave them more therapy than the private sector services. They can appear to do it cheaper, but kept people in longer and they are more likely to go back again. Is that a similar thing?

TS:
It's a similar thing. I think one of the areas is that our staff asked me why are our overheads so high? Why can't we do these things? By overheads they think about pay, finance, all the back-office function. The highest overhead we carry is 14.3%, as it will be next year, pension costs. If you go to the private sector it is nowhere near that level of overhead on the pension costs – if they are providing a pension package for their staff beyond the barest minimum. I think that's one of the areas where certainly there's a higher cost.

One of the other areas is their basic pay rate for some of these places is significantly below the NHS's, and their expectation of staff. I think we have to query this slightly ourselves about what we expect our staff to do. I think we underestimate our staff and their abilities sometimes. We don't necessarily use unqualified staff, I don't mean untrained I mean unqualified staff, to their full extent – as the private sector do. Maybe training's purpose is for the job, but doesn't mean you have to be a qualified nurse to do that job.

For many unqualified staff it gives them a step up. We've been working for a number of years with Band 4 staff in psychology. They are quite often graduates who come in and have an interest in mental health and want to try it. The patients engage far better with those staff and find they've got more time and we get very positive feedback around what those staff do. They are not in place of a nurse but they enable us to run wards – sometimes quite challenging wards – in a more effective manner.

RL: We've side-tracked you. You're going through your list?

TS:
You mentioned earlier on about additional investment. I think you've got to be careful when you look at the additional investment that's coming down. Even if it's ring-fenced there's been a lot of talk about improved access to mental health. We – and we are not done with our investigation on this – have seen some of this extra investment going initially into consultancy. It doesn't mean it's not going to get through to the front-line services, but commissioners seem to be spending time and money on getting external consultants to tell them on how they should spend money.

One of the other issues which I mentioned last time but forgot to mention this time is around commissioning. I made a point about how I felt commissioning support units (CSUs) actually got between the CCGs and the trusts. In North-West London we've now had the CSU disappear. It's too early to say how successful that will be, but certainly talking to colleagues in the CCGs they also felt that was prompted by problems that we encountered last year, which was having the CSU in the way. I do wonder whether it would be worth going back on that and seeing how that does improve matters.

To some extent there was large criticism sometimes of CCGs. They were handed an agenda. They are in the early stages of development, even now, on how and what do they do with that agenda. I think they are going to be challenged in some cases to exist given the scale of their funding going forward, and I think we are going to see more combinations of CCGs. I don't know quite how well In London that will go down with the local authorities. I think they will still be a legal entity – Ealing CCG – but in North-West London we've got the two chief accountable officers within CCGs but how will that be mirrored across London?

RL: It will be the same as a PCTs!

TS: Supposedly the extent to which the GPs engage is far more. I question that. It does very hugely.

SR: We took evidence from the leader of Hammersmith & Fulham who talked about groupings of local authorities.

TS:
What's interesting in the inner group in North-West London is you've got tri-partite boroughs, you've got five CCGs. There isn't a map mirroring there. Sometimes it's quite challenging to have the debates as a provider because you're not actually quite certain of how many different organisations you need in the room if you're looking to provide services across a geography that has tri-partite plus two boroughs and five CCGs acting as one.

RL: We're drawing to a conclusion really. What's your feeling for finance across the piece, across London particularly? Are there enough services do you think to fight the pressures?

TS:
I think there probably will be this year, but I don't think next year will be the same. I think last year was worse than people expected, it was worse than our plans. I think this year we're going to see sums of money being thrown, we have already, into the system. There isn't the strategic infrastructure within London to plan on how that's used effectively.

RL:
It's coming back to haunt us from last year, in our report we said there was no strategic overview. And it's come out, it came out when we were talking to witnesses last week, the lack of a strategic interlocutor if not an organisation. We had quite an interesting conversation with the LMC representative, to the extent to which the LMCs might step in in some way or other.

TS:
It am just reflecting on the BMA's view on the financing of PFIs, which is that it wasn't necessarily their issue, clinical care was. I think just as I believe as a finance director that finance is extremely important, I think clinical care is extremely important. I don't think that either of them divide those two things out. Maybe the LMCs could provide something. My concern about the LMCs is we are looking at one professional group. Where do the Royal College of Nursing, where do the Society of Physiotherapists or other professional groups come into this?

RL: You end up inventing a committee that looks like a camel again! Do you have a view on PFI?

TS:
I do have a view on PFI. In principle. Before I was in this job I led with Peter Burroughs, who was director of development at UCLH, the UCLH PFI. I dealt with the finances around the PFI bid.

RL: Why is that successful and Barts isn't?

TS:
I think the answer was given too you earlier. Not in the way that they thought they gave it. Barts is a huge PFI. Barts is a huge building. If you go to failed PFIs, if you go to Peterborough, it didn't happen but if St Mary's had happened as a PFI it would have failed. But because UCLH was landlocked we had to design something that fitted into that space.

In doing that we produced something that may have and does have problems. But it was in a very small space, in which case some of the excesses that were built into some of the other PFIs couldn't happen because you had to build and design jointly. I went in as a sceptic on the PFI front. The discipline of the process of design and build, which is not designed by architects – I'm talking about having the nursing teams, the medical teams, in with the planners. What do we do to make a building as fit not just for 2004 but try to guess what we will need in the future?

There are rooms in the outpatient wing, the podium, which have air-conditioning which can be used for not minor but major-minor surgery because the air-conditioning is over-engineered in case that's where we saw things going in the future. The building was built so that a section can come out of the middle so that when the linear accelerator needs to be replaced: part of the building comes out, the crane comes over, lifts out the old linear accelerator and the new one goes in. But it is all about how do we fit it into that space?

PT: Can I just go back to your financial problem? £5 million and you've never had debts before. Have you seen any of these funds? Has any of it come your way? Where's it gone?

TS:
There are no bungs. We negotiated with our commissioners this year to reduce the impact of what they want to take off us as QIPP in North-West London. What we ended up with – and it took us 6 months to negotiate it, we hadn't signed our contract until the 28th of October – is what we called a flat cash position for this year. We didn't reduce the pressure from the previous year which was within the system.

Going back to GP engagement, one of the stories from the previous year about QIPP was in one of our CCGs they wanted us to take more patients out of community settings in secondary mental health and pass them back to general practice. We started transferring these patients back to general practice because they were considered not ill enough to require a secondary of mental health care. The chair of the CCG was on the phone immediately to my boss, then the medical director, to say 'Why are you discharging these patients back to us?' We said 'This was part of the scheme as a CCG you wanted us to do to transfer these patients back'. 'But we haven't got the ability to cope with these patients, we haven't had the training'. Part of the scheme was that there was supposed to be training put in place to enable them to take on these patients. It all ended up with an amicable agreement. But the critical point was, we had funding taken out of our baseline in the year for those patients. That was replicated in numerous schemes.

PT:
Can I just ask one thing? Could you not do something next time a contract comes up, and say 'You know what? You're not giving us enough to put up a viable quality service in this area, we're not going to do it any more.' Why shouldn't you walk away from places? If they are not giving you the money for the quality of service you think you need why can't you just say 'Well, we won't do that'?

TS:

Two things. One is under our contract at the moment everything that we do for health is under the banner of commissioning present services, which is far more difficult to walk away from than if it wasn't under commissioning of present services. It's up to the commissioners to decide what is or isn't in that part. You have to go through various hoops if we were to go along that line. We've had that debate with the commissioners.

There's one service that's transferring away from us, which is the large unit in St John's Wood that is going to go on 1 April over to a private-sector supplier. The commissioners have been out to tender on it. It wasn't our choice to go to a private sector supplier, but we couldn't afford to continue to run it at the funding we were getting from it.

We have on a local authority contract given notice on a in-patient unit for detox. One of only three units in the country. We've been out to consultation on it. The option for the commissioners which are the local authorities was to increase the funding for it. Part of the problem with the detox unit was that the number of patients coming through were too low to maintain it as it was. We were losing £600,000 a year on it.

RL: In-patient detox, there's a big argument isn't there about the rightness of It as a clinical model?

TS:
Yes. This was for the very high end, higher need patients. But even so there are so few of them that to actually run that unit can be very difficult financially.

SR:
Can I just ask you, we have heard from a hospital-based paediatrician working with the community paediatric service in South-East London who was faced with what he described as a machismo-driven CCG saying 'You need not even think of applying for this contract unless you can cut the price by 20%'. There's got to be a line hasn't there when you actually say 'No, we can't do it'?

TS:
There has been a line. We've drawn a line on several occasions. We regularly have to re-tender 70% of our addiction services every 10-12 months. At the moment fortunately we have managed to retain those contracts to date. That's against the trend. But each of them is being met at a lower price than previously. Part of how we are managing that is that we do and always have worked with private-sector partners, and it's about a balance of service in terms of what we would like as a preferred service versus what level of secondary care those into that service.

In terms of mainstream services we are constantly up against this in terms of what can be a cost-effective model going forward? We see it more with the local authorities because of the nature of regular re-tendering, but because of the health budgets we are more open to that now in terms of going for the tendering exercises than we were in the past.

RL:
We are going to have to a close now I'm afraid. Just something quickly if it's in your head: 70% of your addiction services have been re-tendered. What has re-tendering cost you internally?

TS: Internally excess of £1 million a year.

RL: Just to participate in tendering?

TS: Yes.

RL: Well on that bomb-shell, thank you very much!

LI: That's £1 million just for tendering for addictions or all tendering?

TS: That's all tendering.

PT: Every year?

TS: Every year. That's taking into account the time the management have to spend on these things.

RL: You've saved the best until last. Thank you for coming to see us again.