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ANALYSIS

Planning for closure: the role of special administrators in reducing NHS hospital services in England

A proposed amendment to the law will give special administrators powers to reconfigure health services well beyond those provided by the trusts they are administering. **Allyson Pollock and colleagues** argue that this will undermine equal access to care in England

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One of the effects of the Health and Social Care Act 2012 was to remove the organisations that used to plan health services for geographical areas in England on the basis of need. Instead market forces are to have more influence, with competition among providers leading to more innovative and patient focused services.[1]

A recent legal judgment has made the government realise that it may have lost too much control and it is proposing to amend the law in order to restore a partial planning function. A proposed amendment to a bill going through parliament (tabled in October 2013 and currently awaiting a second reading in the House of Commons) would provide trust special administrators (who are sent in to manage trusts that have large deficits) with the power to reconfigure neighbouring services as well as those of the trust that is in trouble.[2] However, the special administrators would have no complementary duty to plan health services for the population of that area on the basis of need; their responsibility is simply to ensure that trusts can pay their debts.

We explain why the government is making this amendment and how such an ostensibly obscure provision could undermine equity of access and the provision of a comprehensive health service to some populations in England.

Lewisham: a reconfiguration too far

The idea that market forces not public planning should shape the English NHS has been a cornerstone of government strategy since Labour's NHS Plan in 2000. The approach was taken further by the current government, culminating in the controversial Health and Social Act 2012, which abandoned the system of planning services for geographical areas that had underpinned the NHS since its creation in 1948.[3 4] Under the act the government's statutory duty to provide or secure a comprehensive health service was repealed and strategic health authorities and primary care trusts, which had been responsible for implementing that duty, were abolished.

The sign that this loss of public control might have gone too far came with an Appeal Court ruling on 29 October 2013 that trust special administrators cannot draw up plans that affect trusts other than the one to which they have been appointed.

In July 2012 the Department of Health appointed a special administrator under the "unsustainable provider regime" to manage the South London Healthcare Trust. This regime provides for special administrators to take over the running of trusts that do not generate enough income to cover their costs and gives them the power to reconfigure services. The administrator recommended a solution to the South London Healthcare Trust's financial crisis that would close the emergency department and close or reduce the size of the maternity unit at neighbouring Lewisham Hospital, which is part of a different trust.[5] The local general practice commissioners opposed the plan, and when the government endorsed it Lewisham Council and local campaigners sought a judicial review on the grounds that administrators did not have a legal power to recommend area-wide service changes and the government did not have power to accept them.

The High Court ruled in favour of the complainants. The government appealed, arguing that the "unsustainable provider regime" could be used as a mechanism for area-wide service reconfiguration,[6 7] but in October 2013 the Court of Appeal upheld the original judgment.

The government promptly proposed an amendment to the Care Bill currently going through parliament that would remedy this deficiency. The amendment would give administrators the power to reconfigure neighbouring trusts and services "where necessary for and consequential on action taken in relation to" the trust to which the administrator has been appointed.[2] This would allow administrators to resolve deficits in one trust by recommending major service change in neighbouring trusts. But the amendment does not give them the same duty as commissioners, who are required to arrange provision to meet reasonable requirements.

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This is important because although clinical commissioning groups have a legal duty to provide most services for their populations, trust special administrators will be able to over-rule commissioning groups, as they did in Lewisham, and a large number of trusts may potentially fall under special administrators.

Current guidance on reconfiguration

Proposals to reconfigure health services must normally be formulated under a system of checks and balances designed to ensure that the changes are in the interests of the communities affected. However, special administrators operate under separate guidance in which these controls have been diluted or removed.

Current reconfiguration guidance is based on a series of reviews for the Department of Health conducted in 2007-10. This highlighted the deficiencies in the quality of information that underpinned many of the proposals to reconfigure services that were being consulted on at the time.[8] Of particular concern was the absence of detail about the relation between healthcare needs and current and future provision, criticisms echoed in annual reports of the Independent Reconfiguration Panel.[9] In 2010 the Department of Health responded with revised guidance. The strategic health authorities for London and for Humber and North Yorkshire subsequently produced guides setting out the information and evidence necessary to judge whether proposed service changes would meet the health needs of their communities (box).[8 10]

The guidance for special administrators differs from the general reconfiguration guidance in two main respects. Firstly, it changes the requirements for consultation. The local authority overview and scrutiny committees that now manage reconfiguration under normal circumstances do not have a mandatory role in formulating proposals under the special administrator process; nor does the Independent Reconfiguration Panel, which reviews proposals for service change that are contested by local authorities. Before the Health and Social Care Act 2012 the oversight committees could refer to the secretary of state any reconfiguration proposal they deemed not to be "in the interests of the health service in the area of the committee's local authority."[11] The National Clinical Advisory Team, set up in 2008 to ensure that service change proposals are "safe and accessible for patients," has no role in the special administrator process.[12]

Also, the consultation period for special administrators is reduced so that proposals can be drafted, consulted upon, and implemented within 120 days for NHS trusts and 150 days for foundation trusts.[6 7] Reconfigurations outside the special administrator process are not subject to a statutory timetable and may take several years to formulate and implement.

The second way in which special administrator guidance differs from general reconfiguration guidance concerns the information requirements about population healthcare needs. The 2012 act established three special administrator regimes: one for companies providing NHS services; one for NHS foundation trusts run by their regulator Monitor; and a third for NHS trusts run by the Department of Health. Under Department of Health guidance, NHS trust special administrators must consider four reconfiguration tests set out in the NHS operating framework (2010-11): plans must "demonstrate support from GP commissioners, strengthened public and patient engagement, clarity on the clinical evidence base and support for patient choice."[6] Monitor's guidance for administrators instead requires continuation of "location specific services," services that "need to be kept running if a provider were to fail."[7] Assessment of healthcare needs is not explicitly required in either case. No guidance has been issued for the administration regime for companies.

What have special administrators actually done?

So far only two reports from special administrators have been published, for South London Healthcare NHS Trust and, in draft, Mid Staffordshire NHS Foundation Trust.[5 13] The evidence that they have taken account of the overall current and future needs of the wider community is not encouraging.

Both special administrators recommended major service changes in several acute and community trusts. The recommendations in south east London included specified reductions in beds and staffing in three other acute trusts as well as in the South London Healthcare Trust (table⇓). These were based on assumptions about substantial transfers of patient activity from the acute sector to community settings but with no plan for how that transfer would take place.

The Mid-Staffordshire special administrator also suggested reductions in beds across several acute trusts and transfers of patient activity to the community. However, in the wake of the legal challenge mounted in Lewisham, the draft report did not make these formal recommendations. According to the report's authors, the special administrators recognised that "actions across the local health economy [were] essential" but they did "not have the power to recommend these actions."[13]

Neither of these reports produced by special administrators contains the information prescribed by NHS Yorkshire and the Humber and NHS London (box 2).[8 13] Thus neither report provides a basis for assessing current needs or for ensuring that the proposed provision will meet future need.

Many trusts are vulnerable to special administration

Many NHS trusts and several foundation trusts are vulnerable to having special administrators imposed on them and thus being subjected to the lightly regulated reconfiguration proposals. If the amendment to the Care Bill is passed these reconfiguration proposals will be able to affect neighbouring trusts and may be approved even in the face of objections from commissioning groups and local authorities.

Trust deficits in England are driving closure of hospital and community services, even though the service is in balance overall and for the past two years has returned a surplus to the Treasury.[14] In May 2013 the Trust Development Authority, which is responsible for overseeing the transition of NHS trusts to foundation trust status, reported that progress had slowed because "the remaining NHS trusts include many which face significant challenges to deliver sustainable services"; it is also "working closely with 14 NHS trusts that are not considered sustainable in their current form."[15]

The financial position of NHS trusts has been worsening since 2009-10 (figure⇓). The position will worsen further if NHS England moves £2bn from acute budgets to out of hospital care, as it currently proposes.[16]

In July 2013 there were 61 acute NHS trusts and 99 acute foundation trusts in England. According to the Trust Development Authority, 38 acute NHS trusts had financial deficits and five were in "special measures" and had to publish improvement plans. According to Monitor, five foundation trusts were under investigation and a further 20 in special

Box 1: Information required to justify major changes in health services[8]

Activity

- All relevant patient flows and capacity are modelled and assumptions are clear and reasonable
- Changes in bed numbers are clearly stated
- Activity and capacity modelling clearly linked to reconfiguration objectives
- Evidence that activity links consistently to workforce and finance models
- Modelling of significant activity, workforce, and financial effects on other locations or organisations

Workforce

- Workforce plan is integrated with finance and activity plans with any risks to the workforce and mitigating actions clearly stated
- Secretary of state's assurance that proposal makes most effective use of workforce for service delivery and is compliant with all relevant guidance
- Implications for the future workforce are set out clearly
- Evidence that staff have been properly engaged in developing the proposal

Box 2: Missing data from special administrators' reports

The following items are planning data that should accompany any proposal for major health sector reconfiguration and do not appear in the special administrator reports for Mid Staffordshire and South London trusts[5 13]

Demographic indicators (by local authority and clinical commissioning group (CCG)areas)

Population by sex and five year age groups

Epidemiological indicators (by local authority and CCG areas)

Mortality indicators: deaths by age groups, sex, and specific causes

Morbidity indicators: disease specific prevalence and incidence and socioeconomic group

Provision of services (current and projected)

Hospital and community services

Acute beds number by specialty and per 100 000 population

Medical equipment by category

Nursing homes/residential homes (No of beds/100 000 population)

Day centres (No of places per 100 000 population)

Staffing (whole time equivalents and per 100 000 population)

GPs

Community nurses by category

Community psychiatric nurses

Occupational therapists

Physiotherapists

Medical hospital staff by specialty and training status

Nursing hospital staff by specialty and training status

Scientific and therapeutic hospital staff by specialty

Technical and administrative hospital staff by specialty

Use of services (current and projected patient flows, activity by specialty and by treatment//100 000 population)

Hospital services

Emergency department attendances/100 000 population

Elective and day case admissions by specialty

Non-elective admissions by specialty

*Adapted from strategic health authority strategic change assurance processes of NHS Yorkshire and the Humber and the London strategic health authority cluster

measures. Thus, almost two thirds of acute NHS trusts and a quarter of foundation trusts were either in deficit, under investigation, or in special measures. More than one third of acute NHS trusts in deficit were hospitals built under the private finance initiative, which is known to exacerbate financial problems because repayments are indexed so that they increase every year even when income is falling in real terms.

Threat to services and patients

The published reports from special administrators suggest that they have not measured service use, and they have not provided detailed plans for how the needs of populations within an area will be met after services have been changed. This suggests that the unsustainable provider regime is being used to resolve provider debts and accelerate hospital closures without proper consideration of equity, the needs of a local area, or a whole systems approach to care.

Mr Justice Silber's judgment in the Lewisham case was categorical about whose view about need should weigh most: "The [trust special administrator] in not regarding the views of the Lewisham GP Commissioners in relation to the changes at [Lewisham Hospital] as being the crucial matter means that the views of those GP Commissioners most affected by the changes did not have the importance which they should have had."[18] That failing will not be addressed by the government's

amendment to the Care Bill. On the contrary, it will become routine.

If wider powers are given to special administrators many more communities will be at risk of having their hospital downgraded like Lewisham Hospital was, simply because a nearby trust has a deficit. But many deficits are the product of factors outside an institution's control, including historical debts, private finance initiative repayments, variations in government subsidies, reductions in funding, and withdrawal of funding by NHS England and commissioners.

Clinical commissioning groups may, of course, change their purchasing patterns in response to the reasonable requirements of their populations, and that means that services will need to be reconfigured. But until implementation of the Health and Social Care Act 2012 such reconfiguration was managed by a public authority with a statutory duty to provide or secure comprehensive health services. Now changes in purchasing patterns by one commissioning group can, by creating trust deficits, frustrate the efforts of neighbouring groups to meet the reasonable requirements of their patients.

The Health and Social Care Act 2012, in repealing the secretary of state for health's statutory duty to "provide or secure" comprehensive health care, has abolished the planning structures and information systems required to discharge the duty.[19] There is no longer a single line of legal accountability for meeting the healthcare needs of all residents in a geographical area, and as a result deficits are more likely to drive future service change.

Patients and staff are threatened as much as they were at Stafford Hospital, where the Francis inquiry concluded that undue weight given to financial targets compromised the quality of care. It is ironic that after the trust spent more on staffing to correct the problem, it incurred a deficit and was put into an unsustainable provider regime,[13] where once again financial targets are likely to take precedence.

Since the secretary of state's duties have been diluted merely to promoting a comprehensive health service, he can wash his hands of the need for needs based planning structures and information systems. Parliament would do better to support Lord Owen's bill to reinstate a duty to provide and secure comprehensive services together with the necessary planning powers and structures.[20]

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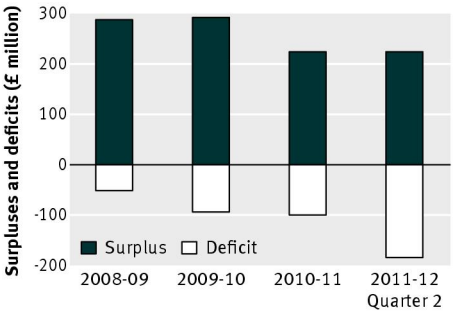
Table

Table 1| Current hospital beds in south east London and those proposed by the special administrator for the South London Healthcare Trust[5]

	Current bed provision 2012		Special administrator's recommendations for 2017-18			
	Total available	Operational	No of available beds required	Change in No of operational, (available) beds	%change in operational beds	% change in available beds
Lewisham	419	290	246	–44 (–173)	–15.2	–41.3
Princess Royal*	587	580	626	46 (39)	7.9	6.6
Queen Elizabeth*	532	531	532	1 (0)	0.2	0.0
Queen Mary*	240	53	19	–34 (–221)	–64.2	–92.1
St Thomas's	968	914	849	–65 (–119)	–7.1	–12.3
Guy's	379	309	274	–5 (–105)	–11.3	–27.7
King's College	928	928	928	0 (0)	0.0	0.0
Total	4053		3474	–131 (–579)	–3.6%	–14.3%

*Hospitals in South London Healthcare Trust.

Figure



Aggregated NHS trust sector surpluses and operating deficits, 2008-09 to 2010-11 final accounts[17]