House of Commons

Committee of Public Accounts

Innovation in the NHS—the acquisition of the Heart Hospital

Twenty-third Report of Session 2002–03

HC 299

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Report, together with formal minutes and minutes of evidence

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The Committee of Public Accounts

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Committee staff

The current staff of the Committee is Nick Wright (Clerk), Leslie Young (Committee Assistant) and Ronnie Jefferson (Secretary).

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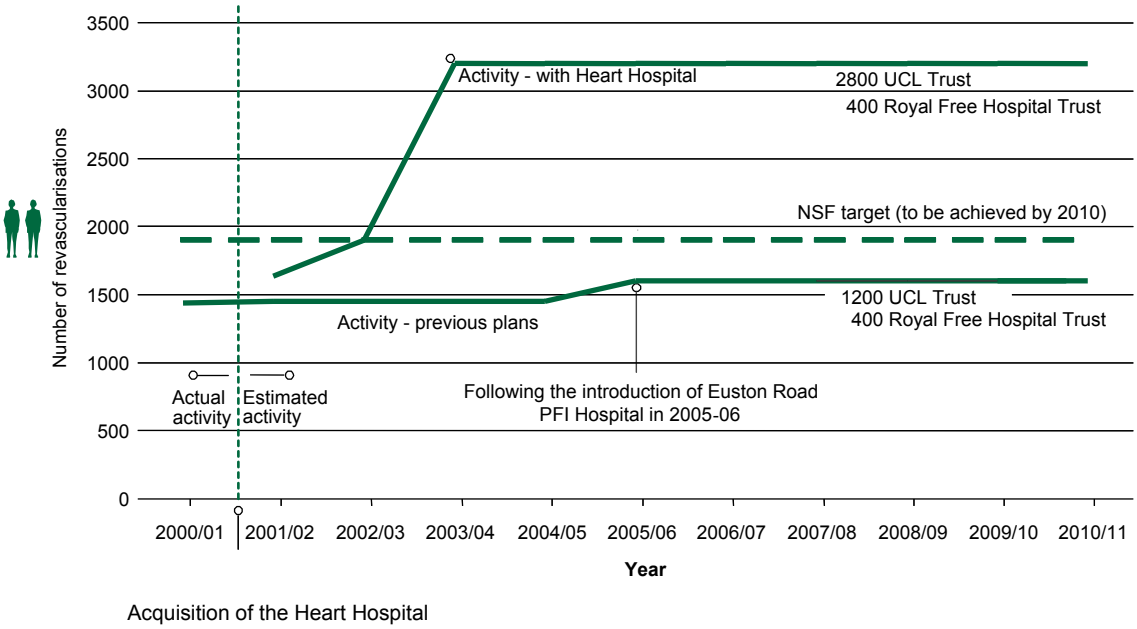
Report

Summary

In September 2001, University College London NHS Hospitals Trust (the Trust) acquired the Heart Hospital from private owners Parkway Holdings Limited (Parkway). The hospital is in the medical district centred on Harley Street in central London and a short distance away from the Trust's other hospitals. At the time, the hospital was operating at only one-third capacity, leading to financial losses and Parkway's decision to sell. The Trust moved quickly to take advantage of this opportunity to help meet a priority need for higher levels of cardiac treatment. The Trust acquired the hospital and its equipment at £8.5 million less than the independent valuation of the hospital and its equipment and some £17.5 million less than the estimated cost of a new construction. By 2003–04, the Trust expects that the acquisition will enable it to treat double the number of patients in need of revascularisations—cardiac procedures to improve the blood flow to the heart (**Figure 1**).[1]

Figure 1: Potential revascularisation activity in North Central London

The acquisition of the Heart Hospital should enable the North Central London sector to fully meet its target for revascularisations by 2004—6 years early—and provide capacity to treat patients from outside North Central London



NOTES
1. Figures up to and including 2000–01 are actuals; figures from 2001–02 are maximum estimates (as at the time of acquisition).
2. The North Central London sector contains two Trusts that perform cardiac revascularisations—University College London (UCL) and the Royal Free.

Source: Department of Health

1 C&AG's Report, *Innovation in the National Health Service—the acquisition of the Heart Hospital* (HC 157, Session 2002–03), paras 1, 3–4, 8, 11, 15

On the basis of a Report by the Comptroller and Auditor General,[2] the Committee took evidence from the Department of Health and the Trust on the management of the acquisition and on maximising its benefits.

Our main conclusions are as follows:

- The acquisition of the Heart Hospital was well conducted, avoiding procedural obstacles but with due attention to risk. It represents a strategically important addition to NHS capacity which is bringing clear benefits to patients. It enabled the Trust to reduce rapidly its maximum waiting times for cardiac treatment, from 12 months in September 2001 to below 6 months by July 2002.

- Many patients in other parts of the country are, however, waiting much longer than 6 months for cardiac treatment. As the Trust increases revascularisation activity to full capacity of 2,800 in 2003–04, it should seek to reduce waiting lists elsewhere, for example by marketing the hospital to out-of-area general practitioners as a potential cardiac treatment site for their patients.

- The Department of Health was able to fund the acquisition of the Heart Hospital from underspending on other capital projects. The Department has since established what it terms an NHS bank, with the aim of providing risk reserves for Primary Care Trusts and overdraft facilities for NHS Trusts, and a means of investment for long term and innovative capital projects. The Department should provide guidance on the relative role of the NHS bank and other forms of funding that could be used to finance innovative capital projects.

- The Trust would not have achieved the acquisition in five months, and the resulting patient benefits, if it had followed the Department's normal, time-consuming procedures. Other investments capable of delivering patient benefits may similarly require quick decisions. The Department should develop its formal approvals procedures to allow fast track decision making where warranted.

2 C&AG's Report, *Innovation in the National Health Service—the acquisition of the Heart Hospital* (HC 157, Session 2002–03)

1 The management of the acquisition

1. The decision to pursue the acquisition was not included in the Trust's existing business strategy. Rather, it was a response to the need for higher levels of treatment of coronary heart disease. In April 2001, the Trust held a meeting with Parkway to explore ways of using surplus capacity at the Heart Hospital, and identified the possibility of purchasing the hospital.[3]

2. The Trust faced various challenges to securing a successful acquisition. The Trust concluded that because of underperformance the Heart Hospital would be likely to enter administration. The Trust was also aware of at least two other bidders for the hospital, and it therefore decided to complete the deal quickly and to pay for the property and leases upfront. One of the bidders was a private health company, Health Care International, which withdrew its bid following referral to the Office of Fair Trading and the Competition Commission in light of concerns about a reduction in private cardiac medical services in central London.[4]

3. The Trust also had no defined process or guidance to follow as the acquisition of a private hospital was a novel undertaking for the NHS. Decision-making on major capital projects is usually time-consuming, partly because of the need to consult numerous stakeholders. A decision to build a new hospital, for example, would normally take two years. The Trust quickly mobilised support for the acquisition at a high level and developed a quicker process for obtaining the necessary assurances and approval than normal.[5]

Use of a fast-track approval process

4. **Figure 2** shows the normal process for capital investment and the process developed by the Trust for this deal. The key differences are that the first few stages of the normal process—design, specification, bidder selection, and consultation with the public—were not required in this case and a number of activities were carried out concurrently rather than sequentially.[6]

3 C&AG's Report, para 7

4 *ibid*, paras 14, 2.9; Qq 122–124

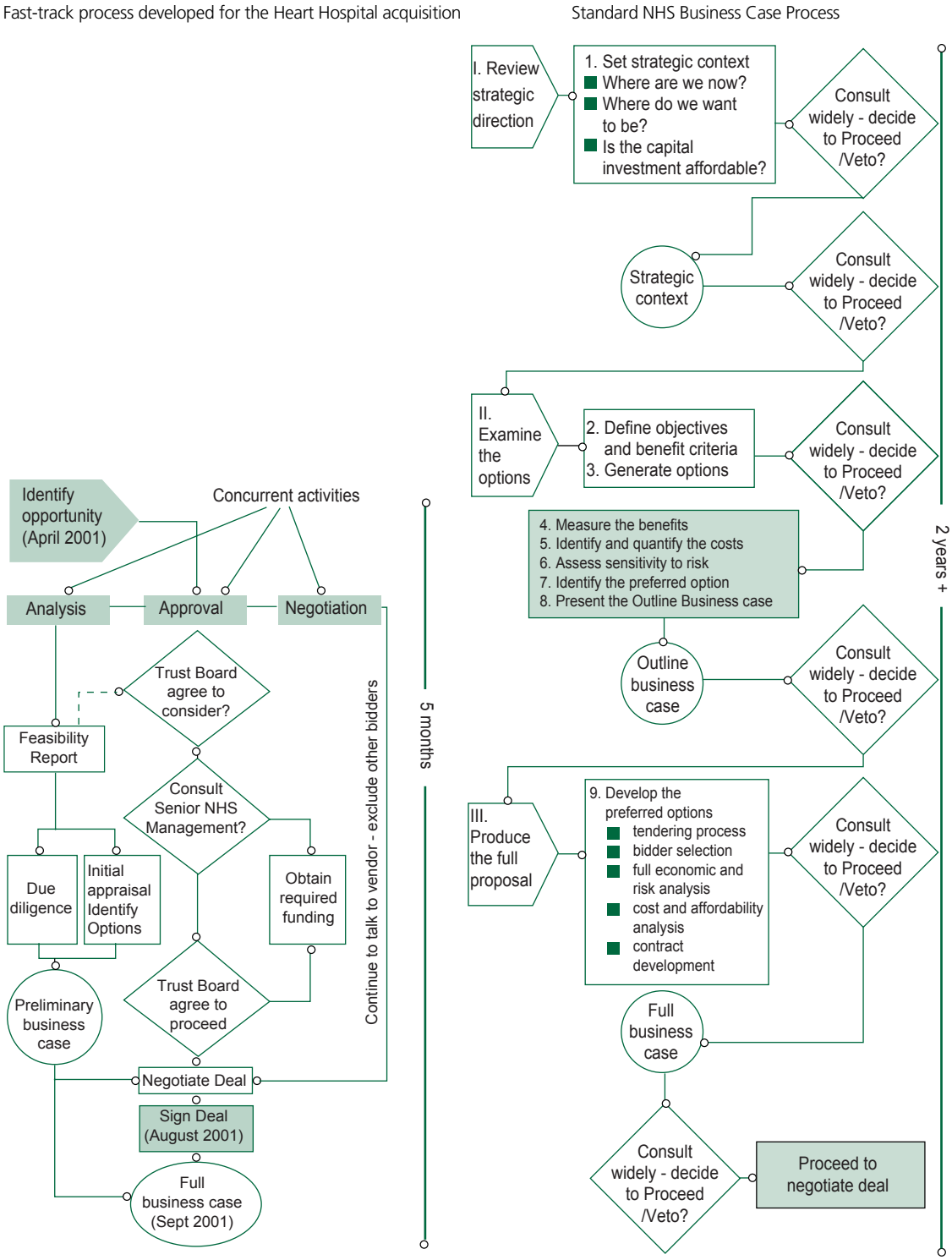
5 C&AG's Report, paras 8, 2.16

6 *ibid*, para 2.17; Q 4

Figure 2: The fast-track approval process developed for the Heart Hospital acquisition

Capital investment processes in the NHS

The acquisition of the Heart Hospital was achieved more quickly than normal capital spending projects in the NHS—partly through the Trust undertaking a variety of key activities concurrently and reducing the time taken for due diligence and business care analysis



Source: Department of Health / National Audit Office

5. The Department believes that the lessons it can learn from the fast-track process used in this case will depend on the complexity of the deal, the complexity of the proposals and the risks that might attach to it. The processes used in the Heart Hospital acquisition would be most relevant to proposals of a similar size. This kind of fast-track process would therefore not have been appropriate in the major rebuilding of the Trust's main site hospital. Nevertheless, the Department recognises that it should try to develop a more streamlined approval system, provided that the risk involved in the deal and the fit with service strategy can be properly assessed.[7]

Funding of capital projects

6. The £27.5 million acquisition of the Heart Hospital was funded out of underspending on other capital spending programmes. Without the underspending, the acquisition might not have taken place, and the Trust might have found it difficult to meet national targets for cardiac care. For the financial year 2001–02, there was net capital underspending across the Department of £75 million, around 3% of the overall NHS capital expenditure of £2.2 billion for the year. The Department was unsure how many hospitals or trusts were notified that this funding was available, but future underspending might be made available if further worthwhile opportunities came up.[8]

7. Following the acquisition, in May 2002, the Department established an NHS "bank" to devolve more power and responsibility to the front line over how money is spent. During 2002–03, the "bank" operated in shadow form, with a board of NHS governors. Once fully established, it is designed to operate at arms length from the Department. It has the stated goal of providing risk reserves for Primary Care Trusts and overdraft facilities for NHS Trusts, and acting as a source of investment for long term and innovative capital projects. The Department has allocated an initial £100 million to the bank. At present, the "bank" performs two functions:

- Provision of assistance to "health economies" that are in financial difficulty.
- Managing a system of brokerage, whereby those in the NHS that are overspending can borrow from those who are underspending and those that wish to engage in a particular project can borrow from others. The brokerage system was until recently undertaken by the Department.[9]

8. The Department is currently considering giving additional financial freedoms to highly performing Trusts, including how they manage their capital assets. Any Trust that gains 3-star status is entitled to apply for Foundation Trust status, which means that they will be able to act as free-standing organisations, within the NHS but outside the "line management" by the Department of Health. They will be accountable instead through legally enforceable contracts with NHS commissioners and oversight by a new organisation called the Commission for Healthcare Audit and Inspection. With consent from the regulator, Foundation Trusts will be entitled to dispose of assets, but the proceeds from any sale must be used for the provision of health care. University College London Hospitals

7 Qq 3–4, 93–95

8 C&AG's Report, para 31; Qq 85–88, 96

9 Press release by the Department of Health, 2002/0231, 15 May 2002; Q 97

Trust, which is a 3-star Trust, made a preliminary application for Foundation Trust status in February 2003. The Department will consider this application and, if accepted and the Trust retains its 3-star status following inspection in the summer of 2003, the Trust will be invited to submit a more detailed application.[10]

Value Added Tax liability

9. The Department of Health agreed to fund a £3.2 million Value Added Tax (VAT) liability that fell on the Trust in acquiring the Heart Hospital. Without support from the Department, the deal might have been prevented. In certain situations a refund can be made, for example when a public body is contracting out and is trying to establish a level playing field between in-house and external bids. In this case, there was no provision to waive the VAT. The private sector status of the Heart Hospital had allowed Parkway to defer VAT but the Trust—as a public sector body—was not eligible to continue this deferral. The Department was able to find the necessary £3.2 million from its £57 billion annual programme.[11]

Communicating with staff about service changes

10. In completing the acquisition, the Trust had to communicate the impact of change to 162 existing private Heart Hospital staff that were transferred to the Trust as part of the deal and to 142 staff who were expected to redeploy from the cardiac unit at the Trust's Middlesex hospital. Because of the need to preserve commercial confidentiality until negotiations were complete, staff on both sides did not know the implications for their jobs until after the acquisition. There were other concerns, such as those of the existing private hospital staff who felt that the Trust might reduce standards and staffing levels, and those of Trust staff who perceived that the staff in the private sector were being paid more than them. These concerns have to date not been realised, since private standards have been maintained, staffing levels have increased by 18%, and there are limited differences overall between the pay and conditions of the two groups of staff.[12]

11. The Trust made significant efforts after the acquisition to communicate what had happened, why it happened, and how it might affect staff. It did not, however, develop a comprehensive communications strategy. As a result, some staff felt they suffered uncertainty for longer than was needed and it was some months after the acquisition before all their concerns were assuaged. This uncertainty may have contributed to staffing levels dipping initially. The number of staff fell from 297 in September 2001 to 264 in March 2002. From May 2002, staffing levels started to increase to levels above those at the time of the acquisition.[13]

Sharing lessons from the acquisition with others in the NHS

12. The Department recognises that it is important to communicate success and, along with the Trust, it has tried to do so with the Heart Hospital case. Since the acquisition, the

10 Department of Health, *Foundation Trusts: Eligibility Criteria and Timetable*, July 2002; Qq 88–89, 91

11 C&AG's Report, para 2.27; Qq 102–104

12 C&AG's Report, para 3.8, 3.19, 3.25; Qq 32, 37

13 C&AG's Report, para 30, Figure 12; Q 32

Department has undertaken several innovative deals that have taken on board lessons from the Heart Hospital acquisition. In the case of the acquisition of the Stamford Hospital in North-West London, which the Directorate for Health and Social Care (London) oversaw, one of the first things the Directorate did was to put the management of that particular Trust in contact with colleagues at University College Hospital, so that experience could be shared and the management team could position itself appropriately.

13. The Department reports that lessons from the Heart Hospital acquisition, on managing the risks, and making sure the Department has the right commercial expertise for the negotiations, were also applied in the cases of a commercial deal with BUPA for a diagnostic and treatment centre at Redhill Hospital and the purchase of plasma collection centres in America. Based on its experience of the Heart Hospital acquisition, the Department of Health recognised that not all Trusts are headed up by managers with the skills to undertake successful commercial deals. In those cases, it might not be sensible to devolve the same degree of responsibility in pursuing similar opportunities. As part of the selection process for foundation status, the Department intends to assess management capacity.[14]

Decision-making on other acquisitions

14. Some other potential acquisitions, such as the purchase of the private King Edward VII Hospital in Sussex, have been considered and not taken forward by the NHS. In this case of the King Edward VII Hospital, a liquidator was put in place and sought to discover whether the NHS wanted to increase its use of the hospital. The Department was not clear that the hospital fitted the service and the strategic context in the same way that the Heart Hospital did. The Department was also concerned that it was not in the same condition as the Heart Hospital and might require refurbishment and other investment, which the Heart Hospital did not. The Department would not purchase any hospital that came up for sale or was in difficulty. Each one had to be looked at on its particular merits.[15]

The comparative costs of cardiac revascularisation

15. It is for individual trusts or health authority commissioners to decide how they use private sector hospitals to meet their particular targets and within their budgets. There is no single unit cost for revascularisation but there is a reference cost index from which an average cost can be derived. The Trust reported that its range of revascularisation costs, both before and after the acquisition, were lower than the average unit cost for all Trusts across the NHS that perform these operations. It was also optimistic that at full capacity the price per patient would be significantly lower than the average private sector cost, though it did not say by how much.[16]

14 C&AG's Report, para 2.22; Qq 106, 111

15 Q 31

16 Qq 5, 54–56, 59, 68; Ev 20

2 Maximising the benefits of the acquisition

16. The Department of Health estimates that coronary heart disease affects around 1.4 million people across the United Kingdom and is the biggest cause of premature death in England, responsible for some 110,000 deaths per year. Tackling coronary heart disease through increased treatment, alongside better diagnosis and prevention, is therefore one of the Department of Health's main priorities for the NHS.[17]

17. With the acquisition of the Heart Hospital in September 2001, the North Central London sector, which the Trust is part of, should be able to almost double its capacity for revascularisation, from 1,438 revascularisations in 2000–01 to 2,800 per year from 2003–04 (**Figure 1**). If this happens, it will allow North Central London to meet and exceed national revascularisation targets of 1903 revascularisations per annum 6 years early. The Trust has already reduced its maximum waiting times for cardiac treatment from 12 months in August 2001 to 6 months by July 2002.[18]

18. There are number of risks to the hospital achieving its full potential:

- Ensuring increased access to treatment for out-of-area patients, which should help reduce waiting lists elsewhere.
- Making sufficient efficiency savings to break even.
- Ensuring adequate staffing levels to reach full capacity.
- Treating patients with multiple conditions on a specialist site location.[19]

Reducing waiting lists elsewhere

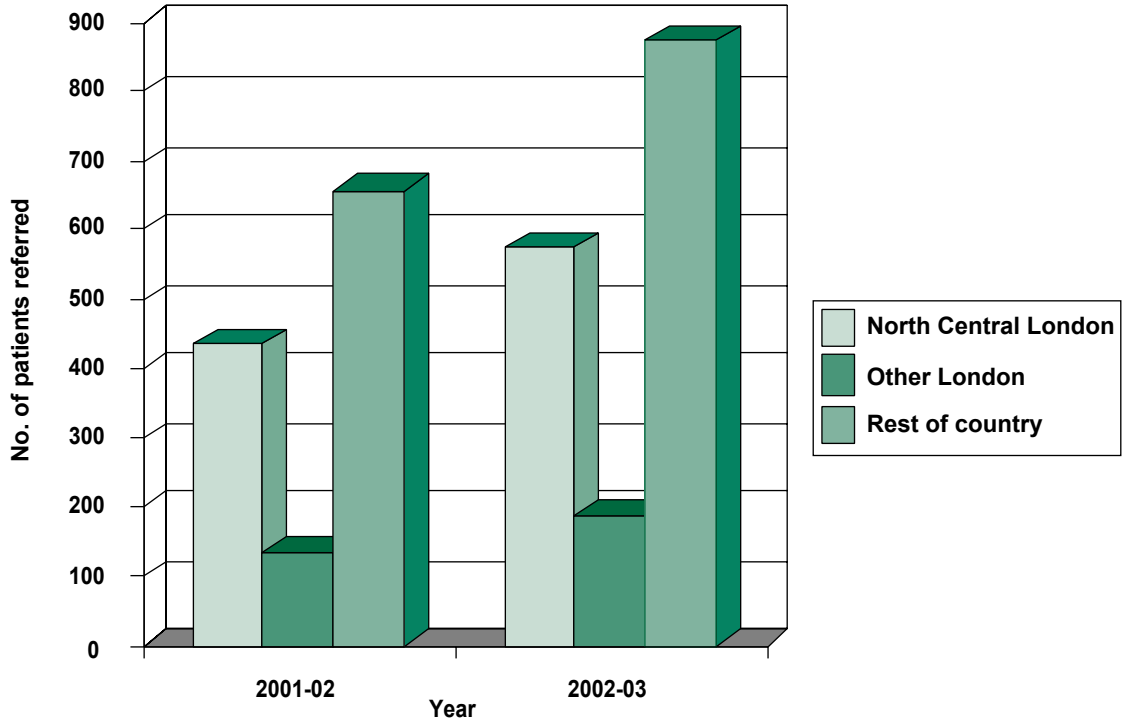
19. While the acquisition—funded out of underspending on other programmes—has reduced the Trust's waiting times to 6 months, patients elsewhere in the country still have to wait between 9 and 12 months for a cardiac revascularisation. The Department's target for maximum waits is 12 months and it estimates that some 330 patients are still waiting over 9 months. The Department is bringing forward its target of achieving three-month maximum waits from 2008 to 2005.[20]

20. The Trust expects more patients to come to the Heart Hospital for cardiac treatment under the Patients Choice Initiative, which allows any patient waiting longer than 6 months for their operation to choose to be treated at another NHS hospital or private hospital. As part of this initiative, patients will in time be able to consult an Internet site, which will show waiting time by consultant. As **Figure 3** shows, if current patterns continue, the Trust will treat more patients from outside North Central London in 2002–

17 C&AG's Report, paras 1–2
18 *ibid*, paras 1.6–1.7, 3.13 and Appendix 2
19 *ibid*, paras 21, 23, 1.12–1.13
20 *ibid*, paras 2.15, 3.13; Qq 7–8

03 than 2001–02. Between April 2002 and October 2002, some 510 cardiac patients referred to the Trust resided outside London (33% more than the 2001–02 total at an annualised rate), with some 111 coming from other parts of London (40% more than the 2001–02 total). Since the September 2001 acquisition, the Trust has treated 130 patients under contract from Barts and London acute NHS Trust, with a further 350 due to be treated by the end of 2002–03.[21]

Figure 3: Origin of referrals to the Heart Hospital (for cardiac revascularisation)



Source: UCLH

Making sufficient efficiency savings to break even

21. At the time of the acquisition, the Heart Hospital was undertaking only 600 surgical procedures per year and was making losses. The business case for the acquisition assumed a progressive expansion of capacity and activity levels to 2,800 revascularisations per year. To avoid destabilising the Trust's overall financial position, the London Regional Office (now the Directorate for Health and Social Care—London) committed to fund ongoing losses of up to £9 million over the period until full capacity and break-even is reached in 2003–04.[22]

22. To reach break-even at 2,800 revascularisations per year in 2003–04, and avoid the need for further subsidies, significant efficiency savings are still required at the Heart Hospital. Given a current rate of 600 revascularisations per quarter, the Trust must make 14% additional efficiency savings on top of those already achieved. The efficiency gains are largely dependent on making the best use of the hospital's resources. The Trust's approach involves "just in time" techniques to make sure that everything is in the right place at the

21 C&AG's Report, para 3.21; Qq 42–44; Ev 19

22 C&AG's Report, paras 2.28, 3.19

right time and patient throughput is maximised. For example, the Trust is seeking to ensure that operating theatre sessions are used for another purpose when a consultant goes on leave, rather than being "lost", and that patients are not admitted too early or discharged late.[23]

Ensuring adequate staffing levels to break even

23. To meet the target of 2,800 revascularisations per year, the Trust also needs to increase staffing levels at the Heart Hospital against the constraint of limited supply. Following the acquisition in September 2001, the Trust employed 297 cardiac staff. As at December 2002, the hospital employed 351 cardiac staff, or 83% of a full complement of 424. The Trust is confident that it will be able to recruit sufficient staff, although recruitment was initially slower than expected and there are challenges to recruiting and retaining nursing staff in central London. In the first year, turnover rates at the Heart Hospital were high, as with other hospitals in London. Between September 2001 and September 2002, some 30% of staff left the Heart Hospital. This rate appears to be falling, however, with a turnover rate between April 2002 and October 2002 of 19%, on an annualised basis.[24]

24. The Trust believes that the high quality working environment at the Heart Hospital will help increase staffing levels. At a regional level, the Directorate for Health and Social Care (London) reports that it has well-developed approaches to providing temporary staff within London, including the London Agency Project under which there is a collective agreement with the agencies to provide temporary staff to hospitals in a flexible manner.[25]

25. To date, the Trust's monitoring of sources of recruitment shows no material impact on other individual Trusts. Between September 2001 and September 2002, approximately half of 124 new recruits came from elsewhere in the Trust or were employed at UK temporary agencies or in the UK private sector. No more than 7 staff, or 6% of the total, came from one individual Trust.[26]

Treating patients with multiple conditions on a specialist site location

26. The Heart Hospital is located on a separate site to the rest of the Trust's activities. There is significant debate about the clinical risks and benefits associated with specialist hospitals. Possible benefits of a separate site include reduced disruption to specialist treatment that happens sometimes in generalist hospitals due to inflow of emergencies and lack of control over bed usage. The hospital is therefore more able to get on with its planned work than it might otherwise. But there are risks in not having other specialties on one site.[27]

27. The Trust has recognised the risk in treating patients with both cardiac and renal problems at the Heart Hospital. It has appointed a substantial number of intensive care staff with renal experience to provide patients with additional support or advice should

23 Qq 12, 49–58, 81–82, 127–132

24 C&AG's Report, paras 3.8, 3.19, 3.22; Qq 10, 142, 144, 153; Presentation by the Trust to Committee members during a visit to the Heart Hospital , 13 January 2003

25 Qq 142, 146

26 C&AG's Report, para 3.23

27 *ibid*, para 1.13; Q 9

they require it. The Trust also intends to make use of its experience in managing specialties on other individual sites. The National Director for Heart Disease, Dr Roger Boyle, emphasised this risk to the Trust during the acquisition and, while he does not generally favour specialist cardiac hospitals, he agreed with the Trust's assessment of the manageability of the risks in this case.[28]

28 C&AG's Report, para 1.13; Q 9

Conclusions and recommendations

1. At full capacity the Heart Hospital will need 17% more staff than the 351 employed as at December 2002. The Department's Directorate for Health and Social Care (London), which oversees performance across London Trusts, should encourage all hospitals in London to collect up-to-date information on the sources of recruitment and turnover patterns so that efforts to recruit and retain staff—and thus increase capacity—are undertaken in a coherent way.

2. The Department of Health agreed to fund a £3.2 million Value Added Tax liability falling on the Trust as a result of tax deferment not available to the Trust as a public sector body. To put the Department in a position to respond as rapidly in any future cases, it should keep the fiscal regime applying to NHS bodies under review so as to understand any significant differences from private sector organisations in undertaking commercial transactions.

3. It is unclear why some opportunities to bring private sector facilities and staff into the NHS have gone ahead while others have not. Greater clarity about the Department's policy and about the reasoning behind individual decisions would both aid public understanding and lead to better focussed effort within the NHS.

4. The Department is seeking to make use of surplus private sector capacity in a variety of ways. For example, the NHS is leasing a BUPA hospital in Redhill, Surrey for routine orthopaedic operations. Such contracting with private sector providers is currently undertaken at the discretion of individual Trusts. To promote better collective purchasing power with the private sector, Primary Care Trusts and Strategic Health Authorities should collate and share information on the relative cost of service provision across different private and public health care providers.

Formal minutes

Monday 19 May 2003

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Brian Jenkins
Mr Nick Gibb	Mr David Rendel
Mr George Howarth	Mr Gerry Steinberg

The Committee deliberated.

Draft Report (Innovation in the NHS—the acquisition of the Heart Hospital), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 27 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Twenty-third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned till Wednesday 4 June at 3.30 pm

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Wednesday 15 January 2003

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