HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.59 * Spring 2004

20 YEARS campaigning for our NHS

Health Emergency was launched in April 1984

INSIDE this 12-page issue

Forking out a fortune for Paddington PFI

Controversial plans for a new Health Campus to link the Royal Bompton, Harefield and St Mary's Hospitals have not only rocketed towards the £1 billion mark, but run up a huge bill for external consultants.

Figures released by ministers reveal that the project – which has yet to secure planning permission or select a consortium – spent £2.5m on advisors in just 9 months. This brings total spending to £5.6m, without any visible progress.

PFI hospitals in cash and beds crisis

Andrew Wiard

Ministers were warned: Dudley Hospital strikers challenged PFI

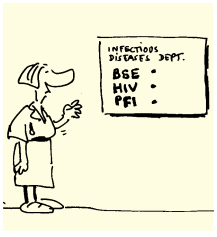
Hospitals built under the government's controversial "Private Finance Initiative" are struggling to cope with the pressures of demand for emergency and waiting list treatment: most face soaring debts and chronic bed shortages.

A 'snap shot' survey of ten first-wave hospital Trusts in England and Scotland found combined deficits of almost £50 million and a succession of problems due to the reduced numbers of beds in the new hospitals, all of which have opened since 2000.

One, the £93m Queen Elizabeth Hospital in Greenwich, has resorted to the desperate measure of closing a ward to save money towards its £6m deficit – despite the fact that this will add 600 more patients to its waiting lists.

The more recently-opened West Middlesex Hospital in Isleworth, West London has also announced that a ward will close at the end of March, and staff redeployed to cut spending on agency nurses, and save money towards the Trust's £2.5m deficit, even while patients wait hours on trolleys for admission for lack of beds.

And at least one Trust, County Durham and Darlington Acute Hospital NHS Trust, has now publicly admitted that the new £97m University Hospital of North Durham was built with too few beds.



Pressure group London Health Emergency which carried out the survey warns that while PFI hospitals have been struggling so far, and often failing to meet government targets on waiting times, their position is likely to worsen in the coming financial year, as new arrangements for "financial flows" within the NHS are introduced.

The new system, designed to offer Foundation Trusts additional scope to win extra contracts and revenue, will mean that in place of existing block contracts, which guarantee a certain level of income, hospitals will only be funded for the work they do.

The PFI hospitals, with restricted numbers of beds, extremely high levels of bed occupancy and little if any spare capacity, will be poorly placed to generate additional revenue. Some may lose existing work, with patients sent for treatment elsewhere, meaning that the money that will "follow the patient" to rival neighbouring Trusts.

LHE's Information Officer John Lister, who has followed the development of PFI in the NHS, warns that the first-wave PFI hospitals face a unique handicap in the new competitive environment from April:

"The PFI contract – normally 30 years or so – involves the Trust paying a monthly index-linked fee to the consortium to cover the lease of the new building and the provision of all non-clinical (ancillary) services and maintenance.

"This means that if the Trust runs into financial difficulties – and some of them are deep in debt with no obvious answers available – the only parts of the budget the Trust itself still controls are clinical services: doctors, nurses and patient care."

To make matters worse, it appears that the Department of Health, which offered a number of Trusts long-term subsidies (so-called "smoothing payments" of as much as £1.4m a year, rising with inflation) to enable them to afford PFI schemes which otherwise would have been rejected, is now planning to phase out this funding, leaving some Trusts high and dry on a mountain of debt.

All of these problems were pointed out to ministers and health service chiefs long before the PFI schemes were signed, not least by London Health Emergency. John Lister adds:

"The underlying problem is that first-wave PFI schemes are inherently very expensive buildings, in which the apparent price was artificially reduced by making them smaller, and by government handouts: now the chickens are coming home to roost.

"The next wave of PFI hospitals seems likely to offer a different set of problems: they will be bigger, with more beds – but massively more expensive, and therefore even less affordable by NHS Trusts.

"If this policy continues, PFI will result in a massive haemorrhage of resources from the NHS, and permanent financial crises in new hospitals throughout the country."

THREE PAGE PFI special round-up: Centre and page 8

Issues 1-6 – April 1984- February 1985

20 years of Health Emergency

THIS ISSUE celebrates the 20th anniversary of Health Emergency, the tabloid newspaper for NHS campaigners launched by London Health Emergency in April 1984 in its bid to widen its base of affiliates and supporters.

Initially funded by the GLC through LHE's publicity budget, Health Emergency aimed to bring campaigners the most up-to-date information on government policies, and to share experiences from local battles against cuts, hospital closures and the first wave of competitive tendering.

The paper swiftly established a base of affiliates throughout London and reaching many other parts of England, Wales and Scotland.

It was this base of support which enabled the paper and LHE to survive GLC abolition in 1986.

Leaked document reveals shambles of East London PFI hospital

A DEVASTATING report by private consultants for East London and City Mental Health Trust has laid bare a whole raft of major problems that have hit a new £12.5m mental health unit in Newham built using the controversial Private Finance Initiative (PFI).

The report, a copy of which was leaked in January to pressure group London Health Emergency, makes it clear that the new building is too small, in the wrong place, poorly designed, poorly built, and suffers from poor quality support services from the private consortium.

Almost every paragraph of the 36-page report from consultancy firm Hornagold & Hills points to another basic flaw in the process that led to the Newham unit's completion:

The bidding and negotiating process was delayed, but even after two years the contract did not adequately specify the obligations of the PFI consortium.

No details were specified of acceptable room temperatures or lighting levels.

The architects' full fees were not paid, and so the architects did not inspect works, certify completion or identify defects. No drawings exist of the finished building.

The original design provided no office space at all – and the resultant reorganisation to squeeze in offices has left some admin staff having to pass through wards to go in and out.

The ward arrangement makes gender segregation impossible.

Cold water tanks on the ground floor mean that all water has to be pumped into the building, and at opening there was a total failure of water supply.

The wrong specification baths were used, but the proper replacements were too big to go through the doors.

The wrong specification windows were used: standard windows are unsuitable for a mental health establishment, and have suffered damage and broken handles.

A number of toilets were not connected to drains, "leading to obvious problems".

The site is polluted and releases methane, raising serious hazards for smokers.

Floor coverings are defective, alarm and call systems unreliable, emergency systems non-functional, staff were ill-informed and alienated, and the contractor has been uncooperative and adversarial.

LHE's Information Director John Lister, commenting on the report said:

"This has been a classic cock-up from start to finish, a case study in how PFI can go wrong. But managers seem to want to keep the problems quiet. That would be an even bigger disaster.

"If other PFI schemes forge ahead and do not learn the lessons of the Newham fiasco we can expect even bigger and more costly blunders."

"Bleakness and squalor" and "glimmers of hope" in UK psychiatric wards

THREE national mental health charities - Rethink, SANE and The Zito Trust - have joined forces with top clinicians to launch a disturbing new report on the current state of UK hospital care for people with psychiatric illness.

Entitled *Behind Closed Doors*, the report reveals that, despite some 650 national strategies, guidelines, frameworks and protocols issued by the government over the last five years, much still needs to be done to improve the harrowing conditions under which some of society's most vulnerable people are treated.

"Too many psychiatric wards remain overcrowded, unhygienic, chaotic and run-down," says Paul Corry of Rethink. "Added to this, serious staff shortages and safety concerns persist, patients are often left for days on end with nothing to do, and abuse of street drugs is commonplace."

SANE's Marjorie Wallace adds: "There can be no freedom of choice or chance of better treatment while the acute wards remain in many places filthy and overcrowded, and staff demoralised. It is no wonder that people who are disturbed or depressed will only stay in hospital if sectioned, and that doctors are forced to take the risk of not admitting people who may urgently need in-patient care."

"To make matters worse," comments Jayne Zito of the Zito Trust, "Too many people with severe mental illness are still being prescribed outdated medicines with intolerable side-effects – despite rulings by the government's medicines' watchdog NICE that they should receive improved, modern drugs."

Yet all the groups agree that it doesn't have to be like this. In some notable cases, the government's reform programme has brought about positive changes, improving inpatients' safety, privacy and engagement with staff.

The hugely unpopular first draft of the new Mental Health Bill is finally undergoing revision. And progress with pharmaceutical research promises a better experience with medication.

Dr Zerrin Atakan of Bethlem Royal Hospital, who treats people in the throes of particularly acute psychiatric crises, comments: "Up until now, we've had to inject them with old-style antipsychotic drugs – risking very unpleasant side effects such as acute dystonia, tremors and rigidity– since the modern alternatives were not available in injectable form."

Now, however, olanzapine, a fast acting injectable antipsychotic has been introduced with fewer and less severe side-effects compared to haloperidol, making early hospital experiences more tolerable for those still struggling with the trauma of sectioning.

"We've also seen a welcome move towards involving the people who actually use mental health services, and their carers, when planning and delivering new initiatives," Rethink's Paul Corry says. "Clearly, good intentions are there. Now they must be harnessed at the frontline of psychiatric hospital care to effect real, widespread and lasting change."

■ ***Behind Closed Doors can be obtained from www.rethink.org.***

Issues 7-12 May 1985- May 1986

Foundation Trusts face dire shortage of stooges

Going in … the first ten Foundations mark the start of a major switch back to competition

WHEN TONY BLAIR's fixers late last year finally managed to squeeze the controversial Bill though the Commons establishing Foundation Trusts, they may well have heaved a sigh of relief that the wafer-thin majority of 17 was sufficient to trigger the promised new round of "modernisation".

But the real problems and embarrassments of implementing the policy are yet to come – and will take shape not within the hallowed corridors of Westminster but in hospitals (and constituencies) in towns and cities across the country.

Those MPs who were strong-armed into ignoring Labour Party Conference policy and the urgings of the trade unions, or who suspended disbelief to endorse Foundations as an exercise in "local democracy" or even "popular socialism" may yet have bitter reason to regret their decision.

The reality is that Foundation Trusts remain almost completely bereft of popular support. The first ten Foundations launched on April Fool's Day are anything but popular, democratic or socialist.

Consultation meetings during the application process frequently drew attendances in low single figures: one meeting in South East London, called jointly by Guy's and St Thomas's *and* Kings College Trusts, to promote their parallel Foundation bids, drew a total attendance of just five people – including a chief executive!

Lack of punters

The absence of bums on seats was predictably matched by a lack of punters signing up to 'join' the Foundations.

Last autumn a Department of Health spokesperson announced that Foundations would be expected to establish a minimum "membership" of 7,000-10,000 people.

In practice, according to a *Guardian* survey in January,

Frank Dobson: Foundations have no real mandate

only two of the first wave Foundation Trusts, King's College Hospital and University Hospital Birmingham had even topped the 3,000 mark, with many languishing in the low hundreds.

"Entryism" fear

The flagship University College London Hospital – with its gleaming white £450m PFI hospital taking shape at the top of Gower Street – was the first to voice fears that with so few people interested, they could fall prey to "entryism", and be captured by "an interest group or a Trot element". UCLH's foundation project director told the *Guardian* that the progress so far had been a "fiasco".

At Hackney's Homerton hospital, Trust bosses fearing "single interest groups" promised that anyone discovered to entertain a "single interest" would be excluded.

Elsewhere Foundation applicants promised that candidates for the new governing councils, to be elected from the limited ranks of "members", would be required to sign a pledge – a latter-day McCarthyite promise – that they are not now, nor ever have been, proponents of a "single interest".

This raises obvious questions: how tightly defined is the notion of a "single interest group"?

Would it potentially mean the exclusion of pensioners' groups, kidney patients, rheumatic patients or diabetics?

Conversely, how many apolitical, disinterested citizens are likely to be found who would willingly serve as stooges rubber-stamping the policy-making of an NHS Foundation Trust?

By making a lack of interest or commitment a precondition for allowing punters to become involved, the Trusts are excluding precisely those concerned and motivated local movers and shakers who might conceivably make Foundations accountable and democratic.

Drafting in patients

As the Bill reached its final phase, Ministers had a bright idea to make up the numbers: simply draft in the existing staff … and patients … of the Foundation applicants.

The amended Act includes a provision that Foundations may count as "members" any past or present patients and staff members who have not specifically written to "opt out" of membership.

University Hospital Birmingham has opted for the patient membership list, adding tens of thousands to its "membership".

From a Trust point of view, the entire procedure involves the cost and expense of maintaining a mailing list of the passive and unresponsive: the ideal membership base from the point of view of maintaining control would include thousands of elderly patients too polite, too confused, too immobile – or too dead – to send back forms declining to join.

Such large numbers might impress the Regulator, but few if any of these members will vote, or put themselves forward for the governing council: the risk of capture by a small, active, organised minority has not been tackled.

Empty seats

A *Health Service Journal* survey of 8 of the first wave of 10 Foundation trusts showed that of 138 publicly elected seats, 20% were uncontested or attracted no candidates.

A ninth Foundation, the Royal Marsden, has left almost half its 17 elected seats vacant, while only 5 places were contested in elections – in which fewer than 400 people voted.

In Basildon & Thurrock University Hospitals Trust, which claims 3,300 "members", two thirds of publicly elected seats were elected unopposed or left vacant. No member of staff could be persuaded to stand for the reserved seat. A trust spokesperson, whistling in the dark, told the *HSJ* "This is real democratic legitimacy".

In Peterborough Hospitals Trust, and in Doncaster and Bassetlaw, more staff voted than members of the public.

As former Health Secretary Frank Dobson points out, this gives the Foundations no democratic legitimacy whatever: but such details seem unlikely to deter the relentless "modernisation" process.

£40m slush fund to bail out failing Foundations

Potentially the most devastating aspect of the Foundation Trust proposal arises not from Foundations themselves, but from the changes to the financial structure of the NHS that have been brought in to enable Foundations to act in an "entrepreneurial" way, and compete for contract income against other (less well resourced) NHS Trusts.

The new system of "financial flows" that is being phased in from April 1 effectively restores much of the Tory "internal market" system which New Labour boasted it had scrapped after 1997.

Foundations (and other Trusts) will increasingly be "paid by results" for the level of treatment delivered, and in Thatcher's phrase "the money will follow the patient".

The only difference from the Tory market is that the competition will not be on price, but on a new, fixed tariff, which leaves some Trusts pocketing a handsome profit, and others wondering how they can cut costs by as much as 9%.

A number of "specialist" Foundation Trusts have been promised a share of a £40m Department of Health sink fund which will bail out some of the biggest losers in this new market: other Foundations will get nothing, while non-Foundation Trusts – many of them already facing massive multi-million deficits – will be left to their own devices, and have to fight through yet more obstacles to survival in a new, even more unequal, 2-tier NHS.

Is that what New Labour MPs thought they were voting for, when the Bill finally got the go-ahead on December 12?

It is certainly what many of their constituents will blame them for, if the wheels come off another half-baked plan in the run-up to the next election.

Up to the limit

The first 25 Foundation Trusts will be able to run up private borrowing – but only to a maximum of £350m, according to estimates published by

the independent regulator Bill Moyes (left).

The prospect of being able to lay hands on an average of less than £15m each – and that at commercial rates of interest – will hardly set the bosses buzzing with excitement, or enable large-scale projects to go ahead.

Poor stooges

Meanwhile Mr Moyes has criticised the calibre of the non-executive directors of the first dozen Foundation applicants.

Which brings us back to the well-travelled question:

Q: What's the difference between a non-exec and a shopping trolley?

A: A shopping trolley has a mind of its own … but you can get more food and drink into a non-exec!

Issues 13-18, Sept 1986- February 1988

London Trusts face mounting debts

Many of London's acute hospital Trusts have been through a desperate battle to balance their books in the final days of the financial year – with the prospect of tougher times to come since April 1.

Figures collated from the latest papers of the five Strategic Health Authorities covering the capital, together with local press coverage and other sources, show unresolved problems totalling over £62m in the hospitals alone, without taking into account the additional forecast deficits and pressures facing mental health services, Primary Care Trusts and the StHAs themselves.

The deficits come despite substantial injections of new funding into the NHS by the government in the last three years. Much of this extra money has come with strings attached in the form of more ambitious performance targets, which involve additional costs and pressures on Trusts.

London Health Emergency's Information Director John Lister, who compiled the survey of financial shortfalls said:

"The fact that so many front line Trusts are deep in the red after years of economies shows that London's front-line hospitals are still not properly resourced to deal with a continued increase in emergency admissions and GP urgent referrals, which are running at very high levels across the capital.

"We must remember that these figures are just the tip of the iceberg of a much bigger underlying problem: these are the deficits that Trusts have not been able to sort out or cover up during the year, despite the pressure on them to make it look as if everything is fine and they are delivering on financial targets.

"And while some of the deficits are expected to be covered by one-off use of contingency funds, or handouts from the health authorities, it is clear there is a fundamental imbalance in the finances of some very large Trusts."

The problem for London's hospitals will increase from April as the government phases in a new system of "payment by results", which will reward hospitals with low costs and spare capacity to treat additional patients, but penalise hospitals grappling with the cost pressures of delivering services in the capital.

Most of London's acute hospitals are already running with well in excess of 90% beds occupied, leaving little scope to treat additional patients.

Among the London deficits (latest available figures, March 2004)

● St George's £10m, ● Epsom & St Helier £5.3m, ● Kingston Hospital £5.8m, ● Bromley Hospitals £4.2m ● Queen Elizabeth Hospital, Woolwich £4.5m, ● Barts and The London £5.6m, ● Newham Healthcare £3.2m ● Barnet & Chase Farm £3m, ● Whittington £4m, ● Royal Free £4m, ● North Middlesex £1m, ● Hammersmith Hospitals £3.5m ● North West London Hospitals £5.5m, ● Chelsea & Westminster £3m ● Hillingdon Hospitals £2.3m ● West Middlesex University Hospital £2.5m

What do you do when the figures don't stack up?

A whistleblower's tale

IAN PERKIN was Finance Director at St George's Hospital in Tooting, SW London. Here he charts his fall from grace – for revealing the truth about NHS finances.

A public sector worker for over thirty years I believe there is no better way of providing schools, hospitals, the police or any other vital public service.

Whatever is said about PFI schemes and private sector efficiency, the fact is the Treasury borrows money more cheaply than anyone giving the public services a huge in built financial advantage over the private sector which needs to earn an investor return.

Add the huge dedication shown by many public sector workers who want to work for organisations that have a moral purpose and you have another huge inbuilt advantage.

Ian Perkin

However the public sector still has to deal honestly with problems arising from huge demands for its services and limited government funding.

That is why as Finance Director at St George's, a large NHS hospital I could not remain silent when it became apparent that the number of operations being cancelled at short notice was being misreported and that the hospital was heading for a £2.5 million financial deficit.

When the NHS found out about the impact of these two "whistle-blows" in July 2002 I was asked to resign and when I refused I was subjected to a completely unfair disciplinary procedure and dismissed from my job, without the right to appeal as required by the ACAS code of conduct.

I took my case to an Employment Tribunal confident of reinstatement.

However, after being made to wait, not for the usual four weeks for Chairman John Warren's judgment, but instead for seven and a half months, I was shocked to find that while it was found that I had been unfairly dismissed.

Though the Trust accepted that I had "whistle-blown" on the cancelled operations, I was not to be reinstated or compensated because of my "management style" and because I had robustly defended myself.

The shock was heightened when I found that the judgments conclusions about my management style were in part reliant on the incorrect transposition of documents submitted in my defence and which had had their meaning altered by the Tribunal to my clear detriment.

Fortunately my union, the GMB, are funding my appeal, and I will continue the fight to clear my name and expose the wrongdoing which I highlight in my website www.nhsexpose.co.uk in the hope that the NHS and the Employment Tribunal Service treat others more fairly in the future.

What has happened at St George's since my sacking? John Parkes who misreported the cancelled operations, has gone on to be the Chief Executive at other NHS Trusts, and Catherine McLoughlin Trust Chairman, who the Tribunal found had lied under oath, remains an NHS ministerial advisor.

The financial position has gone into melt down with St George's heading for a deficit of over £11million, which includes an unexplained £1 million compromise payment to the Trust's PFI partners.

And me? Well I'm signing on every fortnight at the job centre, as an NHS warning to others not to blow the whistle.

DRIP-FEED

Franchiser franchised out

The experiment of "franchising" the management of failing NHS Trusts appears to have died the death after one of the first managers to win a franchise was dumped by Barnet and Chase Farm Hospitals Trust.

The Trust – the fruits of a merger of two long-term financially challenged Trusts – seems set to lose the one star it gained under the stewardship of Paul O'Connor, who was given a 3-year contract to 'turn it round'.

It now seems to have turned the full circle, failing on A&E targets, waiting times and facing a £4.3m deficit.

Mystery shortfall

Hospitals around the country have been blaming a big increase in A&E attendances as the factor behind mounting deficits.

Royal Cornwall Hospitals Trust claims to have spent an extra £2m dealing with 3,000 extra cases (10%) by December.

Plymouth Hospitals claim attendances are up by a massive 12.6%.

But it is hard to blame A&E attenders for Southampton University Hospital Trust's deficit of almost £9m as early as November last year: it has pointed the finger at soaring costs of agency nursing staff.

And Milton Keynes General Trust, in the red by over £3m says it is down to the cost of meeting an ever-growing list of targets.

Consultants' pay poser

ANOTHER FACTOR that could push Trusts across the country off financial balance is the unfunded cost of the new consultant contract, estimated to run as high as £3m in each large-scale acute Trust

Cardiac failure

Staff in Swansea's Morriston Hospital were worked so hard to bring down cardiac operation waiting lists that elective surgery had to be halted for a week in March to let them catch their breath.

Overtime, including weekends and other additional hours had been worked in the unit, which has 18 beds and two theatres.

Hospital waiting lists *abolished!*

How long have we waited for a headline like that?

Of course people are still waiting for treatment, even though the maximum length of time most people now wait for an operation has been halved from 18 to 9 months as a result of the increased funding and resources pumped in to front line care.

But the waiting list has been abolished by an even cheaper and simpler device: the name has been changed. From now on, what you need to watch out for are "access figures".

It makes you feel better already.

Issues 19-24 May 1988- March 1991

Private sector pockets millions in contracts for NHS treatment

The share of NHS spending being siphoned off into private sector companies seems set to rise still further as Department of Health bureaucrats prepare long-term contracts for block booking of private hospital beds.

Treatment costs for NHS patients admitted to private beds under the controversial Concordat signed by Alan Milburn with private hospital bosses in 2000 have been a staggering 40% higher than the equivalent within the NHS. Hip operations costing an average £4,700 in the NHS have been charged at over £6,800 by private hospitals. Treating just 60,000 patients this way cost the NHS a massive £100 million.

The mark-up to private companies has offered bonanza profits: one small company in Wales arranging private treatment for NHS patients pocketed a surplus of almost 25% – £1.6m on turnover of just £6.8m.

And the government is already committed to transfer as many as 250,000 elective operations a year from NHS hospitals to privately-run treatment centres.

But it's not just acute hospital care that is offering a bonanza for the private bosses: one chief executive of a private company told the *Health Service Journal* in February that he expected to see 15% of the NHS budget opened up to the private sector over the next few years, including contracts for long-term care and primary care services.

Ministers appear to believe that if they purchase more and more private treatment they can create excess capacity that will force down prices while eliminating waiting lists.

No doubt ministers will claim that one example of this new competition within the private sector is to be seen in the Nuffield Hospitals group, the largest charitable hospital chain in Britain, which is tipped to win contracts to treat thousands of NHS patients at prices close to or even below NHS reference costs.

Nuffield plan to ship in doctors from overseas, and to pay them and moonlighting NHS consultants between 30-50% below the standard private sector fee (NHS consultants have become accustomed to charging among the highest private fees in the world for their extra-mural activity).

It also involves utilising spare capacity in its 45 hospitals, in which (as in many private hospitals) large numbers of the 1800 or so beds are empty.

The Nuffield scheme has brought cries of 'foul' from other private sector medical companies, who claim they are unfairly using their charitable status to cut costs, while others have to generate profit.

But even this scheme threatens to poach nursing staff – and rip off the funding for the treatment costs – from neighbouring NHS hospitals, which would otherwise have done the work.

Sky high cost rules out private operators

WHILE MINISTERS insist on forging ahead with the privatisation of an ever-larger share of elective surgical treatment, the going has not been easy in the last few months.

First came the collapse in February of negotiations with a private consortium, headed by Mercury Health, that was bidding to provide general surgery and orthopaedic operations from ten centres across England.

Now Department of Health negotiators have dropped Anglo-Canadian, the company seen as the most likely to secure the contract to provide 30,000 operations a year in north, east and central London.

Significantly it appears that the breaking point in the talks with Anglo-Canadian was the inflated prices the company wished to charge for minor operations:

"If we had gone ahead with the Anglo-Canadian deal it would have cost ridiculously more than the NHS tariff for these operations" a DoH 'source' told the Guardian. This should be no surprise: in Anglo-Canadian's home territory of Calgary private waiting lists for hip operations are longer than for the publicly-funded Medicare system, and private MRI scans are 21% more expensive than public sector provision.

It is unclear why it should take the DoH six months to find out that Anglo-Canadian's charges are too high: the firm had promised to bring in staff from overseas, and to build new units at Chase Farm hospital in Enfield, the over-stretched King George's hospital in Ilford and the Royal National Throat Nose and Ear hospital in Bloomsbury.

Of course the government had given every impression that money was no object and that all it wanted was to negotiate contracts designed to buy in additional capacity rapidly and reduce NHS waiting lists.

Contracts worth a massive £2 billion over five years were put out to tender last September, even while NHS Trusts made plans to increase their capacity.

One costly contract is for the controversial ophthalmic treatment centre that has now been imposed upon Primary Care Trusts in Oxfordshire – despite the threat it poses to the long-term future of Oxford's specialist Eye Hospital. This allows the winning firm to cherry-pick the least demanding operations, while still charging well above current NHS rates, and leaving NHS hospitals to carry the costs and responsibility of the more serious operations and long-term treatment.

The Oxford treatment centre has promised bring in medical and nursing staff from South Africa, making a nonsense of earlier government pledges that the NHS would not poach trained staff from developing countries, especially those struggling with AIDS epidemics.

PFI: first wave Trusts count costs of a failed policy

Last year LHE's John Lister visited PFI-funded hospitals around the country to record the staff experience for two UNISON pamphlets. But how are the new hospitals coping in the increasingly competitive world of the "modernising" NHS. Here are a few highlights of a recent survey.

Hereford: wartime huts next to too-small PFI hospital

Worcester's right Royal cash crisis

Hundreds of patients waiting for treatment at Worcester's new £97m PFI-funded hospital have had their operations cancelled because of a rise in emergency admissions, and inadequate numbers of beds, Chief Executive John Rostill has publicly admitted.

The knock-on effect was contributing to the Trust's financial deficit, projected to reach a massive £15m by April, compared with a £10m overspend last year.

Estimates of the total shortfall have edged up and up as each month has gone by, increasing by around £1m per month. As late as October managers were looking to a £7m shortfall.

More than 800 operations known to have been cancelled on the day they were due to take place in the Trust, which runs the new PFI-financed Worcestershire Royal Hospital, the Alexandra Hospital in Redditch, and the "downsized" Kidderminster Hospital, where a new £19m treatment centre has just opened in place of the full-scale district general hospital that was functioning prior to the controversial PFI scheme.

A county-wide plan to tackle the soaring deficit has failed to meet targets, although there has been a reduction in spending on agency nursing.

With the Trust currently failing on 11 out of 14 waiting list targets, spending on additional surgical sessions at overtime rates to deal with cancelled operations and keep down waiting times amounts to as much as £6m of the deficit.

Mr Rostill, who has warned that the Trust is unlikely to be out of the red before 2006, told the Worcester *Evening News* that "There is no short term solution".

He has insisted that the cash crisis would not affect jobs, services or patients: but it is hard to see, with the hospital already working to full capacity and unable to generate additional revenue, how sums equivalent to 7% of the Trust's £188m budget could be saved without cutting at least one of these, if not all.

The task of making savings is complicated further by the fact that almost all non-clinical support services in the new hospital, including maintenance, are incorporated in a legally-binding monthly payment to the PFI consortium amounting to £17m a year: this means that the only areas within the control of Trust bosses are clinical services – doctors, nurses and patient care.

The Worcester Hospital crisis is likely to have serious consequences for other health services in the county. Work on two long-awaited new health centres planned for Malvern and Upton-Upon-Severn has had to be suspended as a result of a collapse in funding. Tom Wells, leader of Malvern Hills District Council told the Malvern Gazette:

"It's clear the residents of Malvern and Upton have to pay for the financial incompetence of Worcestershire Royal Hospital".

Flashy exterior masks cash crisis in Worcester

Hereford: too small for comfort

Hereford's small £64m PFI hospital has reined in a deficit which had been projected to rise as high as £2.5m, to forecast a shortfall of just £500,000 by April. But hospital staff are struggling with inadequate bed numbers, and working extra hours in an effort to meet waiting list targets.

The Trust's budget was initially based on assumptions of an 85% bed occupancy rate, but actual figures have been much higher. Last year the Trust spent £1.2m in referring NHS patients to private hospitals in order to meet waiting time targets.

2004 has begun with an estimated 11% of the hospital's beds "blocked" by patients who should have been discharged to care elsewhere, while community hospitals are reported by the Primary Care Trust to be "stuffed to the gunnels". War-time huts that were to have been demolished when the new hospital was built are still needed to cope with demand.

Greenwich PFI: most costly bed closures?

Faced with an escalating cash crisis, managers at London's first PFI hospital have resorted to the desperate tactic of closing wards and beds in the 646-bed £93m hospital, even though it will lengthen waiting lists.

The Trust's projected deficit has been variously estimated at £4.5m or £6m. Trust bosses told BBC correspondents in February that the problem had been worsened by the Department of Health's decision to phase out the government subsidies (known as "smoothing payments") which had been paid to facilitate the PFI scheme, leaving the Trust to pay the full cost of the new hospital.

The closure in December of Ward 19, which has 28 beds and carries out elective surgery, was aimed at saving £200,000 – but also added 600 people to the Trust's waiting list. The ward had to be reopened for a week in January to help the Trust cope with a surge of emergency admissions.

But this and a further eight beds – four paediatric and four oncology – closed again in the new year.

Bromley faces loss of subsidy

The scale of the deficit in the Trust running Bromley's 525-bed Princess Royal University Hospital is not explicitly stated, but appears to be in the region of £3m-4m.

The Trust Board Finance Report (November 2003) reported that £1.7m "efficiency savings" had been identified, but confirmation was still awaited over a one-off hand-out of £2.5m from the Strategic Health Authority. Meanwhile Bromley also stands to lose its £1m-plus smoothing payment, which helped make the PFI project affordable:

"The Department of Health were considering the withdrawal of funding for the PFI scheme and the Trust was working to address this."

West Middlesex axes beds

Board papers of West Middlesex University Hospital Trust (February 23 2004) refer to a forecast deficit of £2.6-£4m, partly due to extremely high levels of emergency admissions (12% above last year).

The Trust told staff that a ward (H2) would be closed at the end of March, and staff redeployed, to save money on agency bills.

Local campaigners had warned from the beginning that the new hospital had too few beds, and an increasing number of patients awaiting emergency admission are now being kept overnight in makeshift accommodation in the endoscopy unit.

Norwich hospital just can't cope

ENGLAND'S BIGGEST operational PFI hospital, the £229m Norfolk & Norwich Hospital is running with an underlying deficit of £6.5m, and an overspend of £1.5m on its planned budget.

The hospital, which with 989 beds was widely criticised for being too small to cope, has been struggling with a near 10% increase in emergency admissions, and this is

Underlying problems mean Norfolk & Norwich is still in the red

Credit cards are not only accepted but vital to cover sky-high parking at Edinburgh Royal Infirmary (above and right) – but don't ask for beds, as a refusal often offends

limiting the scope to meet waiting list targets. Managers claim that 70 more beds are occupied by emergencies than two years ago.

Bed shortages in the hospital have brought increasing pressure, especially in the orthopaedics department, where staff have been working extra shifts and weekends in an effort to meet government waiting time targets: all this overtime working has increased the hospital's costs.

Orthopaedic patients from Norwich have been dispatched for treatment "to Bury St Edmunds, BUPA hospitals and even the Royal National orthopaedic Hospital in Stanmore," according to UNISON Branch Secretary Harry Seddon.

Penny-pinching economy measures include scrapping the supply of biscuits and bottled water to the Boardroom, and a drastic 120% increase in staff car-parking charges, while visitors to the hospital could also be asked to pay a minimum £2 for any stay over 30 minutes.

South Manchester faces shortfall

Trust Board papers (February 4) report that the cumulative outturn for 9 months has been an "adverse deviation from plan of £1.245 million".

But the Trust, which runs the PFI-funded Wythenshawe Hospital, was hoping to get through in rough balance by transferring £4m from capital to revenue.

Next year however the problems intensify, with unfunded cash pressures estimated at £11.5m, against which there are planned efficiency savings of just £6m, leaving a gap of at least £5.5m to be resolved next year.

Carlisle up against Cumberland gaps

Carlisle's £65m zero-star Cumberland Infirmary has been rocked by a succession of crises since it became the first English PFI hospital to open in 2000.

Precise figures are hard to establish in a notoriously secretive and politically sensitive Trust. The most recent deficit admitted by the Trust to union reps is £2.3m, although this is widely regarded as an optimistic under-estimate.

The local health economy, which has only been running deficits since the PFI hospital opened its doors, is facing a combined shortfall of over £26m.

Meanwhile the latest questions over the quality of the innovative PFI hospital centre on the glass panels used on three walkways above the large atrium area which runs through the centre of the hospital.

Two of these panels, which are supposed to be toughened safety glass, have shattered in the first few weeks of the new year. The other panels are now taped up while anxious talks take place on whether the Trust or the PFI consortium will face the cost of replacement.

Edinburgh: the flagging flagship

Scotland's flagship PFI hospital, the £184m Edinburgh Royal Infirmary, is leaking funds below the waterline: the most recent estimate is an £8.5m deficit by April – an improvement on earlier forecasts that the gap could be as wide as £13m.

This includes costs of increasing use of agency staff to fill vacancies: agency bills amounted to £6.4m last year.

A report by the Auditor General warned at the end of last year that if they are not controlled, the Lothian University Hospitals Trust's debts could spiral to reach a staggering £180m by 2008.

The hospital, which embodies a substantially reduced number of beds on the hospitals it has replaced, has been struggling to cope with demand for emergency and waiting list treatment. In January hospital chiefs admitted that 22 operations had been cancelled at short notice, some of them just hours before patients were due to arrive.

Round in circles as Durham's new hospital runs out of beds

40 operations were similarly cancelled last October, again because of a shortage of beds. Expectant mothers have been sent as far as Dundee to have their babies after ERI ran out of neonatal cots.

While ministers and managers point to bed blocking, critics of the scheme have always warned that the bed reductions represented a serious gamble.

The hospital which fully opened in 2003 has also been dogged by a series of problems flowing from the poor design and quality of the building, including power cuts, leaks in the roof, ventilation failures, abandoned attempts to computerise patient records, and sky-high (£10 per day) car parking charges which are higher than those in the centre of Edinburgh.

Poor services have also been a problem, with staff facing restricted supplies of sheets and bedding as a result of laundry problems, and strong criticisms raised by a patient who had formerly been an NHS manager over the quality of patient meals, which are prepared in Wales and shipped up for reheating in Edinburgh.

The Trust pays £33m a year to the PFI consortium lease the new hospital with and non-clinical services – leaving only clinical services as potential areas for cost-savings.

Beds crisis grips Great Western

Swindon's £180m PFI-financed Great Western Hospital was closed to all but life-threatening emergencies for 12 hours in January, with three patients ferried by ambulance to Oxford's John Radcliffe hospital after an "unprecedented" level of emergency admissions left the GWH without beds.

The hospital which opened at the end of 2002 has since added a 36-bed orthopaedic ward and 26-bed ward, and opened a discharge lounge to ease pressure on beds.

The hospital is building a new £30m diagnostic and treatment centre, which will have another 128 beds and cost almost £16m a year to run when it opens in April 2005.

A week later the hospital was again in the headlines after a 67-year old woman had her urology operation cancelled for the fourth time in two months because of a lack of beds.

On January 16 an expectant mother was taken by ambulance to Portsmouth for treatment when she threatened to give birth prematurely: the GWH had no capacity to care for her in the special care baby unit

Durham Trust admits beds blunder

The University Hospital of North Durham was forced to close its emergency department for ten hours in early January after running out of beds. Ambulances were diverted to other hospitals in the region.

Management of the County Durham and Darlington Acute Hospital NHS Trust told the Northern Echo that the £97m flagship PFI hospital had too few beds.

"Since this new Trust has been formed we have been of the view that the hospital was built by the previous trust with fewer beds than it should."

The same spokesperson also blamed bed blocking for part of the problem, claiming that 30-40 beds were "blocked" by patients who should have been discharged for treatment and support elsewhere.

The hospital also faces the possible loss of its urology specialist services in a new plan to rationalise this service across North Durham, Sunderland and South Tyneside. Durham patients could face a journey to Sunderland for more serious operations and treatment.

Prefab houses makeshift beds at Carlisle's already crumbling Cumberland Infirmary

Too few beds are among the problems at Swindon's PFI hospital

Issues 25- 30 July 1990-June 1992

£521 million, and rising as costs leap 66% in two years

Soaraway costs of Brum's PFI superhospital

The new PFI hospital for University Hospital Birmingham Trust has been mushrooming in cost, well before the final stage negotiations open up with preferred bidders Consort Healthcare: final stage talks customarily increase the eventual price by anything up to 100%.

Back in 2002, the project for a new single site hospital to replace the popular Selly Oak Hospital and Queen Elizabeth Hospital, together with new mental health facilities, a treatment centre and other facilities, including a claimed

increase of 95 beds was provisionally costed at £306m.

But just two years later as Trust bosses announced the preferred consortium and commenced the final stage talks behind closed doors, it had increased to a massive £521m – an increase of over 66%.

Trust financial director Peter Shanahan tried to explain away this runaway escalation in costs as "building cost change". Speaking to the *Health Service Journal*, he said:

"Because the construction industry is so buoyant, prices are moving way ahead of inflation."

He then pointed out that – as critics of the scheme had thought from the outset – the initial costings were little more than "an educated guess".

It is a fair bet, then, that from this primitive and naïve starting point, the Birmingham Trust will be eaten for breakfast by Consort Healthcare, who know, because Mr Shanahan has said as much, that the Trust has no choice but to sign up for PFI regardless of the cost.

This is the approach that has landed so many first wave PFI Trusts in deep financial water. Birmingham Trust bosses should look and learn – or the second city's health care will face a looming cash crisis.

Bart's and London PFI tops the billion mark!

The mega-PFI development of Bart's Hospital, which has been tagged on as part of the scheme to rebuild the Royal London Hospital, Whitechapel, is set to create some of the most expensive hospital floor space in history.

Campaigners have calculated that on the most recent projected figures the new building will come out at a staggering £64,400 per square metre.

To make matters worse, the refurbished building will provide only 343 beds, compared with the previous capacity for 850 – while offering no additional patient services.

The Save Bart's Campaign points out that among the building space to be lost in the rebuild will be 1930s medical and surgical blocks that contain "some of the most practical and user-friendly wards in the country".

Nurses Home

And among the buildings being demolished in advance of any final plans being agreed is the Queen Mary's Nurses Home – at the very point where affordable accommodation for nursing staff in London has been at such a premium.

Bart's, one of the oldest established hospitals in the world, was originally a fully-fledged teaching hospital in its own right, until it was recommended for closure in the Tomlinson Report in 1992, and "reprieved" only by being merged with the Royal London.

Its A&E unit and many acute services were closed down, reducing it top a specialist cancer and cardiac unit.

Now 40% of the controversial PFI scheme to rebuild the Royal London (last estimated to total at least £1.025 billion) is to be spent refurbishing Bart's: three quarters of the floor area is due to be new build, while some of the more attractive and useful buildings are to be demolished.

The PFI prospectus claims that the development will replace "Victorian buildings" – in spite of the fact that Bart's uses few Victorian buildings for patient care.

The scheme is claimed to represent an overall increase in bed numbers, but the original capacity of Bart's and the London together was 1700 beds, and the combined total of the PFI project would be just 1248.

Even in the unlikely event that the "final stage" negotiations now under way between the Trust and Skanska Innisfree stick to the latest estimated price, the Trust, which has struggled every year to balance its books, is likely to be facing an annual rent in the region of £150 million, to be top-sliced from its income.

In the quarter of London which finds three of the country's most deprived and impoverished Boroughs, it seems that health ministers are presiding over a project more costly but no more financially viable than the Millennium Dome across the river.

UCLH: last of the first wave PFIs?

IT LOOKS splendid from the outside, but the gleaming green and white £422m PFI-funded University College London Hospital at the top of Gower Street is not built to the latest Department of Health specifications.

Inside the glass and concrete structure bed centres will be just 2.7 metres apart, instead of the 3.3 metres that has been recommended since the first wave of PFI hospitals came on stream four years ago.

The difference, just 22%, may not seem significant, but staff in the first wave Trusts have repeatedly complained that there was too little space between beds to move and use modern equipment, to minimise the spread of hospital-borne infections, and for nursing staff to be able to move freely.

The DoH guidelines changed in 2003 – too late to alter the plans for UCLH, which were drawn up in the 1990s: a showpiece 21st century hospital is being built to the cramped space allocations of one of the meanest periods of the 20th century – and it will also have 50 or so fewer beds than the various smaller hospitals it is replacing.

It's not all going to be sardine-style accommodation: two of the 18 floors will be occupied by just 51 private patients, for whom there will be no lack of space and luxury.

But for NHS patients every other floor will take a maximum of 63 beds.

The building is also unique in allocating no space at all for nursing stations.

Instead there will be "podiums" with IT equipment at the end of each bay, encouraging nurses to keep moving at all times rather than relaxing for an instant. That should do wonders for recruitment and retention of scarce staff.

WHIPPS CROSS: Demand reinstatement of Kola Shokunbi

Kola Shokunbi

AS WE GO to press, support staff at Whipps Cross Hospital are holding meetings to decide on how to take forward the fight for the reinstatement of a key UNISON activist.

Kola Shokunbi, a leading activist in last year's successful pay strike against the previous contractors, ISS-Mediclean, was dismissed by Initial Hospital Services Limited on Wednesday April 7th.

UNISON believes Kola was dismissed because of his trade union activities, and has lodged an appeal against his dismissal with the Employment Tribunal.

Kola had received no warnings from management under the disciplinary procedure prior to his dismissal. The company alleged that Kola had intimidated a manager by shouting at her.

This is denied. The manager, who was under pressure at the time, approached Kola and began lecturing Kola about work he was not responsible for, and then began to tell him how to behave as a union representative.

In May, Kola and his colleagues will receive UNISON's national award for recruitment and organisation. This award is in recognition of work done for members on low pay at Whipps Cross.

Kola was also a key player in UNISON's Migrant Worker Project. The company have refused him permission to continue to work on the project at Whipps Cross.

Staff should note that the same management team who suspended Kola has been reported to senior management for an alleged invasion of one of our member's privacy. It is alleged that the day prior to Kola's suspension, a 61-year-old worker had her uniform opened against her will, in front of two male colleagues. We believe the purpose of opening the worker's tunic was to expose a necklace she was wearing.

These matters are of extreme concern to UNISON. We believe that Initial management are working under extreme pressure to "get results".

The struggle for Kola's reinstatement goes on.

■ Messages of support to and further details from UNISON Waltham Forest Health Branch, UNISON Office, Whipps Cross Hospital, Leytonstone, London E11 1NR.

Slim pickings where NHS goes private

NHS hospitals coined in £388m from private patients in 2002-3, up almost 8% on the previous year, according to market analysts Laing & Buisson.

But the share of total NHS income generated by private work remains insignificant, at less than 1% of Trusts' core income from patient activity.

A handful of Trusts, most of them in London, account for the lion's share of the private work: the top ten Trusts between them accounted for a third of the total private patient revenue across the NHS.

At the top of the list was the Royal Marsden, newly launched as a first-wave Foundation Trust, with over 23% of its total income flowing from private treatment.

The Royal Brompton and Harefield Hospitals Trust, which made almost £16m in 2002-3, was the next highest in share of income from private work, at 13%.

The only non-London Trust in the top ten earners from private patients was Oxford's Radcliffe Hospitals Trust, which secured £12.5m in revenue, 4% of its income.

Northwick Park porters prepare to fight privatisation threat

Gerry Mooney, Portering Steward, Northwick Park Hospital

Gerry Mooney

AS WE GO TO PRESS the situation at Northwick Park is that the tendering evaluation of Portering and Domestic services are concluding and to be presented to the Board on Wednesday 28th April 2004.

On Monday 26th April 2004, Unison will be balloting Portering members at Northwick Park Hospital for industrial action.

As porters and some of the lowest paid NHS working we did not wish to take this type of action, but we feel that the Trust is moving us towards privatisation.


UNISON
Union eTes
Central Middlesex Hospital, Northwick Park and St Mark's
Bulletin of UNISON North West London Hospitals Branch
Issue 1 ● Winter 2003 ● Free to members
INSIDE:
Privatisation? No thanks – p6
Chatwell wires their new switchboard – p2
UNISON backs new partnership for equality – p3
Will ESC in our Price Draw – p7
Private hands off our porters!
UNISON takes on the private contractors – and wins!
Trust heads into the red

Philip Sutcliffe in an Executive paper to the Trust board in December moved toward this Agenda.

In October this year we are due to have a new pay deal for the whole NHS,Agenda for Change: this was sold by a former Secretary of State of Health as a pathway from a porter to a consultant.

Well if Mr Sutcliffe has his way, most of us will not be able to achieve this dream: instead we will be taken out of the equation, and hived off to the private sector.

From the outset our union (UNISON) has argued that we should not have been part of this market testing exercise, since the portering services at NPH, like most support services are relatively low-tech, labour intensive services: the only way private contractors can cut costs and still make a profit is to cut corners and do less work, or to make staff work harder for less money.

We are aware from our trade union that our joint bid with the domestics as a stand alone in-house domestic and portering service has been ruled out at the evaluation stage: we would have liked to have an in-house joint domestic and portering service as one support service under an NHS banner.

To our UNISON domestics, who presently work for Sodexho at NPH, we say we are sorry that the people who were paid to put our joint contract together failed you.

Their bid price was excessive, and this left the porters as a stand alone NHS service bidding for the contract.

We will be asking questions of the Trust board, and asking them to explain why this was allowed to happen.

In future articles we will name and shame the management team who failed you.

We would ask ALL UNISON MEMBERS at NPH for your support for the portering service throughout our period of action in the coming months: we pride ourselves on being a first class service and delivering to patients and staff.

We would also remind the staff that the action we take today, you could be taking tomorrow.

If there is any disruption in services due to our dispute, we will try and keep these to a minimum.

It has been a long time since there was any type of industrial action at the NPH site, so support your NHS service and keep the porters where they belong … in the NHS!

North West London Hospitals UNISON congratulates **Health Emergency** on 20 years of campaigning to defend our NHS.

Message from the Branch Secretary

Secretary Pat McManus and Derek Helyar

Congratulations to Health Emergency, which at this year's UNISON Health Conference in Glasgow will celebrate 20 years as the newspaper for all those health workers and others campaigning for the NHS.

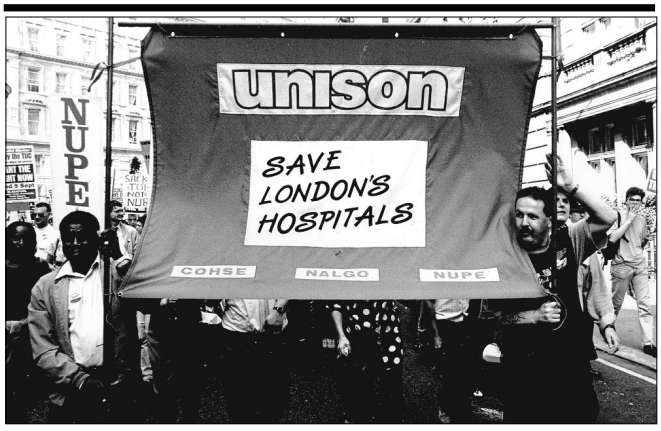
As we attend UNISON conference the struggle over the coming months will be around Agenda for Change: do we like it? do we reject it? do we support it? and what's in it for me?

Our Branch chair, Derek Helyar, has been released to work on AfC, after a momentous struggle with his management team. He is the Trust/staff side lead on Job Evaluation, and co-lead on KSF (Knowledge and Skills Framework).

Derek, along with Kirstie Wood will be leading the training programme at NPH and CMH.

If Agenda for Change is accepted, as members of UNISON, we would like to have in place our own UNISON Agenda for Change reps, who will be trained in all aspects of Agenda for Change, and will sit on job evaluation and KSF panels.

You can contact the UNISON office on 020-8869-3960 for further advice.



Footnote: In 1994 London Health Emergency, along with other socialist organisations and local Labour Party activists and MPs kept the Central Middlesex Hospital Accident and Emergency department open.

Now in 2004, like the Phoenix arising out of the ashes, a new hospital has been born.

So 10 years later we would like to say thankyou to all our friends at LHE, and to all socialist organisations and the Labour party for all your support over the years.

How to contact UNISON North West London Hospitals Branch

UNISON

Branch Office (Northwick Park) 020-8869-3960

Branch Secretary	**PAT McMANUS** 07818-064152
Branch Chair	**DEREK HELYAR** 07740-766244
Branch Treasurer	**SANJAY PATEL** 020 8869 3177
Membership Secretary	**SHARON SOUTHWOOD**, switchboard NPH 020-8864-3232
Health and Safety officer	**FRANK CONWAY** Works Dept CMH 020-8965 5733
Equalities Officer	**PETER IZEKWE** Outpatients Dept 07958 685156
Welfare Officer	**STEVE SAVAGE** ACAD CMH 020-8963-8931
Welfare Officer	**MAUREEN JARRETT** St Marks NPH 020-8235-4022

Stewards

Welcome to these new stewards. ***At CMH:***
A. BOCHDADI Target/Excel domestic
IRENE NZALLE MUKORO - Outpatients CMH
At NPH:
JANICE FERNAND - Wheelchair Service
NATALIE DWYER Nurse in Gray Ward.

Other stewards

CATHERINE THOMAS (Admin & Clerical) St Marks OPD, NPH 020-8869-5295
LEONIE ROBERTSON (Domestic Supervisor) Target CMH 07961-353218
BAZ CARLTON (Porter) Ancillary dept NPH 020-8869-2240
GERRY MOONEY (Porter) Ancillary dept NPH 020-8869-2240
JAMAL EI ESSAOUDI (Health Care Assistant) Bonnin Unit CMH 020-8453-2004
GEORGIA WESTON (Carpenter) Estates Dept NPH 020-8864-3232

If you're not a member, join now! Forms to join and recruit your colleagues can be obtained from UNISON Direct 0845-355-0845, or from any Branch rep.

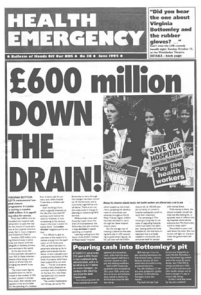
To join UNISON call **UNISONdirect** on **0845 3550845**

text 0800 0967968
6am-midnight Monday-Friday, plus 9am-4pm Saturday

An interview with Editor John Lister

20 years of Health Emergency

A complete back file of *Health Emergency* on CD-ROM, to include the next issue (60) will be available in the autumn.



How would you sum up Health Emergency's formula for survival?

"The paper made itself useful – to the unions and campaigners – and bloody awkward to ministers with duff policies.

It was launched to be the voice of campaigners resisting a wave of hospital closures in the capital triggered by cuts earlier in 1983 by Thatcher's Chancellor Nigel (now Lord) Lawson.

Health Emergency took of the role of a London-wide voice in defence of the NHS – against not only closures, but privatisation as well, which was being driven hard by the Tories, encouraged by what had effectively been a defeat for NHS ancillary staff in the pay strikes of 1982.

Its first issue was in the spring of 1984, when the whole agenda of the LHE Steering Committee was dominated by the Barking Hospital strike – the first real fightback against privatisation. It was also the start of what became the Miners' Strike.

HE picked up this issue and ran with it: we helped build support for the Barking picket line, we started to build a database on the private contractors, and we produced five issues of *Health Emergency* in the first 9 months.

We posted out hundreds of copies around the country, trying to link up with union activists and campaigners outside London. We have always tried to be a campaign that linked up activists across the country: if it hadn't been for affiliates and branches commissioning work from LHE in Wales and all over England, the paper would not have survived.

By 1985 there were strikes all over the country against privatisation. We had also had established *HE*'s links with that movement. While most GLC-funded campaigns disappeared shortly after abolition, we were able to carry on.

HE and LHE supplied the only source of London-wide facts, figures and press comment on the growing crisis in the NHS. It backed strikes and struggles against cuts and closures.

1988 was the 40th anniversary year of the NHS: it began with an unofficial strike by Manchester nurses demanding improved payments for working unsocial hours.

This was the arrival of nurses as an industrial force, after years in which health unions were dominated by ancillary staff. There were disputes all year.

But it was also the year in which Thatcher began the bizarre "review" of the NHS which culminated in the market reforms of 1990-91: and it also saw the Griffiths Report on community care, which brought a further privatisation of the care of older people and the widening of means-tested charges.

Early in 1989 Thatcher unveiled her market-style "reform" package, and *HE* championed the fightback.

It warned right up to the 1992 election that the Tories would axe thousands of beds if they got reelected.

We were working very closely with the London Region of COHSE (one of the health unions that merged in 1993 to form UNISON) and we stepped up the campaigning that autumn and right through 1993 under the slogan 'Londoners need London's Hospitals'.

This work led on to us working with campaigns in defence of Guy's, Charing Cross, Bart's and Edgware Hospitals in London, and hospitals and services all over the country.

By 1997 UNISON was affiliated to us nationally, and in a number of regions, along with over 100 branches. But we could also work with other unions, with pensioners' campaigns, with many Labour Parties, with a lot of councillors and council officers, and with lots of MPs, including most of the shadow health team, running up to the election.

But Gordon Brown had already committed himself to sticking to Tory cash limits for 3 years – which he did. That had to mean more cuts. Labour had also turned turtle and adopted the Private Finance Initiative.

HE gave Labour ministers a few months grace to show which way they were going – and then resumed normal service, delivering independent analysis of the policy and resource issues facing the NHS and health unions. They tried to shut us down by cutting off what council funding we still had.

20 years on it's almost like deja vue as we see New Labour ministers re-creating the market system they boasted about scrapping in 1997-98. *HE* has continued to fight PFI, to oppose all forms of privatisation, and to demand proper resourcing of the NHS.

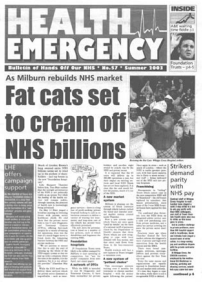
HE now gets no council funding at all: each issue, and the campaigning we do in between, has to be financed through affiliation fees, donations and commissioned research and publicity work from unions.

Now we can see Labour ministers going far further than Thatcher ever dreamed towards the privatisation of health care – with new private, profit-seeking Diagnostic and Treatment Centres snatching the cash from existing NHS services.

As Karl Marx said, when history repeats itself, the second time is farce.

The simple message is that if health workers or local campaigners want to fight in defence of the values and principles of the NHS, HE is still there as a resource. We can still offer useful support.

I think we have a lot to offer. But we could do much more. I'm hoping we can help stir some fresh embers of revolt – and strike a few more blows for public services before we reach our 21st anniversary!



Issues 53-58, April 2001-Autumn 2003

Specialist care for the worried wealthy

THE FIRST privately run "casualty unit" in Britain is claiming a huge success after treating 8,000 paying patients at its facilities in Brentford.

The misleadingly-named "Casualty Plus" has announced that it will open two operating theatres and launch a new day surgery service, after apparently treating 50% more patients than expected in its first six months.

Far from "casualty plus", the unit is only open from 7am -11pm, and falls well short of the level of support that would be expected even in the smallest of NHS A&E units. It will expect no life-threatening conditions.

Indeed the Audit Commission has argued that full A&E units treating fewer than 50,000 patients a year – more than three times the "Casualty Plus" level – are uneconomic and should be amalgamated into larger units with the full clinical back-up of a general hospital.

The "Casualty Plus" set-up on the other hand stands or falls by its takings – with a £29 minimum charge, and a long and complex tariff for each and every item of treatment it provides to the worried wealthy who choose to divert to the Great West Road rather than get themselves seen in a proper hospital.

Bring your cheque book

Even a simple steristrip plaster carries a minimum charge of £15: a large dressing could set you back £35. If you have anything more serious to be looked at you could be clocking up big money: even the simplest X-ray comes in at £40 per shot, pathology tests run upwards from £20 per item, with "specialist tests" running from £50 to £95 – even a cervical smear test is a thumping £49.

The "Casualty Plus" website suggests that treatment for a coughing fit could set you back £36.50, a sprained ankle or sore throat £59, and a cut hand £84.

Perhaps the most shocking aspect of this shameless rip-off is that ministers instead of exposing it as a waste of time and money have welcomed this new expansion of the private sector.

If nothing else, what this set-up underlines is what brilliant value the NHS represents – and how desperate the situation would become if poorer people as well as the worried wealthy are ever obliged to use "Casualty Plus" and its ilk rather than GP and A&E services.

A funny thing happened on the way to the Patient Forum...

THE PATIENT Forums which were supposed to have taken over some of the key tasks from Community Health Councils at the end of last year are in many areas struggling to function at all, let alone carry out their statutory duty to monitor Trusts.

575 forums, most with just a handful of active members, have been theoretically established since the autumn of 2003, to function alongside Patient Advocacy Liaison Services (PALS) and local authority scrutiny committees: but almost every aspect of their functioning has been shambolic.

This entire set-up is supposed to be overseen by the so-called Commission for Patient and Public Involvement in Health (CPPIH) – itself a tenuous body which appears to have already been marginalised by ministers.

While the CPPIH has spent £27m setting up a network of smart offices, it has passed on next to no resources to the Patient Forums.

No support

In what seems like a deliberate attempt to prevent the Forums developing the same level of organisation and influence as the CHCs they have replaced, they are being given no budget, no premises or staff: and their support services – including administrative support, arranging meetings, and so on – have been contracted out to a rag-bag of 140 voluntary organisations and charities.

CPPIH chief executive, Laura McMurtrie told the Health Service Journal that the chaotic system is working in some parts of the North East, but admitted there were "problems in some areas".

But LHE has received phone calls from SE London complaining at the total lack of support for Patient Forums.

The London Ambulance Service forum, too, has "only a few hours of administrative support a month, no office, no photocopier, no computer and virtually no resources to develop the new patients' involvement system" according to its chair, Malcolm Alexander.

That, of course, is just the way ministers intended: otherwise why would they have scrapped CHCs in the first place?

Engendering suspicion: PFI giant adopts an implausible Latin disguise

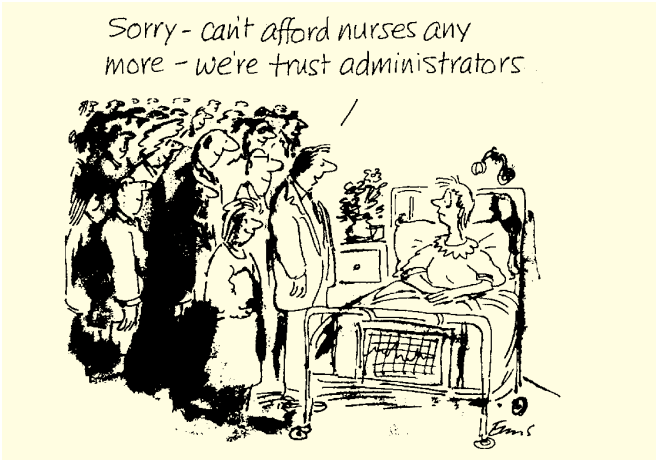
Jarvis, the failed rail contractor that is also heavily into PFI, has done a Ratners – and changed the name that has made the company a by-word for shoddy maintenance.

Gerald Ratner famously wrecked his family jeweller's business by telling a shareholders meeting they were making a fortune out of selling "crap".

It only began to recover after he had gone and the name of the firm had changed.

Jarvis was the firm at the centre of the Potters Bar rail disaster, and some time after that accident announced that its poor reputation on rail maintenance was having such a negative impact on the company's share values that it was pulling out of that area altogether.

But now it has gone further and invented a cod-Latin name "Engenda" to mask its identity for much of its business building PFI schools and delivering other public services.



NHS managerial revolution – official!

Managers and senior managers now make up only 3% of the workforce, according to Health Secretary John Reid, unveiling the government's spin on the latest census of NHS staff.

There is no shortage of alternative views: according to London's Evening Standard there are "More bosses than GPs, as bureaucracy soaks up extra NHS billions".

Of course both are true in a way.

Numbers of top managers have rocketed more rapidly than any other category of staff since the early 1990s, when the Tory government's market-style reforms bumped up the cost of running what had been a very cheap and efficient system.

New Labour, despite its pledge to slash £1 billion from bureaucracy, has retained the costly purchaser-provider split, and is busily restoring other aspects of the market system – and as a result has continued to increase management numbers.

While the Tory reforms boosted top management numbers by almost 6,000 (36%) in the five years to 1997, New Labour has further increased those numbers every year since, adding over 13,000 new bosses – an increase of 59% since they took office.

Overall, numbers of top management have risen by a staggering 80% in the last ten years, while the total NHS workforce they are managing has increased by just 27%, and qualified nursing staff have increased in number by just 21%.

By comparison numbers of hospital consultants have risen by 63% in ten years – but numbers of GPs have been much slower to rise, and are just 8.5% higher now than they were in 1993.

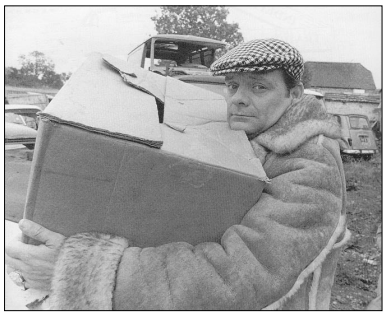
There has also been a smaller increase in other administrative and clerical staff, whose numbers have increased by 28% since 1995.

There are now just 2.6 a&c staff per manager, compared with 3.5 in 1995, and 10.9 qualified nursing staff per top manager, compared with 15.2 in 1995.

There were 11.3 nursing assistants and HCAs for every top manager in 1995, but there are only 8.4 per manager now.

So if it seems that there are ever more people in suits trying to impress other people in suits by making you work harder – it's true!

New NHS system brings patients 'must-watch' telly



Patientline's unturnoffable tellies make Delboy's Albanian camcorders seem like a bargain

THE RECENT revelation that thousands of patients in NHS hospitals are being subjected to repetitive TV trailers and adverts on bedside screens for over 15 hours a day seems too bizarre to be true.

The system had previously hit the headlines as a result of the extortionate rates charged to callers who ring in to the bedside phones to speak to relatives in hospital. The service is much cheaper for patients to ring out, resting on the assumption that most friends and relations will call them back – and pay through the nose to do so.

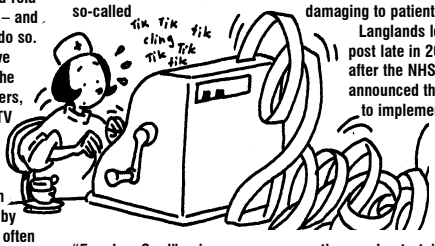
And health workers have angrily pointed out that the system requires pensioners, who are entitled to free TV licenses at home to fork out up to £3 per day to watch TV: larger TV sets that had been installed in sitting rooms and wards by Leagues of Friends have often been removed, to leave patients with no choice but to pay up if they wish to watch the box.

But it is a fact that in 32 hospitals out of the 115 equipped with bedside units there is no 'off' switch at all to give patients any relief from the relentless repetition of trailers for services offered by Patientline, the private firm that supplies the 17,500 switchless bedside sets.

As a result the sets flick on as early as 6am and pump out their tide of advertising until 10pm, regardless of the wishes of the patient.

But life is not necessarily any easier for the 38,500 patients with the more modern bedside sets, which do have an 'off' switch – but one that can be over-ridden at the discretion of the hospital, again giving relief only from 10pm-6am.

Only patients who purchase a so-called "Freedom Card" gain any control over the equipment during daytime hours, although a useful technique is the so-called "McMaster Procedure" (named after a resourceful and angry patient), which involves switching the system over to the (free) radio service, which effectively overrides the screen display, and then disconnecting the headphones, thus silencing the machine.



The Department of Health have been unusually keen to defend Patientline, which boasts former NHS chief executive Sir Alan Langlands on its board, and which was set up by former Prison Service boss Derek Lewis.

A DoH spokesperson has downplayed the problem of the non-stop compulsory TV, and poo-pooed suggestions that being permanently subjected to flickering TV images can be damaging to patients' health.

Langlands left his NHS post late in 2000, shortly after the NHS Plan announced the intention to implement the so-called 'Patient Power' system, involving bedside communications and entertainment. Early in 2003, he signed on as a non-executive director of Patientline, which has a near-monopoly of the provision of bedside units.

But it seems that more and more patients are demanding the power to *switch off* Patientline and its tedious trailers.

What was that about Patient Choice?

20 years on – and still campaigning!

2004 HAS BROUGHT the 20th anniversary of Health Emergency newspaper, and we are hoping to to go into our third decade by stepping up the campaign to expose the consequences of the restoration of the "internal market" system, Foundation Hospitals, PFI and privatisation in all its guises.

So it's a big thankyou to those union branches that have taken out adverts to help us fund this 12-page issue – and we urge all affiliated organisations to consider taking an advert in the next, 60th issue, in the autumn.

A full page is £480, 1/2 page £250, 1/4 page £130, 1/8 £70, 1/16 £35. Send us your artwork, or just the text you want in your advert and we can design one for you.

But remember LHE can also help your organisation in campaigning – developing detailed and researched responses, or campaigning newspapers, newsletters and other publicity.

KEEP US POSTED with your local news: 020 8960 6466, or email us at: news@healthemergency.org.uk

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