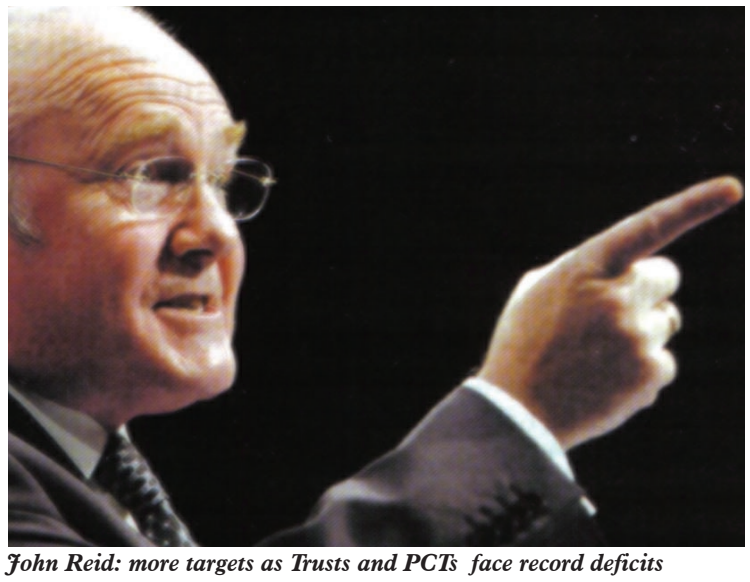
HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.60 * December 2004

SEASONS GREETINGS TO ALL OUR READERS AND SUPPORTERS!

LHE is on the move... *Reaffiliate* for 2005! **SEE BACK PAGE**

Beds closed, jobs axed, as private sector scoops up windfall contracts



John Reid: more targets as Trusts and PCTs face record deficits

NHS reforms bring back market chaos!

New NHS cuts shock

A NEW ROUND of cuts in beds, jobs and patient care is ripping through the NHS as Tony Blair's "modernisation" package goes horribly wrong.

The NHS budget, at £67 billion, is now double the figure from 1996-97, but relentless government targets for reduction of waiting lists and waiting times have forced managers to run hospitals and other services at levels well beyond their financial means.

The result is massive and growing deficits in Trusts and Primary Care Trusts throughout the NHS.

A snapshot survey of England's Strategic Health Authority websites by London Health Emergency revealed combined deficits in excess of £500 million by November – but the very patchy and late publication of figures means that this figure is likely to be a serious underestimate.

● MORE DETAILS: page 3

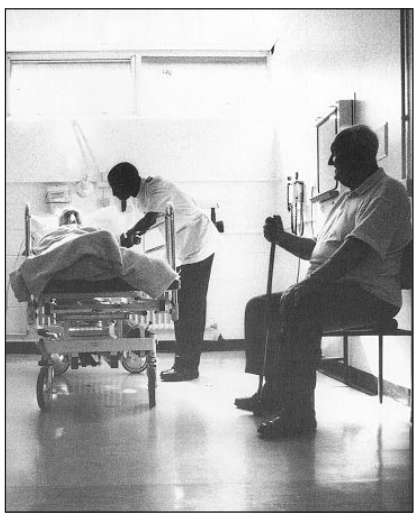
New Labour's reconstruction of the "internal market" has already gone even further than Thatcher ever dreamed: indeed it is increasingly clear that the ambition is to create not an internal but a free market in health care, in which the NHS is only one among many varying providers of services.

The National Health Service is set to become little more than a "brand name", a centralised fund that commissions and pays for patient care, while NHS hospitals compete on ever less favourable terms with private sector companies for a share of the budget and for the staff they need to sustain basic services.

Beds axed

As billions are being funnelled into contracts with private hospitals and health providers, NHS hospital Trusts and PCTs across the country are facing massive deficits, closing beds and cutting jobs as they struggle to balance the books.

Ministers have made it clear that they want at least 10 percent of elective (i.e. non-urgent, waiting list) operations to be carried out by the private sector next year, rising to 15 percent by 2008.



By the end of 2005 Primary Care Trusts will now be obliged to offer almost all patients a "choice" of providers from the time they are first referred – including at least one private hospital.

GP Fundholding has also returned, under the guise of "practice based commissioning", with GPs encouraged to shop around for waiting list treatment for their patients, with the promise that they can retain half of any unspent funds within their practice.

As the new GP contract allows family doctors to opt-out of on-call work and 24-hour responsibility for patient care, private companies are striking deals to fill the gap, some working in liaison with ambulance Trusts.

But ministers have also encouraged the private sector to develop chains of primary care outlets, which could begin to squeeze NHS primary care.

Nursing homes

Already much continuing care of older people has been privatised, with the mass closure of NHS geriatric beds, and an increasing reliance upon privately-run nursing homes and private domiciliary services to deliver care to frail elderly patients.

The drive towards increased private provision of all forms of NHS-funded treatment has been reinforced by the introduction of a new "payment by results" system, under which from next April hospitals will begin to receive only a fixed price payment per item of treatment delivered, rather than the previous block contracts with local Primary Care Trusts.

This scheme was designed to open space for Foundation Trusts to win extra income in competition with other NHS hospitals.

Ministers admit it could force the closure of "failing" NHS Trusts.

Indeed it is so disruptive it is being phased in over four years.

It threatens the viability of any hospitals which for whatever reason have costs above the NHS "reference cost".

It also opens up fresh possibilities of switching patient care – and the funding that goes with it – from NHS to private providers.

Payment by results

Ironically the payment by results system seems set to have its most serious consequences for new hospitals funded under the Private Finance Initiative (PFI) – which are saddled with high, fixed overhead costs, while lacking spare beds and capacity to take on additional patients.

In 1997 Blair warned we had 'Ten days to save the NHS'.

But as he prepares to do battle for a third term in office, who will protect this most popular public service from a further round of privatisation and wasteful market-style reforms?

MARKET MADNESS BRINGS SCANNER SCANDAL

MRI scanners purchased as part of a modernisation of NHS facilities are standing idle in many hospitals, "mothballed" as a result of the lack of funding for staff to operate them.

So says the College of Radiographers, which has protested strongly against the government's more recent decision to commission 12 mobile scanners, to be run by the private sector (Alliance Medical) with a view to reducing waiting lists across the country.

According to the College the NHS has bought 42 new MRI scanners, and announced a further £90m programme to replace scanners and CT scanners that are more than ten years old.

But the private provision has been decided centrally as an initiative to raise scanning capacity by 16 percent, delivering over 130,000 scans a year.

Nobody favours delays and queues for these vital tests: but does John Reid's left hand really know what his privatised right hand is doing?

● NHS Treatment Centres fight for life - p4: ● Payment By Results - Back page

Pension threat draws trade union anger

THE CIVIL Servants led the way in fighting government moves to slash public sector pensions, with a strong national strike by the PCS in November, and plans for renewed action in the New Year.

But news that NHS staff and local government employees could also face a reduction in their pension entitlements has brought an angry response from UNISON and other public sector unions.

The government proposes to raise the normal public sector retirement age from 60 to 65, and to increase the age at which people can take early retirement from 50 to 55. This will affect many workers who typically take early retirement before 55 due to the stress of their jobs, or who have accumulated enough benefits from service.

UNISON's Davce Prentis said:

"What really riles me is the breathtaking hypocrisy of MP's who recently voted themselves the best pension scheme in Europe, but say they can't afford it for anyone else.

"This is a position that UNISON cannot accept and will oppose. It will lead to conflict between UNISON and the government, if not this year then next."

Prentis with UNISON delegation on this summer's TUC demo for pensions

Trick question key to SW London gamble

THE "consultation" on the plan that threatens to close one of two general hospitals serving a catchment population rising towards 700,000 people in Merton, Sutton and Mid Surrey, was a sham from start to finish: it revolved around a trick question to which there is no correct answer.

Local people were asked where they would like a new, single site hospital to be located: but we are not being asked whether they accept the fundamental assumption behind the scheme – that the area could be properly served by just one, smaller hospital, in place of the two they have now.

Unfortunately this trick question was not only employed by the local health service planners – who have tried repeatedly to push people down the road of a single hospital in the area: local politicians have taken up more or less the same theme.

Each of the main political parties seems to be telling its local supporters that a single site hospital would be fine – as long as it's in their patch.

This is not only divisive – playing off one locality against another – but also dangerous: because unless the flawed logic of the NHS planners is challenged, people arguing for just one hospital will ensure that one hospital does close, leaving local people across the whole area facing longer journeys, less choice and greater risk.

A hard-hitting report *Gambling with Our Lives* drafted by London Health Emergency for UNISON, rejects the notion that a single site hospital would do anything to improve access to health.

It argues that the scheme proposed in the consultation document would drastically reduce the numbers of front-line beds to care for emergency admissions at the very point emergency admissions are soaring across the country.

Ripples of chaos

Bizarrely, the scheme would also result in thousands of local patients being forced to use hospitals outside the current catchment area – piling new pressure on hospitals like St George's, Kingston, Mayday, East Surrey and St Peters which are already struggling to cope.

Several of these hospitals have yet to recover from previous closures of surrounding hospitals and A&E units like Queen Mary's Roehamp-ton, Ashford and Crawley.

The loss of local patients would drain millions in revenue from Epsom & St Helier Trust, but create new problems because surrounding hospitals lack the funds (and staff) to build and run new wards to take the additional caseload.

UNISON's detailed response to the consultation document also exposes the contradictory figures that have been used by planners and business consultants in drawing up their plans to switch patients to "local care hospitals" and "intermediate care", with 70 or more to be given "intensive support" in their own homes.

UNISON notes that not a shred of evidence has been published to convince local people that the scheme is properly worked through, costed, or viable.

Despite the plan's title, the proposals set out in the consultation document don't offer "Better healthcare closer to home": they offer less healthcare, longer journeys and greater risk for patients needing urgent treatment.

Those who endorse these plans are gambling with local people's health care – and their lives.

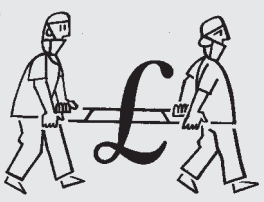
They must be told to go back to the drawing board and start again – with a plan for two general hospitals, and based on local health needs.

■ For more details on the local campaign contact:
kobrien@unisonfree.net

Shock as St George's faces £20 million health cutbacks

The shock announcement by St George's Hospital that they will need to take urgent measures, including staff reductions and bed cuts, to claw back a £20 million deficit has rocked health services across the South West London area.

And as we went to press unions at Kingston Hospital were warning that staff shortages were compromising safety in the maternity unit.



St George's managers have claimed that their accumulated deficit of between £20 - £35 million results from years of using capital funds to prop up day to day expenditure – an accountancy device now outlawed by the government, forcing the Trust to claw back the cost of years of underfunding.

Initial cuts planned will result in the loss of 25 front line beds and 100 jobs, although local unions have warned that these measures will save £2 million at most, and are likely to be the tip of the iceberg.

UNISON officer Michael Walker has already warned staff that the Bolingbroke Hospital could be next on the hit list. Battersea and Wandsworth TUC are working with unions at hospitals across South West London to make sure that the full extent of the local health carve-up is brought to public attention. That publicity campaign will run through Christmas and into the New Year.

Geoff Martin, from Battersea and Wandsworth TUC, said today:

"There is no way on earth that St George's can slash £20 million from their budget without having a devastating impact on patient care.

"That means longer queues in accident and emergency and growing NHS waiting lists right across our area. "Our demand is that the government step in to bridge the financial gap and give George's the money it needs to run services at a level that meets patient demand."

WISHING HEALTH EMERGENCY
A VERY MERRY CHRISTMAS
AND A PROPEROUS NEW YEAR

UNISON North West London Hospitals Trust

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UNISON

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Peter Nzekwe	07909556704/ 0208 453 2605	EQUALTIES OFFICER/ LDR OF BLACK MEMBERS
Sanjay Patel	07884183671/0208 869 3177	TREASURER
Sharon Southwood	07753750465/0208 864 3232	MEMBERSHIP SECRETARY/ EDUCATION OFFICER

Manchester mental health mayhem

Manchester's Mental Health and Social Care Trust, set up to bridge the divide between NHS and social service budgets, was officially declared a basket case over the summer.

Auditors warned that its deficit and its historic debts of £6.3m raised the prospect of the Trust being the subject of a "public interest report", tantamount to a first move to wards bankruptcy.

A £2.7m cuts package included vacancy freezes, a renegotiation of service agreements, and an attempt to squeeze down soaring costs for supported accommodation.

But even while managers scoured the service in a hunt for further savings of £2.7m, the Trust has been compelled to inject extra resources to tackle staff shortages on mental health wards.

So dire is its financial plight that Greater Manchester Strategic Health Authority has intervened with an injection of £11m in capital to bail it out of its involvement in the PFI-funded rebuild of Manchester Royal Infirmary, to avoid further debts building up.

Keep us posted

Health Emergency will be monitoring and publicising the latest wave of cuts and closures throughout the winter and up to the election.

It is already clear that some cuts can be

forced back if ministers fear an electoral backlash – see page 5.

So if your Trust or PCT are slashing beds, services or axing jobs, make sure you contact us at health.emergency@virgin.net, fax us on 020 8960 8636 (up to February 1), or ring 07774 264112.

Mid Yorks fingered over £40m shortfall

AT THE END of September financial watchdog body the Audit Commission issued a dramatic "public interest report" confirming UNISON's warnings that the Mid Yorkshire Hospitals Trust finances had been going from bad to worse.

The report, produced for the Commission by firm of auditors appointed to monitor the Trust, pointed to an already accumulated deficit of £20.8 million, and projected a shortfall of up to £40m by the end of the current financial year.

It warned that this would mean the Trust would be in breach of its statutory duty to break even, and has referred it to the Secretary of State.

Previous warnings by the auditor early this year that the Trust had to draw up and implement a "Recovery Plan" had produced no tangible progress.

Indeed the report is no surprise: it is if anything slightly more optimistic than the report to the previous meeting of the West Yorkshire Strategic Health Authority, which projected a shortfall of £46m by next March, comprising £30m of debts carried forward from last year, and an additional deficit this year of £16m.

In the spring, a potential deficit as high as £53m was revealed in the *Wakefield Express*, alongside proposals to freeze vacancies and spending on new developments.

Senior finance chiefs in the Trust and at SHA level seem to be living in denial, with plans for financial balance hanging on a massive programme of Cash Releasing Efficiency Savings to the tune of £46m, and in June Trust finance chief Tony Waite insisted that it was planning "savings" and aiming to restore financial balance "next year".

The Mid Yorkshire Trust's chronic financial crisis is a major factor in its relegation to no-star status.

But as UNISON has warned, savings on this scale can only mean a wholesale axing of services and of jobs.

"Whichever way you look at this, there is more pain in store for local patients and for NHS staff," says Branch Chair Adrian O'Malley.

"There is no real alternative to injecting more money: our MPs should be fighting for more money to fund NHS services in Wakefield."

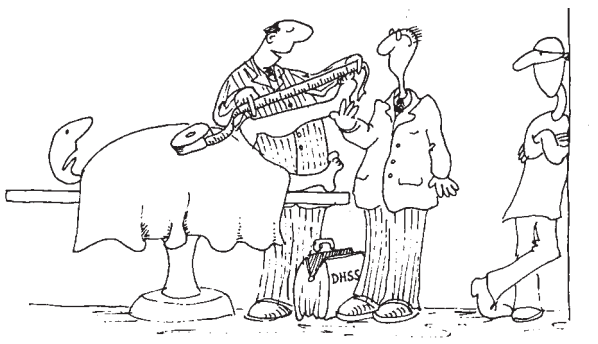
Bigger budgets, bigger deficits

Beds and jobs axed as Trusts cut back

With deficits projected to reach unprecedented levels across the country as Trusts grapple with ever-more ambitious government targets, the brakes are now being slammed on in a last-ditch – and generally doomed – effort to balance the books.

The scope of the cuts that are now being contemplated is indicated by a *Daily Mail* telephone survey of 72 NHS Trusts in late November, which showed that two thirds were in deficit, and some were implementing major cutbacks.

- Leeds Teaching Hospitals Trust, facing a £16m shortfall had closed 8 wards (250 beds) and four operating theatres
- Southampton University Hospitals Trust, £11m in the red, and sore from its rejected bid for foundation status, had axed 85 beds, merged two wards, cut out 400 mainly vacant, jobs and imposed 100 redundancies.
- Hammersmith Hospitals, £6m in the red, had closed 90 beds and limited staff recruitment.
- Oxford Radcliffe Hospitals Trust, seeking to address an underlying £42m deficit, has made specialist nursing staff redundant – while spending £20m a year on agency staff. Mail room porters have taken strike action over cuts in their overtime.
- Bradford Teaching Hospitals Trust, the Foundation Trust whose deficit has rocketed from a projected £4m to £11.3m, has axed five wards and four operating theatres (see page 7).
- St George's Hospital, South London, facing a deficit of between £20m and £35m, had barely scratched the surface with the closure of 24 beds and axing of 100 mainly vacant posts.



As Trusts contemplate their options to save money with just four months of the financial year to go, an extra pressure compelling them into action has been the new rules that prevent them spending money from their capital funds to bail out the revenue account.

The stock response from the Department of Health is that Trusts can "borrow their way out of trouble by approaching the NHS bank for a loan".

Whether some of the most indebted Trusts would be seen as a secure risk for a loan, and how they could hope to pay it back while their finances are so massively out of balance is not so glibly explained.

No bail-out

Indeed Health Secretary John Reid has insisted that ministers will not bail out Trusts in financial crisis.

Replying to the Commons Health Committee in November, he argued that pumping extra cash into Trusts facing deficits "just means that somewhere else a patient has to wait longer in pain".

"Our approach is that we must not undermine or detract from the responsibility taken by local management."

If necessary Trusts facing financial problems should change their management, suggested Dr Reid.

This will come as no great comfort to the Trusts facing an impossible combination of targets and cash pressures in the next few months.

Nor will it delight many New Labour candidates who seem likely to face a fight for re-election amid a barrage of hostile press headlines on cuts and chaos in the NHS.

Deeper into the red ...

LHE's snapshot survey results, showing actual and projected deficits in latest Strategic Health Authority papers, November 2004

SHA	Deficit
NW London	£31m
N Central London	£19m
NE London	£12m
SE London	£15m
SW London	£32m
Avon Gloucs & Wilts	£27m
Beds and Herts	£11m
Birmingham & Black Country	£11m
Cheshire & Merseyside	£12m
Cumbria and Lancs	£72m
Greater Manchester	£14m
Hampshire and IoW	£47m
Leics, Northants	£14m
Norfolk, Suffolk & Cambs	£54m
SW Peninsula	£16m
Surrey & Sussex	£20m
Thames Valley	£37m
West Midlands South	£21m
West Yorkshire	£33m

NB: these figures are taken from published SHA papers, some of which date back to the summer: they may seriously underestimate the ill-health of the local health economy.

The new flagship £420m PFI-funded UCLH is not yet open, but already the Trust is facing losses on its NHS Treatment Centre

With odds stacked on private providers

NHS treatment centres seek "level playing field"

GOVERNMENT determination to forge ahead regardless with a chain of privately-run "Independent Treatment Centres" to poach elective surgery from existing NHS providers remains undiminished, despite the mounting evidence that the private units are neither needed nor welcome.

The case of the private treatment centre specialising in cataract operations, to be foisted upon Oxfordshire's Primary Care Trusts despite the evidence that it will cut the ground from below the well-established Oxford Eye Hospital has achieved national notoriety.

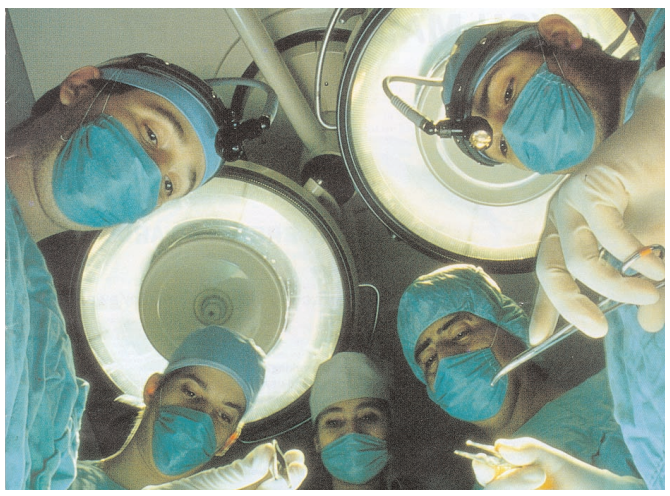
A report into the affair has now vindicated (but not reinstated) the chair and a non-executive of SW Oxfordshire PCT who both resigned rather than rubber-stamp the Whitehall-driven scheme: but precious few PCT members have been prepared to take such a strong stance in defence of the NHS or PCTs' own local autonomy.

Spotting the weakness, ministers have been cranking up the pressure to divert an ever-larger share of NHS elective surgery towards private providers.

In January the government will invite tenders to deliver a further 250,000 operations a year, worth an estimated £500 million annually: in addition another £400m worth of X-rays, scans, blood tests and pathology tests will be hived off to the private sector.

These moves will almost double the number of private sector operations to be purchased by the NHS, pushing the government's total spend in the "independent sector" up towards £1.5 billion – two thirds of the total £2.3 billion turnover of the private medical industry in 2003.

These latest moves come despite signs during the summer that a planned chain of privately-run treatment centres in North London was on the verge of collapse because NHS Trusts had developed plans to deliver the additional treatment "in-house".



Who is really getting stitched up in new Treatment Centre deals?

Barnet & Chase Farm, the Royal Free and Barking Havering and Redbridge Trusts were all given the go-ahead which had been denied to Oxford Eye Hospital – to expand NHS capacity, and deliver the additional treatments at a lower price than the private sector.

But while these NHS Trusts will celebrate their opportunity to keep the private sector at bay, the arbitrary conduct of these negotiations underlines the extent to which decisions are being taken at national level by Department of Health bureaucrats, with little or no reference to local people and local services.

Even where public capital has already been invested in state of the art NHS-run treatment centres there is no long-term guarantee that these will remain viable or operational. Some are already in trouble.

The blatant bias that is being shown in favour of private providers and against the NHS is exposed by the problems faced by one of the pioneering NHS-run treatment centres, the Ambulatory Care and Diagnostic (ACAD) unit at Central Middlesex Hospital.

While the privately-run treatment centres receive long-term guaranteed income on a "play or pay" basis, and have been allowed to charge higher than NHS reference costs, not of these conditions applies to NHS treatment centres.

Elsewhere NHS consultants have been instructed by managers to pass over a share of their waiting list workload for treatment in private sector units – another "target", but one which ministers are no so keen to publicise in the mainstream press. But no such pressure exists to maintain the flow of patients to NHS units.

Instead, under the "payment by results" system, hospitals will have a greater incentive to hold on to the largest possible share of their own potential caseload.

Already by mid November the ACAD had spare capacity to treat 3,000 more patients, Hammersmith Hospitals had 4,000 spare slots, and the new unit at Kidderminster Hospital had scope to treat 2,000.

Partly-used NHS facilities result in rising costs and poor productivity – giving ministers a ready-made pretext for favouring an apparently cheaper and more efficient private sector.

One foundation Trust, University College London, has warned that it may have to scale down its treatment centres if the odds remain stacked against them: but it seems that the government's fixation with expanding the private hospital sector could lead them to ban Foundation Trusts from bidding for the provision of the next round of treatment centres in the January tendering process.

Alternatively foundations may be encouraged to strike deals with private health providers, in which the Trust would have only a minority stake, to submit tenders for treatment centres.

All this is designed to ensure that private firms are given no grounds to question the government's commitment to privatising an ever-increasing share of clinical care.

Meanwhile many frustrated NHS staff seem to be the ones that need reassurance that the government is not backing out of its commitments to them and their trade unions.

Companies bid to make primary care their business

PRIMARY care, too, could face the prospect of slices of its work being hived off to private sector providers under new guidelines from the Department of Health.

GPs who may have thought that competition was simply a problem for hospital Trusts may be shocked to discover plans to create a new market in primary care, with "alternative provider medical services" being invited to bid for contracts where local GPs are struggling to meet government targets.

City and Hackney PCT is among those that have decided to advertise for private providers to bid for work filling gaps in local primary care services.

One firm which pioneered the private provision of GP services in Essex, East London and Brighton has publicly considered floating on the stock exchange to raise further investment capital.

Many people may wonder whether the emergence of new companies with shareholders as major providers of primary care is really a step towards modernisation – or a giant step backwards to the days before the NHS.

Now private hospitals feel the squeeze

NHS SUCCESS in reducing waiting lists and waiting times is having a major impact on private medical companies, which are now looking for ways to boost flagging numbers of individuals with health insurance.

Long waiting lists have always been the main recruiting sergeants for BUPA and other medical insurers, but if patients can expect swift treatment on the NHS – perhaps even in a private hospital – then the incentive to fork out hefty premium payments is drastically reduced.

Now three of the main private hospital chains, BUPA, Nuffield hospitals and Capio, have entered into talks with health insurer over a plan to reduce premiums by cutting charges for treatment.

Insurers are demanding price cuts of 20-25 percent to make their limited cover packages more attractive.

But with the NHS pumping billions in additional funding into the private hospitals, there may be little incentive for the companies to play ball with the insurers.

Private medicine, with its exclusion of emergency care and chronic conditions, remains an option for those with more money than sense.

Oxford ophthalmic treatment centre row

Back-room bullying exposed

Earlier this year there was a stand-up row between SW Oxfordshire Primary Care Trust and the Strategic Health Authority over the decision to endorse a new privately run "independent treatment centre" that could cut the ground from beneath Oxford Eye Hospital.

Non-executive PCT director Jane Hanna and chair Professor Martin Avis resigned after being threatened with fines or surcharges by Thames Valley Strategic Health Authority if their opposition to the new ophthalmic treatment centre resulted in the deal collapsing.

The back-room bullying by NHS bureaucrats was driven by Department of Health officials, who were determined to make the deals they had done with the private sector appear as "local" schemes, and to force them through regardless of the consequences for existing local services.

Consultants at the Eye Hospital had angrily pointed out that they already had plans in place to expand NHS capacity to deliver cataract operations to meet government targets on waiting times: the new services, they showed, were more expensive, unnecessary, and a threat to the continuity of teaching and other specialist care at the Eye Hospital.

But as the echoes of the Oxford confrontation rumbled on, it emerged in July that two north London Trusts, the Royal Free and Chase Farm, had successfully beaten back plans for a new treatment centre in their area – by expanding NHS capacity.

It seems that while Oxford's row may have hit the headlines, the benefits of the resistance by PCT directors have been reaped elsewhere.

Why, then, are Oxford's services now still being thrown into jeopardy by a centrally-imposed contract that nobody in Oxford really wants?

NHS Trusts like St George's could be pushed over the edge of bankruptcy by Patient Choice

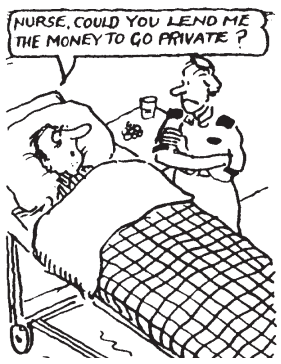
Private choices that could bankrupt local NHS Trusts

By the end of next year Primary Care Trusts will be compelled to offer patients a choice of treatment by private sector providers as well as alternative NHS hospitals.

Guidance from the Department of Health instructs the PCTs that – regardless of their local circumstances or of patients' wishes – they must include at least one private provider out of a "menu" of four or five alternatives for five of the ten most common elective procedures.

Among the companies hoping to cash in on this new bias in favour of privatisation are Swedish private health firm Capio and Nuffield hospitals.

PCT choices will be restricted to which of the ten most common procedures should offer patients the option to use a private hospital.



Minister threatens closures

Health Minister John Hutton has insisted that the government will not 'bottle out' of tough decisions to close hospital which "fail" as a result of patient choice.

While claiming that this did not mean hospitals would be closed at the first sign of difficulty, and that efforts would be made to revive and support the stragglers, he made clear that the ultimate sanction could and would be used, and that failing hospitals could be sacrificed to force through New Labour's vision of a market system in health.

"We are going to be tough about it. A lot of people think we will bottle it at the last minute. We won't. It will be a very different NHS," he told a fringe meeting at Labour Conference.

But it is clear that in some areas, especially those where private hospitals are few and far between, PCTs could find themselves obliged to meet their targets for private sector referrals by effectively denying patients the option of NHS care.

Critics are also warning that if large numbers of individuals are encouraged to opt for a private sector provider they could trigger the financial collapse and even closure of local health services or even whole NHS hospitals – even those which are doing well under the current system.

Hospitals which lose a slice of their elective care will see their unit costs go up, as existing capacity is used by fewer patients, and as they are left to deal with the more expensive, more complex and chronic cases which the private sector does not wish to offer.

The BMA, which seems to have been extremely slow to recognise the scale of the problem in the latest changes, has warned that even hospitals losing less than 10 percent of their patients to private sector or other NHS Trusts could be forced to close.

Pre-election pressure forces retreat on closures

CONTROVERSIAL plans to rationalise and cut back maternity services in North London have been put on the back burner until after the General Election.

Under the proposals, backed by local Primary Care Trusts over the summer, paediatric, neonatal and maternity services were to be moved from the Royal Free Hospital in Hampstead to the Whittington Hospital in Islington: but the plan was immediately denounced by consultants at the Royal Free, who went public with their protests.

As the boat rocked dangerously in full public view, the project director was forced to warn that negative publicity prior to the election could incur the wrath of the Department of Health.

But in December the *Health Service Journal* reported that consultation on the entire scheme had been put back until the summer of 2005.

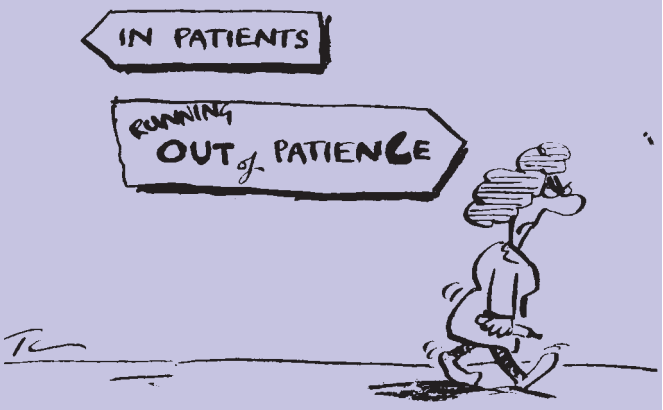
Consultants at the Royal Free argue that this leaves them and their services in limbo, and that the postponement seems more like a stay of execution than a reprieve.

Meanwhile a similar delay has been adopted on a consultation on reorganisation in the cash-strapped Barnet and Chase Farm Trust.

■ The pace for electorally-conscious retreats was set during the summer with the Hartlepool by-election, in which New Labour was challenged by campaigners fighting to save the local hospital. John Reid promptly ruled that the hospital should remain open … presumably at least until after the votes are counted.

ONS Report skews NHS productivity statistics

Private sector cost inflation exposed as NHS staff work harder than ever



The recent Report on Public Sector Productivity issued by the Office of National Statistics on October 18 has been widely reported as revealing a "slump" in productivity in the National Health Service.

The *Financial Times* (October 19) headlined its front page "NHS fails all tests on improved efficiency": the article was based on a press release from the ONS, and it has subsequently emerged that some journalists seeking the full report on which this press release was based were told it was not available.

For those looking to stick the boot into NHS staff it seemed too good a story to miss. Tory Shadow Chancellor Oliver Letwin claimed that the figures were "damning", and that they pointed to "health inflation, waste and inefficiency", with spending on hospitals rising five times as fast as the number of hospital treatments.

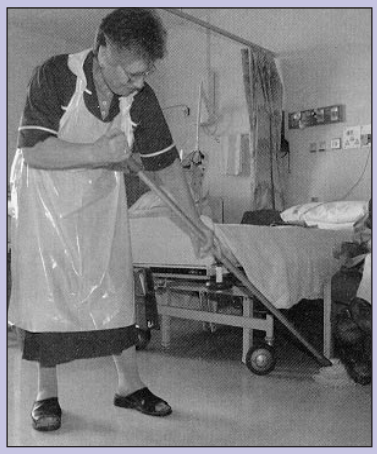
Although Health Secretary John Reid branded the figures "absurd" and pointed out (as the ONS specifically admit) that they have excluded any measurement of quality of care, he did not challenge the assertion that somehow NHS staff – even while working under more pressure than ever before – have somehow fallen back in productivity.

But a closer look at the ONS report reveals that the underlying cause of the "health inflation" is not NHS staff, but the many and various private sector suppliers of goods, services and even some elective health care: they now make up a majority and a steadily rising share of NHS spending.

Page 13 of the ONS Report shows (in Table 2) a breakdown of NHS spending between Labour, "Intermediate consumption" [i.e. procurement of goods and services from the private sector, including services from private sector health providers], and "capital consumption".

"Bureaucracy"

And the shock finding for those seeking to prove "bureaucracy" or flagging productivity among NHS staff is that while in 1995 labour costs amounted to 57% of NHS spending, and "Intermediate consumption" just 40%, by 2003 this picture had completely changed: then only 46% of spending was on labour and 52% on "Intermediate consumption".



NHS staff are working harder

Comparing the rate of growth of spending in these two categories shows the situation even more clearly: from 1995-2003, spending on labour went up just 44% (from £22 billion to £32 bn), in a period in which the NHS workforce, again according to the ONS report, increased by 22% (as whole time equivalents, p15).

By contrast spending on "Intermediate procurement" rose by a massive 133% – from £16 billion to £37 bn.

50 percent increase

In other words for every £1 spent on staff in 1995 just 71p was spent on goods and services from the private sector, but by 2003, for every £1 spent on staff £1.14 was spent on procurement – an increase of 50%.

Over this same period capital consumption as a share of NHS spending fell back from 2.8% to 2.2%, but NHS *output* (ignoring factors which might be argued as improving the quality of care) increased by 28% according to the ONS.

Since the key factor in expanding health care capacity, and the most frequent causes of bed and ward closures, delays and shortages in health care revolve numbers of staff, it is clear that the efforts of the NHS workforce are the key to the real gains in output and quality of care that the government has been keen to highlight.

Perhaps just as shocking is the ONS admission that its statistics make no distinction between the different skill levels of the NHS workforce and their contribution to patient care: everyone becomes reduced to an abstract number of hours worked. The October document admits the standard manual on measuring productivity stresses that:

"… 'an hour worked by a highly experienced surgeon and an hour worked by a newly hired teenager at a fast food restaurant' should be differentiated for productivity analysis, but although desirable, this is difficult".

Without such a breakdown it becomes very difficult to work out where the increased spending on staff has gone, and whether, as the Tory leadership claim, too much is still being frittered away on bureaucracy as New Labour recreates the same wasteful market-style system that Thatcher began in 1989-90.

But the figures do suggest that any search for efficiencies should begin with a more rigorous scrutiny of the costs and profit margins of NHS suppliers, and the inflated sums being paid to purchase treatment from private sector providers.

Significantly these aspects of the figures are ignored by the ONS document, its press release and its conclusions, and few, if any, of the journalists who have covered the story have had the wit or curiosity to check further..

Perhaps we should be calling for an independent audit of the ONS, its agenda and its methods?

■ *The full report is available via the ONS website, at* http://www.statistics.gov.uk/pdfdir/healthpr1004.pdf

Rocketing cost as Reid agrees more PFI projects

PFI Hospital projects worth £4 billion were given the go-ahead by Health Secretary John Reid during the summer, many of them reflecting the massive cost inflation of PFI chemes since the first wave was rubber-stamped back in 1998.

The new projects include:

- Bedfordshire and Hertfordshire (£880m) – A major acute service reconfiguration in the Hertfordshire area, including plans for redevelopment and expansion at Watford and a new hospital at Hatfield, incorporating a new cancer centre for Bedfordshire & Hertfordshire.
- North Bristol and South Gloucestershire (£310m) – Options include the relocation of specialist acute services onto a single site in North Bristol / South Gloucestershire, complemented by a network of new community facilities and community hospitals.
- Papworth Hospital NHS Trust (£148m) Options include redeveloping the existing Papworth site or co-locating with Addenbrookes on the "Cambridge Biomedical Campus."
- Sandwell and West Birmingham Acute Trust (£591m) - New acute sector facilities including development of community based alternatives to hospital care.
- Maternity and Childrens Hospital in Leeds (£204m) - Key to the Trust's strategy of locating acute services onto a single main hospital site.
- Hillingdon Hospital redevelopment (£271m)
- North Mersey Future Healthcare Project (£1,008m) - The North Mersey Future Healthcare Project involves :
  - the redevelopment of facilities at the Royal Liverpool Children's Hospital incorporating the concept of a 'Children's Health Park,
  - the redevelopment of the Royal Liverpool University Hospital (at a cost of £499m),
  - an elective care centre and additional ward facilities at University Hospital Aintree
  - and the further and improved provision of mental health facilities.
- Northwick Park and St Marks (£305m) - The project will redevelop the site to create a 'state-of the art' 600 bed acute hospital.

Carlisle confession: PFI design a cock-up

CARLISLE's troubled Cumberland Infirmary was "too small" when it was built, and will need to be redesigned – its Trust Chief Executive has now admitted.

Unions and campaigners argued long and loud that the project would create chaos for lack of beds and would make it impossible to fund expended services in the community.

But the £87m project forged ahead regardless, and opened in 2001 as the first PFI hospital in England.

It is not the first in which management have been forced to admit their predecessors got it wrong: Durham's Dryburn Hospital has also been admitted as a planning foul-up, and Bishop Auckland's PFI Hospital has since been subject of repeated debates on how it can be downgraded to play a role in the local health service.

Despite the fact that it stands next to a former hospital block which could be refurbished relatively cheaply to supply the missing 100 or so beds that should have been included from the start, the Carlisle hospital now seems likely to be supplemented by a new hospital in Whitehaven, also to be funded through PFI.

Whether this will be any better planned remains to be seen.

Paddington: four long years of PFI failure

By Jean Brett, Chair, Heart of Harefield Campaign

FOUR YEARS after it was hard sold as being up and running by 2006, the Paddington Health Campus lacks both an Outline Business Case and Outline Planning Permission, despite having drawn up and submitted both in 2000.

How could such a flagship scheme have regressed this far?

The answer lies in the basic flaws in the original business plan, the unwise choice of a constrained inner London site for the development, and the inefficiency of the project's management.

Nor can the buck be passed on this occasion to a PFI "partner": no such partner exists, nor has one yet been advertised for.

Yet despite this track record of failure and the damning findings of an independent review in September, there have been no resignations. This is, after all the world of business, not the NHS.

The September 2004 review of the project was conducted jointly by the National Audit Office, the Treasury, and the Department of Health.

It was triggered by the rise in cost from an initial estimate of £360 million to £800 million. The review was charged with finding the reasons for this huge discrepancy in the figures, and the process by which it had arisen.

On September 6, Sir John Bourn, the Auditor General, wrote

to the MP who had raised concerns over Paddington's soaring costs and gross mismanagement, saying that there had indeed "been shortcomings in the way the Paddington Health Campus scheme has been run".

Among the review findings were:

- The scheme was not deliverable for the price set out in the original Outline Business Case.
- The project team could no longer be certain that the preferred option in the original Outline Business Case remained best value for money.
- There was no definition of an affordability envelope within which the scheme had to remain. This contributed to the scheme having a lack of focus and permitted cost drift.
- The project as reviewed by the team in February 2004 was probably not affordable as it did not have the required definition nor the clear support of the local health community.
- The annual revenue gap for the reviewed project was £48 million.

This is an extraordinary catalogue of errors in an NHS scheme which employed a Project Manager on a high salary, backed up by an in-house team.

Added to this was £6m of public money spent on external consultants and the close interest which the Chief Executives of the Trusts concerned were supposed to be taking in the project.

Yet despite a barrage of bad publicity from informed quarters, it took a 3-pronged external review to uncover what efficient management should have prevented happening.

Three months after the publication of the independent review report, the necessary new Outline Business Case for the Paddington Campus is still awaited.

This is despite Julian Nettel, the Chief Executive of St Mary's Trust, working on it full time.

The crux of the problem has always been the lack of space on the Paddington site to accommodate not only St Mary's, but also the Royal Brompton and Harefield Hospitals. Disgracefully, the breaking up of the Western Eye Hospital, part of St Mary's, is still being considered as one way to ease the space problems on the selected site.

While chasing the fantasy of a huge hospital complex, NHS management ignored the fact that Harefield Hospital could not and would not be moved into London.

It was always better that resources should be focused on the priority of rebuilding St Mary's, the district general hospital for Paddington.

Until there is any accountability in the NHS, public money will continue to be squandered on projects like the Paddington Campus, which from the outset lack viability.

Even the independent report clearly lacks any teeth to force a change, leaving the much-criticised management intent upon the same path, rather than learning from past blunders.

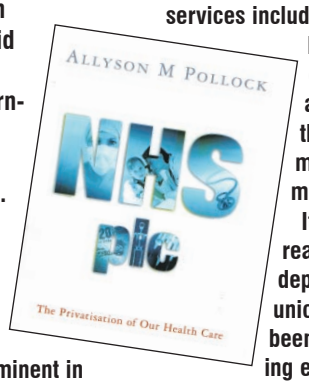
The tragedy with the Paddington project is that it raises such serious questions over the calibre of the most senior NHS management who have been involved in the last four years of fiasco.

Contact Heart of Harefield Campaign c/o 12 High St, Harefield, UB9 6BU. Phone 01895 824689.

BOOKSHELF

The must-read book for all NHS campaigners

NHS plc, The Privatisation of Our Health Care, by Allyson M Pollock, Verso £15.99.



A NEW book by outspoken academic Allyson Pollock lifts the lid on the scale and pace of the government's privatisation of a growing share of the NHS.

Professor Pollock, whose School of Public Policy at University College London has been prominent in challenging the Private Finance Initiative and the more recent policy of Foundation Hospitals, opens up the book with a hard-hitting Who's Who of the big-hitters from the private sector who have been welcomed in to key policy roles and around the NHS by Tony Blair and his ministers.

Chapters deal with the market-style policies introduced first by the Tories and now again by New Labour, the extent of the privatisation of services including almost all long-term care of older people, and the inroads that have been made into primary care.

It's a fascinating read – if a little depressing for trade unionists who have been on the receiving end of so many of the attacks.

At least LHE has consistently been on the right side of the arguments on PFI and Foundation Trusts: and we will fight on against cuts, closures and any further privatisation.

Coming soon: the searchable HE archive

The promised CD-ROM carrying a searchable back file of all 60 issues of Health Emergency – going back to 1984 – has been delayed in production, but will be available in the New Year. The price will be £25 to affiliates and supporters, and £75 to other organisations and individuals.

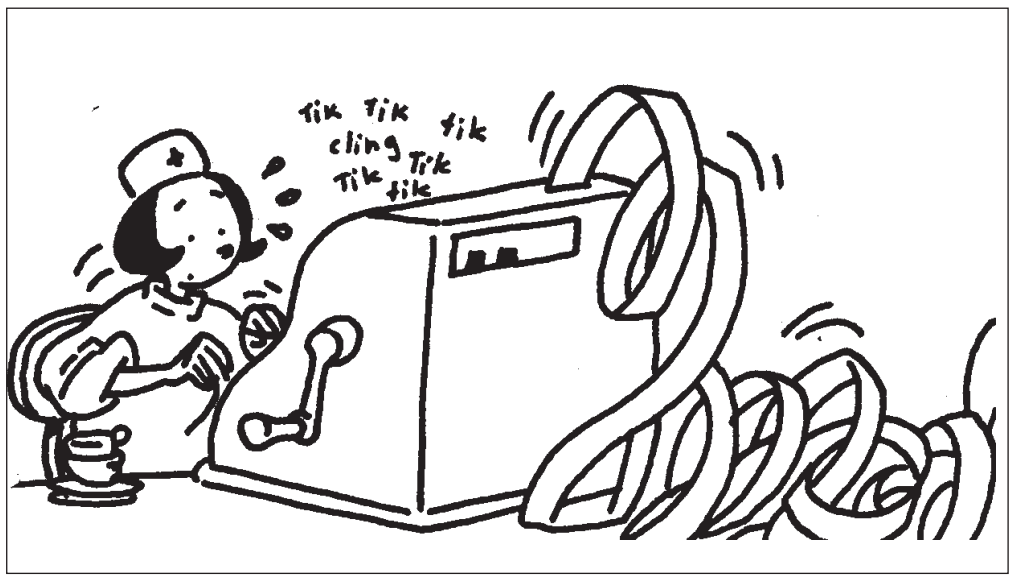
Is there a doctor in the organisation?

Lister disguised as parrot

LHE's Information Director John Lister has been awarded a PhD at Coventry University.

His 120,000-word thesis on market-style reforms in health care systems around the world was written over 5 years in collaboration with LHE.

Readers will be relieved to know that *Health Emergency* has decided NOT to serialise it in the next 25 issues



Accountants flown in to salvage first floundering Foundation

A firm of hard-nosed New York-based business trouble-shooters has been brought in to sort out the growing financial crisis in the first failing Foundation Trust.

Bradford Teaching Hospitals NHS Foundation Trust had already run up a growing cash shortfall, and was predicting a £4 million deficit after just six months as one of the very first Foundation Trusts to get the go-ahead from the independent regulator (the office established to scrutinise the running of foundation trusts, now known as Monitor).

Despite the fact that this level of deficit is modest compared with many NHS Trusts, Monitor decided to step in.

The company, Alvarez & Marsal (A&M), was chosen and called in by Monitor: but the costs of flying in a team of "turnaround management consultants" will have to be paid by the Bradford Trust.

Monitor claimed there were advantages in bringing in advice from outside the NHS: but staff in the Bradford Trust are likely to see it differently.

Certainly A&M are well outside the NHS: their own website says their approach centres on helping to "stabilise financial and operational performance by developing and implementing comprehensive profitability and working capital [sic!].

"A&M's involvement reassures creditors that the company is taking important steps to address its problems and maximise its value."

Insofar as this jargon makes any sense, it underlines the concerns of campaigners who fought against Blair's government ramming through the establishment of Foundation Trusts.

The policy scraped a wafer-thin majority in the Commons last year, with 62 Labour MPs voting against. Among the arguments raised against Foundations was that not only would they gain additional "freedoms" denied to other Trusts, creating a 2-tier NHS, but they would be encouraged to act like normal businesses.

In particular they would be free to pick and choose which services to provide and which to withdraw; and free to embark on asset-stripping – and, if all went horribly wrong, there was a real chance that some could go bust.

As if to underline precisely these fears, A&M go on to itemise some of the policies in which they specialise, which include:

- Implementing cash conservation guidelines and controls
- Identification and disposal of non-core assets
- Development and review of cost-reduction initiatives

Bradford bosses will no doubt be encouraged to learn that the firm will also help out with "pre-bankruptcy planning".

But while the regulator has seen fit to intervene so publicly and dramatically, Ministers are predictably washing their hands of the whole business.

The Department of Health told the BBC it was all a matter for Monitor, while in the Commons Health Secretary John Reid has issued a statement refusing to answer parliamentary questions on any foundation trusts, declaring that:

"Ministers are no longer in a position to comment on, or provide information about, the detail of operational management within such Trusts. Any such questions will be referred to the relevant Trust chairman."

While the level of Foundation Trust autonomy has been questioned by the rapid Monitor intervention, Foundations are also far from locally accountable.

Indeed while Ministers look the other way as soon as things go pear-shaped, the 'elections' to the Bradford Trust's Board mobilised a puny 541 people – far short of one percent of the local population – to elect its 17 Governors.

Meanwhile the problems that have tripped up the Bradford Trust are set to trigger a wave of cash crises among front-line hospital Trusts across the country from next April.

As the trouble-shooters start measuring up assets for disposal, recommending which services the Trust should drop, and sizing up the workforce for redundancies, it is worth noting that Bradford's problems today will be those of many more Foundations and other Trusts in the months and years ahead.

If Blair comes back for a third term, he is committed to pressing all Trusts to become Foundations.

Seeing stars?

Government determination to press-gang the remaining Trusts into Foundation status is leading to a fresh volley of reforms to the already bruised NHS.

First it was announced that the bar would be lowered to allow 2-star Trusts to apply to become Foundations, instead of restricting it to the 3-star elite.

But then came an even bolder move – to sweep away the star ratings systm altogether, and bring in an even more complex system that nobody really understands.

That way EVERY Trust can be forced on board, no matter how bad their finances

Auditors to probe PFI windfall profits

Private companies have always seen profit as paramount in PFI deals

MASSIVE windfall profits coined in by PFI consortia from refinancing and selling on their stake in completed projects are to be investigated by the National Audit Office.

The so-called "secondary market" in PFI-built hospitals, roads, prisons, schools and other projects has expanded as the number of completed projects come on stream.

Latest estimates suggest that around £32 billion worth of schemes are now operational, and the Financial Times has argued that this could open up a market of as much as £6 billion worth of equity shares (up-front investment by PFI companies), carrying guaranteed, index-linked revenue from these projects, to be bought and sold.

So far at least £700m worth of deals are known to have taken place, most of them in the last two years.

And while straightforward refinancing schemes for PFI projects are now obliged to share some of the proceeds with the public sector, this does not apply to the booming market in equity – hence the NAO investigation.

The equity stakes are a relatively small component of a PFI investment (normally around 10 percent): but they can be very lucrative. Carillion, which sold on its stake Dartford's Darent Valley PFI hospital quadrupled its £4m investment in six years, generating a clear profit of £11m.

Investors expect to recoup around 10 percent each year on their stake in operational PFI schemes, while new projects commonly offer a rate of up to 15 percent – three times the level of return from conventional long-term investments.

And with minimal risk and the government/taxpayer footing the bill, it seems that the runaway costs of the next round of PFI hospital schemes will be putting a smile on the face of city slickers and shareholders for a generation to come.

Plymouth anger over broken PFI promise

MANAGEMENT have reneged on a pledge to keep exclude non clinical services from the £340m project for a new hospital in Plymouth, the largest scheme in the South West.

The plan is to build a new 280-bed elective care centre, and refurbish the existing Derriford Hospital.

But the GMB has protested that management plans to bring privatised support staff back in-house had been dumped without consultation.

Trust bosses responded that since the staff had been privatised for ten years, they would not be affected by the new project.

But since the scheme faces a massive £10m a year affordability gap, it is clear that private sector bidders are being given the nod and the wink to cut costs by 20 percent to bridge that shortfall – and this could only be done at the expense of support staff and the quality of the services they deliver.

LHE offices to relocate

We're going west ... but we're going strong into 2005!

London Health Emergency will be uprooting from its White City offices at the end of January, and heading for Heathrow.

The lease on our present office expires in February, meaning that we have to move or pay substantially higher rent and council tax charges. And with fewer staff working for LHE, it seems sensible to go for a smaller place, to hold down the overhead costs, so that the greatest possible share of affiliation fees and donations can be used to keep affiliates and supporters and the media informed.

After exploring a number of options, we have Paul Kenny, London regional Secretary of the GMB, to thank for the help in securing a new premises in West London.

Our new office will be in Hayes, not far from the airport, but in easy striking distance of the M4, M40, M25 and therefore the rest of the capital.

So from **February 1** our contact address will be

213 Church Road, Hayes, Middlesex, UB3 2LG. Our phone number will be **020 8573 6667**. A fax number will be notified. Email and websites will be unchanged.

20 years on: part of the LHE archive

Meanwhile we are urging all trade union branches, organisations and individuals who have been affiliated to LHE and kept it alive during the long hard years since 1983 to reaffiliate in 2005, and help us keep up the pressure.

If anyone felt that LHE has no further role to play in keeping activists and campaigners informed, just take a look at the content of this issue. Who else will keep you up to date on:

- PFI
- Payment by Results
- Patient Choice
- Foundation Trusts
- Cuts, closures and job losses
- Rationalisation
- Changes in Primary Care
- Campaigns and struggles around the country.

What other organisation offers its affiliates

- A tabloid newspaper (now in full colour)
- Research services
- Help drafting responses and promoting your case
- Publicity services, including Branch newspapers and newsletters
- Campaigning assistance
- Speakers for your meetings and events.

LHE is still the only source offering this on a national level, and with 20 years experience in supporting campaigns to defend the NHS and fight privatisation.

We no longer have any council funding to support us: all our resources come from affilliations, donations and commissioned projects from trade unions.

We do need and value your support. Our affiliation fee is just £25 per year. **Make a resolution to reaffiliate in 2005, and if possible send a donation to help us take forward the fight.**

2005 is expected to be an election year: so whichever party you want to win, make sure you take the opportunity to push the NHS to the top of the political agenda.

PBR could KO high-cost Trusts

The controversial new system of Payment by Results (PBR) for Trusts will be phased in to the NHS over four years to 2009.

The slow take-off is no doubt linked to the prospect of a General Election in the spring of 2005, since it threatens to be destabilising, and its consequences still are not clear for many Trusts and Primary Care Trusts, some of which stand to gain, and others lose.

Trusts whose costs are currently above the new fixed prices that they will be able to charge for treatments they deliver under PBR stand to lose out heavily: unless they can find ways to slash back costs, or closing down loss-making departments, they face the prospect of losing money on every patient they treat.

PCTs in these areas will recoup a windfall gain, paying out less for the same level of hospital care. But in some areas they will need to increase cash allocations to match the new fixed prices in Trusts which have been operating at below this level of costs.

Here Trusts stand to make windfall gains, at the expense of other Trusts and the wider health care economy.

PBR will initially apply only to acute hospital care, leaving out mental health where standardising costs has proved even more problematic: but it already seems set to trigger a fresh stand-off between primary care and the hospital sector, since Trusts will be given a fresh incentive to treat patients in hospital in order to claim the funding, while GPs will potentially be able to retain more funding for primary and community care if they keep larger numbers of patients out of hospital.

'We're short-staffed – find your own corridor to dump yourself in'

This new market-style system makes no reference to social and other inequalities, and runs the risk of funnelling an ever-larger share of the NHS budget to the best-resourced and largest Trusts and GP practices at the expense of those struggling to cope in more deprived areas.

But the new system also represents the end of 30 years of efforts to equalise allocations of NHS spending on the basis of population and local health needs.

Now PCTs in areas where Trusts are currently delivering services below the new NHS reference costs will require extra cash to pay an increased fee – which will become a "surplus" for the Trust.

Conversely PCTs whose Trusts currently deliver relatively high-cost treatment will see their cash allocations reduced.

None of this bears any relation to social deprivation, the age profile or relative health of the population: the new market system emerges as the enemy of equality.

Special deal for PFI

Some specialist services – but not all of them – may be given special exemption from the full rigours of PBR, Health Minister John Hutton has told the *Health Service Journal*.

The additional costs associated with specialist medicine could be moved "off tariff". Some treatments may attract top-up payments.

Hutton has also hinted that PFI hospitals, carrying high fixed and index-linked overheads, could also be given extra concessions to avert major problems.

The first wave of PFI hospitals contained dramatically fewer beds that the services they replaced, but have been obliged to pay out a larger share of their budget to secure use of the new buildings: this puts them at a double disadvantage in delivering care at the same costs as other NHS Trusts.

But while Hutton was evasive on what concessions might be made to accommodate PFI hospitals, he was adamant that there should be no limit on the windfall profits that could be racked up by Trusts which deliver services at below the new tariff rate.

"We won't be putting a cap on aspiration, and we won't be putting a cap on ambition, and we won't be putting a cap on profits to be reinvested in better services," he told the HSJ.

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ALSO: LHE can draft research and response documents to hit back at local rationalisation and closure plans

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