UNISON Public Eye

Campaign paper of UNISON Health NW Anglia District Branch. September 2001 (120,000 copies)

Two into one won't go: the costs and complications of switching services from Peterborough District to Edith Cavell Hospital could squeeze services

New hospital could cost an arm and a leg!

The £135m scheme for a new single-site hospital in Peterborough, approved by Health Secretary Alan Milburn in February of this year, is due to be finalised in May 2003 and operational by 2006.

But because the hospital is to be funded by private companies as part of the so-called "Private Finance Initiative" (PFI), it is certain to cost the local NHS far more than £135m, and is likely to trigger a fresh escalation in the pressure on front-line hospital services in the city.

UNISON is convinced that the scheme will set back rather than improve health services for patients. The assumptions made by local planners leave large potential gaps in care, especially for elderly and frail patients and all those whose care would be switched from existing hospital services to vaguely-defined new services – to be delivered by already overworked GPs and primary care staff.

Switching acute services from Peterborough District Hospital to the less accessible Edith Cavell Hospital site will also cause problems of access for those least able to drive or afford private transport.

UNISON is also concerned at the chronic lack of sufficient social service provision to support ever-larger numbers of frail elderly patients in their own homes or in nursing and residential care, without which the new hospital will struggle to achieve its highly ambitious targets.

This is far from the first time that the health needs of older people in Peterborough and the local area have been pushed to one side by NHS chiefs eager to save money or put their hands on private capital.

But UNISON, in common with other trade unions and organisations in the city, is convinced that this PFI plan is the most serious problem so far: in our view it is a formula for failure.

Its costs, which would hang like an albatross around the neck of local health care for at least 25 years, would squeeze other important areas of health care – mental health, community services, primary care – and worsen the problems of morale that have already affected the recruitment and retention of professional and medical staff.

We want to see new hospitals and proper investment in Peterborough's NHS: but we don't want services distorted by the costs of a scheme which siphons cash from front-line care.

If ministers are serious in wanting to see services develop, and meeting rising public expectations, they must inject public funds, not open up the NHS to the predatory forces of private profiteers.

A few new hospitals funded by NHS capital are being built in various parts of the country. UNISON wants to see this type of investment in Peterborough.

Once an affordable source of capital has been identified, we would be happy to discuss the best model for the development of 21st century health services for the

PFI = Profits From Illness

THIS newspaper has been produced by the UNISON NW Anglia District Health Branch as a way of publicising our concerns about the proposal to build a new, privately-financed single site general hospital on the Edith Cavell Hospital site.

The plans are set out in the Integrated Health Investment Plan, supported by local health service Trusts, health authorities and Peterborough City Council.

To maximise public awareness of the issues 120,000 copies of this paper are being circulated, covering every household in Peterborough.

We welcome your comments and invite your support for our campaign. UNISON can be contacted c/o Union Office, Peterborough District Hospital, or ring us on 01733 331491

INSIDE

Peterborough Constituency Labour Party

Peterborough CLP is opposed to PFI in all its forms and believes that our health and other public services should be publicly funded.

We support UNISON's campaign to keep public services under public control and run not for profit but for need.

Phone 01733 347079

Peterborough Co-operative Party

The Co-operative Party believes that the NHS can only provide the best service when it is publicly owned, funded and run. We support UNISON's campaign to stop the creeping privatisation of our public services.

Phone 01733 551502

Peterborough Pensioners Association

Peterborough Pensioners Association is absolutely opposed to the introduction of PFI into the NHS and supports UNISON's campaign to keep our services publicly owned and publicly funded.

Together we built the NHS, together we will make it stronger!

01733 554791

UNISON

Cambridgeshire County Branch

"We support your campaign to achieve a properly funded Health Service and to oppose Private Finance Initiative (PFI) funding in the NHS. We hope that the campaign is successful and wish you well in your work to achieve your goal."

01223 717015 (fax 01223 718123)

Peterborough Trades Union Council

Peterborough TUC calls for an end to PFI, PPP and any other attempt to introduce privatisation to the public services.

We want a National Health Service available to all, providing the best possible service free at the point of delivery. Private industry only wants to make a profit.

We urge all trade unionists to actively support UNISON's campaign.

Phone 01733 560164

Socialist Appeal

Readers of Socialist Appeal support UNISON's campaign for publicly funded public services. Only a publicly owned and democratically managed and controlled NHS can meet modern needs and provide a National Health Service free to all at the point of delivery!

No more sell-offs! Renationalise the privatised industries!

Phone 01733 755186

Website: www.marxist.com

UNISON

Kings Lynn Branch

Fully supports the campaign to keep PFI out of the Health Service

01553 613613

Get some respect!

JOIN A UNION!

This newspaper has been produced by the NW Anglia District Health Branch of UNISON, Britain's largest trade union, representing workers in all parts of the public sector.

It has been supported by other trade unions and organisations concerned with the provision of health services in the Peterborough area.

We know that our views and concerns on the new hospital project will shared by many individual members of the public. But NHS "consultation" exercises take little or no account of individual views.

And employers take little notice of individual workers: we only have any strength if we get organised, and speak collectively, through a trade union.

If you work in the public sector and you are not yet a member, why not join UNISON, and our campaign against PFI and privatisation?

If you work in other sectors, you can join other unions which will speak up for you. Just fill in the form below and we will forward your details to the appropriate local union, who can send you an application form.

YES, I want to join a union

❑ Please send me a UNISON application form

❑ Please forward this to an appropriate local trade union

Name .....

Address .....

.....

Occupation .....

Employer .....

Send to: UNISON Health NW Anglia District Branch, c/o Peterborough District Hospital, Thorpe Rd, Peterborough PE3 6DA

Graphical Paper and Media Union (GPMU) Anglia Branch

We send our support to the UNISON campaign against the introduction of PFI in the Health Service.

Good luck, from the officers and Branch Committee.

01638 664044
Fax 01638 664430

The Peterborough Hospitals Trust Joint Staff Committee (Staff Side)

Supports UNISON's campaign of opposition to the Private Finance Initiative.

PUBLIC MEETING

The Private Finance Initiative (PFI) in the NHS

Tuesday October 9, 7.30pm

Great Northern Hotel
(Peterborough Rail Station)

Speakers:

STEVEN WEEKS (UNISON National Officer, Health Service Group)
JOHN LISTER, Information Director, London Health Emergency
Speaker from the LABOUR PARTY

ALL WELCOME!

PFI schemes mean fewer beds

The first wave of PFI hospitals became notorious for the scale of the cuts in bed numbers they represented, with reductions in front-line acute beds ranging from 20% to 40%.

PFI planners wanted to axe almost 40% of beds in Hereford (from 414 to 250) and North Durham (from 750 to 450) – and as a result the newly-opened North Durham Hospital has been plunged into an immediate beds crisis.

"It must be serious – they've found me a bed"

Two other PFI hospitals embodying large-scale bed reductions have so far opened, in Dartford and in Carlisle, and both are already struggling to cope with pressures on the depleted numbers of beds remaining.

These bed numbers were based not on the actual experience of front-line Trusts dealing with current levels of caseload, or on any actual examples of hospital practice in this country, but on the wildly over-optimistic projections of private sector management consultants working for PFI consortia.

The verdict is still awaited on one of the other big bed cuts based on this type of approach, in Worcestershire, where the Health Authority forced through plans to for a new PFI-funded Worcester Royal Infirmary which would cut 260 acute beds – over 200 of them in Kidderminster – as well as beds in Redditch – a county-wide cutback of 33%.

In Edinburgh the new Royal Infirmary will involve a loss of 500 of the existing 1,300 beds, and a halving of the 6,000-strong workforce.

Since the findings of the NHS Beds Inquiry, commissioned by the Labour government to report on the adequacy of bed numbers, Alan Milburn has become more sensitive to the charge that PFI is further reducing front-line capacity.

Milburn has insisted that new PFI schemes must at least match the existing numbers of acute beds.

This has in turn led to a further escalation in the costs of the new generation of PFI schemes.

PFI = Plumbing Failures Instantly!

Unveiling the latest round of PFI schemes receiving the rubber stamp, Alan Milburn argued that:

"For too long investment in NHS infrastructure has been a low priority when it should have been a high priority. …

"The consequences are plain for all to see. Buildings that are shoddy, equipment that is unreliable, hospitals that are out of date. In too many places the environment that staff work in and patients receive care is simply unacceptable."

But the experience has been NEW buildings which are shoddy and NEW equipment that is unreliable – at a higher price than before. After just a few months of the first PFI hospitals coming on stream:

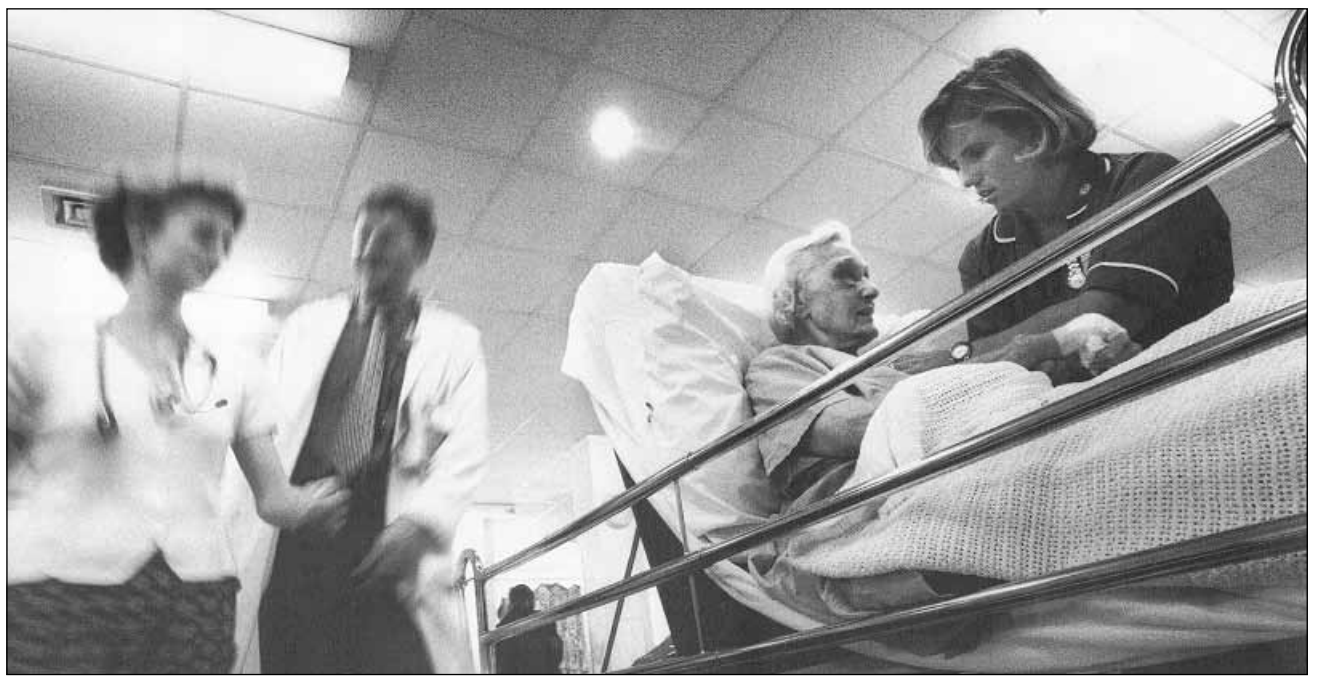
● In Carlisle, a chapter of disasters and catastrophes began with an impractical design – with a huge glass roof, but no air conditioning – and continued with the use of cheap sub-standard plastic joints for pipes, resulting in leaks of water and sewage.

Faulty equipment and fittings have brought a succession of power cuts, while cuts in support staff have meant that broken equipment goes unrepaired. Walls are too thin for staff to be able to put up shelves.

● In Dartford, too, plumbing was a central issue in the new hospital. Taps ran dry in operating theatres a fortnight after the hospital opened, and supplies of sterilised supplies ran out, bringing elective surgery to a halt.

Consultants complained that the portering contract did not cover wheeling patients back to wards after operations.

● In North Durham the saga continues, with generator failures plunging operating theatres ITU and casualty into darkness, overheating, poor planning, and plumbing faults which include sewage flooding through ceiling areas and cold taps that give out hot water.


The first PFI hospital schemes have axed beds and siphoned extra cash from front line patient care

What is PFI?

THE INITIALS stand for Private Finance Initiative: PFI is a Tory policy, first devised in 1992, which was strongly denounced by Labour's shadow ministers until a few months before the 1997 election.

According to Tory Chancellor Kenneth Clarke, who in 1993 introduced the policy, initially for NHS projects costing £5m or more, PFI means: "Privatising the process of capital investment in our key public services, from design to construction to operation."

In 1995 Margaret Beckett, then shadow health secretary, voiced Labour's line when she told the *Health Service Journal* "As far as I am concerned PFI is totally unacceptable. It is the thin end of the wedge of privatisation."

But in the summer of 1996 Shadow Treasury minister Mike O'Brien announced a change of policy: "This idea must not be allowed to fail. Labour has a clear programme to rescue PFI."

By the spring of 1998, PFI was: "A key part of the Government's 10 year modernisation programme for the health service."

Scam

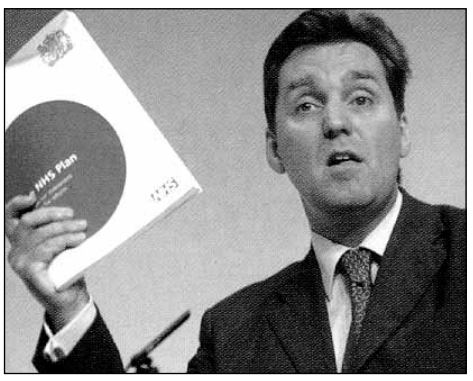
But *Guardian* financial columnist Larry Elliott has dismissed PFI as "a scam":

"Of all the scams pulled by the Conservatives in 18 years of power – and there were plenty – the Private Finance Initiative was perhaps the most blatant. … If ever a piece of ideological baggage cried out to be dumped on day one of a Labour government it was PFI."

Despite its popularity with ministers, and especially with the Treasury team, PFI has incurred the increasingly vociferous opposition of the BMA, the Royal College of Nursing, almost all trade unions, local campaigners in affected towns and cities, and a growing body of academics.

So what does the policy involve?

In short, large-scale building projects, which would previously have been publicly funded by the Treasury, are now put out to tender.



Man with a (flawed) plan: Alan Milburn

This means inviting consortia of private banks, building firms, developers and service providers to put up the investment, build the new hospital or facility, and lease the finished building back to the NHS – generally with additional non-clinical support services (maintenance, portering, cleaning, catering, laundry, etc).

Lease agreements for PFI hospitals are long-term and binding commitments, normally at least 25 years.

The NHS Trust involved, which (since the Tory government's "market-style" reforms of 1991) would normally expect to pay capital charges on its NHS assets, instead pays a "unitary charge" to the PFI consortium, which would cover construction costs, rent, support services, and the risks transferred to the private sector.

The big difference from capital charges is that not only are the costs much higher, but PFI charges do not circulate within the NHS. Instead they flow into the coffers of the private companies, and are issued as dividends to shareholders.

The appeal of PFI both to the Tories and to the Labour government is that it enables new hospitals and facilities to be built, without the investment appearing as a lump sum addition to Public Sector Borrowing .

The government can appear to be funding the "biggest ever programme of hospital building in the NHS", while in practice injecting less public capital than ever.

Only six major NHS-funded schemes, totalling less than £300m, have been given the go-ahead since 1997. By contrast, the Labour government has so far given the go-ahead to 38 PFI-funded NHS schemes totalling almost £4 billion, and aims to increase this to £7 billion by 2010.

The NHS Plan calls for a total of 100 new hospitals. 85% of all new capital investment in the NHS is now coming from the private sector.

Costs

But as with all "easy" borrowing, the short term benefits of PFI are outweighed by the long term costs.

By 2007 the annual cost to the NHS of PFI payments involved in leasing these privately-owned, profit-making hospitals, and buying ancillary services from private contractors, will be in the region of £2.1 billion: together with capital charges, the total bill will add up to £4.5 billion a year.

These – and other, less obvious, costs are being picked up by the taxpayer, by patients, and by hospital staff struggling to keep the service afloat under mounting pressure.

Private firms pocket proceeds

In the new North Durham hospital, the WRVS volunteers have to pay rent to the PFI consortium for space in the new building, while patients have to fork out up to £25 per week to watch the new bedside TVs.

These are just some of the changes that will be ushered in when private firms own the hospital and its surrounding facilities.

Car parking

Car parking charges and rent from shops, cafes and restaurants on the hospital site, which might previously have gone to the Trust, become yet another income stream for the PFI consortium.

These services also move out of the control of the Trust: in Cardiff, the new PFI-funded car park at the giant University Hospital of Wales now levies punitive charges on patients and visitors, backed up by zealous imposition of fines of up to £25, regardless of the circumstances.

The Trust is powerless to intervene.

Policies that fail elderly patients

AT THE CENTRE of the Peterborough *Integrated Health Investment Plan* is the assumption that it will be possible to switch the care of large numbers of older patients from "expensive acute hospital beds" to "a community setting". This has a grimly familiar ring to it.

In 1997 UNISON challenged the cost-cutting plans to close the Fenland Wing at Peterborough District Hospital, with the loss of 30 beds for the elderly, warning that too many of the Peterborough Trust's proposals seemed to "victimise elderly patients".

We argued then that switching services from PDH to Edith Cavell Hospital would be a blow to many elderly patients and their friends and relatives who come to visit them.

Many pensioners are in the lowest income groups, and are less likely to own cars than people of working age. Many have visual impairment or other difficulties that prevent them from driving. Many more have mobility problems which limit their ability to use public transport, even when it is available.

We also pointed to the lack of any joint plan with Social Services for the improved discharge and continuing care of older patients.

The same point had also been made by a Birmingham University report for Cambridgeshire County Council two years earlier. The Birmingham team complained that "The absence of detail in the documents has hampered our analysis."

But four years later many of the same problems are obvious again in the *Investment Plan*, which fails to spell out just what changes it proposes in the care of the elderly, or who is expected to carry them out.

The scheme aims to "separate acute and non-acute/ intermediate inpatient care, particularly for rehabilitation, longer stay elderly patients, and short term emergency support for the elderly who do not need to be admitted to hospital but cannot be supported in their own home." (piii)

Unfortunately the details on how this is supposed to work are at best vague and at worst evasive, leaving little confidence that despite the worthy calls to "centre services on the needs of the patient" any solid, workable proposal is in place.

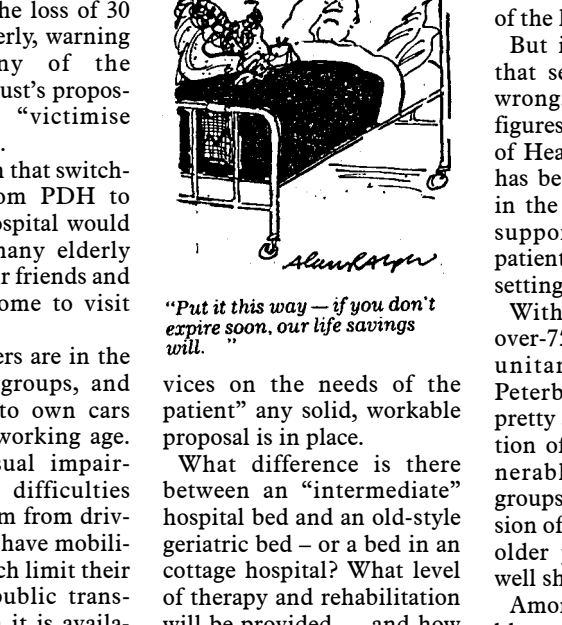
"Put it this way — if you don't expire soon, our life savings will."

What difference is there between an "intermediate" hospital bed and an old-style geriatric bed – or a bed in an cottage hospital? What level of therapy and rehabilitation will be provided … and how can this be done for 50% of the nursing costs of a normal "acute" hospital bed?

Increase

The *Investment Plan* predicts that numbers of patients treated will increase by 18% between now and 2010 – but fails to point out the implications of a projected 30% increase in medical emergency admissions – most of whom are elderly patients, and who will still require hospital beds.

According to Department of Health figures, the current complement of elderly care beds are running at a massive 96% occupancy – and therefore constantly on the brink of crisis.



Lengths of stay for older people admitted as emergencies tend to be longer than for 'elective' patients and those of working age: it appears that the Investment Plan seriously underestimates the impact of this continually increasing element of the local hospital caseload.

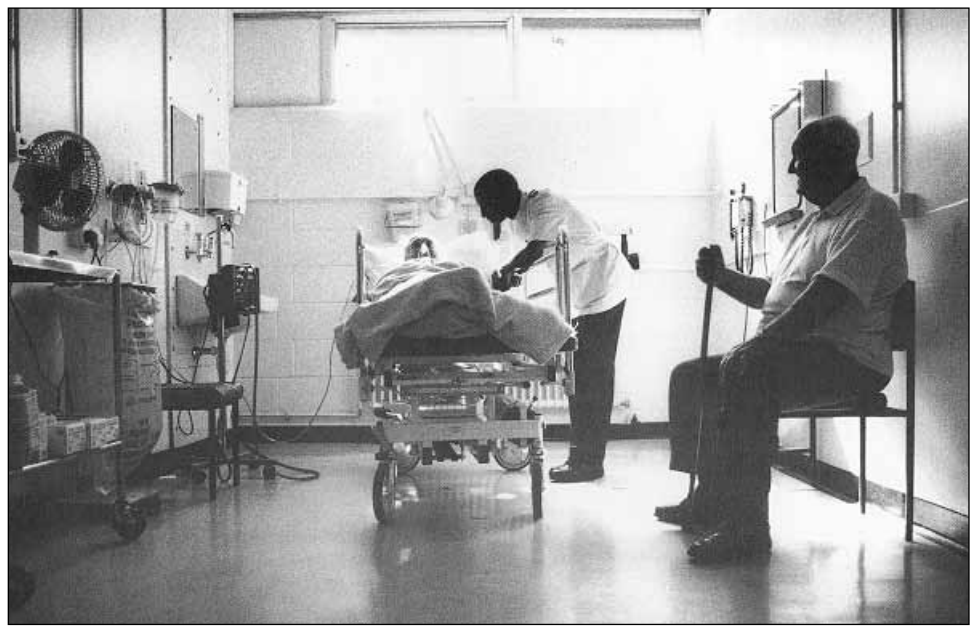
But it's not just the NHS that seems to be getting it wrong. The latest available figures from the Department of Health suggest that there has been little improvement in the level of social service support for frail elderly patients outside the hospital setting.

With an estimated 9,500 over-75s living in the unitary authority, Peterborough has a pretty average proportion of the more vulnerable older age groups. But its provision of services for the older pensioner falls well short of average.

Among 46 comparable unitary authorities, Peterborough ranks

- NEAR the bottom of the scale (5th lowest) in spending on home helps for the over 85s
- SECOND from bottom in provision of home helps for the 75-84 age group (with less than half the English average)
- FOURTH lowest in the numbers of social service staff providing domiciliary support for the over 75s – with just over a third of the English average provision
- FOURTH from the bottom in the proportion of over 75s receiving permanent support in nursing homes, with just 60% of the English average
- TENTH from the bottom of the scale in spending on home support for the over 75s, falling over 30% below the English average
- NINTH HIGHEST (and 40% above the English average) in the incidence of hospital admissions for over 75s suffering hypothermia or injured by falling.

Despite these obvious shortfalls, which leave a substantial gap where a supportive service should be, it seems that Peterborough council has no qualms about signing up to the PFI scheme without making any additional provision for its services for the elderly, leaving the health service to pick up the pieces.



But without improving these services to improve the coordinated discharge of older patients and supporting them to live at home, the increased burden of responsibility will be beyond the capacity of GPs and primary care teams to cope.

Hospital

The upshot will be that even larger numbers of frail older people will wind up in hospital beds – despite the fact that the system is designed on the assumption they will no longer be there.

This is a recipe for the type of "bed blocking" that threw the new North Durham PFI hospital into crisis from its first opening.

People who depend on Peterborough's hospitals deserve better than the vague promises in the Investment Plan.

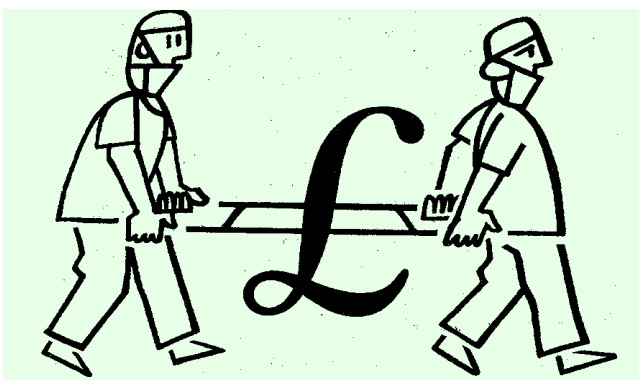
Older people, who have paid all their lives for an NHS that will be there for them when they most need it, expect more than tokenistic talk of a service.

If they are to be offered a real alternative to hospital care when they fall ill, that service has to be concretely planned, with real beds and facilities.

Staff with the right skills have to be recruited and trained; and the NHS, social services and all local organisations have to show they have a concerted plan of action to deal with the various needs that will arise.

The sickest situation of all would be one in which the promised improvements in care for the frail elderly fail to materialise, but in which the profits to the PFI consortium start flowing from day one, leaving a service dislocated and plundered.

Until the health authority and Trust can show real plans exist to care properly for older patients, UNISON will be convinced that the PFI proposals are putting these services at risk in order to secure private funding for a hospital that cannot cope.



Why the Edith Cavell site?

The Hospital Trust's obsession with switching services to the least accessible site is clearly not because there are any big financial savings to be made.

Indeed their own projections on the cost implications of the scheme show that using the PDH site as the "hub" for acute services would actually be £600,000 *cheaper* per year than moving everything to Edith Cavell.

The projected savings from the shift to intermediate care, and the projected investment in this new type of care are more or less the same in each case.

Despite the denials in the Investment Plan, UNISON is not convinced that the proposal is not determined by the property value of the PDH site.

Intermediate beds
Cheap and cheerful?

WE ARE NOT told much in the Investment Plan on what an "intermediate bed" might be, but we get a clue as to what it is NOT, when we see that the projected nursing cost per intermediate bed is just 50% of that for a bed on an acute ward.

Whether this saving would be made by increased use of lower-paid unqualified staff, or by fewer nursing staff, is not clear.

UNISON is concerned that most of the arguments put forward in the Investment Plan in favour of intermediate beds focus on cost.

Despite the document's rhetoric about centring services on patients, the balance sheet seems to be the main concern of the planners.

We are told that "intermediate care in the community" will provide:

- "A ***lower cost*** environment for those patients who do not need ***expensive*** hospital care
- More capacity for those who really need ***expensive*** hospital facilities and care
- Streamlined care pathways and ***reduce the duration*** of an individual episode
- Better ***value for money*** as care can be tailored to the patient's real needs
- Eliminate duplicated services and ***operational inefficiencies*** …
- Eliminate ***excessive transport costs*** …
- Release under-utilised and functionally unsuitable buildings for ***disposal***
- Reduce clinical risks such as hospital acquired infection and ***negligence claims***" (p11)

But the ambiguity on where the expanded intermediate care services will be provided remains unresolved by the Investment Plan: will there be new, small, localised services, or a number of wards on the main hospital site?

WHAT exactly will be provided in the way of more local diagnostic services and rehabilitation?

WHO will pay for it, and who will take on the job of organising it?

Without answers to these basic questions the suspicion remains that an intermediate bed is simply a cheap and cheerful dumping ground for frail patients for whom there is no alternative support outside the NHS.

Prime site + easy access = prime target for closure: Peterborough District Hospital

ECH: in the wrong place for easy access

Once again health service chiefs are telling us that it is OK to centre health services on the least accessible Edith Cavell Hospital site because the council is looking at the possibility of improving transport links.

But with no guarantee that any improvements will be put in place, UNISON reiterates its concern that the most deprived section of the hospital's catchment population could lose out most heavily with the switch of acute services to ECH.

Public transport links to ECH are notoriously poor, and virtually non-existent on Sundays. Its poor geographical location was a major factor in the controversy over the failed PFI scheme in 1995.

ECH is on the wrong side of the city to cope with the main areas of expanding population. And it is in the wrong place for patients, outpatients and visitors travelling by public transport from outlying areas around Peterborough.

The stock answer from health planners – who seem to travel everywhere by car in luxurious off-peak isolation from the real world – is that only 7% of patients attending PDH arrive by public transport.

But given the pressures of attending hospital, it is safe to assume that almost all of these 7% were people with no choice – no access to a private car or money for taxi.

UNISON is still convinced that even if there ought to be a rationalisation of services on a single site, ECH is the wrong place for a single site hospital. But once a PFI hospital is built, the NHS will be stuck with it in that place for then foreseeable future – at least until the contract with the PFI consortium expires, in 25-30 years.

Backlog bill used to boost bid

The claimed £8m backlog maintenance bill for Peterborough District Hospital is testament to the long-standing preoccupation of the Trust with the switch to a single-site hospital.

Back in the 1990s the claimed backlog maintenance bill, then put at £12m, was ritually wheeled out in an effort to make the case for the doomed PFI bid.

Then, as UNISON pointed out, the backlog total was transparently inflated to strengthen the case for the Edith Cavell site rather than PDH.

We witnessed the bizarre spectacle of the Trust planning to move patients OUT of modern refurbished wards in the Fenland Wing in PDH, into disused, derelict wards at ECH, which had to be refitted and re-equipped for the purpose.

The underlying factor in all these changes is that the property value of PDH as a land asset close to the city centre and transport links is much higher than ECH.

The Investment Plan estimates the PDH site value at upwards of £6 million. But it skirts around the issue of how this potential cash pot fits in the scheme of things in the run-up to PFI.

We are told that it is owned by the Secretary of State, not the Trust, and that its value has been excluded from the initial costings of the new hospital, but it is hard to see how an asset this large can remain outside such a major financial deal.

We can imagine that numerous PFI consortia may be lured by the prospect of getting their hands on this prized piece of real estate.

Day surgery – in whose interests?

The Investment plan admits that the new PFI scheme is designing a hospital based on "challenging" targets for treating more patients than ever before as day cases.

But are these targets realistic?

It's hard to tell.

The official Department of Health statistics on Peterborough hospitals show numbers of completed "episodes" of patient treatment which are completely different from the figures presented in the Investment Plan.

Which set of figures is right? Are they both right in a way, or wrong in a way?

We can't tell. But what is clear from the DoH figures is that only one in five of the patients treated at Peterborough Hospitals Trust is was treated as a day case in 1999-2000.

But the PFI scheme assumes that almost 40% of patients will be treated as day cases by 2010. The Trust is supposed to heave itself up by its own bootstraps from one of the lowest rates of day cases in the Eastern Region in 1999-2000 to a higher level than any have yet achieved by 2010.

How will this happen? How would a new hospital change the habits of surgeons?

We are not told.

To achieve progress it is necessary to do more than outline "challenging" but impossible targets: it is necessary to map out ways in which they can be achieved and convince the key players that it can be done.

The Investment Plan makes no attempt to set out any action plan, and shows no sign that any steps have been taken to learn from best practice in any of the Trusts which have successfully established much higher levels of day case treatment.

UNISON welcomes the medical advances that make it increasingly possible for patients to receive surgical treatment, but then safely to recuperate in more congenial and familiar home surroundings.

But it is vital to ensure that this progress is centred on the needs of the patient, not on the pressure on the Trust to cut numbers of beds or save money.

New patterns of health care

The projections on bed numbers for the new hospital claim to be based on an 18% increase in workload over the period to 2010.

But the Investment Plan skates over the big change in the pattern of in-patient treatment over this period.

In 1999-2000 the Trust treated over 13,000 surgical in-patients (6,300 of them emergencies) and 11,000 medical in-patients (all but 500 of them emergencies).

But by 2010, the projections show a reversal between the two, with medical cases overtaking surgical in number to hit almost 14,000 in-patient episodes, while surgical admissions would fall back to just over 11,000. (page 22)

These figures need to be taken with a pinch of salt, since the expected reduction in surgical admissions requires the Trust to virtually double in the numbers of patients treated as day cases. But the greater number of medical cases reflects a continuing national trend.

Staying longer

The implications for hospital planning are important, since medical cases are almost all emergencies, and tend to be older patients, who also stay longer on average in hospital.

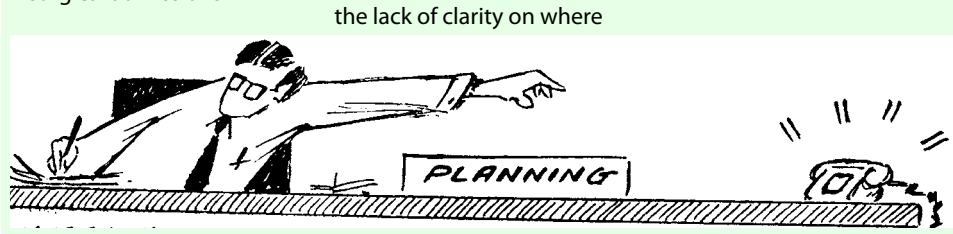
If there are not enough medical beds available, these emergency cases are the ones that wind up stuck for hours or days on end on trolleys in corridors, or becoming "outliers" in surgical wards.

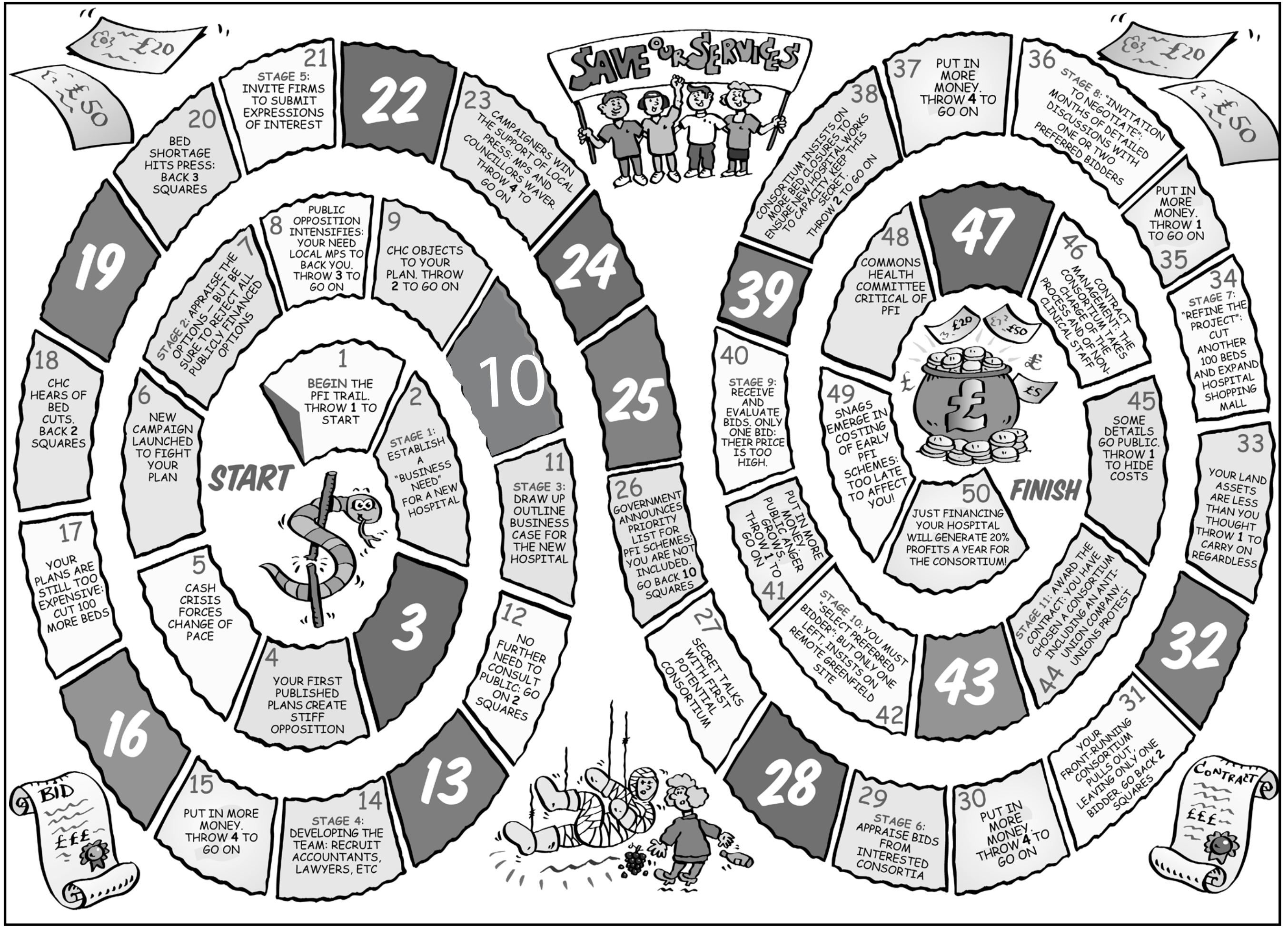
UNISON is anxious to ensure that any plans for new hospital facilities take a realistic view of the need for sufficient medical beds.

We are also concerned at the lack of clarity on where the proposed "intermediate" beds, which might be expected to care for many of the medical emergencies once they have been stabilised, would be situated.

Even the NHS Eastern regional Office has pointed out that the next document, the Outline Business Case "will need to address the issue of where non acute/ intermediate care is located within the system".

Enough of these intermediate beds will need to be available on the same hospital site as the acute beds, to facilitate easier transfer of patients from one to the other: any other system will involve complex and costly transfers by ambulance.




START
1 BEGIN THE PFI TRAIL. THROW 1 TO START
2 STAGE 1: ESTABLISH A "BUSINESS NEED" FOR A NEW HOSPITAL
3
4 YOUR FIRST PUBLISHED PLANS CREATE STIFF OPPOSITION
5 CASH CRISIS FORCES CHANGE OF PACE
6 NEW CAMPAIGN LAUNCHED TO FIGHT YOUR PLAN
7 STAGE 2: APPRAISE THE OPTIONS – BUT BE SURE TO REJECT ALL PUBLICLY FINANCED OPTIONS
8 PUBLIC OPPOSITION INTENSIFIES: YOUR NEED LOCAL MPS TO BACK YOU. THROW 3 TO GO ON
9 CHC OBJECTS TO YOUR PLAN. THROW 2 TO GO ON
10
11 STAGE 3: DRAW UP OUTLINE BUSINESS CASE FOR THE NEW HOSPITAL
12 NO FURTHER NEED TO CONSULT PUBLIC: GO ON 2 SQUARES
13
14 STAGE 4: DEVELOPING THE TEAM: RECRUIT ACCOUNTANTS, LAWYERS, ETC
15 PUT IN MORE MONEY. THROW 4 TO GO ON
16
17 YOUR PLANS ARE STILL TOO EXPENSIVE: CUT 100 MORE BEDS
18 CHC HEARS OF BED CUTS. BACK 2 SQUARES
19
20 BED SHORTAGE HITS PRESS: BACK 3 SQUARES
21 STAGE 5: INVITE FIRMS TO SUBMIT EXPRESSIONS OF INTEREST
22
23 CAMPAIGNERS WIN THE SUPPORT OF LOCAL PRESS: MPS AND COUNCILLORS WAVER. THROW 4 TO GO ON
24
25
26 GOVERNMENT ANNOUNCES PRIORITY LIST FOR PFI SCHEMES: YOU ARE NOT INCLUDED. GO BACK 10 SQUARES
27 SECRET TALKS WITH FIRST POTENTIAL CONSORTIUM
28
29 STAGE 6: APPRAISE BIDS FROM INTERESTED CONSORTIA
30 PUT IN MORE MONEY. THROW 4 TO GO ON
31 YOUR FRONT-RUNNING CONSORTIUM PULLS OUT, LEAVING ONLY ONE BIDDER. GO BACK 2 SQUARES
32
33 YOUR LAND ASSETS ARE LESS THAN YOU THOUGHT. THROW 1 TO CARRY ON REGARDLESS
34 STAGE 7: "REFINE THE PROJECT": CUT ANOTHER 100 BEDS AND EXPAND HOSPITAL SHOPPING MALL
35 PUT IN MORE MONEY. THROW 1 TO GO ON
36 STAGE 8: "INVITATION TO NEGOTIATE": MONTHS OF DETAILED DISCUSSIONS WITH ONE OR TWO PREFERRED BIDDERS
37 PUT IN MORE MONEY. THROW 4 TO GO ON
38 CONSORTIUM INSISTS ON MORE BED CLOSURES TO ENSURE NEW HOSPITAL WORKS TO CAPACITY. KEEP THIS SECRET. THROW 2 TO GO ON
39
40 STAGE 9: RECEIVE AND EVALUATE BIDS. ONLY ONE BID: THEIR PRICE IS TOO HIGH.
41 PUT IN MORE MONEY. PUBLIC ANGER GROWS. THROW 1 TO GO ON
42 STAGE 10: YOU MUST "SELECT PREFERRED BIDDER": BUT ONLY ONE LEFT, INSISTS ON REMOTE GREENFIELD SITE
43
44 STAGE 11: AWARD THE CONTRACT: YOU HAVE CHOSEN A CONSORTIUM INCLUDING AN ANTI-UNION COMPANY. UNIONS PROTEST
45 SOME DETAILS GO PUBLIC. THROW 1 TO HIDE COSTS
46 CONTRACT MANAGEMENT: THE CONSORTIUM TAKES CHARGE OF THE PROCESS AND OF NON-CLINICAL STAFF
47
48 COMMONS HEALTH COMMITTEE CRITICAL OF PFI
49 SNAGS EMERGE IN COSTING OF EARLY PFI SCHEMES: TOO LATE TO AFFECT YOU!
50 JUST FINANCING YOUR HOSPITAL WILL GENERATE 20% PROFITS A YEAR FOR THE CONSORTIUM!
FINISH
SAVE OUR SERVICES
£20
£50
£5
BID
£££
CONTRACT
£££

Your PFI Board Game

The game opposite is based on the eleven actual stages of the PFI process, to illustrate how long and complex it can be.

It puts you in the position of the capitalist consortium negotiating a deal, or the hapless NHS Trust boss trying to negotiate affordable terms.

To play, you need a single dice, one counter per person, a large wallet of cash, several bottles of expensive wine, a team of lawyers, and as many hours or weeks as you can allocate to make it realistic.

Even greater realism can be achieved by playing the game behind locked doors and refusing to tell even family members what you are doing, or what progress is being made.

UNISON regrets that we are unable to pay any cash prizes for those who complete the course successfully.

The only winners from the PFI process are the banks and big companies which are lining up for a slice of NHS cash.

So why not join our campaign to roll back PFI in Peterborough?

GPs to bear the weight of change

The PFI scheme will have a heavy impact on primary care services in the Peterborough area, which will be expected to take on steadily more areas of responsibility currently dealt with by hospitals.

The Investment Plan's attitude to this aspect of the scheme is profoundly contradictory.

On the one had it draws attention to the fact that a quarter of the city-based GPs are aged over 55, and claims that many GPs find the present configuration of services is "causing major problems with recruitment". (page ii) One problem is that "it places exceptional demands on them" (page 11).

Elsewhere it quotes last year's the Cambridgeshire HA Health Improvement Programme as stating that:

"Local hospitals, primary community and social services are all operating at capacity. All public services are predicting increased demands on their services; from regional specialist services … to services at local hospitals and GP practice-based services …" (page 7)

But on the other hand, it makes clear that the workload to be dumped on to GPs and primary care staff would increase sharply with the building of the PFI hospital. GPs would add to their already hefty list of duties a whole new series of tasks – from minor operations to taking X-rays. The suggested list includes:

"Training for GP and nurse specialists to undertake some of the work currently performed in hospital, including minor surgical procedures, basic diagnostics and chronic disease management." (page iii)

"Many more patients will be treated closer to their home. GPs will have more choice for the care of their patients …" (page iii)

"Local GP-led diagnostic and treatment centres containing low-tech diagnostics such as basic X-ray sets, ultrasound and rehabilitation facilities." (page 8)

How many 55-year old GPs are aching for the chance to fill their few spare minutes a day with a session taking amateur X-rays or fiddling with a scalpel is anyone's guess. Nor are we told how much extra they might expect in sessional and other payments for this work in lifting the load from hospitals.

But even if we set aside the potential safety hazards of relatively inexperienced GPs attempting to use equipment and techniques for which they have not been specifically trained, what is clear from repeated warnings from the BMA is that the soaring workload on GPs is already a major factor destroying morale and impeding recruitment.

How will intensifying this pressure help bring new GPs to Peterborough?

600 DUDLEY Hospital workers, backed by UNISON, staged a series of strikes over almost a year in their efforts to prevent the privatisation of support services as part of a PFI deal, originally costed at £65m, but eventually signed in May at £137m. 70 front line hospital beds are also to be lost in the deal. Ministers subsequently agreed pilot schemes that will try to separate support services from the provision of new buildings.

Will the new hospital have enough beds?

The latest Department of Health figures (1999-2000) show Peterborough Hospitals Trust with 676 in-patient beds.

The PFI scheme claims to be increasing bed numbers by 100. But the totals given on page 6 of the Integrated Health Investment Plan show just 726 in-patient beds by 2010 – an increase of only 50 on the current availability.

The difference lies in the inclusion of Day Case beds (63 of them) in the total of beds, and a reduction of almost a quarter in the availability of maternity beds – down from the present reported level of 59 to just 46.

But there are other problems: the planned total includes 73 "intermediate" beds, a category that is not currently listed separately, but of which the Investment Plan claims there are now 29

(presumably included in the Trust's beds for the elderly).

So the "extra" 100 beds are not extra beds in the conventional meaning of the word.

Nor are these projected bed numbers a reliable prediction of what the new hospital will contain.

Under PFI, NHS managers and consultants no longer plan the detail of new hospitals: instead they specify "outputs" (numbers of patients of different categories to be treated) and leave private sector whiz kids to calculate the bed numbers required.

Few of the management consultants brought in to plan new hospitals have any direct experience of running hospitals, and many of them tend to feed off each others' over-optimistic projections.

That's why three of the first wave of PFI hospitals to open have immediately run into severe bed shortages. And more schemes embodying drastic cuts in bed numbers are in the process of completion.

In North Durham the new Dryburn Hospital is already so short of beds that managers have contemplated a new deal to build another 40 beds – again funded by the private sector.

A management report has claimed that the planned bed numbers were correct … but that alternative systems to care for frail elderly patients outside of hospital had not been able to do as they were expected.

This attempt to blame the problem on "the wrong type of patients" will be profoundly worrying for Peterborough residents, since similar assumptions about an expansion of primary care and other community based alternatives to hospital underlie the bed numbers proposed in our local PFI hospital plan.

If they do not bear fruit, we can expect growing numbers of elderly patients to be stuck, as they are in Durham, in the "wrong type of hospital beds", while NHS managers try to duck their responsibility for the chaos.

Mental health setback

Among the victims of the PFI shot points out that the new This is unlikely to offer proposals – which will inevitably lead to years of secretive negotiations and delays in building a new hospital – are the clients who depend on the availability of mental health and learning disability services.

Plans were already advanced for the development of a £15m acute adult and elderly psychiatric service and facilities for learning disability, to be built on the Edith Cavell Hospital site.

But now they face a "double whammy".

One is a new level of delays, as the free-standing scheme is roped in to the much larger general hospital PFI scheme.

At the end of the Investment Plan, a parting PFI hospital scheme is likely to put the mental health project n hold, while the Hospitals Trust and the Northwest Anglia Healthcare Trust consider "packaging" the hospital scheme with "the already approved mental health development in a single PFI scheme.

"This will reduce the procurement cost, provide additional opportunities for generating savings and ensure greater synergy between both projects." (p20)

The other half of the double whammy comes in the implications for the mental health unit of finding itself potentially dumped into a corner of what would be a busy general hospital site.

much scope for therapeutic space: the scale of the unit is likely to be squeezed, and its relative importance – as around 10 percent of the overall building project rather than a free-standing scheme – will be reduced.

UNISON believes that local people have already had to wait too long for serious investment in mental health services. It is wrong that the agreed project should now be put on hold for an indefinite period, and subjected to the pressures of PFI negotiations.

SIGN ME UP!

- I am opposed to the plans for a PFI hospital in
- Peterborough and want to join the campaign
- to defend our local NHS.
- Name .....
- Address .....
- .....
- Post code .....
- Phone .....
- email .....
- Send to UNISON Health NW Anglia District
- Branch, c/o Union Office, Peterborough District
- Hospital, Thorpe Rd Peterborough PE3 6DA

PFI costs would squeeze local care

Local health chiefs have been trying to get a single site hospital on the Edith Cavell site since 1995.

The original PFI proposal, costed at £55m, involved a cut of up to 200 beds, and was thrown out by ministers.

More recently, since the growing shortage of front-line beds was underlined by the National Beds Inquiry, Health Secretary Alan Milburn has insisted that new hospitals funded through PFI must have at least the same number of beds as the hospitals they replace.

The new Peterborough plan claims to increase bed numbers by 100. But, like the previous scheme, the new plan could well also involve buying support services from the PFI consortium that will own the hospital and lease it to the Trust.

This means that even if the price does not increase from the present estimate of £135m, and PFI costs are in line with those in the first 20 schemes given the go-ahead, the total cost to the Trust could be five times the value of the hospital – upwards of £650m.

The annual payments for building and services could be around £25m.

By contrast a 25-year mortgage at 6% would cost just £261m (£10.5m a year) – and leave the NHS free to decide what support services it required.

Index-linked

PFI deals are legally binding, with strict penalties for any late payments, and the monthly payments are index-linked, so that (unlike a mortgage) they *increase* each year with inflation.

But those PFI deals which cover support services as well as the building and maintenance of the new hospital have another important impact on the NHS.

With no control over the cost of support services, the only scope for hospital bosses seeking to reorganise or economise in the future would be to squeeze the funding of *clinical* staff – the doctors, nurses and professionals who deliver patient care.

Any future financial problem that may affect the Trust would therefore inevitably fall most heavily on the quality and volume of services to patients – while the payments (and profits) flowing to the private contractors would be protected against all risks.

Soaring bill for private finance

NHS schemes completed, under construction, or on the list for approval between now and 2006 already add up to a staggering £6.4 billion, and the sums of money committed in terms of annual payments are far larger than that, with most deals lasting 25 years or more.

The combined annual payments on the six PFI hospitals which are already operational adds up to £83m a year, giving a total payable of £2.4 billion – SIX TIMES the capital value of £423m.

The annual fees on the next 14 schemes in the queue for which details are available add up to £250 million a year, giving a total cost of £7.9 billion – over FIVE TIMES the capital value of £1,507 million.

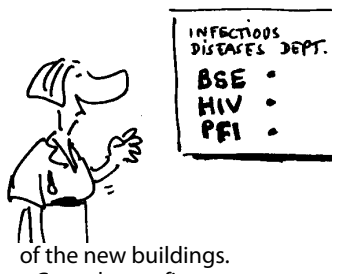
If these deals are replicated in subsequent PFI schemes, the NHS could wind up paying between £32 billion and £38 billion in real terms (index linked payments) to private consortia over the next 25-30 years.

The NHS is only part of the total PFI borrowing. As Sunday Times correspondent David Smith pointed out recently, the Treasury's budget report shows deals worth £14 billion already generating revenue:

"Even if no new PFI deals were signed, the government would pay nearly £4 billion a year, on average, in fees and charges to PFI contractors

PFI firms to coin in profits on every side

THE PROFITS flow to the private sector at every level in PFI. Building firms, banks, business consultants and other PFI hangers-on are eagerly anticipating a generous flow of profits as the first hospital schemes take shape.



An investigation in the Health Service Journal showed building contractors "expecting returns of up to 20 percent a year on the equity stakes they hold in the project companies" as soon as the building is complete and Trusts start paying for the use of the new buildings.

Consultancy firms, too – architects, engineers and surveyors – are pocketing above average fees for work on PFI schemes. As the HSJ article pointed out: "there is little chance of the construction industry losing interest in PFI hospitals".

And once the building is finished, maintaining and providing services in the buildings will deliver comfortable, guaranteed profits of up to 7 percent for firms holding service contracts.

The first two waves of PFI hospital schemes all involved the privatisation of any non-clinical support services that were not already in the hands of the contractors.

Will local Primary Care Turkeys really vote for Christmas?

Health services in Peterborough are increasingly under the control of Primary Care Trusts (PCTs), with the key role in determining local hospital services being played by the North and South Peterborough PCTs.

PCTs, as the name suggests, have been set up with a view to increasing the involvement of local GPs and Primary Care staff in the planning and commissioning of local health services.

But will these PCTs really press ahead with a costly PFI project which siphons extra cash from the NHS budget (and therefore *away* from primary care, community services and mental health) into the acute hospital sector – and into the pockets of private investors in PFI companies?

And will the PCTs still take that decision even when it becomes clear that the PFI hospital can only achieve its financial and performance targets by obliging GPs, primary care and community services to undertake more work for little or no extra money?

The *Investment Plan* calls for moving "a significant number of services" out of the hospital – such as chronic disease management and low tech diagnostics.

GPs and nurses

This will, the Plan says, be supported by "the development of GP and nurse specialists to undertake tests and procedures within local diagnostic and treatment centres".

This raises two obvious questions: ***WHERE*** will these centres be – and ***WHO*** will pay for the investment in staffing, training, and equipment?

Is it any more efficient to decentralise part of the diagnostic work, thus multiplying the numbers of staff required and the need for equipment, while leaving the more complex tests on-site in the hospital?

Extra work

And do GPs and primary care nursing staff really want to add these responsibilities to their workload?

The figures itemising "savings" from the scheme point to a projected 50% cut in spending on the Hospital Trust's Outpatient department – "transferred to primary care", and a 30% "saving" on rehabilitation costs ("cost shift to Primary and Intermediate care").

This is why we still do not know whether key players will be willing to endorse the scheme when its final details become clear.

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