UNISON Manchester Community and Mental Health Branch

A Millstone Round Our Necks

Central Manchester and Manchester Children's Hospitals PFI project: an update on the impact on the local health economy

Report produced by John Lister, London Health Emergency, June 2004

Background

The plan to develop a new mega-hospital complex to provide four new hospitals in Central Manchester to replace dilapidated and outdated buildings has been under consideration for several years. Last year the Full Business Case concluded that the capital cost of the new buildings had increased from a projected £250m in the Outline Business Case (OBC) in 1999 to £422m – an increase of 68 per cent.

The economic impact of the new version of the scheme represented a dramatic variation from the modest promise of an overall £2m cost saving for local purchasers outlined in the OBC: in the Final Business Case the £2m saving has been transformed into an ***additional cost*** of ten times as much per year (index-linked), half of which was to fall to Central Manchester Primary Care Trust.

An analysis of the project conducted by London Health Emergency for the then Central Manchester Community Health Council concluded that there were "ten reasons to be concerned", summed up as:

"1. Soaring costs

"The cost of the project is substantially higher than that in the Outline Business Case in 1999. From the promise of savings in excess of £2m per year for the local health economy, the plan now brings an additional cost of over £20m, plus transitional costs to be borne by local PCT. Although PCT budgets are set to increase, it is reasonable to expect many of the funding obligations of PCTs to increase at least as rapidly over the next few years.

"2. Fewer front-line beds

"Getting information about planned bed numbers is almost impossible. The latest, and more expensive, versions of the scheme appear to give an increase in beds for both children and adults. But there is to be a substantial *reduction* in front-line acute beds which does not appear to

correspond to the pattern of emergency admissions and the growing proportion of medical inpatients compared with surgical.

"3. Design and Quality

"There are reasons to be concerned about the consortium that has been selected. Catalyst has been involved in three PFI hospital projects – Calderdale, Worcestershire Royal Hospital and a small PFI hospital in Hexham. However unresolved problems with the design and quality of the Worcester hospital seem to be echoed in plans set out for Manchester.

"4. Standards of service

"The facilities management arm of the consortium is Sodexho, which has also been involved with the PFI hospital in Hereford and controversially involved in a major dispute last year in Scotland. These experiences also create worries over the likely quality of care and services in the new hospital.

"5. No guarantees on support services

"There is no firm commitment on staffing levels in any of the support services, these are labour-intensive services, the quality of which is heavily determined by the numbers of staff in post and the ability to develop a team which can work closely with clinical staff.

"6. Costs growing at double the rate of facilities

"It is clear that the costs of the project have grown since the Outline Business Case was agreed, it is not so clear that these are justified." [The Community Health Council had estimated that there had been a 28% increase in costs for a 14% increase in bed numbers.]

"7. Shifting the costs to other local services

"Some of the Trust's [Central Manchester and Manchester Children's Hospital NHS Trust - CMMC] planning assumptions on the reduced length of stay and level of hospital use by older patients clearly hinge on resources made available by PCTs for community-based and primary care services and by social services. None of these assumptions is made explicit: there must remain a concern that as with other PFI hospitals the Trust is seeking not only extra resources to fund the hospital but to transfer additional responsibilities to PCTs and other providers.

"8. Fiddling the figures on the cost of an NHS-funded scheme

"As in all PFI schemes there is meant to be a 'Public Sector Comparator' – a notional version of the scheme that is publicly funded, against which the private scheme is compared. This 'PSC' is primarily a straw man to be unfavourably contrasted at various points with the PFI scheme." [The Community Health Council believed that the scheme was using outdated assumptions on costs that the Treasury has now amended and that, even using official government accounting methods (that favour private sector investment) the PFI project is substantially more expensive than public funding.]

"9. Taking money out of the rest of the NHS

"The PFI project argues that one advantage is that it is "off balance sheet" and assumes that over £18m can be diverted from capital charges towards the payments to the private sector. However this involves removing money currently circulating within the NHS, and may well have a longer-term impact on other NHS Trusts and PCTs.

"10. The missing comparison

"How much cheaper would it be for the NHS just to borrow the capital and repay it over time? Initial calculations suggest that if the money were borrowed at 3 per cent the new hospital could be paid off in just 25 years rather than the 38 of the PFI scheme with an annual saving of £6m and an overall saving of £762m."

Running into trouble

While many of these criticisms from last year remain unresolved problems in the PFI scheme, the most serious stumbling block appears to have been the heavy additional costs that would land onto the three Manchester Primary Care Trusts.

The Final Business Case encountered heavy criticism from Primary Care Trusts (PCTs) across Greater Manchester, and under especially severe pressure from Central Manchester PCT, the Trust was obliged to review the project and seek ways in which it could be reduced in scale to cut the annual bill for PCTs.

An outline agreement to reduce annual costs by £10m was drawn up in November 2003, with the involvement of business consultants Grant Thornton, the Trust, the Greater Manchester Strategic Health Authority (GMSHA), and Greater Manchester PCTs.

Key to this cost reduction package were:

- A REDUCTION of 4,300 square metres (3 per cent) of the floor area of new build in the new complex.

- A REDUCTION of 150 beds. According to the new proposals, the space for these beds is to be constructed – but would be "shelled", or used for other purposes [GMSHA Paper A, April 2004] unless the Trust obtains an express agreement of all parties to open additional beds [as in November Outline Agreement (Appendix 2) Point 6.]

- A REDUCTION of 4 operating theatres (to be built, but "shelled" and not opened). UNISON notes that the economics of "shelling" have been challenged by Grant Thornton, as not giving Value for Money.

- SPACE in the new hospital would similarly be set aside for the reprovision of paediatric burns, cleft lip and palate and paediatric intensive care beds, but services would only be commissioned if and when money becomes available to fund them.

- FACILITIES for bone densitometry and cochlear implants would not be included unless sufficient charitable and non-NHS funding was made available.

- A TRUST "EFFICIENCY SAVINGS PLAN" would help reduce the revenue cost of the building by £10m – although no details have been given.

This proposal was subsequently elaborated in the April documents of the GMSHA, which formulated the financial and other tasks as a series of "Caveats" which may impede financial close. Caveat 2 specifically required the Trust to supply the GMSHA, PFI Project Board and National Audit Office no later than the end of May 2004 with a document setting out a savings plan, with milestones, to manage a series of identified financial risks.

> "These plans will form the foundations on which to build the NAO-driven and led financial scrutiny process"

No such document had been completed by the GMSHA meeting on May 27 – one working day before the end of May. No such scrutiny process has therefore yet begun, as the clock ticks down to financial close.

However, much of the cost saving that has been proposed appears to involve a 15 per cent REDUCTION IN STAFFING across the board – with the PFI hospital planning to employ 1,086 fewer full time equivalent staff than the current Trust hospitals. The FBC last year presented the figures thus:

Figure : CMMC – Staff in Post – October 2002

Staff Group	Actual WTE	Actual Headcount	%
Medical (incl. doctors in training)	565.7	656	8.8
Nursing & Midwifery	2,070.6	2,316	32.1
Nursing Support	729.0	813	11.3
Professional & Technical	1,243.0	1,369	19.3
Admin & Senior Managers	1,296.6	1,477	20.1
Others	549.4	728	8.5
Total	**6,454.3**	**7,359**	**100.0**

The above figures do not include vacancies. Other includes non-clinical e.g. estates, facilities and other staff"

The figures in the most recent proposals do not coincide at all with those presented in the above Table from last year's Full Business Case. The current "Capital Schemes Appraisal Proforma (presented to the GMSHA on 20th April 2004) reports current WTE staff numbers as totalling 7208, reducing to 6122, with a claimed annual "saving" of £10.5 million.

The FBC did not discuss job losses, but from its breakdown of staff groups it would appear that 1086 jobs could represent as much as 17 per cent of the workforce, and that to cut 1086 jobs, the Trust would not only need to dispose of its entire ancillary workforce ("others" in the Table): some of the other categories of staff would also have to lose their jobs.

This level of planned job cuts has never been publicly explained by the Trust. It seems most improbable that so many staff could be axed while general levels of activity are maintained, without a severe and enduring negative impact on the quality of patient care – and a worsening of the recruitment crisis for professional and medical staff.

- The GMSHA's Caveat 2 in April also required the Trust to "deliver a cost improvement saving of £9m per year over the next 3 years" as part of the annual cost improvement programme. (Once again, no details have been offered to indicate how such large additional savings could be made.)

Caveat 2 additionally required CMMC to implement further economies to reduce its costs for treatment from the current 111 per cent of NHS Reference Costs to 100 per cent or below by 2008, after which the new hospital would open in an NHS run according to the new "Payment by Results" financial regime. Of course in the absence of any detailed proposals to cut costs by 10 per cent it is not possible to judge the impact such cutbacks may have on the availability and quality of timely and appropriate care in the new hospital. However it is clear that a hospital such as CMMC, with very high, and inflexible overhead costs bound up in the legally-binding PFI contract, is likely to be at a serious disadvantage in the new Payment by Results system, if it is obliged to compete for contracts with NHS hospitals whose capital charges are substantially lower than the PFI availability charge.

This disadvantage would be further compounded if the 150 intermediate beds – which were to be included in the new hospital as a means to ensure the maximum use of the reduced number of acute beds – are not provided elsewhere by those PCTs who have insisted on an alternative model of care. If this were to happen, we would anticipate a rapid escalation of bed-blocking to crisis levels, again with serious financial repercussions to the Trust under Payment by Results.

- Even after all of the economies, the most recent projected annual cost of the PFI tariff – at £51m – is actually ***higher*** than the £47m projected in the Full Business Case last year. Although this fee includes an estimated £21m for non-clinical services, the PFI fee will be a legally-binding and increasing (index-linked) commitment for the Trust, leaving the Trust Board with discretion only over clinical budgets and clinical staff. The combined costs of PFI payments, residual NHS interest charges and facilities management will total £64m a year – almost 20 per cent of the Trust's total revenue.

This is a very substantial, inflexible overhead cost, which will rise by a minimum of 2.5 per cent per year for the 38 years of the PFI contract. Last year it was calculated from the (lower) FBC estimates that by year 10 the annual payments to be made by the Trust would have inflated to £58m a year, by year 20 to £74m, by year 30 they would be £95m and from at least year 33 the Trust would be paying over £100m per year – £2m per week – for the hospital and support services. The Payment by Results system which will be operational by the time the new hospital opens, offers no guarantee that the Trust will be able to generate sufficient revenue to cover these costs and maintain the planned levels of patient care.

Even relatively cheap first-wave PFI hospitals such as Queen Elizabeth in Woolwich (which has been forced to close beds) and Worcestershire Royal Infirmary (£15m in the red) are facing massive financial problems as a result of high and inflexible costs: the problems for CMMC could be substantially worse. The PFI scheme is a monster gamble with Manchester's health care.

Where in the community?

While the above economies would largely impact upon the CMMC Trust, the new proposals agreed in November were also to include compensating measures which fall to the responsibility of Greater Manchester PCTs – and in particular Central Manchester PCT:

- The CMMC Trust's activity levels are assumed not to rise at all from 2003-4 contract levels, in part "reflecting the shift of secondary care to primary care". No evidence is

offered to indicate that this is yet the position in Manchester – not least at a time when A&E caseloads and numbers of emergency admissions have been rising by an average 10 per cent across the rest of the country. Central Manchester PCT heard a report on May 26 stating that A&E admissions at MRI continue to rise, reaching their highest-ever level on Monday May 24. It appears that none of the promised switch of caseload has yet occurred.

Nor have any concrete plans been published that would begin this dramatic and unprecedented shift of responsibility from hospitals to primary care. It seems that these will not see the light of day – let alone be discussed, scrutinised or accepted by primary care professionals and the Trust – until days at the most before the date fixed for financial close.

Indeed UNISON's understanding is that the Central Manchester PCT's Professional Executive Committee regards this target as unachievable – raising the prospect that demand could increase while the necessary hospital services and beds have been cut back.

- The PCTs would establish plans (not yet published) to *reduce* demand for hospital admission and contain it within "expected activity levels": but the PCTs would also have to expand their own provision of community based services to enable CMMC to achieve "length of stay reductions" – which imply greater support for older patients discharged more swiftly from acute beds. Such changes cannot be achieved by CMMC without the active commitment and co-operation of PCTs.

- "With Central Manchester PCT in the lead, 52 of the rehabilitation beds originally planned to be in the new hospital will instead be provided as "beds … or 'bed equivalents' in the community". In this case it appears that there are some relatively well-advanced plans – but they have not been finalised, or put into the wider public domain – or even seen by the PCT as a whole. However worthy the intentions of the PCTs in proposing this alternative model of care, this method of proceeding is hardly calculated to build confidence across the wider health economy. The underlying problem for the PCTs is in finding the capital required, the staff they need and the additional revenue to fund these additional beds.

- Even if answers were forthcoming on these beds and services, there remains the larger question of the additional 100 rehabilitation beds which were to have been included in the new building, but have now been removed at the PCTs' insistence. If these beds and the necessary services to go with them are not provided elsewhere by 2008, the basic viability of the new hospital will inevitably be called into question. Already the experience of many first-wave PFI hospitals, including those in Edinburgh, Durham, Carlisle, Worcester and Norwich, confirms that large-scale cuts in bed numbers, imposed without the accompanying (in each case promised, but unfunded) development of rehabilitation and other suitable community based services, is a recipe for bed-blocking and crisis.

Indeed without the PCTs delivering on their promised expansion of services, the end result of their intervention would simply be a smaller hospital, with fewer beds, fewer staff, fewer theatres, fewer patients – and a massive, growing financial problem.

- The transfer of services to the PCT are regarded by the GMSHA as a transfer of risk, since the PCT would be effectively signing up to absorb any future increase in

demand, while ensuring that CMMC continues at 2003-4 levels of activity. It does not seem that any robust scheme for organising or funding this open-ended commitment has been agreed: one possible outcome could be mounting crisis for both CMMC and the PCT.

- While these issues should properly be the subject of extensive debate, especially if GPs and other PCT professionals are to be involved in the planning and delivery of care, the break-neck schedule for decision-making imposed by the GMSHA – seeking a "financial close" in June 2004 – makes any proper planning almost impossible.

In this context it is a major contradiction that on the one hand the GMSHA as late as April 2004 insisted that the PCTs complete a "demand and capacity review", and that their plans be scrutinised by the National Audit Office. Since it is clearly impossible even to conclude serious plans within the few weeks allowed by the GMSHA before financial close it is hard to see what of substance the NAO will find to audit.

Other unanswered questions

- The revised proposals concede that there is still no certainty over the availability of the £20m assumed to be forthcoming from charitable sources to fund part of the scheme. In particular, there is no discussion of what the Trust would do to bridge the gap if only part of the expected cash support is available: the GMSHA has simply declared that "any shortfall would need to be managed by the Trust" – and that it should produce "contingency plans" to show how it would do this. Where are these plans?

- The Mental Health facilities which are being effectively swept along in the wake of this mega project threaten to land significant additional costs onto the Mental Health & Social Care Trust. The GMSHA (April 2004) suggests that this might be alleviated by the use of Exchequer funds to build the new mental health wing. But if that would be a cheaper option for Mental Health, why not save money on the rest of the project as well, and scrap the costly and chaotic PFI deal?

- One of the factors cited to explain the soaring costs embodied in last year's Full Business Case was the need to expand the space within the building (at a cost of £31m) beyond the original plans to take account of NHS Estates guidance on issues of "consumerism". Since the only subsequent changes to the space within the building is an unspecified reduction of 4,300 square metres, it is not clear where the additional space has been sacrificed, or what impact it will have on the patient environment. We note that the GMSHA has urged the Trust to ensure a "flexible, spacious and light" building – but note also that such objectives are likely to conflict with cost-savings.

- In addition, the FBC plans appear to have been completed *before* the issue of revised guidance from the Department of Health increasing the space between beds by 22 per cent (increasing the gap between the centres of each bed from 2.7 metres to 3.3). These and other guidelines from the DoH triggered a major redesign of the controversial PFI redevelopment of St Mary's in Paddington, incorporating the Royal

Brompton and Harefields Hospitals – helping to push the projected cost from £340m to over £800m, and consequently forcing a major review of the project's affordability.

UNISON notes that the £420m UCLH PFI hospital in London is currently being built to 1990s specifications, having been finalised before the new guidelines – which reflect the bitter experience of cramped and uncomfortable wards, corridors and outpatient areas in first-wave PFI hospitals – were applied. We would be most concerned if Central Manchester's long-promised 21st century hospital was also designed on the basis of discredited 20th century planning guidance.

We call on the PFI Project Board to publish immediately the assumptions on which the space allocations within the new building have been drawn up, and to declare categorically whether the most recent 2003 NHS Estates guidance has been incorporated.

- UNISON is also concerned that the FBC at no point makes explicit reference to the provision of office and storage space, both of which are essential to the efficient running of a hospital, and both of which have been in desperately short supply, often added as a bodged afterthought, in first-wave PFI hospitals. A hospital on the scale envisaged by CMMC without adequate space for administrative and secretarial staff would be a nightmare to manage, and equally bad to work in.

Conclusion

The available evidence so far suggests that the Central Manchester PFI is based on decidedly shaky foundations. The attempts to scale back the hospital to realise relatively small-scale savings for the PCTs could result in a whole sector of care – the care and rehabilitation of frail older patients – being left in a limbo of good intentions and a desperate shortage of resources.

Indeed, while the initial FBC was based on (optimistic) projections of demand for in-patient care, and calculated the new hospital's bed numbers on these projections, the revised scheme has cut beds by an arbitrary number, with no reference whatever to existing or likely patterns of demand. There is no sign as yet that a plausible alternative system can be established that would guarantee patients will be appropriately diverted into suitable and properly-resourced care at primary level.

However seriously the PCTs may wish to remodel services, it is hard to believe that robust plans to replace a substantial and growing pressure on hospital beds with primary care services and "beds and bed equivalents" in the community could ever have been formulated, funding identified, stakeholders (notably GPs) properly consulted and involved, adopted, and genuinely scrutinised by the NAO in less than two months. It clearly has not occurred.

Nor are we convinced by the vague assertions that cost savings of the gigantic order required can be achieved by the CMMC Trust. We note that Grant Thornton last summer advised that Cash Releasing Efficiency Savings (CRES) of 1% were "tough", while CRES targets upped to 1.5% were unlikely to be delivered. Yet local PCTs and other NHS bodies across Manchester face the prospect of finding economies ranging upwards from 2%, with some as high as 4%, not only this year but on a recurring basis.

We are especially alarmed at the prospect that large numbers of jobs are likely to face the axe if cost reductions on the scale proposed are to be implemented, since it is likely that such cutbacks can only be achieved at the expense of the quality of patient care.

The PFI scheme was identified in the CHC response last year as a costly way to finance the new hospital that Manchester definitely needs. But the latest plans, coupled with government moves to introduce the Payment by Results policy between now and 2007, show that it is not just costly, but risky.

Managers – in the CMMC Trust, GMSHA and PCTs – may be rushing now into decisions they will seriously regret in a few years, and which will cost the entire Greater Manchester health economy dearly. And (if other PFI projects like Edinburgh RI and Worcestershire are any guide) decisions which their *successors* will struggle to cope with, after they have moved on to other employment.

The scheme so far is clearly a shambles: every key condition set, in November and in April, has so far been ignored, while the GMSHA single-mindedly shoves the Trust and the PCTs towards agreement regardless. The PCTs wanted the Children's Hospital completed earlier: it's now clear it will be even later than first promised. The PCTs, and then in April the GMSHA in its Caveats, demanded chapter and verse from the Trust on how it could make really substantial cash savings to cut the cost of the scheme – and promised a rigorous audit

by the NAO: it's now clear that the plans still do not exist, and the NAO has nothing to scrutinise. Yet regardless of these accumulating problems the GMSHA, possibly humming "one wheel on my wagon", keeps relentlessly rolling along.

The driving force behind this unseemly haste is the costs and the demands of the PFI process and the consortium. Anyone seeking more time to ensure that robust and financially viable plans not only exist on paper, but have the support of key front-line providers and stakeholders, is bullied with the threat that a further delay would cost more money. In practice the scheme has already become even more expensive, while the services it is to include have been cut back – further illustrating that PFI, with its complexities, delays and overhead costs, represents rotten value for the taxpayer, patients and NHS staff.

We suggest more time has to be taken to answer many of the unresolved problems outlined above – many of which have in any event been identified by PCTs, the GMSHA and the Trust. At the same time it would be useful to explore the possibility of accessing cheaper capital through Exchequer funding – cutting out the PFI middle men, and constructing not a liability as a millstone round the neck of the Trust, but an asset that will be owned by the NHS for the generations yet to come.

Do it properly: plan it thoroughly: fund it publicly!

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June 2004