HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.54 * October 2001

INSIDE

Oi, Mr Milburn ...

Where are all those extra beds?

The first wave of Privately-financed (PFI) hospitals became notorious for the scale of the cuts in bed numbers they represented, with reductions in front-line acute beds ranging as high as 40% in Hereford and North Durham.

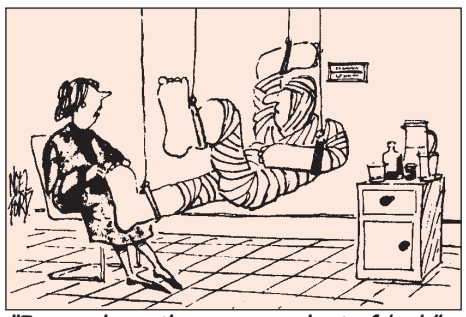
As a result the newly-opened North Durham Hospital was plunged into an immediate beds crisis. Two other PFI hospitals embodying large-scale bed reductions, are both already struggling to cope with the depleted numbers of beds they have left.

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 two of the other big bed cuts based on this type of approach:

■ In Worcestershire, the Health Authority plans for a new PFI-funded Worcester Royal Infirmary originally meant a county-wide cutback in beds of 33%. Even modified schemes meant cuts of well over 25%.

■ And in Edinburgh the new Royal Infirmary will involve not only the loss of 400 of the existing 1,300 beds, but also a major cutback in its nursing and medical staff to hack £32m a year from spending.



"I never knew they were so short of beds"

Elsewhere the shape of PFI schemes – or at least the way they are presented – has changed since the findings of the NHS Beds Inquiry, commissioned by the Labour government to report on the adequacy of bed numbers.

Health Secretary Alan Milburn has become more sensitive to the charge that PFI is further reducing front-line capacity. At first he insisted that new PFI schemes must at least match the existing numbers of acute beds.

But in February he went further, and insisted that the historic run-down of hospital bed numbers will not only be halted but reversed, through PFI schemes. He told MPs:

"Overall, these new hospital developments will provide almost 3,000 extra beds on the number currently provided. Indeed, in every single one of these new developments more beds, not less, are now planned."

This has policy in turn led to a further escalation in the costs of the new generation of PFI schemes: but the Department of Health remains coy on the numbers of beds these schemes will provide.

Indeed there is little, if any evidence in the figures published by the Department to support Mr Milburn's claim that the second and subsequent waves of PFI schemes will increase bed numbers at all, let alone by the hefty 3,000 figure he has claimed.

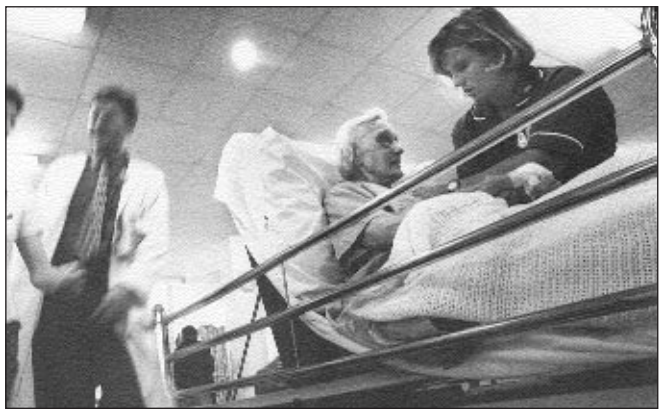
Of course in some areas a cut in the number of front-line acute beds may be masked by an increase in the numbers of less intensive "intermediate" beds, which are then included in the totals.

This is the case in South Birmingham, where the Trust is proposing a PFI scheme that would cut over 200 of the present 1017 acute beds, but replace 150 of them with cheaper on-site "intermediate" beds.

Intermediate beds can play a role in the longer-term care of frail elderly patients: but they do not play the same role as front-line acute beds in dealing with emergencies and waiting list patients.

The issue of intermediate beds is central to the debate over adequate bed numbers. Recent reports have highlighted the demand by consultants at Carlisle's Cumberland Infirmary for an urgent 50-bed extension to the PFI hospital to reduce the numbers of cancelled operations.

But Trust managers are sticking to the line of the PFI plan, that the number of beds is right, but that there are too many of the "wrong type of patients" in them, who ought to be transferred to "intermediate" beds elsewhere!



And a new Birmingham University report on the massive bed cuts proposed as part of the Herefordshire PFI scheme has concluded that the Trust will only be able to meet government waiting list targets if more beds than planned are kept open.

The consequence could be that old-fashioned "hutted wards", which were due to close with the opening of the new hospital would have to stay open indefinitely.

However the figures are massaged, the pressures of rising demand for emergency treatment, and for waiting list care will expose any weaknesses in the new system planned around the requirements of PFI and the private businesses involved.

Health unions, local politicians and campaigners should unite to demand Mr Milburn comes clean and tells us:

■ *WHERE* are these promised extra beds?

■ *WHEN* will they open?

■ *WHEN* will extra beds be opened in the areas already suffering from massive PFI-driven bed cuts?

New cash crisis ahead for social services

Social services have been short-changed in their dealings with the NHS over winter pressures, and many are now facing mounting deficits and a gap in resources to maintain levels of care.

These are the stark conclusions that emerge from a survey of the 150 social services departments in England conducted recently by the Association of Directors of Social Services.

Of 138 authorities responding, three quarters overspent last financial year, by an average 2%, giving a total shortfall of £183m.

But almost 90% of authorities report a gap in resources this year, with more than half in a worse situation than they were a year ago. Many have tightened their own "eligibility criteria" in an effort to hold down demand.

One factor in this worsening position was the impact of £47m of "winter pressures" money allocated to social services last year, which now ties councils into spending £173m in the current financial year.

The ADSS survey revealed widespread concern at the lack of sufficient affordable places in nursing and residential care and the costs of domiciliary services, which are likely to hamper councils' ability to speed the discharge of frail older patients from hospital this winter.

Jean Brett and campaigners press their defence of Harefield

Government cash bails out private sector failures

The bail-out of the failed private Heart Hospital in central London with £27.5 million of NHS money proved conclusively that when it comes to propping up private medicine there is no shortage of government cash.

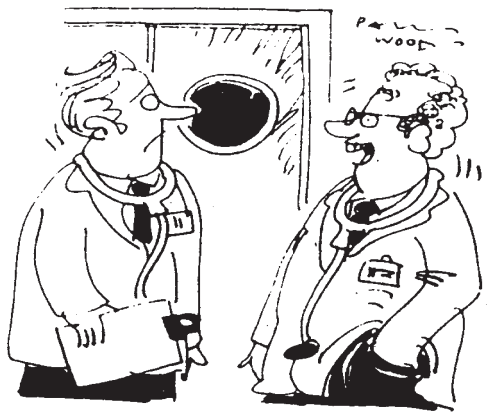
The Heart Hospital had been closed in a round of NHS cutbacks under the Tory government back in the early 1990s.

After laying empty for several years it was bought up by a combination of cash from hospital consultants and a Singapore-based private company who thought that they could make a killing marketing private heart treatments to rich patients across the globe.

They were wrong. In a classic failure of the private sector to manage what should have been a nice little earner the hospital was on the point of going bankrupt earlier. That was until the government stepped in with the cash to bail them out.

Despite the spin, this was a million miles away from being a "renationalisation" as the government initially tried to portray it.

It soon became clear that the entire private patient caseload at the hospital, subsidised with much-needed NHS funds, would be ring-fenced and protected – while the NHS patients would play second fiddle and only get use of the spare capacity.



"I'm a plastic surgeon. I only operate after I've seen their credit card"

The consultants, their income protected and their investment returned, are laughing all the way to the bank. At least a third of the hospital's work will be private, the highest percentage of any NHS hospital in the country, in a move which proves that there are now no limits on the extension of private beds in the NHS.

The government claimed that over 90 nurses would be transferred to the NHS. Again, the figures unravelled as it was revealed that most of the Heart Hospital nurses are agency, hired in on a casual basis and only when the caseload demands.

Even worse, the government were so determined to manage the bail-out of the Heart Hospital as a "good news" story that none of the staff at the cardiac unit at the Middlesex were consulted. The word is that the £27 million was spent simply to try and undermine the union campaign against privatisation.

The grandiose claims about how many NHS patients will benefit from the deal will need to be verified.

How the whole thing sits with the planned £400m PFI hospital to replace the UCLH and the Middlesex a quarter of a mile away on Tottenham Court Road also remains to be seen. The complexity of continuing to run two high-tech units each with ITU beds raises the possibility is that the Heart Hospital could earn the dubious distinction of being the only NHS hospital to be closed down twice through finance-led cuts.

We'll be watching this one closely.

■ A new deal for the treatment of 40 heart patients from Liverpool will provide a very welcome £300,000 boost to the biggest private hospital north of the border, the giant HCI International Medical Centre in Clydebank.

HCI, a £181m white elephant, has been struggling for survival ever since it was built with controversial subsidies from the Tory government: but a hefty 20 percent of its budget comes from NHS work.

The Liverpool deal covers patients who have waited more than six months for heart surgery at the Cardiothoracic Centre.

By contrast the maximum waiting time for Scottish heart patients is 12 months. HCI has operated on 60 Scottish heart patients this year.

According to *The Scotsman*, numbers of Scottish NHS patients to be treated in the private sector are likely to increase sharply this year: a deal to treat up to 900 waiting list patients from Grampian University Hospitals Trust at the private Albyn Hospital in Aberdeen is reportedly close to agreement.

Harefield Hospital campaign halts Paddington plan

Jean Brett

The plans of NHS bureaucrats to close Harefield Hospital by transferring its work to a yet-to-be-built, over-large and over expensive monolithic structure in the Paddington area have ground to a halt, ten months after the much criticised public consultation process ended.

Alan Milburn the Secretary of State for Health still has not given his consent to the Paddington project. This has left the NHS managers who have stated since the new year a decision was imminent and bound to go their way embarrassed by their ow n spin.

Recent events have also underpinned the soundness of the Heart of Harefield campaign group's objections to closing what is accepted internationally as a centre of excellence.

We had stressed that there was no evidence to support the claim that transplant units which were part of large teaching hospitals produced better results. The damning September report of the Commission For Health Improvement on the high percentage mortality rate of transplant patients at just such a large hospital, St George's, sadly proved our point.

When transplantation was stopped at St George''s in October 2000 onl the grounds of patient safety, its waiting list patients were redirected to the speciality transplant hospitals of Harefield and Papworth.

Neither can NHS bureaucrats logically argue against such specialty hospitals – after recently buying one, the London Heart Hospital.

The latest news on when a decision mil be made on Harefield said "this autumn".

We are in autumn, and still we wait. However at Harefield the second stage expansion of the clinical research centre has been agreed, and with Professor Sir Magdi Yacoub at its head the future looks bright.

As hopeful is the fact that the person cutting the first turf on October 31st to formally mark this progress will be Alan Milburn Secretary of State for Health What better occasion could there be for Alan Milburn to then announce that the shadow of closure over Harefield Hospital is lifted!

● Contact Heart of Harefield on 01923 777066, fax 01923 774990

Green light to export waiting list to Europe

THE NHS may be frantically importing doctors and nursing staff from anywhere it can find a pool of qualified English-speaking recruits: but Health Secretary Alan Milburn has now given the nod to the export of patients for treatment in under-used hospitals in Europe.

The first patient to take advantage of this new relaxation of NHS rules and receive a knee replacement in a German hospital is a 60-year old woman from Wiltshire who had been waiting 22 months since she was first referred by her GP.

Jackie Whatley and her husband will have to fork out for air fares and accommodation in Germany.

But the logic of Milburn's NHS paying out £6,000 to finance the operation in Rodbalen, near the French border, rather than ensuring that British hospitals have the resources to cope with waiting lists is far from clear.

PCTs have now been empowered to buy treatments from European hospitals, ranging from one-off operations for people waiting more than the maximum 18 months to batches of operations such as cataract and hip replacements.

It appears to flow more from the government's defeat in the European Court and its fixation with increasing links with the private sector than any serious attempt to plug gaps in local services. No extra cash is being provided to pay for overseas treatment.

And the new arrangement is thought to be most attractive to patients from the south east corner of England, where they may actually be closer to a French hospital than one in the NHS.

French docs unimpressed

French hospital chiefs have been far from enthusiastic at the prospect of treating a queue of health refugees from our under-funded NHS. Doctors and nursing staff are paid less than their British counterparts, and hospital budgets are fixed, regardless of the level of activity for the year.

The mayor of Montpelier , a major medical centre, warned that the timing of the British move is not clever. Speaking to London's *Evening Standard*, he said: "We are shortly to implement our own 35-hour week and that is going to put extreme pressure on our own hospitals and we could well end up with waiting lists of our own. What are we meant to do then? Send them packing off to London in the opposite direction?

"What Britain really needs to do, if I may say so, is to improve its medical infrastructure and invest in its public services – as we have done."

France spends 9.4% of its gross domestic product on health, and Germany 10.3% compared with just 6.8% in Britain.

Scots to stay nearer home

A very different line has been taken by Mr Milburn's Scottish counterpart, Susan Deacon. "Why send a person from Falkirk to Frankfurt when perhaps he could be treated in Fife?" she asked, pointing out it would be easier to cross to a different Health Board than to cross the channel looking for treatment.

The Scottish NHS is to simplify the process of paying for patients to be treated in hospitals outside their area of residence.

Watch out, CHI's about!

Geoff Martin

Staff and patients at the Epsom and St Helier Trust woke up on a sunny summers morning to find out that their hospital had been branded as the worst hospital in Britain by the government's inspector's, the Commission for Health Improvement (CHI).

The CHI report exposed a number of long term problems at the Trust which the Unions had been raising for years and which are all directly related to years of cutbacks, under investment and low pay:

- Massive pressure on beds
- Poor quality environment
- Dirty buildings
- Longs waits in A&E
- Chronic staff shortages

Along side all of this, CHI were also heavily critical of the management of the Trust and talked of a "them and us" culture, with staff scared to speak out.

As soon as it was clear that the CHI report was to damn the Trust, the Chief Executive, Nigel Sewell, opted to jump from the sinking ship and take early retirement rather than face the music.

His pension and pay-off entitlements were all protected, and he has been allowed to wash his hands of a crisis-torn Trust which he presided over, without ever being called to account for his performance.

It was Nigel Sewell and his team who put forward the plan which would have stripped key front line services out of the Epsom site, which led to a mass exodus of staff. Although the plan was later pulled, much of the damage was done and the Trust is yet to recover.

Morale at Epsom and St Helier was already at rock bottom, and the Trust was dealing with the worst nurse shortages in London, when the CHI report was dropped like a bombshell into the Trust. The last remaining shreds of public confidence in the hospitals has been shattered and yet more staff have walked.

Meanwhile, CHI have walked away from the problem and have left the Trust swinging in the breeze. The only recommendations that they have made have been purely cosmetic and they have claimed that the action that Epsom and St Helier really needs, a massive injection of capital investment, is outside of their remit.

Unions at the Trust are furious that the CHI report made no reference to the role of the staff organisations in rebuilding confidence and morale in the wake of such a devastating report. Unions were given about 20 minutes by the inspectors to air their views but nothing was incorporated in the report.

The CHI experience at Epsom and St Helier, and at other Trusts, raises some important issues, not least why bother having an inspection if the final recommendations cannot deal with funding issues.

CHI looks set to become another government buffer zone, able to slag off Trusts and staff without calling the government to account for failing to invest the money needed.

Ambulances outside St Helier: staff morale has plunged in the country's "worst hospital"

Trust bosses see stars as Milburn puts the boot in

There were "no surprises" in the list of the 12 worst performing hospitals in the country, according to Health Secretary Alan Milburn.

Unveiling the 'star ratings' – the latest set of "league tables" to be imposed on a battered and confused NHS workforce – Milburn claimed that NHS insiders had known which were the worst hospitals for years, but nobody had told patients.

More significant from the point of view of staff and service users, the "insiders" have sat smugly on the information … and ***done nothing about it***, leaving the hospitals to be made sacrificial scapegoats in Milburn's "get tough" campaign.

An idea of New Labour's longer-term plans can be gleaned from the goodies handed to the elite "3-star" hospitals.

They will be given more freedom from Whitehall control and urged to become more involved in the private sector, setting up spin-off companies to develop new technology for profit.

And while the chief executives of the failing Trusts have been given three months to improve or face the sack, the bosses of the elite Trusts can award themselves fat bonuses and pick up salaries of £200,000 a year or more if they take over the additional task of reviving a no-star failure.

The complexities of the calculation of the 21 performance indicators used to compare the 173 acute hospital Trusts mean that some have failed as a result of problems they are powerless to resolve.

The Oxford Radcliffe Hospitals Trust, for example has been struggling against the odds to recruit and retain sufficient nursing and professional staff despite the fact that property prices in Oxford are close to London's inflated levels – but staff receive no London weighting.

Staff shortages have led to bed closures, and bed shortages to trolley waits – and brought the mark of failure.

But a kick in the face from Labour ministers and Department of Health civil servants is likely only to compound problems of morale and recruitment.

Out of date figures hamper plans for care of elderly

An insight into the chaos of elderly care is given by the plight of health services in West London. Ealing Hammersmith and Hounslow health chiefs were told that while nursing home closures across West London are "a cause for concern", "robust local figures are not available".

If the Health Authority responsible for planning care doesn't have the figures, who does? The lack of local figures means that there can be no accurate national data either.

London Health Emergency has warned that Department of Health statistics on care of the elderly, the 2001 "Key Indicators" on the provision of nursing home care in London's 30 boroughs, are a massive 6 YEARS out of date.

In 1995-96, the last time details were collected, only two London boroughs matched the English average for provision of nursing home places. Two thirds of all London boroughs had fewer than half the English average of 46.6 nursing home places per 1,000 residents over 75.

Successive governments since 1980 have seen an expansion of privately owned nursing homes as the key to discharging frail elderly patients from front-line hospital beds: but the latest figures suggest that this policy is doomed to failure in the capital.

LHE's Information Director John Lister warns that these old figures could be masking an even bigger problem.

"We know that across the country as a whole 15,000 nursing home places closed last year. Private owners complain they are not making enough profit from clients funded by social services.

"Nursing and residential homes are being sold off as luxury accommodation. The failure to monitor the changes on the ground is a real scandal: but these shocking figures may well understate the scale of the problem.

"The private sector has had ten years to deliver, but has failed in this key area, and the result can pile even greater pressure on hospitals struggling to treat and discharge growing numbers of older patients.

"Any expansion of nursing home care for frail older people will have to be provided and funded publicly, and this means a major cash injection to enable the NHS and social services to pool resources and establish new purpose-built facilities.

"If not, our hospitals are going to be reduced to constant crisis, in the winter peak, and all year round."

Strategic Health Authorities:

Shifting the deckchairs

John Lister

THE LATEST reorganisation of the NHS, under the general heading of "Shifting the Balance of Power" is – as always – larded with bland and pointless rhetoric about making the service more responsive to patients.

The consultation document on the merger of London's 14 remaining health authorities into just five "Strategic" Health Authorities to cover the capital's 7 million population is no exception to this general rule of bullshit and double-talk.

NHS Regional Director John Bacon declares in his pompous introduction:

"Delivering this radical agenda requires real change in the way the NHS works as an organisation and with stakeholders.

"The balance of power must be shifted towards frontline staff who understand patients' needs and concerns. It must be shifted towards patients and local communities so that they have real influence over their development."

Does this mean that at last health authorities are to be elected, and that staff working in our pressurised hospitals and mental health services are to get a voice in decision making?

Are Mr Bacon and his superior, Mr Milburn, proposing workers' control, and genuine accountability to service users?

Of course not.

The health authorities are to be merged into even more remote, faceless and anonymous organisations, run as now by appointed members and full-time managers.

The Primary Care Trusts which have been hastily assembled to replace the Primary Care Groups will be more local, borough-based organisations, but will also be run by a narrow cross section of GPs, primary care professionals and appointees.

The only organisations within the NHS which have allowed any elected representation, and offered service users any chance of an independent voice – the Community Health Councils – are also to be scrapped, and replaced by a hugely complex and vaguely defined series of new bodies that will lack the expertise, the overview, the focus and the statutory powers of the CHCs.

Also to bite the dust in the latest reforms will be the Regional Offices – the last surviving pretence at any wider strategic planning of health services, which in any care are now staffed only by civil servants and hold no public meetings.

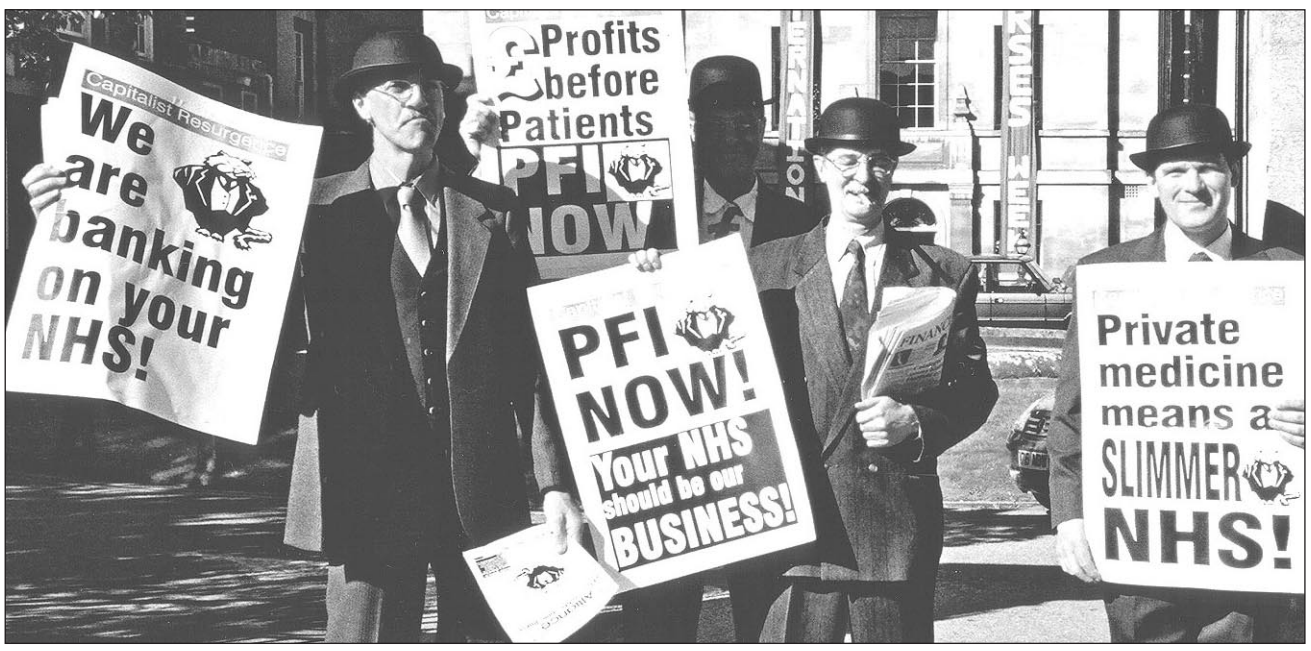
The upshot of these changes at national level is to INCREASE the number of quangos. In place of the old post 1948 network of 14 regional health authorities there will be 30 "Strategic Health Authorities", nine regional integrated public health teams and four regional directorates of health and social care.

Instead of the old pattern of 180 health authorities and 90 family health service authorities there will be over 300 Primary Care Trusts, plus the Trust boards running hospitals, community and mental health services.

The whole exercise appears to be one of constant and mindless organisational change to create the impression of progress and create a succession of new scapegoats for ministers to blame for failures in services.

Patients and health workers will be steadily more confused as to which body is responsible for planning their local services, and progressively less able to hold anyone to account, lobby health authority members or in any way influence the decisions of such remote bodies.

As with the famous "inverse care law", which pointed out that the level of health care resources tends to be the greatest in the areas of least ill-health, and most inadequate where health needs are greatest, it seems that the more the government talks about a patient-centred service giving communities more influence, the less power is given to patients to speak up for themselves.



Bankers' favourite: lifting the lid on PFI

Addicted to private funding: Milburn

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."

Margaret Beckett, shadow health secretary in 1995, summed up what had became a common line from Labour 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."

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?

Large-scale building projects, which would previously have been publicly funded by the Treasury, were to be put out to tender, 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 "unitary payments", rather than circulating back within the NHS, flow into the coffers of the private companies, from where they 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 the Public Sector Borrowing Requirement.

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.

But as with all 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.

The extra costs of PFI:

Increased "headline" costs of schemes

PFI hospital projects have become notorious for the massive level of increase in costs from the point at which they are first proposed to the eventual deal being signed.

The first 14 PFI deals escalated in cost by an average of 72 percent, from a total of £766m to £1,314m by the time they were approved.

This inflation has obviously had an impact on the final bill to be paid. The new Dartford Hospital was originally projected to be "at worst cost neutral", but it soon emerged that purchasers were going to have to foot the bill for an extra £4m a year if the Trust were to be enabled to pay the PFI costs.

Rate of return for private investors

PFI consortia don't build hospitals for the sake of our health. They want profit for their investment.

A BMJ article in 1999 pointed out that shareholders in PFI schemes "can expect real returns of 15-25 percent a year", and went on to explain how little actual risk is involved for the companies in PFI consortia.

In Barnet, the second phase of the new general hospital, originally tendered at £29m, went ahead at a cost of £54m, with capital borrowed at 13% over 25 years. In Dartford the rate was 11%, and the £17m annual payment represents a massive 35% of the Dartford & Gravesham Trust's revenue.

The new Worcester Royal Infirmary, a project which was originally estimated at £45m when it was first advertised for PFI tenders in 1995, was eventually given the go-ahead at a total cost of £110m.

But the annual charge of £17m is more than a quarter of the Trust's projected income. Of this, £7.2m is the "availability" charge, or lease payment on the building, giving a total cost of £216m to rent the hospital for 30 years. The scheme will cost the Worcestershire Health Authority an extra £7 million a year.

While most NHS Trusts spend around 8% of their income on capital, those with PFI schemes are spending between 12% and 16%. In part this is because the private sector has to pay more to borrow money than does the government – but the net result is that the taxpayer picks up an inflated bill, while the banks coin in an extra margin.

Margins for PFI consortium partners

But 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". The *HSJ* article pointed out: "there is little chance of the construction industry losing interest in PFI hospitals".

An idea of the profitability of PFI is given by the figures from Balfour Beatty, which is involved in a number of PFI deals. As *Observer* journalist Nick Cohen pointed out,

"It reported last month that PFI projects accounted for 20 percent of sales, but 40 percent of operating profits. In other words, the prudent Treasury is allowing companies to take profits from the taxpayer at twice the rate they can make in a competitive market."

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.

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.

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 involves a loss of 400 of the previous 1,300 beds, and a halving of the 6,000-strong workforce.

But campaigners in West Hertfordshire, faced with bed cuts on a similar scale, in a scheme to replace Watford General and Hemel Hempstead hospitals with a new, smaller hospital, were able to persuade their local Labour MPs to rally to the defence of local services. Ministers were forced to intervene and instruct the Health Authority to think again.

Lesser, but significant bed reductions are also involved in most of the PFI schemes currently under construction:

Bromley's new £121m hospital will have 13% fewer beds than the hospitals it replaces.

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 frontline capacity. He 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.

Staffing levels reduced

The Cumberland Infirmary scheme involved a cut in clinical staff of £2.6m, and in North Durham the financial balance of the plan involved staff cuts to save £3m.

In Bromley, the Full Business Case projects savings in staff costs of £2.9m a year, which arise, among other things, from "the reduction in the number of beds and theatres. 136 jobs are expected to be axed, including 34 nurses and 8.5 doctors, while the reduction in qualified nursing is to be compensated by a higher ratio of health care assistants.

Privatisation of support services and staff

In the first few PFI hospital schemes, staff working in non-clinical support services have been routinely "sold on" to private contractors providing "facilities management" for the PFI consortium.

Since the 2001 Election, Alan Milburn – in the aftermath of nearly a year of strike action by support staff at Dudley Hospitals Trust fighting their compulsory transfer to a private contractor as part of a PFI deal – has now announced three "pilot" schemes, in which support services will be separated from the financing of the new building.

It is not yet clear whether the PFI consortia will agree to this loss of what they saw as a valuable additional income stream. It is possible they will respond by seeking to increase other charges to compensate for the loss of additional profit.

A document for the Barts and the London Trust, discussing the so-called "Soft Facilities Management" services (portering, cleaning, catering and laundry) pointed out that "Potential bidders view the inclusion of Soft FM services as important to making the Trust's Project attractive".

Squeeze on clinical staff

With all non-clinical support services covered by rigid, legally-binding "unitary payments" clinical services become the only area of Trust spending where Trust managers can seek the "cost improvements" and "efficiency savings" which they are required to make each year by government and by NHS purchasing bodies.

As the Wellhouse Trust was told in the negotiations over the new Barnet General Hospital – where even medical records have been incorporated into a PFI contract in a new computerised system:

"Part of the price … has been to agree to an indexation regime which has no in-built cost improvement and is linked to the published RPI index … The Trust will not therefore be in a position to impose Cost Improvement Programme targets across most of its support and operational services. … The scope for future mandatory CIP targets will be limited to clinical services and to the few support services remaining under the management of the Trust."

Squeeze on community and other services

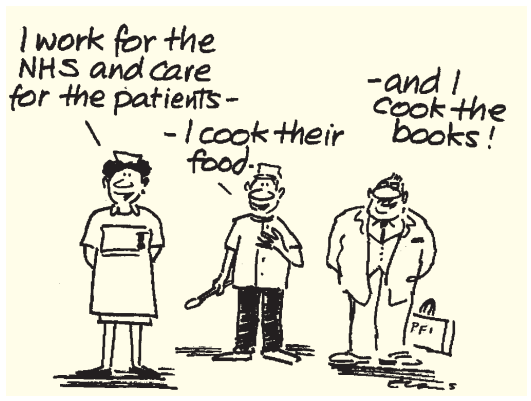
If more has to be spent in paying inflated costs of building new acute hospitals through PFI, less cash is left in the pot to finance other aspects of health care in each area.

As we have seen, many of the first wave of PFI hospitals have had to be heavily subsidised by local health authorities in order to make them affordable. The Worcestershire scheme means that an extra £7 million is being allocated to acute services to enable the Trust pay for the new WRI: this has to be found by squeezing cash allocations for mental health, community services and primary care.

How does PFI show "value for money"?

Untested assumptions

As we have shown above, the inability of the first PFI hospitals to meet pressures for emergency and elective work with substantially fewer beds has already been exposed.



In North Durham, within 12 weeks of the new hospital opening there have been calls for an additional 42 beds to be provided to prevent patients enduring 12-hour waits in A&E.

But their ability to deliver dramatic increases in efficiency has always been seen as key to the affordability of PFI hospitals, and the principal way in which they can defray the additional money they cost the Trust.

As the full financial cost of operating the new system – including the use of increased numbers of community beds and services – is counted, the underlying false assumptions will be fully revealed and the heavy price of PFI will be revealed.

The next generation of PFI hospitals, embodying Alan Milburn's call for schemes to be at least "bed neutral", or embody an increase in bed numbers, will find it even harder to show that they offer value for money.

NHS innovation excluded

Any Trust seeking PFI investment has to depend upon the private sector to suggest the best way of meeting estimated clinical activity, leaving scope for innovative developments.

By contrast, any public sector comparative scheme is required by the Treasury to be "based on the recent and actual method of providing that defined output (including any reasonable and foreseen efficiencies the public sector could make)".

This is especially ironic when we see the quite unreasonable and unrealistic assumptions on which some of the PFI schemes have been based.

Cooking the books: "Public Sector Comparator"

Every PFI scheme is supposed to prove that it represents value for money by being contrasted with a "Public Sector Comparator.

But it is clear from the outset of such an exercise that the comparison is not between like and like: the investment of energy and commitment into selling the PFI scheme to attract the only likely source of funding will not be matched by the ritualistic development of a hypothetical and unloved alternative, whose main virtue is to appear less attractive.

Government guidance spells out that the public sector scheme is not a real plan for a real hospital but just a fig leaf to hide the blushes of the PFI plan: "The purpose of the PSC is to provide a benchmark against which to form a judgement on the value for money of PFI bids".

Discounting the future

One of the manipulative techniques that works consistently to the advantage of a PFI deal in comparison with the PSC is the calculation of the "net present costs".

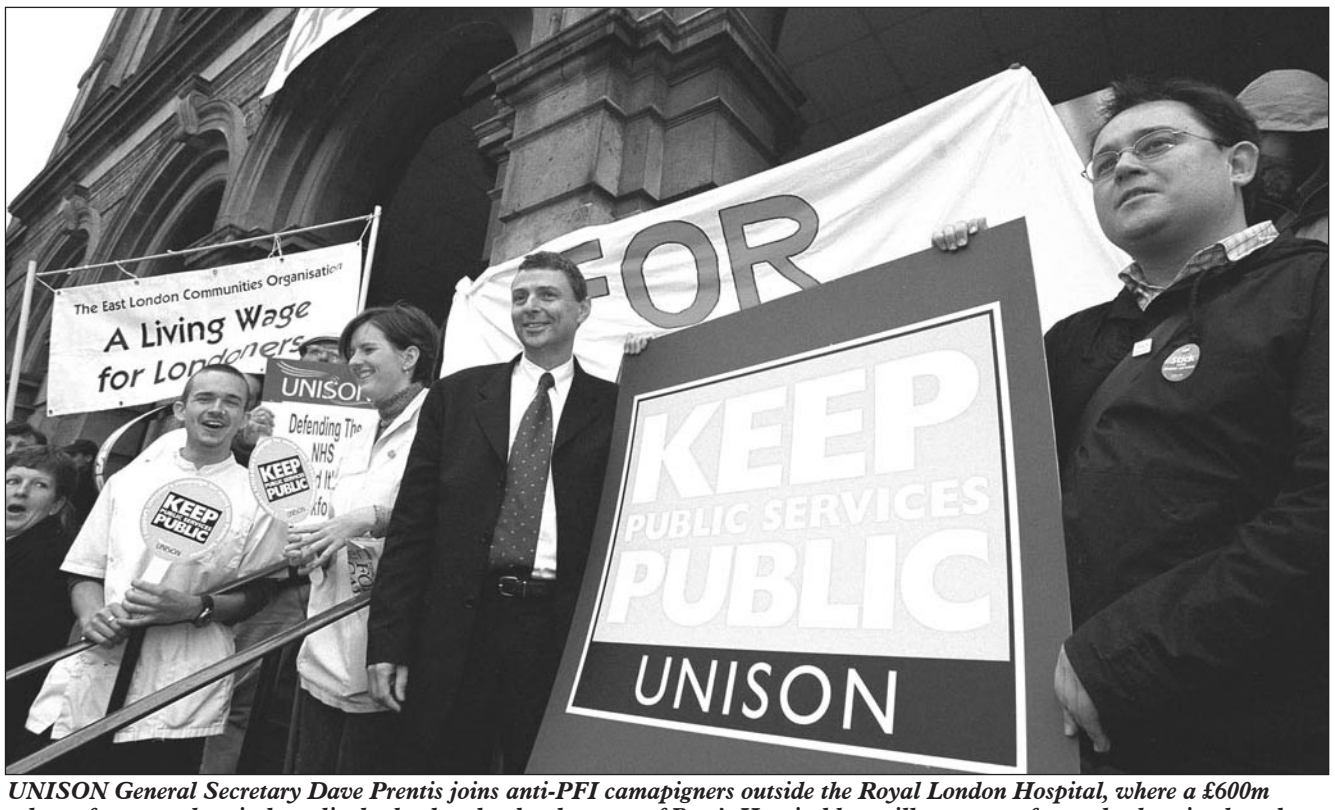
This assumes that money spent now is worth more than money spent in five, ten or twenty years time – and that the full costs of a hospital development will be paid in the first few years of the scheme (when the value is highest) while the costs of a PFI deal can be defrayed over the whole life of the contract.

On one level this is true, given the effects of inflation and the costs of borrowing a large sum up front.

But the exercise is made surreal by selecting an arbitrary, and high, level of 6% per year – well above current and projected levels of inflation – as the basis for discounting the value of future payments (which in any event are index-linked, and do not diminish but increase each year to keep pace with inflation).

By this measure, £100 of expenditure in five years has a present value of £74.73, and in 20 years £31.18. Even a small (0.5%) reduction in this "discount rate" would be enough to wipe out the claimed economic advantage of the Carlisle hospital PFI.

A former Treasury advisor has suggested a much more realistic figure would be 4%: but such a discount rate would leave most PFI deals clearly more expensive than the PSC.



Paul Mattsson

UNISON General Secretary Dave Prentis joins anti-PFI camapigners outside the Royal London Hospital, where a £600m scheme for a new hospital, medical school and redevelopment of Bart's Hospital has still not got as far as the drawing board.

The rising tide of PFI costs

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 unitary 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 argument that support services are included in this overall cost falls flat when we contrast this cost of financing a project through PFI, in which every £1m of capital eventually costs £5-£6 million, with a standard 6% mortgage.

Every £1m could be financed this way over 25 years for just £1.94 million, less than double the amount borrowed, and with no obligation to buy any other services, and freehold tenure of the assets at the end of the deal.

But how does all this represent value for the public sector? While the costs of the large schemes are big enough to cause long-term dislocation to the finances of the NHS, the cumulative costs of financing some of the smaller schemes (less than £20m) through PFI can be ludicrously large.

Some small scale deals – which ought to be affordable from one-off capital funds – are to be paid off over 25 or 30 years, with a resultant cost as high as 24 times the value of the scheme.

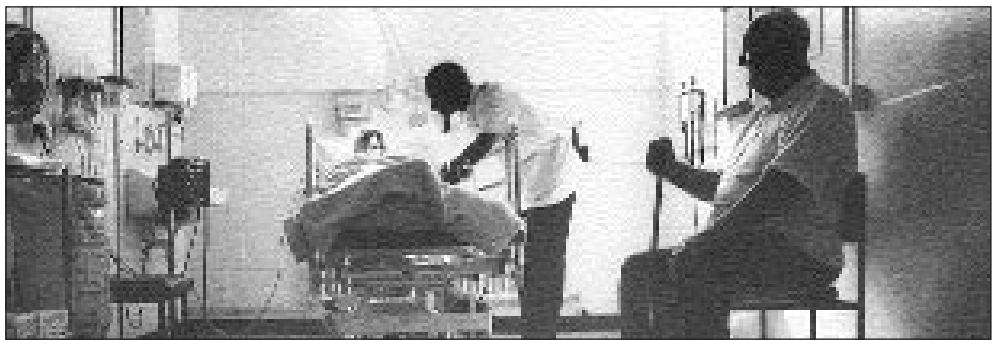
- Queens Medical Centre catering: value £1m total cost £23.8m
- North Birmingham Mental Health: value £12.4m, total cost £163.5m
- North Bristol Brain Rehab unit: value £4.9m, total cost £42m

The more money that is squeezed out of the NHS in PFI payments to bankers and private providers, the less that remains to treat patients, pay clinical staff and develop modern, appropriate services.

■ The full text of this dossier on PFI, which was commissioned by from LHE by the GMB, can be found on the GMB web site www.gmb.org.uk

Short of money, staff and beds

Health chiefs up against London-wide care crisis!



Throughout London many Trusts are facing an "unexplainable" 7% increase in emergency admissions, according to West Middlesex Hospital boss John de Braux.

Barking & Havering

WAITING LISTS and queues for outpatient treatment in Barking and Havering appear to be lurching out of control.

Almost 700 extra patients have joined the list for operations since April, leaving the HA 7% above its target, and numbers waiting over 12 months for treatment are also rising – to almost 60% above target. Numbers waiting over 13 weeks for outpatients are also more than 50% above the target level.

One factor in the waiting list problem is the rising numbers of patients whose discharge has been delayed for lack of community care or nursing home services.

Oldchurch Hospital A&E is struggling to cope with demand: a young man recently died there after waiting 6 hours for treatment.

Whipps Cross

In Redbridge and Waltham Forest, the Local Capacity Planning Group has recognised that Whipps Cross Hospital will be unable to cope with "unprecedented emergency demands" and "constraints in social care" without additional beds.

Unfortunately, despite a limited injection of cash last year, "a substantial funding gap remains."

Camden queue

During the first quarter, Camden and Islington's waiting list rose by 16.5%, while numbers of outpatients waiting over 13 weeks went up by 24%.

The Whittington Hospital is trying to implement a "recovery plan" to deal with a potential £4.3m shortfall: but by September 20 it was already £1.8m adrift having failed to achieve its planned savings. It is now projecting an underlying £3.6m deficit for next year.

Obstacle course in SE London

Lambeth, Southwark and Lewisham Health Authority's Modernisation Taskforce has joined those warning that "affordability", inadequate capacity, increasing demand and recruitment are among the key obstacles to achieving NHS Plan targets.

But the HA's Performance Management report also points out that with emergency admissions running 4.4% above target, the government's NHS Direct service may actually be worsening rather than relieving pressures on A&E:

"There is evidence that a number of NHS Direct calls result in patients being sent to the Out of Hours service of their GP or to the A&E Departments."

Local Trusts are feeling the strain, with King's College Hospital running 5-10% above budgeted levels, Guy's and St Thomas's facing a £1.9m deficit, and Lewisham Hospital up against a recurring £2m shortfall.

Missing targets

Greenwich health chiefs may be celebrating the opening of a new PFI-financed hospital, but, in common with their colleagues in Bexley and Bromley they are far from optimistic that they can achieve the targets set out in the NHS Plan.

A report from the Bexley, Bromley and Greenwich Modernisation Review points repeatedly to problems of funding and staff recruitment as obstacles to achieving targets on access to care, cancer treatment, coronary heart disease, children's services, mental health and care for the elderly.

"Improving access to services was seen as the highest risk to delivery of the NHS Plan", with concern focused on the need to "develop acute services in this part of south east London in order to address the significant pressures in the system." In other words, more beds, staff and cash are urgently required.

NW London

Levels of overspending by the merged North West London Hospitals Trust (Northwick Park and Central Middlesex) have led to crisis meetings with health authority and regional chiefs to discuss a bail-out package.

West London in the red

Ealing Hammersmith & Hounslow Health Authority is struggling to resolve an underlying £15m deficit running into 2002/3, while local Trusts have been struggling to cope with increased numbers of emergency admissions.

A September report finds that levels of emergency admission are 9.5% higher than a year ago.

The HA estimates that around a 5% additional revenue is needed to enable local Trusts to meet the targets of the NHS Plan.

"There are specific local difficulties recruiting midwives, radiographers, therapists, health care assistants and 'lower status but essential' staff" … but apparently there is no shortage of senior managers.

West Middlesex Hospital Trust is struggling to cope with demand, with numbers of waiting list patients running 25% below plan – and patients from the local health authority 30% below plan in July – while emergency admissions are 10% above planned levels.

Kids' hospital lacks nurses

Great Ormond Street Hospital Trust is facing a constant staffing shortfall.

Nursing vacancies, reported as 43 whole time equivalent posts, are disguised by including the equivalent of 46 full time staff working overtime as bank nurses, and 70 agency staff.

The Trust points out that the premium on agency staff employed in August "equates to the cost of an extra 68 additional staff in post for the month". In fact the Trust has the "very high" figure of 159 nursing vacancies.

Crisis looms in Kingston

Kingston and Richmond Health Authority has drawn up plans which it hopes will tide local Trusts through a possible £4.4m deficit.

But it warned in September that "Whilst a forecast of financial balance remains official policy, it is evident that the level of high risk is increasing dramatically, and moreover much of the high risk is translating into real overspend."

Despite an unexplained 10% drop in A&E attendances at local hospitals, there has been a sharp rise in numbers waiting overnight in A&E, which the HA admits "result from a lack of available beds".

In June meeting Kingston Hospital Trust admitted just 76% of A&E cases to the wards within four hours – against the government target of 100%. In July this fell to 63%, and in August, despite a ten percent drop in A&E attendances, it fell again, to just 61%.

Ominously, the number of elective patients waiting more than a year for admission has risen to 483 – nearly double the target figure for the end of the year.

These figures have been compiled during the "quieter" summer months and just show that the pressure is now on all year round and not just in the winter.

Meanwhile th situation has been worsened by Richmond Council, which has run out of money and called a halt to new social care placements. This means that patients who would have been transferred from hospital to social services accommodation will instead have to stay on medical wards.

Richmond Council's leader is a member of the Kingston Hospital board.

Last winter, in the run up to the general election, special measures were put in place to avoid a winter crisis in the NHS, including putting extra social services accommodation on stream to take the pressure off acute hospitals.

Now beds on the medical wards are filled with patients who could be cared for by social services.

Vulnerable patients requiring placements are – "unless there is a risk to the individual or other people" – now being put in a queue, which the HA said for cash reasons "will be deferred until the next financial year" – a 6 month delay.

SW London in panic plea for cash

Merton Sutton and Wandsworth Health Authority (MSW) in September received a chilling report on the failure of its two key hospital Trusts to meet demand for emergency or waiting list treatment.

But MSW points out it does not have the extra cash it needs to open extra beds that would enable St George's and Epsom & St Helier Trusts to cope with the extra pressures during the coming winter months.

The HA's Performance Improvement Plan sets out a stark picture of the situation in local Trusts, with St George's facing the greatest problems:

- Cancelled operations almost doubled in number
- Numbers of patients waiting over 4 hours on trolleys increased by a massive 76% in the three months from April – normally a quieter period.
- In August alone 177 patients waited over 12 hours in "beds in a supervised area" of the A&E department – for lack of proper beds on wards.
- The Trust's waiting list has increased during the summer and is now over 900 (15%) above plan. But day cases, too face delays: numbers waiting over 15 months are 80% above target, while numbers waiting over 12 months are 43% higher than planned.
- 2388 are waiting over 13 weeks for a first out-patient appointment, 64% above plan, while around 700 have waited over 26 weeks – 71% behind target.

Epsom & St Helier, which was last month branded as the worst hospital Trust in the country in a devastating report from the government's own inspectorate, the Commission for Health Improvement, is also struggling, with a near FOUR-FOLD increase in cancelled operations, long trolley waits, and too many patients waiting over 13 weeks for an outpatient appointment.

John Lister from London Health Emergency said:

"These figures show that years of under-funding have reduced health services in this part of London to a desperate state. Immediate action is needed if patients are not going to suffer even greater discomfort and indignity in queues for care or on trolleys waiting for beds.

"Both Trusts say they could open another 82 temporary beds each to relieve the pressure. We say the NHS Regional Office must step in and give the Health Authority – which has no contingency funds – the cash for extra beds."

East London & City

The September report on the Modernisation Review warns that there is a serious risk of not achieving National Plan targets on waiting times at Barts & the London Trust, on emergency and acute service access in "all 3 acute Trusts" and access to GP services throughout the HA.

50% of GP premises are still below minimum standards. Poor ambulance response times are among the risks in failing to achieve targets on coronary heart disease.

And the target of increasing staff numbers is seen as a "significant risk area across East London".

In Newham, "reduction in winter funding from £1.2m to £560,000 has reduced the ability of the Trust to increase capacity during winter pressures. The Trust has estimated a potential 18 bed shortfall over the peak winter period …"

"Current nursing vacancy rates are 20% for nursing staff and 10% for senior medical staff."

In Tower Hamlets the closure of 3 residential homes with a total of 112 beds next February could mean delays in discharging patients from hospital beds.

Four local Trusts were overspent at the end of July: BLT (£1.5m, Homerton £800,000, Newham £400,000, East London and City Mental Health £1.4m.

New hospital "could cost an arm and a leg"

THE COSTS of the proposed £135m scheme for a new single-site hospital in Peterborough are being questioned by health union UNISON, in a unique publicity blitz to challenge the scheme.

All 120,000 households in the city will receive a copy of *Public Eye*, an 8-page tabloid newspaper produced for the local UNISON health branch by London Health Emergency, setting out the response to the health authority's plans.

UNISON warns that because the hospital is to be funded under the so-called Private Finance Initiative (PFI), it is bound to wind up costing the local health service far more than £135m.

UNISON believes that the dangers of PFI in Peterborough include:

- Inadequate numbers of front-line beds to cope with emergency admissions
- Insufficient provision of health care for older patients
- Relocation of services from the popular and accessible Peterborough District Hospital to the Edith Cavell Hospital site – to raise cash from land sales
- More work thrust upon local GPs and primary care services, despite growing problems of recruiting and retaining staff
- Postponement of long-overdue plans to improve mental health services

Peter Mitton, Secretary of UNISON's local NW Anglia Health Branch, launching the publication of *Public Eye*, said:

"Like anyone else, we want to see new hospitals and proper investment in Peterborough's health services: but we don't want services distorted by the costs of a scheme that funnels profits into private companies.

"The costs of PFI would hang like an albatross round the neck of local health care. Rather than the solution to the problems of Peterborough Hospitals Trust it would be just another financial headache for the future, forcing cuts in staff, beds and services.

"We want local people, and our local MPs, to back our campaign to keep private hands off our NHS, and invest public funds to build first class public services."

Med secs fight on

300 Glasgow medical secretaries are on strike, with Edinburgh secretaries balloting for action as we go to press.

They have already staged two strikes in their fight for regrading.

Scottish "surplus" bails out crisis Trusts

Scottish Health Ministers have been sat on a surplus of almost £150m while front-line Trusts have been planning drastic cuts in staff and services to cope with mounting deficits.

Only after Tayside Health Board and local Trusts had run up a massive £16m deficit, and Lothian University Hospital Trust (faced with the huge costs of the new £210m PFI-financed Edinburgh Royal Infirmary) had unveiled plans to axe 200 doctors and other staff to tackle a £5.2m overspend, did Health Minister Susan Deacon announce that an extra £90m was to be pumped in to clear debts in Scotland's NHS.

It will also provide an extra £11m for "winter pressures". Glasgow gets £1.3m to clear debts and other Scottish Health Boards share out £65m extra cash.

Even this belated reprieve for jobs and services will leave another £58m unspent, and Deacon has insisted she may not decide how it should be allocated until next year.

The new money will wipe out debts but not enable any expansion of services in Tayside, where further cuts are planned for next year and 2003 to balance the books.

In Edinburgh, too, the cash injection should forestall the threat to axe 3 of the 8 high dependency beds in the neurosurgical unit, which could have meant patients with severe head injuries being diverted to Aberdeen or Glasgow.

But the long-term costs of the PFI hospital still seem likely to force cuts in medical and nursing staff.

£30m gap in Manchester's PFI fiasco

The £250m PFI hospital scheme for new adult and children's services in central Manchester could land the local NHS with a cash shortfall as high as £32m a year, according to papers leaked to the *Health Service Journal*.

The best-case scenario is a recurrent financial deficit of £12.9m a year, part of which is the result of the Trust admitting that it cannot achieve projected savings of £4.4m, and part due to £4.1m increased revenue costs of the new hospital.

Other pressures and factors including inflation on construction costs mean that the scheme could at best cost commissioning bodies an extra £26m, or as much as £32m in the "worst case".

Health authority chiefs tried to pooh-pooh the figures, telling the *HSJ* that the gap in funding was only "about 1 percent of total spend in Manchester".

This is the latest example of back-room closed door PFI schemes going seriously wrong, and the local CHC has called for the documents and debate on the scheme to be made public.

Scandal of cuts in care for deaf

Patients with hearing problems are getting a raw deal from cash-starved NHS audiology services, according to the Royal National Institute for Deaf People.

An RNID survey of 111 audiology services found long delays before patients are seen, budget cutbacks and inadequate staffing levels.

42% of departments had suffered budget cuts, and some were running out of money for hearing aids half way through the financial year. Patients were denied hearing aids for lack of funds in an eighth of departments.

Waiting times have increased by an average of 30% – with patients in some areas waiting a year fir a hearing test and two years for a hearing aid.

There is also a "postcode lottery", with some areas spending much more on hearing aids than others – from a low of just £20 to an average of £95 per hearing aid. Wide variations in staffing levels also mean that some patients get much more help than others in how best to use their hearing aids.

The RNID's campaigning magazine ***One in Seven*** makes the point that as the world's largest single customer in the market, the NHS can obtain the latest technology hearing aids and revolutionise patients' lives for around £150 "a fraction of the current equivalent cost on the High Street".

But to take advantage of this the NHS has to recognise the need to modernise and invest in audiology services – the demand for which is steadily growing with the rising number of older people in the population.

■ For campaign details contact the RNID 19-23 Featherstone St, London EC1Y 8SL.

NHS finds new recipes for failure

A year after the fanfares launched yet another new government initiative – this time on the old bugbear of hospital food – the Audit Commission has again slammed the state of catering in hospitals.

Patients are still being confronted with unappetising meals, often meals they didn't order, and many, especially elderly patients, are not eating enough and facing the danger of malnutrition.

Chef-inspired

The lack of progress on this long-term problem is no great surprise given that the Department of Health itself abandoned its attempt to get hospitals to include at least one "leading chef inspired" dish on each daily menu – a move which grabbed national headlines, and was to be headed up by TV's Lloyd Grossman.

In June of this year NHS Estates issued an e-mail to Trusts postponing the requirement for inclusion of chef-inspired dishes from July to December.

Trust bosses heaved sighs of relief, because – as London's Whittington Hospital Trust pointed out – these new dishes "have the potential to be the most expensive part of the programme".

Not only do the ingredients cost more, but the stipulated portion sizes are "much larger than those currently in use".

Costs per patient per day could rise by almost 40%, from a pitiful £2.61 to a tight £3.64.

Even giving patients the option of two biscuits in the morning and a piece of cake in the afternoon could cost the Trust an extra £33,000, and may have to be postponed.

The full set of changes to comply with the government guidelines would cost the Whittington an extra £357,000 in a full year.

Leeds cancer unit: what will it really cost?

£163m is the headline price tag for the new mega 300-bed cancer unit – with12 linear accelerators, six new theatres, 16 dedicated critical care beds and modern diagnostic facilities – the Trust wants to build on the St James's Hospital site in Leeds.

It would bring together services currently provided at Cookridge Hospital and at St James's, and represents the efforts of the Leeds Teaching Hospitals Trust to meet the more stringent requirements under the government's national plan for improved cancer services.

But among the doubts hanging over the gigantic project, one of the biggest is how much it will eventually cost – both in cash, and in the jobs and conditions of NHS staff? If it follows the lines of similar schemes already under way, it could cost the Trust upwards of £20m a year over the next 25 years.

Lobby Parliament for a better NHS

Tuesday 6 November 2001

1pm rally - Westminster Central Hall, Storeys Gate
3pm lobby of MPs
House of Commons, St Stephens entrance

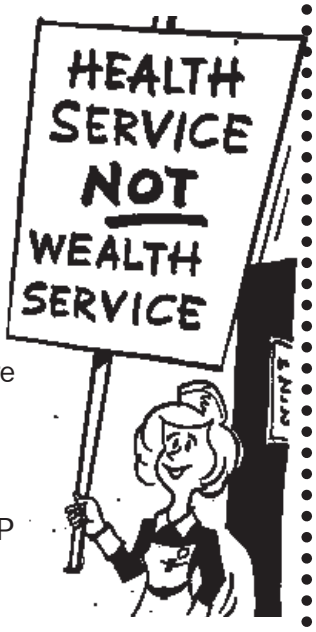
organised by **NHS Support Federation**, **National Pensioners Convention**, **Community Care Protection Group**

Come and help get the message across

- free nursing and personal care
- stop privatisation in the NHS
- adequate funding for health and social care care based on need
- no pension reductions for patients

Speakers at the rally:

■ Rodney Bickerstaffe ■ Dr Richard Taylor MP
■ Claire Rayner ■ Jack Jones
■ Prof Allyson Pollock ■ Prof Peter Millard



UNISON members use an Open Day of Barts & the London Trust to protest at the looming £600m PFI deal to rebuild the Royal London Hospital. The collapse of Railtrack and the continued controversy over the cost of privately-financed schemes whether in cash, lost beds or the impact on NHS support staff all add urgency to campaigns in defence of publicly-funded public services. *PFI explained – INSIDE, centre pages*.

Mental health cash savings – at what price?

The decision by one of London's biggest mental health Trusts, South London and Maudsley, to seek to eliminate the use of private beds for acute "overspill" admissions is generally to be welcomed, even if it was designed to save rather than redirect money.

LHE has pressed for many years for an end to this haemorrhage of cash from the NHS to the private sector, which has left front-line mental health services unable to cope.

But it is not enough simply to decide to stop using private beds: the logical conclusion of such a policy has to be ensuring that sufficient NHS beds, and that units of properly staffed, supported accommodation are in place to take care of those clients who will inevitably require admission or longer-term care.

Unfortunately this second step appears to have been lacking as the Trust has moved to reduce the numbers of acute overspill patients.

The problems seem most severe in Southwark, where the target since April has been to reduce the overspill to zero, compared with around 30 in January: the lack of NHS beds has been causing havoc for the staff and patients at the sharp end – on overcrowded wards.

Mattresses

There have been persistent reports of beds at the Maudsley running at over 100 percent occupancy, with patients sleeping on mattresses on floors: and staff are feeling the strain with sickness rates and stress levels soaring on the worst affected wards.

A similar short sighted pursuit of financial objectives at the expense of patient care can be seen in the continuing attempts by the Trust to close down the highly successful PACT community mental health team – which has been keeping large numbers of severely ill patients out of hospital in Southwark.

A detailed UNISON response to the management plan, drafted by LHE, has pointed out that the closure of PACT would at best save the Trust £150,000 a year, a relatively insignificant sum against a Trust budget of £190m and a deficit last year of £2.8m.

But a break in the qualitative support that has been given to PACT's clients could easily result in the Trust facing far higher costs for repeated episodes of in-patient treatment, which would otherwise be avoided.

LHE is opposed to quantifying mental health services in purely financial terms.

When the Trust Board tell us that they are "saving" money by these one-sided, half-baked economies, we ask "At what price? And at whose expense?"

We need plans, and quickly, for the expansion of acute bed numbers in Southwark to relieve pressure and prepare for future peaks in demand.

We also need to see PACT retained, and plans developed for 24-hour nursed accommodation to ensure that people with long-term and severe mental illness are not stuck for long periods on inappropriate acute wards.

Services getting worse

ALMOST two thirds of psychiatrists think that conditions in mental health wards have made no progress or actually got worse rather than better over the last four years, according to a survey by the mental health charity SANE.

42 percent also thought that community-based services were unchanged or worse than they were four years ago, while only 37 percent of those responding said they detected any improvement.

Chaos over "free" care for elderly

Confusion continues over the implementation of the government's policy of providing free nursing care for people receiving continuing care in nursing homes in England.

Help the Aged has called for the "complex" plan, which should have become operational on October 1, to be "sent back to the drawing board".

Some 42,000 people living in nursing homes need to be assessed to determine which of three official "bands" of nursing care they should be entitled to – whether this be to the value of £35, £70 or £110 per week.

Up to 35,000 of these people are currently having to pay the full cost of their nursing home care, as a result of the Tory government's so-called "community care" reforms.

Ministers have expected that one in ten will receive the lowest allocation, with the bulk of their care being regarded as "social" care and still subject to means-tested charges.

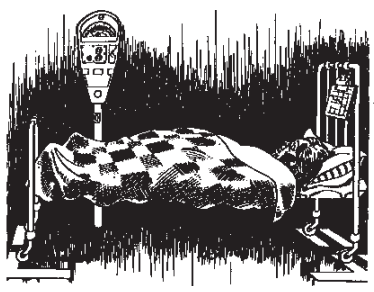
Excess costs

Even those awarded the maximum £110 per week could still wind up facing charges in excess of £200 per week for "social" care, which can include help with such essentials as washing, eating and using the toilet.

Charities representing older people have pressed for the introduction of a fourth band, in which all care costs will be met for those whose nursing needs are greater than £110 per week.

There are also fears that decisions on which band is appropriate will be inconsistent between one area and another – a new form of "post-code discrimination" – and that decisions will be influenced by the financial plight of the health authority.

Age Concern has warned that many older people will be "bitterly disappointed" at the level of funding they will get. Anger will be even greater in England, because in Scotland nursing home residents with similar needs should get all their nursing and personal care paid for by the government.



The government has given health authorities just £100m to fund the changes between now and next April, despite the act that the cost is estimated at £1.4 billion in a full year. Each HA has a limit on how much it has to spend.

The criterion for nursing care is also very restrictive – covering only services delivered by a qualified nurse: but in many nursing homes the bulk of all care is delivered by nursing assistants, with only a very small proportion of registered nurses in post, as proprietors seek to maximise their profits by holding down salary costs.

But the task of deciding on behalf of the health authority and social services what level of care should be "free", and paid for by the NHS, has to be carried out by a specially trained registered nurse – and the government guidelines on how this should be done were only finalised *five days* before the new system was due to come into operation!

Meanwhile doubts are being raised over the apparently free care to be provided in Scottish nursing homes. A recent article in *The Scotsman* newspaper highlights the fact that the "free" care will mean the loss of £55.30 a week Attendance Allowance paid to 135,000 Scots pensioners, while the payments will continue for those receiving nursing home care in England.

And the actual cost of personal care is significantly higher than the £90 a week which the Scottish Executive will pay – leaving "subsidised" rather than "free" social care.

Campaigners, and health unions fighting for all health and nursing care to be provided free of charge and funded from taxation may have won the backing of the government's Royal Commission, but there is still a long way to go before they win the policy in practice – north or south of the border.

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