Pure Financial Incompetence

The heavy price of PFI for the NHS in Eastern Region

A report researched for UNISON Eastern Region by
Dr John Lister, London Health Emergency

Introduction

Hospitals in the old East of England Strategic Health Authority[1] are still counting the cost of the system of using private capital to fund major projects in the NHS, first devised in 1992. Although no hospital projects financed in this way were signed off under John Major's government, the Private Finance Initiative (PFI) has been the almost universal source of capital for new building since the election of Tony Blair's government.

Nationally over 100 schemes have been completed or are under way. And despite the miserable experiences of many of the Trusts which have signed ambitious and unaffordable deals – only for their successors to rue the decision – more schemes have been signed off since 2010 by the Conservative-led coalition, and more are still awaiting Treasury or Department of Health approval, including a lavish new £206m Papworth Hospital lined up to commence next year, and a new £300m hospital complex in Watford to serve West Hertfordshire is still on the drawing board.

In Eastern Region, according to optimistic Treasury figures which seem to understate the costs, three large hospital projects with a capital cost of £642 million are now complete (Norfolk & Norwich, Peterborough and Chelmsford), and set to cost a staggering £4.25 billion by the time the last payments are made in Chelmsford and Peterborough in 2043. The Norfolk & Norwich Trust is set to cost more almost ten times the initial capital cost, while the cost of the Peterborough PFI is the key factor threatening the very survival of the Trust.

Of course the "unitary charge" payments on PFI contracts also include the cost of contracted support services (on average around a third of the total contract price is for support services), but the resulting cost of securing new buildings this way is hugely inflated above what would have been the cost had they been financed on a conventional mortgage. Even at 6% interest a mortgage would have brought a total cost for the same three hospitals of less than £1.3 billion over just 25 years, and much lower, predictable payments. This would have left the Trusts much greater flexibility in shaping services around local needs and changing pressures.

[1] NHS East of England is now merged into the huge 'NHS Midlands and East' in the 4-way carve-up of the NHS preparatory to the roll-out of the controversial Health and Social Care Act

PFI is not just a costly problem for big projects. Smaller schemes, some of them obviously poor value for money, dragging out payments on small sums of capital over 30 years, have also been signed off in acute hospitals (Addenbrookes in Cambridge, Ipswich, and Luton & Dunstable), along with community hospitals in Rayleigh, Brentwood and Bishop's Stortford.

At least one other 30-year project (a state of the art £22m treatment centre at the troubled Hinchingbrooke Hospital in Huntingdon) does not for some reason appear on the Treasury list of signed projects, although the regular monthly unitary charge payments are all too real a factor in the financial difficulties that the Trust has been thrown into.

Excluding the Hinchingbrooke payments, the Treasury figures show that PFI projects in Eastern Region faced "unitary charge" bills (covering the building, maintenance and non-clinical support services) of £88.6 million last year, rising to £131m in the current financial year (2012-13).

One of the most worrying aspects of PFI is that the costs of each scheme (triggering legally binding payments, which take the first slice of any Trust income) are set to rise year by year over all 30 years of each contract, regardless of the Trust's income or ability to pay. As a result, the Eastern Region bill rises every year to a peak of £208m in 2030-31, when the first hospital to have been completed, the Norfolk & Norwich Hospital, reaches the end of its contract. Even after this, the outflow of NHS cash to private banks, private equity and other investors continues at more than £120m a year until the final payment of £97m in 2043.

PFI projects in Eastern Region

Project Name	Procuring authority	Constituency	Contract duration (years)	Initial capital costs (£m)	Estimated unitary charge payment 2012-13 (£m)	Total estimated cost over contract period	Equivalent total cost on 6% mortgage	Annual payments over 25 years on 6% mortgage
Addenbrookes	Cambridge University Hospital NHS Foundation Trust	Cambridge	30	**76.0**	7.2	**266**	152	6.1
Herts and Essex Community Hospital	Hertfordshire PCT	Hertford & Stortford	30	**14.8**	2.5	**81.5**	29.6	1.2
Garrett Anderson Treatment Centre	Ipswich Hospital NHS trust	Ipswich	30	**36.1**	3.5	**134**	72.2	2.9
St Mary's Wing	Luton & Dunstable NHS Foundation Trust	Luton North	30	**14.7**	1.5	**46.1**	29.4	1.2
Chelmsford	Mid Essex Hospital Services NHS Trust	West Chelmsford	32	**148.1**	16.1	**766.1**	296.1	11.8
Acute Hospital services	Peterborough & Stamford Hospitals NHS Foundation Trust	Peterborough	32	**336.0**	41.2	**1963.0**	67.2	2.7
Runwell hospital	South Essex Partnership NHS Foundation Trust	Rayleigh	30	**32.0**	2.7	**115.2**	64	2.6
Brentwood Community Hospital	South West Essex Teaching PCT	Brentwood & Ongar	30	**32.0**	4.1	**170.9**	64	2.6
New District General Hospital	Norfolk and Norwich University Hospitals NHS Foundation trust	Norwich South	30	**158.0**	52.2	**1526.3**	396	15.8
Totals				**847.6**	**130.9**	**5069.1**	**1170.5**	**46.8**

Data from HM Treasury and from mortgage calculators

However we already know that the government's demand for a massive £20 billion "efficiency savings" from the NHS by 2015 has been coupled with a freeze on NHS spending since 2011, leaving NHS resources reduced each year in real terms, compared with rising demand for services, the cost of new drugs and treatments, and levels of price inflation.

The 3-year "Integrated Strategic Plan" adopted by NHS East of England covering 2011-14 makes clear that acute hospital Trusts are required to deliver productivity increases averaging 22%, with an even higher 33% target for Peterborough: the aim is a 2% reduction in inpatient activity and a 9% reduction in outpatient activity, along with 14% fewer attendances at A&E. The Plan projects a reduced requirement for acute beds of 9% (900 beds) across the region – bad news for Trusts with costly PFI buildings delivering precisely the services NHS commissioners are now trying to cut back.

The pace is accelerating: the new Midlands and East Strategic Health Authority has set out plans to generate £789m savings this year in acute hospital Trusts. And for Foundation Trusts and those desperately seeking Foundation status there is the added pressure of Monitor, the regulator, which is already regretting the decision to rubber stamp 11 applications from now failing Trusts, but which appears completely indifferent to the problems flowing from PFI contracts – the most recent Monitor commentary has just one mention of PFI.

The King's Fund and NHS Confederation have warned that this "financial winter" is likely to last well beyond 2015, possibly to 2020 or even later. So the hospital trusts which in the early 2000s may have optimistically planned on the assumption of continuously rising NHS budgets, low inflation and increasing caseload face a new and hostile environment.

Primary Care Trusts (PCTs) (soon to be replaced by GP-led Clinical Commissioning Groups) have been working to cap and reduce numbers of patients referred for hospital treatment, while the price paid for each item of treatment (the so-called "NHS tariff") has also been reducing year by year.

PFI hospitals are saddled with long-term, tightly-written, contracts imposing high, inflexible and rising overhead costs for buildings which in many cases were smaller, with fewer beds, than the buildings they replaced. There is no scope for trusts to 'work their way out' of financial problems by treating more NHS patients – but neither can they cut their way out: since non-clinical services are now run by private contractors, and part of their legally binding contract with the PFI consortium, any cuts have to fall on clinical staff and services.

To make matters worse, the system of funding hospitals through the system misleadingly known as "Payment By Results[2]" means that any cutback in services reduces the income to the Trust, while their overhead costs remain largely unchanged – effectively deepening the crisis.

[2] [2] The Payment by Results (PBR) system is of course nothing to do with results in the sense of judging the outcomes of treatment or quality of care: it is purely a fee for service arrangements which attaches a nationally-decided tariff of payments per treatment, and pays hospitals only for the patients they treat. The main motivation for this has been to create "competition" between the NHS and the private sector, in that any

None of this is any surprise to UNISON, which has campaigned from the beginning against the use of PFI, and for new hospitals to be funded – as all hospital building was, under Tory and Labour governments, before 1992 – from the Treasury, so that they remain as public assets rather than massive public liabilities and a lucrative profit-stream for the private sector.

UNISON has also consistently opposed the introduction of the market system and the costly and bureaucratic division of the NHS between "purchasers" (soon to be CCGs) and "providers" (NHS and Foundation Trusts), which has led to the current destabilising system of "Payment By Results".

However it's now clear that the double whammy of ever-rising PFI costs alongside the dwindling resources of the NHS are triggering a new and intractable problem for hospital managers in Eastern region and beyond. In February 2012 seven English NHS Trusts including Peterborough were given access by Health Secretary Andrew Lansley to a new £1.5 billion bailout fund – clearly designed to leave the main structure of PFI intact. The Trusts had to jump through hoops and show they had plans for cuts and efficiency savings to qualify for the money.

In South East London, the first PFI-damaged hospital trust has been declared insolvent and handed over to a Special Administrator – but the first to suffer this indignity might well have been the struggling Peterborough and Stamford NHS Foundation Trust, which has repeatedly hit national headlines as its massive and costly PFI scheme has lurched predictably out of control.

As ministers pump in crisis loans and send in "hit squads" of costly management consultants in the hopes of stabilising the most obviously vulnerable trusts while preserving PFI, and signing new deals that will spread the agony even further, this report aims to pull together an overview of the impact of PFI on trusts, the costs of care, on services and on the wider health economy in Eastern Region.

Four years after the melt-down in the banking sector triggered a massive financial crisis and brought a halt to the expansion and improvement of public services, the taxpayer still owns some of the banks that were most active in exploiting the profits from PFI, and which are still milking hefty payments from troubled NHS trusts.

It seems inexplicable that a governing party that was so happy in opposition to make political capital of the way in which Tony Blair's Labour government implemented the Tory policy of PFI – and so eager now to blame bad PFI deals on the previous government – should now be seeking so vigorously to prop up PFI and extend it, rather than recognise the need for government intervention to bring these schemes back into public ownership and stem the damaging flow of public money into private pockets.

NHS patients treated in private hospitals or treatment centres take the money with them, leaving their local NHS hospitals poorer, and less able to sustain a full range of viable services.

The projects and their cost

Norfolk & Norwich Hospital

The 987-bed hospital in Norwich was one of the first round of PFI projects, signed off in January 1998 and completed in August 2001. Described by the Treasury as a "new District General Hospital", it is one of the largest hospitals in England, and is also a University Hospital carrying out extensive teaching of doctors and other health professionals.

Strangely for a hospital which initially incorporated no office space, and belatedly converted windowless, enclosed storage areas into uncomfortable, stuffy offices, and was widely criticised by staff, it won design awards in 2002.

Although the PFI component of the project is listed by the Treasury as costing just £158m, the original project was costed at £214 million, and soon perceived as being too small to meet local needs: 144 more beds were subsequently added to the building at an extra cost of £15m, bringing the cost to £229m – and shoe-horned onto the site by taking over space designed for storage and technical work. The Partnerships UK website interestingly records the cost of the hospital PFI at £335m. The Trust's own website makes clear that the contract is for 60 years, with a break point after 35 years, although the Treasury records it as a 30-year deal.

If the latest Treasury figures are to be believed, they show that the Norfolk & Norwich is proportionally still one of the most expensive PFI deals in the NHS, with cumulative payments up to 2031 adding up to £1,526 million – almost **ten times** the initial £158m PFI investment. By comparison £11 billion of PFI contracts in England's NHS are set to cost a total of £64 billion – averaging just under six times the initial cost.

Indeed the Norfolk & Norwich Trust has already paid £464m, close far more than double the initial cost of the hospital: of this, £315m is the "rent" component (68% of the unitary charge) – almost exactly double the initial PFI cost of the building. Interestingly this is also the total that would have had to be paid if the hospital had been financed on a conventional 6% mortgage over 25 years: but under PFI the Trust has another 19 years of payments still to make. Research by Chris Edwards, a Senior Fellow at the University of East Anglia, has estimated the additional cost of PFI funding to the Trust at £19m a year, including the costs of referring patients on to private hospital beds for lack of sufficient capacity in the N&N Hospital itself.

Since the hospital opened, the financial side of the project has come under extensive scrutiny. The refinancing of the scheme on lower interest rates by the consortium Octagon in 2003, almost as soon as the "risk" of the construction phase was complete, yielded a massive £95m windfall profit to the consortium[3], trebling Octagon's rate of return on the scheme from 19% to 60%.

[3] a collaboration by Barclays, Serco, John Laing, 3i and Innisfree

The Trust, by contrast, secured just £34m of the windfall – in exchange for prolonging the basic contract from 30 to 35 years, and was told that it was lucky to get that, since PFI standard contracts had made no provision for the sharing of benefits from any subsequent refinancing. Indeed the Trust was advised by the Department of Health that it should not push for any larger share of the money, for fear that future PFI investors might be deterred if they had to share these pay-outs.

The refinancing was investigated by the Commons Public Accounts Committee in 2006. Its Conservative chair Edward Leigh concluded:

> "It is hard to escape the conclusion that the public sector staff managing the project were not up to the rough and tumble of negotiating refinancing proposals with the private sector ... The unacceptable face of capitalism."

The Trust has had to cope with a double strain: on the one hand even the 987 beds have been barely enough to cope with continually rising demand for emergency services, leading to frequent red and even black alerts when there were no beds available. On the other the unitary charge payment of £47m last year was 11% of the Trust's £427m income in 2010-11 – and that income includes a £3.8m "PFI smoothing payment" to help subsidise a project that has always created financial problems.

A detailed discussion of the Trust's financial situation is obstructed by the fact that since it obtained Foundation status in 2008, NNUH has published no Board papers, and therefore no regular financial information. The snapshot aggregated annual figures published retrospectively in the Annual Report make it almost impossible to gauge accurately the financial state of a Trust, or the trajectory of change.

But of course 2008 also marked the onset of a new tougher regime as prospects for further growth of NHS budgets were squashed by the banking melt-down, and the following year the McKinsey proposals claiming to outline ways to "save" £20 billion by 2014 were simultaneously denied by Labour ministers and adopted by PCTs and Trusts across the country.

The proposals adopted by NHS Norfolk's "Norfolk System Integrated QIPP (Quality, Innovation, Productivity and Prevention) and Reform Plan" from 2011, aimed at generating £184m savings to bridge a projected funding gap by 2014, call on hospital trusts to deliver two thirds of these savings, while admitting that there is little leeway for such savings to be made.

The plans are dressed up as 'efficiency' savings, but in fact represent substantive cuts in services, and for the Norfolk & Norwich Trust the key proposals represent a major threat to the revenue needed to service the costs of the hospital, since they aim to reduce the numbers of patients treated. If the PCT manages to achieve its plans:

- The numbers of people being admitted to hospital in an emergency or for planned (elective) operations will decrease to 2008/09 levels
- Fewer people will attend hospital out-patient clinics

By 2014/15, the plan prescribes, there will be:

> "A 12% reduction in activity levels in the acute sector which will be partially offset by an increase in tertiary and repatriated activity.
>
> "A net reduction of beds used for admissions to acute care in NHS providers is estimated to be 45, which will be mostly offset by 36 beds used to repatriate activity for local providers. "

However the document admits that "Benchmarking the efficiency of provision in Norfolk shows that whilst there are opportunities that must be realised, overall providers achieve average or above average efficiency." Any savings therefore have to come in other ways. We are told that as a result of "detailed 'deep dive' work by McKinsey & Co.," the emphasis needs to be on developing:

> "new models of out of hospital care that keep frail older people healthy and reduce their need for expensive acute care. These should enable communities to care for local people with less need for traditional models of social and mental health care." (Integrated QIPP Plan: 6)

The emphasis in this paragraph has to be on the world "should" – the plans have not yet been tested and there is no evidence they will work in the planning time frame: but in the meantime it's clear that the diversion of patients and resources away from the Norfolk & Norwich Hospital will cause very real and tangible problems of resourcing and viability, which could put the longer-term future of key services at risk.

On page 45, the plan sets out the expected cash pressures on the Norfolk & Norwich, totalling £55m (£15m in tariff reductions and £40m in QIPP measures) to 2014. So as the budget declines, one constant is that the PFI contract requires year by year ***increases*** in the unitary charge payments for the hospital, regardless of what services are provided there.

Peterborough & Stamford Hospitals Trust

If Norfolk & Norwich is proportionally the most expensive PFI in the region, Peterborough's £25m City Care Centre and £310m Peterborough City Hospital are the largest capital investment – and the biggest ongoing financial headache.

The Trust's decision to ignore warnings from UNISON and local campaigners, and, astonishingly from Monitor, the Foundation Trust regulator that the PFI scheme was unaffordable, and to press ahead with the doomed scheme in 2007, has led to the construction of a 612-bed hospital which "ranks among the best hospital facilities in the UK", but which has brought predictable and disastrous financial consequences.

Prior to the deal being signed off, it had been extensively revised. One common factor has been the high cost relative to the income of the Trust. In 1995 a modest £55m PFI scheme that would have brought substantial cuts in bed numbers was rejected by ministers. In 2001, the cost of the scheme had grown to £135m, but again the level of repayments would have posed problems for a Trust which then had a revenue budget of just £90m.

In 2005, shortly after the Trust achieved Foundation status, the scheme was announced to be for a 760-bed hospital at a cost of £340 million: but then NHS chiefs began to recognise that the rental payments on the new buildings were becoming unaffordable. So the scheme agreed in early 2007 by Patricia Hewitt was for just 612 beds, at a reduced cost of £282 million. However the cost per bed had actually increased, from £447,000 to £460,000 – and UNISON pointed out there were still serious concerns over affordability. In the event the hospital came out at £310m, averaging £500,000 per bed.

Meanwhile the private consortium went out to borrow extra money on the back of the project: ABN-AMRO managed to float bonds worth £442.8 million in the summer of 2007. A nice little earner all round … for the private sector, on the brink of the massive banking crash. The takeover of this bank by Royal Bank of Scotland helped trigger the melt-down of RBS, and forced a massive government intervention that is now the driving force behind the £20 billion squeeze on the NHS.

The revised PFI scheme may have secured the endorsement of ministers, but it did not impress the regulator Monitor, which has now published a detailed 32-page report on its involvement with the deal[4]. This makes clear that Monitor wrote to the Trust Board in January 2007 (and to the Department of Health and the Treasury which had to sign off the contract) "stating that it believed the long term affordability of the proposals to be in significant doubt". These warnings went unheeded. So was a further letter in March 2007. The Trust ignored them. The flawed contract was signed, and rubber stamped by ministers and civil servants – and the chaos was unleashed.

The Monitor letter was a considerable understatement: the deal was quite clearly unaffordable from the very outset. In fact Monitor itself had never properly assessed the financial standing of the Trust, and had allowed the Trust to supply over-optimistic and unreliable figures, especially for the final quarter of 2010.

So when the new hospital opened at the end of 2010, the deficits began immediately, requiring a £10m injection of "transitional funding" for the final quarter of that financial year. By June 2011, six months after the hospital opened, with NHS budgets frozen and falling in real terms, it became clear even to the Trust and to Monitor that "the underlying deficit in the new hospital was in excess of £40m per annum on revenues of £200m". At this stage there were still 32 years of the PFI contract to come.

The staggering and constantly rising cost of the PFI hospital was part of the problem: but the Trust had also consistently over-estimated the amounts it might generate in savings through "cost improvement programmes", and this backlog of failed initiatives contributed £12m to the deficit, along with a £10m shortfall in commissioning budgets which has remained a problem for the Trust.

£22m of the deficit is put down to "structural costs" of the PFI – defined as "the difference between the actual charges for the PFI (which includes interest and depreciation) and those that are regarded

[4] 'Learning and Implications from Peterborough & Stamford Hospitals NHS Foundation Trust', researched by KPMG, June 26 2012.

as affordable based on the latest guidance for new PFI schemes." In other words the Trust itself now sees that half the annual payments it signed up for cannot be afforded.

The Trust's Annual Report shows that the first full year's "unitary charge" payment in 2011-12 was £41.3m – almost 20% of its total £211m income, far higher than the already high projection of 15% when the deal was signed.

But with inflation still running high, these costs continue to grow, while the Trust's income, along with other NHS budgets, is squeezed. In the final quarter of 2011/12 the Trust was again bailed out with another "temporary advance" of £41.2m from the Department of Health with no specified repayment date.

Government policies and the perverse measures employed by NHS Peterborough have compounded the problem. As the Annual Report points out, patient numbers in 2011/12, especially those needing emergency treatment, were significantly higher than planned in the Trust's main contracts (not least because NHS Peterborough's own proposals to switch patients to forms of care outside hospital were impractical and unworkable): this has had a negative impact on the Trust:

> "The Trust received more income than contracted, incurred higher than expected financial penalties, and agreed a financial settlement (below national tariff) for the additional work relating to two of its commissioners." (Annual Report page 17)

That a Trust with inflated overheads is compelled by commissioners to deliver emergency services at below tariff (cost) price is an absurdity. There obviously is no real choice but to treat patients who arrive as emergencies, especially when it is over 35 miles to Addenbrookes Hospital or any surrounding hospital. But it turns out that the growing emergency caseload is also a factor driving up spending on employing agency staff to fill gaps: spending on this went up 9% in 2011-12.

The Peterborough Trust Annual report is an astonishing statement of failure, making no secret of the fact that with its huge inflexible overhead costs as a millstone dragging it down for the next 30 years, the Trust – despite its Foundation status, which should mean it is run as a non-profit business without any government involvement – is dependent upon handouts and subsidies to keep afloat.

The PFI liability is a central factor in all of its problems. Because of the move to the new hospital, the Trust recorded a retained deficit of £168m in 2010/11, while in 2011/12 its deficit was £45.8m (p17). This is the shape of things to come. According to the latest Treasury figures the PFI deal is set to cost a massive £1.96 billion by 2043, although this could be further increased by inflation.

> "The Trust will continue to face a major financial challenge with a significant underlying deficit, a very challenging NHS operating environment and the need to deliver significant efficiency improvements whilst safeguarding the quality of patient care provided". (p 18)

The Trust faces a need for 5% per year increases in efficiency, partly to cope with continued reductions in the tariff, and financial challenges to its commissioners, who are seeking to reduce

their payments to the Trust, by moving more patients into alternative forms of care. But while the income is reduced, the cost of the PFI is forced upwards by inflation linking to RPI. Even cutting the workforce has cost £2.4 million in severance payments in the last year.

The Trust appears to have no answers to any of the problems it faces. It hopes for more handouts:

> "The Trust is expecting to incur a deficit during the next 12 months and as a result will require significant additional external funding from the Department of Health. Although this funding stream is not yet formally agreed, the Trust's Board of Directors has a reasonable expectation that the required funding will be provided." (Annual Report p18)

As a result of the handouts so far the Trust has itself paid only a small fraction of the PFI unitary charge on the new hospital it insisted on signing up for. In August 2012 a summary financial plan revealed even worse figures:

> "The Trust has a huge financial problem. Last year we recorded a deficit of £45.8m and this year we forecast a deficit of £54.3m Consequently we are in breach of our terms of authorisation with Monitor".
>
> "The plan tells us that **theoretically** the Trust can get back into financial balance over five years. The key word (and massive caveat) here is **theoretically**." (Monitor Financial plan Summary, p 4)

Success depends on:

- A "huge" efficiency programme
- Attracting substantial new business (additional patients)
- Continued "special Department of Health support for the excess cost of the new Peterborough City Hospital"

None of these is certain: as the document explains:

> "The numbers are frighteningly large – and would require delivery of efficiency savings by years four and five which are (we believe) unprecedented in this country and which may prove well beyond our reach. The business growth we require over five years can only be achieved if health services are substantially reconfigured across a wide area – and this is something we can influence but not control. And the level of special PFI support we need from the Department of Health may be significantly more than the Department would be prepared to provide."

In fact the "plan" could only hope to deliver a surplus if the Trust can secure a regular annual subsidy of £24m this year, rising to £26m in 2016/17. And its hopes of securing extra patients to treat at a realistic price hinge on forcing a "reconfiguration" of services in the surrounding area – clearly angling for a share of the caseload as and when Hinchingbrooke Hospital finally hits the buffers. But with the pending abolition of Strategic Health Authorities, and the fragmentation of commissioning

into a patchwork of unconnected Clinical Commissioning Groups, it is not clear what mechanism the Trust believes could force through a wholesale reconfiguration of services.

Otherwise the "plan" would see the deficit running in excess of £50m each year at least to 2016/17, with no significant reduction achieved even by cost improvements which they hope will add up to £58.7m over the five years.

In fact the situation is even more desperate, since the Trust only has cash to operate up to the end of November 2012, and cannot survive without another cash handout of £50m from December. Despite hopeful plans to expand the Trust's business with additional treatments to raise £25m a year by 2016/17, all that is certain so far is that its existing commissioners want to *reduce* activity and pay for *fewer* patients to be treated at *lower* tariff costs, with a near 10% reduction over the five years.

Meanwhile the Trust is struggling to maintain services. In January 2012 it missed national targets for treating patients within four hours of arriving in A&E – falling well short of the 95% target, delivering just 88%. In June 2012 it was ninth worst of 18 acute Trusts reporting the largest percentages of delayed diagnostic tests, with 6.2% of its patients on the list for tests kept waiting over 6 weeks.

In August Peterborough was among the seven Trusts singled out for the attentions of government-organised "hit squads" of accountants and lawyers who were to attempt to renegotiate contracts and reduce the haemorrhage of cash before Trusts became completely insolvent. It was pointed out that some of the contracts they would be scrutinising for loopholes are 2,000 pages long – and carefully constructed by highly-paid lawyers and accountants to ensure they were watertight and guaranteed profits would flow, with PFI payments effectively ring-fenced as a first-charge against any Trust income. So far no results have been forthcoming.

The then health minister Simon Burns told the Daily Telegraph the government would not walk away from the PFI contracts because this would "leave the NHS facing years of legal disputes".

It is striking that as the chaos continues from the fateful decision to sign up for the PFI deal, not a single Director of Board member from Peterborough has been held to account or in any way been obliged to answer for their irresponsible actions. Perhaps any such public exposure would be seen as undermining the government's continued support for PFI.

Broomfield Hospital, Chelmsford (Mid Essex Hospitals Trust)

The next biggest PFI deal in Eastern Region is the new £148m wing at Broomfield Hospital, built for Mid Essex Hospitals Trust by French multinational Bouygues, containing 300 beds, and A&E, five day case operating theatres, a maternity department with neonatal intensive care unit and a new renal unit. The hospital fully opened in 2011 and the contract runs to 2043, at a total estimated cost of £766 million.

However the Trust has had a rocky ride up to the opening of the hospital, mainly centred around the ongoing financial problems, which also mean that the financial stability of the Trust hinge on continued subsidies.

News that the Trust was offering £1,000 per day for a "turnaround director" on a 6-month contract, to drive the spending cuts also made easy headlines with rentaquote statements by local MP and newly-appointed health minister Simon Burns, who declared himself "staggered" by the fees on offer, although McKinsey and others are known to charge much more .

In the autumn of 2010, as the Trust was struggling to cut £40m from its budget, with the loss of jobs, to balance the books, critics seized on the ambitious plans to line the new PFI wing with paintings, statues and "modern art" by eight commissioned artists, at a cost variously estimated at £415,000-£3 million.

By early 2011 as the chief executive abruptly left his post, soon after the hospital opened up, beset with building faults, a replacement was swiftly found in the form of Malcolm Stamp, who had experience of driving through the PFI deal at Norfolk & Norwich Hospital. Among the issues that needed urgent attention was a cold atrium, faulty lifts, incorrect signs and other problems that seem endemic in PFI-built hospitals. Eye and fracture clinics were thoughtlessly at the opposite end of the hospital to the new car park.

Nine months later, still struggling financially, the Trust was singled out by Health Secretary Andrew Lansley as one of 22 trusts in which PFI costs put "clinical and financial stability at risk". Local Tory MPs grumbled about the inflated costs of PFI – a Tory policy. But the financial plight of the Trust was worsened not only by the unitary charge payments, which began at £15.1m (6% of the Trust's total income) but by the additional capital charges on the remainder of the hospital site, and by the combination of real terms cuts, reducing tariff and the drive by PCTs to reduce numbers of patients referred to hospital.

The Trust's Annual Plan for 2012-13 makes clear that it's carrying a recurrent deficit of £27m, and finding it difficult to carry through its "cost improvement programme": it only avoided a deficit last year as a result of a one-off land sale that raised £4m. Income was 6% above plan, but expenditure was 10% higher, and 33% of its £25m cost improvements were not achieved.

Like other trusts Mid Essex has also been hard hit by the failure of commissioners to deliver on their own plans to reduce referrals to hospital: the reduction in planned activity did not occur, but the extra clinical income of £7.4m was all but wiped out by the extra cost "at premium rates" to cope with the unplanned activity. The Trust is leaving itself little leeway to cope with unexpected extra demand as it scales down its workforce year by year, with a 9.5% reduction in nursing and other clinical staff planned between 2010 and 2014.

The plan for this year assumes once again that there will be an overall reduction in activity in "non-elective admissions", electives and in outpatients, with only A&E attendances staying constant. Yet for reasons not explained, the Trust also assumes an increase in income compared with last year.

Only if this increase takes place, together with £6m of "non-recurrent" Strategic Health Authority support and £3m of "transitional" support for the PFI scheme do the Mid-Essex books balance up.

The Trust makes clear that a break-even therefore depends on closing a £27m shortfall, although only £16m of cost improvement programmes have been identified, and last year they fell £8.5m short of their savings target.

The Board appears to have pretty much given up on achieving this without external help, and the Annual Plan makes clear that it is in discussion with the EoE SHA (to be abolished in April) and the Department of Health "concerning income support in 2012/13 and 2013/14 consistent with developing a viable and sustainable Foundation Trust application." If this is not forthcoming, there are few options:

> "The Trust will start the Financial Year with approximately £0.5m cash in the bank account. This gives very little margin for slippage on income and expenditure plans." (p 37)

The "tight financial situation" leaves no capital reserves to utilise for investment, and the Trust already had three loans totalling £19m at the beginning of the financial year.

Meanwhile the brand new PFI wing at Broomfield was revalued as it was handed over to the Trust at the end of 2010 – and the estimate reduced from a previous assumption of £161m to just £129 million This is less than the headline cost of the scheme, and just 17% of the £0.76 billion that will be spent on it by 2043.

In this situation it's no great surprise to see the Trust's Financial Risk Rating is RED for 2012/13.

PFI debt in the making: Papworth Hospital Foundation Trust

After attempting and discarding smaller scale (£20m in 1996) PFI projects to rebuild parts of the existing Papworth Hospital, a new project to relocate the hospital in a new build 300-bed unit on the Addenbrookes Hospital complex in Cambridge was advertised in the Official Journal of the European Union in August 2010, with bidders now shortlisted to two, one led by Bouygues and another led by Skanska. The new hospital scheme has already seen a hefty price inflation from £150m in 2010, to £165m in 2011 when the shortlist was announced.

The Treasury website now lists this as a project for signing in the spring of 2013 and completion of the hospital in 2016 – at a projected cost of £206m. Even if it stays at this level (which seldom happens in the finals stage of PFI negotiations), the new hospital is likely to cost upwards of £21m in unitary charge payments in year one (17.5% of the Trust's current annual revenue), escalating in cost each year to give a 30-year minimum cost of £920m by 2046.

The business case for the new hospital, which has apparently got the go-ahead from Monitor, appears to centre on very substantial year on year increases in activity from Cambridgeshire (up 34% in 2013/14 from 2007/8), Norfolk (16%), Bedfordshire (19%) and Peterborough (up by an extraordinary 54%). Of course Papworth is a highly specialised hospital and so operating to slightly

different constraints than district general hospitals, but as the NHS cash squeeze tightens it seems highly unlikely that cardiac services will remain immune from the problems.

The timescale set out in the outline business case has already slipped by three years: experience elsewhere in Eastern Region suggests that a lot more could change before Papworth Trust Board has to sign on the dotted line and gamble with the future.

West Hertfordshire: new hospital and "health park" plan

After years of debate, with repeated false starts, flawed consultations, half baked and unaffordable plans and broken promises since the mid 1990s, the latest plans for reconfiguring hospital services in Hertfordshire still seem mired in confusion, with mixed messages on how it is to be funded, when it is hoped to start work, and compounded an incomplete and confusing website which still contains an outdated Spring 2007 "vision for West Hertfordshire" that predicted work would begin in 2008 and the hospital would be completed by 2014.

The project seemed to hang on through 2007, outliving a doomed plan for a £420m mega-hospital to be built with PFI funding in Hatfield, which was dropped because even health bosses realised it was completely unaffordable. But the Health Campus ran into problems in 2008 with the financial melt-down, despite the West Hertfordshire Hospitals Trust's insistence in December 2008 that the strategy was "not to panic".

A year later and the Watford hospital plan was mired in political dog-fighting between Labour MPs based in Watford, and Conservative MPs from Hemel Hempstead, who were warning that a Conservative government would immediately launch a "review" of acute health services, and potentially abandon the £300m hospital project. Shadow Secretary Andrew Lansley denied plans to demolish Watford General Hospital, but blamed the row on Labour's failure to press ahead with a £300m PFI investment in Watford.

Just after the 2010 election brought David Cameron's coalition government to office, it became clear that there were serious doubts over the 510-bed Watford Hospital project, now costed at £323m, implying PFI unitary charge payments beginning at upwards of £40m a year – more than 15% of the Trust's annual income. The recession and difficulties raising the money had set the scheme back again.

The latest information on the Trust's website suggests that two companies, Kier Ventures (looking for something bigger than their Hinchingbrooke and Ipswich schemes) and John Laing have been shortlisted as potential private partners for the NHS project, although the non-NHS components of the project (including Watford Borough Council and Watford Football Club) were moving faster than the NHS. The wider project, with an additional price tag of £350m, and potentially involving seven other organisations aims to develop a 'Health Park' around the Watford General Hospital site[5].

[5] Details at https://www.projectplace.com/customers/case-studies/west-hertfordshire-hospitals-nhs-trust/

The danger remains that the West Herts Trust, desperate to renew the crumbling Watford General Hospital, but still lacking any public sector option for funding the new building, will be drawn like Peterborough, Norfolk & Norwich and Mid Essex into a heavy and unaffordable commitment that will place a continual strain on health services for three decades or more, while the funding for health services is frozen and cut in real terms, tariff prices reduce, and commissioners work to reduce hospital referrals.

As this report is completed, Hertfordshire Primary Care Trust has outlined plans to cut spending by £276m – 17% – over the next four years by measures including reducing hospital admissions and requiring patients to "manage their own care".

Hinchingbrooke Hospital Treatment Centre

Hinchingbrooke Hospital obviously hit the headlines when its management was contracted out to Circle Health, a company with expertise only in building and running high-cost, tiny bijou private hospitals at a loss. But prior to the process that opened up this risky venture the Trust had been wrestling with various problems thrown at it by national government policy and by the East of England Strategic Health Authority.

Despite having apparently complied with virtually every aspect of the government's regime of targets and reforms, HHCT has become one of the most obvious victims of the many complex market-style reforms introduced by the Labour government from the time of the NHS Plan in 2000, the Trust lost out under Payment By Results. Its caseload has been squeezed by Foundation Trusts in Cambridge and Peterborough; its budget has been cut so that PCTs could send NHS patients to private hospitals; and the merger of Cambridgeshire's PCTs also worked to the detriment of Hinchingbrooke.

Facing an increasingly serious financial situation, in 2005 the Trust tried to work its way out of the problem, and outlined a business case for a new NHS Treatment Centre at Hinchingbrooke, which would supplement the limited and over-stretched capacity for elective work in Cambridgeshire, and attract patients who might otherwise have gone to Cambridge or Peterborough.

The plan appeared to fit in with the government's policy of promoting "patient choice" and was endorsed by PCTs in and adjacent to Cambridgeshire. The HHCT Board was told in May 2005 that almost £9m in additional income could be generated through this and other measures to speed up the process of discharge of patients and reduce length of stay.

The Treatment Centre, offering 24 beds, five theatres, outpatient facilities, and a full range of diagnostic and clinical support services was built through the controversial Private Finance Initiative, managed by Kier, who also provide all the non-clinical services.

The PFI funding means that although the build cost in 2005 was just £22m, and the initial unitary charge payment was just £2.5 the total cost of the contract over 30 years will be at least £96m: the Trust paid £3.2 million in 2011/12, although spending figures for 2012 show payments of more than

£600,000 per month, an annual rate of £7.2 million, suggesting the total cost could be much, much higher – with possibly another £180m to pay.

In December 2011 Kier 'sold' its stake in the Hinchingbrooke PFI … to itself, for £3.1m, transferring it to the Kier Group Pension Scheme.

Meanwhile the income stream that was supposed to pay the unitary charge to the PFI consortium has fallen well short of expectations. When the Treatment centre opened in November 2005, financial pressures were beginning to be felt by other Trusts and PCTs, and it became obvious that the promised referrals would not be coming to Hinchingbrooke. New projections warned of a £5 million loss in income.

South and East Cambridgeshire PCTs broke their commitment to send additional referrals, while Addenbrookes and Peterborough hospitals have both stepped up their provision of elective care and competed strongly for any available revenue.

As a result the Treatment Centre has yet to be fully utilised by HHCT: instead of an asset it has become a rather costly mistake, since the Trust invested in increased clinical and support staff to do the new work that was expected, in addition to the cost of leasing the new building. Instead of opening up a steady surplus it has contributed to the financial problems of the Trust.

East of England SHA declared the aim of diverting 60,000 elective operations and treatments a year to private sector providers, with a consequent loss of even more potential revenue to NHS Trusts. Whether these policies will outlast the doomed SHA, and continue to undermine NHS providers (and especially those with costly commitments like Hinchingbrooke) remains to be seen.

Meanwhile the arrival of Circle Health has brought a new dimension to the crisis: Circle has been promised the lion's share of any surpluses, but has yet to deliver anything looking like a surplus. Amid the incessant chirpy sales routine from Circle boss Ali Parsa, cleaning staff numbers have been reduced, nurses have lost their jobs, and the finances have remained in the red. Questions are being asked about how long Circle's powerful private equity and hedge fund financial backers will tolerate such poor results from the company before pulling the plug or forcing an even more desperate drive for profits.

While the PFI bill is not the central factor in Hinchingbrooke that has become in the deficits and crisis of Norfolk & Norwich, Peterborough and Broomfield, it is a continued pressure, limiting the options of Circle and any other would-be private owners or operators in the hospital.

Ipswich Hospital Garrett Anderson Centre

Also built and operated by Kier, the £36m Garrett Anderson A&E unit is expected by the Treasury to cost a total of £134m by the time of the final payment in 2037. But again monthly spending figures published by the Trust show payments, boosted by inflation, currently running at around £4.2m per year, suggesting the total could be significantly higher, with PFI payments rising as Trust income is squeezed.

As with other Trusts in this study, the 2011/12 Annual Report shows Ipswich struggling to hold its own as PCTs set out to cut levels of referrals, and an unusual £4m reduction in income from treating fewer emergency patients.

The £3m increase in income was entirely down to £5.5m of support payments from the SHA and another £3m to cover the cost of redundancies. Operating costs, inflated by the redundancy payments, went up. As the Trust comments:

> "2011/12 was the year when Ipswich Hospital really saw the new economic reality bite. … We still carry the burden of our legacy debt, which stands at just over £3.6m, and each year the Trust is hit by the double whammy of falling prices … and falling activity levels."

Ipswich needs to find £22m of savings – almost 10% of its projected £224m budget in 2012/13 – "to deliver our planned break-even position, let alone cover the cost of our loan repayment". So although the PFI cost is not the biggest problem, it is an extra burden, and an inflexible cost when economies are being sought on every other front.

The Trust claims to have "engaged a team of experts" to help find the savings they need to meet "the toughest financial challenge we've ever seen."

The strain is already beginning to show. In May 2011 the Trust's care of older patients was criticised by the Care Quality Commission. In December 2011, with a deficit running at over £11m, a round of voluntary redundancies saw over 200 staff queue up to leave, with 150 more posts to go after 100 had already departed. The following month UNISON was warning that as a result, staff shortages were threatening standards of care in the hospital, since many of those leaving were more experienced clinical staff. Managers were seen feeding patients and pushing beds around.

Also in January, the hospital lost its specialist vascular surgery services to a new unit 20 miles away in Colchester, and was forced to postpone its bid for Foundation status until progress had been made on its finances.

In April there were fresh concerns, this time over the quality of cleaning services delivered by private contractors ISS, after redundancies had taken their toll, and with the company seeking to cut staff working hours.

In June the Trust appeared on a list of 18 Trusts in England singled out for delays in delivering diagnostic tests, with 4% of its patients waiting for tests waiting more than six weeks. Bottlenecks in these services and in general surgery led to some treatment being contracted out to private hospitals.

The latest available figures as this report is compiled, half way through the financial year, show the Trust sadly slipping behind on almost all its financial targets, with income below plan, spending above plan, and cost improvement plans still failing to deliver the hoped for savings.

As every surplus cost is cut back, the extra, growing burden of servicing even this relatively small PFI contract (for an A&E unit, at a time when emergency caseload is being reduced and tariff prices are falling) can only push Ipswich further towards the brink.

Spotting the warning signs: Colchester scheme dropped

Colchester University Hospital Trust came close to signing up for a costly PFI project, which attracted international interest from architects and construction companies, with 18 "expressions of interest" by the January 2004 deadline.

The £127m scheme for what was then Essex Rivers Health Care Trust would have redeveloped the Colchester General Hospital site, enabling the closure of Essex County Hospital, and providing 70 extra beds to add to the 680 already on site, a cancer centre, and ophthalmology unit, increased car parking and a new airport-concourse style entrance.

By January 2005, with Amec (builders of the first PFI hospital in England, and of London's University College Hospital) selected as the preferred bidder, and funding from Innisfree, the estimated cost of the scheme had already been inflated to £220m.

The Trust spent £3m itself on preparatory work, plus much more on consultancy and management costs before the scheme was axed by the Trust in June 2006, after concluding that it was unaffordable – especially in the context of uncertainties over demand for acute services at a time when the government was pressing for the establishment of Independent Sector Treatment Centres which threatened to divert some of the routine caseload from NHS hospitals. Colchester General expected a new ISTC in Essex to take up to 20% of its elective work, and was also concerned at the financial instability that would flow from the still new "payment by results" system that only paid hospitals for work done rather than on regular contracts.

The last minute decision to pull the scheme triggered an angry demand for £7m compensation from Amec: but the Trust is now delivering regular surpluses and able to invest in smaller scale specialist services, while those which have plumped for PFI remain on the financial rack, dependent on subsidies to balance their books.

Appendix 1:

Peterborough's Costly Care Centres

A closer examination of the two new NHS facilities opened this summer in Peterborough

Researched in September 2009 for UNISON NW Anglia Branch by Dr John Lister, London Health Emergency

Introduction

Peterborough's new City Care Centre (CCC), which opened in May 2009 on the site of the old Fenland wing of Peterborough District Hospital, is intended to operate as an "integrated care" unit. Although it is commonly described as "part of the £335m Greater Peterborough Health Investment Project", health chiefs have been reticent on the £25m actual cost of the centre, which is to be followed up by a much larger new 612-bed general hospital, adjacent to new mental health facilities already open on the Edith Cavell Hospital site.

The entire scheme is of course not funded directly by the Treasury, but is a "Private Finance Initiative" scheme (PFI), through which private sector companies design, finance, build and operate the new facilities, which are then leased back to the NHS over a 35-year contract. According to figures on the Department of Health website, the £336m worth of new buildings are set to cost more than five times as much – a minimum of £1,716m in index-linked annual "unitary charge" payments over the lifetime of the contract.

According to the Final Business Case for the Project, the new hospital alone is set to cost Peterborough and Stamford Hospitals NHS Foundation Trust an extra £8.5 million a year compared with existing hospital facilities. The additional £4.25m a year costs of the City Care Centre will be shared by the hospitals Trust, the Primary Care Trust, and the Cambridgeshire and Peterborough Mental Health Trust.

The mental health services at the CCC brought a quadrupling in rent from £80,000 a year for the previous facilities to £330,000, while the available space has been effectively halved, with question marks hanging over the usability of some of the new facilities.

But in the new insecurity of the National Health Service "market", hospital Trusts are now only paid per item of treatment delivered under the "payment by results" system. Payment is calculated on a fixed tariff that makes no allowance for the increased overhead costs of PFI. Add to this a real threat of a spending squeeze from next year, and the financial security of this scheme and the Foundation Trust seems far more questionable now than it did when the contracts were signed with the private sector consortium.

In fact the PCT's directly-provided services are currently projecting a substantial £6.8m (7.5%) reduction in income from 2010, with only marginal growth in following years, suggesting that the extra costs of the CCC may be more of a burden than previously expected.

Unfortunately PFI unitary charge payments normally go up by a minimum of 2.5% a year, or the rate of inflation if higher, every year of the contract, regardless of the income or financial problems of the Trust. Peterborough is no exception, and the PFI contract is both rigid and legally binding – it must be paid regardless of what other services may have to be cut to balance the books.

Interestingly the PCT's plan for Peterborough Community Services involves a reduction of almost 8% in the wage bill (therefore fewer staff) by 2012, alongside hopes for a 10% cut in non-pay and non-drug spending. So it seems that reduced staffing is seen as an area for economies to help pay the increased cost of the new building.

THE IMPACT OF PFI

One of the many disadvantages of the Private Finance Initiative is that it leads to extremely complex and legally binding documents, which are also extremely expensive and time consuming to produce: once signed, the contracts are rigid and inflexible, since the private sector wants to be absolutely certain of obtaining its guaranteed profits.

Here too, Peterborough has been no exception. But this has less obvious consequences. The usual long time delay between deciding to pursue a PFI-funded project and signing the deal that allowed building work to begin has meant that the plans for the CCC and other parts of the Project have been overtaken by events, and in many ways were no longer appropriate even when the deal was finalised. In fact the plans were already seven years old by the time the final contract was signed, and from then on there was no scope to change any of the details of the buildings.

The promotional leaflets for the CCC feature pictures of the beautifully-equipped children's playground and references to other children's services – despite the fact that these services had already ceased to be part of the plans for the building even before they were constructed. This care is now delivered elsewhere. The leaflet boasts with little justification that

> "The building is also uniquely designed so that the services can adapt to the changing needs of the local community in the coming years"

Far from being future-proof, in fact the building has not even been properly adapted to the changing needs of the mental health and other services already in the building. Interior fittings were specified without reference to front-line staff with clinical experience of what is required, and have resulted in spaces which are not fit for their intended purpose.

One lesson which UNISON draws from this process is that it is vital for managers, architects and designers to consult with and listen to the concerns of front-line staff if more money is not to be wasted on inappropriate buildings, fittings and facilities.

Unfortunately the same problem has been observed in many of the PFI hospitals built so far, and there seems to be no process through which lessons can be learned. It seems that once they have signed up to colossally expensive new buildings, and basked in the rosy glow of positive press coverage as new buildings are constructed and opened up, NHS managers everywhere are utterly resistant to any attempt to evaluate the successes and failures of the new project, or publicising problems – which might help prevent similar errors of judgement elsewhere.

But if we cannot learn from mistakes in such hugely expensive buildings, which will be paid for by a whole generation to come, we are condemned to repeat them – missing an opportunity to improve patient care and allow staff the satisfaction of delivering higher quality and more effective services.

This has already happened with first-wave PFI projects: it seems that we are still doomed to see the same failures repeated.

THE CCC

The City Care Centre opened this summer with predictable and well-orchestrated press coverage praising up the "light, airy" and "stunning" modern-looking building. From the beginning the building had been planned to include mental health services, especially Child and Adolescent Mental Health Services (CAMHS): but it was also to house 34 en-suite rooms offering purpose-built facilities for intermediate care, mainly for older people needing extra help before being discharged home from hospital treatment. Additional specialist facilities such as hoists are also included for care of older patients.

The architects, Nightingale Associates, for whom the Peterborough XXX scheme is their biggest contract so far, said:

> "Key features of the building are the sweeping rendered curved blocks with accentuating timber pressurised laminate panels, coloured rendered panels, and overhanging roofs. These sweeping blocks and the central linear element enclose four tranquil landscaped courtyards.
>
> "A protruding rotunda signifies the main entrance, which leads directly into a double-height concourse area lit by two large rooflights and glazed curtain walling. The main departments are accessed from this central concourse and a feature staircase provides access to a balcony refectory area and first floor departments. Departments within the building have been designed to maximise daylight and views onto landscaped gardens and courtyards."

Staff report patients enthusiastic about the en-suite facilities, despite some difficulties with some of the fittings (discussed below). Project manager Ele Milne, delighted with the building, told the Evening Telegraph: "I can't imagine that anyone wouldn't like it."

An estimated 500 staff were to work in the CCC, including nursing staff, physiotherapists, occupational therapists, social care workers and admin staff.

The facilities include an ultrasound and X-ray machines, and partly because of this, in the summer of 2008 managers proposed to include a walk-in centre in the CCC with minor injuries services, alongside the planned outpatient clinics for services including rheumatology, pain management, audiology, neurology and dermatology.

The Walk in Centre, transferred from the Rivergate site, is open seven days a week until 10pm. As yet there are no data on the numbers using the service or the unit costs of providing it, so it is too early to tell if this offers value for money compared with opening a primary care facility alongside the main A&E unit.

PLANNING AND FABRIC OF THE BUILDING

As with many PFI-funded schemes – most of which were designed with little, if any office space – the area allocated to administrative work in the CCC has been severely squeezed. Clinical staff sharing phones and facilities and admin staff crammed into a tight space with little flexibility.

Another problem common in new PFI hospitals is technical and infrastructure failures, which tend to be dismissed as "teething problems", ensuring nothing is done to prevent them in future.

In the CCC there was a flood in the downstairs of the building, with sewage coming in and also blockages in several of the toilets.

But other more persistent plumbing issues include excessively high water pressure, creating problems when staff have to turn taps fully on to get hot water. Staff felt that the automated taps run for too long, giving no opportunity to turn them off sooner.

There are no plugs in sinks, and the showers have been set up with fixed shower heads, making it extremely difficult for staff to assist a dependant patient without themselves getting wet from head to foot. Older patients have struggled with the mechanical "push button" flush on the toilets in their en-suite rooms.

Other alarming infrastructure problems include the fact that both lifts in the CCC have failed from time to time in the few months since the building opened, and on one occasion both were out of action at once. Staff have found them unreliable and some are reluctant to use them.

Doors in the building don't stay open long enough before automatically closing. Lights come on and turn off automatically in some rooms, but not in others, causing problems and uncertainty for staff, especially those new to the building. And staff facing impossibly stuffy, hot working environment as the new building opened were told not to open the windows to allow the air conditioning to take effect – until it became clear that the air conditioning did not work.

The utility room is already dirty and unpleasant. Infrequent cleaning can mean that spillages can wait days to be cleared up.

And none of the public phones worked in the first three months.

STAFF FACILITIES

Adequate facilities are important to ensure that staff can work effectively and efficiently, and that the various employers delivering services from the CCC are able to recruit and retain a proper skill mix of staff to ensure quality care for patients.

However the record so far of PFI hospitals is that this has been a neglected area, with all too many cramped and inadequate workspaces and often serious inadequacy in facilities for staff to take breaks and take care of themselves.

The CCC is no exception: staff on the intermediate care wards have been concerned that the staff toilets and the staff room have been placed on the acute services side of the building. "We have no staffroom, no toilets, no lockers", says one member of the nursing team. "We have to share the toilet on Maple 2.

Night staff wanting to use a microwave to warm their meals are not allowed to use the ADL (??) kitchen, used for the assessment of patients, or the catering kitchen which serves food for patients. Instead they have to use much of their half hour break on night shift to go to a microwave on the other side of the building.

Staff are also concerned that at weekends visitors cannot get in and out of the building, since the ward clerk who opens the doors for people on weekdays is not there on Saturdays and Sundays. This means that nursing staff have to keep opening the door.

Problems also affect staff who should be based at the CCC but for whom there is no room. Community nursing staff were originally promised space for "hot desking", but the pressure on admin space has meant this has not been possible.

> "We are now out in the old dental centre, a dilapidated building with no land line telephone, fax or computers! This makes it difficult to do our job properly."

Community nursing staff have to travel to GP surgeries, but also regularly have to input data, documenting everything they do and each journey they make. "A lack of elementary facilities to do this makes our lives more difficult."

The five-strong team of community matrons – supervising the 60-plus district nurses and dozens more staff delivering intermediate care and 'hospital at home' services – has been disrupted, because they now have no common meeting place. The GP surgeries they work with are themselves already tight for space, and the GPs don't want to have to find room for matrons employed by Peterborough Community Services.

One big problem facing staff in both the Walk In Centre and in mental health is that during the week they cannot park at the workplace, but have to park by the old B&Q and use the shuttle bus. With the WIC running until 10pm, this leaves staff stranded, since the shuttle is no longer running.

> "There is lighting outside, but it's still dark round here, and there is only one security guard, too far away for comfort".

Parking at the CCC is only agreed for staff who use their cars for their job – and doctors, who "went ballistic" when it appeared they may not be allocated spaces. Community matrons also face the irritation that every time they leave their parking space they have to pay another £1 to get out.

The additional time required to use the shuttle bus serves to lengthen the working day for staff, whose hours only start when they arrive in the building. But while it finishes too early for the end of a night shift, the shuttle bus often runs empty during the day – raising questions of how long this service will remain available as the PCT seeks to cut costs.

There are also underlying worries that the additional costs of the building – around £250,000 a year for the mental health Trust alone, may be paid for through reductions in staff: despite publicly insisting that "it doesn't matter what the new building costs", the Trust has not been keen to replace staff who have recently left, and services are being reduced.

SUITABILITY FOR PATIENT CARE

The lack of proper staff facilities are an ongoing source of irritation to health workers, but they have been possibly more concerned about the failings in the quality and specification of the CCC building which undermine its intended purpose – notably the clinical rooms in the Child and Adolescent Mental Health service.

These rooms are required to give clients and their families a strong sense of security and privacy: instead the building has been fitted with clear glass windows in all doors, allowing those outside to see who is inside: and the thin walls and doors leak sound, enabling others to hear what is happening. Requests for blinds inside and "Occupied" signs to warn rooms are in use have so far proved fruitless.

Unfortunately the final specification for the new building took no account of these issues of patient confidentiality: as a result any attempt now to modify the rooms or soundproof them would be immensely complex, costly and time consuming.

The building is not owned by the NHS, but by the PFI consortium, and any changes to its fabric have to be agreed – and implemented – by the private management.

> "To get anything done, you have to get a form from maintenance, get it signed by your line manager, and passed to the general manager of the building. If it is approved it will get done eventually, but there aren't many maintenance people around".

Even though it is a new purpose built facility, none of the rooms in the intermediate care unit have piped oxygen, so staff have to use bottled oxygen supplies. Even this was not well thought through:

> "They spent hundreds on trolleys to carry the oxygen, but they don't work properly."

Some staff also feel the CCC building was not properly suited for use as a Walk In Centre, although the immediate access to X-ray and ultrasound is an advantage, provided these are properly staffed with qualified radiographers throughout the hours of the Minor Injuries Unit. The CCC service replaced the Rivergate unit, which had been located in a refitted building and had worked well for five years.

Staff feel that the establishment of the Minor Injuries Unit has also raised the need for enhanced training.

CAVELL CENTRE

Mental health services are also provided in the brand new 102-bed Cavell Centre, built in two phases as part of the same PFI package, and opened at the same time as the CCC. It too is spacious and modern in appearance and, has single en-suite rooms. It offers adult acute psychiatric wards, psychiatric intensive care, mental health facilities for older people, and specialist care for people with learning disabilities.

According to architects Nightingale Associates:

> "The single-storey buildings have been designed as a series of linked pavilions, set within landscaped gardens and each with their own architectural identity. The curved form of the adult inpatients and older people's wards eliminate long corridors and add to the 'hotel' and patient-led feel of the units. The choice of materials, both externally and internally, enhances the patient's environment."

PATIENT CARE

Many of the staff concerns about this building are similar to those in the CCC: some of the fittings of the building are already showing themselves ill-suited to the client group requiring care.

> "Our elderly patients are encouraged to be independent, but the toilet flush in their room is a mechanical push-button in the wall, and the frailer elderly people just can't push it in. They don't like it, especially since many have arthritic fingers. Some of them resort to using the handle of a toilet brush – holding the wrong end! Others don't flush at all."

There is no alcohol gel on the wards to assist infection control, and no alternative on offer. Hand washing is also a problem for patients:

> "The taps are unfamiliar. For hot water you have to pull a lever. People have to learn another new procedure, and their age and mental condition does not make this easy. No plugs are allowed, although we are not sure why: surely a short chain would not be a hazard?
>
> "Nurses like to mix hot and cold water to get the temperature right for patients: but there is no way to hold the water in the sink to get it right. The water runs for 15 seconds at a time, although it was originally twice as long.

> "We also have problems because we can't regulate the water flow when helping patients use the showers. We come out soaking wet. One manager was very helpful, suggesting we should wear flip-flops!"

The new building is supposed to feel like a hotel, but many of the items needed to help patients in the bathroom – towels, incontinence pads and such like – are stored some distance away from where they are required. Some staff contrast the layout of the new facility unfavourably with the previous building:

> "At the old unit in the Gloucester Centre we had everything – pinnies, gloves, pads for incontinent patients: but now we have to leave patients on the toilet and walk several yards down the corridor to collect what we need. While you do that, the patient can get up and wander off."

There are also problems in accessing the single Clinomatic machine to dispose of used bedpan linings.

> "You have to put it in a yellow bag and then walk through the dining room, and down the corridor past day therapy."

The previous Intermediate Care unit had "gorgeous home cooked food" produced by its own cook. But now food is prepared elsewhere and reheated.

> "Some of our staff like the new food, but the patients who transferred from the old unit preferred the food they used to get there. And of course we have catering staff with no work left to do."

STAFFING ISSUES:

> "We used to take a break just next door to the patients: but now if we take a break we have to leave the patients, and many of us don't take proper breaks now. The staffing levels are too low to give us proper cover."

Low staffing levels are also undermining the quality of care, even in a gleaming new building.

Managers were told that additional staff were needed to cover the Day Therapy services, but instead the therapy group that used to be provided in the old centre has now stopped, and staff are concerned that what used to be high quality services are being run down or eliminated without any proper discussion or debate:

> "We provided therapy while social services ran social groups. There were 12 members of staff, including six registered nurses, at Gloucester Place, but that is now down to one. People have left and not been replaced.

> "We used to have several groups running, including anxiety management and confidence building, but now they have all been cut. We just have a Health Care Assistant trying to do everything. It's as though they want Day Therapy to be scrapped."

Staff were unclear whether NHS Peterborough was aware that the therapeutic care was no longer provided.

> "Who from the PCT is supposed to check what the Trust is doing? Where are they?"

The move to the new building has not panned out so well for this group of patients:

> "They really loved the old unit. We had a big beautiful sensory room for our relaxation group. We told them they would soon get used to the new building. But now we have a room – a very narrow room, entirely the wrong shape.
>
> "The settee is very high and very deep, so you can't sit back in it with your feet on the floor. Patients can't sit on it comfortably, so lie on it!
>
> "We now have leather chairs which are not patient friendly and have no headrest for relaxation. The layout of the room is ridiculous, with a noisy corridor outside – hardly relaxing. Some of the chair coverings have to be removed for washing, but have shrunk: we had two nurses at a time trying to get cushions back into their covers!
>
> "The day room is inappropriate as well: there are nowhere near enough small tables, so you can make people cups of tea but there is nowhere to put a cup down."

To make matters worse, staff have noted a reduced capacity in the new mental health services to treat younger people suffering early onset dementia, and drug and alcohol dependency. It is not clear where these people are expected to go for health care

> "None of us was consulted on any of this. We hoped the consultants would speak up: they know how good the previous service was."

CONCLUSION

UNISON is concerned that if lessons are not learned, the Cavell Centre and the CCC may offer a foretaste of problems and disappointments to come when the much larger Peterborough City Hospital opens up in 3 years time.

The irritations and errors in a 102-bed mental health unit and a 34-bed Integrated Care Unit could easily be multiplied and dwarfed by the scope for blunders in a massive 612-bed hospital costing almost £300m.

As with the two smaller units, the specifications and plans for the new hospital were already 7 years old when the deal was signed in 2007. We have seen on a small scale the potential this has to cause problems for staff and for patients. In addition there are question marks over whether the new hospital – which has 50 fewer beds than the current provision in Peterborough's hospitals – will be large enough to cope with the city's growing population.

The financial questions, too, raise serious concerns. It seems that the increased overhead costs of the new buildings have been a factor in the rundown of staffing levels and the rapid decline of some mental health services – with the virtual elimination of Day Therapy services.

The new hospital will bring a much heavier increase in overhead costs, adding £8.5m to the Foundation Trust's running costs, while the scope to recoup this from treating additional patients is limited by the constraints on NHS Peterborough's budget.

It will be a tough environment to open a new and more expensive hospital: all the predictions are that the growth in NHS spending will be squeezed, and spending may even contract in real terms from 2011 as the government of the day wrestles with the £1.5 trillion costs of rescuing the banking system last year.

The Foundation Trust will remain under scrutiny from Monitor, the regulator, to maintain a surplus – while unitary charge payments to the PFI consortium are legally binding and inflexible, rising by 2.5% each year regardless of the Trust's income or any other pressures it may face.

UNISON welcomes new hospital facilities for Peterborough, and we accept that many of the new facilities are and will be a big improvement on what went before. But if the NHS locally and nationally cannot learn from relatively small scale mistakes, it will be condemned to repeat them on an ever-larger and more costly scale.

It is late in the day to conduct any meaningful dialogue, but we do urge Peterborough and Stamford Hospitals NHS Foundation Trust and NHS Peterborough to study and respond to this report, and to seek the views and concerns of front-line staff in PDH and ECH before the final stages of the new hospital are completed.

Leaving aside our concerns over the costs and other drawbacks of private financing, UNISON believes that the NHS objective should be the development of buildings and facilities that not only look good to the outside observer, but which are genuinely user-centred.

This means centred on the needs both of the patients who receive care, and of the staff who have to work in the buildings to deliver that care. This cannot be done without consultation, and consultation that offers staff a real opportunity to help shape the outcome.

These are buildings in which at least a generation of health workers will have to deliver care – and with hundreds of millions of investment at stake, it makes sense to try to get it right first time.

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