A sledgehammer to crack a nut

An analysis of the PFI scheme to fund the new Northern Neuro Disability Services Centre on the Walkergate Park site

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Introduction

The Full Business Case for the building of a new £27m specialist Neurological Centre on NHS-owned land adjacent to Walkergate Hospital was approved by the Northumberland Tyne and Wear Strategic Health Authority on July 7 2005.

This was a landmark in a project which had begun ten years earlier as a proposal to establish a rehabilitation centre in the Neuro Sciences block at Newcastle General Hospital, and three years later evolved as a plan for a free-standing Northern Neuro Disability Services Centre.

The Walkergate site was identified in 2000: and the Outline Business Case for a £19m development was approved in October 2003. The PFI process then involved an advertisement in the Official Journal of the European Communities inviting companies to bid for the project.

It was almost two more years before the preferred provider had negotiated a Full Business Case, by which point the number of beds to be provided had been scaled down by 11% from 73 (OJEC) to 65, while the projected overall cost of the project had risen over 40% from £19m to £27m.

Construction work is now under way, and the long-awaited replacement of obsolete and maintenance-hungry facilities – some dating back to the mid-late 19th century – with modern, purpose-built facilities, will be widely welcomed by staff and well as service users and their visitors.

UNISON welcomes the development of new, modern buildings for the NHS to improve services for patients and working conditions for staff, and broadly supports the Walkergate Park project, which largely maintains and consolidates existing levels of services.

UNISON especially applauds the fact that, following a value for money exercise, the Northgate & Prudhoe Trust decided that the scheme – unusually for a PFI-funded hospital – would NOT involve the privatisation of non-clinical support services. It is our view that if genuine value for money considerations had been taken into account in first-wave PFI hospital projects – rather than succumbing to the pressure from private sector companies to open up an additional "income stream" through privatisation of support services – many other hospitals would have opted to keep services in house.

Our concerns and criticisms focus on the involvement of the private sector in the financing of a project which should have been a routine part of the bread and butter investment in upgrading, refurbishing and maintaining NHS premises.

The use of the PFI mechanism for this project means that the Trust is paying an inflated cost for the project; but it also underlines the extent to which the NHS as a whole has now been almost entirely starved of public sector capital, with a staggering 96 percent of all new hospital projects since 1997 dependent upon PFI funding.

A close examination of the Full Business Case and the methods it has employed to justify the use of PFI also indicates that the claims that PFI represents "value for money", or even better value for money than the public funding of the same project are at best tenuous, and in many cases seriously misleading.

While UNISON shares the hopes of staff and service users that there should be no further hitches and problems in the Walkergate Park PFI now it is already under way, we note that the FBC, like many other PFI schemes, has paid no attention to the unfortunate experiences of larger and similar sized PFI hospital projects that have misfired and caused serious difficulties elsewhere in England, Scotland and Wales.

The PFI policy itself as embraced by ministers at national level has always rested on the avoidance of evidence, a failure to evaluate early schemes, and an optimistic expectation that all will turn out for the best in the best of all possible worlds.

UNISON continues to argue that unless the lessons from previous mistakes are acknowledged and made the basis of changes in practice, other NHS Trusts will be doomed to repeat similar blunders, incur similar inflated costs and disruption of service, and adopt similar flawed designs and assumptions.

In UNISON's view all of the alleged "advantages" and innovations attributed to the involvement of private sector "partners" in PFI could equally be incorporated into a publicly-funded scheme which adopts modern "smart procurement" methods and strict value for money criteria.

PFI remains a high-cost way of investing in the infrastructure of the NHS, in which the costs are passed on for a generation or more to come, turning our health service increasingly into a tenant of private sector companies which see PFI as no more than a guaranteed profit stream to benefit shareholders. The additional resources diverted in this way out of the NHS and into the dividends and surpluses of private corporations could better be employed in delivering patient care.

The Walkergate Park Scheme

The new hospital, which has taken the name Walkergate Park for Neurorehabilitation and Neuropsychiatry, represents a consolidation and centralisation on one site of services which until now have been geographically dispersed. Health professionals will welcome the opportunity to work more closely together as a regional centre, involving teams specialising in the management of the most severe physical disabilities, neuro psychological and neuro psychiatric problems.

The neurorehabilitation service, which will have 27 inpatient beds will transfer from Hunters Moor in Newcastle. The neuro-behavioural unit offering assessment and treatment for those who have suffered serious brain damage after head injuries, will have 15 beds, including 11 transferred from the Janie Heppell Unit and Annexe at Prudhoe Hospital, and four additional beds to facilitate the admission of female patients. The 16 beds for neuro-psychiatry will replace services at the Hartside Unit in St Nicholas Hospital, Gosforth.

With the inclusion/relocation of a further 7 beds for longer-term NHS Health care, this will give a total of 65 beds in the new hospital, in addition to outpatient and day patient services, and the provision of facilities for the Regional Disability Team, the Mobility Centre, Communicate, the Environmental Controls Systems and the Regional Technical Aid Service (RTAS).

There are reasons for concern that the scheme as a whole may have been influenced by cash constraints, not least once the private sector consortium had been selected and the final planning process began. The Full Business Case (2, pp31-36) outlines the (rather limited) information on the likely level of local demand and sub-regional for the new hospital's highly specialist services, noting that there is insufficient information to allow any serious comparison between services in different parts of the country.

The FBC explains that the current level of waiting lists for patients requiring admission to the neuro-rehabilitation services at Hunters Moor (with 3 to 4 people "usually" waiting 4-6 weeks for beds), while waiting times for treatment at Hartside's neuro-psychiatric unit are described as varying from one to eight or even twelve weeks "and there are usually about 3-4 people waiting to be admitted". Despite this evidence that existing levels of bed provision are not adequate to meet demand, and evidence over a five-year period of an "upward trend in demand", the bed numbers in each case are to remain unchanged.

> "Examination of past trends of inpatient and outpatient activity indicates a sustained demand on the service. Indeed, there has been a steady increase in service demand over recent years. There is no clinical reason to suggest that this demand will change in the coming years." (FBC, p35)

The argument for leaving the numbers unaltered rather than increasing them hinges on the fact that across the regional population catchment of the North East there are already 59 "sub-regional" beds in Carlisle, Whitehaven, Middlesburgh, Sunderland and Stockton in addition to the Newcastle provision. When the new unit is included, there will be 117 neuro-disability beds across the region, compared with a projected ball-park estimated requirement of 84-126.

However the existence of bottlenecks and delays in the system with the existing bed numbers suggests that an opportunity could have been taken to expand capacity rather than continue with systematic delays in the admission of extremely vulnerable patients.

Despite proposals in the Outline Business Case for limited increases in bed numbers, the FBC concedes that issues of "affordability" were the deciding factor in holding bed numbers down to the present level (p35). It also notes that there has been no proposal to increase beyond the provision of 7 long-term continuing care beds, even though "the type of patients admitted to these beds are certainly becoming more complex, and the new admissions are likely to be only those in minimally conscious or vegetative state".

UNISON notes that while the staffing costs of opening and running these specialist beds are relatively high, the additional building costs of incorporating additional capacity at the development stage is comparatively small, and we have

concerns that short-term considerations of affordability may have resulted in a unit which will later be seen as too small.

Design of the new building

The FBC outlines the process through which United Medical Enterprises (UME) having secured the position of preferred private sector bidder, was "tasked with resolving outstanding design issues and assisting Northgate & Prudhoe Trust to improve the affordability of the building".

The Trust came forward with new proposals to reduce the number of beds in the building by eight (11%). And in order to contain the cost, the PFI project went on to investigate ways of reducing the amount of space required in the new hospital – again with one eye on the cost implications.

> "Through these methods it was possible to reduce the size of the scheme from 11,537 sq metres to 10,992 [a reduction of 5%] improving affordability whilst still achieving functionality." (FBC 5.3.2)

There are grounds for concern here, in that first wave PFI hospitals have in many cases been constrained in size in efforts to contain costs, only to discover that vital aspects of the new building – often the space required for offices, administration, confidential consultations, and storage of basic goods and supplies – have been omitted or under-provided.

In early 2004 a confidential report by private consultants Hornagold & Hills on a £12.5m PFI-financed mental health facility in Newham for East London and City Mental Health Trust revealed a catalogue of errors attributable to the PFI process and the failure to secure sufficient guarantees from the private consortium.

The consultants concluded that the new building was too small, poorly designed, and poorly built: in addition it suffered from poor quality support services from the private consortium – a risk which we are pleased to note that the Walkergate park project has prudently avoided by keeping services in house.

The 36-page report pointed out that the process leading up to the building of the Newham unit was deeply flawed:

- The bidding and negotiating process was delayed, but even after two years the contract did not adequately specify the obligations of the PFI consortium.
- No details were specified of acceptable room temperatures or lighting levels.
- The original design provided no office space at all – and the resultant reorganisation to squeeze in offices within the floor space left some admin staff having to pass through wards to go in and out.
- The ward arrangement made gender segregation impossible.
- Cold water tanks on the ground floor meant that all water had to be pumped into the building, and at opening there was a total failure of water supply.
- The wrong specification baths were used, but when this was noted and corrected, the proper replacements were too big to go through the doors.

- The wrong specification windows were used: standard windows are unsuitable for a mental health establishment, and have suffered damage and broken handles.
- A number of toilets were not connected to drains, "leading to obvious problems".
- Floor coverings were defective, alarm and call systems unreliable, emergency systems non-functional, and the contractor had been uncooperative and adversarial.

The variety of the problems experienced in the Newham project, and the number of them that were connected with the design and pre-planning of the new building should have been the subject of a much wider discussion and learning exercise throughout the NHS. Instead, every PFI project has effectively seen the NHS and local management teams starting from scratch: hence the commonplace shortages of office space and repeated design failures throughout the first wave of PFI hospitals in England, Scotland and Wales (Lister 2003).

The Newham experience also involved the private sector buying inappropriate windows and other fittings, despite the long years of NHS experience on the type of fitting required to take the pressure of use by staff and patients. This should ring bells in the case of the Walkergate Park scheme, since one of the ways in which the so-called "Public Sector Comparator" (PSC) is made to appear more expensive and less attractive than the PFI option is because the PSC costs

> "are based on the initial installation of traditional heavy-weight superstructure and high quality finishes and fittings, and make full allowance for frequent replacement to maintain the required standards." (FBC 1.6.5)

The PSC, for reasons unexplained, assumes that there would be no on-site maintenance staff, and that any repairs would require bringing in contract staff, while the PFI contract takes a very different approach, making extravagant and unsupported claims:

> "The PFI company would be providing the same level of quality of finishes and fitting: but they are able to procure this at lower cost … . With regard to the impact of patient damage/fair wear and tear, the PFI company has taken a commercial decision within their risk transfer profiling to include a small premium in their financial model to cover this possible expenditure. Secondly they have allowed a permanent on-site Hard FM service, which it is envisaged will undertake an increased level of preventative maintenance to extend the life cycle of the finishes and fittings."

Experience in mental health units and other hospitals built through PFI suggests that the consortia consistently attempt to spend less than the NHS on quality fittings and finishes, including lighter-weight doors, windows and handles – sometimes on the assumption that proper quality fittings can be replaced by swift replacement of lower-quality fittings – only to face a constant problem of delays in replacement, resulting in facilities not able to be fully used.

The option of the NHS, too, keeping full-time maintenance staff on site to repair any fittings that may have been damaged is conspicuously excluded from the Public Sector Comparator, which is clearly not in any way seen as a genuine comparison, but simply a decoy scheme that can easily be shot down to make way for the PFI option,

which is now clearly seen by management as the only way to secure NHS capital project.

The 2nd issue of the Project Newsletter (October 2003) admitted this to be the case, when it pointed out that

> "It is highly unlikely that this design will be built: it is developed to help us compare and evaluate the three bidder designs.".

The same newsletter also declared that the Project Board was "determined the design of this centre should be to the highest possible quality": but with a consortium and the Trust Board seeking every possible means to squeeze down costs, it seems that this objective was inevitably compromised from the outset.

The project also seem to have fallen into the same poor practice of early PFI schemes, in drawing insufficient information from front line staff, instead making reference only to "a number of stakeholders", and leaving the whole project open to the danger of failing to provide adequate space or facilities to sections of staff who have been left outside of the planning process.

UNISON is concerned that errors made at the planning stage of PFI schemes in the final negotiations with the preferred bidder occur within a framework of confidentiality and secrecy. This tends to ensure that there is little or no possibility of correcting them until after the building is complete. The resulting errors are therefore more expensive to correct than if genuine cooperation and modern public sector management techniques are brought to bear.

Mistakes made at this stage often reflect the private sector's lack of experience in dealing with NHS service issues, combined with NHS managers' lack of experience in designing new buildings and controlling the pressures from large and powerful corporations which – in the absence of any substantial availability of NHS capital for new hospital projects – can always threaten to walk away and trigger a collapse of the project.

No serious comparison

Time and again the Full Business Case makes it plain that the Public Sector Comparator is a hollow exercise, a rigmarole through which management seek to "prove" that PFI offers better value for money.

The relatively small amount of capital required (even given the inflation in the cost of the Walkergate project during the long process from its inception to the eventual signing of the PFI contract) means that the overhead costs of PFI – the large amount of NHS management time involved, the use of external accountants, business consultants and advisors – will be comparatively big, although the FBC offers no real accounting for these costs, most of which are borne directly by the Trust.

The apparent cost of the PSC is conspicuously "padded" by a variety of devices, which include assuming unlikely and inefficient ways of working, assuming the NHS would pay higher costs for quality fittings and finish (see above), and the assumption that the PFI consortium would take over a very considerable burden of "risk". While

of course the claimed advantage of PFI is that it is supposed to deliver "on price, on time and to budget", whole the private sector accepts the risk involved in their possible failure on one or more of these fronts. However this claim has been widely perceived as hugely exaggerated, and Walkergate Park is no exception.

While the consortium may well face a financial penalty for failures in completing the building on time (construction and development, availability and performance), and may even face costs as a result of design failures, the main problems and pressures if any of these risks misfire would fall on the Trust and its employees and the service users struggling through with inadequate resources.

In London, the £30m redevelopment of the Whittington Hospital in Islington ran into crisis as a result of the financial plight of the main PFI contractor involved, the struggling Jarvis. Building work ground to a halt for months on end and the new building is now long overdue, while costs have risen 50% to £45m. Even though the cash problems have resided with Jarvis, the problem for the Whittington Trust is that patients and staff – and local residents – have been left to cope in a building site.

The risk of the building costing significantly more than expected to operate is seen as three times higher under the Public Sector Comparator than under PFI, even though PFI hospitals such as the Edinburgh Royal Infirmary and Norfolk & Norwich Hospital have faced demands for increased payments to the PFI consortium after patient numbers exceeded agreed levels.

The risk of "variability of revenue" is one that the Trust alone has to carry: the PFI unitary charge to the consortium is fixed, index-linked, and legally binding for the 32-year contract – offering no flexibility if the Trust's revenues are reduced, or the Trust faces other cash pressures – yet the PFI project is portrayed as if it were a means to transfer some of the financial risk for variability of revenue.

In all, the comparison of risks retained or transferred suggests that the Public Sector Comparator would leave the Trust holding risks totalling £8.55m, while the PFI scheme would cut this by two thirds to £2.74m (Table 12.3). But since the Trust is giving the PFI consortium payments far in excess of the full £8.55m, it is clear that this risk is not really be transferred at all, simply paid for on hire purchase.

If this largely spurious burden of excess risk amounting to almost £6m was not allocated in this arbitrary way to make the PSC appear more costly, the PFI-funded scheme would emerge as clearly the most expensive means to deliver the new hospital. The cash flows to pay for the two projects are significantly higher (7.5%) for the PFI scheme than the PSC (FBC 11.1). The Full Business Case concedes how close the two alternative schemes are when it concludes that the difference over 32 years could be as little as £2m, and the annual difference is just £126,000

> "The Net Present Cost of the PSC over 32 years is £49,729K… the NPC of the PFI solution is £47,742K, … demonstrating that the PFI options offers better value for money." (18.2)

However the cost of the Public Sector Comparator has been systematically padded – with unproven assumptions of increased risks, including allocating notional risk to the PSC for possible failures in services which the PFI consortium will not be undertaking.

£1m is added to the risks of a Publicly funded scheme on the basis that patient infection might be triggered by poor facilities management – even though the PFI company will not be delivering support services.

A massive £2.335m (three times the figure assumed for a PFI scheme) is added to the projected cost of the PSC to cover undefined "other risks"! The PSC is made even more unattractive by incorporating a series of unlikely and unwise decisions designed to put the PFI scheme in a good light. In 1.6, for example, we are told that even though the PSC involves using off-site contract maintenance staff while the PFI scheme would have three staff on site around the clock, the PSC scheme is claimed to have Hard FM costs 16% higher per square metre than PFI. And the PSC scheme for replacement of furniture and fittings is argued to cost over 17% more than the PFI proposals.

By contrast the PFI scheme involves hefty payments of interest to private banks and institutions outside of the NHS, with interest rates cited varying from 12% to 13.76%: the PFI unitary charge, beginning at £2.09m per year, would be index-liked, and therefore increase each year.

Many other PFI deals include a baseline increase of 2.5% per year or inflation whichever is the higher: simple projections show that instalments of £2.09m rising at 2.5% would result in payments in excess of £3.5m a year after 22 years, and total payments of more than £100m over the 32-year period.

This confirms that PFI is an extremely costly means of borrowing money for NHS or other public sector projects, for which government borrowing offers much lower rates of interest, with fewer strings attached and the prospect of shorter repayment periods and greater flexibility on the use of the new buildings. A mortgage even at 6% interest would offer the chance to pay off the project in 25 years on just the same payments.

In December 2005 the Trust Board voted to accept a further variation of the scheme which added another £225,000 to the project cost, and increased the annual payments by £20,000. With indexation, this amount too would increase almost five-fold over 32 years to £943,000. For the lack of relatively trifling sums of routine NHS capital for new hospital projects, Trusts are being forced to incur major and escalating legally-binding costs for a generation to come.

UNISON believes that small schemes like Walkergate, and the even smaller variation now incorporated into the scheme, should be routinely funded through the NHS and the Treasury rather than forcing Trusts to spend years negotiating complex deals with major corporations, when management attention and resources would better be focused on improving patient care.

Costs and sources of funding

The PFI scheme will cost the Trust an extra £2.2m a year above its existing costs and revenue, the majority of which is to be underwritten by local PCT commissioners. In other words the inflated cost of the project is being passed on to the surrounding health care services, all of which are paying more than would be needed if the scheme was publicly funded.

However there are some worrying ambiguities surrounding the Trust's projections on the income to be derived from the new unit. The FBC refers to the prospect of the centre's "extra capacity" [which as we have noted is very limited] by local Primary Care Organisations or

> "occupancy of the beds by other commissioners." (FBC 13.1)

Appendix 4.6 itemises an estimated £720,000 a year to come from

> "local PCOs or independent sector"

We note the reference in section 2.3 to the "close links" with the few private sector providers already active in this sector of health care in the North East, and the reference to strengthening links and forming some form of joint clinical network. Given the pressure on NHS facilities and the historic lack of interest from the private sector, we need to ensure that no such networks are allowed to undermine existing NHS provision or the principles on which NHS care is delivered.

UNISON wants an assurance that the limited numbers of beds in a front-line new NHS facility, funded in this way through PFI, will not be used to care for private patients, but will remain mainstream NHS beds delivering care free at point of use to NHS patients on the basis of need.

Conclusion

- **While UNISON welcomes the planned new hospital on the Walkergate site, we have concerns over the way it has been planned and the value for money of a project that – like 96% of all new hospital spending since 1997 –hinges on the Private Finance Initiative.**

- **There is still no evidence that PFI can deliver new hospitals more cheaply or effectively than modern methods of public sector procurement: nor will there be any chance of testing this out unless the government remedies the desperate shortage of capital for new hospital projects.**

- **Experience of other PFI projects in the NHS in England, Scotland and Wales suggests that there have already been expensive mistakes made and lessons to be learned from hospitals already completed: but the Walkergate scheme, like every other project in the NHS appears to learn nothing from others' experiences.**

- **UNISON will work with staff to monitor the quality and the adequacy of the new facilities to deal with a potentially increasing and vulnerable patient group, and to learn the lessons that NHS managers seem reluctant to explore.**