HEALTH EMERGENCY

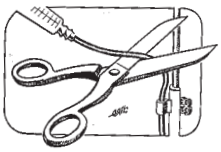
Bulletin of Hands Off Our NHS * No.56 * February 2003

INSIDE

NEW CASH CRUNCH FOR TRUSTS

Hospitals and Primary Care Trusts all over the country are facing a massive cash shortfall for the current financial year, which in some cases means cuts and bed closures despite the extra billions that have started to flow into the NHS.

A London Health Emergency snap-shot survey of Trust and HA papers in January found eleven Trusts in London in the red to the tune of a massive £33m, with desperate managers in Epsom/St Helier Trust telling staff to cut orders for pens and stationery to claw back another £5m overspend, the Whittington Hospital short by over £5m, and St George's Trust £4m .



Other London Trusts known to be facing financial pressures include the giant South London & Maudsley mental health Trust (£4m), West Middlesex Hospital (£3.2m), Barts and The London Trust (£2.6m) and NW London Hospitals (£2.4m).

There are also £1m-plus shortfalls in Newham Healthcare, Hammersmith Hospitals, Chelsea and Westminster Hospital and Queen Mary's, Sidcup.

But outside the capital the situation is also grim in many areas. Worcester acute hospitals Trust – where the £100m PFI hospital is already running out of beds – is £6m in the red, while Oxford's Radcliffe Hospitals Trust have revealed a £13.6m deficit, driven by agency nursing bills which added up to a massive £2.7m in November alone.

In Manchester, PCTs are facing a total £27m shortfall, £5.5m of which is down to South Manchester PCT, where the costs of a PFI hospital are causing havoc.

The two big Bristol Trusts, North Bristol and United Bristol Hospitals are facing deficits of £11.6m and £10.6m, with additional debts facing the city's PCTs.

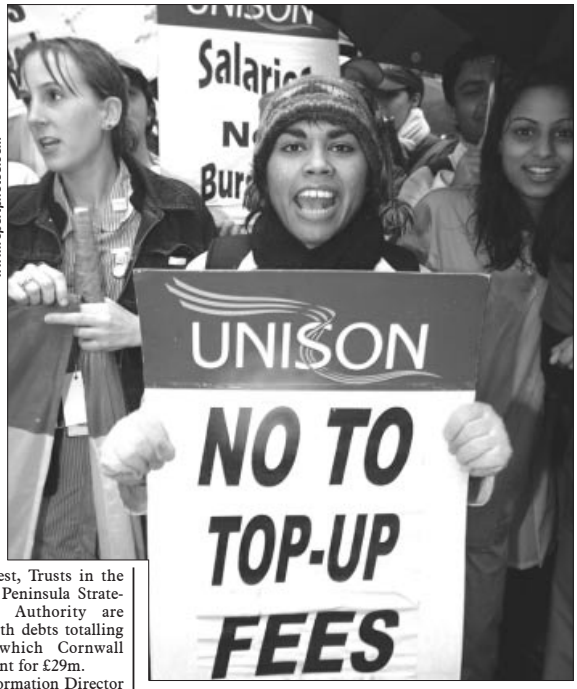
Further west, Trusts in the South West Peninsula Strategic Health Authority are wrestling with debts totalling £43m, of which Cornwall Trusts account for £29m.

LHE's Information Director John Lister said:

"Many of these deficits have been inherited from the bad old days of Conservative cash limits.

"But some are the result of soaring agency nursing bills, which reflect the government's failure to get on top of recruitment and retention of staff.

"The agency bills also show the cash costs of plunging morale in the midst of Alan Milburn's relentless 'modernisation' – at the expense of traditional NHS values."



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Student nurses – who are campaigning for salaries in place of their pitiful bursaries – lend their support to the protests against the government's plans to charge "top-up fees" for some subjects in the "top" English Universities.

How war will hit NHS

NHS wards will close to make room for British casualties from the war against Iraq. Thirty hospitals nationally have been told to put wards on standby to prepare for 'level one' trauma centres.

The Ministry of Defence is also requesting lists of medical reservists to volunteer. This will force the closure of dozens of surgical wards across the country.

Selly Oak Hospital in Birmingham will be the first to receive casualties, and once this is full, injured casualties will be sent to NHS Trusts in large teaching hospitals in London, Manchester and Leeds amongst others. The government has been aware since 1997 that reserve medics make up the shortfall in the Medical Defence Services because of cutbacks in the armed services.

The 1990 Gulf War saw similar reliance on NHS beds and staff. At that time managers were told to ring-fence up to 7,500 beds for military use.

One hospital in Bristol closed three wards of 50 beds each.

John Radcliffe Hospital in Oxford closed wards and cancelled operations, and Luton and Dunstable closed three operating theatres and halted admissions.

Staff in many hospitals became 'unofficial' reservists when their shifts were extended. In Enfield, student nurses were asked to sign up to 'volunteer' if needed.

At Glasgow's Gartnavel Hospital, psychiatric nurse training was suspended when tutors were transferred to the hospitals trauma unit.

This time round the British Medical Association's Armed Forces Committee are arguing that the NHS should be prepared to cancel non urgent operations as doctors are called up as reservists.

The effect on the already over-stretched NHS will be more disasters waiting to happen.

That's why thousands of health workers are expected to join up to a million protestors on the February 15 march through London called by the Stop the War Coalition.

What's happened to our A&E units?

In today's climate of "modernisation", perhaps it had to happen. Accident and Emergency units are to be rebranded as 'Emergency Departments' to deter people from using them.

Quiet words of encouragement are being issued from the Department of Health to hospitals to drop the word 'accident' from Accident and Emergency units.

The cost of changing thousands of signs has apparently not been calculated, but many believe it to be a window-dressing exercise to ease pressure on a service where according to the Department of Health's own figures 25 percent of patients wait 4 hours or more to see a doctor.

There are also fears that the move isn't purely symbolic, but an attempt by government ministers to scale down the services currently available.

The president of the British Association of Accident and Emergency Physicians, John Heyworth argues that the change is justified; 'because there are fewer major accidents now, and more acutely ill patients who come into the department.'

Yet on average emergency ambulance call outs increase by 5 percent a year, while emergency readmissions have increased 'significantly'.

In another statement to the press, John Heyworth argues that targets cannot be met without hundreds more specialist doctors.

The government should cut the spin, stop fiddling the waiting list figures and recruit more doctors now.

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NHS: why we're still waiting for signs of improvement

Karen O'Toole

HOSPITAL waiting lists have remained above 1 million for nearly a decade.

But with hospitals struggling to cope with demand, even getting into hospital doesn't always save lives. Every year 400 people die within three days of surgery because of insufficient critical care beds.

More hospitals are now reporting amber or red status related to beds crisis, and tens of thousands of operations are cancelled every year.

The crisis in the NHS is most reflected in waiting lists and cancelled operations. Between 1998/99 cancelled operations stood at 56,000. By 2000/1 78,000 patients had their operations cancelled at short notice.

During this period it was reported that nine NHS Trusts manipulated waiting lists to meet government targets. By February 2002 the government announced plans to tackle the problem by appointing specialist managers to help cut waiting lists, giving just £75,000 to trusts failing to meet the target of maximum four hour waits in Accident and Emergency.

Yet this is a drop in the ocean when the scale the problem is examined. In Trusts in North East London Health Authority, 60 percent of patients were

treated within the target time of 4 hours spent in Accident and Emergency, compared with the national average of 72 percent, and a national taregt of 90 percent.

In Wales over 83,000 were waiting more than six months for a first out-patient appointment, the highest since records began. In Gwent, orthopaedic waiting lists rose by 65 percent between July and August 2002. In Leicester, hospitals were on amber plus alert in October 2002 due to bed shortages.

But the biggest crisis is in London, and affects services which go beyond the usual beds crisis. Barnet and Chase Farm Hospitals NHS Trust was the subject of recent revelations when over 800 unprocessed referrals for ultrasound scans were found stuffed into a drawer.

An understaffed IVF clinic at St George's Hospital in Tooting was closed after embryos were implanted into the wrong patients.

Meanwhile, the bill for using agency nurses to plug the gap eats into budgets in too many hospitals. In almost every area of healthcare waiting lists present a problem. So what can explain the sickness in the system?

Gordon Brown's 2002 budget announced the 'biggest ever sustained spending in the history of the NHS', with £40 billion in extra resources by 2007-8. Many were hoping that the crisis would now be over.

Yet no sooner had the budget been announced, than press reports began to appear claiming that much of the money promised had already been allocated two years before, and had been 'double-counted'.

For instance; guarantees that there would be 15,000 more doctors by 2008 incorporates targets already announced in 2000 – when the government promised 9,500 more doctors by 2004. Since then, only 2,700 new doctors have been recruited.

Ministers also announced 'an increase in treatment capacity equivalent to over 10,000 beds' on top of the 7,000 promised in 2000.

Yet since 2000 only 714 new beds have been introduced into the NHS.

Similar claims have been made about increases in the number of nurses. In some London hospitals, the nursing shortage is so acute that bank or agency staff are filling one third of posts, and some, such as North East London Health authority cite agency staff bills as reasons for overspends, resulting in cancelled operations.

Even though the government has increased the budget for health spending, all too often patients seem to be the last priority.

A recent study at the Whittington Hospital found that 40 percent of time at the urology outpatients clinic is lost to 'administration and inefficiency', with doctors spending less time with patients and more time finding notes, administrating or fielding telephone interruptions. The report recommends proper investment in support staff.

The NHS is now more bureaucratic than it ever has been, with more than 20,000 extra managerial posts created in the past five years.

Yet as the report from the Whittington Hospital highlights, more management does not necessarily lead to more efficiency.

Instead, the NHS must plough the resources permanently into nurses, doctors and support staff.

Who wants joint 999 control rooms?

Speculation that the government plans to merge fire and ambulance control rooms is running rife.

Rumours first began to circulate during the fire dispute, that part of the 'modernisation' package, would be to join up the services.

The army and police tested the possibilities during the strike and called them a great success. UNISON responded by saying; 'Ambulance controllers aren't dispatchers like a local minicab service.'

UNISON has also pointed out to those ministers and others who want fire engines to carry defibrillators for heart attack victims that a fire engine is not an ambulance. We need more professionally skilled paramedics responding to emergencies, not lumping another task onto firefighters.

But much of the modernisation agenda appears to be cash-driven. If it goes on like this, perhaps Tony Blair could follow the lead of the banks, and transfer the whole 999 service to call centres in Bombay.!

Island taken for a Ryde

There has been an angry reaction to plans that would mean emergency services on the Isle of Wight would have to evacuate patients to mainland hospitals for treatment.

This would be the result if local health authority plans go through to shut the island's last remaining Accident and Emergency department.

Other key services such as coronary care, the children's department and obstetrics could also be transferred to Portsmouth or Southampton.

The authority's plans suggest that the Solent should not be seen as a barrier for patients needing emergency treatment. The Isle of Wight Healthcare NHS Trust, which runs St Mary's Hospital has rejected the plans.

'There have been several occasions in the past few weeks where ferries were unable to run and helicopters could not fly.'

They also warned that cutting obstetric services could put expectant mothers at risk.

Ten years ago there were two A & E departments on the Isle of Wight, which has a population of 130,000. Due to NHS rationing one department in Ryde was closed, now health chiefs are coming back for more.

Campaigners unite against new Mental Health Bill

Karen O'Toole

Fear and stigma of mentally ill people have been exaggerated by sensationalist reporting of rare violent acts. Is it any wonder then that more than one in three members of the public (37%) would be deterred from seeking help from their GP for depression if proposed new mental health laws go through?

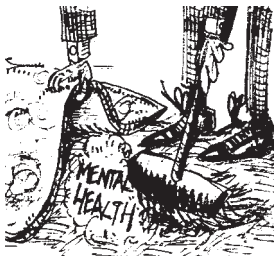
According to a survey carried out for mental health charity MIND, fears of being forcibly treated or detained under the draft Mental Health Bill would prevent people from seeking treatment.

The draft bill, described by the Royal College of Psychiatrists as 'public order legislation in disguise' will also introduce compulsory treatment orders in the community.

Proposals were put forward four years ago to introduce forcible treatment in the community to bring 'dangerous' people with severe personality disorder (DSPD) under mental health legislation. But it is estimated that no more than 600 people with these conditions are living in the community; the legislation includes proposals to lock them up indefinitely.

Compulsory treatment in the community will apply to a further 26,000 people a year. Yet even though the bill compels patients to receive treatment when the law sees fit, it does not give people a legal right to treatment.

According the Royal College of Psychiatrists the draft bill would mean that people with Parkinsons disease, multiple sclerosis, learning difficulties and those addicted to drugs or alcohol could be sectioned.



The proposed shake-up has been condemned by many bodies including the Mental Health Alliance, the Royal College of Psychiatrists, the Law Society and even the House of Commons health committee, who said they were 'unable to support' the government's plans.

"Criminal Justice"

Many believe the legislation will restrict human rights. But Mental Health Tzar Professor Louis Appleby defended the proposals, stressing that the DSDP measures will primarily be a 'criminal justice measure' which will rarely apply to anyone who is not before the courts or in prison.

Yet he admitted they could be used on people who have never committed a violent act before.

The criminal justice elements in the bill have their origins in cases such as that of Michael Stone, the psychopath convicted of the murder of Lin and Megan Russell in 1996. The case became a media sensation because Stone was known to the mental health authorities.

Yet in March 2001 Professor Appleby's own university department argued that only ten percent of those who committed murder had been receiving treatment for mental health problems, suggesting that most murderers do not fit the image of 'psychopath'.

It found instead that people with mental health problems were far more likely to harm themselves, or to attempt suicide whilst receiving in-patient care.

40 percent of in-patient suicides harm themselves 'during or soon after in-patient care'.

Dr Jenny Shaw, assistant director of the research said at the time; 'The low figures for stranger homicides show that the risk to the general public from patients with mental illness has been greatly exaggerated. The public are more at risk from heavy drinkers.'

So why is Professor Appleby defending the draft bill?

There has been a marked increase in compulsory admissions to psychiatric units since 1989. By 1998 the level of compulsory detentions and admissions stood at 46,300.

The Mental Health Alliance believes the aim of any new law should be to reduce compulsion and ensure that services are available when people are looking for help.

Many believe that the closing of psychiatric beds and the move towards 'care in the community' have resulted in a psychiatric 'revolving door', with patients receiving inadequate support within the community.

One in four of the population experience mental health problems at some time of their life.

The draft mental health bill could criminalise many more people, particularly black and ethnic minorities, than it will help.

● Mental health tribunals

Will authorise all compulsory treatment beyond 28 days. Tribunals will comprise a legally qualified chair and two other members with a mental health background. The Royal College of Psychiatrists estimates that another 600 psychiatrists would be needed to staff the tribunals alone.

● No right to assessment

Organisations such as Mind have asked for the right to assessment, but this has been refused.

● No role for social workers

Social workers will no longer be involved in the process; the decisions will be based on clinical criteria alone.

Milburn ignores medical advice

Foundations for fiasco?

Health Secretary Alan Milburn is doggedly pressing through his controversial plans for "Foundation Trusts", which will give new powers and privileges to ten or a dozen of the country's top-rated "3-star" hospitals.

The plan has been denounced by health unions and by the BMA as a return to the type of market-style methods wheeled in by Margaret Thatcher's government in the early 1990s, and which Labour ministers claimed to have swept away after 1997.

Former health secretary Frank Dobson and other former ministers have also attacked the plan for precisely these reasons, pointing out that the new "freedoms" to be granted to Foundation Trusts could only be at the expense of other NHS Trusts that have been excluded from the elite status.

Foundation Trusts will have extra freedoms to borrow, including from the private sector – but their borrowing will count against the total cash limits on the NHS, and so their extra will mean less capital for maintenance or new building in other Trusts.

They will be free to retain any cash raised from the sale of Trust property assets, prompting fears that some may embark on a new round of asset-stripping.

They will be free to set up private companies that offer managerial and other services inside or outside the NHS and which can bid to run neighbouring "failing" Trusts under the government's franchising scheme.

"It says there's an extra ten percent on offer at St Michael's, or six percent, a day's holiday and luncheon vouchers at the RI"

- **Foundations will be able to borrow from the private sector**
- **They can vary pay scales for staff up or down – making a nonsense of Agenda for Change**
- **"Stakeholder" groups can elect members to a "Board of Governors"**
- **But all key decisions will still be taken by an unelected Management Board**

They will also have freedoms to vary the pay of their staff, giving scope in some areas to offer more to recruit staff with particular skills – subject only to vague restrictions on "poaching" staff from other Trusts.

And they will be given a guarantee of independence from legal direction by the Secretary of State – raising serious questions over the extent to which they can be prevented from using these other freedoms in ways which threaten the survival of other Trusts.

"Locked"

Despite all the unpleasant echoes of the Tory 'reforms' which first created the internal market within the NHS, establishing the bureaucratic and wasteful "purchaser provider split", Mr Milburn has insisted that the Foundation Trusts will be non-profit making bodies, with their assets "locked" to prevent Foundations being privatised at a later stage.

But what of a Foundation Hospital that is already owned by a private consortium through PFI? What protection would there be against it being converted into a straightforward business, selling care to the NHS, with profits bolstered by its local monopoly position?

Mr Milburn should take warning from the experience of the first foundation-style hospital experiment in Sweden, where a major hospital in Stockholm was privatised by its board – against the wishes of the local health authority and the government.

He has already retreated in front of those warning that Foundations would (like the first wave NHS Trusts in the Tory reforms) seek to expand their treatment of private patients and numbers of private beds.

He has insisted that they would be prevented from doing so, and that applications will be preferred which propose to switch existing pay-beds back to treat NHS patients: it is not clear if any such plans exist.

He has also argued that Foundations will remain "part of the NHS", and that they will be controlled by elected "stakeholder" members from the local community, who would elect representatives to comprise a majority of a Board of Governors.

However the real power would remain in the hands of an unelected Management Board, and the extent to which local stakeholders would actually influence the day to day running of the Trusts – if at all – is not clear.

There are also big questions to be answered over the extent to which such "stakeholders" groups would be representative of anybody, let alone the ethnic and social mix of the communities they cover.

The probability is that control freakery would rule the roost, and that the usual suspects – ex-councillors, former MPs and bigwigs from local quangos and businesses – will find themselves included, with the usual absentees – working people, and those with disabilities and particular health needs – will again be left on the outside.

Some of Milburn's colleagues, such as Ian McCartney, have gone even further, and argued that Foundation Trusts – supported as they are by the Tory Party, and Thatcherite organisations such as the Institute of Directors and the Adam Smith Institute – represent "popular socialism" and hark back to the 'old Labour', 'socialist' values of "mutualism" and the cooperative movement.

Businesses

But the Foundations will be run as ***businesses***, and encouraged to show 'entrepreneurial' spirit: they will have to pay commercial interest on any loans they take out with the private sector. They might not be for-profit bodies, but they will have to break even, and will seek to retain a growing surplus year on year.

We should expect that like City businesses, they will set up a generous scheme of bonuses and salaries for their top directors.

And they will inevitably seek to strengthen their market share by competing against other Trusts for contracts to treat more NHS patients as another aspect of Milburn's reforms – a re-establishment of the internal market system through a new system of payment by results – takes effect. (see inside, p2)

They may even pick and choose which specialities and services they see it as economic to offer to local Primary Care Trusts – and which they see as less attractive and leave to non-Foundation Trusts.

With so many unanswered questions, it is perhaps surprising that a mere two dozen Labour MPs out of over 100 who had expressed reservations abstained on the second reading of the legislation for Foundation Trusts.

The level of debate will have to be raised to ensure this latest half-baked plan, which few if any health workers support, is not railroaded through a dozy House of Commons.

Milburn's latest market madness

John Lister

Like a dim-witted tourist returning with a straw donkey and a back-pack of hideous souvenirs, Health Secretary Alan Milburn has again borrowed more "modernising" ideas from abroad for his latest planned reforms in the NHS – this time from the disastrously unfair and expensive US health care system.

You may well not have noticed the few low-key paragraphs in the Guardian (October 18) announcing the new 'payment by results' policy – which amounts to a more extreme version of the "internal market" system introduced by Thatcher's government in the 1990s, at colossal expense and with miserable consequences.

New Labour boasted in 1997 that it was to "scrap" this internal market: now it is coming back, big time.

Beginning next April, a steadily growing share of hospital caseload will no longer be funded on the basis of "block" contracts with local Primary Care Trusts, but commissioned on a case by case basis.

Hospitals would be financially penalised for every case they failed to deliver – while those that managed to attract and deliver additional work could increase and retain the extra cash.

All this will cost money, time and effort. But the decisive point, which is set to destabilise the NHS as this system comes in, is that no negotiation will be allowed over the price to be charged for each operation or treatment: these will be fixed nationally by a single "tariff", calculated by the Department of Health, leaving only small regional variations.

This potentially means that dozens of major hospitals whose costs per treatment are currently above the "average" will have to squeeze down their costs, or face losing money on every operation they carry out.

And since upwards of 70% of NHS spending is on staff, this means that nursing and professional staff are likely to come under the hammer.

The situation will be the sharpest in the new wave of PFI hospitals, where all support services such as cleaning, portering and catering are already subject to a separate, legally binding contract. The only staff whose pay and conditions can be controlled by these Trusts are clinical staff delivering patient care.

This relentless drive for a new, more savage internal market comes with the promise that patients can "choose" which hospital they want for their operations – a move expected to benefit the more prestigious teaching hospitals at the expense of district general hospitals. The same language of "choice" was also used to sell the Tory government's market reforms in the NHS.

The result now, as then, is a formula for competition, chaos and increased privatisation.

The reforms are being railroaded through at a reckless pace, regardless of the chorus of opposition from health unions, professional organisations and a conspicuous lack of public support.

To make matters worse, the statistics on which the new tariff of fees per operation will be based are notoriously unreliable: for example the figures in 2000 for a basic hip replacement ranged from a reported minimum of just £566 (barely enough to pay for the replacement joint itself) to a maximum of almost £13,000.

Even the most carefully adjusted figures show a variation between almost £7,000 in Shrewsbury and £2,200 in Preston. Any "average" will leave many stranded above the line looking for cuts.

Dozens of hospitals are already in the red: dozens more will be driven into crisis by these plans.

If the tariff is set too low, there is always the danger that local Trusts may opt out of providing certain treatments altogether, or decide to market their services to private patients who can be charged more for the same treatment.

Millions of patients seem set to be used as guinea pigs in this new, mad experiment with market methods. So far, few MPs seem to have noticed or responded to the changes taking place. The health unions and campaigners have to join forces to stop it.

Like sponsors' boards round a football pitch, the names of the PFI profiteers are proudly displayed around the new £180m Edinburgh Royal Infirmary, which will cost the taxpayer £900m.

5 short answers on why PFI is rotten value

DURING the autumn, under fire from the unions, ministers scraped around for arguments to justify their view that PFI is the best way to finance new hospitals public services. They failed to win the argument – but PFI schemes continue to grind through in many areas.

Here are a few answers to the questions the ministers raised.

1.) Would a review of PFI mean delays?

PFI schemes are notorious for the delays, bureaucracy and consultancy fees involved. The most notorious is the Walsgrave Hospital project in Coventry, which has been under debate since 1995, when a plan to refurbish the city's two hospitals was floated at a cost of £60m.

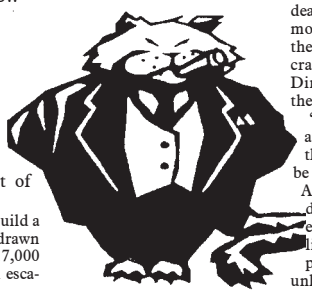
By 1996 a contract to build a new hospital had been drawn up that comprised 17,000 pages. By 1997 this had escalated in cost to £174m.

The eventual deal – at £359m – was only signed seven years later. It was the only hospital project signed in 2002. Dozens more are stuck in the pipeline.

Even the building contractor Amec, with eight PFI deals and in the bidding for more has complained about the costly delays and bureaucracy involved. Finance Director Stuart Siddall told the BBC's World at One

"The PFI process is slow and expensive – anything that can streamline it would be welcome."

Against this pattern of delays, a pause while the experience of over £20 billion worth of schemes is properly investigated seems unlikely to be noticed.



2.) Would public investment mean "reckless borrowing"?

PFI schemes represent the most massive expansion of long-term borrowing: the 512 schemes already completed under PFI have a capital value of more than £22 billion.

All of this will be repaid by the public sector – with interest and a hefty profit margin on top – over the next 30 years.

New PFI-financed buildings are not assets but long-term liabilities, taking the first slice out of the budgets of public services in rigid, legally-binding deals.

The average combined cost of lease payments and services for the first round of PFI deals in the NHS add up to FIVE or SIX TIMES the capital value. If this continues the NHS alone could wind up paying £35 to £42 billion (index-linked) over the next 30 years for 68 new hospitals valued at just £7 billion.

By contrast, even a standard 6% mortgage would pay off the same amount for less than £14 billion over 25 years.

The government can borrow as cheaply as 2 percent: the extra interest in a PFI deal goes straight into the profits of the private sector.

So WHO is being reckless with public money?

3.) Is PFI "extra" investment?

No: of 68 new hospital projects, with a total value of £7.3 billion, that have been given the go-ahead since 1997, just SIX (8%) are publicly-funded, with a combined value of just £220m (3% of the total).

This is sending a clear message to NHS managers: if you want a new hospital, PFI is the only game in town.

4.) A PFI moratorium will "deny the public services they need"

But PFI itself, with its extra costs, has brought a squeeze on services: the first wave of PFI hospitals had up to 30% fewer beds, and some have already had to add prefab buildings to expand capacity. PFI-funded hospitals and schools offer less space for patients, pupils and staff. The London Underground PPP will deny passengers any new trains or stations for at least 7.5 years, while requiring a subsidy equivalent to a 25% fare increase.

5.) Are privately-funded facilities built to better quality?

No! Tell that to staff at the shoddily built hospitals – like Carlisle, Hairmyres, and Dartford, Halifax, and North Durham – where plumbing and other structural faults have caused chaos for patients and staff alike.

Or in Worcester, where the new hospital's corridors are now too narrow for trolleys to pass each other.

Or in Hereford, where maintenance engineers have had to re-weld the lift floors after the hospital has been open for less than a year.

Or in the award-winning Norfolk & Norwhich Hospital, where the largely windowless offices have no airconditioning.

Harefield heart-op plan caught in Paddington PFI chaos

CAMPAIGNERS are stepping up the pressure on Alan Milburn to release the funds for a £3.8m expansion of heart surgery at Harefield Hospital, to enable consultants to carry out an additional 570 operations a year.

The scheme, which was forwarded with detailed costings in a letter to Mr Milburn on July 9 by Prof Anthony Newman Taylor, the acting chief executive of the Royal Brompton and Harefield NHS Trust, would create additional theatre and bed space at Harefield.

But it would also assist the Trust in retaining vital nursing and other staff at Harefield, which faces the long-term threat of closure.

However the controversial PFI scheme for a new mega-hospital in Paddington, combining the existing Harefield and Royal Brompton services, last costed at more than £350m, is lurching from one crisis to another.

Under new Department of Health standards for space allocation the floor area of the hospital would need to be expanded by up to 18% from current plans, pushing costs still higher.

Gloomy Trust bosses are now questioning whether the new hospital, originally projected for 2008, will now be open by 2011 – if at all. The costs – and thus the affordability – of the scheme are equally unknown.

New pamphlet out soon!

The PFI experience

Interviews with staff in nine PFI hospitals in England, Scotland and Wales

Researched for UNISON by John Lister of London Health Emergency.

Norfolk & Norwich Hospital

Private firms to bid for waiting list surgical units

TWO DAYS before Christmas the Department of Health sneaked out the news that it is inviting private health care companies to bid to build and run eleven new "Diagnostic and Treatment Centres" (DTCs) to carry out over 30,000 operations a year for the NHS.

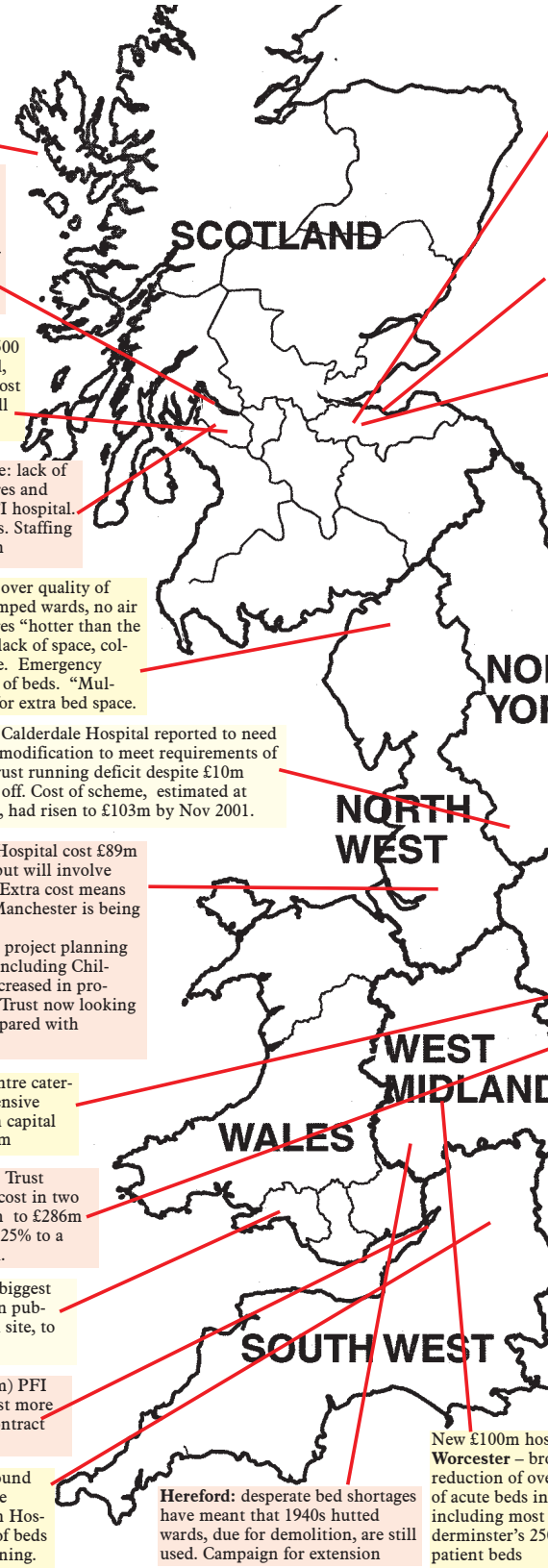
This is Alan Milburn getting round his promise not to privatise any clinical services through PFI: instead new, privately-run clinical services will siphon off NHS cash.

As one angry consultant surgeon told Health Emergency:

"We don't know how much this will cost until the bids come in, but if there is this much extra money around it would seem more sensible to expand NHS capacity rather than set up more small units with all the overhead costs.

"And while the new units are supposed to supply extra staff, it's hard to believe they won't be poaching them from the NHS."

PFI: is another costly failure coming your way?



Skye Road Bridge: with the highest Road tolls in the world – £5.70 each way – "the only place in the world where you get mugged and get a receipt"

Glasgow £225m schools scheme: Public Sector Comparator was £35m cheaper until £70m "risk transfer" was added into calculations. Complaints include collapsing classroom ceilings, reductions in classroom sizes

Wishaw Hospital: Almost 200 of 500 non-clinical support staff jobs axed, with services privatised. 130 beds lost in Lanarkshire. £110m hospital will cost £648m over 30 years.

Hairmyres Hospital, East Kilbride: lack of beds, lost patient records, IT failures and structural faults in new £67.5m PFI hospital. Holes in walls, sewage system leaks. Staffing levels cut, staff morale rock bottom

Carlisle: Catalogue of complaints over quality of £87m Cumberland Infirmary: cramped wards, no air conditioning (summer temperatures "hotter than the Sahara", according to local press) lack of space, collapsing ceilings, poor maintenance. Emergency admissions halted July 30 for lack of beds. "Mulberry UNIT" (prefab ward) used for extra bed space.

Halifax: new Calderdale Hospital reported to need redesign and modification to meet requirements of NHS Plan. Trust running deficit despite £10m debts written off. Cost of scheme, estimated at £34m in 1994, had risen to £103m by Nov 2001.

Manchester: New Wythenshawe Hospital cost £89m (against initial estimate of £40m) but will involve payments of £630m over 35 years. Extra cost means that every NHS Trust in Greater Manchester is being told to make 2% cuts.
CHC has complained of secrecy in project planning for new Central Manchester PFI, including Children's Hospital, which has now increased in projected cost from £250m to £300m. Trust now looking at deficit of over £13m a year, compared with expected savings of £2m.

Nottingham: Queen's Medical Centre catering scheme possibly the most expensive small scale PFI scheme of all: £1m capital value, but total cost to Trust £23.8m

University Hospitals of Leicester Trust scheme has massively escalated in cost in two years, almost doubling from £150m to £286m in 2001, and then rising by almost 25% to a staggering latest estimate of £363m.

Neath: £66m PFI hospital built (biggest PFI in Wales): but no information published on value of Neath Hospital site, to be sold off as part of deal.

North Bristol: Small scale (£4.9m) PFI deal in Brain Rehab Unit will cost more than eight times as much over contract period (£42m)

Swindon: £45m refurbishment wound up as a £148m hospital on a remote greenfield site. New Great Western Hospital, with 80 fewer beds, ran out of beds and trolleys within 3 weeks of opening.

Hereford: desperate bed shortages have meant that 1940s hutted wards, due for demolition, are still used. Campaign for extension

New £100m hospital in **Worcester** – brought reduction of over 25% of acute beds in county, including most of Kidderminster's 250 in-patient beds

Amersham Hospital: No space for clinical waste. Bathrooms too small for hoists to lift patients. Penalty clauses invoked after failure of electrical power system.

Dartford (Darenth Valley): Projected cost £97m: eventual cost £137m. 100 fewer beds. Refinancing gave £20m extra to developers. National Audit Commission found there had been no competition, since only one consortium tendered.

Whipps Cross Hospital Trust upgrading scheme has soared in price to £313m, questioning its financial viability.

Norfolk & Norwich Original plan £90m and major bed cuts: later revisions added beds but pushed up costs to £228m. Bed shortage continues, no airconditioning, office temperatures up to 35 degrees.

University Hospital of North Durham, loss of over 100 beds: Trust now admits bed numbers inadequate. Surgery halted for lack of ITU beds on day hospital opened by one Mr T. Blair. New hospital costing £800,000 a year more to run. Repeated problems with flooding and leaks.

Bishop Auckland: Brand new £67m hospital faced with probable downgrading and merger with other local hospitals, losing maternity, children's and major surgical services. No space for medical records.

Middlesbrough: (South Tees) Publicly financed hospital scheme was £29m cheaper, but "risk transfer" estimated at £67.8m to justify PFI funding

NEWCASTLE DSS building: Cost to DSS rose from £0.4m a year to £4m: scheme cost £51m more than previous accommodation. Cost of advisors rose from £250,000 to £3m

West Lothian College, opened in Spring 2002, forced to turn students away and cut staff as result of cash crisis. PFI payments £1.1m a year, plus another £11m over 20 years, equivalent to 13% of College turnover – a "major contributory factor" to cash problems.

Edinburgh Royal Infirmary involves 28% cut in beds, 18% cut in staff costs, massive increase in patient throughput. Restricted car parking charged at £2.20 per hour. The cost of the building is £184m, but the land of the City hospital and the Princess Margaret Rose, sold off for £12m to the consortium, is now worth in excess of £200m. So the land itself could have paid for it!

Lothian PCT has abandoned plans to build new psychiatric hospital with PFI money because it would delay scheme by 2 years.

TRUST OUT OF TOUCH: this sign still directs people to the A&E department at Bart's hospital in East London, even though it was closed eight years ago (Jan 1995) by the Bart's and London Hospital Trust (see below)

Top auditor slams PFI

Early in June the NAO 's deputy controller and auditor general, Jeremy Colman, questioned the way in PPPs, and PFIs before them, have been shown to represent better value for money than more traditional sources of public infrastructure procurement.

Speaking to the Financial Times he argued that much of the financial analysis weighing PPP projects against so-called "public-sector comparators" ranges from the "spurious" through "pseudo-scientific mumbo-jumbo" to "utter rubbish".

"People have to prove value for money to get a PFI (or PPP) deal," he told the FT.

"If the answer comes out wrong, you don't get your project. So the answer doesn't come out wrong very often."

That same month, Audit Scotland published a study of six of the twelve current PFI schools projects – covering schools in Falkirk, Glasgow, Stirling, Highlands, Edinburgh and West Lothian – and found that in all six cases operating costs were higher than a publicly-funded comparison, while borrowing costs were also higher than if the councils had simply borrowed to finance the schemes themselves.

MPs slam PFI

In July the Commons Public Accounts a highly critical report on the first 400 PFI schemes so far signed, effectively arguing that the public sector – and the taxpayer – was being conned.

The Committee 's chairman Edward Leigh MP – a right wing Tory, sympathetic to the private sector – warned that: "In too many cases value for money declines after contract letting, and the approach of many authorities to managing their contracts is seriously deficient."

Accountants slam PFI

A survey of nearly 200 Association of Chartered Accountants members working in the UK public sector, including the NHS, local government, central government, education, charities, the police and prison services, published in October, found that a majority of its members think PFI is such poor value it shouldn't be used.

Only 2% felt strongly PFI was having a beneficial effect on public services.57% did not believe that PFI generally provides value for money.

The same percentage agreed that, as PFI is often the only available source of investment in public services, public sector organisations are prevented from achieving value for money.

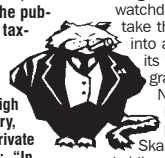
58% did not believe that PFI schemes are objectively tested on whether they provide value for money.

Standards watchdog asked to probe Pett project

A former chief executive of Barts and the London NHS Trust, who has been accused of "unethical" involvement in its £620m PFI scheme, has emerged as project director of the biggest and most expensive privately financed hospital project outside the capital.

Ray Pett was Chief executive of the Barts and the London NHS Trust in East London until 2000, but now works – alongside other former senior managers and a former chairman of the same Trust – for a division of the giant Skanska Innisfree consortium, active on PFI.

Mr Pett's role in Skanska Innisfree's PFI bid to build a new Royal London hospital in Whitechapel was challenged last year by City & Hackney Community Health Council, who declared it "unethical" that former senior managers with detailed knowledge of the Trust should be involved.



The government's standards watchdog has said it will take the CHC's comments into account in planning its future work programme.

Now Mr Pett has been named as project director of Skanska Innisfree's subsidiary the Coventry and Rugby Hospital Company, which has won the contract to build the £359m Walsgrave Hospital in Coventry.

One common factor to both the Barts & London and the Walsgrave PFI projects has been the massive escalation in cost – in each case to almost double the initial projection.

The Walsgrave Hospital was expected to cost £174m at the "best and final offer stage", but has now been agreed at £359m – index-linked fees of £50m a year for the next 35 years.

If costs of the Bart's and London scheme are comparable, this could mean payments of up to £100m a year.

Agenda for Change … unanswered questions

Agenda for negotiation

Geoff Martin, London Regional Convenor, UNISON

AFTER YEARS of delay, ministers in November suddenly speeded up the stalled talks with the health unions over the restructuring of NHS pay – and then rushed out some details of the long-awaited 'Agenda for Change'.

It seems that Alan Milburn, who had been dragging his heels, objecting to any substantial uplift in NHS pay scales, saw an opportunity to do a deal that would drive a wedge between NHS staff and the firefighters, and put pressure on the FBU to agree to "modernisation".

So at the end of November the Department of Health claimed that agreement had been reached on what they described as "ground-breaking reforms to working practices".

Reports have suggested that increases "worth an average 12.5% in basic pay" will be made available over a 3-year period – in exchange for new ways of working. Media reports ignored the fact that the deal was to be phased in over at least three years, and trumpeted the plan as a 10% – or even a 16% – pay deal for health workers.

It seems that many of these estimates are wildly exaggerated. While on face value many lower-paid health workers seem likely to benefit from the move to a £10,100 minimum wage in the NHS, this would not be phased in until the end of 2004.

And while the deal has been promoted as offering a "leg up" for the lowest paid staff, it covers only those directly employed by the NHS – *excluding* the tens of thousands of low-paid staff exploited by private contractors.

Surely the very least that should be included to protect these staff is a "fair wages" clause to ensure that contractors' staff are brought level with those in the NHS.

If this does not take place, the gap between NHS and privatised staff will widen even further. And this in turn will undermine the unions' fight against a 2-tier workforce: it might even encourage more Trust bosses to contemplate privatisation of support services.

What's in it for the lowest-paid?

■ The deal offers an increase of 10 percent over 3 years – 3.2 percent a year, with any extra to come from "flexibility"
■ The NHS minimum wage would rise to £10,100 – but contractors' staff are excluded.
■ Overtime rates for Sunday working are cut to time and a half.
■ The new standardised 37.5 hour working week means many including Admin & Clerical staff will have to work longer
■ Estimates suggest anything up to 15 percent of NHS staff could lose out

Any of the additional increases over and above the 10% over 3 years (a modest annual increase of 3.2%) will be available only in exchange for new "flexibilities", or to a minority who can pass competency tests to move up the new pay scales or onto another band.

(All of the pay levels have been given at 2002-3 levels: the value of each of the pay bands is to go up by 3.225% in April, with similar increases in 2004 and 2005. This raises the question about what will happen to the current pay round, for which the unions have already submitted claims).

Further details of the final proposals, which eventually emerged after after three years of talks between ministers involving 17 organisations and unions representing NHS staff, were promised in January, but now seem likely to be delayed. This makes it very difficult to assess exactly who will win and who will lose under the new formula.

But since the plan is cash limited and revolves around a restricted injection of new money, there will inevitably be losers as well as winners: the *Health Service Journal* estimated that as many as one in six health workers could wind up worse off, while even the Department of Health concedes the figure could be one in twelve – around 100,000 staff.

The health unions failed in their attempt to secure a single pay spine to cover all 1.2 million NHS staff: instead there will be THREE: one for doctors; one for pay review body staff; and another for the rest.

But one of the hugely contentious issues that has not yet been resolved is exactly where all of the multitude of different jobs within the NHS, currently spanning 650 job titles, will be slotted in to the new 8-band pay structure.

This makes it quite impossible to identify for certain who will win or lose on the pay front. Job evaluation will be carried out on the basis of 16 separate criteria, taking account of such issues as skills, responsibilities and mental and physical effort.

DoH handouts were keen to hint that healthcare assistants could be the lucky ones, with a potential rise from their current maximum to £13,485 to a giddy £17,500 in Band 4: but it seems unlikely that many would fit the required "job profile" to reach this level, or whether they would even be put on Band 4.

The complexity of the new gradings could open the floodgates to a new tide of appeals, as happened after the Clinical Grading exercise for nurses and midwives in 1988.

But there is strong pressure from the DoH to cap the number of appeals to a maximum of 10,000 across the whole country. To achieve this, individuals will be denied the right to appeal – only groups of staff will be able to challenge their position on the pay spine.

Paramedics could gain from unsocial hours payments and a reduction in their working week.

For those who stand to lose out, the proposal is that rather than face a cut in their pay, their pay will stand still for up to five years while other grades rise around them: the upshot would be no increase in pay even to keep pace with inflation.

Once the new jobs have been allotted their rank in the pay banding, staff will no longer get automatic annual increments: any increase or progression will require them to learn new skills, or pass a competency test to show they merit a higher level.

The principle of London weighting as a lump sum payment which is of more benefit to lower-paid staff is also to be scrapped. Although some on the lower scales would benefit initially from an increase to a minimum of £3,000 a year, there would be a new link between the 'London allowance' and wages.

Staff would get 20% of salary up to a maximum London weighting of £5,000 – still well short of the £6,000 plus free travel currently paid to the Met police.

Outside London, even in areas where living costs can be nearly as high, the maxi-

www.cpphotos.net

Medical secretaries in Sunderland followed the lead of their Glasgow counterparts and staged successful strikes to win regrading

mum allowance – currently only paid to nurses – will be paid to all staff at just 5% of salary, with a minimum of £750 and a maximum of £1,300.

Trusts will also be empowered to step outside the new pay bands, and offer "recruitment and retention" premium payments of as much as 30% of basic pay to cope with severe staff shortages.

But the deal also involves a standardisation of working hours – to 37.5 per week, making it possibly the first major pay package to lengthen working hours for many people.

Many of those to lose out on this will be Admin and Clerical staff, mostly women. It is not clear how this squares with the claim to be promoting "family friendly" policies.

Staff facing a lengthening of the working week – some by as much as 4.5 hours – will also have it phased in after a period in which existing hours will be protected.

Not enough

It seems that the NHS unions are concerned that while some staff – such as those on the current minimum NHS pay scales – may stand to gain in the deal, for most the basic increases of just 3.2% per year for three years are insufficient to persuade them to accept the many strings attached.

Indeed NHS pay increases for most staff over the last few years have jogged along at between 3-3.6% a year – without any of the strings attached to Agenda for Change, which also include;

- a rolling together of annual leave entitlement and Bank Holidays, and standardised leave entitlements for all staff geared to length of service
- all overtime other than Bank Holidays will only be paid at time and a half, sweeping away the double time for Sunday working that has helped boost many ancillary workers' pay packets. Bank holiday working will be at double time, but it appears that the additional day off in lieu which is currently awarded would be swept away.
- a scrapping of leads and allowances, with the money recycled into basic pay. Instead fixed pay supplements would be calculated on the average amount of work each member of staff is expected to undertake outside normal hours over a defined period. This will be extremely complex for those with varied work patterns.
- and standardised supplements ranging from 2% to 9.5% for staff working on-call.

The scheme is still fiendishly complicated, with managerial advisors warning that even if it is endorsed by all of the relevant health unions it could take years rather than months to sort out the details.

There are doubts as to whether that endorsement will be forthcoming.

While unions and management in the first dozen "pilot" Trusts struggle to work out exactly what the deal means in practice for the workforce, it is clear that initial hopes of being able to flex the deal upwards and secure preferential terms – perhaps establishing a higher minimum wage – at local level are unfounded.

Agenda for Change is above all a *national* agreement, and it would negate the whole purpose of it to allow the pilots to strike local deals that depart from the framework.

Any problems that emerge from the local pilot schemes point to the need to renegotiate the whole structure, not strike one-off deals at Trust level.

Foundations

But of course lurking in the background is the other factor undermining the credibility of Agenda for Change as a national agreement – Foundation Hospitals.

Foundations would be free to set their own pay scales, riding roughshod over any nationally negotiated framework. And though a handful of Trusts will become Foundations in the first wave, many more are likely to follow.

The "national" deal would simply apply to the weakest Trusts, and the whole exercise would be revealed as a colossal waste of time.

Activists in many unions have been distinctly underwhelmed by the amounts of money on offer, and even national officers of some organisations appear to have bottled out of any attempt to sell the deal.

The RCN council is understood to have decided not to take a decision but to ballot members: early motions in from some UNISON health branches appear critical, with one insisting that the UNION should reserve the right to renegotiate on parts of the deal its members reject; and the London health committee of Amicus/MSF has voted to oppose the deal.

While the package may represent a starting point for further negotiation, unless there are some more concessions made, it is likely that given a Milburn-style ultimatum to "take it or leave it", many union members will opt to leave it.

What is unclear is what happens if, after all these years of talks, a few unions vote to accept while others vote to reject. Or if UNISON's ancillary staff, for example, vote in favour, while other staff oppose the scheme.

Much more information is required, and more debate will certainly rage over the pros and cons in the next few crucial months.

But remember: if you're a health worker and want to register a view on the proposals, you have to be in a union: nobody else's views will be taken into consideration.

Scotland shows the way

UNISON has struck a deal with the Scottish Executive which secures pay rises of 12-16 percent for 30,000 low-paid NHS ancillary and other support staff.

14,500 ancillary staff who have been on £4.62 an hour get a 16% increase to more than £5.30. Thousands more low-paid admin and clerical staff get an increase of almost £1,400 – over 14 percent to a new rate of £11,061.

And the bottom three points are to be removed from the lowest nursing grade. Professional and Technical staff also make big gains.

UNISON's Scottish organiser for healthcare, Jim Devine, welcoming the deal, said:

"UNISON is proud to be associated with this step towards ending low pay in the Scottish Health Service."

The deal follows a prolonged campaign by UNISON which secured a £5 minimum wage for NHS staff in the Lothian health district and Argyll and Clyde.

UNISON has also targeted private contractors in Scotland, forcing Sodexho to agree a £5 per hour minimum wage in Glasgow Royal Infirmary, and forcing them out of Glasgow's Victoria Infirmary, by winning agreement that South Glasgow Hospitals NHS Trust would bring back in-house over 250 people cleaning, switchboard, catering and portering staff by 1st November .

The Trust-by Trust strategy has paid off in the agreement to substantial pay increases, and confirmed that the best way to get private contractors out of the NHS is to undermine their profits by ensuring they have to pay wages and conditions at least equal to the NHS.

Who are these right wing bigots?

Many campaigning groups are set up to monitor and report on the more abusive side of life in the global economy; human rights mental health, and many others.

Many do a very good job. London Health Emergency sees itself in this vein.

But occasionally a new group is set up which looks on the surface to be a credible campaigning group. One such group is 'Healthwatch (UK)', who have been running adverts in the national press since January.

The adverts have headlines such as 'Is the national health service safe in his (Alan Milburn's) hands?' Not an unreasonable question. They claim to be independent of all political parties and organisations.

Yet they have an overtly political and racist agenda. They claim that the reason why the HS is in crisis is due to 'people seeking treatment (who) have no knowledge of English and whose origins are in countries without reciprocal health arrangements.'

This is just a thinly veiled attack on asylum seekers – reinforcing the stream of bile poured out by the right wing tabloid press.

Healthwatch (UK), which has apparently spent more than £15,000 so far on adverts, are now being investigated by the Charity Commission.

It is run by a David Homer, who refuses to say where the funding comes from.

Give Healthwatch (UK) a wide berth. You don't know where they've been!

Private patients rip-off Great Ormond St

Private patients owe Great Ormond Street Hospital for Sick Children millions of pounds in unpaid medical bills.

The biggest debtors are international embassies, namely the Kuwaiti and United Arab Emirates who owe £768k and £1330k respectively. But other embassy debts stand at £771k.

The Children's Charity is funding a new extension to the hospital costing £75 million. The Botnar Wing will provide two floors of accommodation for private and overseas patients.

How many donors realised their donations were funding private beds?

Cuts hit West Mid

Managers at a West London hospital are closing wards to save money.

The West Middlesex University Hospital NHS Trust is implementing a cost recovery package which includes closing an Accident and Emergency room to save £100,000.

Other bed closures are expected to save over half a million. They are also freezing posts in nursing and an emergency cardiologists post. One Intensive Care Unit bed was closed to save just £30,000.

Just in case visitors thought they might escape the ravages of the market, increases in car parking charges are set to claw back £35,000, whilst student nurses face increased rent for their student accommodation.

Cuts in night cover

IT'S NOT ONLY firefighters who face the threat of a reduction in night-time services (if the Bain Report is implemented).

Ministers have announced cuts in night cover provided by hospital doctors, raising fears over safety. Instead nurses will take charge of wards outside normal working hours.

The government are exploiting new restrictions on junior doctors working hours under the European working time directive, which limits working to a maximum of 58 hours a week from August 2004.

Nobody doubts that junior doctors work excessively long hours but why has the government done nothing to increase the numbers of doctors available?

In principle, none of the professional organisations seem opposed to giving nurses more responsibility, but when the Department of Health talks of 'breaking down traditional barriers' it means multi-skilling with no extra pay.

Nurses should beware of taking on extra duties, particularly with the current levels of nursing staff available. If anything goes wrong, the government will try to pass the buck.

Bed shortages in Worcestershire have been created by the axeing of in-patient services at Kidderminster Hospital, too few beds in the new Worcester PFI Hospital, and a cash crisis in social services, which has been facing a £4.6m deficit. Fines would only compound the problem.

Fines won't solve bed-blocking problem

The government is planning to penalise Social Services departments which fail to meet targets to reduce "bed blocking" of local hospital wards.

Hospitals will charge departments £100 a day for keeping elderly people in hospital once their treatment is complete.

The government claims that the allocation of extra cash (£100 million a year) to social services will solve the problem, but even some politicians are sceptical as to whether this is new money, or simply double counting.

Many discharges are delayed because of insufficient capacity in private care homes. All nursing homes and most residential homes are now run by the private sector. Government and local authorities therefore have no control over the numbers of beds available.

Help the Aged said;

"Local authorities are not sitting on pots of money, refusing to give people places in homes. They are rationing services, sometimes even waiting for people to die before sanctioning another placement."

Market failure

But who will be responsible when the market won't deliver the sufficient number of beds to enable punctual discharge? And why are local authorities being fined if private providers can't deliver? This is just another example of the madness of the market.

With "benchmark" fees that councils pay for nursuing home placements squeezed by the limited cash for social services, and with costs rising, an estimated 50,000 private care beds have been lost across the country over the past five years.

In areas such as London where property prices are highest, care home owners make more money keeping their properties empty, or selling them on for luxury flats.

Across the country, care homes close at the rate of two per day, whilst at any one time up to 7,000 acute hospital beds are occupied by elderly patients who have no care home allocation.

A Local Government Authority spokeswoman said the plans would be "a spectacular own goal against their stated aim.

"We are all hard pressed to ensure sufficient residential ad community services now – taking more money out of the system, or blaming one part of the system will hardly help."

Nursing crisis deepens

Karen O'Toole

Staff shortages put patients' lives at risk. That is the conclusion of a health inspectors report of September 2002 into the death of a 74 year old patient at London's Whipps Cross Hospital, who died after waiting for more than eight hours on a hospital trolley.

The government's NHS Plan may set out a vision of a health service designed around the patient, but patients cannot nurse themselves back to health. London's acute hospitals alone have a nursing shortfall of over 4000 full time posts.

Even if the government's promises to recruit 20,000 extra nurses by 2004 are fulfilled, the Royal College of Nursing (RCN) claims that more still are needed, and the NHS will need to recruit 110,000 nurses by 2004 even if retirement levels and other losses remain the same.

The RCN claim 22,000 nursing vacancies are covered by temporary or agency staff in NHS hospitals in England and Wales, costing the NHS almost £810 million a year.

The number of registered nurses has been declining since 1997, with only sustained recruitment campaigns overseas stopping a dramatic fall.

But high levels of vacancies and turnover in staff mean that permanent nurses have increased workloads, with many having to supervise agency staff unfamiliar with the wards.

The average age of nurses and midwives is rising: almost half working in the NHS are now over 40, suggesting that nursing is not an attractive career for young people. Around one third of the 24,686 who qualify to register every year do not take-up posts in nursing.

Across London's trusts, the turnover of nursing staff averaged around 30 percent. Pay for nurses is woefully inadequate, even by public sector standards, with both teachers and unqualified police officers getting higher rates.

But the cost of housing in London makes the question of pay even more urgent. In June 2001 the average house price in Greater London was £205,831, meaning that you would have to earn £60,000 – around three times the salary of a staff nurse – to get a typical mortgage.

The 'key worker' scheme sets a target of 10,000 subsidies for key workers in London, but with 4000 nursing vacancies in the capital, the scheme is set to be massively over subscribed.

UNISON rep sacked – for fighting East London PFI

Phil Billows is the UNISON branch secretary of the Barts and London NHS Trust. He was sacked in November last year for 'serious insubordination to management and bringing the Trust into disrepute.'

Phil's crime was that he opposed the massive £620m PFI project the trust is embarking on, the largest in the country, and supported taking strike action to oppose it.

Phil has received huge support from union branches up and down the country since his sacking.

The Trust seem very worried about this, and have postponed his appeal tribunal three times.

Another possible reason for their concern is that two senior managers, who are now being investigated themselves by the Committee on Standards in Public Life for possible conflict of interest concerning the PFI bidders (see inside, p6), submitted evidence to Phil's disciplinary which led to his suspension and eventual sacking.

■ Messages of support can be sent to; The Union Office, Royal London Hospital, Whitechapel, London, E1 1BB.

Rebuilding work at LHE!

As we enter our 20th year of campaigning for the NHS, London Health Emergency has to offer an apology – for the long gap since the last issue of the paper was published last spring – and extend thanks to all those affiliated organisations that have stood by us through a very difficult year.

Throughout 2002, LHE had only one member of staff to cover all of the activity required to maintain a functioning office.

While we were very successful in delivering local publicity and research services to a large number of affiliated branches and regional trade union organisations (including a first-ever newspaper for UNISON's Scottish Health Committee), this was inevitably at the expense of other work, most notably Health Emergency.

However the resources raised by the project work are now being reinvested in strengthening the LHE network. A new part-time member of staff, Karen O'Toole, has joined us.

New: Karen O'Toole

We aim to produce three more issues of Health Emergency this year, revive our London round-ups and media work, and to work with more branches fighting PFI, privatisation and a host of half-baked "modernising" reforms.

We must also thank all those who donated to the appeal from relatives and friends of that doughty campaigner, the late John Courcouf for money to be sent to LHE. We received over £900 – and this enabled John Lister to carry out the research for the forthcoming UNISON pamphlet The PFI Experience (see page 4) – which is dedicated to John. 2003 is a landmark year for LHE: we hope to be able to mark it in style when the anniversary comes around in the autumn. Stay with us – and watch this space for more details.

Old: John Lister

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