HEALTH EMERGENCY

Bulletin of Hands Off Our NHS * No.57 * Summer 2003

INSIDE

As Milburn rebuilds NHS market

Fat cats set to cream off NHS billions

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Resisting the Fat Cats: Whipps Cross Hospital strikers

LHE offers campaign support

As the shortlist of Trusts bidding for Foundation status is announced, it is clear that this coming autumn will see a testing time in many areas as the formalities of a "consultation" process are gone through.

Ministers will avoid giving health workers or local communities any real say in the form of a ballot or referenrdum on foundation status: but the consultation process does give campaigners an opportunity to push the issues into the local media and step up pressure on elected politicians.

London Health Emergency played an active role in launching the Hands Off Our Hospitals campaign, challenging Trust opt-outs and the Tory market reforms from 1989 onwards.

We are now offering our services in helping with publicity and research to support local campaigns against foundation hospitals.

Much of Gordon Brown's long awaited extra NHS billions seems set to wind up in the pockets of shareholders – and top bosses in the new "foundation hospitals".

Like Margaret Thatcher before him, Tony Blair realises that the outright privatisation of the NHS is not politically viable as an option: but while the *funding* of the health service will remain public, through taxation, the *provision* of health care is increasingly being privatised.

On May 13 Blair staged a breakfast meeting in Downing Street with private sector healthcare chiefs. He told them that the private sector bids to run 11 new Diagnostic and Treatment Centres (DTCs), offering fast-track surgery for a variety of waiting list operations, were just the start of a much bigger move to break down the remaining barriers between the NHS and private medicine.

"We are anxious to ensure that this is only the start of opening up the whole of the NHS supply system so that we end up with a situation where the state is the enabler, it is the regulator, but it is not always the provider." (*Guardian* May 14)

While the NHS itself has to deliver those services which the private sector dismisses as unprofitable – such as emergency services – there is a long line of profit-seeking private hospitals looking to cash in on lucrative contracts to deliver a variety of waiting list treatments, and long-term care of the elderly has already been effectively privatised.

The new drive for privatisation is based on a number of key policies, each of which destabilises and fragments the existing NHS.

Foundation hospitals

29 Foundation Trusts seem likely to be rubber-stamped by Milburn to start operating as competitive, but "not for profit" companies from next April. (see centre pages)

A network of DTCs

While the NHS is intended to run 46 Diagnostic and Treatment Centres, 11 have been earmarked for private bidders and another eight would be jointly run by the NHS and private sector.

It is expected that the 65 units will deliver up to 300,000 operations a year, but their impact on existing services and local NHS Trusts has not yet been explored. It is clear that the cash would follow the patient, much of it out of the NHS.

A new market system

Milburn is phasing out the system of block contracts through which Labour curbed the hated and wasteful internal market system created under Thatcher.

Now a new system under which Trusts are once again "paid by results" on the basis of a national tariff of payments (fixed by the Department of Health) ensures that those Trusts which are now struggling to cope with local demand will lose money, and that extra cash flows from them to the best-resourced Trusts.

Health workers will face a new squeeze as Trusts struggle to minimise costs.

A new system of "patient choice"

This encourages patients waiting over 6 months for treatment to choose another hospital – with the money again following the patient. Once again in areas – such as much of London – where the NHS is under greatest pressure, with least spare capacity, this is likely to mean money – and staff — being siphoned out of the NHS and into private hospitals.

Franchising

Management in "failing" Trusts which cannot cope in the new competitive NHS will be 'franchised' – the old bosses replaced by outsiders: this means privatisation, since none of the 3-star NHS hospital bosses have applied for this work.

The combined plan threatens turn the NHS from an integrated public service into a cash cow purchasing care from private medicine, and a safety-net service covering the parts the private sector don't want.

Fourteen years ago when Thatcher floated the Tory market reforms she triggered a wave of protest and high level opposition from the health unions and the BMA.

There were broad campaigns, petitions, meetings, lobbies and protests everywhere against the first Trust opt-outs.

Today the same unions and organisations are equally opposed to foundation hospitals and market-style reforms.

It's time they began to raise the stakes, while there is still a recognisable NHS to defend.

Strikers demand parity with NHS pay

Contract staff at Whipps Cross Hospital in east London have staged a solid 2-day strike in a bid to win pay parity with their NHS colleagues, and staff at Tower Hamlets Health were also due to strike as this issue goes to press.

And in another challenge to private profiteers, more than 300 hospital support staff in Scunthorpe, Goole and Grimsby have staged a second wave of strike action, in a long-running pay and conditions dispute with the private contractor Carillion.

At Whipps Cross, the UNISON members, employed by the multinational ISS Mediclean in catering, portering and cleaning services, submitted a pay claim last sum-

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Up to one in five London nursing posts reported vacant

AN *EVENING Standard* report has shown nurse vacancy levels verging on 20 per cent in London's 30 acute hospital Trusts, while the average figure of just over 10 per cent is hugely distorted by some ridiculously implausible figures.

Interestingly some of the more severe staff shortages are at would-be foundation hospitals – Guy's and St Thomas' Hospital reports an 18 percent vacancy rate, and Moorfields 15 percent, while University College London Hospital has one nursing post in eight (12.5 percent) vacant.

In many cases these figures seem to have been made to look more presentable by counting in bank or agency staff in the totals: but no such tinkering could explain the laughable claim that the crisis-ridden Barnet and Chase Farm Trust has just 0.2 percent vacancy rate. Last summer official Department of Health figures showed Barnet with a vacancy rate of almost 15 per cent.

The *Standard* figures also show Mayday Hospital in Croydon apparently overstaffed by 0.5 percent, while last year Mayday included shifts equivalent to 214 bank staff in order to create a "net vacancy" rate of 1.8 percent.

The underlying problem facing all London's Trusts (and mental health Trusts not covered by the *Evening Standard* survey) is the sky-high price of property in the capital, making it next to impossible for nursing staff (or junior doctors and other vital members of the NHS team) to afford a place to live.

The NHS London weighting has fallen way behind inflation, and the new system of local area weighting to be incorporated into Agenda for Change is also well below the £6,000 flat rate which UNISON and other public sector unions have been demanding.

While the Department of Health dawdles interminably on the publication of its overdue figures on vacancy levels , the *Standard's* figures show that more urgent action is required if some front-line services are not to be subjected to extortionate costs of employing agency staff to fill the gaps.

The great A&E waiting time fiddle

A BMA survey has shown that two thirds of A&E departments in England engineered an artificial and temporary improvement in waiting times during the one week in March for which they were monitored.

● 56% of departments had hired extra doctors and nurses

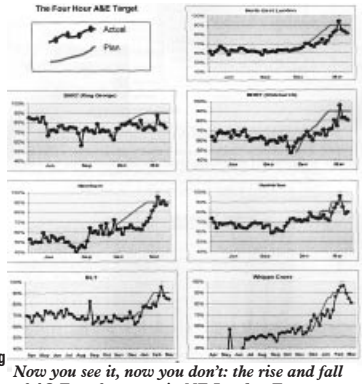
● 25% had forced staff to work double or extended shifts

● 14% cancelled routine waiting list surgery to leave beds free.

■ Up to 90 percent of hospital trusts have misreported their waiting list information, in some cases, deliberately. That was the finding of an Audit Commission report published in March.

They carried out spot checks on 41 trusts last year and found that 90 percent of trusts had serious flaws that raised concern over the accuracy of waiting lists.

While most problems were caused by weaknesses in recording data or outdated IT systems, three trusts were found to have deliberately fiddled the figures. East and North Hertfordshire NHS Trust, Scarborough and Yorkshire Healthcare NHS Trust and South Manchester University Trust either excluded long waiters from the data, incorrectly recorded length of time waited, or 'disappeared' patients from the lists.



Now you see it, now you don't: the rise and fall of A&E performance in NE London Trusts

All the waiting list information published by the Department of Health is provided by Trusts themselves.

But a huge amount of pressure is put on staff to deliver their targets because the figures are used to decide the star ratings for trusts, which in turn decide whether or not a Trust is eligible for Foundation status.

This competition at the heart of the NHS Plan is leading to corruption or corner cutting by hospital managers, and a culture of victimisation and bullying.

3-star hospitals could kill you off!

The controversial star ratings system which measures hospital performance has been slammed as inadequate by an independent review, which points out that 13 of the "3-star" hospitals eligible for foundation Trust status had above average death rates.

Dr Foster, an organisation which compares the levels of staffing and other aspects of hospitals, has drawn attention to the act that none of the key targets for achieving 3-star status is clinical. Instead the focus is on waiting times, cleanliness and financial balance sheets.

"Your husband's dead … but the good news is our star rating is not affected"

Hospitals which fall foul of these measures will receive no stars, irrespective of the quality of care provided by their doctors and professional staff.

Having passed this hurdle, Trusts are then compared with others on another 28 performance indicators, only eight of which take clinical care into account, and only one measures levels of mortality: most are concerned with waiting times, patient satisfaction surveys and management targets on sickness absence.

Dr Foster revisited the star ratings by devising a way of comparing mortality statistics to take account of the different age profiles, diagnosis and severity of condition to ensure that teaching hospitals treating serious illness or those in areas of deprivation or with an elderly catchment are not disadvantaged.

But this revealed that mortality rates in some three-star hospitals were worse than in some with no stars, and that 13 apparently top-flight hospitals had above-average mortality, the worst being Walsall Hospitals (26 per cent above average), Essex Rivers (15 per cent above) and Basildon and Thurrock (12 percent above).

The 1994-5 fight to save the A&E at Central Middlesex was part of a London-wide campaign

Greetings to *Health Emergency* from North West London as we get ready to celebrate the 10th anniversary of the successful Hands Off Central Middlesex Hospital campaign

Agenda for Change: key unions vote for trial run

Medical secretaries battled their way to regrading: but they have not done well in the initial Agenda for Change banding

55,000 copies of the London Health Emergency Fact Sheet on the Agenda for Change proposals for restructuring NHS pay were purchased and distributed by health union branches in England and Wales, giving an idea of the hunger for objective information on the deal that has been 4 years in negotiation.

The 4-page tabloid fact sheet incorporated the most up to date and detailed information available from the first batch of job profiles, and gave a graphic illustration of the comparative pay scales, which were drawn to scale as dramatic red blocks on the centre pages.

A panel listed the 'plus points' argued by those who saw few if any problems with the deal – but also identified some of the unanswered questions and contentious areas which had been raised by those sections of staff who stand to lose out if it is implemented as it stands.

"I've done all the sums, and it will cost me £60 a week," one ancillary steward said as he took delivery of a consignment of the Fact Sheets.

His problem, like many who have calculated that they would be losers, is that he works a lot of unsocial hours and overtime: Agenda for Change is of most benefit to those who work their basic hours and no more.

The snags were sufficient to prevent either UNISON health service group or the health group in amicus-MSF putting the Agenda for Change agreement to a vote unamended.

Only two of UNISON's 37-person service group executive voted in favour of endorsing the deal as it stood, with 33 against. The union's ancillary sector voted unanimously against the package.

In the event both UNISON and amicus-MSF opted instead to seek agreement to press ahead with a "third way" – allowing branches and union officers to proceed with the implementation of Agenda for Change in the pilot Trusts, in the expectation that any anomalies and difficulties could then be renegotiated before the deal is endorsed by a further vote for rolling out at national level.


HEALTH EMERGENCY
Agenda for Change Special Fact Sheet
Agenda for Change
What do you think of it so far?

This is not a million miles away from LHE's conclusion in our last issue that the deal as it stood would be best regarded as an "Agenda for Negotiation".

However the LHE analysis had also drawn attention to the pitifully low basic pay rise – 3.225 percent a year over three years. With inflation currently at 3.5 percent and a further 1 percent deducted from pay in National Insurance since April, this is already a real terms cut in pay.

Nevertheless this has also been incorporated into the deal, and the "third way" composite at UNISON's health conference effectively endorsed it.

After a serious and high calibre debate, UNISON delegates voted by a surprisingly large margin to support the compromise proposal: the membership ballot has just concluded as we go to press. A ballot on the same lines in amicus-MSF delivered a 3-1 majority to proceed.

Elitist

As might have been expected, some of the elitist health unions with no record of fighting on NHS pay, have gone much further: the Royal College of Nursing, which knows little and cares less about any other sections of NHS staff, voted by a thumping 88 percent to endorse Agenda for Change – only to hear their leaders admit afterwards that they were still not clear on the small print or whether enough money was available to fund the full deal.

For UNISON in particular – as the only healthcare union representing all sections of staff – it is vital to get the package right. Opinion within the union has sharply polarised.

Many members have been understandably angry at the notion in the wording of the agreement which states that it will only be deemed to have run into problems if in the pilot Trusts more than 8 percent of staff are losers: for UNISON this is equivalent to more than 30,000 members. They pay their dues expecting the union to defend them and fight to improve conditions, not to negotiate a cutback.

While some who stand to gain from the deal may be willing to accept that others lose out, their arguments carry little weight with those – especially on the lowest pay bands – who face at best a 5-year pay freeze, or even a reduction in real terms pay.

How would those who gain from Agenda for Change feel if *they* were among the losing 8 percent, with everyone else telling them to support it?

UNISON cannot afford to give the impression that it has two tiers of membership, or that the pay and conditions of some sections of staff can be subordinated to benefit others.

Many activists feel very strongly that no deal should be endorsed until there is a clear and proven guarantee that all staff will at least maintain their current levels of take-home pay.

Much now depends on how the scheme is developed, with large numbers of job profiles yet to be published, and the hugely complex task of implementing the scheme likely to soak up vast amounts of management and union time.

Even if all goes according to plan, and the scheme is endorsed by further ballots next year in UNISON and amicus-MSF, implementation of the deal would not begin until the autumn of 2004.

In the meantime unions will need to be vigilant against management attempts to put off harmonisation and regrading issues, and will need to build their strength in readiness for the challenges to come.

STOP PRESS

The UNISON ballot to endorse the pilot projects testing out Agenda for Change has just concluded, with over 80 percent voting in favour of the "third way" proposal.

However the turnout of just 22 percent means that just under one in five of UNISON's health members have registered support for the recommended policy.

Clearly negotiators will be under pressure to deliver results before the next ballot.

Carlisle: women lead charge on low pay


CARLISLE
Don't get sore ... get EQUAL!
UNISON's EQUAL PAY BREAKTHROUGH

A ground-breaking victory for women workers at Carlisle's Cumberland Infirmary, overturning 50 years of institutionalised sex discrimination, has been met by a wall of silence from the Department of Health.

UNISON's successful legal battle for equal pay for work of equal value brought a dramatic collapse by the employers, and will mean increases of £8,000 a year for a D grade nurse, and £4,000 a year plus a 2-hour cut in the working week for a qualified cook – all backdated for 12 years.

Karen O'Toole and John Lister from London Health Emergency travelled to Carlisle to meet some of the staff involved and UNISON Regional Officer Peter Doyle.

This pamphlet tells their story, and shows how other public sector staff can pick up and use the work already begun at Carlisle to pursue their own equal pay claims.

Single copies £1.50, ten or more £1 each, cash with order only, from LHE, Unit 6, Ivebury Court, 325 Latimer Rd, London W10 6RA

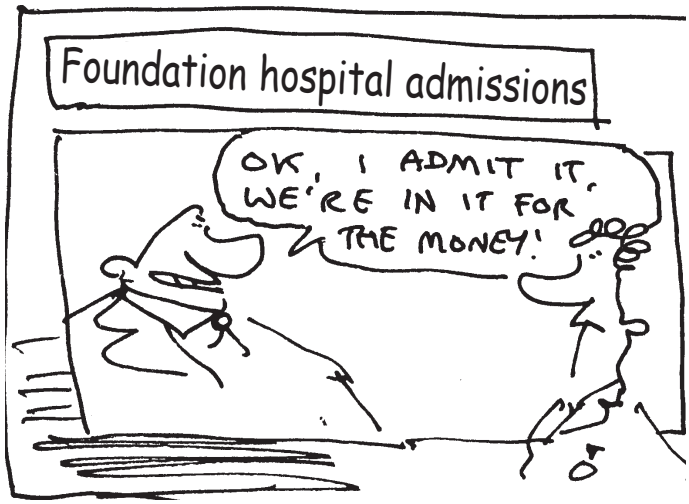
Commons revolt on key vote muted by Tory antics

Just 63 Labour MPs voted against Foundation hospitals in the eventual Commons showdown.

Many more who had declared their opposition had effectively been neutralised by government promises that details could be sorted out in the Bill's committee stage, and by warnings that they might wind up in the same lobby as Iain Duncan Smith's opportunist Tories, voting against Milburn's plan because it does not go far enough.

In the event the Tories voted against the Bill, but only abstained on the key amendment on Foundation hospitals – while the fraudulent promise of scrutiny at the committee stage has been effectively sidelined by the decision to stuff the committee with Blair loyalists who endorsed the original proposal.

Once again we face the bizarre situation where any serious scrutiny of a Bill has been left to the unelected House of Lords.

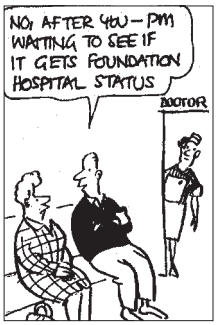


Spain, Sweden count cost of foundations

Foundation hospitals in Spain are accused of creaming off the most lucrative short-stay patients, and leaving the more complex, costly and unpredictable work to the mainstream health service hospitals.

This way they get to appear very efficient, and also retain a surplus that can be used to pay more money to top bosses and doctors. Spanish foundation hospitals are free to borrow money – and issue shares. They are private companies, though most of their income flows from Spain's national health service.

● The best-known foundation hospital in Sweden, St Goran's in Stockholm, was privatised by its board – and sold off to the private hospital company Capio, which is now in the bidding for more NHS contracts in Britain: the Swedish government immediately passed new legislation to prevent further privatisation of hospitals.



New Boards, same old bosses

Foundations' Boards of Governors will have to include at least one "representative" of service users elected by "members" who pay £1 per head to join the Foundation, and one representative from the hospital's staff: each Foundation will be free to set their own rules for the election of governing bodies.

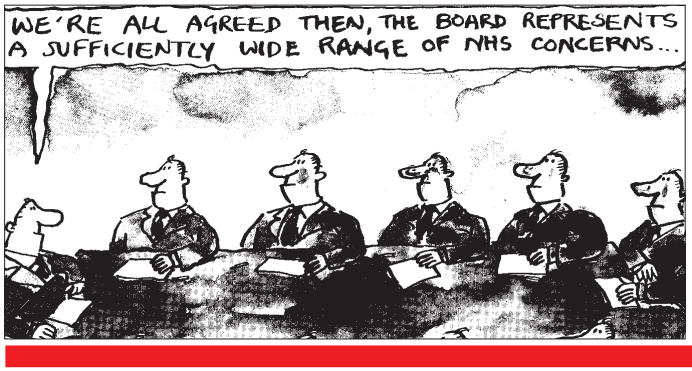
But don't be fooled by the talk of "local democracy". Behind the window-dressing of a local "stakeholders" group, the day to day decisions will be taken by the same old board of executive directors – or the "non-profit" label: foundations will be encouraged to act just like for-profit firms, in an 'entrepreneurial' way, striking deals with private sector companies.

Foundation Trusts that wish to borrow money for expansion will be obliged to compete against other NHS Trusts for additional contracts to raise the money to pay back the bankers.

Ministers have hinted that Foundations will be permitted to borrow up to 30 per cent of their annual turnover – which could be as much as £100 million for a larger teaching hospital.

However such borrowing comes at a heavy price: one accountant has calculated that to service borrowing equivalent to a quarter of their turnover, foundations would have to double their income.

This will add pressure on Foundations to compete more strongly with other local Trusts.



CHI warns against excess of reforms

The Commission for Health Improvement and the Audit Commission have been among the less likely organisations to challenge Milburn's Foundation Hospital scheme: but both have made clear their doubts that the "reforms" will deliver the promised improvement.

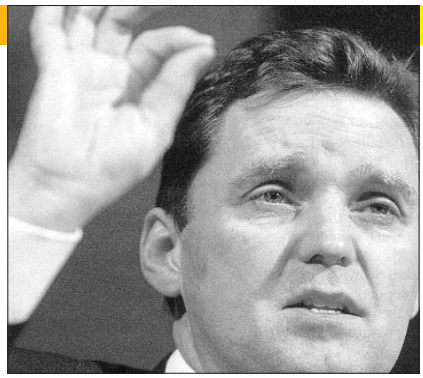
CHI chair Dame Deidre Hine has told Tony Blair that managers are already "punch drunk" from a succession of non-stop reforms since 1997, and that the pressure on top bosses was such that it was becoming difficult to recruit senior executives.

A CHI report on the state of the HS has warned that the limited improvements that have been made could be put at risk if the government keeps moving the goalposts and setting new targets.

Meanwhile the Audit Commission chair, James Strachan, has questioned whether Trusts have sufficient managerial expertise to take on the new freedoms offered to them by Foundation status. He points out that the rating system which qualifies a Trust to apply to become a Foundation assesses hospitals on very different basis – and has been running since well before this latest scheme was announced.

His warning has been underlined by the fact that three of the original 32 3-star Trusts which expressed an interest in Foundation status – East Cheshire, Frimley Park and the Royal National Hospital for Rheumatic Diseases had been deleted from the short-list of applicants by the Department of Health because they were not seen as sufficiently financially viable.

Mr Strachan has called for "strong regulation" of Foundations, and expressed concern that another department and a new regulator had been set up to carry out this work, rather than the Commission for Healthcare Audit and Inspection which examines other hospital Trusts.



Mr Milburn shows how much notice he takes of his critics

MPs warn plan could end in tiers

The Commons Health Committee pulls its punches in its analysis of Foundation Hospitals, but still concludes that the scheme could be divisive, and result in Foundation hospitals "poaching" key staff at the expense of their non-Foundation neighbours – especially in areas like London.

The MPs argue that far from slashing bureaucracy, the Foundations will be answerable to a new regulator, government hospital inspectors, the Primary Care Trusts which commission their services, and a new Board of Governors.

The committee points to the danger that foundations will widen inequalities by giving more resources and freedoms to the best resourced Trusts at the expense of those struggling to cope. If the money follows the patient, Foundations will attract extra business and revenue while other Trusts see their contract income reduced.

The all-party committee also questions whether it will be possible to meet Alan Milburn's pledge that all Trusts will be raised to foundation status within five years, and questions whether there will be any incentive for foundation trusts to improve their performance.

And an underlying concern is that a new reorganisation focusing heavily on hospitals and acute services is likely to tilt the balance back away from the previous emphasis on primary care and community services.

■ While Alan Milburn insists how bold, new and radical his reforms are, we might recall that the original Tory notion of Trusts which preceded Foundations was based on the post-war teaching hospitals – which under Nye Bevan's National Health Service initially retained their independent 'boards of governors', and preferential allocations of cash.

These went when both Tory and Labour governments recognised the need to distribute hospital investment more evenly, and to target areas of deprivation rather than to humour the reactionary elitism of a handful of consultants.

Milburn's shortlist

The 29 applicants being considered for foundation Trust status next spring are:

- **Addenbrooke's, Cambridge**
- **Aintree Hospitals**
- **Basildon & Thurrock**
- **Bradford Hospitals**
- **Calderdale & Huddersfield**
- **City Hospital Sunderland**
- **Countess of Chester**
- **Doncaster and Bassetlaw Hospitals**
- **Essex Rivers Healthcare**
- **Gloucestershire Hospitals**
- **Guy's and St Thomas' Hospital**
- **Homerton University Hospital, Hackney**
- **King's College Hospital, London**
- **Moorfields Eye Hospital, London**
- **North Tees and Hartlepool**
- **Nuffield Orthopaedic Centre, Oxford**
- **Papworth Hospital, Cambridge**
- **Peterborough Hospitals**
- **Rotherham General Hospitals**
- **Royal Devon and Exeter**
- **Sheffield Teaching Hospitals**
- **Southern Derbyshire Acute Hospitals**
- **Stockport NHS Trust**
- **Newcastle upon Tyne Hospitals**
- **The Royal Marsden, London**
- **The Queen Victoria Hospital, Sussex**
- **University Hospital Birmingham**
- **Walsall Hospitals**
- **University College London Hospital**

Foundation Hospitals compared with Trusts

The idea of foundation hospitals is very similar to the original conception of Trusts as put forward in the Thatcher government's White Paper Working for People in 1989. And although some of the more extravagant excesses of the Blair-Milburn proposals have been sacrificed in order to win Labour back-bench support, the essence is still very much the same. Yet the foundations would in some ways have more freedoms than Thatcher's Trusts. See how they compare, point for point

Trusts

- "Opted out" of health authority control, but 'owned' by Secretary of State.
- Part of a wider market-style reform.
- First wave began with 50 Trusts, but eventually all NHS providers became Trusts.
- Became "public corporations", each with a chair and five non-executive directors appointed by the secretary of state.
- Despite the promise that they represented a step towards "local control", the boards were to meet behind closed doors, and obliged to hold just one public meeting each year: not until 1997 did Labour ministers compel Trust boards to meet in public.
- Funding dependent on winning contracts from health authorities and fund-holding GPs in an annual contracting round. Obliged to compete for contracts with other Trusts
- Obliged to balance their books and to deliver a 6 percent return on their assets.
- Trusts were to be free to expand private medicine, and many invested in new pay beds and private wings.
- Free to retain surpluses: but also "free" to go bankrupt: ministers insisted that they would not step in to rescue those that failed in the new NHS market.
- Free to fix local pay and conditions for staff, replacing national pay scales. Free to sell surplus property (and encouraged to do so by the introduction of capital charges on assets). Prohibited from mortgaging their assets.
- Original plans giving Trusts freedom to borrow were effectively abandoned, leaving Trust borrowing restricted by an "external financing limit".

Foundations

- "Opt out" of control by strategic health authorities and the Secretary of State.
- Part of a wider market-style reform.
- First wave to begin with up to 29 Foundations, but all Trusts are promised the right to opt for Foundation status.
- Foundations will be "not for profit" companies (or "public interest companies"): this opens the possibility of private "non-profit" organisations (such as BUPA) bidding for Foundation status.
- Foundations will nominally be run by a Board of Governors, But in reality control will remain in the hands of the unelected Management Board, which will be composed of existing and new full-time directors.
- Funding will be dependent on winning contracts from Primary Care Trusts, on the basis of work done (on the principle of the "cash following the patient") — giving an advantage to the best-resourced Trusts, but also pushing Foundations into competition with neighbouring Trusts.
- Foundations will be obliged as businesses to balance their books.
- Foundations will not be allowed to expand private medicine, although some are already rushing through expansion plans before they get Foundation status, and others are looking to work with private medical companies.
- Foundations, like Trusts will be free to retain surpluses, but Gordon Brown has pointed out that the government would ultimately be obliged to step in and bail out any Foundation that ran up huge losses.
- Foundations will be free to fix local pay and conditions for staff, replacing national pay scales, although they are all likely to begin from the framework of the new Agenda for Change system which ministers want to operate from the end of 2004.
- Original plans giving Foundations freedom to borrow in the private markets were effectively abandoned. Instead their right to borrow will be subject to the decisions of the regulator.
- Any borrowing by Foundations will be from the total capital available to the NHS, so any preferential treatment for them will be at the expense of other Trusts.
- Foundations will be subject to a "lock" on their core assets, preventing them from selling them or using them for non-health purposes without permission from the new regulator. Nor will they be allowed to mortgage their assets.
- Foundations will have no shareholders to distribute profits to, but are expected to work in an "entrepreneurial" way – and are free to work 'in partnership' with private companies which can generate profits and give them to shareholders.

Andrew Wiard

Trusts were strongly opposed as an attack on the NHS: Foundation hospitals are set to be even more damaging

Worcester's PFI-funded Royal Hospital: a big space in the foyer, but fewer beds, cook-chill food, narrow corridors and "office staff working in cupboards"

British privateers take quality off the menu

A recent ***Observer*** feature article comparing British and French hospitals refers to the "hotel" feel of the "wide airy spaces" in St Philibert's Hospital in Lille.

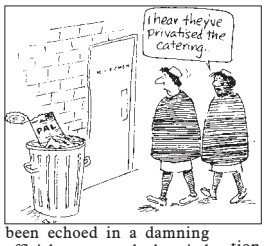
But this is not only a contrast with the older stock of pre and post-war NHS hospitals: it is perhaps even more different from the wards and corridors of the new generation of PFI-financed hospitals, most of which have been planned to offer the minimum possible floor area, as a new report for UNISON — ***The PFI Experience: Voices from the front line*** – makes plain.

Researched for UNISON by John Lister of London Health Emergency, this 48-page pamphlet consists of first hand accounts by staff – porters, cooks, domestics, nurses, admin and clerical and many others – of what it feels like to work in these new buildings, which have been widely portrayed as the very latest in innovative and cutting edge design.

In practice the wide airy spaces tend to be confined to large glass atrium areas around the front entrance, while wards, corridors and above all office space are cramped, poorly ventilated and uncomfortable places for staff and patients alike.

The eagerness of nursing staff at England's first PFI hospital, the Cumberland Infirmary in Carlisle, to switch from a ward in the new building to the portakabin outside the main entrance that now provides some of the additional beds to cope with demand is just one example of the way in which the new buildings have skimped on quality in the working environment.

The same findings have been echoed in a damning official report on the hospital by the Commission for Health Improvement, which points out that patients have complained about the lack of space and privacy in the £87m hospital, where ward areas are cramped and ward corridors are too narrow for three people to walk abreast.



But another feature is that the new PFI hospitals like Carlisle are generally being built without kitchen facilities on site: instead they rely on supplies of "cook-chill" meals, often transported hundreds of miles.

Again the comparison with French hospitals shows how standards have been sacrificed here in the desperate rush towards privatisation and profits. Observer correspondent Jo Revill reports a telling exchange:

"Do you have a cook chill service?" asked one of the British dieticians to the French caterer. "No of course not," the woman replied indignantly. "How would patients get heir fresh vegetables if we didn't prepare the food properly in our own kitchens?"

The PFI experience

Voices from the front line

A 48-page pamphlet presenting interviews with staff in 9 PFI hospitals and lifting the lid on the scandals and cock-ups ministers want to hide

Researched for UNISON by John Lister of London Health Emergency.

Copies available from UNISON Positively Public campaign. Single copies (£1.20 postage) from LHE, Unit 6, Ivebury Court, 325 Latimer Rd, London W10 6RA. Or download from UNISON or LHE websites: www.unison.org.uk or www.healthemergency.org.uk

Strikers demand parity with NHS pay

(continued from front page)

mer seeking parity with NHS staff employed doing similar work.

They rejected an offer made by the company, which did not offer parity until April 2006.

On top of the pay claim submission, UNISON has lobbied the Whipps Cross NHS Trust and the North East London Strategic Health Authority, to put more money into the contract with ISS Mediclean.

The UNISON members in Scunthorpe, Goole and Grimsby – who work as cleaners, porters and caterers at three hospitals – started a five-day strike on June 28. This follows earlier strike action and an overtime ban, in a dispute which goes back to the beginning of April.

The union is demanding a pay increase, from the current minimum of £4.25/hour to a minimum of £5.02, and parity with staff colleagues employed by the NHS.

The industrial action follows the members' overwhelming rejection of a pay offer from Carillion.

The company has now approached ACAS in a bid to resolve the issue.

The union has urged the North Lincolnshire and Goole NHS Trust, which is responsible for all of the hospitals affected, to intercede on the workers' behalf.

The company announced profits of more than £50 million last year, and paid one director a bonus on top of his wage of £140,000.

These battles for pay parity follow successful strikes by UNISON health members employed by contractors in Scotland and in Swansea.

Milburn head-hunts private bosses

In another re-run of a failed Tory policy, the NHS is also mounting a new campaign, "head-hunting" private sector managers from industry and elsewhere – exactly the mixture of misfits, retired colonels and bully-boys that achieved so little for such high salaries during the Thatcher years.

Patients and visitors count cost of congestion charge

Great Ormond Street Hospital reports that since introduction of congestion charges, more than 50 percent fewer patients have been claiming parking permits.

The Central zone within which the £5 per day travel charge applies covers six major hospitals – UCLH, Bart's, Guy's and St Thomas's, Moorfields Eye Hospital and Great Ormond Street Hospital for Children.

All six are specialist or teaching hospitals, receiving patients not only from London but from throughout the South East and other parts of Britain.

Between them they receive upwards of 1.3 million outpatient attendances a year, all of them on weekdays during the hours for which the charge will be levied, and admit around 250,000 inpatients, many of whom are in hospital for some time for specialist treatment, and therefore likely to expect visits from friends or relatives.

Even when patients satisfy hard-line requirements to show they are too ill to travel by public transport, they can only claim reimbursement of the Congestion Charge through the NHS Trust they are visiting, and this will land a hefty new administrative burden on the Trusts.

Edinburgh: the case of the vanishing beds

THE SCALE of the hospital bed reductions embodied in the first round of PFI-financed hospitals has been a constant source of embarrassment to ministers.

They have attempted to argue – in the face of all the evidence that the closures were on a scale unprecedented in the NHS – that the bed cuts were the result not of PFI but of 'clinical' decisions in which consultants were involved.

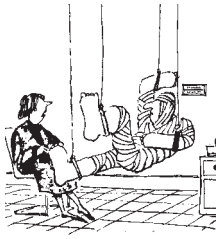
Now, with the full opening of the new £180m Edinburgh Royal Infirmary, the leading academic opponent of PFI, Professor Allyson Pollock has got together with Glasgow academic Matthew Dunnigan to explore the loss of beds involved in Scotland's biggest PFI hospital.

In a devastating article in the *British Medical Journal* (April 26) they conclude that:

■ The Edinburgh PFI was based on a reduction of 24 percent in acute beds – as a result of the new hospital being smaller and the closure of five other acute hospitals.

■ But at the same time, the target was to achieve a massive 21 percent increase in hospital admissions by 2002-3.

■ By 2001 over 80 percent of the bed closures had



been achieved, but admissions had risen by just 0.3 percent, while surgical admissions had fallen by 13 percent.

■ Patients were staying on average longer in hospital because only the most severely ill were being admitted as a result of bed shortages.

■ The promised expansion of community hospitals and services in the surrounding Lothian area had not taken place.

■ Edinburgh had 7 percent fewer nursing home places, while places in the rest of Scotland had increased, and the closure of NHS elderly care beds had been more rapid than in the rest of the country.

■ Both Lothian and Lanarkshire, the two Health Boards containing PFI hospitals, had seen a far more rapid closure of acute beds since 1995 than the other 13 Scottish Health Boards: closures had run at 20 percent in Lothian and 14 percent in Lanarkshire, compared with 7.8 percent in the rest of Scotland.

■ To make matters even worse, the expected financial savings had not materialised, leaving the Lothian University Hospitals Trust facing a major shortfall, and needing to slash a massive £25.6 million a year from its budget by 2006-7.

Dunnigan and Pollock warn that the unresolved financial problems could have a long-term knock-on effect on other services in Lothian or, if the Trust has to be bailed out, throughout Scotland.

Meanwhile even as they defend these first wave PFI fiascos ministers have changed line, and have now insisted that new PFI schemes should have as many or even more beds than the hospitals they replace.

The impact of this has been to force the costs of the next round of PFI hospitals sky-high – raising serious problems of affordability for the Trusts involved.

All in all, the evidence makes clear that PFI is exceedingly expensive and rotten value for money.

● **Edinburgh is one of the PFI hospitals covered in *The PFI Experience* – see p5**

UNISON

South London and Maudsley Health Branch

Campaigning with LHE to keep mental health on the agenda

Union eyes

UNISON ● UNISON South London & Maudsley Trust Branch bulletin ● No. 12 ● Autumn 2002

As Trust heads for £7.5m deficit, union warns

MIND the GAP!

A&C staff press for more respect

Interview with Chief Executive Stuart Bell - centre pages

BRIAN LUMSDEN Secretary, **LEE ROACH** Chair

Union office, Bethlem Royal Hospital, Monks Orchard Rd, Beckenham, Kent BR3 3BX

Firms queue up for DTC deals

Diagnostic and Treatment Centres (DTCs) are expected to attract a growing share of the "elective" (waiting list) cases currently in the queue for treatment in over-stretched NHS hospitals.

As small units detached from any A&E services, the theory is that DTCs would be able to maximise the numbers treated without the disruption of finding beds for emergencies.

Private companies bidding for DTC contracts have to guarantee that they will bring in the staff needed to run the entire operation, without poaching scarce professionals from the NHS: this inevitably means that they are based abroad, one of them in South Africa, where Britain has previously promised the government it would no longer poach scarce nursing and medical staff.

One Canadian company bidding for DTC work has joined up with Jarvis – a British firm embroiled in private contracts ranging from rail maintenance to school and hospital PFIs.

Trusts run up record debts

Bristol

North Bristol NHS Trust, which runs Southmead and Frenchay hospitals, is to face an independent inquiry into its runaway deficit, which rocketed from a projected £11.6m in November to £44.3m at the end of the financial year.

The Trust is now projecting a further £38m deficit this year – well over 10 per cent of its £300m budget, and has warned that it will take at least five year to balance its books.

However it seems that maybe North Bristol was just following in line with its local Strategic Health Authority, Avon Gloucestershire and Wiltshire, which has been branded "incompetent" by the district auditor after notching up its own breath-taking £59m deficit. This might have been even higher if not for £45m in Department of Health handouts over two years.

Oxford

Oxford's spendthrift Radcliffe Hospitals Trust is forging ahead with a £125m PFI-funded scheme that will cost £20m a year, despite struggling with a ballooning deficit fuelled by agency

nursing bills.

Last year the Trust ran up a £20m shortfall, and was spending a massive £1.2m each month plugging gaps in the nursing workforce: a similar deficit is expected for this financial year. Despite near-London prices for housing in Oxfordshire, health workers receive no London-style weighting to compensate.

At the end of March it was announced that the Trust was to spend half the £40m proceeds from selling off the Radcliffe Infirmary site on clearing its overspend, leaving no capital for investment in the new building.

Campaigners have likened this to "selling your garden to pay the gas bill", and called on the Trust to pull out of further talks on an "unaffordable" PFI scheme. Instead health chiefs are urged to link up with local campaigners to lobby for NHS funding for the new hospital wing.

St George's Hospital, Tooting, has been one of the SW London hospitals under constant pressure during more than 20 years of under-funding

Under-funded, under-bedded, under pressure

THE CHRONIC cash crises facing the main hospital Trusts in South West London – Epsom/St Helier, St George's and Kingston – are the result of years of under-funding of health services going back to the 1980s, according to a detailed report by London Health Emergency for the Battersea and Wandsworth TUC.

The area has now received a below-average increase in spending for the next 3 years, with Wandsworth facing an estimated £5m shortfall as a result of a new funding formula.

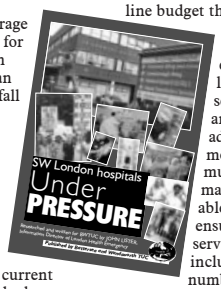
The SW London Strategic Health Authority calculates that more than 300 extra beds are required to meet local pressures over the next 3 years, but current plans fall almost 200 beds short of this – forcing health chiefs to contemplate sending local people to out-of-area NHS Trusts or costly private beds in order to meet government targets.

The situation has been compounded in April by the imposition of the government's new 'Patients Choice' policy, which will encourage patients who have been more than 6 months on waiting lists to opt for treatment elsewhere: given the lack of local capacity in SW London, this will inevitably siphon even more cash out of the budgets of local Trusts.

The report concludes by offering a number of recommendations:

Runaway costs of employing agency staff to plug gaps in the full time NHS workforce have to be tackled: this requires a fundamental rethink of government policy, including a substantial uplift in London weighting and a further increase in the pay for all grades of nursing staff, as well more flexible and family-friendly policies to enable Trusts to retain and attract back nursing and other staff who prefer to work part-time or particular hours to suit family responsibilities.

There is an urgent need for a thorough and independent audit of the financial situation in all local NHS Trusts, to establish a realistic baseline budget that will sustain the necessary level of services – and the additional money must be made available, to ensure that services – including bed numbers – are expanded as required on a stable and sustainable basis.



Any planned deals with private hospitals should be abandoned, and priority should be given instead to the most rapid expansion of local NHS capacity, alongside longer term plans for the renewal of old and obsolescent buildings.

PFI schemes should be abandoned as too costly and inflexible to suit the needs of the NHS. Instead the government should make NHS capital available – if need be as a long-term low-interest mortgage – for the further upgrading of Epsom, and a new publicly-funded hospital to replace St Helier, together with local treatment centres to complement the services already available in smaller local hospitals.

■ The latest ill-conceived plans to replace Epsom and St Helier with a single PFI-funded hospital to cover 800,000 people would have dire knock-on consequences for overstretched services at St George's, Mayday and Kingston, UNISON has warned in a hard-hitting response to management plans backed by Merton and Sutton TUC and by LHE.

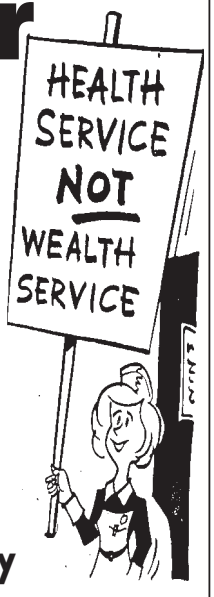
The most likely location for a single site hospital, the Sutton Hospital site, is too small to accommodate the number of beds and other supporting services that would be required to deliver adequate care to such a large catchment population.

The financial consequences for a health economy that is already reeling under existing pressures would also be disastrous.

UNISON

Epsom & St Helier
Health Branch

Keep our public services public!



ANNIE HOLNESS, Chair
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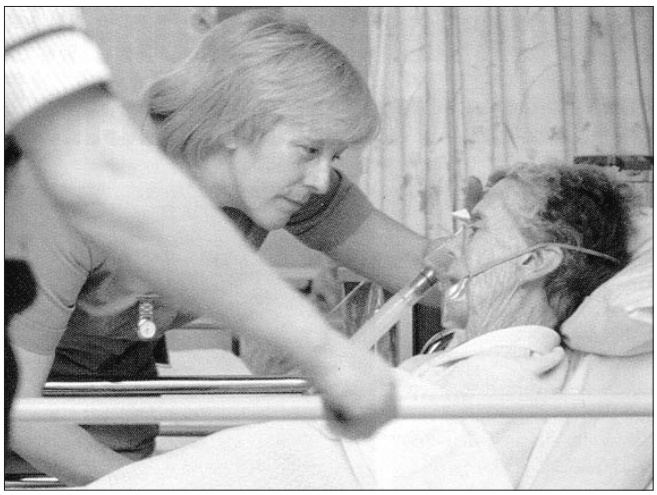
Contact: The Branch Secretary, Leeds Teaching Hospitals Branch 13352, Union Office, Trust Headquarters, St James University Hospital, Beckett St, Leeds LS9 7TF

Health and social services pass the buck

It's chaos in the community



A suitable case for real modernisation: the continuation of Tory "community care" policies means more older people are staying longer in hospital as nursing homes close

TEN YEARS after the Tory government's reactionary "community care" reforms effectively privatised the lion's share of continuing care services for frail older people, the crisis in long-term care keeps rumbling on.

Even as it pushes through legislation that would fine social services departments that failed to provide community care services for older people awaiting discharge from hospitals, the New Labour government is now being accused by campaigners of conniving with health authorities to deny vulnerable patients the NHS-funded care they should be entitled to.

Around 25,000 people at any one time are now paying fees for places in nursing homes who 20 years ago would have been entitled to free NHS care: and instead of acting to resolve the problem, Labour ministers are making things worse.

The Tory reforms, drawn up by Sainsbury's boss Sir Roy Griffiths back in 1988, but implemented from 1993, set out to ensure that older people with savings or property would be have to pay some or all of the cost of their care – and therefore transferred responsibility for continuing care from the NHS (where services are free at point of use, funded through taxation) to social services, where historically means-tested charges have applied.

Sell homes

From the outset the scheme caused anger and chaos, with an estimated 40,000 people a year being forced to sell their houses to fund their own care.

Two years later, health authorities were required to draw up "eligibility criteria" – more accurately exclusion criteria – to define exactly what medical conditions would qualify a frail older patient to NHS-funded care.

Many draconian measures were floated, including the notorious (and later abandoned) proposal in Cambridgeshire that a patient might be eligible for NHS care if likely to die "within two weeks". Many similar clauses have remained in force seven years later.

On the basis of these wholesale exclusions, many Trusts and health authorities have set out to close down local NHS beds for the elderly – regardless of the level of availability of nursing and residential homes. The result has been an ever-upward spiral of older people admitted to front-line hospital beds as medical emergencies.

In opposition Labour at first welcomed the Tory proposals as an extension of social services, then belatedly recognised them as a "poisoned chalice", and in the run-up to the 1997 election promised to set up a Royal Commission on long term care.

But when this Commission eventually reported, Ministers in England refused to implement its clear recommendation that all nursing and personal care should be free of charge.

Instead the government announced that only care by a registered nurse would be covered, and that each patients' needs would be assessed to determine how much nursing care was required – with three bands to choose from at £40, £75 and £120 per week.

Avoid paying

But health authorities have gone to absurd lengths in their efforts to avoid paying the full cost of nursing care even for patients with substantial health care needs.

In 1999, North and East Devon health authority, challenged over their treatment of a severely disabled 50-year old woman, Pamela Coughlan, tried to describe as "general care" services a long list of obviously medical services, including:

- artificial feeding
- continuous oxygen therapy
- wound care
- pain control
- administration of medication
- catheter care
- bladder wash-outs
- tracheostomy

The health authority lost the case, and the court ruled that where a patient's needs are primarily health care, then the NHS should pay the whole cost of their care.

But rather than issue clear instructions along these lines, the Department of Health has tried to duck its responsibility through introducing its partial system of paying for "nursing" care, while effectively encouraging local NHS organisations to deny vulnerable people their rights.

But while the battle over funding continues, the government's tight cap on social services spending has held down the fees payable for nursing home and residential home places. In Lincolnshire, private care home bosses calculate that there is now a gap of £35 per person per week between the amount they need to be viable and the amount paid by the county council.

Bed losses in care homes are running at an estimated 20,000 a year.

Meanwhile a coalition of three charities, a solicitor and a former director of social services has warned that the latest twist of government policy – seeking to reduce the numbers going into care homes, triggering more closures – is causing hundreds of premature deaths.

A joint call by Relatives Action Group for the Elderly (RAGE), Elderly People in Crisis (EPIC) and Independent Community Care Management warns that a perverse effect of the government's policies is that more older people stay longer in acute hospital beds.

The coalition are seeking a meeting with health minister Jacqui Smith to discuss ways of halting the home closures.

20 years on – and still campaigning!

AUTUMN 2003 WILL BRING the 20th anniversary of London Health Emergency, and we are planning to mark the occasion by stepping up the campaign against the restoration of the "internal market" system, Foundation Hospitals, PFI and privatisation in all its guises.

LHE has survived this long because – no matter who has tried to shut us up – we have stuck to the basic principles of defending the NHS as a public service, free at point of use, and a service which can only deliver quality care if it has sufficient staff, decently paid and fairly treated. It is this principled stand that has won us the solid support we have been so pleased to receive from health unions and from local campaigners and activists.

Since New Labour took office, we have been stripped of all the funding we once received from local government, and we are now entirely dependent upon research, project work and LHE's publicity services in order to finance and staff the office – and on affiliation fees and donations to produce and distribute the newspaper.

So it's a big thankyou to those union branches that have taken out adverts to help us fund this issue – and we urge all affiliated organisations to consider taking an advert in the next, anniversary issue, to be produced in early September. A full page is £480, 1/2 page £250, 1/4 page £130, 1/8 £70, 1/16 £35. Send us your artwork, or just the text you want in your advert and we can design one for you.

KEEP US POSTED with your local news: 020 8960 6466, or email us at: news@healthemergency.org.uk

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