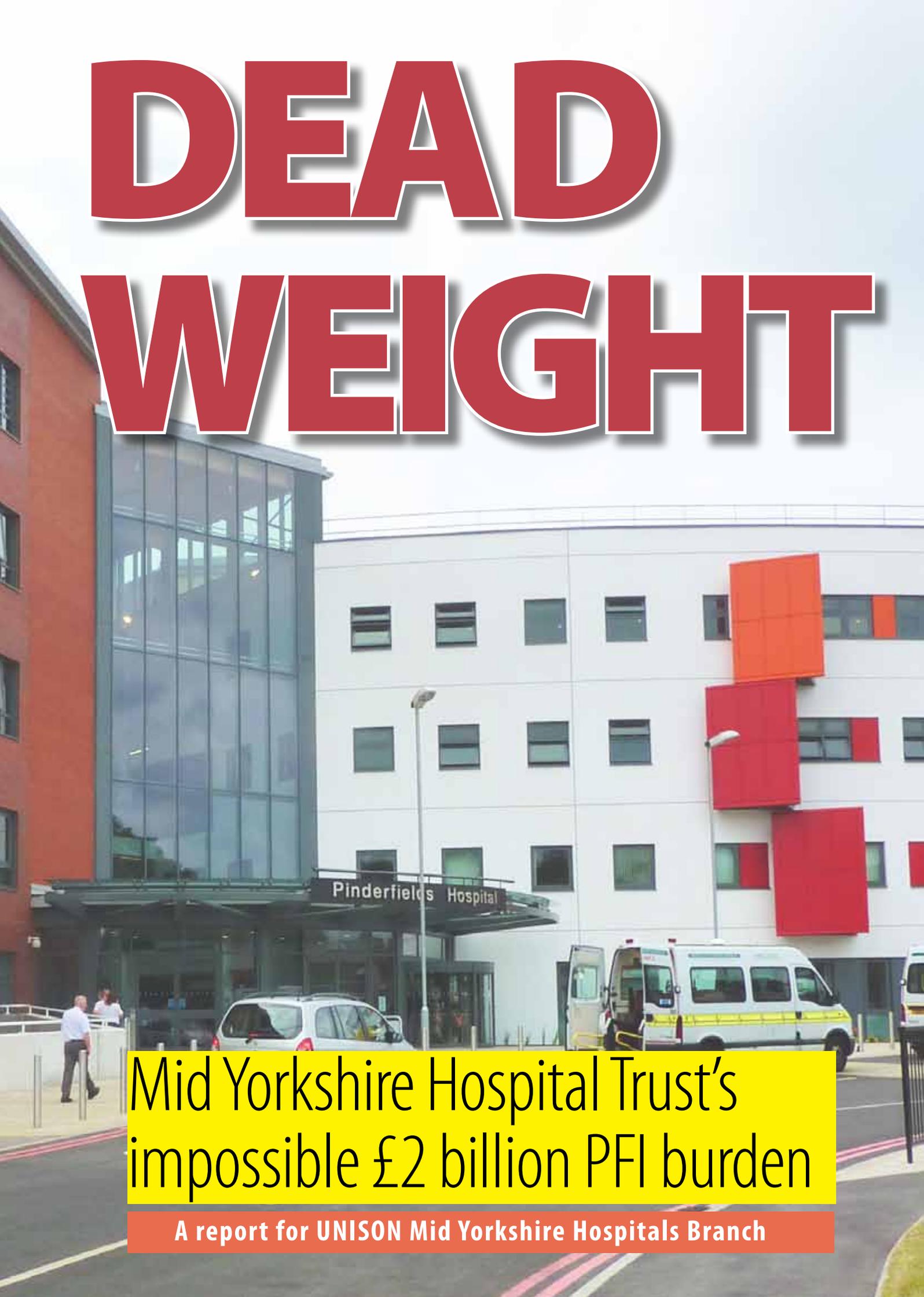


DEAD WEIGHT



Mid Yorkshire Hospital Trust's
impossible £2 billion PFI burden

A report for UNISON Mid Yorkshire Hospitals Branch

FOREWORD

by UNISON Mid Yorkshire Hospitals Branch Secretary Adrian O'Malley

From Crisis To Crisis

The history of Mid Yorkshire Hospitals NHS Trust and its predecessor, Pinderfields and Pontefract Hospitals NHS Trust, is one of permanent financial crisis and instability. UNISON has consistently argued that the financial problems were due to the longstanding underfunding of the NHS within the district and the lack of primary care to back up the acute services provided by the district's general hospitals.

Pinderfields, Pontefract and Dewsbury hospitals provide much needed healthcare to one of the poorest populations in the country. A population with workplace and poverty related health issues far higher than the national average.

This report documents the history of both the financial crises and the disastrous decision to build the much needed new Pinderfields Hospital funded by the Private Finance Initiative.

At every stage during the processes of the many Trust mergers, public consultations and PFI stages UNISON has commented that that building the new hospitals would result in hospital closures, a reduction in the number of beds and the loss of hundreds of jobs within the local NHS.

Nationalise the PFI

We have been accused of "scaremongering", "opposing change" and "not moving with the times" for opposing PFI, by Chief Executives and Directors long since gone. But this report, produced two years after the new hospitals at Pontefract and Pinderfields opened, shows we were correct to warn of the threat to our local NHS services.

Pontefract District General Hospital is no more, replaced by an outpatient and patient rehabilitation centre.

Dewsbury District Hospital is set to go the same way unless the people of Dewsbury, along with the hospital staff, rally around the campaign to keep acute services on the Dewsbury site.

While services at Dewsbury are under threat and with many Trust staff worrying whether they will have a job or be facing massive pay cuts like our Admin and Clerical members, the only certainty within the Mid Yorkshire Trust, the only guarantee of payment, is to the PFI consortium Consort. Over £41 million guaranteed for 2013/14, indexed linked to RPI inflation, 50% of which will go to tax dodgers based in the Channel Islands!

This is a scandal that must be stopped immediately, which is why UNISON has called for the nationalisation of the PFI and for the PFI companies' profits to go towards ending the Trusts' debts.

Democratise the NHS

The debacle of the PFI and the rundown of local NHS services have been imposed from above, against the wishes of the local communities by unelected, unaccountable Chief Executives and Directors. The corporatisation of the NHS, which started in the 1990s with the introduction of NHS Trusts, was intended to turn the NHS into competing bodies rather than a cooperative public service.

This report is also a history of the corporatisation and commercialisation of the NHS in Mid Yorkshire, which could ultimately end in its total privatisation. Now more than ever we need democratic control over OUR NHS with managers accountable to the communities that rely on its services.

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Dead Weight has been researched for UNISON Mid Yorkshire Health Branch by Dr John Lister of London Health Emergency, making use of the published data from the Full Business case, additional Trust Annual reports and Board papers, Strategic Health Authority and Clinical Commissioning Group board papers, local press reports from *The Press*, the *Wakefield Express* and other press reports, and statistical data from the NHS Information Centre.

The report also draws on wider reports and previous publications on PFI by UNISON, and material researched for the branch by Professor Allyson Pollock and her team, and by John Lister (*Union Eyes* newspaper and occasional reports and responses to consultations).

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Executive Summary

Mid Yorkshire Hospitals Trust (MYHT) delivers services from three main hospital sites – Dewsbury District Hospital, and the new hospitals in Wakefield (Pinderfields) and Pontefract constructed at a cost of £311 million under the “Private Finance Initiative”.

MYHT now faces a crisis driven by the government’s unprecedented spending squeeze and pressure to deliver an additional £20 billion in “efficiency savings” across the NHS by 2015, as a result of which commissioners are seeking to reduce referrals to hospital, and reducing the “tariff” of fees paid per treatment delivered by NHS hospitals. All of these factors limit the Trust’s income as the costs of the contracts for the new hospitals, to be paid over 32 years, are rising with inflation, and consuming a growing share of the Trust’s budget.

UNISON has consistently questioned the viability of the restricted size of hospitals seeking to cope with high levels of local caseload in an area of deprivation and chronic health problems, especially given the long-term failure to deliver on promises of expanded services in the community and primary care.

PFI

Since its origin in the 1990s, the idea of using private capital in place of Treasury money to finance new hospitals has effectively wiped out public funding of hospital projects – and led to massively inflated costs and sky-high, long term bills to pay off contracts of 30 years and more for over 100 hospital schemes signed off since 1997. The combined capital investment of £11 billion will incur repayments of more than £65 billion, while real terms funding to the NHS is frozen or falling year by year.

The Commons Public Accounts Committee has warned that the PFI model is “unsustainable”. But it seems that Chancellor George Osborne is clinging to it in order to avoid public sector borrowing.

Health & Social Care Act

The financial plight of MYHT could also be worsened by the implementation of the government’s Health & Social Care Act, which seeks to bring more competition and more private providers (“any qualified provider”) into the delivery of NHS-funded services, reducing the income of the Trust. It also requires MYHT and other NHS Trusts to become Foundation Trusts – and therefore resolve seep-seated financial weaknesses, which in the case of MYHT include the costs of the PFI contract.

There have been threats that ministers may invoke the “Unsustainable Provider regime” to install a special administrator and break up or downsize the Trust and surrounding services – along the lines of the recent carve-up of South London Healthcare Trust and Lewisham Hospital.

The MYHT PFI deal

The PFI contract was signed at a time when the Trust was £85m in debt: the details when eventually revealed and brought up to date suggest that the “unitary charge” payments, capital and finance costs have brought a sharp increase in the share of Trust income spent on buildings – to 13.5% of the Trust turnover. The dead weight of PFI costs is a major factor in its worsening financial plight, while the inadequate capacity of the new hospitals is holding back the Trust’s performance.

Bed numbers and staffing have been reduced, and face further cash-driven cuts, while admissions – emergency and elective – have increased sharply.

Countdown to chaos

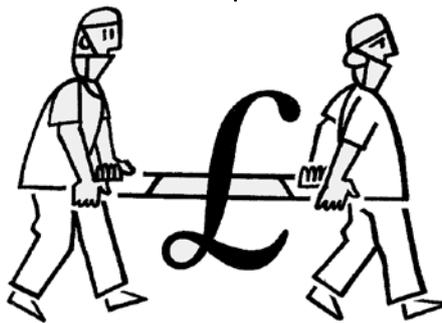
Since the PFI contract was signed in 2007, alongside a “turnaround plan” aimed at saving £77m in five years through cuts in clinical staff, a 23%

cut in beds and a 35% cut in outpatients, there have been a succession of unsuccessful and incomplete plans to shift services from hospital into the community, and moves to reduce hospital bed numbers and staffing.

The crisis has deepened since the new Pinderfields Hospital opened in 2011: the Trust senior management has changed, and a new costly Chief Executive installed: firms of management consultants have picked up millions in contracts for failed schemes.

Dewsbury Hospital, the one without PFI overheads, has suffered a series of cuts. In 2011 the Trust revealed a plan for £60m cuts over two years. The following year the new chief Executive claimed to have found a “black hole” in the finances. In May 2012 the Workforce Challenge set a target for £14m savings from staffing budgets, provoking ongoing industrial action by admin staff.

In March 2013 consultation began on another cost-saving scheme that could axe 200 beds and strip acute care out of Dewsbury. The Trust is missing performance targets, dependent on external cash handouts, and facing the highest emergency caseload in northern England: the dead weight of PFI is dragging it down. UNISON is calling for action to lift this burden and focus NHS resources on patient care rather than private profit.



The Trust

Mid Yorkshire Hospitals Trust provides acute (hospital-based treatment) specialist and community health services to around half a million people living in the Wakefield and North Kirklees areas. Patients also access MYHT services from surrounding areas, including South Leeds, North Yorkshire, Barnsley and Doncaster.

In 2010, the Trust also started providing community therapy services and intermediate care services, and in April 2011, it took over provision of community health services for the Wakefield district and declared itself to be “a new integrated care organisation for local people”.

In March 2011 a £330m hospital development scheme was completed and new, state-of-the-art hospitals opened in Wakefield (Pinderfields) and Pontefract, four years after the contract was signed. The Trust also runs a modern district general hospital in Dewsbury.

The Trust has an annual income of more than £440 million and currently employs more than 8,500 staff.

The crisis

Mid Yorkshire Hospitals Trust (MYHT) has been almost permanently in a state of financial crisis since it was

formed from the merger of the Pinderfields and Pontefract Hospitals Trust and Dewsbury Hospitals Trust 11 years ago. But this crisis has now been compounded by the fixed and rising annual costs of the two new hospitals funded through the Private Finance Initiative, which are forcing ever more desperate efforts to squeeze cash savings as the Trust falls behind on its performance targets.

This local crisis is itself worsened by the national-level crisis in the NHS, created by government insistence on driving unprecedented ‘efficiency savings’ (cuts) of 4 per cent per year to 2015, aiming to release cumulative savings of £20 billion. These cuts have for the last two years centred on a pay freeze that – especially at a time of above target inflation – has cut the pay of 1 million health workers: but they also increasingly require more far-reaching economies, which inevitably impact on the availability and quality of services.

Figures from the NHS Confederation confirm that the projected growth of just 0.1% in real terms health spending throughout the four years 2011-2015 makes it by far the most vicious spending squeeze ever seen since the NHS was founded in 1948. This microscopic increase in spending falls far below the constant upward pressures on NHS budgets from an ageing population, new treatments and technology fuelling increased

The Mid Yorkshire story

The promise of a new hospital on the Pinderfields Hospital site in Wakefield goes back to 1992, when both Pinderfields and Pontefract submitted separate bids to form NHS trusts. By 1996 the now merging Pinderfields and Pontefract Trust was proposing a £37m scheme, funded through the Private Finance Initiative (PFI) to rebuild Pinderfields.

Four years later the estimated costs of the rebuild had escalated five-fold to £176m, and discussions on this scheme were still dragging on in 2002 when the trust was again merged, this time with a Dewsbury Trust that had had many of its local services removed. Both sides of the merger were financially challenged from the outset, driven together more in desperation than hope, in a merger located in financial pressure rather than development of patient care.

Two years later, with no deal yet finalised, another team of private management consultants, Secta, warned of an £11 million

‘affordability gap’ in the PFI scheme, and proposed it be scaled back and services ‘reconfigured’ to cut the costs – removing a whole floor from the new building. Meanwhile the Trust was being investigated by the Healthcare Commission, which took the unprecedented step of calling on the Secretary of State to intervene to address ‘systematic management failings over a number of years’.

In 2005, with the original scheme now described as “unaffordable”, another “rescoping” review of the PFI scheme called for bed numbers to be reduced by 30% from the original planned total, leaving them 40% below the 2004 bed numbers: the new building would have “less outer wall area”.

This was linked with vague suggestions of alternative services in the community – theoretically to be provided by Primary Care Trusts: but in fact neither funding nor firm plans had been agreed for these promised new services, which, as

UNISON warned, never materialised.

Eventually, on June 28 2007, after a charade of a “consultation” and extensive delays beyond the target for “financial close” the Full Business Case was signed off for the new hospitals, which now included a new small hospital on part of the Pontefract Hospital site, with just 60 rehab and assessment beds, 4 maternity beds and a scaled-down “A&E” service to deal only with minor cases.

6 months later the inadequacy of the plans was underlined as the Trust announced plans to spend £4.4m to expand services and relieve pressure on acute beds.

The new Pinderfields Hospital was built to contain 698 beds, some to serve a wider catchment than MYHT. 134 beds were for specialist use, including 33 in Critical and Coronary Care, 34 specialist spinal injury beds, 7 specialist beds in the burns unit and 60 paediatric beds, including burns.

expectations, and pharmaceutical costs constantly rising above inflation. So there is LESS money to go round in the NHS as demand for treatment is going up.

The “tariff” of prices hospitals are paid for each treatment is being systematically cut each year, so hospitals get paid less for doing the same work, as their costs go up. And hospitals like MYHT that treat above planned numbers of emergency admissions because other local services are not willing or able to offer any alternative care and support, are systematically penalised for their efforts: every patient treated as an emergency above 2008-9 levels is paid for at 30% LESS than the tariff price – in other words less than the cost of treatment.

But this is made even worse by the present government’s policy of squeezing even more out of the NHS. The Treasury snatches back any money that is kept as a reserve or surplus at the end of each year. In the past two years they have clawed back £3 billion allocated to the NHS. In 2012-13 it seems another £2.2 billion has been left unspent, even as services are squeezed, beds closed and staff pay frozen and cut – and most of not all of this surplus will also go into

George Osborne’s pot to pay for his tax cuts to the rich. And it gets worse. For 2013-14, analysts predict the “extra money” supposedly allocated to the NHS to buy patient care will not even leave the Treasury.



Of course the claim has been that these “savings” were to be reinvested in the NHS: in reality they were always simply a sneaky way of forcing cuts in the NHS at the same time as other public sector budgets are cut back.

What is the impact on MYHT? It gets caught by every one of the blows being struck. Its contract income is squeezed. It gets paid less each year for each treatment it delivers. It gets penalised for treating too many emergencies – or potentially pilloried like Mid Staffordshire Hospitals Trust if it fails to treat them. It gets none of the surpluses that have been piled up by Primary Care Trusts, and will get none of any surpluses that will now be piled up by the local Clinical Commissioning Groups brought in by the Tory Health & Social Care Act.

At the same time the ability of local councils to expand, improve and even maintain social services and continuing care for frail patients who do not need to be in hospital care is being systematically undermined by a never-ending series of cuts in central government funding, which in turn has led to councils across the

country cranking tighter the “eligibility criteria” restricting access to any form of social care – making it almost impossible for anyone with less than the most severe needs obtaining any council-run care, and dumping this problem back onto hospitals like MYHT.

Competition and privatisation

The Health & Social Care Act will also undermine the efforts of the Trust by potentially opening up more community health services and elective operations to competition from private companies, and open up some services to “Any Qualified Provider”, allowing untested private companies to bid for a share of the work (and income) that is currently held by MYHT. Any patients who may be persuaded or pressurised to use private providers instead of MYHT will of course take the funding with them out of the NHS and deepen the financial hole and instability of the Trust.

To make matters even worse, MYHT’s efforts to reduce its operating costs and work more efficiently are hamstrung by the dead weight of the 32 year PFI contract, with its

legally-binding “unitary charge” payments for use of the two hospitals and for support services, which increase each year by 2.5% or by inflation – whichever is the higher. These increases are written into the contract, and take effect regardless of how much money the Trust has coming in: the PFI costs must be paid as a first charge on any Trust income – even if this

impacts on patient care.

In the background there are mounting threats of intervention, potentially invoking the draconian powers of the “Unsustainable Provider Regime” to install a “special administrator” – as took place in the summer of 2012 against the massively-indebted South London Healthcare Trust where two costly PFI schemes had created an impossible financial impasse. This has had disastrous consequences both in terms of the break-up of SLHT, with plans for drastic cuts in its staffing, and more dramatically the dismemberment of a nearby successful and viable Trust, Lewisham Hospital, in an effort to prop up the PFI contracts at the expense of local health care.

As MYHT embarks on a new consultation aimed at cutting back services to save money, and the crisis lurches onwards, this report aims to explain how we got into this situation, how big the problem is and what we can expect to come next. The final section looks at possible answers – none of which can simply be implemented at local level: the economic crisis, the

squeeze on the NHS, and the policy of PFI have all been foisted on Mid Yorkshire from the outside, and all require national action to stop or reverse them.

The Mid Yorkshire example is sadly not unique, and this shows the need for political action to prevent lasting and irreversible damage being done to our health care services while the money extracted from the NHS through PFI contracts is used to line the pockets of shareholders and offshore speculators.

Ever-rising caseload

The viability of this restricted size of hospital delivering the more complex surgery from a single site has always rested on the assumption that community based services and primary care would be expanded and improved to relieve the pressure on beds. But in fact there has been no significant reduction in hospital caseload: the general trend has been upwards, especially in the last couple of years: emergency admissions in 2012 were 12.7% higher than ten years previously, while admissions overall were 7% higher. The hospital trust has been carrying the burden of the policy failures of the Primary Care Trust and the inadequacy of local primary care services.

Even MYHT's takeover of community health services in Wakefield in 2011, which brought in 650 staff and a £38m boost to the budget, has not been sufficient to ensure the long-promised transfer of services from hospital to community would be achieved. The trust remains vulnerable to decisions taken elsewhere, which shape its budget and its workload. The commissioning budget has remained in the hands of the PCT, and is now controlled by local Clinical Commissioning Groups (CCGs): unless there is a clear commitment by the CCGs to invest in and expand services outside hospital, and definite plans put in place to ensure this takes place, no amount of fine words will make any difference.

Far from opening up a new vista of improved or integrated services in the modern and expensive new hospitals, the combination of pressures on the Trust have resulted in desperate decisions, such as squeezing additional beds into the "state of the art" 4-bed bays in Pinderfields to create a few more spaces to park emergency patients.

And now further cash pressure is leading to another "reconfiguration" exercise in which even more services would be concentrated in the limited space of Pinderfields, while front line capacity is set to be even more seriously under-used at Dewsbury and the expensive Pontefract building.

PFI: from humble beginnings to major problem

In 1981, under Margaret Thatcher, 98% of spending on infrastructure, including hospitals, was financed by the state. But this consensus has since been broken, not least with the Private Finance Initiative. The notion of PFI seems to have originated in John Major's government in the early 1990s, and Chancellor Norman Lamont was an early advocate: it was described by Kenneth Clarke as a means to "privatise the provision of capital" which up until then had been a responsibility for the Treasury.

Although there were early, improbable, claims that PFI projects could be cheaper than those funded through conventional public finance, and of course there was the usual salesmanship seeking to promote an image of the private sector as somehow more 'innovative', NHS trusts were only persuaded to take PFI seriously by a combination of carrot and stick.

The stick came in the form of a rapid reduction in the allocation of Treasury capital to fund new hospital development – sufficient to halt almost all new hospital schemes from 1992 through to 1997 when New Labour signed off the first PFI projects. The carrot was the alluring (largely empty) promise that the private sector would shoulder all of the risk involved in the construction phase of the project, and that it would deliver 'on time and to budget'.

What was not said was that the NHS would be charged handsomely for handing over the risk – and effectively still wound up stuck with the bill, in the form of a 25, 30 or 35 year rigid contract, during which time the hospital building itself was the property of a private consortium and a guaranteed, index-linked profit stream for private shareholders.

Even though both carrot and stick were waved by John Major's Tories, and PFI was initially attacked by Labour as the "thin end of the wedge to privatisation", by 1997 the Tories had failed to finalise a single hospital contract, and it was left to New Labour, which in the six months before the election had dropped its principled line and embraced PFI, to sign the first PFI deals in the NHS.

From the Labour government's point of view it appeared that one attraction would be that PFI schemes, by delegating the borrowing to private sector "partners" would effectively be "off balance sheet" for the government, and therefore not count as public borrowing – allowing Gordon Brown to build new hospitals even as he continued with his line of "prudent" borrowing. In practice this, too, has turned out to be a short-term illusion, since at the insistence of EU accountants many of the schemes have now had to be put back onto the government's balance sheet as the scam failed to convince.



UNISON
Union eyes
Bulletin of UNISON Wakefield and Pontefract Hospitals Branch.
No.4 ● Spring 2004. ● Free to members

AGM
Have your say!
Don't miss the Branch Annual General Meeting, to be held on **Thursday April 1 7pm** Wakefield Labour Club, Vicarage St.

Warning voices from the front line

● "It's all about money. They are ripping off the NHS" – porter

● "I used to feel good going to work and you had some satisfaction going home at the end of the day. Now there is no more satisfaction for porters than working in a factory or a shop" – porters' steward

● "Privatisation has taken the care out of our jobs. We just haven't got time to do those extra things that show we care" – catering worker

● "I think patient care has suffered" – nurse

● "The hospital in terms of bed capacity is absolutely woful. The bed utilisation has been 99% in recent weeks after running for months at 97%. The last week has gone beyond red alert – to 99% only. Whoever did the estimates here for bed capacity has been disastrously wrong" – UNISON rep

● "The single biggest thing for nurses is the constant bed crush. The hospital seems to be continually in a beds crisis" – specialist nurse

● "The only time the wards are really clean now is after an outbreak of diarrhoea and vomiting, or when we have a visit from a minister" – health care assistant

● "We've got kitchens in the middle of the building. Who ever heard of that? A kitchen with no window to let the heat out!" – catering worker

● "It seems that PFI can be summed up as 'lower your standards'" – porter

● "I have always been a cook. I'm not happy with the quality of the food we serve. It comes up from Manchester. I suspect they don't have proper cooks either. People say "Can you tell me what's in this?" and I have to say "Sorry, I haven't a clue!"

● "We can wait up to four hours for a bed to be made" – nurse

● "We liked our jobs. But I'm beginning to hate mine now" – domestic

● "Clerical staff are sharing rabbits hutch style offices" – nurse

● "Because the building is privately-owned, you can't even hang a picture on the wall without permission from Criterion: they keep telling us it's 'their' building" – UNISON rep

● "The place is manky, because the cleaners also have to do the beds and do the meals; those jobs come out of their cleaning time" – nurse

More voices from the front line on PFI inside (centre pages)
Plus: Have your say. Referendum planned – Editorial p3

"They put Ronnie Biggs behind bars for the Great Train Robbery, but nobody is going to be serving a sentence at all for the great NHS rip-off"

rapidly driven up under PFI. In 1997 the average cost of a new first-wave PFI hospital was less than £100 million. But since then there have been new planning guidelines increasing the amount of space that must be allowed per bed and for patient areas, and the projects have become much larger and more elaborate: many of the more recent schemes, like the MYHT scheme, are now in excess of £300m – with an inflated price tag to go with the higher cost.

As a result, Trusts desperate to secure new facilities have been persuaded by PFI consortia, by ministers and by conniving financial advisors to sign up for expensive contracts that have turned out to be unaffordable. PFI has become a major factor undermining the financial viability of a number of Trusts, with 22, including Mid Yorkshire, admitted in 2011 to be facing PFI-related financial problems.

In May 2012 the Commons Public Accounts Committee, having taken evidence from the Treasury that it too was engaging in a "rethink," declared that the current model of PFI is "unsustainable". The Committee was also highly critical of the lack of transparency on PFI contracts, leaving the taxpayer in the dark on how much the public sector was paying in interest and other charges and what level of profits were being creamed off by investors, several of them offshore institutions paying little if any tax on the money they make. In too many cases, the Committee argued, investors appeared to be making "eye-wateringly high" profits while taxpayers were footing the bill for inflexible and expensive contracts and NHS trusts were forced to seek deeper cuts in other budgets to maintain PFI payments.

And despite the fact that the Treasury had been reviewing PFI for 6 months, and Chancellor George Osborne had promised in opposition that the Tories would stop using PFI, over 40 new PFI contracts had been signed by the coalition government in its first two years in office, with another 30 being negotiated.

Borrowing targets

One explanation for this is that Osborne, like Gordon Brown before him, has set a tough target for borrowing, committing the coalition to ensure the public sector net debt is falling by 2015-16: so he, too, is drawn to PFI by the fact that a proportion of the borrowing is manipulated to be "off the books" – even at an inflated long-term cost.

Osborne has claimed that the government has already "driven changes in existing PFI projects", but no details of these changes have been published, and the efforts so far to renegotiate reductions in contract costs have been largely fruitless.

In August 2012 "hit squads" of lawyers and accountants were sent in to seven of the most indebted hospital

The first wave of PFI hospitals were signed off at the end of 1997 and completed new hospitals began to open up from 2000: most were significantly smaller than the hospitals they replaced, both in terms of footprint and in capacity, with an average 25% reduction in numbers of beds in the first wave. Many also were obliged to squeeze down numbers of front-line staff, while in early PFIs non-clinical support services were part of the income stream for the consortium, and so once contracts were signed, non-clinical budgets and staff have effectively been removed from the Trust's control.

Labour's 2000 NHS Plan looked forward to at least 40% of the value of the NHS estate being less than 15 years old by 2010. But since there was little if any public sector capital available, this was effectively a commitment to privatise 40% of the £22 billion asset base of the NHS – through PFI.

They may have achieved this target: certainly much of the NHS has been transformed from landlord to tenant. There are now over 100 hospital PFIs in England, with a combined capital value of £11 billion, but with a combined cost in excess of £65 billion over the lifetime of the PFI contracts. The scheduled payments in 2012-13 totalled £1.6 billion, although many will have been further inflated by inflation.

The average cost of a new hospital has also been

trusts to seek to renegotiate their PFI contracts before the financial pressures drove them into bankruptcy: Mid Yorkshire was not included in this most vulnerable list. However once again there appear to have been few if any successes from the high-profile interventions, not least because health minister Simon Burns made clear from the outset that the government would not walk away from any of the contracts, for fear of years of legal disputes.

With the PFI consortia convinced that any government threats are empty, they are sitting tight on copper-bottomed contracts that guarantee them a long-term profit stream.

In December 2012 Osborne unveiled another approach, with the announcement of a new form of PFI, to be known as "PF2". It would create contracts in which the public sector would become a minority shareholder, and therefore in theory share in any profits that are to be made – from the public purse.

But this shareholding comes at a cost – it requires public money to be invested up front as part of the capital for the project, alongside private sector risk capital. And the "profits" are derived entirely from the public purse, in the form of inflated payments by the hospital trusts.

However it's clear that Osborne intends the new scheme, whether improved or not, to remain the "only game in town", leaving trust bosses at the mercy of ruthless and skilled private sector negotiators. It seems that the costs of investing this way may actually go up, although there is still no guarantee at all that the private sector will be minded to invest in this way if there is any potential risk involved.

Implications of the Health & Social Care Act

In April 2013 the full implementation of the Health and Social Care Act will create new uncertainties and problems for PFI hospital trusts. New, untested commissioners (Clinical Commissioning Groups) will take over responsibility of £65 billion of contracts, including most contracts with local hospitals. Commissioning of specialist hospital services will be in the hands of the new NHS Commissioning Board, now boldly named as "NHS England".

The CCGs, ostensibly to be led by GPs, will be under constant, tight scrutiny from NHS England, which will be checking their compliance with cash limits – effectively forcing the CCGs to step up the pressure on Trusts, which have nowhere else to pass the buck of



A central aim of the Act is to open up the NHS to "Any Qualified Provider" – here are two candidates

spending cuts.

As the financial constraints become ever tighter, the Trusts with heavy PFI commitments and rising costs for their hospital buildings will find themselves under the most severe pressure of all. Worse, the Health & Social Care Act also requires all the remaining NHS trusts to become foundation trusts by 2014, or to be taken over by a foundation trust. MYHT is one of a beleaguered group of 47 NHS Trusts that are seen by the NHS Trust development Authority as having "no standalone solution" to make it viable (HSJ March 2013).

The principal barrier to foundation status for MYHT is its financial plight: the regulator, Monitor, which has already stated its regret that some early applications for foundation status were approved with inappropriate financial scrutiny, to create less than viable FTs, is unlikely to be impressed with current and past performance. So one of the reasons for MYHT's new plans for rationalisation and cost-cutting is to open the way for a potential bid for foundation status next year.

However there is already speculation that Mid Yorkshire may have to be split up, to allow it to be taken over by more than one Foundation Trust – but within MYHT only Dewsbury Hospital is unencumbered with PFI liabilities, and this is being steadily stripped of specialist services as they are "centralised" at Pinderfields. So there are questions over which Foundation, if any, might find Dewsbury – and, even more problematic, the rest of MYHT – an attractive business proposition.

As if to make MYHT even less attractive to other foundation trusts, the Act also requires the CCGs to work to open up an ever-growing share of local services to competition from "Any Qualified



Lansley thought it would work

Provider”, potentially destabilising even some of the staple elective and community services provided by the Trust.

Annual Reports already show a significant increase in the value of work paid for by the Trust from private providers: every increase in this and in the share of local health spending diverted to other providers by the CCGs will leave less resources available to MYHT, and create further tensions in financing the rising costs of the PFI unitary charge.

And of course partly as a response to continuing cash pressures, and partly in line with contemporary thinking, PCTs and now CCGs are also committed to reducing referrals to hospitals, and building up alternative services in the community and primary care. Even though some trusts like MYHT also deliver community health services, this switch of caseload potentially threatens to leave the huge capital investments in modern hospitals high and dry without sufficient income from patient care to cover their fixed costs – although so far there is little sign of any of these much-vaunted alternative services having the promised impact of reducing pressure on hospitals.

The MYHT PFI deal

The PFI contract (“Project Agreement”) was signed off in the summer of 2007, in the midst of the developing banking crisis, and at a time the Trust was £85 million in debt. Only after a prolonged battle by the UNISON branch at the Trust was a highly edited version of the Full Business case eventually published.

However even the sections that escaped the censor’s indelible marker underlined two key concerns about the scheme that had been raised throughout by UNISON:

- The price – and therefore the resultant ongoing cost – of the PFI contract
- The capacity of the new hospitals and their ability to meet levels of demand for emergency and elective care

The cost

The expectation was that the full revenue costs of the first year of the new hospital (2011-12) would add up to £41.2m. This combined the unitary charge (estimated at £35.3m) with additional costs for ICT (£900,000), loss of income from facilities management (car parks, shops, catering, etc) of £3.3m (since these services would become part of the income stream for the PFI consortium), and another £1.7m of costs (FBC Appendix 10-B).

This was to have been covered by various means including support from the PCT, £16.6m of expected savings from the previous hospital budget, and a hefty £19.7m in Cost Improvement Programmes (CIPs). However it is not clear whether either large target for savings was fully achieved.



And the cost has been inflated from the beginning by higher than expected inflation, which pushed up the unitary charge to £43m. As a result the Trust was struggling from day one of the new hospitals opening, and the gap has grown wider since then.

The calculation of the relative cost compared with the income of the Trust was bizarrely carried out using 2005-6 figures (Appendix 10-E). The experts came to the conclusion that the unitary charge would be a whisker under 15% of the turnover of the Trust.

The actual figures show that with the higher unitary charge and lost income the combined revenue cost to the Trust in year one was more like £46-£50m. The Trust turnover in 2011-12 was estimated at £444m, of which around £40m was directly linked with the community health services in Wakefield, and so not part of the revenue base servicing the PFI. So the revenue costs of the PFI itself add up to 11.5-12.5% of the turnover of the acute services.

However to calculate the real cost, on top of this must be added the continuing payments on the “public dividend capital” (the value of Dewsbury Hospital and other publicly-owned assets retained by the trust’s community services, which are not part of the PFI). The increased cost of PFI is the difference between the original capital charges and the combined PFI charges, lost income, finance charges and residual PDC payments.

Trust annual reports show that these payments have varied over the years, from a high point of £9.7 million covering all of the trust’s assets in 2007-8, reducing to £5.7m in 2009-10 and £3.1m in 2011-12, while additional ‘finance costs’ driven by the PFI have risen from £1.5m in 2008-9 to £11.6m in 2011-12. Between them these two payments stack up to a combined additional outlay of £14.7m on top of the PFI unitary charge.

PFI and other capital and finance costs together in 2011-12 therefore add up to almost £60m, equivalent to 13.5% of the trust's total turnover. This is substantially higher than the national average of 10.3% capital costs for other trusts with PFI projects, and well above the overall average of 8% capital costs across the NHS (a figure inflated by the costs of PFI).

Indeed the costs of capital for hospitals with major PFI schemes are all much higher than the notional figure of 5.8% of trust income payable by trusts on their public dividend capital and depreciation (public sector assets). That is the figure used as the basis for the costing of average services, from which the 'payment by results' tariff of prices is calculated, fixing the fee paid to hospitals for each item of treatment they deliver. If MYHT were spending this much smaller share of its income on capital costs the Trust would be paying out around £26m a year on capital charges instead of £60m – leaving it a massive £34m a year better off than its current situation.

The dead weight of PFI and all of the related additional costs faced by MYHT as a result of the contract are therefore a significant factor in the worsening financial plight and uncertain future of the trust. Although there may be some marginal reduction in payments of public dividend capital if Clayton Hospital and other under-used assets are sold off, the costs are set to remain high and be driven higher by inflation through the annual index linked increases built in to the PFI contract – even as trust income begins to fall in real terms through reductions in tariff, reductions in referrals, and more services being carved out for private sector providers.

Up to now MYHT has only been bailed out of heavy debt and escaped more serious deficits by significant borrowing and one-off payments from the Strategic Health Authority and the Department of Health. No such support seems likely to materialise in the new, tough and increasingly competitive market place opened up by the Health & Social Care Act.

Insufficient capacity

As with so many other PFI projects, the Mid Yorkshire PFI has brought a constant downward pressure on bed numbers, even as admissions and emergency admissions have continued their upward trend. A third of beds have closed in just ten years, almost half of these closures since 2007 when the PFI contract was signed.

In 2001-2 the Pinderfields, Pontefract and Dewsbury Hospitals had 1594 beds to serve their local population: by 2011-12 this had fallen to 1073. The five years from 2007 saw bed numbers fall by over 15%.

Back in 2000 UNISON published *Clutching at Straws*, a response to the consultation document *Grasping the Nettle*, pointing out that this management plan for rationalisation of services proposed to switch £12m in annual spending out of the hospital budget, but did not offer any corresponding increase to community services.

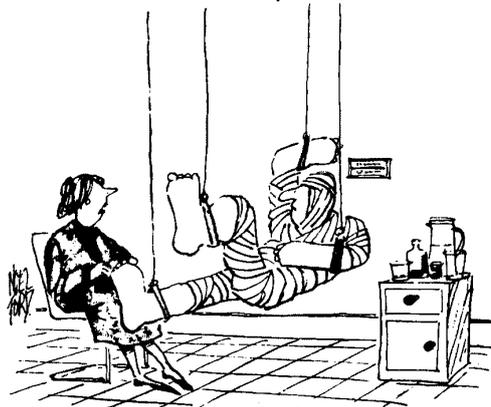
UNISON asked:

"Where will the proposed 'intermediate' beds be situated? Where will staff be recruited and trained? Who will be in charge? Where will they work from?"

And of course there was the underlying question: how would such a service be financed?" None of these questions has ever been answered.

Yet the steep reductions in bed capacity have gone further than the plans set out in the second Strategic Outline Case for a new build single site PFI hospital at Pinderfields, which in 2002 proposed a 24% cut in beds by 2007. This plan also called for capital investment in primary care and the creation of 148 new "intermediate" beds in North Kirklees, Wakefield and Pontefract by 2004, and another 180 by 2007. Once again, as with *Grasping the Nettle*, no details were set out to show where these new beds might be, or how these new services might be staffed or funded.

This evasion proved to be telling, since – as UNISON suspected – the proposed £18m investment never took place, and the promised extra capacity still has not been created in the community – hence the continued rise in admissions and emergency caseload handled by the Trust.



'I never dreamed the bed shortage was so acute.'

Looking both ways on bed numbers

Five years later, the Full Business Case (FBC), setting out the argument for a massive £311m investment in new hospital buildings, appears to ignore the previous broken promises of expanded community health services. It claimed that:

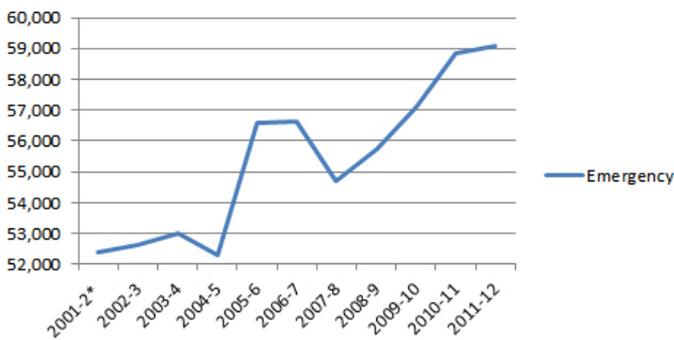
"The service planning undertaken when formulating the Trust's long-term clinical model was predicated on a visible shift towards healthcare in primary and community care settings. Thus future investment is intrinsically linked to a shift of resources to these settings and consequently is based on a preventative model for care." (Executive Summary 1.4)

However it was immediately obvious from the plans and the financial costs of the scheme that this was simply a form of words, paying mere lip-service to a new model of care. Had the policy been applied in practice, it would

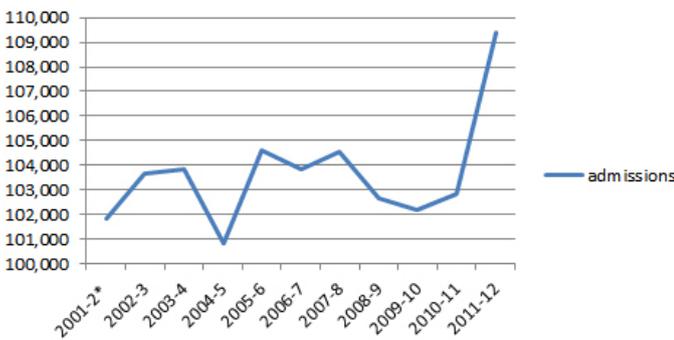
MYHT area: changing numbers of general and acute beds



MYHT area: emergency admissions



MYHT area: All admissions



have pulled the financial rug even further from beneath the Trust, which was planning a costly capital investment in traditional hospital care.

On the very next page of the Executive summary a contradictory (and exceedingly optimistic) passage in a table claimed that:

“Should the Trust prove popular in the market there is scope within the scheme for productivity growth to support higher volumes”

This makes it clear that the Trust was not really expecting any diversion of patients from hospital: but they needed to echo the trendy rhetoric of the times and also find some way to explain away the reducing numbers of beds that would be available. The Hospital Development Plan proposed to cut bed numbers from 1388 to 1176, with

the biggest drop of all being the massive reduction at Pontefract from 388 to just 64 beds. Dewsbury provision was expected to remain unchanged.

The FBC went on to argue that the proposed reduction in acute bed numbers was

“the result of the analysis of the total PCT projected activity for 2010/11 (including taking into account the most recent guidance on reduction to emergency admissions...)”

And it also argued (without identifying any evidence to back up the assertion) that:

“Studies ... have shown that alternative intermediate health care provision would best serve around 30 percent of patients currently admitted to the acute hospitals”. (1.5.3)

Even if this were true, there was no indication of how this had actually shaped the proposals and projections of the Trust and the PFI project. Indeed, far from dropping by 30 percent, projected inpatient demand was expected, according to figures worked up by the trust itself for the FBC, to dip by at most 15 percent, before increasing again (Appendix 3D).

The Financial Appraisal (Chapter 10 of the FBC) set out projected income from elective and emergency admissions to hospital from 2007 to 2012/13: but far from showing a substantial switch to primary and community services, the figures showed no real change was expected in the elective (waiting list) income, which would be the same in 2012 as in 2005, and a continued substantial year-on-year increase in income from emergency admissions (to a new peak in 2012, 30 percent higher than 2007-8).

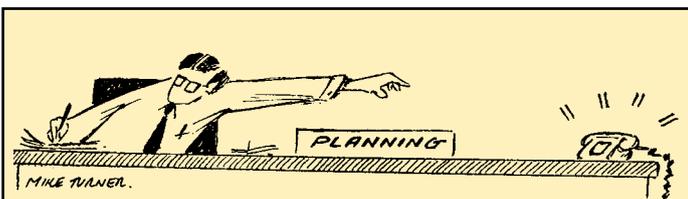
This financial projection raised the question of whether the new hospitals in Wakefield and Pontefract, with 15% fewer beds than five years earlier, and no frontline acute services left in Pontefract to share the load, would have enough capacity to cope with the level of demand. Would it be clinically viable? If not, what was the Plan B? How far would local patients have to travel to access appropriate hospital care?

UNISON has not been alone in raising concerns over the capacity of the new hospitals: these also feature prominently in the Risk Register developed by the Trust and its advisors, and published as part of the FBC. Six of these risks were summed up as having the potential impact of clinical facilities being constructed that “are not aligned against revised clinical care paths and capacity modelling”, while five posed the possibility of requiring extra capital costs as a result of revising the plans for PFI facilities. In the event, the plans were not substantially revised after the contract was signed: but the mismatch between capacity and actual patterns of clinical care has remained a major problem for the Trust.

Emergency caseload has risen by 12.7% since 2001-2, elective caseload has remained almost constant, giving an overall increase in admissions of 7.4% maintaining heavy pressure on over-stretched hospital staff and facilities: there is no sign in these figures of any impact from "alternative intermediate health care provision," which has remained at the level of empty rhetoric displayed again in the 2012 CCG *Strategic Plan*.

One reason for this is no doubt the cost of the capital investment in the new hospital buildings, which has drained available resources that might otherwise have been invested in expanding community based health care and primary care services. But now any substantial expansion that did succeed in switching patients (and revenue) away from the new hospitals would trigger an even more severe financial crisis for the Trust, since its core capital costs would remain unchanged – only the revenue to pay them would be reduced.

Far from being part of a scheme to develop new, integrated services and greater provision of care outside hospital, the PFI scheme is now a major obstacle to any such plans in the future, and a substantial burden on the local health economy.



Staff cuts

The planned reduction in the workforce was 17% over four years, from 6,508 to 5,392. The plans inflicted the heaviest cuts on nursing, which accounted for 38% of the job cuts and faced a 16% reduction from the 2006 total of 2,620 whole time equivalent posts to 2,198 by 2010-11.

A greater reliance on vocationally trained health care assistants in place of professionally qualified nursing staff was to reduce costs by diluting the skill mix.

The next largest group under the axe was admin and clerical staff, with 17% of the job cuts in (192 posts to go, equivalent to 17% of the 2006 staffing). Scientific and Technical staff were 12.5% of the total cuts, losing 22% of their 2006 total (139 jobs) and medical staff cuts were to make up 11% of the job losses, with 18% of doctors losing their posts (127) (Table 7-1).

The FBC argued that to meet its "turnaround" targets the Trust had to reduce staffing costs in this way, by the equivalent of 450 whole time equivalent posts, to generate savings of £18m.

Where does the money go?

The initial consortium, collectively Consort Healthcare, defeated a rival bid by New Hospitals (Taylor Woodrow/Innisfree) to become the preferred provider in the autumn of 2004, in a process delayed by further discussions aimed at squeezing down the cost of the project in response to the Trust's ongoing and unresolved financial problems.

Consort's partner companies in the early stages were Balfour Beatty Infrastructure Investments Ltd (with Haden Young delivering the construction side, and the subsequent maintenance services and Balfour Beatty the non-clinical support services, with staff retained as NHS employees supervised and managed by the company) and Royal Bank of Scotland (Royal Bank Project Investments Limited) as the financial advisors and main additional organisers of the capital required.

Over £352 million were raised by the consortium on the strength of the Mid Yorkshire PFI – more than £40m in excess of the costs of the new buildings. But just 9 percent of this money was put up in equity and 'subordinated debt' by Balfour Beatty and RBS, leaving the remaining 91% to be financed as debt, borrowed on the basis of an index-linked Bond for £171m and an index-linked loan from the European Investment Bank for another £150m.

In explanation the FBC argued that debt is a cheaper way of funding than equity. The financial model for the contract was drawn up by the Royal Bank of Scotland, and checked out on the Trust's behalf by PricewaterhouseCoopers – without being fully audited by the Trust or PWC.

However in 2011, with the most "risky" phase of the project nearly complete, RBS – which had to be massively bailed out by the British government following the 2008 banking crash and is now 84% owned by the taxpayer – sold on its 50% share of the deal to the Guernsey-based HICL Infrastructure, an arm of the HSBC bank.

As a result, all payments that previously would have flowed to the RBS are now funnelled into the offshore coffers of a bank that pays no UK tax, and therefore none of the surpluses it accrues flow back in any way to the NHS or public services. It simply creams off a profit from the PFI and distributes this to its shareholders, leaving the NHS and the taxpayer to foot the rising bill.

Cutting corners to cut costs

In 2005 Consort Healthcare, now as preferred bidder, undertook a further five month "rescoping" exercise to squeeze costs down still further. This was in response to proposals issued by the Trust in March 2005, and included further revisions to the number of adult inpatient beds at the Wakefield site and much greater use of existing estate.

"Consort Healthcare was made aware of the contribution to affordability that was expected

to be delivered – partly through the reduction in capital costs and partly through revenue measures within its control such as changes to the Facilities Management submission” (FBC Chapter Five).

The reduction in costs had to be considerable, to stand any chance of achieving the estimated £77m ‘headline financial challenge’. MYHT however admitted that the increased cost of the new hospitals would be an additional financial challenge on top of this “headline financial challenge”.

Even the optimistic £77m figure rests on the assumption that from 2009 onwards the Trust will only be expected to generate 1 percent of ‘cost improvements’ each year, compared with 2 percent or more in every previous year. The Board meeting which rubber stamped the PFI scheme in 2007 (despite the extensive sections of documentation being withheld even from Board members) was told that if the cost improvement targets were instead to be fixed at 2.5% in future years – “the Trust’s headline financial challenge would increase to £90 million.”

In the event of course, as a result of the banking crash, the required rate of efficiency savings was pushed up not just to 2.5% per year, but to a much higher, recurrent 4% per year from 2011-2015 as part of the £20 billion target for NHS savings.

Add to this the ‘net revenue impact’ (i.e. additional cost) of the PFI scheme – £17.7m a year at 2006-7 prices (FBC 10.31) – and it is clear that there has always been a substantial affordability issue, especially since the bank meltdown. To make it look as if the sums all balanced up, the Trust seems to have assumed it would receive a large (29 percent) increase in total clinical income without a related 29% or higher increase in costs. But there was never any guarantee at all that this money would materialise.

Previous reports from the Audit Commission (Public Interest Report 2004) and the Healthcare Commission (2005) had made clear that there is no local solution to the Trust’s historically accumulated financial difficulties: MYHT was unable to reach its statutory breakeven duty, and had been bailed out with £77m in cash support.

In the event the plan that was drawn up was purely for local level cost savings, which it was hoped would

The price of PFI secrecy: no alternative views considered

Now the finances and organisation of the new hospitals have begun to go horribly wrong, managers have only themselves and their predecessors to blame.

After nine years of furtive and secretive negotiations, half-baked “consultations” and inadequate information the Board opted in 2007 to take a reckless gamble and press ahead with a hugely expensive PFI scheme that had more holes in it than a Tetley teabag.

UNISON had to battle long and hard to extract a copy of the Full Business Case for the new hospitals, despite the fact that a condition for Department of Health approval for the FBC last summer was that it should be published in its final form within a month of completion.

However even six years later the complete report is still not available for scrutiny: when the massive collection of documents was eventually grudgingly handed over it was studded with deletions of information which managers claim is commercial and confidential.

Simply listing the omissions,

We cannot give you that information on grounds of national security!



with a few sketchy and formulaic arguments on why they had been omitted, required 13 pages of A4. Among the subject areas the Trust and the PFI consortium believe are still too sensitive to allow the public to know the details are:

- Figures on the rate of return to be generated by the consortium
- Numerous details on the treatment of non-clinical support staff under the TUPE (transfer of undertakings) arrangements, through which they would be seconded to work under the management of the consortium, while remaining NHS employees
- A whole appendix analysing

the transfer of staff to the management of the consortium

- Details of any additional borrowing to be carried out by the consortium
- Details on the time that would be allowed for rectification of problems – a significant component of the accountability and monitoring of the PFI contract
- Letters from some of the long list of high-cost financial and legal advisors giving their view of the contract and its financial implications, and allegedly supporting the project.

Perhaps just as worrying as the omissions are some of the clauses and conditions that were accepted, and the unrealistic projections on bed numbers and caseload which have continued unchanged from earlier negotiations, and which UNISON consistently argued were hugely over-optimistic.

The deal was entirely the work of discussions behind firmly closed doors, from which any critical or questioning voice had been carefully excluded.

nevertheless bridge this cash gap and put the Trust's budget into balance. This level of optimism in the plan is perhaps understandable in that it was drawn up at a time when NHS spending was still rising year by year, and the banking crash had not yet even begun. The growth in spending halted abruptly in 2010-11, and the cash squeeze has tightened on the NHS ever since, making the plans a nonsense.

The key elements in the hopes of cost savings, most of which rested on savings from staffing costs and increased productivity by front line staff, were:

- A five year cost and income improvement

programme;

- A Turnaround plan "to deliver run rate balance in October 2007 and in year balance for the 2007/08 financial year";
- A workforce plan to deliver demonstrable pay bill reduction (with planned reductions in medical, nursing and other clinical staff as well as corporate staffing costs);
- A bed reduction plan to release up to 23% of current capacity – by achieving Dr Foster 25th percentile efficiency in all specialties on all sites;
- An outpatient reduction plan to release up to 35% of current capacity;

The saga of the Freedom of Information application

The Trust achieved financial close and signed its privately financed new hospital development deal on 28 June 2007, and should have made public its full business case (FBC) document within one month of that date.

However at that time it was claimed the conditions of the so-called 'Project Agreement' laid down an obligation upon the trust and private sector "partners" Consort, to agree the FBC before it became a public document.

A month after the signing of the agreement UNISON requested a copy of the FBC, and the Trust stated that the copy would be forwarded by August 3. At the same time we also lodged a complaint with the Information Commissioner's Office (ICO), raising our concerns that the trust had withheld the public disclosure of the FBC for over three months.

The ICO requested the Trust to conduct an internal review and to detail its reasons for the delay and nondisclosure at the time. The Trust maintained that it was right not to publicly issue the FBC at that time. Ultimately the Trust finally released to the public and to UNISON its Version 1 of the document in December 2007, nearly 6 months after the agreement was signed.

On receipt of the FBC UNISON immediately responded to the Trust and the ICO to raise our objections over the extent of the information which was still withheld. A 13 page document detailed a long

list of over 60 admissions. In effect, virtually every piece of information referring to finances was withheld on the grounds of "commercial confidentiality" – i.e. all financial transactions connected to the deal were viewed as a trade secret, and disclosure was not deemed to be in the public's interest.

UNISON therefore continued with our application for full disclosure of the FBC, emphasising our point that the value for money case could not be proven whilst all the financial details continue to be withheld.

On 27th of December 2007 UNISON were sent a letter from the ICO explaining that our case would be allocated to "case resolution team". Unison requested our application be prioritised, and the ICO replied on February 6, 2008 that they disagreed, and backed the Trust's position that they would periodically review the pattern process and disclose further information as and when they felt appropriate.

On April 11, 2008 the ICO communicated that the Trust was now ready to release further "substantial" information that had previously been withheld. However this substantial information (i.e. FBC addendum 5.1) was not received until May 27, 2008. On July 2, 2008 we complained to the ICO that the latest substantial information disclosed was a mere two documents, leaving a further 61 document still undisclosed.

One of the documents received

was the papers and minutes of the Trust's Hospitals Development Project (HDP) meeting held in November 2004. This detailed the trust's decision when picking its preferred consortium partner from the shortlisted bidders. Although this pile of information could be viewed as being substantial, it was of little use or relevance a full four years after the event.

We continued with our application for the disclosure of the FBC in its entirety. The ICO advised that it would review our case on a quarterly basis. On September 3, 2008 we expressed concern that five months had passed with no updates being forthcoming. A letter dated October 2, 2008 was received from Claire Walsh, the ICO senior complaints officer, informing us that our case had been allocated to her for investigation.

The Trust's director of corporate affairs Dawn Stephenson communicated that the FBC was to be reviewed on a six monthly basis, and version 5.3 of additional information disclosure will be made available in July 2009.

On March 19, 2009, Claire Walsh, the ICO complaints officer, clarified that she felt that some of the Trust's withheld information had in fact had section 41 exemption criteria correctly applied. However a letter dated April 2, 2009 highlighted that the ICO and UNISON agreed that there remained a list of 12 outstanding omitted documents that UNISON still disputed.

● A theatre efficiency plan to deliver 20% productivity gains. (FBC Chapter 10).

In the event few of these were achieved.

Massaging the figures to paint PFI as value for money

The Full Business Case tries to argue that funding the new hospital buildings through the Private Finance Initiative (PFI) represents 'value for money', despite the evidence so far that the NHS is set to repay a staggering £65 billion on PFI projects with a total value of just £11 billion,



'One... two... three... CLEAR!'

resulting a thumping great guaranteed profit stream for the private sector for a generation to come.

To make the cost of PFI seem less extortionate, the Treasury and Trust bosses have concocted a completely deceptive system of "comparison" between the PFI scheme in question and a purely theoretical "Public Sector Comparator".

Of course it's a joke: nobody wants or expects ever to build a hospital based on

On June 1, 2010, Peter Martin, the clerk to the tribunal's service intervened, stating that we had not provided adequate grounds for appeal and requested we forward further details.

We responded as follows:

"We fully expect that it will be the Information Commissioner's Office view that technically it is not in the public's interest to know how much private profit is made out of our healthcare services. However we wish to record our objections."

Peter Martin responded by informing us that the "principal judge" had asked for further written reasons why we consider the decision notice to be wrong. Our reply of June 15, 2010 stated:

"To secretly convert massive public funds into private profit using commercial confidentiality to avoid openness and transparency is both morally and financially bankrupt. Health services will be at risk in order to allow secretive private profiteering. It is my view that this cannot possibly be in the public's interest."

To our great surprise Peter Martin's response stated that the tribunal's principal judge had accepted our grounds of appeal.

However a subsequent letter of June 25 from Richard Bailey the ICO solicitor said there had been some confusion about our complaint. It was claimed in our case had been resolved 'informally', and there had been no tribunal Decision Notice

in respect of the case, and previous references were in relation to another similar case!

I reiterated that we had accepted some of the arguments and nondisclosure of some of the information, but were still challenging 12 undisclosed items.

Richard Bailey replied as follows:

"It is the Commissioner's recollection that we had resolved informally..." and "... I note that you didn't respond to the Commissioner's letter of April 27, 2009 and, as such, file closed."

The letter of April 27, 2009 – from Claire Walsh – stated:

"Thank you for your help in resolving this complaint informally, and as agreed I will now close it."

We never received this letter at that time. If we had done we would definitely challenged any suggestion that our claim had been informally resolved.

A letter dated June 30, 2010 from Peter Martin the clerk of the tribunal stated:

"... Only the complainant or public authority can appeal against a Decision Notice, therefore the tribunal is proposing to strike out your appeal."

Consequently this is exactly what happened in July 2010.

Lessons

We were seemingly led a merry dance and sent on a wild goose chase for a full three years!

However we persisted and ultimately had to be deceived and hoodwinked in order to finally curtail any further information disclosure.

Our experience highlighted the relative ineffectiveness of the Freedom of Information Act when dealing with requests for detailed financial information on PFI.

Commercial confidentiality clauses are not compatible with public services contracts. All of the trust's financial transactions with its PFI 'partners' are subject to the so-called Project Agreement, which is basically a closely guarded trade secret.

As a result, "affordability" and value for money deliberations are not transparent. Disputes between employer and staff in respect of jobs, pay and conditions cannot be resolved under the present arrangements. Trade unions are effectively attempting to negotiate with both hands tied behind their backs.

We are being doubly exploited, since the taxpayers have also had to bail out the PFI "Private" financiers – the Royal Bank of Scotland (and other banks).

PFI deals should be renationalised and brought back fully into the public hands. Commercial confidentiality and private profiteering should be abolished from public services.

Mick Griffiths retired community rep/former UNISON branch secretary.



Autumn 2006: marching for the new hospital to be publicly funded

the Public Sector Comparator (PSC): indeed there is no public sector capital available to build one even if it were to prove cheaper and better. So the PSC is never simply a plan for the same hospital: it is always a much less attractive and less interesting project, generally involving the refurbishment of old buildings rather than construction of new ones, but funded through public sector borrowing at government borrowing rates.

However the fiddles don't stop there: the PSC, because it involves less new build, can often come out at close to the same cost as the PFI scheme. The PSC in the Wakefield and Pontefract project, according to the Full Business Case, was less than one tenth of one percent (0.1%) more expensive than the PFI over 35 years.

So to make a case for PFI representing better value for money, the PSC has to be made to appear far more expensive than it actually is – and this involves an elaborate argument that the private sector is shouldering a large amount of “risk” under the PFI contract, whereas that risk would remain in the NHS under a PSC: then all this is required is to make up a suitable cash value for the “risk” ... and PFI can begin to look like a bargain.

UNISON has consistently raised its concern that one of the major risks was that while the private consortium was responsible for designing the hospital, the Trust has always remained responsible for the clinical effectiveness of the designs – leaving the Trust holding all of the risk when it becomes clear that they have got their sums wrong. But just like the rest of the local population, the UNISON branch was excluded from any significant involvement or voice in the decisions that were taken in secret by the Trust board, advised by a large and expensive circle of private sector “experts”.

In the case of the MYHT PFI scheme, the FBC assumed that the PSC would leave the NHS carrying a ‘risk’ of up to £120m, while the PFI would reduce that to just £54m (Table 1-4). This may sound significant, but few of the

‘risks’ actually become liabilities (hence the enthusiasm of the private sector to sign more PFI deals, and the hefty profits they pile up from doing so) – and in exchange for escaping a theoretical short term risk the NHS would be forking out a hefty long term guaranteed payment.

And when the scheme is looked at over the 35-year contract period, the claimed “saving” adds up to just 1.6% of the total outgoings. At the end of the day the PSC figures were just make-believe, a fig-leaf to protect the modesty of the Trust as it signed up for a deal that was set to cost at least £1.4 billion for a hospital costing £311m to build.

Board kept in the dark

UNISON was shocked to discover that was not just the unions and the wider public who were kept in the dark by the failure to publish the full details of the PFI Full Business Case: the Trust Board too was left to guess at the content of the missing sections, and as a result has effectively signed up for a pig in a poke.

Union reps were frustrated at the lack of transparency – but they were not the ones required to give their endorsement as Board members to a deal that would cost at least £1.4 billion.

Looking at the shambolic, vague and inadequate paperwork that has now been published, it is amazing that Board members were prepared to vote through the project with as little information as they were given. It's hard to believe that a regular bank would regard this level of documentation, with all its inconsistencies, as sufficient to back a development loan for a whelk stall, let alone £311m worth of new buildings, to be financed on a 35-year contract.

But by then two of the non-executive directors had already been involved in PFI-style deals (NHS LIFT) elsewhere – so maybe they at least thought it was normal to be kept in the dark and to nod through schemes without having the full details in front of them.

Countdown to chaos: events since the PFI contract was signed

Just eight months after the PFI contract was signed in June 2007 the Trust announced plans to close 92 more acute beds in addition to the 125 that had already closed since 2006 – allegedly as part of a £4.4m investment in community health care. The announcement in February 2008 came just a week after figures revealed that 92% of the Trust's 1268 beds were occupied across all three hospitals. (Wakefield Express February 11 2008).

But even as they defended the decision, Trust bosses were having to explain why two years after previous announcements that services were going to be reorganised to reduce length of stay in hospital and enable more patients to be treated in fewer beds, the predicted reduction in demand for beds had not yet taken place – in fact numbers needing hospital care were still increasing. The Trust was actually having to open up additional spare capacity in hospitals and recruiting additional staff to cope with the caseload.

Among the plans floated in the new proposals were the establishment of 25 rehabilitation beds for those who did not need a front-line acute bed, a community respiratory service to treat people "in the community" and avoid hospital admissions, a scheme for supported discharge of stroke patients who would receive the remainder of their care "at home or in the community" and the investment in more community based therapists.

Still elusive was any definition of just what was meant by the phrase "in the community" and where any community facilities were to be located.

In February 2010 the focus shifted to Dewsbury Hospital as the Trust announced that plans for a £29m 60-bed specialist cancer wing had been scrapped for lack of

cash, raising wider concerns of the future of other services at Dewsbury as new investment appeared to be increasingly centred only on Pinderfields.

In October these fears were reinforced when another round of "centralisation" led to the decision to axe trauma care, inpatient children's surgery and neo-natal intensive care at Dewsbury, once again transferring services to Pinderfields. In exchange for the loss of these specialist services, Dewsbury was to become the dumping ground for more "general medicine" cases that would otherwise have been treated in Wakefield, and an extra 1,400 medical patients a year were to be diverted there at peak points of peak demand.

In 2011, as the consortium neared completion of the new Pinderfields Hospital and RBS sold on its share of the project to the tax-dodging HSBC subsidiary HICL Infrastructure Investments, Trust chief executive Julia Squire was forced to admit that the Trust was in serious financial trouble as a result of the PFI contract. It later emerged that the Board had been warned of this the previous November, when members were told that they had made "inaccurate financial assumptions". Ms Squire told the local Dewsbury paper *The Press*:

"The contract was assessed as affordable, but the way it is structured does increase the trust's savings programme year on year. In the new economic climate this is a pressure."

The services finally transferred into the new Pinderfields in March 2011: by June it was already clear that the Trust had got its calculations badly wrong, and after closing 250 acute beds as part of the PFI project, the MYHT board was discussing reversing some of its previous decisions – and reopening 76 beds it previously closed in Dewsbury.

Pinderfields even as it opened was already too small, and could not cope with additional patients from outside its immediate catchment area: the new state of the art hospital was consistently failing by some margin to meet

UNISON
Union Eyes
Wakefield and Pontefract Hospitals UNISON No. 12, Spring 2008

PURE FINANCIAL INCOMPETENCE!

Ministers warn of more NHS pay restraint

After months we get (most of) the documents that show the facts behind our £311m hospital scheme ...

JOIN UNISON today: form on page 7

UNISON Branch AGM
April 3, 7.30pm
Wakefield Labour Club, Vicarage Rd

INSIDE:
● Do the sums add up? Your guide to what's there and what's missing in the PFI Business Case
● Secretary's Annual report, ● and much more!

If the finance or organisation of the new hospitals now being constructed in Wakefield and Pontefract go wrong, managers will have only themselves to blame. After two years of further half-hearted investigations and selective manipulation of inadequate information they are presenting ahead with a plan that has more holes in it than a UNISON toilet paper roll and most of the staff have had a copy of the Full Business Case for the new hospitals in their hands. It is clear that a crowd of people in the PFI bid team were that they should be punished in the final form within a month of completion.

Whether the complete report is still not available for details are: ● Focus on the case of return to be generated by the consortium ● Numerous details on the investment of new clinical support staff under the T1P1 arrangements, although which they would be allocated to work under the management of the consortium, while re-

maining NHS employees ● Details of any additional funding to be carried out by the consortium ● Details on the time that will be allowed for notification of problems – a significant component of the accountability and monitoring of the PFI contract

Letters from some of the long list of high-cost financial and legal advisers during their financial inspections and fully supporting the project. Further, just as every one of the consortium are some of the have been accepted, and the projected on bed numbers and cost which have consistently changed from earlier negotiations, and which our

branch has consistently argued and highly over-optimistic. The industry of beds, which the Trust is allowed to be just over 10% less than the full 1,400 being lost in Dewsbury, and the real cost of the scheme will be felt in Wakefield and Pontefract where the combined bed loss will be almost 20%.

Too small to cope In UNISON's view these will result in a hospital that will be too small and as a result will struggle to cope with the same way as many other trusts across the country that are already stuck with hefty bills for the long-term use of county PFI hospitals. We can now see the scale of this type of problem in many trusts across the country. Bromley Hospitals Trust in South East London, the consortium, faces a massive cumulative deficit of £10m over the life of their PFI. Nearby the Queen Elizabeth Hospital in Warwick has huge "technical losses" by the

all the rights coming out of the Government are that over years of pay restraint. What that means is more pay awards that fail to meet inflationary pressures, and other policies on the increase that cost of raising for health care staff is squeezing salaries hard. We can also expect to see more engaged pay restraint which come back the odd pay rise to help grip up the union. Gordon Brown needs to have the words of warning from UNISON and the other

Making public sector workers pay the price for the booming economy will be the only way that Labour Party's economic goals will be achieved and have the real world to back off. To find out more about UNISON's campaigns on pay and conditions – and how to take a look at www.unison.org.uk

The Workforce Challenge

In May 2012 the Trust launched the Workforce Challenge – as a means to make savings by reducing staffing and the pay bill. It began with the assertion that the Trust's deficit for the previous last year was likely to be £19.7m, and that the underlying deficit was estimated at £37m.

The argument was simple: since there was a hole that big in the finances, and 70% of the Trust's income was spent on staff, staff had to carry the lion's share of any savings to balance the books. The document said as much:

"While staff are at the heart of our patients' experience, the burden of meeting this challenge will impact most on our workforce."

The working assumption was that the Trust needed 'cost improvements' of £24m by 2013, but the Workforce Challenge admitted that only £14m of potential savings had been identified. Towards this target no less than ten reviews were set up, the most significant from UNISON's point of view being the Admin and Clerical review and the review of Clinical Nurse Specialist arrangements.

The Admin & Clerical review set out to cut the equivalent of 40-80 jobs to save £1-£2 million, primarily from medical secretaries, booking teams, coordinators and facilitators, and ward clerks. The main focus was on staff below Band 7. This was the review which led to the ongoing industrial dispute that has brought repeated strikes as admin and clerical staff resist downbanding that could cost some staff more than £2,000 a year in lost salary.

There was also to be a separate review of management, seeking to cut between 2 and 6 jobs, even while admitting that management costs in the Trust were higher than comparable Trusts elsewhere.

A review of nurse management also set out to cut 2-6 posts, as

did the review of Clinical Nurse Specialists review which also wanted to cut 2-6 posts (from a staff of 197, including staff transferred into the trust as a result of the takeover of community services). Yet another review of estates and facilities management set a target of cutting 40-80 staff to save £1-£2 million.

The Trust stated that this was partly based on recommendations from the PriceWaterhouseCoopers review of the PFI contract, which – in keeping with its policies on transparency and engagement – the Trust refused to release to the unions or to the wider public.

On top of this the Workforce Challenge included reviews of

I think we'd work better if we'd been party to decisions about working practices!



Operating Theatre Productivity (seeking to save £1.9m this year); Out Patients productivity – based on more consultancy, this time from Ernst & Young – and aimed at saving £1-£2 million; and procurement practices, with no immediate threat to jobs.

So the Workforce Challenge was consistently aimed at seeking savings from the lowest paid and least senior staff, while leaving in post the managers whose systems appear to be seriously deficient in comparison with other Trusts, and whose financial incompetence had brought soaring bills for consultancy and of course the signing of the PFI contract – with all the consequences we can now see.

its performance targets of seeing 95% of emergency patients within four hours, delivering just under 89%, with reports of seasoned nursing staff being reduced to tears by angry patients waiting for treatment. It was the only Trust in the region, and one of only ten in the country to miss the A&E targets.

Pressures on Dewsbury Hospital were also highlighted by the inquest verdict castigating management at Dewsbury Hospital for not improving its procedures 11 months after a baby died as a result of a 61-hour delay in a caesarian operation because midwives were too busy.

The Primary Care Trust – perhaps realising that the level of demand was linked to the PCT's own continued failure to deliver promised improvements in primary and community health care – had agreed to fund the additional emergency admissions at the full tariff price, rather than impose a reduced rate on those that exceeded the target. Barnsley Hospital 11 miles away had also agreed to take on some of the additional elective patients who were being diverted into private hospital beds to reduce the waiting list backlog that had built up at MYHT, as a result of beds being clogged with emergencies.

The MYHT Board had earlier admitted to its failure to take inflation or VAT into account when calculating the costs of the new buildings. It set a massive £60m target for budget cuts over two years in a desperate attempt to balance the books. Inflation had helped to push up running costs by £6m a year above previous projections, and the Trust was facing penalties of up to £5m for exceeding permitted levels of readmitting recently discharged patients to hospital. It was already falling £14m short of its new savings target.

Private management consultants Finnamore were brought in to draw up plans for "reconfiguration" of services to cut spending in the

hopes to achieving foundation trust status, with potential cuts including cardiology services, A&E and the children's ward at Dewsbury.

In July 2011 the Trust's auditors warned that "it is recognised that the trust is dependent upon future financial support to achieve statutory break-even in 2011-12". Discussions on such support "have yet to be concluded". By September 2011 MYHT was the only hospital declaring a deficit in Yorkshire and Humber.

By October MYHT was missing its targets for seeing elective patients within 18 weeks of referral, getting to just under 80% of those referred within the target time, rather than the required 90%.

The regional efficiency plan published by Yorkshire and Humber Strategic Health Authority warned that the first full year of the PFI unitary charge at MYHT would, together with the national target of efficiency savings, create a massive £45m target for savings in 2011-12.

The elusive "black hole" in the finances

Stephen Eames arrived with dire warnings, apparently based on findings by costly management consultants Ernst & Young, who had been wheeled in by Yorkshire & Humberside Strategic Health Authority. They warned that the trust faced "massive challenges" if it was to turn its finances around.

They declared themselves alarmed by the financial problems they had uncovered. They claimed that growing numbers of local patients were no longer being treated in Mid Yorkshire hospitals, but were instead being referred by local GPs to hospitals as far afield as Goole and Barnsley.

The Trust was told it needed to strip out 20% of its costs (saving £2 for every £10 of spending) and concentrate on its 'core services'. This could even mean moving the regional burns unit out of Pinderfields to another Yorkshire trust, despite the costs and loss of revenue of such a massive change.

But as staff reps tried to get more details of the "black hole" it seems to have vanished as swiftly and mysteriously as it first appeared.

It was first reported at the beginning of May. But by the June Joint Consultative and Negotiating meeting with staff side it was no longer being discussed, and in July new figures were presented which stressed the need for £80m in savings by 2015 and a reduction of 1100 whole time equivalent posts to scale down the workforce.

Early in August UNISON's secretary Adrian O'Malley asked what had happened to the black hole, but no

answer was forthcoming.

The Trust had just appointed a new 'Associate Director of Organisational Wellbeing' – while seeking cash savings that undermined the wellbeing of low paid staff.

By September more questions were being asked about the black hole, which management no longer mentioned in discussing the financial situation. Instead they made clear the objective of saving £20-£23m a year through Cost Improvement Programmes for each of the coming 3-4 years.

Management were repeatedly questioned on the value for money of employing Ernst & Young



and other costly management consultancies when the plight of the Trust had not been improved by any of the many previous consultants' reports.

Staff side argued that since public money was being spent on consultancy work, the details of the contracts with Ernst & Young and others should be in the public domain.

The few details that have been

published show that in the first nine months of 2012 the Trust forked out £2.65 million in fees to Ernst & Young, but with no apparent targets being set for them, and no value for money assessment of the work they do.

MYHT later revealed that the decision to award the contract had been made in a secret meeting of the Trust Board, and not put out to competitive tender. There was no fixed timescale for the contract, which could therefore potentially be eked out for many more months by E&Y, who were getting paid by the day, but had been set no savings targets and were not being paid by results. There was no incentive for them to finish, and every incentive to milk it as long as they could.

Unsurprisingly given this generous approach there have been no attempts to benchmark the spending on consultancy in MYHT against the levels of spending in other NHS Trusts.

One reason information on the finances was so hard to obtain was that the previous finance director, on whose watch any "Black Hole" may have developed, was no longer around to answer any questions, having unaccountably been declared "redundant" and left on MARS (the Mutual Agreed Redundancy Scheme which up to now seems primarily to have benefited senior managers).

And as further evidence that the Trust has its eye on the ball, as the PFI bill drove the Trust deeper into crisis, the director of estates, who was also in charge of PFI, was also absent, on "gardening leave".

The following month MYHT was identified by the newly merged NHS North of England SHA as one of five trusts with 'high risk' on its finances, with the question of financial support to bridge its £14m gap in efficiency savings still unresolved. The downsized 24-hour emergency service at Pontefract Hospital was closed at night (10pm-8am) after the Trust failed to recruit sufficient medical staff.

The financial situation worsened abruptly as 2011 ended with a Leeds employment tribunal ordering the Trust to pay a massive £4.5m compensation to a hospital consultant who had suffered mental trauma after colleagues campaigned to get rid of her following maternity leave. Dr Eva Michalak, who worked at Pontefract General Infirmary, won claims for sex and race discrimination and unfair dismissal against the Trust and three of its senior staff members. The tribunal panel, awarding what was a record-breaking high payment, had been "positively outraged at the way this employer has behaved" and concluded the Polish-born doctor would never be able to work again.

By January 2012 the Trust's deficit had grown even further, and was forecast to be just under £20m by the end of the financial year – enough to tip the entire region into the red. A team of accountants from yet another consultancy, Ernst & Young, uncovered 'significant shortfalls' in the planned £31m savings programme, even though the £14m gap in the budget had finally been covered by a handout from local commissioners.

By the end of January 2012, with their management regime discredited and their financial projections in ruins, desperate problems staffing emergency services, and the Trust facing an increasing struggle to survive, Chief Executive Julia Squire resigned, swiftly followed by the Trust chair. She was replaced on an ad-hoc basis by Stephen Eames, until then chief executive of County Durham and Darlington Foundation Trust – who took office in March, with a salary package that has risen to cost MYHT an inflated £300,000 per year.

There were warnings that the Trust may have to be



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Wakefield and Pontefract Hospitals UNISON No. 13. Spring 2009

UNISON
Branch AGM
3 meetings,
3 dates,
3 venues...
3 chances to
attend and
win **£100**
in our new
prize draw!
SEE BACK PAGE



RBS is now 70% owned by the taxpayer: so why should NHS still pay through the nose?

NATIONALISE our PFI hospital!



UNISON is calling on the government to nationalise the £200million project for building new hospitals at Pinderfields and Pontefract. At present the scheme is financed primarily through the Royal Bank of Scotland under the Government's Private Finance Initiative (PFI). But since the contract was signed, RBS has been plunged into a massive crisis as part of the meltdown of banks in the UK and other countries worldwide. Gordon Brown and Alistair Darling stepped in with tens of billions in support – and the government now effectively owns 70% of RBS. Logically this level of public sector support should mean that PFI projects like the Mid Yorkshire Hospitals project should be completely reexamined: our branch is calling for PFI schemes involving RBS to be nationalised.

What is the point of our Trust continuing to pay a massive, index-linked 'rental charge' to RBS for the next 32 years – valued at £123 million – when the government now owns the bank? Why should we squeeze down staffing levels by 1,100 in this Trust alone, in order to line the pockets of the remaining RBS shareholders? Even now the government has become secretive as over the fine detail of the Final Business case they signed with the Trust. For more than a year now, UNISON has been making repeated requests under the Freedom of Information Act for the Trust to publish additional key details which were concealed as 'commercial in confidence' when they reluctantly published the bulk of the FBC in 2007. So persistent have we been in trying to get this information that a special Freedom of Information commissioner has been assigned to deal with this case. But despite the fact that there is no legitimate argument for the missing details to be kept confidential, despite the fact that it's now effectively OMB Bank that is refusing to publish the details, and despite the fact that MPs in our local area include two leading government ministers, we – and local people – are still being kept in the dark, while leaving the bankers free to privatise the profits – which include making millions from our local PFI project. This is delivered neither value for money nor accountability in our health service. That's why UNISON says:

- Nationalise the PFI scheme
- Stop any further PFI deals
- Abolish 'commercial confidentiality' in public services. Open the books – tell us the truth!

AGM: see back page **Join UNISON today: see page 7**

dissolved and its services split up between other nearby trusts. The Trust even revealed it was investigating the possibility of using Army medics to staff the A&E at Pontefract, but eventually rejected the idea.

In February 2012, with Pontefract A&E still closed at night, Channel Four News ran a major exposure of the "flagship PFI hospital turning away patients because of lack of capacity", quoting figures showing 87 such "service transfers" in 2011, with patients sent to Dewsbury instead.

£23m "cost improvements"

Stephen Eames' arrival at the trust was swiftly followed by

the announcement of a plan to make £23 million cost improvements in 2012-13, once again focused above all on reducing the cost of the workforce. These included reduced hours and offers of unpaid leave for staff. There was a fresh emphasis on the notion of "integration" of services, and talk of possibly downgrading Pontefract's already downsized A&E to a minor injuries unit.

At the end of April a detailed report on the Trust by the *Health Service Journal's* Dave West raised the obvious question of whether the cash handouts which had managed to keep the Trust afloat so far would continue once GPs took over responsibility for commissioning decisions.

"The health economy is one of the most deprived in the country, with associated problems particularly long-term conditions leading to early acute illness. It means there is heavy demand on general acute services. These can often have a lower – if any – earnings margin for the trust, compared to elective procedures. At the same time the trust sees relatively less demand for the financially beneficial elective work. There is very little opportunity for the trust to ease its finances with private sector income." (HSJ 24 April 2012).

Other issues include the development of new trauma centres in Leeds, Hull and Sheffield, which were expected

to reduce further the number of serious emergencies dealt with at MYHT and make recruitment of A&E specialist doctors more difficult.

The confusion deepened when also in April 2012 extra beds opened in the casualty unit at Dewsbury district Hospital to help cope with demand following the night closure of the A&E Department at Pontefract. Into June of 2012 rumours that specialist care services at Dewsbury were to be closed were being strenuously denied. Meanwhile the trust attempted to set a target to reduce accident and emergency admissions in Wakefield by 8%.

Just a month later consultation was opened on plans to shift a number of specialist services to Dewsbury and Pontefract to deal with capacity problems at Pinderfields. Neuro rehabilitation services, a 12 bed unit, would move from Pinderfields to Dewsbury to deal with patients who had suffered strokes, brain injury and other conditions, and link up with Dewsbury's stroke rehabilitation services. Ophthalmology services would be transferred from Pinderfields to Pontefract. There would also be additional orthopaedic services at Dewsbury and Pontefract to expand elective capacity, after it was revealed that half of the trust's hip and knee replacement operations were being sent to independent sector hospitals, draining scarce resources out of the NHS.

MYHT blocking Foundation Trust pipeline

Also in May the *Health Service Journal's* Ben Clover revealed that Mid Yorkshire Hospitals Trust had been one of 19 trusts formally warned by the Department of Health director of provider delivery Matthew Kershaw that it had fallen behind the schedule required by the "foundation trust pipeline" to prepare them for foundation status. Writing to Stephen Eames, Kershaw – who later became the special administrator presiding over the carve up of South London Healthcare trust and Lewisham Hospital – had suggested that "the unsustainable providers regime could help identify a sustainable service strategy." According to the *HSJ* summary,

Kershaw also pointed out that the finances of the trust's PFI project had been based on a plan to reduce the workforce by 20%, which had not been achieved. The letter came close on the heels of the resignation of all four of MYHT's non-executive directors – creating a clean sweep of chair, Chief Executive and non-executives on



Adrian O'Malley, Branch Chair

At its July board meeting the Trust decided to impose changes to the Protection of Pay and Conditions, Attendance Management and Grievance/Disputes policies. The new policies were given to the Trade Unions in March for comment with a so called 'consultation period' of 3 months, but it was clear that any comments which were contrary to the proposals would be ignored.

A meeting was arranged to discuss the policies where the Trade Unions opposed the major changes and offered alternatives. As we suspected most of our comments were ignored and the original proposals were passed unchanged.

What are the main changes to the policies?

Protection of Pay and Conditions

The Trust has claimed that staff within Mid Yorkshire have a generous protection policy compared to staff in neighbouring Trusts. This is a lie.

5 years maximum long term protection (for pay bands) and 12 months maximum short term protection (for unsocial hours etc) is the norm within Yorkshire.

The Trust's plans to give 2 years long term protection and 6 months short term protection are a cynical attempt to save money as they move hundreds of staff around the Trust as the new hospitals open.

Attendance Management (Sickness policy)

Staff will now be forced into the stressful formal procedure after 3 separate sickness occasions in 12 months, instead of 4.

This will increase the number of staff going through formal meetings as well as put pressure on those who are already coming to work when they are ill in order to avoid getting a sickness caution.

On top of this strict cautions will last for 6 months instead of the current 4 months.

At a recent meeting Susan Tyler, Assistant Director of HR, admitted that sickness levels for the previous month were at 4.1% which is nearly at the Trust target of 4%.

Trust declares war on terms and conditions



The massive cost of the PFI hospital is the driving force behind the latest round of cuts

UNISON believes this shows there is no need to impose stricter targets on short term sickness and the Trust should concentrate on assisting staff to get back to work from long term sickness, which causes far more problems on the wards and departments.

Grievance Procedure

Currently staff or groups of staff can appeal through 4 stages of management if they have a grievance, with the final stage being a panel made up of 3 Directors/Senior Managers and 2 Trade union reps.

The Trust wants to replace this with an appeal to the individual line manager and a single appeal to a level above. This reduces staff's rights to an appeal to a higher level within the Trust.



It also increases the likelihood that staff will end up in Employment Tribunals or

the Courts if they are unhappy with the internal grievance outcome.

What's the latest position?

In a letter to the Trade unions it was stated that the new procedures came into effect on 1st August 2010.

But at the time of writing the new policies have not been put on the intranet.

UNISON and the other Trade Unions have lodged a collective dispute opposing the changes, and have invoked the Status Quo – which means that no changes should be implemented until the dispute is resolved.

We are waiting for a reply from the management side. The grounds for our dispute are:

a) The Trust has not followed its own jointly agreed consultation procedures by imposing the new policies;

b) The Trust has ignored the Agenda for Change Handbook, Section 19, which says that Terms and Conditions "will be determined locally following consultation with staff representatives"; and

c) The staff within the Trust have not been given legal notice to the changes to their contracts.

We have made it clear to the Trust that we will not sit back and let them slash our Terms and Conditions. We will keep UNISON members informed about developments and if necessary ask for your support in fighting these attacks.

INSIDE

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- £55m cuts to pay for PFI – p4
- NHS White Paper – p6



U Floggen, Facilities Supervisor
Facilities staff: forward to the 19th century!

The new hospital is coming and so, we are often told, are 'new ways of working'.

For those staff in Facilities, who are being retained by the Trust as Housekeepers and Patient Movement Porters the Trust has entered the modern world with a bang!

Without any consultation with staff whatsoever (after all consulting with staff and their trade union is so old fashioned) the modern managers have brought in a wonderful new 'clock machine'.

This new-fangled machine allegedly ensures that staff are paid when they attend work – except when they are 6 minutes late; then for some reason it docks staff 15 minutes pay.

Confusingly if staff clock off 6 minutes late, it doesn't pay them 15 minutes extra!

To get around this problem managers are insisting that staff attend work 15 minutes before and after their shifts: that would be 2½ hours a week unpaid for full time staff. How wonderfully modern that is!

Staff have also been told that tea breaks are also 'old-fashioned', and unless a member of staff works 6 hours he or she will not get a break! Apparently this is the law of the land. Which law and which land has not been clarified.

So if you see a Housekeeper or Porter not moving – or even worse, sat drinking tea – report them immediately to your gangmaster, carry supervisor, so that they can have their pay docked.

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the board since the beginning of the year.

In August 2012 it was revealed that as a result of cash shortages nurses at Dewsbury Hospital were having to clean wards two days a week. Standards of care that elderly patients at Dewsbury were strongly criticised in a report by inspectors and trust bosses were given a formal warning by the care quality commission, following a similar warning over the hospitals maternity unit six months earlier.

With the trust headed for a £26 million deficit by 2013, there was speculation as to the actual figure being paid out as the unitary charge on the PFI hospitals. The Dewsbury local paper *The Press* reported that the 2012-13 year payment was £43 million: trust bosses claimed that the figure was £34.2 million but a spokesperson refused to answer questions on how much Balfour Beatty was making from the deal, arguing that "all information relating to our PFI deals is commercially sensitive."

UNISON
Jeyes

Mid Yorkshire Health UNISON No. 16, Summer 2011

INSIDE
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● New hospital in pictures - p2

£60 million cuts over 2 years!

We have two brand new hospitals, but we still have the same old financial miseries, now compounded by the steadily rising cost of payments on the £1.1bn PFI contract that hangs like a millstone round the neck of our Trust.

Indeed Mid Yorkshire Hospital was named in April by the Department of Health as one of 23 hospitals that have high cost PFI schemes whose financial situation means they are unlikely to be able to achieve Foundation Trust status.

Interestingly the Department also fears that Trusts like ours – desperate to meet Andrew Lansley's deadline to become a Foundation by 2013 or face being 'franchised out' to private managers or broken up and taken over by other Foundation Trusts – may resort to dangerously low staffing levels in order to cut costs.

This of course is what happened a couple of years in the disastrous failure of care at Mid Staffordshire Hospital, which was rubber-stamped by Members of a Foundation Trust even as appalling failures of care were literally killing patients in A&E and on the ward.

Managers had slashed nursing staff and medical staff to well below basic levels in a drive to cut spending by 15% a year.

But now our Trust faces pressure to cut £60m over two years, more than one eighth of the Trust's annual budget to stay afloat.

It's tucked away in the Rowley wing of the April 12 Trust Brief, but it's official. Half of this £120m is to meet the government's massive 4 percent per year target for so-



Driving cuts and privatisation: Health Secretary Andrew Lansley

500,000 joined the TUC protest march through London on March 26 to fight cuts in public services

It is not even clear if they have one committee looking at this, or two separate ones: the Team Brief talks in two successive paragraphs about a "Health Economy Foundation Trust Board" and then a "Financial Services Recovery Board" which is apparently "working up schemes". Which of these is really in charge?

And why do we need two bodies, when it is clear that because so much of the Trust's routine non-clinical budget is now committed to two fixed PFI "salary charge" payments, all of the cuts must fall on clinical budgets, "postnatal" and "daycare".

The Team Brief says that "significant" must reduce by 8% for clinical service groups and 10% for corporate: this is likely to mean "outsourcing" some services, sharing some others and "developing new

partnerships". It's all terribly vague and unconvincing. There will be fears that having taken over local PCT services, the Trust will squeeze some of these, and milk resources from this sector to prop up its hospital budget.

But of course reducing community health services would be especially counter-productive if the Trust also wants to spend up the discharge and shorten the average length of stay in hospital.

Gaps

The Team Brief says that the Trust spends £20m a year on temporary staff, overtime, waiting list initiatives and clinics, but to plug the gaps that the temporary staff help to fill.

As staff in the Trust, UNISON could turn all these questions round and question

management's seriousness: **WHY** is the agency and overtime bill so high? **WHY** is our average length of stay so high? **WHY** are so many outpatient clinics cancelled? **WHY** are theatres so poorly utilised?

And **WHY** has the PCT not been paying us the right amount for the treatment we

Suggestion box

UNISON has always claimed that the reduced level of services at Pontefract would result in an under-used hospital then, coupled with unacceptably greater non-PFI overheads.

That's exactly what's happening. Staff are full and struggling to cope – while facilities at Pontefract are in under-use. It has been described as "inefficient".

For one service (do we can offer the Trust to revisit this and restore some of the services they used in Pontefract, to ensure they and local people get full value for money from that over-building, after all, we are all set to be paying for until 2048!

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Financial burden of A&E services

In October 2012 *nationalhealthexecutive.com* reported a study showing that seven out of every 10 Accident and Emergency departments were losing money, even though they are having to deal with increasing numbers of patients. Hospitals had increased their efficiency in diagnosing and treating patients in A&E, but trusts were receiving an average of just £79-£123 for each A&E patient while costs averaged between £69 and £129.

The study, by the Foundation Trust Network, argued that numbers of admissions could be reduced by providing increased nursing and physio services in A&E before discharging patients, and by increasing out of hours primary and community services – precisely the policies that have been repeatedly discussed, but never materialised in Mid Yorkshire.

Also in October plans were finally revealed the downgrading the A&E service at Dewsbury and also its maternity unit. Services will be centralised at Pinderfields. The formal public consultation was due to start in January 2013.

November saw the Commons Public Accounts Committee name Mid Yorkshire as one of ten hospital trusts in serious financial trouble. PAC chair Margaret Hodge argued that it was unclear how the Department of Health could continue to underwrite PFI payments to hospitals like mid Yorkshire, and said:

"We do not know whether a bankrupt trust would be allowed to fail, or how and when ministers will intervene. And it is not clear how the Department of Health would ensure essential services are protected if the trust fails."

In December the *Health Service Journal* reported David Bennett, the chief executive of the health regulator Monitor saying that he felt it would be worth examining the possibility of a public sector buyout of a slightly larger PFI contract than Mid Yorkshire, the £330 million PFI hospital at Peterborough, which was then in deficit to the level of almost 25% of its turnover, and, like MYHT, entirely dependent on external additional funding to fend off insolvency.

In January 2013 the MYHT board heard that the year end deficit was forecast to hit £24.7 million, which was regarded as an improvement against the original plan. The finance performance report argued in justification that "all statutory duties are being met ... with the exception of the duty to break even".

The Trust's financial plight and performance both appear to have improved marginally to the end of the financial year according to the latest available Board Papers (March 2013) as this report is prepared.

But MYHT is still reliant on handouts, as the financial situation of the NHS gets tighter, with the heaviest pressure on front line trusts with high volumes of emergency work.

Another MYHT "consultation": 200 more beds at risk

All the hopes of balancing the books of MYHT now hinge on forcing through a massive programme of cuts under the heading of the Clinical Services Strategy. It would axe 200 beds, hundreds of jobs and downgrade services at Dewsbury in the hopes of delivering £15m of 'savings' by 2017.

The plans, set out for the public in a skimpy and superficial A5 document, were submitted to a token "consultation" in early March, and in theory this is due to run to the end of May: but it's already clear that health chiefs have made up their minds, and intend to drive through their "Option 2" regardless of public views and opposition. So barring truly massive protests by local communities, patients, campaigners, health workers and politicians the Trust could once again be on the slippery slope to more failing services and chaos by next winter.

The £38m plan to reorganise services would reduce Dewsbury's A&E to an urgent care centre, and downgrade Dewsbury hospital to deliver only elective and rehabilitation services – with all serious emergencies and complex cases having to travel to Wakefield.

The bed cuts have been planned at the very same time as the new Pinderfields hospital has been cramming



extra beds into its state of the art 4-bed bays to ease the pressure on bed numbers – at the expense of patient care, safety and efficiency.

But the Trust admits that if the cutbacks will not put the Mid Yorkshire Hospitals Trust back into financial balance even by 2017: if it all works exactly as planned the Trust would still be running at more than £10m in the red each year. So the prospect is more cuts to follow these,

and more cuts after that. At the centre of the Mid Yorkshire crisis is still the soaring cost of the £310m PFI scheme to fund the new hospitals in Pinderfields and in Pontefract.



UNISON Union eyes

Mid Yorkshire Hospitals Branch

No. 17, Spring 2012

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Lansley's £1.5 billion handout for Trusts saddled with PFI

Our Trust has been excluded from the list of seven Trusts whose survival chances are most severely blighted by unsatisfactory PFI bills. However Mid Yorkshire Hospitals NHS Trust was very much one of the 22 Trusts which were named last year by the Department of Health as being at risk due to PFI, with financial problems, so severe they could not at present expect to achieve foundation status.

The seven selected Trusts will be able to bid for a share of a £1.5 billion pot of cash over the lifetime of their PFI contracts – but with rigorous strings attached. Others, including Mid Yorkshire, will have to scrape by as best they can.

Lansley's scheme seems aimed both at diverting some attention from the mounting opposition to his Health and Social Care Bill (with almost every group of specialist doctors now joining union calls for it to be dropped), and at propping up PFI by subsidising some of the weakest. As a result PFI and its profit streams to shareholders are not only left intact, but Lansley himself is still signing off new contracts: last year he signed new PFI hospital schemes worth £750m in Liverpool and Hartlepool.

999 crisis: our new hospitals can't cope

UNISON's warnings that our two PFI hospitals were not big enough and that promises of diverting patients into the community were worthless have again been borne out.

Channel 4 news on February 10 revealed the ongoing failures of 999 emergency services, with the Pontefract A&E service closed at night – reportedly down to staff shortages – and now Pinderfields, under pressure, has been turning away 999 ambulances.

Mid Yorkshire declared 87 what it calls Service Transfers last year.



Hurry up George, they're about to close another A&E

each lasting between two and 10 hours. This is the result of the hospital having no further capacity. Patients will normally be taken to Doncaster a further 10 miles away.

Jim Peters, director of professional standards for the College of Paramedics told Channel 4 News: "Patients may be suffering if it takes longer to get them to a point of definitive care".

Shadow Home Secretary Yvette Cooper, also a local MP, described the figures as dreadful: "What that means is huge number

of patients supposed to be going to Pinderfields being sent and not given the treatment they need as fast as they need it".

UNISON told reporters that the divisions are a symptom of a mismatch of patient provision and demand, and that the new £330m PFI, has fewer beds than the one it replaced.

Branch secretary Adrian O'Malley told Channel 4: "We wrote to Mr. various ministers both Labour and Conservative. There's nobody who

can say they weren't aware of this".

The Trust has to pay £60m a year to the PFI company, putting even more pressure on services and staff in the hospital".

The channel 4 report concluded: "Whatever the causes, the long term prognosis for Pinderfields may not be good. The PFI arrangement is in place for 35 years and the hospital was built smaller with the hope that more people could be treated in the community – according to the paramedics we've spoken to that just isn't happening".

Not yet a UNISON member? Join now to make sure there's someone to speak up for YOU - page 8

The basic costs have now risen to more than £40m a year for the Unitary Payment, rising every year, index linked, for the next 29 years: in total even this bill for the new hospital is over £1.5 billion – while the Trust has also to fork out millions more in capital charges and has lost considerable potential revenue income, making the real cost of the scheme much higher.

While Pinderfields was built too small to deal with local health needs, only part of the capacity of the £60m Pontefract Hospital is being used. But the rising cost of PFI payments year by year mean that plans have to revolve around maximum use of these hugely expensive buildings.

So none of the 200 beds to close will be in Pinderfields, because the cost of the hospital does not go down even when services are reduced. That's why, in the quest for savings, Dewsbury Hospital, which does not have a PFI bill attached, is being milked of services and funding.

The Trust's latest "Outline Business Case" is neither a full outline, nor a business case. There is no table to show a



PFI triggers cuts and closures in SE London

In the summer of 2012, Health Secretary Andrew Lansley invoked the draconian powers of the "Unsustainable provider regime" and dispatched a "special administrator to deal with the soaring £200m-plus debts of South London Healthcare Trust, a merged trust with TWO unaffordable PFI hospitals (Queen Elizabeth and Princess Royal).

The administrator decided to throw the net far wider than the stricken trust itself, and reorganise services right across South East London. His proposals, which were subject to just four week's pretence of "consultation" were to break up SLHT and slash back its staff numbers, to write off its accumulated £207m debts, and subsidise the two PFI contracts to the tune of over £22m per year for the next 20 years.

But he also decided to CLOSE the remainder of the third hospital in SLHT, and, worse, to CLOSE acute services and 60% of the buildings at the highly successful and solvent Lewisham Hospital, which is not part of SLHT at all. The plans all hinged upon the assertion that an "urgent care centre" could replace 77% of the work of Lewisham's busy A&E, and that community health services would somehow reduce the need for hospital care.

Despite huge local protests and evidence-based critiques of the proposals, the cuts were rubber stamped in February by Lansley's successor, Jeremy Hunt.

proper breakdown of where beds would be closed, or how this correlates with local patterns of demand and health needs: no explanation of where the "extra" 50 beds and other bits and pieces of expanded services would be tacked on to the (privately-owned) Pinderfields Hospital, and no correlation between the sums of money referred to and the specific changes, cutbacks and investments.

Admission of failure

The document and the supporting Data Sheet on Emergency/Urgent Care amount to little more than an extended admission of the failure of all the previous proposals to shift care out of hospital and expand services in primary care and in the community. Once again there are no details of where the notional "community teams" would be based, how they would be organised, when and how they would be recruited and trained, or why these same proposals should work this time when on every previous occasion the fine words have delivered none of the promised changes.

The Emergency Services Data Sheet makes clear that attendances at MYHT's A&Es increased by a massive 9% last year – and the fact that many of these are seriously ill is underlined by the fact that the increase in emergency admissions, 10%, was even larger.

The total Trust caseload of over 220,000 A&E attendances each year is enormous by almost any comparison. A massive 33% of A&E attenders at Pinderfields were admitted to hospital. Even given the downgrading of Pontefract has meant a greater proportion of more serious cases would be diverted to Pinderfields, this is a very high proportion.



Dewsbury campaigners protesting at the continuing threats to their local hospital

These figures for emergency services are described as the highest or second highest in the North of England: another way to look at it would be to argue that the development of alternative, community based services and primary care in Wakefield and Kirklees is the weakest in the North of England.

Time and again the level of emergency admission is described in the consultation document as “unnecessary”, “avoidable”, or inappropriate – without explaining what other services might be able to take this additional caseload, or how such services might be established. Glib summary tables suggest that a total of 202 beds could be replaced by “investment in services outside hospital” – without at any point saying where that investment is to come from. The £38m development funds detailed on page 44 are all to be invested in hospital beds and services, almost all of them at Pinderfields.

The massive expansion needed to cut A&E attendances and 17,000 emergency admissions a year, reduce outpatient appointments by 20%, deliver minor surgery in (undisclosed) alternative non-hospital locations, and reduce lengths of stay in hospital would clearly cost a similar amount if not more, and require hundreds of staff, properly managed and organised with appropriate information systems and transport, etc.

Yet there is no concrete proposal on who might be in a position to foot the bill for this. The GPs from the two local Clinical Commissioning Groups, now formally in charge of the local NHS budget, appear content to express general support for the proposals without any commitment to make the resources available.

And yet until viable alternative services are put in place, established, and accepted by local people, there can be no real prospect of altering the current focus on services around emergency departments and hospital care.

The document indicates that neither the Trust nor local commissioners have learned anything from previous failed exercises. It’s like groundhog day as we read another account of the same old promises. *Meeting the Challenge* does not even meet its own challenge and boldly set out a clear way forward:



“Give it to us straight. How long have we got?”

- MYHT tell us they want to reduce the use of hospitals, and treat more patients in their own homes or in the “community”: but they outline no practical plan to set up and resource suitable alternative services.
- They say they aim to speed patients through hospital more quickly, but give no detail on how they hope to achieve this.
- They want to reduce use of A&E services, but do not analyse the needs of those attending A&E, or establish what alternatives might ensure they are treated in other ways.
- They announce the need to give more support to frail elderly patients in their own homes, and admit that a major stumbling block to this is the patchy and often inadequate services delivered by GPs and primary care – but the Trust does not control primary care, the body that has done so has just been abolished – and the new body that has taken over also has no plans to improve GP services.



To make matters worse, many of the documents that have been produced up to now, have not been the work of highly paid Trust managers, but produced by even more expensive management consultants, who have cost over £4m in the past year alone.

So the only real winners in all this have been city accountants Ernst and Young, who are being lavishly paid by the day with no fixed timescale to complete their work – and therefore have every incentive to spin it out as long as possible to milk more fees from gullible Mid Yorkshire health bosses.

These management consultants know nothing and care less about the people of Wakefield, Pontefract and Dewsbury. In fact some of the documents seem to have been written by visitors from another planet.

But local health chiefs are also contemptuous of their own staff and local communities: that's why they have repeatedly organised meetings with "stakeholders" that exclude front line health workers and their organisations, and include only token, hand-picked "representatives" from patients and community groups.

While local services face five miserable years of cuts, debts, instability, pointless reorganisation and confusion, Ernst & Young and PricewaterhouseCooper are laughing all the way to the bank – along with a growing list of the Trust's senior managers (who have wangled themselves massive pay-offs to leave, rather than face up to the magnitude of their failure), and its acting chief executive who is picking up a staggering £300,000 a year salary.

The outcome of the scrutiny of the PFI contract by the "hit squad" sent in by the Secretary of State is not yet known as this report is finalised. The consultation on Meeting the Challenge continues, with an utterly predictable outcome

in terms of the decisions that will be taken, but no clarity on what steps might be taken to attempt to implement the new Clinical Service Strategy.

Dependent on handouts

The Trust is still lurching along, dependent on cash handouts and strategic decisions taken elsewhere. Nobody yet knows how willing the new CCGs in Wakefield and Kirklees may be to continue the generous subsidies of their predecessor PCTs that have so far kept MYHT afloat: nobody yet knows what intervention may be led by the NHS Trust Development Authority, Monitor or NHS England's Local Area Team to open up a new and sharper crisis.

What we do know is that the Trust's projections on which they signed the PFI contract in 2007, and almost all of their figures and proposals since the 1990s have been hopelessly unrealistic, and have pushed the Trust into an increasingly desperate situation.

We know that while the Trust Board, numerous directors and Chief Executive have been replaced, the replacements appear to continue relentlessly squandering millions on external management consultants whose plans have repeatedly failed to deliver, and attempting to make cash savings at the

expense of hard working and lower paid staff, while the PFI consortium, tax dodgers and all, management consultants and senior managers are protected.

And we know that the new hospitals as they stand are too small to meet the health needs of a local population in the absence of significant improvements in primary care and a large-scale investment of real money in community based services: and that neither of these developments has even got as far as the drawing board, let alone been formulated into a practical plan of action.



Conclusions

UNISON has argued throughout that PFI was rotten value for money, and an extremely expensive way to build new hospitals. We warned that while local people needed a new hospital, the PFI funding could undermine the financial standing of the Trust and make it impossible to make the best use of this modern building.

When RBS was bailed out by taxpayers' money, our UNISON branch urged that the nationalisation of the bank should be followed up by nationalising the PFI deal, and all of those involving RBS and any other state-owned banks.

But while it was obviously ridiculous that MYHT should have been paying through the nose from public funds to keep up PFI payments to a bank 80% owned by taxpayers, it is no less ridiculous that now the RBS 50% share has been sold on to HICL, taxpayers' money is being funnelled to an offshore tax-dodging bank that simply doles out the profits to its shareholders, and makes no contribution to public services in the UK.

We are not the only ones to have considered ways in which PFI contracts might be bought out or brought back into public ownership. Even Monitor boss David Bennett, a former McKinsey director, has floated the possibility of buying up publicly-traded shares in the £330m Peterborough Hospital PFI.

As we have seen time and again in Mid Yorkshire, in

South London and other PFI-burdened trusts, there is no local solution to problems which flow from sky high and rising overhead costs for buildings which are too small to allow any possibility of trusts working their way out of problems, and a continuing, tightening squeeze on NHS funding that is taking a heavy toll of jobs and services at the front line.

It was government policy that withdrew the option of public funding and effectively forced trust boards down the PFI route; it's government policy to freeze NHS budgets as costs and pressures rise; and it's government policy to encourage commissioners to talk and make promises about switching services from hospitals to the community – but not to allow them the resources to make it happen.

Unless these damaging policies are changed, there is no chance that salami slicing away the jobs, pay and conditions of NHS staff, piecemeal closures of beds and services, and empty rhetoric about care closer to home will solve the problems – or lift the dead weight of PFI from the shoulders of Mid Yorkshire Hospitals NHS Trust.

UNISON will continue to stand up for its members in MYHT, and to fight the loss of services and erosion of quality of patient care. In the aftermath of the Francis Report on the scandalous failures of care at Mid Staffordshire Hospitals, and the recommendations that Trust boards should speak out against inadequate budgets rather than cut services regardless of the consequences, we urge MYHT directors to stand with us and fight for the NHS, rather than work to undermine it.

Previous UNISON publications on PFI and Mid Yorkshire Hospitals

- *Clutching at Straws*: a response to the consultation document *Grasping the Nettle*, John Lister, UNISON leaflet 2000
- *Merger plan: yet another pig in a poke*, John Lister, UNISON leaflet January 2002
- *Debts, deficits and service reductions: Wakefield Health Authority's legacy to primary care trusts* David Price and Professor Allyson Pollock, April 2002
- *Union Eyes* newspaper (editions 2002-2013), written and designed by John Lister for UNISON branch

Documents available from UNISON website www.unison.org.uk (most recent first)

- UNISON Response to Government Reform of PFI, 10 February 2012
- UNISON Response to Government Reform on PFI: The role of private finance in public investment, 16 August 2011
- *Refinancing: profiteering from public services*, 1 November 2008
- *PFI: Against the Public Interest*, 29 July 2008
- *Public risk for private gain?* The public audit implications of risk transfer and private finance 7 July 2008

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