Central Manchester Community Health Council

The Central Manchester PFI Scheme:
Reinventing the flat tyre?

A response to the Full Business Case for the Central Manchester New Hospitals Development, proposed by Central Manchester and Manchester Children's University Hospitals NHS Trust.

Introduction

Central Manchester Community Health Council has produced this report to assist members of Primary Care Trust Boards, Professional and Executive Committees and the Strategic Health Authority in Greater Manchester to make informed decisions about the Full Business Case (FBC) for the Central Manchester New Hospitals Development.

This commentary draws on information from the FBC itself, previous – very different – proposals made in the Strategic Outline and Outline Business Cases, the Final Invitation to Negotiate (FITN) documentation, and information abut the way that other Private Finance Initiative Schemes have developed in England.

The Community Health Council has explicitly and publicly expressed its opposition to PFI because we do not believe that investment in public services by the private sector – driven by their need for profits – is likely to make economic sense, or protect the vital public sector ethic of our NHS.

In developing this commentary, however, we have tried to some sure that we look at the scheme on its own merits and in detail.

The Community Health Council's particular perspective is one of looking at the impact of the scheme on the provision of health services to local people in Central Manchester – in primary care and through community health services – as well as acute services.

Our wider perspective is one of trying to look at the wider impacts of the scheme on the NHS in Greater Manchester as a whole – whether it offers a way to develop specialist children's services and acute hospital services while allowing other NHS services to develop.

Summary

The NHS is currently experiencing one of the longest sustained periods of growth it has known. The growth in revenue allocations to PCTs expected for the rest of the decade should allow for growth in the NHS that allows services to be developed, made more accessible, and closer to patients.

Across Greater Manchester it would be fair to assume for the rest of the decade that the revenue available to all the PCTs collectively will be somewhere close to £300m a year extra.

But, there is a problem… a lot of the money is already earmarked to meet inflation in existing services, meet higher pay costs, etc leaving a far smaller amount to invest in change.

There is a second, even bigger, problem… the cost of providing new upgraded buildings from which services can be provided – to make up for years of under-investment – will not only eat into the growth, it will create huge financial problems.

And the PFI scheme adds a third problem… it is a hugely costly way of funding those new buildings that will mean that the potential for growth and development is squandered for nearly four decades, and it will be squandered to pay, virtually guaranteed, profits to private sector firms.

Because the costs of capital investment are taken out of the revenue expenditure of PCTs the impact of the combination of problems means the growth in funding is not growth at all. We assume that if all the capital schemes planned across Greater Manchester in this decade go ahead – at a cost of over £1,000 million – the impact on the revenue budgets of the PCTs will be a massive, and growing deficit, that could reach that £1,000m figure.

The part that the Central Manchester New Hospitals Development could play in that looming crisis is a major one. The PFI Scheme is the largest single scheme planned in the conurbation, indeed the most expensive hospital project so far in England. The capital cost of this single scheme accounts for over 40% of the cost pressures faced by the PCTs in Greater Manchester as a result of new building costs… and our concern is whether it will be money well spent.

The impact on Central Manchester – an area which has wards with some of the worst health indicators in the country, together with some of the other surrounding inner-city PCT areas – will be disproportionate.

A huge ‘affordability gap’ towards the end of the decade could leave the PCT needing to find £100,000 million in cuts elsewhere to fund the PFI scheme.

In this document we detail many of the problems with the PFI scheme. We predict it will result in major damage to the NHS locally because of the drain on resources of the local health economy. Our prediction is based on the already established facts about PFI schemes around the country, and the details provided about this scheme.

This document outlines the 10 key reasons why the PFI scheme is not an answer to the health issues facing our area

- It is a very costly scheme
- It has ‘the wrong type of beds’
- It takes away money needed to develop community services
- The design has many of the problems of other PFI hospitals
- The contractors involved have an unenviable track record
- Concessions in the scheme will squander NHS assets
- The figures on PFI vs public funding don’t add up
- It doesn’t consider staff and the quality of care they give
- It will drain resources out of the NHS locally

Our conclusion is **not** that the development of a new specialist children’s hospital should be stopped – decisions already made mean we could not ‘turn the clock back’ even if we wanted to.

Neither do we conclude that a smaller development of acute hospital services in the area is needed – we believe that the predictions of greater need for acute beds (as well as for services in the community) because of an aging population are accurate and well-founded.

We do, however, conclude that there is a better way to produce the right result – to insist that real investment should be made though public borrowing, and that the control of services should remain with the NHS.

A public sector alternative would not just be cheaper, it would allow for more flexibility over time, and would keep the control and planning of services in the hands of the health service, not put it into the hands of unaccountable private sector firms.

We believe this PFI scheme should be rejected – and the case made properly for a positively public alternative.

1. A very costly scheme

The latest estimated cost of the planned new 1622-bed hospital complex to replace Manchester Royal Infirmary, Manchester Children's Hospital, the Eye Hospital and the continued accommodation of mental health services, is £422m, making it the most expensive hospital project so far in England. It is nearly double the cost of the 953 bed Norfolk & Norwich Hospital, which opened in 2001.

If the additional £73m of enabling schemes, funded by the NHS, are included, the entire Central Manchester project carries a cost of £495,000,000.

However the total amount to be paid over the 38 years of the contract with the PFI consortium is far in excess of this. Index-linked annual payments to the consortium for the use of the building and for support services will begin at £47.47 million per year, and rise by a minimum of 2.5 percent each year. This means that the minimum cash payment over the 38-year period would be almost £3000,000,000. This makes it a very expensive way of obtaining a new £495,000,000 hospital.

By year 10 the annual payments to be made by the Trust would have inflated to £58m a year, by year 20 to £74m, by year 30 they would be £95m and from at least year 33 the Trust would be paying over £100m per year – £2m per week – for the hospital and support services.

The capital cost of the overall scheme is substantially higher than proposed in the Outline Business Case given only four years ago. Then the total headline cost of that scheme was put at £250m, itself a substantial increase on the £164m scheme first outlined in the Strategic Outline Case.

Perhaps even more significantly, the economic impact of the new version of the scheme represents a dramatic variation from the modest promise of an overall £2m cost saving for local purchasers outlined in the OBC: in the Final Business Case the £2m saving has been transformed into an ***additional cost*** of £20m per year (also index-linked), half of which will fall to Central Manchester PCT.

There have also been warnings that any further delay in sealing the deal could see even further increases in costs and the fees to be paid by the Trust. On top of this, there will be transitional costs involved during the completion of the project, which will again fall on the main PCTs which refer to the Trust.

We note that £52m of the £422m headline cost of the project is claimed to represent "inflation" since 1999 on the new, higher base figure of £370m: this represents a cumulative inflation of over 14 percent, while in practice general price inflation has been much lower than this. This additional cost built in to the scheme – and to be paid off, with interest and further inflation added, over the next 38 years – represents one of the ways in which the NHS is effectively being required to carry the financial risk involved in the prolonged delays stemming from the PFI process.

We further note that the majority of the £119.5m additional cost of building the new scheme is put down to the costs of expanding and improving the hospital to meet local and national requirements, notably an increase in the overall totals of bed numbers (adults up by 13 percent, children's by 14 percent).

However this expansion of around 14 percent in capacity appears to require an increased investment equivalent to 48 percent of the cost of the original planned project, even before inflation is taken into account. This serves to underline the extent to which this scheme is both costly and inflexible.

2. The wrong type of beds?

We welcome the proposal to increase bed numbers in line with more recent government policy since the National Beds Inquiry, which further illustrated the unrealistic planning premises for the first-wave PFI hospitals, most of which embodied very large reductions in acute bed numbers. (A number of PFI hospitals have subsequently been obliged to look at converting office or workshop space into wards, building extensions, the use of temporary buildings (Carlisle, Swindon) or forcing old wartime huts or 'surplus' old hospital buildings back into use instead of demolishing them (Hereford, Worcester, Edinburgh).)

However the way in which the various totals of bed numbers are presented and calculated in the Central Manchester FBC is inconsistent between different business case documents, making it hard to compare like with like (see Table 4 Executive summary p12, 3-1). We note that Eye Hospital and Women's Hospital beds are sometimes listed separately and other times apparently included in global totals. Sometimes mental health beds, run by another Trust, are included on the list (6-7). The number of rehabilitation beds proposed and whether they represented an increase or like-for-like replacement was unclear to the PCTs initially. This is not helpful.

It does appear from the figures presented that within the general increase in adult inpatient bed numbers there is to be a very substantial (26 percent) ***reduction*** in numbers of front line acute beds (6-3). While we note that there is to be an increase in dedicated elective (mainly day case) beds and claims of an increase in rehabilitation beds, this is not replacing like with like. Elective beds – while valuable and necessary as a part of the Trust's capacity – are by definition unsuitable for treating emergency cases – yet this acute capacity is being cut back.

A similar pattern is clear on children's beds: it is clear that under the FBC there would be 12 percent ***fewer*** inpatient beds, with an increase in short-stay and other beds (6-4). It is conspicuous that the comparative numbers and percentages are missing from many of the figures that are provided (6-4, 6-5).

These reductions in front-line acute beds come despite the fact that over the last few years, numbers of emergency admissions to what is now the CMMC Trust have remained broadly stable (with a peak in 1999-2000). This pattern gives little support to the notion that beds are less important for efficient functioning, or that hospitalisation levels are on the decline.

Moreover, as a look at the most recent available figures for the Trust will confirm, adult emergencies as a percentage of admissions are if anything on the increase, while children's emergency admissions remain at around a third of total episodes (Table below).

The FBC sets out no plans to explain how the new hospital would use short-stay beds to accommodate emergency admissions of either adults or children: we must therefore assume that the reduced number of "full" acute beds would come under severe pressure from this emergency caseload.

Central Manchester FCE caseload figures 1998-2002				
	1998-9	**1999-2000**	**2000-01**	**2001-02**
CMHT	81367	81373	75150	
Emergencies	15460	17088	15782	
Elective	65907	64285	59369	
day cases %	42	43	45	
Children's	28964	28989	30070	
Emergencies	10717	9856	10224	
Elective	18247	19133	19846	
day cases %	28	32	34	33
Totals				
Emergencies	26176	26945	26005	29399
Elective	84155	83417	79215	75598
day cases %				33
	110331	**110362**	**105220**	**104997**
% emergencies	**24**	**24**	**25**	**28**
Source: Department of Health HES tables				

The proposals on children's services do appear inconsistent. A proportion of the Trust's existing services expected to relocate to other Trusts (Salford and North Manchester), yet the FBC proposes a significant planned expansion in children's beds for precisely the type of elective treatment that might be expected to go elsewhere (1.5.2, 2-19, 2-20).

3. A new model of care?

The FBC makes clear that the planning assumptions underlying the changed profile of bed provision are based on the "Care closer to home" model from the government's National Beds Inquiry (2000) (2.4.17).

However even a cursory reading of that report and of the targets set out for improved efficiency in the FBC shows that the CMMC Trust alone cannot hope to achieve this alternative model of care: to do so requires the commitment and resources of primary care services, PCTs and community-based services and council-run social services.

The FBC also quotes the National Service Frameworks, and especially that for Older People (March 2001) which stresses the requirement for a new range of intermediate care services to be introduced "to prevent unnecessary admission to hospital or long-term residential care, and/or to enhance rehabilitation." (2.4.8, 2.4.14) Central Manchester PCT has been looking at the possibility of expanding such services.

Unfortunately the FBC proceeds from the unspoken assumption that a new, enlarged and improved infrastructure of services is to be put in place by other agencies, without spelling out the financial implications this might have for other NHS bodies and for local authorities, or establishing any clear framework of agreement on the scale and type of services that will be required.

The FBC also echoes the error of the National Beds Inquiry in drawing little distinction between the (falling) use of in-patient surgical beds (as a result of growing levels of day surgery) and the (rising) proportion of beds occupied by medical patients, the large majority of them admitted as emergencies.

Instead it singles out the misleading conclusion that "the use of hospital beds has fallen" (2.4.13) – despite the fact that as we have seen the numbers of emergencies at the Trust have remained fairly consistent, and emergency admissions have risen as a proportion of the Trust's caseload.

The FBC also quotes the National Beds Inquiry's argument that:

> "For older people around 20% of bed days are probably inappropriate if alternative facilities were in place." (2.4.13)

However this is a big "if". The question that immediately arises from such an assertion is ***whether*** the alternative facilities will be in place, ***where*** they would be, and ***who*** should provide them. It must be unacceptable for a major acute Trust to seek to improve its own performance at the expense of landing additional responsibilities and caseload onto other Trusts and PCTs without explicit agreements ensuring that sufficient funding and other resources are available.

Further referring to the National Beds Inquiry, the FBC goes on to set out a number of targets including:

- "A reduced rate of growth in emergency admissions for older people, as a result of ***increased provision of primary and intermediate care services***."
- Further reductions in length of stay, particularly for older people, due to a reduction in bed days for recuperation and rehabilitation, ***which would be provided in non-hospital settings***." (2.4.16)

These objectives will receive general support from most patients, their families and from many sections of NHS staff. Yet despite the assurance in the FBC that the Trust has used these and other findings from the National Beds Inquiry as the basis for the reconfiguration of the hospital since the OBC was approved, there is little evidence to show that any joint plans have been developed or even objectives shared with PCTs, GPs and social services.

Indeed, far from explaining where investment will take place in expanded provision of non-hospital recuperation and rehabilitation, it appears that the FBC proposes tying the local PCTs to commissioning ***hospital-based*** rehabilitation for their residents:

> "Within the new Adults Hospital rehabilitative care will account for approximately 10% of total adult beds and will be particularly tailored to the needs of elderly patients with co-morbidities.
> "The new service model emphasises ward-based rehabilitation …
> "The specialist rehabilitation centre … will be augmented by ward-based rehabilitation." (5.6.2-4)

The FBC does not show how this model of rehabilitation fits with the strategy of local PCTs to develop services closer to home – and less like hospital – for those older patients who require them.

On the contrary, it is likely that the rising costs of the PFI scheme, necessitating a larger slice of PCT funding to flow directly into acute care, could cut across any plans for substantial expansion of community-based services and enhanced provision of primary care support for frail older people.

A number of first-wave PFI hospitals were also premised on the expansion of local community health care services to facilitate a sharp reduction in the provision of acute hospital beds – only to find that the heavy costs of PFI schemes themselves constrained community health care budgets, and prevented the necessary investment in improved services. The result has been a succession of brand new hospitals with dozens of beds "blocked" by delayed discharges of older patients. Unfortunately it does not seem as if the lessons of these negative experiences have been taken on board by the planners of Central Manchester's later, bigger, and much more expensive PFI scheme.

The government has attempted to reduce delayed discharges by putting additional pressure on social services to ensure sufficient supporting services are available – or face "fines" for every day a discharge is delayed. Rather than attempt any analysis of the implications of this in Manchester, the FBC seems merely to assume that other organisations will invest the resources required.

This seems less a move towards a seamless service than an abdication of responsibility by the Trust, and a failure to establish the kind of partnership between NHS and local government that local people might reasonable expect

4. The hospital: what you see is what you get

Under the heading of "consumerism" the FBC attempts tacitly to correct some of the more glaring errors made in the first wave of PFI hospitals. The new guidance urges greater space in patient areas, and better quality buildings – adding 12-13 percent to the cost of the scheme (2.4.26, 4.10.3) This arises from the experience of poky wards, corridors and clinical spaces in most PFI hospitals and early evidence that the construction, far from "engineering in quality" as the public were led to believe, has often used the cheapest possible materials and equipment, creating problems for patients and for staff.

However the proposals mapped out for the building appear to have learned little or nothing from the bitter experiences of the preceding PFI-funded hospitals (or indeed from previous publicly-financed schemes prior to the most recent "smart procurement" techniques, which have ensured that the small number of publicly-funded NHS hospital developments are running to time and to budget).

The focus of any successful procurement system has to be ensuring the fullest and most precise specification of the requirements from the new building is set out in detail in advance, and this in turn has to draw on the experience of the full spectrum of staff currently delivering services for the Trust.

The golden rule – exemplified by the state of the art operating theatre that was built without lights in Edinburgh's PFI-funded Royal Infirmary (with lights later added at extra cost) – is that what you see in the contract is what you get: if the Trust's requirements are not agreed in writing, no amount of well-meaning talk about 'partnership' with the private sector will fill in the resulting gaps. Mistakes can prove very expensive to put right once the building has been completed.

This means it is necessary to scrutinise the FBC closely for evidence that this approach is being taken in the Central Manchester scheme, and that all the likely problem areas have been identified. Unfortunately it appears that this has not yet been done, and that what has become a general pattern of design flaws and quality problems in first-wave PFI hospitals seem set to be reproduced on a greater scale and at far higher cost in Manchester.

The most common problem, affecting most – if not all – PFI hospitals is a desperate shortage of office space: buildings are planned and designed around the clinical areas and the "income streams" flowing to the PFI consortium from car parking, retail and catering outlets, with little apparent consideration for the "invisible" workforce of clerical, secretarial and administrative staff, who facilitate the work of the caring professions and without whom the service could not function.

In many cases – notably the Norfolk and Norwich hospital, Carlisle's Cumberland Infirmary, the Edinburgh Royal Infirmary and Worcestershire Royal Infirmary – allocated office space has been so inadequate that it has proved necessary to convert cupboard and storage space. Staff working there have been given little in the way of windows, daylight or ventilation. In Swindon's Great Western Hospital, much of the planned office space had to be converted at the last moment to additional wards and clinical areas, leaving admin staff working from prefab cabins in the car park and other temporary accommodation.

The 300-plus pages of the Central Manchester FBC and its appendices are conspicuous for making no reference whatever to office space, giving grounds for real concerns that no adequate provision has so far been made.

There are even greater reasons for concern when it appears that the PFI consortium, as in first-wave Trusts, is proposing to take exclusive responsibility for supplying, installing and maintaining fixtures and fittings such as shelves and clocks.

The new hospital seems set to be another PFI-funded project in which the fabric of the building is jealously defended as the property of the consortium and not the NHS, and in which as a result alienated NHS staff are forbidden to put up shelves or hang any calendars, charts or any form of decoration on the walls. The result in many new hospitals has been cramped offices in which disgruntled medical secretaries and other clerical staff struggle to cope with chaotic heaps of notes and documents stacked precariously on the floor for lack of sufficient suitable shelving. This in turn can compound problems of recruitment and retention of staff and create inefficiencies and delays in communication with patients.

Nor is the FBC explicit about the arrangements for medical records. The Trust, in accordance with national government policy aspires to the (as yet unattainable) goal of the "electronic patient record"

> "In order to support patient care the IM&T strategy looks to provide a clinically led patient focused electronic patient record (EPR). This solution will facilitate patient orientated processes, which are efficient and effective; an EPR solution, which is easy for clinicians to use as part of their day-to-day care of patients within the Trust and across organisational boundaries." (20.6.4)

However the FBC does not appear to stipulate sufficient space to accommodate the existing, pre-electronic medical records.

This has also proved a stumbling block in other PFI hospitals, notably Carlisle, where the space allocated to medical records was so dangerously cramped that additional office space had to be rented off site on a nearby industrial estate, incurring extra costs and creating major problems for emergency admissions. In Bishop Auckland, where a modern records department was bulldozed to make way for the new PFI hospital, records were "centralised" miles away in Darlington, again incurring extra overhead costs for the Trust.

Any hope of ensuring the Trust sets new improved quality standards and reduces levels of medical negligence require a continued full availability of properly accessible medical records on site: this must be spelled out and agreed.

While office space is crucial, so too is adequate storage space for equipment, linen, laundry, drugs, other supplies and notes on the wards and in outpatient areas – and this has been a major problem in many PFI hospitals. Stocks that are not properly stowed away may well be stacked up on the floor or on trolleys that can obstruct gangways, corridors and public spaces, creating hazards for staff and patients. Notes not properly stored can open dangers of breaches of confidentiality, or simply get damaged or lost.

Among the other false economies which have been incorporated in the design of first-wave PFI hospitals has been the erection of smart-looking glass-fronted buildings which create major problems with insulation – but lack air conditioning. This has been a particular problem in Carlisle, in Edinburgh and in the Norfolk & Norwich Hospital, where extremely high temperatures have been recorded in offices, kitchens, and glazed areas. A local newspaper reported temperatures "hotter than the Sahara" on one occasion at Carlisle's Cumberland Infirmary, affecting elderly patients in top floor wards as well as other staff, patients and visitors. The same areas tend to be correspondingly cold in winter.

However we note that while the Central Manchester FBC makes repeated references to "light-filled" entrance halls (10-10, 10-19 etc) there is no mention at all of air-conditioning. We also note that the decision not to incorporate air conditioning at Swindon's Great Western Hospital was made by the PFI consortium, on grounds of cost. The experience so far suggests that this is a false economy, and that problems in the insulation and ventilation of the building are more cost-effectively tackled at the design stage than after an uncomfortable and inefficient building has been completed. The health and recovery of patients is thus put at risk, especially the more vulnerable patients. The rehabilitation process will also be hampered by these harmful building designs

Another missing element in the FBC is an on-site kitchen, without which the quality and choice of food available to patients is likely to be more limited. (More on this below).

5. The contractors: an unenviable track record

The Catalyst consortium which is proposed to finance build and operate the new hospital would have its facilities management carried out by French-owned conglomerate Sodexho (the British subsidiary of which, Sodexho Ltd, was formerly Gardner Merchant).

Sodexho Ltd enjoys revenues of £757m a year, and last recorded profits of £39.6m – partly down to the extremely low pay rates for its 39,600 employed staff, whose average wage was just £8,810.

The company already supplies contract services to a number of NHS Trusts, though its half of this contract income remains located in Gardner Merchant's former area – catering.

Despite a relatively limited number of NHS contracts, Sodexho has acquired an unenviable reputation among NHS staff and trade unions, and was embroiled in a major pay dispute in North Glasgow University Hospitals Trust last year, in which the company unsuccessfully attempted to bring in strike-breakers rather than meet the demands of their staff for parity with directly-employed NHS support staff – a minimum of £5 per hour, sick pay and a 20 percent shift allowance.

In South Glasgow, Sodexho's cleaning contract was terminated last year and services brought back "in house" after a Scottish executive inquiry triggered by three deaths and a salmonella outbreak declared the cleaning standards as "inadequate". In Fife, too, Sodexho lost an acute hospital cleaning contract in April 2002, with services returned "in house" at the end of the contract term.

At the Royal Liverpool University Hospitals Trust Sodexho's cleaning standards have been given a "red" (poor) ranking by government inspectors, and staff last year protested at low pay of just £4.15 per hour.

Perhaps it is the record in two of the PFI projects in which the company has been involved that gives most concern about Sodexho.

In South Manchester, where they have the cleaning contract for Withington Hospital, they also received a "red" warning from inspectors, while the Community Health Council last summer complained at cleaning standards. They had found stains and debris on the floor of an acute ward, and stained toilet seats, dust, debris under beds and open waste bins used to wedge open fire doors in a high observation ward just after it had allegedly been cleaned.

Sodexho also has the facilities management contract at Hereford's new PFI hospital, where staff on Sodexho contracts complain of receiving no sick pay even if they are injured at work, high turnover of staff, poor staffing levels and rock bottom morale. For several weeks the laundry service in the new hospital had to be run by managers from the domestic and portering departments because of the lack of staff.

We note that Sodexho is also to take over responsibility for laundry and linen services, which would be provided to Central Manchester from Sodexho's "in-house" laundry at Withington Hospital. Running such services from a remote site places greater demands on storage space and on continuity of the service – both of which may be open to question in the light of experiences elsewhere.

While the FBC makes clear that support services staff would remain as NHS employees, and seconded to Sodexho under the Retention of Employment policy, the management of the services would be in the hands of this company, giving few grounds for confidence that quality in hygiene and patient care will be maintained.

The very poor conditions offered under Sodexho's own standard contract also raises concerns over the company's willingness to fill any vacancies that might arise among the seconded staff, since – like contractors in other PFI hospitals, which have attempted to squeeze out staff on preserved NHS terms and conditions – they may see it as preferable to fill vacancies by employing staff directly on less secure terms and lower hourly rates.

Despite Gardner merchant's origins as a catering company, the FBC makes plain that meals other than the most basic salads and snacks will not be prepared on the premises, but – as with most PFI hospitals – manufactured in a factory elsewhere and transported to the hospital for regeneration. This is described as "the delivered meals principle"!

In this case all meals will be cooked almost 200 miles away in Abertillery. Experience from other PFI hospitals is that such catering systems alienate and demoralise catering staff, whose jobs are de-skilled and devalued, and antagonise nursing staff , who find many older patients are less than impressed with the varieties of food on offer.

A recent ***Observer*** article exploring the qualities of French hospitals by comparison with those in the UK underlined the extent to which the economies sought as part of the privatisation of services in this country can cut against the quality of care for patients:

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

But there remains a further, wider-reaching cause for concern over support services. Not only are we not told how much of the £47.47million index-linked annual fee for the hospital would be to cover the Facilities Management contract [or how much is currently spent on the Trust's equivalent support services] but the FBC gives no guarantees on the numbers of staff that would be employed in what are inevitably labour-intensive services. (Fig 17-4) The local economy and the health of the lowest-paid and their families will not be improved by a round of redundancies among NHS support staff in order to boost the profits of Sodexho shareholders.

There is every reason to be concerned that in terms of facilities management the Trust may be buying a pig in a poke. There are very few details on how the service would be staffed, how much it would cost, and even fewer on what options would be open to the Trust if Sodexho, which is part of the consortium that will own the hospital, is found to be failing once more in the delivery of specified standards.

6. The consortium, the land and profit streams

The Catalyst consortium has been involved in three other FI hospital projects, Calderdale, Worcester and the small hospital in Hexham.

The controversial £116m Worcestershire Royal Infirmary involved the sale of the old Ronkswood Hospital and the Castle Street site to Catalyst for £4.5 million. Castle Street hospital was a neglected old building, a former workhouse, but the front of the building is Grade II listed, the original BMA building, and the back has views of the river and racecourse – making it a prime development site and a very lucrative additional source of profit for the consortium.

The site of the new hospital has also been bought by Catalyst from the Trust, but in addition to the hospital itself three office blocks for private companies have also been erected on the site, along with dedicated car parking. The offices obscure the frontage of the hospital.

The space remaining for hospital car parking has as a result been severely constrained, while Catalyst derives all of the income from the office development on what was NHS land.

Catalyst is not the only PFI consortium to reap additional benefit from the land component of a hospital scheme. The PFI scheme for the new Edinburgh Royal Infirmary resulted in the consortium picking up redundant hospital sites for just £12 million that are now valued in excess of £200 million – enough to have paid for the entire new hospital without any PFI involvement.

The Worcester hospital itself has been described by staff as "like Heathrow, but with office staff working in cupboards". Despite a vast, largely empty glass atrium, upstairs the corridors are so narrow that two trolleys cannot pass without one pulling over and stopping. Bed numbers are so inadequate that old hospital buildings that should have been closed and demolished are still in use.

It seems clear from the Worcester experience that Catalyst's concerns to exploit the profit potential of the site were uppermost in the eventual project, and from this standpoint there are obvious concerns at the various profit streams that have been identified within the Central Manchester FBC.

As with many other PFI consortia, Catalyst proposes a number of initiatives to generate additional income including revenues from:

- Catering
- Car parking
- Commercial retail developments

We are not convinced that the Trust has secured the best possible deal on these potentially very valuable concessions, but we also note with concern that Catalyst have put forward proposals to utilise certain of the surplus land and buildings on the CMMC estate, including the potential redevelopment of the St Mary's and Royal Eye Hospital buildings. In the light of the Worcester experience, in which NHS assets have been sold to the consortium at a rock-bottom rate, we are far from convinced that conceding these parts of the estate to Catalyst represents a good long-term deal for the Trust.

While Catalyst have assumed a £300,000 per annum contribution towards reducing the unitary payment for these proposals, it is safe to assume that they have identified ways in which they will recoup far more than this from the redeveloped sites.

7. When is a comparator not comparable?

The section outlining the so-called "Public Sector Comparator" (PSC) is especially unconvincing, making it clear that the Trust is going through the motions of complying with the Treasury's requirements, rather than genuinely comparing ways of delivering the required development.

It is clear that the Trust has drawn the understandable conclusion that with over 90 percent of new hospitals now being funded through PFI there is little if any real prospect of securing public funding for the central Manchester project.

Conspicuously absent is any side-by-side checklist or other direct comparison to show the similarities and differences between the two schemes, although it is clear that there is more emphasis in the PSC on the retention of almost 500 beds in existing buildings. Interestingly the costings for the capital project come out at more or less exactly the same for both PFI and PSC. (8.4.1)

However the calculations of the comparative costs of the PFI and the PSC have been carried out based on a now outdated assumed discount rate of 6 percent. (11.4.3, 13.1.3) This figure has for years been widely cited by critics of PFI as unrealistically high, and one of the ways in which the figures are "fiddled" to make PFI appear better value than a publicly-funded scheme.

However new government guidelines (contained in the revised Treasury Green Book, October 2002) and which came into force in 2003 have now revised the discount rate downwards to 3.5 percent.

According to former Trade Secretary Stephen Byers (*Guardian* June 3), none of the first 11 hospital PFI schemes that have been built so far would have been allowed to proceed if the new 3.5 percent figure had been in force when they were considered.

In the case of the Central Manchester FBC it is clear that even with the 6 percent discount rate there is little significant advantage in the PFI scheme: before adjustment for "risk" the PSC is cheaper over 40 years, while after the "risk" element is added to make the PSC appear more expensive, the total PFI 'savings' amount to just 0.4% of the total discounted cost over 40 years. (13.3)

The FBC with its various empty appendices does not give enough detailed figures to give an opportunity to recalculate accurately using the new 3.5 percent discount rate, but a rough estimate suggests that it would increase the overall discounted cost of the PFI scheme by 40 percent over 40 years.

This would make PFI more expensive than the PSC, even assuming the PSC were in turn inflated by a massive 28 percent in line with more controversial Green Book guidelines, designed to compensate for unrealistic "optimism" in historic publicly-funded schemes.

In other words the available figures do not make the case for PFI funding, either as representing a significantly cheaper option or as value for money, even if the proposed £47.47m unitary payment is judged to be affordable.

8. Discarded options that may save millions

We are concerned that other ways of financing the hospital development have equally been rejected – despite the fact that they could result in considerable cash savings.

The government is able to borrow money at substantially lower rates of interest than the private sector. Its internal borrowing rate is as low as 2 percent (also the level at which money can be borrowed in international markets such as the Far East). Initial calculations suggest that if the new hospital were financed as a mortgage repayable over 25 years the

building itself would cost around £600 million at 3 percent (with annual payments of £24 million).

Commercially advertised mortgages as this response is drawn up offer rates ranging from 4.7 percent (First Direct, internet July 4 2003) to a rate of 5.09 percent guaranteed for 25 years (Manchester Building Society, advertised *Observer Cash*, June 29 2003). A 25-year loan to build the hospital would cost £28.7m a year from First Direct (a total of £718m) or £29.9m from our local lenders – a total of £747m over 25 years.

Even if we add in the likely costs of support staff and maintenance over the same period, financing the new hospital in this way would yield substantial savings to the Trust and the wider NHS – and would pay off the cost of the hospital over 25 rather than 38 years, throughout which it would remain public property under the undisputed control of the NHS.

The possible savings if the government advanced the cash at 3 percent could be as high as £600 million compared with the PFI option. The Manchester Building Society option could generate savings for the NHS in excess of £400m compared with PFI.

Why have alternative ways of financing the project not been explored by the Trust? Why is there no discussion of a publicly-funded hospital rather than the spurious Public Sector Comparator?

The FBC carries all the trappings and weight of a careful analysis, but in essence it is a long argument focused on justifying just one intended outcome. We are not convinced it offers the best way forward for services and people's needs in Manchester.

9. Support services, staff, quality and care

While there might appear to be some argument in favour of the consortium that owns a hospital building directly employing the staff who will maintain it, we are concerned about the whole process through which the Trust appears to have decided to include Facilities Management in the PFI scheme (FBC section 18).

Once again this appears to be a process in which only one outcome has been seriously considered: indeed it seems that the only reason sterile supplies will remain in-house is because the private contractor withdrew.

We note a number of contentious assumptions, notably the declaration that:

> "The services to be included should have a track record of effective delivery by FM operators and provide opportunities for improvements in service quality and VFM" and
> "This is a large and complex project and therefore as far as practical, the services element should be kept simple, aim to add value and be attractive to the private sector." (18.2.4)

There is an abundance of evidence available since competitive tendering was first introduced in the mid 1980s for NHS cleaning, catering laundry to question the extent to which these services "have a track record of effective delivery by FM operators" – with Sodexho prominent among the names of companies involved in a growing list of recent failed contracts.

Nor do we see it as the proper role of the Trust to be shaping up the profile of support services in order to make it more attractive for private providers – especially since with Catalyst and Sodexho already selected as the preferred providers there is no competition for these services.

While private contractors involved in competitive tendering often appear to offer a cut-price service compared with in-house NHS staff, this is almost always at the expense of poorer terms and conditions and higher levels of work effort by the staff concerned, and seldom if ever linked to measurable improvements in quality.

The experience in PFI hospitals where support services have been privatised has frequently been of rock-bottom staff morale, problems in recruitment and retention of domestic staff, inadequate standards of cleaning (Withington), and the imposition of unpopular and questionable "generic working" practices which can create potential hazards for patients (such as porters in Carlisle being called on to switch from cleaning toilets or collecting rubbish to serving patients' meals).

We are concerned also to note therefore that among the "anticipated service improvements" are measures that have alienated staff and undermined standards of services in other PFI hospitals:

> "The merging of certain domestic catering and portering activities
> "The purchase, instead of production, of bulk catering services" (18.2.10)

The bias towards the privatisation of "soft" FM services continues in the arguments set out in Fig 18-3:

- Once again the objective is declared to be attracting the private sector and the spurious claim to "generate competition"

- The claim – unsupported by any evidence in existing PFI hospitals – that "the private sector will approach a design and build project differently to a design, build and operate project. … An example being spending more in the capital development phase in lieu of lower maintenance, cleaning and operational costs later in the concession period."

- The bogus claim that "some soft FM services will be difficult to operate if they are uncoupled from hard FM services. For example portering relies on the design of access points, the operation of mechanical locks and CCTV". (The logic of this argument is that no private contractors should be delivering services in NHS hospitals where the company has not already designed the building. In fact porters are among the harshest critics of the design and build quality of the PFI hospitals already completed.)

- The ridiculous warning that if they don't get the contract for soft FM services, the private consortium might increase the rent on the new hospital, on the grounds that there would be a "risk" that NHS domestics or porters might damage it and put the hospital out of action!

After stacking the argument dramatically in favour of privatisation, the FBC goes on to rule out even formulating an in-house bid against which the privatised service would be

compared. One of the specious arguments to justify this is that if the in-house bid proved more attractive than the privatised alternative,

> "There may be an issue as to whether the Trusts can withdraw hotel FM services at a late stage in the procurement."

Indeed the fragile feelings of the private sector might be offended by the very act of carrying out a comparison, and there might therefore be no bid from the private sector:

> "The Trusts may not get a committed hotel services supplier if they feel their participation in the process is in doubt."

The limited 'comparison' that the Trust is to undertake is also admitted to be completely one-sided, because the FBC rules out any notion that services currently managed by the private sector could be brought back in-house:

> "Exclusion of soft services would be counter to existing practice."

And to make it quite clear that the entire exercise has excluded from the very outset the option of in-house support services the FBC points out that privatisation will also offer the private sector "an early income stream prior to the finale scheme completion."

We are not at all convinced that this type of approach can secure value for money in the new hospital project. We note than in Durham the Trust converted the jobs of ward-based domestics in order to keep them within the NHS and incorporate their skills into ward teams. Nothing could be further from the approach of the Central Manchester FBC, which seems fixated on privatisation.

Perhaps the most bizarre sentence is the one on page 18-5 which declares that:

> "Advisor intelligence advises the private sector will be able to meet the CMMC large agenda and expectations."

Who are these unnamed "advisors"? What was their brief? How much were they paid for this advice? Why should the people of Manchester be convinced? It might be just as useful to point out that the views of all health trade unions, the Royal College of Nursing and the BMA is that PFI does not represent value for money.

Numbers matter

The quality of care that can be delivered to patients in the new hospital will depend upon its ability to recruit and retain high quality and dedicated staff – medical, professional, technical, and all the varieties of support staff who make up a hospital team.

While we have noted that the FBC gives no guarantees on numbers of support staff that will deliver "soft" FM services, there is an assumption (Fig 17-4 and following) that the new hospital will employ more consultants, nurses, professional and technical, admin and clerical and nursing support staff. We hope that these increases in staff can be delivered: yet the experience of first wave PFI hospitals is that the new conditions they bring can compound or even create problems in staffing.

The first challenge for the Trust will be to retain its existing staff, and persuade almost a quarter of its children's services workforce to transfer over to the new hospital. (17.6.2-10) It might be prudent in this regard to note the negative experiences of many first wave PFI hospitals which have struggled, and sometimes failed, to convince staff to stay on.

The new Worcester PFI hospital ran up such a huge bill for agency nursing staff that the Trust plunged £6 million into deficit last year. Staff shortages have also been part of financial problems in PFI hospitals in Carlisle, Hereford and Durham. Most Trusts with PFI hospitals are facing substantial cash deficits.

It appears that far from attracting additional staff the unpopularity of PFI and the uncongenial changes to working practices mean that the new hospitals have found it harder than ever to keep the staff they need. Ancillary staff, too, especially domestics, have shown themselves ready to walk away from tough working conditions, increased workload and the hard-line management of private contractors.

There is nothing in the FBC to persuade us that this will not also be the case in Central Manchester: PFI therefore represents a big gamble with the quality of care the Trust can deliver, and its long-term ability to meet government performance targets.

10. Back to money: cash siphoned out of NHS

We have noted above that the FBC lacks the detailed figures on support services and other items for us to be able to calculate the likely profit margins for Sodexho or for Catalyst as a whole: but it does appear that financing the new hospital through a mortgage and delivering support services in-house would deliver a far cheaper and more flexible project to the Trust – and that any money spent over and above that can be seen as diverting resources from patient care.

We have also noted that all of the payments to the consortium would be index-linked at a minimum of 2.5 percent each year: but of course there is no guarantee that resources made available to the Trust would rise at an equivalent rate every year for the next 38 years. The government's recent reform to the financial flows within the NHS and increasing reliance on market-style methods could result in a standstill or loss of revenue from one or more of the CMMC Trust's referring PCTs. Future political changes, economic or financial pressures could also cause problems – for two years in the 1980s overall real terms NHS spending declined.

We note in this context that the legally-binding PFI deal will commit the Trust to paying the index-linked unitary charge to the consortium leaving only clinical services under the Trust's day to day financial control.

We further note that the FBC assumption that the new hospital will be "off balance sheet" has been the subject of controversy among accountants and government advisors. This distinction is however important to the affordability of the deal, since it is on the basis of no longer owning the assets of the hospital that the Trust can hope to switch £18m a year currently paid in capital charges to part payment of the PFI unitary charge.

This however has a longer-term impact on the NHS, since the capital charges would no longer be circulating within the orbit of the public sector, but would flow out to bolster the profits of Catalyst and the dividends its component companies can pay shareholders.

In short it appears that not only is PFI a high cost solution to financing the new hospital, but it is one which appears to solve capital shortages in one Trust at the expense of the wider NHS, and by reducing the available resources for local PCTs.

Conclusion

Before deciding to press ahead with such a huge and expensive project the PCTs and the Strategic Health Authority need to satisfy themselves and the people of Greater Manchester that the Trust has taken on board all the necessary lessons from similar ventures elsewhere, and that the deal is both value for money and affordable over the lifetime of the contract.

We have shown in this response a number of ways in which this has not been achieved in the FBC.

- The latest costings incorporate increased building costs equivalent to 48 percent of the OBC cost, while adding just 14 percent additional beds. The additional amounts added for "inflation" represent increases well above recent inflation levels. The project will now drain extra cash from other health care priorities of local PCTs in place of the modest savings originally promised.

- The plans incorporate a cut of more than a quarter of the adult in-patient beds and 12 percent of children's acute beds, despite constant or growing levels of emergency admissions.

- The FBC offers vague proposals which hinge on increased primary and intermediate care services in non-hospital settings – but concrete plans for increased numbers of rehab beds in the new hospital. There are grounds to fear that the larger slice of resources for this high-cost hospital will result in smaller allocations of cash for precisely the intermediate and primary care services that are needed.

- There are grounds for concern that the FBC has failed to specify clearly enough the details of the new hospital which have proved problematic in many first wave PFIs – notably office space, storage space, air conditioning .

- The consortium's "soft FM" service provider, Sodexho, has an unenviable track record of recent contract failures in NHS hospitals in England and Scotland, including problems with PFI hospitals in Hereford and South Manchester.

- Catalyst itself, like other PFI consortia, has shown its willingness to profit from land and property transactions with the NHS over and above the profits to be made from the design, build and operation of PFI hospitals. We do not see evidence that such problems are not to be repeated in Central Manchester, or that the Trust has got the best deal possible on additional revenue streams for car parking, catering and commercial retail concessions which will flow into the coffers of Catalyst.

- The FBC uses out-dated figures and assumptions in calculating the costs of the PFI scheme as compared with so-called Public Sector Comparator. It seems that if the more up to date figures are used the public sector scheme is significantly cheaper than PFI.

- The Trust appears to have discarded in advance and without serious debate the notion of retaining support services in-house. Nor does the FBC examine other

probably cheaper ways of borrowing the capital for the new hospital without the inflexibilities and overhead costs of PFI.

- There is no evidence that PFI hospitals lead to improved staffing levels: rather they may even make problems worse.

- The questionable assumption that the new £400m hospital could remain "off balance sheet" is vital to the financial viability of the Trust's plans, but would result in NHS capital charges being siphoned out of the NHS, with long term costs for the service as a whole.

In short, far from confronting obvious problems and breaking new ground with innovatory solutions, it appears that the Central Manchester project is in danger of learning nothing from previous similar projects – and thus reinventing the flat tyre.

While we are very keen to see a new hospital giving state of the art care to the people of Manchester, we are very worried that this scheme could be nodded through in haste only for local people and NHS staff to repent at leisure. If PFI is the answer, it seems that Trust managers, apparently egged on by their private sector "partners" in Catalyst, have been asking the wrong questions.

Central Manchester Community Health Council

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